CIF Completion

Page updated: August 2020

The Claims Inquiry Form (CIF) is used to request an adjustment for either an underpaid or overpaid claim, request a Share of Cost (SOC) reimbursement or request reconsideration of a denied claim. The CIF can also be used as a tracer. Use the *Remittance Advice Details* (RAD) as described below to reconcile claims pending follow-up:

- Underpayment or overpayment adjustments to a paid claim under RAD heading "Approves" (reconcile to *Medi-Cal Financial Summary*).
- Reconsideration of a denied claim under RAD heading "Denies" (do not reconcile to *Medi-Cal Financial Summary*).
- Trace a "lost claim" that does not appear on a RAD.

CIF examples of SOC reimbursement and Medicare/Medi-Cal crossover claims are included in the *CIF Special Billing Instructions* section in the appropriate Part 2 manual. For CIF submission information, refer to the *CIF Submission and Timeliness Instructions* section in this manual.

Exceptions to Using CIFs

CIFs may not be used for the following inquiries.

All Claims: Incorrect Provider Number

Do not submit a CIF for a claim that reported an incorrect provider number; for example, billing under an individual provider number instead of a group rendering number. Instead, rebill within the six-month billing limit or billing limit exceptions time frame. If this period has expired, submit an appeal.

All Claims Denied for National Correct Coding Initiative Edits

Providers may not use CIFs in connection with claims denied as a result of National Correct Coding Initiative (NCCI) edits. Providers must submit an appeal. Refer to the *Correct Coding Initiative: National* section in the appropriate Part 2 manual.

Pharmacy Claims: POS Network

Do not submit a hard copy CIF to reverse a pharmacy claim originally submitted over the Point of Service (POS) network unless you are returning an overpayment. Instead, reverse the claim over the POS network, then resubmit a corrected claim if necessary. For information about reversing claims over the POS network, call the POS/Internet Help Desk at 1-800-427-1295 or contact your software vendor.

Pharmacy Claims: RTIP

Pharmacy providers should not submit a hard copy CIF to reverse a claim originally submitted over the Real-Time Internet Pharmacy (RTIP) claim submission system unless they are returning an overpayment. Instead, they should reverse the claim through the RTIP system, then resubmit a corrected claim if necessary. Providers may call the POS/Internet Help Desk at 1-800-427-1295 for information about reversing claims through the RTIP system.

Inpatient Claims

Do not submit a CIF to request reconsideration of a denied inpatient claim if claim lines must be added or deleted. Instead, submit a new original claim within the six-month billing limit or billing limit exceptions time frame. If this period has expired, submit an appeal.

Compound Claims

Do not submit a CIF to request reconsideration of a denied pharmacy compound claim if ingredients must be added or deleted. Instead, submit a new original claim within the six-month billing limit or billing limit exceptions time frame. If this period has expired, submit an appeal.

Certain RAD Messages

Do not submit a CIF for the following Remittance Advice Details (RAD) code messages. Providers should submit an *Appeal Form* instead. A review by a person in the appeals unit is commonly used to resolve denials if the claim has a unique circumstance needing human intervention. Additional information is available in the *Appeal Process Overview and Appeal Form Completion* sections of the appropriate provider manual.

‹‹Table of RAD Codes and Messages››

Code	Message
0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
0010	This service is a duplicate of a previously paid claim.
0072	This service is included in another procedure code billed on the same date of service.
0095	This service is not payable due to a procedure, or procedure and modifier, previously reimbursed.
0314	Recipient not eligible for the month of service billed.
0326	Another procedure with a primary surgeon modifier has been previously paid for the same recipient on the same date of service.

‹‹**Table of RAD Codes and Messages (continued)**››

Code	Message
0525	NCCI (National Correct Coding Initiative) void of a column 2 claim previously paid when a column 1 claim has been processed for the same provider and date of service.
9940	NCCI claim line is billed with multiple NCCI modifiers.
9941	NCCI column 2 procedure code is not allowed when column 1 procedure has been paid.
9942	NCCI quantity billed is greater than the allowed MUE (Medically Unlikely Edit) quantity.

Completion Instructions for All Inquiries

The following steps are required when completing a CIF for all inquiry types:

1. Complete Boxes 3, 4 and 5 (Provider Name/Address, Provider Number and Claim Type).
2. Complete the lines on the CIF according to the type of inquiry (such as, reconsideration of a denied claim, underpayment adjustment or overpayment adjustment).

   Note: CIFs for SOC reimbursement, inpatient claims, pharmacy compound claims, Medicare/Medi-Cal crossover claims and tracers should be submitted separately (refer to “Share of Cost, Inpatient, Compounds, Crossovers and Tracers: Separate CIFs Required” later in this section).
3. Sign and date the bottom of the form and submit the signed, original copy of the CIF and all attachments to the California MMIS Fiscal Intermediary. CIFs submitted without a signature will be returned to the provider.

Denied, Under/Overpaid and Void Inquiries

Denied, underpaid, overpaid and void claim inquiries may be combined on one CIF. These types of inquiries each follow unique completion instructions and requirements for attaching documentation.

Correcting NDC/UPN Information for Physician-Administered Drug or Disposable Medical Supply Claims

To correct the National Drug Code (NDC) and/or Universal Product Number (UPN) information previously submitted on a claim form, complete Boxes 7, 8, 9 and 13 for each claim line being resubmitted. These are required fields. Boxes 10, 11 and 12 are optional fields. The corrected NDC/UPN information (Product ID Qualifier, NDC, Unit of Measure Qualifier or NDC/UPN Quantity) should be entered in the *Remarks* field.

Reconsideration of Denied Claims

To request reconsideration of a denied claim line after the six-month billing limit, complete Boxes 7, 8, 9 and 13 for each claim line being resubmitted. These are required fields. Boxes 10, 11 and 12 are optional fields. (Refer to “Delay Reasons” in the claim form submission and timeliness instructions section of the appropriate Part 2 manual.)

Attach a legible copy of the corrected original claim form, a copy of the RAD on which the claim line was denied and all pertinent documentation. In the *Remarks* field, enter the denial code and clearly state the reason the claim should not have been denied.

Underpayment/Overpayment Adjustments and Voids

A CIF adjustment should be used to correct both under and over payments. However, this transaction type is different than requesting a full payment recovery, which is a void. A CIF adjustment is a one-step process. If requesting an adjustment for an underpaid or overpaid claim, the adjustment is completed in one transaction, with the adjudication results appearing on a future RAD. The corrected Claim Control Number (CCN) will appear as a credit and a debit, and will be reflected on the same RAD.

A CIF void may be requested to fully recover or recoup monies paid. In many instances, the provider’s goal was to return funds to a Medi-Cal or specialty program. The CIF void accomplishes that in one step. However, there are cases in which the provider wants to void the original payment and submit a corrected claim. The CIF void is largely an automated process and cannot perform two functions. As a result only the void can be processed.

Note: Submitting a CIF void requires completion of Boxes 7, 8, 9, 10 and 12.

Providers requiring a void and subsequent resubmission of a corrected claim, use a two-step process. First, the CIF void must be submitted to recoup the full payment. Once the void appears on a future RAD, the provider completes the secondary step of submitting an *Appeal* to request processing of the corrected claim.

The *Appeal* must be filed within 90 days from the date indicated on the RAD on which the void appeared. The *Appeal* must include a corrected claim copy, a copy of the RAD that indicated the payment retraction, and any other supporting documentation.

Detailed *Appeal* submission and documentation requirements are included in the *Appeal Form Completion* section of the appropriate Part 2 provider manual. Exemptions to the CIF void process are explained in the *CIF Special Billing* Instructions section of the appropriate Part 2 provider manual.

Note: When conducting the two-step process for diagnosis-related group (DRG) claims with more than 22 lines, ensure that all CCNs associated with the reimbursed claims, including CCNs with zero payment, are voided to eliminate a duplicate claim denial.

CIFs for underpaid claims require completion of Boxes 7, 8, 9, 10 and 11 for each claim line for which reconsideration is requested. CIFs for overpaid claims require completion of Boxes 7, 8, 9, 10 and 12. Boxes 13, 14 and 15 are optional fields for both underpaid and overpaid claims.

Note: A CIF requesting reconsideration of an underpaid claim must be received within six months from the date of the RAD. CIFs received after six months from the date of the RAD on which the underpayment was indicated are subject to automatic denial. CIFs for overpaid claims may be submitted at any time. Refer to the Part 1 manual section *CIF Overview.*

Additional CIF guidelines are as follows:

- Attach a legible copy of the corrected original claim form, a copy of the RAD on which the claim line was paid and all pertinent documentation.
- In the *Remarks* field, clearly state the reason an adjustment is requested.

Note: Although the most recent Claim Control Number (CCN) may be a denied line, the CCN used for an adjustment to an underpaid or overpaid claim must be from the paid line on the RAD.

Diagnosis-Related Group Reimbursed Claims (More Than 22 Lines)

Claims that contain more than 22 lines should be divided across multiple pages; a unique CCN will be assigned to each page. A CIF void must be submitted for all CCNs associated with the stay from admit through discharge to recoup any payments prior to the resubmission of a corrected claim. If all reimbursed CCNs are not voided, including CCNs with zero payment, this can cause the resubmitted claim to deny. A reimbursed claim that is not voided causes the new claim to be a duplicate of the previously reimbursed claim (RAD code 010).

Share of Cost, Inpatient Compounds, Crossovers and, Tracers: Separate CIFs Required

Separate CIFs must be submitted for Share of Cost (SOC) reimbursement, inpatient claims, pharmacy compound claims, Medicare/Medi-Cal crossover claims and tracers. For additional CIF information about SOC and crossover claims, refer to the *CIF Special Billing Instructions* section in the appropriate Part 2 manual.

Inpatient Claims

An inpatient claim with numerous claim lines is processed as one line. An inquiry may not be made for individual lines on an inpatient claim. Therefore, only one claim line per CIF must be submitted.

Compound Claims

A pharmacy compound claim with numerous ingredients is processed as one line. An inquiry may not be made for individual ingredients on a compound claim. Therefore, only one claim line per CIF must be submitted.

Tracers

To request a tracer on a claim, complete Boxes 7, 8, 13, 14 and 15. Leave Boxes 9, 10, 11 and 12 blank.

Claim Form Attachments

Claim form attachments must be a corrected photocopy of the same type of claim originally submitted. Make all corrections directly on the photocopied claim. If the photocopy of the original claim cannot be corrected, submit an appeal (refer to the *Appeal Process Overview* section in the Part 1 manual).

CIF Attachments

Acceptable CIF attachments are listed in the following chart. The documentation applies to all inquiries except tracers and requests for SOC reimbursement.

Acceptable CIF Attachments
Except for Tracers and SOC Reimbursement

- ☑ *Treatment Authorization Request* (TAR) or vision claim indicating prior approval
- ☑ "By Report" documentation
- ☑ Completed Sterilization *Consent Form*
- ☑ *Explanation of Medicare Benefits* (EOMB)/*Medicare Remittance Notice* (MRN)/*Medicare Remittance Advice* (RA)
- ☑ *Explanation of Benefits* (EOB) from Other Health Coverage, such as CHAMPUS or Kaiser
- ☑ Drugs and supplies itemization list, manufacturer's invoice or description, including the name of the medication, dosages, strength and unit price
- ☑ Supplier's invoice indicating wholesale price and item billed
- ☑ Manufacturer's name, catalog (model) number and manufacturer's catalog page showing suggested retail price
- ☑ Copy of Point of Service (POS) printout or Internet eligibility response attached to the claim on an 8½ x 11-inch sheet of white paper

‹‹Chart of Acceptable CIF Attachments››

CIF Completion Reminders	All Inquires	Adjust-ment	Crossover Inpatient and Pharmacy Compounds	Denial	Share of Cost	Tracer
Always enter an “X” in the box to indicate the claim type.	Yes	No	No	No	No	No
Enter no more than four claim inquiries per form. **Note:** This does not apply to crossover and inpatient claims.	Yes	No	No	No	No	No
Fill out each line completely. Do not use ditto marks (“) nor draw an arrow to indicate repetitive information.	Yes	No	No	No	No	No
All information must be exactly the same as that on the *Remittance Advice Details* (RAD). For example, an incorrect ID number on the RAD should be copied exactly on the CIF.	Yes	No	No	No	No	No
Only one claim line per CIF.	No	No	Yes	No	No	No
Be sure the recipient ID number and Claim Control Number on the CIF exactly match the numbers on the RAD.	Yes	No	No	No	No	No
RAD not required.	No	No	No	No	Yes	Yes

‹‹**Chart of Acceptable CIF Attachments (continued)**››

CIF Completion Reminders	All Inquires	Adjust-ment	Crossover Inpatient and Pharmacy Compounds	Denial	Share of Cost	Tracer
Enter the recipient's original ID (the number issued prior to being enrolled in a no-SOC program).	No	Yes	No	No	Yes	No
Do not use the *Remarks* area for additional inquiries.	Yes	No	No	No	No	No
State clearly and precisely what is being requested in the *Remarks* area.	Yes	No	No	No	No	No
Always indicate the denial or adjustment reason code in the *Remarks* area.	No	Yes	No	Yes	No	No
Secure documentation to the upper right-hand corner of the CIF.	No	Yes	Yes	Yes	Yes	No
Do not attach any documentation.	No	No	No	No	No	Yes
Only original CIFs are accepted. Photocopies will be returned.	Yes	No	No	No	No	No

Explanation of Form Items

Each numbered item below refers to an area on the CIF.

Item	Description
1	**Correspondence Reference Number**. For the FI use only.
2	**Document Number**. The pre-imprinted number identifying the CIF.
3	**Provider Name/Address**. Enter the following information: Provider Name, Street Address, City, State and ZIP code.
4	**Provider Number**. Enter the provider number.
5	**Claim Type**. Enter an "X" in the box indicating the claim type. Only one box may be checked. Vision Care Providers: When billing for services prior to July 1, 2006, indicate claim type 07 (Vision). For services billed on or after July 1, 2006, indicate claim type 05 (Physicians/Allied).
6	**Delete**. Enter an "X" to delete the entire line. When Box 6 is marked "X," the information on the line will be "ignored" while the system continues to process the other claim lines. Enter the correct billing information on another line.
7	**Patient's Name or Medical Record Number**. Enter up to the first 10 letters of the patient's last name or the first 10 characters of the patient's Medical record number.
8	**Patient's Medi-Cal ID Number**. Enter the recipient ID number that appears on the *Remittance Advice Details* (RAD) showing adjudication of that claim.
9	**Claim Control Number**. Enter the 11-digit Claim Control Number (CCN) in the *Claim Control No.* box, and the two-digit line number in the adjoining *Line* field for the claim line in question. These numbers are assigned by the Fiscal Intermediary (FI) and are found on the RAD. If this item is blank, the inquiry line will be considered a tracer request.

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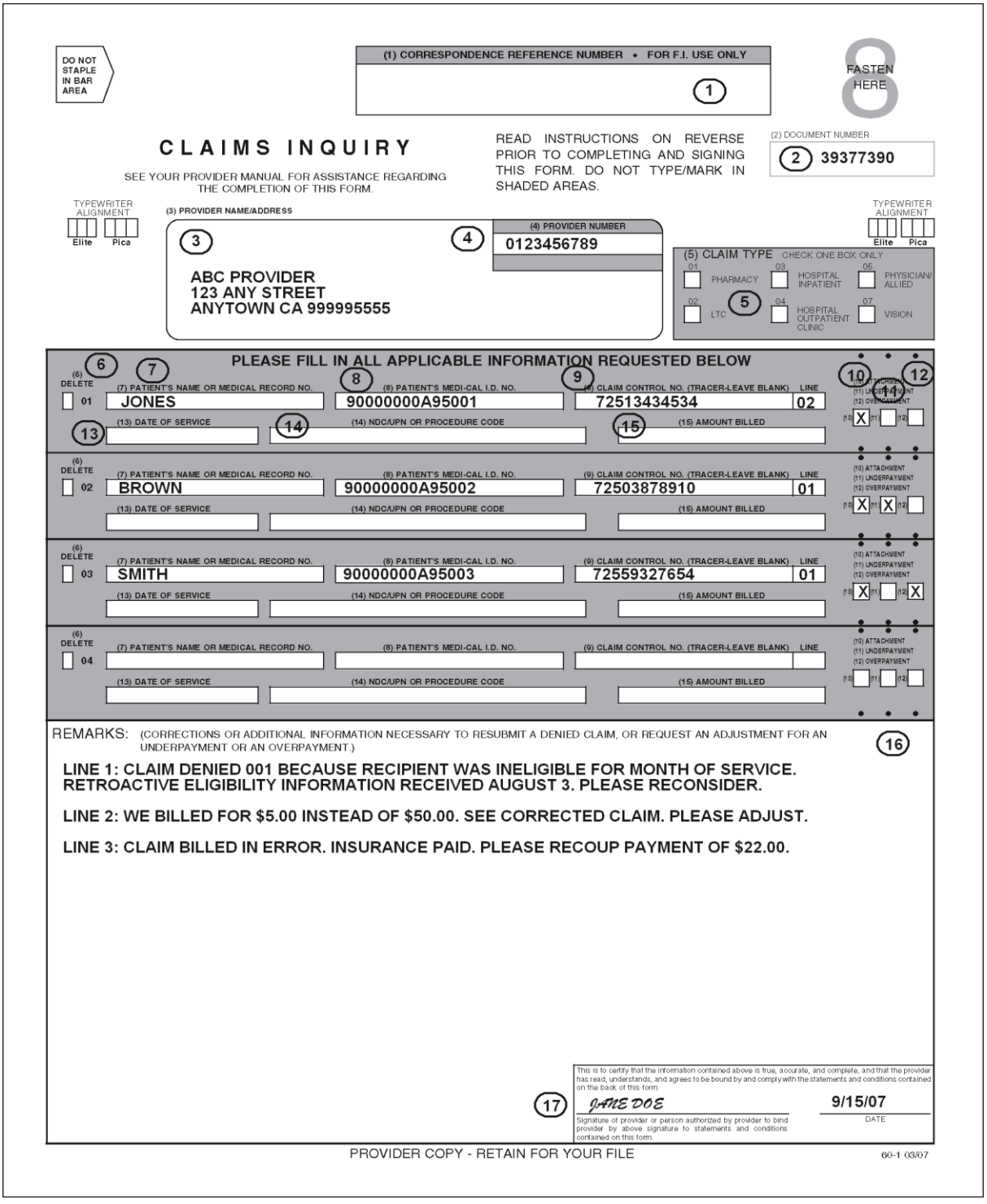
‹‹**Explanation of Form Items (continued)**››

Item	Description
10	**Attachment**. Enter an “X” when attaching documentation and when resubmitting a denied claim. **Note:** All claim inquiries should have attachments except when submitting a tracer. Refer to the *CIF Submission and Timeliness Instructions* section in this manual.
11	**Underpayment**. Enter an “X” for an underpayment adjustment of a paid claim. Do not mark Box 11 if the claim was denied.
12	**Overpayment**. Enter an “X” if all or part of the claim was overpaid. Do not mark Box 12 if the claim was denied.
13	**Date of Service.** In six-digit format (MMDDYY), enter the date the service was rendered. For block-billed claims, enter the “From” date of service.
14	**NDC/UPN or Procedure Code**. Providers should enter the appropriate procedure code, modifier, drug or supply code if applicable. Codes of fewer than 11 digits should be left-justified. For outpatient claims, do not enter the revenue code in this field. Long Term Care and Inpatient providers leave blank.
15	**Amount Billed**. Enter the amount originally billed, using the two boxes to the right of the decimal point to reflect cents.
16	**Remarks**. Use this area to state the reason for submitting a CIF and include the corresponding line number if listing multiple claim lines on the CIF.
17	**Signature**. The provider or an authorized representative must sign the CIF.



DO NOT STAPLE IN BAR AREA

(1) CORRESPONDENCE REFERENCE NUMBER • FOR F.I. USE ONLY

1

FASTEN HERE

CLAIMS INQUIRY

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM.

READ INSTRUCTIONS ON REVERSE PRIOR TO COMPLETING AND SIGNING THIS FORM. DO NOT TYPE/MARK IN SHADED AREAS.

(2) DOCUMENT NUMBER: 2 39377390

TYPEWRITER ALIGNMENT Elite Pica

(3) PROVIDER NAME/ADDRESS

3

ABC PROVIDER
123 ANY STREET
ANYTOWN CA 999995555

(4) PROVIDER NUMBER: 4 0123456789

TYPEWRITER ALIGNMENT Elite Pica

(5) CLAIM TYPE CHECK ONE BOX ONLY

5

01 PHARMACY
02 LTC
03 HOSPITAL INPATIENT
04 HOSPITAL OUTPATIENT CLINIC
05 PHYSICIAN/ ALLIED
07 VISION

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

6 7 8 9 10 12

(6) DELETE	(7) PATIENT'S NAME OR MEDICAL RECORD NO.	(8) PATIENT'S MEDI-CAL I.D. NO.	(9) CLAIM CONTROL NO. (TRACER-LEAVE BLANK)	LINE	(10) ATTACHMENT	(11) UNDERPAYMENT	(12) OVERPAYMENT	(13) DATE OF SERVICE	(14) NDC/UPN OR PROCEDURE CODE	(15) AMOUNT BILLED
01	JONES	90000000A95001	72513434534	02		X				
02	BROWN	90000000A95002	72503878910	01		X	X			
03	SMITH	90000000A95003	72559327654	01		X	X			
04										

REMARKS: (CORRECTIONS OR ADDITIONAL INFORMATION NECESSARY TO RESUBMIT A DENIED CLAIM, OR REQUEST AN ADJUSTMENT FOR AN UNDERPAYMENT OR AN OVERPAYMENT.) 16

LINE 1: CLAIM DENIED 001 BECAUSE RECIPIENT WAS INELIGIBLE FOR MONTH OF SERVICE. RETROACTIVE ELIGIBILITY INFORMATION RECEIVED AUGUST 3. PLEASE RECONSIDER.

LINE 2: WE BILLED FOR $5.00 INSTEAD OF $50.00. SEE CORRECTED CLAIM. PLEASE ADJUST.

LINE 3: CLAIM BILLED IN ERROR. INSURANCE PAID. PLEASE RECOUP PAYMENT OF $22.00.

This is to certify that the information contained above is true, accurate, and complete, and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on the back of this form.

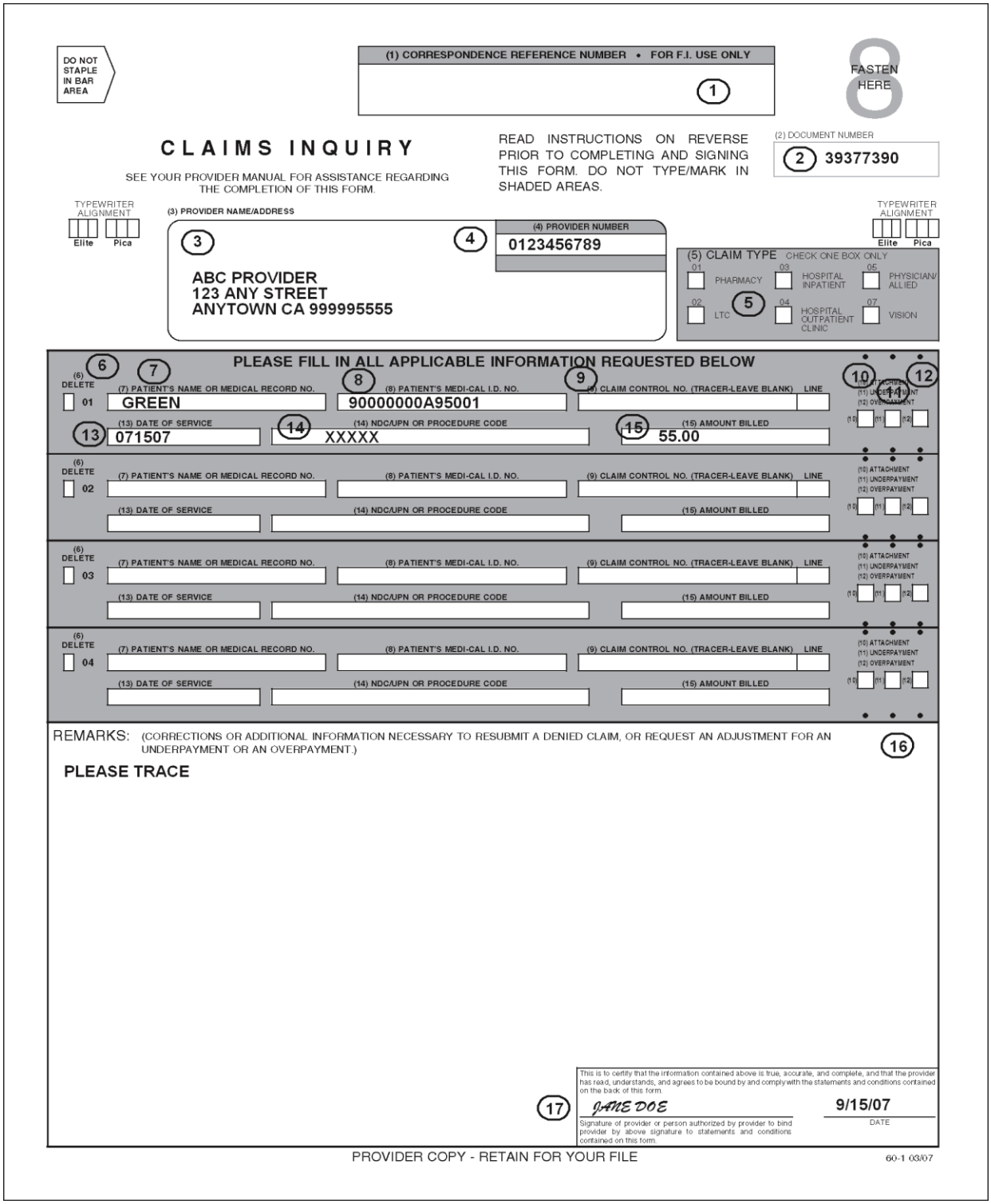
17 JANE DOE — Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form.

9/15/07 — DATE

PROVIDER COPY - RETAIN FOR YOUR FILE

60-1 03/07

Figure 1: Sample *Claims Inquiry* Form (CIF): Denial Resubmission, Underpayment and Overpayment Returns for All Claim Types Except Inpatient and Crossover Claims


DO NOT STAPLE IN BAR AREA

(1) CORRESPONDENCE REFERENCE NUMBER • FOR F.I. USE ONLY

1

FASTEN HERE

CLAIMS INQUIRY

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM.

READ INSTRUCTIONS ON REVERSE PRIOR TO COMPLETING AND SIGNING THIS FORM. DO NOT TYPE/MARK IN SHADED AREAS.

(2) DOCUMENT NUMBER
2 39377390

TYPEWRITER ALIGNMENT Elite Pica

(3) PROVIDER NAME/ADDRESS
3
ABC PROVIDER
123 ANY STREET
ANYTOWN CA 999995555

(4) PROVIDER NUMBER
4 0123456789

(5) CLAIM TYPE CHECK ONE BOX ONLY
5
01 PHARMACY
02 LTC
03 HOSPITAL INPATIENT
04 HOSPITAL OUTPATIENT CLINIC
05 PHYSICIAN/ ALLIED
07 VISION

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

6 7 8 9 10 11 12

(6) DELETE	(7) PATIENT'S NAME OR MEDICAL RECORD NO.	(8) PATIENT'S MEDI-CAL I.D. NO.	(9) CLAIM CONTROL NO. (TRACER-LEAVE BLANK) LINE	(10) ATTACHMENT (11) UNDERPAYMENT (12) OVERPAYMENT	(13) DATE OF SERVICE	(14) NDC/UPN OR PROCEDURE CODE	(15) AMOUNT BILLED
01	GREEN	90000000A95001			071507	XXXXX	55.00
02							
03							
04							

REMARKS: (CORRECTIONS OR ADDITIONAL INFORMATION NECESSARY TO RESUBMIT A DENIED CLAIM, OR REQUEST AN ADJUSTMENT FOR AN UNDERPAYMENT OR AN OVERPAYMENT.) 16

PLEASE TRACE

17 This is to certify that the information contained above is true, accurate, and complete, and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on the back of this form.

JANE DOE
Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form.

9/15/07
DATE

PROVIDER COPY - RETAIN FOR YOUR FILE

60-1 03/07

Figure 2: Sample *Claims Inquiry Form* (CIF): Tracer Request.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.