# Quick Reference Guide: Bridge Funding Service Claims Submission

This guide provides a basic overview of the process for submitting claims for bridge services in the ProviderConnect system.

#### Questions

Please contact the following for questions:

If you have programmatic questions about the Bridge Services policies please contact the GHVP Helpdesk at <u>GH.VP@dbhdd.ga.gov</u>.

If you have questions related to which location to submit claims from or direct claims entry, please contact the Georgia Collaborative ASO Provider Relations at georgiacollaborativepr@beaconhealthoptions.com.

If you have questions related to claims payment contact to John Quesenberry at John.Quesenberry@dbhdd.ga.gov.

## **Claims Guidelines**

- 1. Claims submitted must be in accordance with an approved GHVP-3 form for audit and reconciliation purposes.
- Newly placed individuals on a housing voucher have available up to \$2500 based on specific need. The provider is allowed an initial fee of \$500. This totals to a maximum of \$3000. Any amount exceeding \$3000 will require special DBHDD approval.
- 3. Claims will be submitted through the ASO's ProviderConnect direct claims entry process and cannot be submitted via batch because of the receipt requirement.
- 4. Instead of monthly payments, claims will now be paid weekly. All claims submitted and adjudicated by Beacon's claims staff will be paid with each week's Tuesday check run.
- 5. Beacon's claims staff will be reviewing submitted receipts. Receipts must be from a valid store, vendor, or business and must have the business name, date of payment, and amount paid. If the receipt is for fees paid to the provider (e.g. Initiation, Renewal, etc.), then an invoice style receipt will be sufficient on agency letterhead or other form with agency name.
- 6. If items on the receipt are not an approved reimbursable item, draw a line through that items. Ensure the amount on the claim matches the amount to be reimbursed from the receipt.
- 7. Any claims that have been paid and later it was identified that the expense was outside of the guidelines will require the claim to be reversed and payment recouped.

To access the ProviderConnect Portal use the link below. You must have a User ID and password created by your agency's Super User.

https://www.valueoptions.com/pc/eProvider/providerLogin.do?client=GACO

There are two paths to get to the claims entry screen a) by searching for a specific member or b) by selecting the claims link on the landing page. Steps for both are covered below.

		Switch Account	-Georgia ASO 🗸	ValueOptions Home	Provider Hom
Home Specific Member Search Register Member	. Thank you for using Beacon Health C	ptions ProviderConnect.			
Authorization Listing Enter an Authorization/Notification Request	YOUR MESSAGE CENTER				
View Clinical Drafts Claim Listing and Submission		Your inbox is empty			
Enter EAP CAF Review Referrals	WHAT DO YOU WANT TO DO TODAY?				
Enter Bed Tracking Information Search Beds/Openings Weekly Behavior Analysis Measures	Link/Unlink Accounts NEW     Eligibility and Benefits     Find a Specific Member	- Ent	er or Review Claims Enter a Claim Enter EAP CAF	$\triangleleft$	
EDI Homepage Enter Member Reminders	Register a Member     Enter or Review Authorization Requests	:	Review a Claim View My Recent Prov	ider Summary Vouch	ers
On Track Outcomes Reports Print Spectrum Release of	Enter an Authorization/Notification Request     Review an Authorization     View Clinical Drafts	Enter	PaySpan or Review Referrals Enter a Referral		
nformation Form My Online Profile My Practice Information	Weekly Behavior Analysis Measures		Review Referrals		
Provider Credentialing Application	Enter Member Reminders	> Ente	er Bed Tracking Inform	nation	

If you use Option 2, you will not access the member search functionality and will need to know the member's CID number and date of birth for the claims entry screen.

A list of services and billing codes can be found in Appendix A.

## Option 1: Specific Member Search

1. Once logged into Provider Connect, select the "**Specific Member Search**" link on the left menu bar.



2. At the Eligibility & Benefits Search screen, enter the member specific criteria to search for the individual for which the claim is being submitted and press the "**Search**" button.

Note: Two of the three items below will be required:

- An ID Number (CID, SSN, Medicaid, Medicare)
- Date of Birth
- Last Name (spelling counts as the search will look for an exact match)

Home	
Specific Member Search	
Register Member	Eligibility & Benefits Search
Authorization Listing	Denvired Solds are denoted have activity ( # ) advantable the label
Enter an	Required neitos are denoted by an asterisk (*) aujacent to the label.
Authorization/Notification Request	Verify a patient's eligibility and benefits information by entering search criteria below.
View Clinical Drafts	*Member ID (No spaces or dashes)
Claim Listing and	Last Name
Entor EAD CAE	First Name
Poviow Poferrals	*Date of Birth (MNDDYYYY)
Cetes Ded Tradides	As of Date 08242017 (MMDDYYYY)
Information	
Search Beds/Openings	Search
Weekly Behavior Analysis Measures	

3. At the Member Demographics tab, select the "Enter a Claim" button at the bottom of the page.

		1		
mographics	Enrollment History	COB Benefits	Additional Information	
Individual eligi	ibility does not guarante	e payment. Eligibility	is as of today's date and is provided by	our clients.
Individual?			Eligibility	
Individual ID	400034	860	Effective Date	07/18/2017
Alternate ID			Expiration Date	07/28/2018
Individual Nar	me TEST, T	EST	COB Effective Date?	
Date of Birth	12/13/	1988	View Funding Source Enr	ollment Details
Address	TEST			
	ATLANT	A, GA 30315	Subscriber	
Alternate Add	ress		Subscriber ID	400034860
Marital Status	-		Subscriber Name	TEST TEST
Home Phone	123 - 12	3 -1234		1231, 1231
Work Phone				
Canden	1			
Gender	M - Mal	e		
ndividual Parti	icipates in Message Cent	ter Communication wi	th Providers? No	
f you wish to lease update	o use the ProviderCon e your Profile and con	nect Message Cente duct a new Individu	r to communicate with Individuals al Search for the Individual you wo	who participate in Message Center com uld like to contact.
View Indi	vidual Auths	View Individual Claims	View Empire Claims	View GHI-BMP Claims
Enter Auth/No	tification Request	Enter Claim	nquiry	View Clinical Drafts
Enter Individ	dual Reminders Vi	ew Individual Registratio	ons	

4. At the Service Address screen, select the appropriate location for Bridge Services to be billed from. Typically, this is the primary address from the Provider's contract, administrative offices, or other main office location. Please contact the ASO's Provider Relations Office at <u>gacollaborativepr@beaconhealthoptions.com</u> if you have any questions about which location is currently configured for Bridge Services.

loot Com	√	Provider Last Name CSB	Provider First Name
apture	Vendor ID	Service Address	Pay To Address
0	GA00 0000	CSB 1400 MAIN ST	BEHAVIORAL HEALTH CENTER 1400 MAIN ST
		MACON, GA 31217	MACON, GA 31217
	GA00.0000	CSB	BEHAVIORAL HEALTH CENTER
0	04000000	GA HIGHWAY 12	1400 MAIN 51

 On the Submit a Claim – Step 1 of 3 screen, the Member ID and Date of Birth will pre-populate. Enter the First Date of Service and select "No" for the EAP question then press the "Next" button.

*Note: The first date of service should reflect the date from the receipt.* 

Submit A Claim - Step 1 of 3	
Required fields are denoted by an asterisk ( $\boldsymbol{*}$ ) adjacent to the label	L .
To submit a single claim, begin with step 1 below.	
Provider Name	CSB
Service Address	1400 MAIN STREET, MACON, GA, 31217
Pay To Address	1400 MAIN STREET, MACON, GA, 31217
Vendor ID	GA000000
NPI Number	✓
Taxonomy Code	
Licensure Level	Select Y
*Member ID	(X-digits, no spaces or dashes)
Member Name	(First Last)
Member Account #	(X-digits, no spaces or dashes)
Program/Fund/Group ID	
*Member DOB	(MMDDYYYY)
*First Date of Service	(MMDDYYYY - Enter Earliest Date of Service for this claim)
*Is this claim being billed under EAP Services?	○ Yes ○ No
Previous	Next

6. On the Submit a Claim – Step 2 of 3 screen, select the **Frequency Type** ("Original" will be selected for the first time the claim is being submitted). No Prior Authorization number is required for Bridge Service claims. Press the "**Next**" button.

Frequency Type	ILDI ILDI	12/13/1988	11745	Service Address 512966 175 EMERY HWY, MACON, GA, 31217	175 EMERY HWY, MACON, GA, 31217
	Ori	ginal Reference Number		Prior Authorization Number	
Select	~				
Only populate Othe	er Paver Information field	s(s) if Coordination of Ber	nefit (COB) information i	s applicable to dates of service on this claim. i.e., If ar	w payment from other payer entities were previously applied to this
					, p - /
Does a COB exist fo	or this claim?				
O Yes  No					
-					
ther Payer I	nformation - Prim	ary			
		and a state of the			
ther Paver I	nformation - Seco	ndamy			
)ther Payer I	nformation - Seco	ndary			
)ther Payer I	nformation - Seco	ndary			
ther Payer I	nformation - Seco	ndary			
)ther Payer I	nformation - Seco	ndary			
)ther Payer I ther Payer I	nformation - Seco nformation - Terti	ndary ary			
Other Payer I Other Payer I	nformation - Seco information - Terti	ndary ary			
ther Payer I ther Payer I	nformation - Seco nformation - Terti	ary			

- 7. On the Submit a Claim Step 3 of 3 screen, complete the following items:
  - Service Through (this will be the same as the Service From date)
  - Service Code / Modifiers (enter the specific code being billed including modifiers)
  - Charge Amount (this is the dollar amount of the reimbursement for the specific service)
  - Place of Service (use code '99')
  - Units (use 1 unit of service)
  - Diagnosis (use the individual's mental health diagnosis or F99).

Once you have entered all of the above service information, press the "Add Service Line" button. This will add the detail line information below in the Ready to Submit section. If you need to add additional service lines to the same claim, fill in the service line entry information for the new claim line and then press the "Add Service Line" button. Add additional lines as needed.

Service	Line Ent	ry							
*Service F 0801201 (MMDDYYYY)	rom * 7(	Service Through 08012017	*Service Code T1999 (ex: 86753)	Modifier Code 1 HE (no spaces or dashes	Modifier Code 2	Modifier Code 3 (no spaces or dashes)	Modifier Code 4 (no spaces or dashes)		NDC Numb
*Charge A 156.13 (ex: 123.45)	mount (\$)	*Place of Serv 99 (00 - 99)	ice *Units 1 (3-digits)	]					NDC Units (ex: 765.4 (
*Diagnosis F99 (ex: 765.4)	Code 1	Diagnosis Code 2	Diagnosis Code 3 (ex: 765.4)	Diagnosis Code 4 (ex: 765.4)	Diagnosis Code 5 (ex: 765.4)	Diagnosis Code 6         Diagnosis           (ex: 765.4)         (ex: 765.4)	65.4) Diagnosi (ex: 765.4)	is Code 8 4)	Association (ex:XZ)
COB Paye (ex: 99999	Prima er Paid 1 0.99) e Line	This will add this s	COB Payer F	Secondary Payer aid 2 COB Units P (ex: 999) to the claim	Paid 2 COB Pay	Tertiary Payer rer Paid 3 COB Units F 19.99) (ex: 999)	Paid 3		
Claim D	etail: Re	ady to Subm	it						
Click to	Ser	vice Date	Service Code	Modifier Code 1	Modifier Code 2	Charge Amount (\$)	Diagnosis Code 1		COB Payer Pa
Remove	Start Date	End Date	Place of Service	Modifier Code 3	Modifier Code 4			Primary	Secondary
0	08012017	08012017	T1999 99	HE		156.13	F99		
					Total			0.00	0.00

To attach the associated receipt(s), click the "Upload File" button in the Attached an EOB section. (Note: This section is typically used for submitting EOBs on claims but that is not necessary for Bridge Service claims.) When ready to submit claim, press the "Submit" button.

To remove a servic	ce line, select the "Click to Remove" button for the line needed to be removed, then click the "Remov	ve" button below
Attach an EOB		
	Click Upload File to attach a COB EOB with this daim.	
Upload File This will attach an EOB document to the claim. Attached Documents:		
Remove	Submit	Previous
This will remove the service line selected above	This will submit the entire claim (including all service lines added)	This will return to the preceding data entry page

9. After you have pressed the "Submit" button, the Submission Results will appear.

	OVIDERC EACON HEALTH	ONNECT OPTIONS																	ProviderCo	nnect Hon
Subn	it A Cla	im																		
Sub	mission F	Results :		******	*******	CLAIM ENTER	ED *********	******	****											
You	r claim ha	as been sub	omitted succe	ssfully. You m	ay contact Cla	aims Customer S	Service with an	y questi	ions relat	ed to th	is clain	1.								
Prov	der Name/	ID	CSB-	GAC000556																
Vend	lor ID		GAO	)5468																
Patie	nt ID		4000	34860																
Patie	nt Name		TEST	, TEST																
Prog	ram/Fund/G	Group ID																		
Patie	nt Date of I	Birth	12/1	3/1988																
NPI	Number		1174	512966																
Taxo	nomy Code																			
Prior	Authorizati	on Number																		
Clair	n #	on nomber	082	317- 04065- 00	1001															
jne #	Servio	te Date	Service Code	Modifier Code 1	Modifier Code 2	Charge Amount (\$)	Diagnosis Code 1	(	COB Payer Pa	id	To-Pay	Status		Dollar	Amount (\$	5)		Fund	NDC Number	Assc Qua
	Start Date	End Date	Place of Service	Modifier Code 3	Modifier Code 4			Primary	Secondary	Tertiary			Allowed	Deductible	Pre-Paid	COIN	CoPay		NDC Units/Type	Assc#
1	08/01/2017	08/01/2017	T1999 99	HE		156.13	F99	0.00	0.00	0.00	0.00	А	0.00	0.00	0.00	0.00	0.00	GREG		
							Total	0.00	0.00	0.00										
							Attac	hed EOBs	:											
No I	OB COB Do	cuments Atta	achments																	
		_																		
Enter	New Claim																			

### Option 2: Enter a Claim Link

1. Once logged into Provider Connect, select the "Enter a Claim" link in the center of the home landing page.



 At the Service Address screen, select the appropriate location for Bridge Services to be billed from. Typically, this is the primary address from the Provider's contract, administrative offices, or other main office location. Please contact the ASO's Provider Relations Office at <u>gacollaborativepr@beaconhealthoptions.com</u> if you have any questions about which location is currently configured for Bridge Services.

	~	Provider Last Name CSB	Provider First Name
Select Ser	vice Address		
Capture	Vendor ID	Service Address	Pay To Address
0	GA00 0000	CSB 1400 MAIN ST	BEHAVIORAL HEALTH CENTER 1400 MAIN ST
		MACON, GA 31217	MACON, GA 31217
	GA00 0000	CSB	BEHAVIORAL HEALTH CENTER 1400 MAIN ST
0		OA HIGHNAT AS	

3. On the Submit a Claim – Step 1 of 3 screen, enter the **Member ID**, **Date of Birth**, **First Date of Service**, and select "**No**" for the EAP question then press the "**Next**" button.

Note: The first date of service should reflect the date from the receipt.

CSB
1400 MAIN STREET, MACON,GA,31217
1400 MAIN STREET, MACON,GA,31217
GA000000
×
Select V
(X-digits, no spaces or dashes)
(First Last)
(X-digits, no spaces or dashes)
(MMDDYYYY)
(MMDDYYYY - Enter Earliest Date of Service for this claim)
○ Yes ○ No

4. On the Submit a Claim – Step 2 of 3 screen, select the **Frequency Type** ("Original" will be selected for the first time the claim is being submitted). No Prior Authorization number is required for Bridge Service claims. Press the "**Next**" button.

400034860	TEST TEST	Birth Date 12/13/1988	NPI Number 1174	Service Address 512966 175 EMERY HWY MACON GA 31217	Pay To Address 175 EMERY HWY MACON GA 31217
Frequency Type	1201 1201	Original Reference Number		Prior Authorization Number	1/0 21211 1111 10001 0000227
Select	~				
Only populate Oth	er Payer Informatior	fields(s) if Coordination of Ben	efit (COB) information	is applicable to dates of service on this claim. i.e., If an	y payment from other payer entities were previously applied t
Does a COB evict fr	or this claim?				
	a uns claim?				
O TES O NO					
Other Payer I	nformation - P	rimary			
	and the second se	econdary			
Other Paver I	nformation - S				
Other Payer I	nformation - S				
Other Payer I	nformation - S				
Other Payer I	nformation - S				
Other Payer I	nformation - S	ertiary			
Other Payer I Other Payer I	nformation - S nformation - T	ertiary			
Other Payer I Other Payer I	nformation - S nformation - T	ertiary			
Other Payer I Other Payer I	nformation - S nformation - T	ertiary			

- Service Through (this will be the same as the Service From date)
- Service Code / Modifiers (enter the specific code being billed including modifiers)
- Charge Amount (this is the dollar amount of the reimbursement for the specific service)
- Place of Service (use code '99')
- Units (use 1 unit of service)

Start Date

End Date

ace of Service

T1999 99

• **Diagnosis** (use the individual's mental health diagnosis or F99).

Once you have entered all of the above service information, press the "Add Service Line" button. This will add the detail line information below in the Ready to Submit section. If you need to add additional service lines to the same claim, fill in the service line entry information for the new claim line and then press the "Add Service Line" button. Add additional lines as needed.

Service ]	Line Entry									
*Service Fr 08012017 (MMDDYYYY)	rom *Service Through 7 08012017 ) (MMDDYYYY)	*Service Code T1999 (ex: 86753)	Modifier Code 1 HE (no spaces or dashed	Modifier Code 2	Modifier Code 3 (no spaces or dashes)	Modifier Code 4 (no spaces or dashes)	NDC Number (no spaces or dashes)			
*Charge Ar 156.13 (ex: 123.45)	*Place of Serv           99           (00 - 99)	ice *Units 1 (3-digits)					NDC Units			
*Diagnosis F99 (ex: 765.4)	Code 1 Diagnosis Code 2 (ex: 765.4)	Diagnosis Code 3 (ex: 765.4)	Diagnosis Code 4 (ex: 765.4)	Diagnosis Code 5 [] (ex: 765.4) (d	Diagnosis Code 6 Diag	nosis Code 7         Diagnos           765.4)         (ex: 765.4)	Association Qualifier			
	Primary Payer		Secondary Payer		Tertiary Payer					
COB Paye (ex: 99999	er Paid 1 COB Units Paid 1 .99) (ex: 999)	COB Payer Pai	id 2 COB Units F (ex: 999)	Paid 2 COB Paye	COB Units	Paid 3				
Add Servic	Add Service Line This will add this service line information to the claim									
Claim D	etail: Ready to Subm	it								
		0.1.01					600 D			
Click to	Service Date	Service Code	Modifier Code 1	Modifier Code 2	Charge Amount (\$)	Diagnosis Code 1	COB Payer Paid			

Modifier Code 4

Total

156.13

F99

0.00

0.00

6. To attach the associated receipt(s), click the "**Upload File**" button in the Attached an EOB section. (Note: This section is typically used for submitting EOBs on claims but that is not necessary for Bridge Service claims.) When ready to submit claim, press the "**Submit**" button.

Modifier Code 3

HE

To remove a service	To remove a service line, select the "Click to Remove" button for the line needed to be removed, then click the "Remove" button below									
Attach an EOB										
	Click Upload File to attach a COB EOB with this claim.									
Upload File This will attach an EOB document to the claim. Attached Documents:										
Remove	Submit	Previous								
This will remove the service line selected above	This will submit the entire claim (including all service lines added)	This will return to the preceding data entry page								

7. After you have pressed the "**Submit**" button, the Submission Results will appear.

Quick Reference Guide: Bridge Funding Service Claims Submission

Sub	omission Result	: 📁	*******	***********	CLAIM ENTER	ED *********	*******												
You	ır claim has bee	submitted succe	essfully. You m	ay contact Cl	aims Customer :	Service with an	y questi	ons relat	ed to thi	s claim	L.								
Prov	ider Name/ ID	CSB	-GAC000556																
Vend	dor ID	GAC	05468																
Patie	ent ID	400	034860																
Patie	atient Name TEST, TEST																		
Program/Fund/Group ID																			
Patie	Patient Date of Birth 12/13/1988																		
NPI I			10,1000																
	Number	117	4512966																
Taxo	Number onomy Code	117	4512966																
Taxo Licer Prior	Number onomy Code nsure Level r Authorization Nun	117 Der	4512966																
Taxo Licer Prior Clair	Number onomy Code nsure Level r Authorization Nun m #	117 ber <u>087</u>	4512966 817- 04065- 00	1 <u>001</u>															
Taxo Licer Prior Clair	Number onomy Code nsure Level r Authorization Nun m #	087	4512966 817- 04065- 00	1 <u>001</u>															
Taxo Licer Prior Clair	Number onomy Code nsure Level r Authorization Nun m # Service Date	117 per <u>082</u> Service Code	4512966 8 <u>17- 04065- 00</u> Modifier Code 1	1001 Modifier Code 2	Charge Amount (\$)	Diagnosis Code 1	Q	D8 Payer Pa	id	To-Pay	Status		Dollar	Amount (\$	;)		Fund	NDC Number	Assc Qu
Taxo Licer Prior Clair	Number onomy Code nsure Level r Authorization Nun m # Service Date Start Date End I	082 Over Service Code ate Place of Service	4512966 1817- 04065- 00 Modifier Code 1 Modifier Code 3	Modifier Code 2 Modifier Code 4	Charge Amount (\$)	Diagnosis Code 1	Ci Primary	D8 Payer Pa Secondary	id Tertiary	To-Pay	Status	Allowed	Dollar Deductible	Amount (\$ Pre-Paid	s) COIN	СоРау	Fund	NDC Number NDC Units/Type	Assc Qu Assc#
Taxo Licer Prior Clair	Number           onomy Code           nsure Level           r Authorization Nun           m #           Service Date           Start Date         End I           08/01/2017         08/01	er 982 982 982 982 99 99	4512966 817- 04065- 00 Modifier Code 1 Modifier Code 3 HE	Modifier Code 4	Charge Amount (\$) 156.13	Diagnosis Code 1 F99	Ci Primary 0.00	DB Payer Pa Secondary 0.00	id Tertiary 0.00	To-Pay 0.00	Status	Allowed 0.00	Dollar Deductible 0.00	Amount (\$ Pre-Paid 0.00	5) COIN 0.00	CoPay 0.00	Fund GREG	NDC Number NDC Units/Type	Assc Qu Assc#
Taxo Licer Prior Clair Ie #	Number normy Code nsure Level r Authorization Nun m # Service Date Start Date End I 08/01/2017 08/01	082 Ver Service Code ate Place of Service 017 T1999 99	4512966 1817- 04065- 00 Modifier Code 1 HE	1001 Modifier Code 2 Modifier Code 4	Charge Amount (\$) 156.13	Diagnosis Code 1 F99 Total	Ci Primary 0.00	DB Payer Pa Secondary 0.00 0.00	id Tertiary 0.00	To-Pay 0.00	Status A	Allowed 0.00	Dollar Deductible 0.00	Amount (\$ Pre-Paid 0.00	5) COIN 0.00	CoPay 0.00	Fund GREG	NDC Number NDC Units/Type	Assc Qu Assc#
Taxo Licer Prior Clair e #	Number           anomy Code           nsure Level           r Authorization Nun           m #           Service Date           Start Date           Start Date           Endl           08/01/2017         08/01	Der 987 987 987 987 987 997 999 997 997	4512966 817- 04065- 00 Modifier Code 1 Modifier Code 3 HE	001 Modifier Code 2 Modifier Code 4	Charge Amount (\$) 156.13	Diagnosis Code 1 F99 Total	Crimary 0.00 0.00	DB Payer Pa Secondary 0.00 0.00	id Tertiary 0.00 0.00	To-Pay 0.00	Status A	Allowed 0.00	Dollar Deductible 0.00	Amount (\$ Pre-Paid 0.00	;) COIN 0.00	CoPay 0.00	Fund GREG	NDC Number NDC Units/Type	Assc Qu Assc#

	Procedure	Modifier	Modifier	Modifier	Modifier
Service Name	Code	1	2	3	4
Household Furnishings	T1999	HE	H1		
Household goods and Supplies	T1999	HE	H2		
Moving Expenses	T1999	HE	M1		
Utility Deposits	T1999	HE	D1		
Security Deposits	T1999	HE	S1		
Transportation	T2003	HE			
Environmental Modifications	S5165	HE			
Food/Grocery	T1999	HE	FG		
Medication	T1999	HE			
Rent Payment	H0044	HE			
Fees - Initiation	T1999	HE	F1		
Fees - Renewal	T1999	HE	F2		
Fees - Transfer	T1999	HE	F3		
Other	T1999	HE	X1		

The table below provides a list of services that can be billed for Bridge Services and the associated billing procedure code.

Note: Some modifiers are non-traditional and created for the purpose of state use only.