

Claims Filing Instructions

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PerformCare, hereafter referred to as the Plan (where appropriate), is required by state and federal regulations to capture specific data regarding services rendered to its Members. All billing requirements must be adhered to by the provider in order to ensure timely processing of claims.

Section 6401 of the Affordable Care Act (ACA) requires that all providers must be enrolled in Medicaid in order to be paid by Medicaid. This means all providers must enroll and meet all requirements of the Pennsylvania Department of Human Services (DHS) which then issues a Medicaid identification number called PROMISE™ Provider Identification (PPID). The enrollment requirements include registering every service location with the state and having a different service location extension for each location.

Additionally, DHS has implemented the requirement that all providers must revalidate their Medical Assistance enrollment every five (5) years. (ACA) (§42 CFR 455.414). Claims from providers who have not accurately updated their enrollment information cannot be paid. Providers should log into PROMISE to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at:

<https://www.dhs.pa.gov/providers/Providers/Pages/PROMISE-Enrollment.aspx>.

Reimbursement for all rendering network providers for claims subject to the ordering/referring/prescribing (ORP) requirement is determined by validating that participating ORP practitioners have a valid PPID. Claims subject to the ORP requirement will receive a XE9 (ORP Provider not submitted) or XE0 (ORP Provider not enrolled in Medicaid) EOB Explanation Code when the NPI is missing or not MA enrolled. For more information on claims subject to ORP requirements please refer to, [AD 17 104 Ordering, Referring, and Prescribing Providers](#).

This document is current at the date of printing. Be alert for provider notices and other form changes. Please check the website frequently: pa.performcare.org. Please be sure to register for iContact and you will automatically receive email alerts when items that may interest you are posted to the website.

Claim Filing

When required data elements are missing or are invalid, claims will be **rejected** by the Plan for correction and re-submission.

Claims filed with the Plan are subject to the following procedures:

- Verification that all required fields are completed on the CMS 1500 or UB-04 forms.
- Verification that all Diagnosis and Procedure Codes are valid for the date of service.
- Verification for electronic claims against 837 edits at Optum/Change Healthcare™, Availity or other clearinghouse.
- Verification of Member eligibility for services under the Plan during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that the “out of network” provider has received authorization to provide services to the eligible Member.

- Verification that the provider participated with the Medical Assistance program at the time of service.
- Verification that an authorization has been given for services that require prior authorization by the Plan.
- Verification of whether there is Medicare coverage or any other third party liability and, if so, verification that the Plan is the “payer of last resort” on all claims submitted to the Plan.
- **All 837 claims should be compliant with SNIP level 4 standards, with exception to provider secondary identification numbers (Provider legacy, Commercial, State ID, UPIN, and Location Numbers).**
- **All 837 claims with Claim Attachments should be sent only with Claim Attachment Report Type codes (PWK01) listed under Field #19 for CMS-1500 Claim Form and Field # 80 for UB-04 Claim Form.**

Important: **Rejected claims** are defined as claims with invalid or required missing data elements, such as the provider tax identification number, provider PPID number, Member ID number, that are returned to the provider or EDI* source without registration in the claim processing system.

- **Rejected claims** are not registered in the claim processing system and must be resubmitted as a new original claim.
- **Rejected claims are considered original claims and timely filing limits must be followed.**

Important: **Denied claims** are registered in the claim processing system but do not meet requirements for payment under Plan guidelines. They should be resubmitted as a corrected claim.

- **Denied claims must be re-submitted as corrected claims** within 365 calendar days from the date of service.
 - If sent electronically, the **claim frequency code** (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values “7” for the Replacement (correction) of a prior claim.
 - In addition, the submitter must also provide the original PerformCare claim number in **Payer Claim Control Number** (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files).
 - If the correct claim is being submitted on paper, the claim needs to have the following in order to be processed as such:
 - On a Professional CMS 1500 Claim, the resubmission code of “7” along with the PerformCare original claim number is required in Field 22.
 - On an Institutional UB04 Claim, bill type should end in “7” in Form Locator 4 and the PerformCare original claim number is required in Form Locator 64A Document Control Number.

* For more information on EDI, review the section titled Electronic Data Interchange (EDI) on page 63 in this booklet.

Claim Mailing Instructions

Submit claims to the Plan at the following address, as applicable:

*PerformCare recommends that providers mail claims certified mail. Since the mailing address is a P.O. Box, FedEx and UPS deliveries are not accepted.

PerformCare of Pennsylvania
HealthChoices
P.O. Box 7308
London, KY 40742

*Refer to Important Billing Reminders for more information

The Plan encourages all providers to submit claims electronically. Providers may submit electronic claims via Optum/Change Healthcare or Availity clearinghouses. Hereafter throughout this document we will use “Clearinghouse” to mean either Optum/Change Healthcare or Availity. For those interested in electronic claim filing, contact your EDI software vendor or Optum/**Change Healthcare’s Provider Support Line at 1-800-527-8133** or Availity Client Services at **1-800-AVAILITY (282-4548)**. Assistance is available Monday through Friday from 8 a.m. to 8 p.m. ET.

Note: PerformCare EDI Payer ID # is 65391

Any additional questions may be directed to the EDI Technical Support at:

- Hotline: **1-800-845-6592, option 2**
- Email: edi.support@amerihealthcaritas.com

Claim Filing Deadlines

Original claims must be submitted to the Plan within 60 calendar days from when the date services were rendered.

Re-submission of previously denied claims with corrections and requests for adjustments must be submitted within 365 calendar days from when the date of services were rendered.

Please allow for normal processing time before re-submitting a claim either through the EDI or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered received under timely filing guidelines if rejected for missing or invalid provider or Member data.

Note: Claims must be received by the EDI vendor by 9:00 p.m. in order to be transmitted to the Plan the next business day.

Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 60 days of the date of the primary insurer’s EOB (claim adjudication).

Important: Claims **originally rejected for missing or invalid data elements** must be corrected and re-submitted as new original claims **within 60 calendar days from the date of service.**

Rejected claims are not registered as received in the claim processing system.

Inpatient Admissions Over 60 Days

Providers will need to keep timely filing in mind and bill accordingly. Timely filing for primary claims is based on date of service and not based on discharge date. However, remember that claims cannot span over two calendar years, providers must bill two separate claims when the date of service spans over a calendar year. This rule is for medical and hospital claims. Providers must also bill date spans to align with authorization date spans, additional information can be found in [AD 24 110](#).

Timeliness of Claims Involving Third-Party Liability

Claims involving third-party liability must be received within 365 days of the date of service and no more than 60 days after the EOB date. At least one level of appeal is required to the primary insurance when the primary insurer refuses to pay for a service due to a medical necessity denial before PerformCare will pay, regardless of how long it takes the primary insurer to respond. The EOB from the primary insurance must be attached to the claim (one claim to one EOB). Each claim must have an EOB attached. Providers are not permitted to send multiple claims with one EOB attached. If billed this way, the first claim will process with the EOB, and the other will deny for the missing EOB. Secondary claims are accepted electronically via the 837 file or 275 attachment. For questions regarding electronic submissions of secondary claims, contact your claims clearinghouse.

Adjusted Claims

Claims with issues where resolution does not require complete re-submission of a claim can often be easily adjusted. Adjusted claims cannot involve changing any fields on a claim (for example an incorrect code) and can often be corrected over the phone or through NaviNet. Adjusted claims usually involve a dispute about amount/ level of payment or could be a denial for no authorization when the network provider has an authorization number.

Claim Payment Disagreements

Please review EOB's closely to ensure you are paid correctly. It is the provider's responsibility to monitor payment that is received. In the event of a discrepancy, contact PerformCare immediately via NaviNet Inquiry, Provider Claim Services Unit (PCSU) at 1-888-700-7370, or your Account Executive.

All claims payments from PerformCare will include an EOB. The EOB provides a detailed explanation of the amount of each claim paid and the reason for any amount of the claim that was denied. If a network provider has claims needing adjustment and there is a manageable volume of claims (five or less), the network provider can call PerformCare Provider Claim Services Unit (PCSU) at **1-888-700-7370**. A Customer Service Representative can help facilitate a review of the claims in question.

Please be prepared to provide the provider/facility name, provider/facility NPI, member name and ID number, CPT/Rev code, and DOS. Providers also have the option of submitting a claim inquiry via NaviNet. The **Claim Inquiry** feature lets you request an adjustment and track responses on claims that were previously finalized. For each submitted transaction, you will receive an electronic response to the claim inquiry. The response will indicate if the claims was adjusted or explain in detail why the claim was not considered for an adjustment. PerformCare encourages providers to use the [Claim Inquiry](#) function. However, if you do not have NaviNet access, you can still contact Provider Claims Services.

If the claim is denied because of a provider error that can be corrected, the Customer Service Representative will assist you in understanding the required corrections so you can resubmit the claim. If after reviewing the denial with the Customer Service Representative, you continue to believe that a claim was denied in error, you have the right to request a formal review in writing using the

administrative appeal process as discussed on page 78 of this manual. Your assigned Account Executive can assist should you have questions about the process. PerformCare will complete the review within 30 business days. You will receive a written response to your request outlining the findings of the formal review. You must include all necessary information with your request because the decision of the reviewing committee is final.

Refunds for Claims Overpayments or Errors

The Plan and the Pennsylvania Department of Human Services require providers to conduct regular self-audits to ensure accurate payment. Providers must notify PerformCare of any suspected fraud, waste, or abuse. Provider’s designated Compliance Officer should report such incidents within 72 hours of learning of a potential incident to the Special Investigations Unit (SIU). For more information please refer to the “Suspected/Substantiated Fraud, Waste, and Abuse” section of the PerformCare Provider Manual.

Medicaid program funds that were improperly paid or overpaid must be returned. If the provider’s practice determines that it has received overpayments or improper payments, the provider is required to make immediate arrangements to return the funds to the Plan or follow the DHS protocols for returning improper payments or overpayment.

If a Provider identifies improper payment or overpayment of claims from PerformCare their improperly paid or overpaid funds must be returned to the Plan within 60 days from the date of discovery of the overpayment.

Providers are required to return the improper or overpaid funds by mailing a refund check to,

PerformCare
Attn: Finance Department
8040 Carlson Road
Harrisburg, PA 17112

* Note: Please include the Member’s name and ID, date of service, and Claim ID.

Claim Form Field Requirements

The following charts describe the required fields that must be completed for the standard Centers for Medicare & Medicaid Services (CMS) CMS 1500 or UB-04 claim forms. If the field is required without exception, an “R” (Required) is noted in the “Required or Conditional” box. If completing the field is dependent upon certain circumstances, the requirement is listed as “C” (Conditional) and the relevant conditions are explained in the “Instructions and Comments” box

PerformCare will accept the two existing claims forms, the UB-04 for hospital claims and the CMS-1500 for medical claims. **All claims must be submitted within the required filing deadline of 60 days from the date of service.**

Although the following examples of claim filing requirements refer to paper claim forms, claim data requirements apply to all claim submissions, regardless of the method of submission (electronic or paper).

Required Fields (CMS 1500 Claim Form):

*Required [R] fields must be completed on all claims. Conditional [C] fields must be completed if the information applies to the situation or the service provided. **Refer to the NUCC or NUBC Reference Manuals for additional information.**

CMS-1500 Claim Form						
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
N/A	Carrier Block			2010BB	NM103 N301 N302 N401 N402 N403	
1	Insurance Program Identification	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. (Medicaid)	R	2000B	SBR09	Title Claim Filing Indicator code in 837P.
1a	Insured I.D. Number	Recipient Medicaid ID Number. Enter the member’s Medicaid ID number exactly as it appears on their ID card.	R	2010BA	NM109	Titled Subscriber Primary Identifier in 837P.

CMS-1500 Claim Form

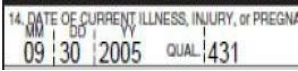

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
2	Patient's Name (Last, First, Middle Initial)	Enter the patient's name as it appears on the Member's Health Plan ID card. (Last name, first name, middle initial)	R	2010CA or 2010BA	NM103 NM104 NM105 NM107	
3	Patient's Birth Date/Sex	MMDDYY/M or F	R	2010CA or 2010BA	DMG02 DMG03	Titled Gender in 837P.
4	Insured's Name (Last, First, Middle Initial)	Enter the patient's name as it appears on the Member's Health Plan ID card	R	2010BA	NM103 NM104 NM105 NM107	Titled Subscriber in 837P.
5	Patient's Address (Number, Street, City, State, Zip+4) Telephone (include area code)	Enter the patient's complete address and telephone number. (Do not punctuate the address or phone number.)	R	2010CA	N301 N401 N402 N403 N404	
6	Patient Relationship to Insured	Always indicate self unless covered by someone else's insurance.	R	2000B 2000C	SBR02 PAT01	Titled Individual Relationship code in 837P.
7	Insured's Address (Number, Street, City, State, Zip+4 Code) Telephone (Include Area Code)	If same as the patient, enter "Same". Otherwise, enter insured's information.	C	2010BA	N301 N302 N401 N402 N403	Titled Subscriber Address in 837P.
8	Reserved for NUCC use	N/A	Not Required	N/A	N/A	N/A
9	Other Insured's Name (Last, First, Middle Initial)	Refers to someone other than the patient. Completion of fields 9a through 9d is required if patient is covered by another insurance plan. Enter the complete name of the insured.	C	2330A	NM103 NM104 NM105 NM107	If patient can be uniquely identified to the other provider in this loop by the unique Member ID, then the patient is the subscriber and identified in this loop.

CMS-1500 Claim Form						
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
						Titled Other Subscriber Name in 837P.
9a	Other Insured's Policy or Group #	Required if # 9 is completed.	C	2320	SBR03	Titled Group or Policy Number in 837P.
9b	Reserved for NUCC use	N/A	Not Required	N/A	N/A	Does not exist in 837P.
9c	Reserved for NUCC use	N/A	Not Required	N/A	N/A	Does not exist in 837P.
9d	Insurance Plan Name or Program Name	Required if # 9 is completed. List name of other health plan, if applicable. Required when other insurance is available. Complete if more than one other medical insurance is available, or if 9a completed.	C	2320	SBR04	Titled other insurance group in 837P.
10a, b, c	Is Patient's Condition Related to	Indicate Yes or No for each category. Is condition related to: a) Employment b) Auto Accident c) Other Accident	S	2300	CLM11	Titled related causes code in 873P.
10d	Claim Codes (Designated by NUCC)	Enter new Condition Codes as appropriate. Available 2-digit Condition Codes includes nine codes for abortion services and four codes for worker's compensation. Please refer to NUCC for the complete list of codes. Examples include: <ul style="list-style-type: none"> AD - Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising from or exacerbated by the Pregnancy itself W3- Level 1 Appeal 	C	2300	NTE	NTE 01 position – input "ADD" Upper case/capital format. NTE 02 position – first six- character input "EPSDT=" (upper case/capital format where the sixth character will be the = sign. Input applicable referral directly after "=" For multiple code entries: Use "_" underscore to separate as follows: NTE*ADD*EPSDT*=YD _YM_YO~

CMS-1500 Claim Form

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
11	Insured's Policy Group or FECA #	Required when other insurance is available. Complete if more than one other medical insurance is available, or if "yes" to 10a, b, and c. Enter the policy group or FECA number.	C	2000B	SBR03	Titled Subscriber Group or Policy # in 837P.
11a	Insured's Birth Date/Sex	Same as # 3. Required if 11 is completed.	C	2010BA	DMG02 DMG03	Titled Subscriber DOB and Gender on 837P.
11b	Other Claim ID	Enter the following qualifier and accompanying identifier to report the claim number assigned by the payer for worker's compensation or property and casualty: <ul style="list-style-type: none"> • Y4 - Property Casualty Claim Number Enter qualifier to the left of the vertical, dotted line, identifier to the right of the vertical, dotted line.	C	2010BA	REF01 REF02	Titled Other Claim ID in 837P.
11c	Insurance Plan Name or Program Name	Enter name of Health Plan. Required if 11 is completed.	C	2000B	SBR04	Titled Subscriber Group Name in 837P.
11d	Insurance Plan Name or Program Name	Enter name of Health Plan. Required if 11 is completed.	C	2000B	SBR04	Titled Subscriber Group Name in 837P.
12	Patient's Or Authorized Person's Signature	On the 837, the following values are addressed as follows at Optum/Change Healthcare, Availity, or other clearinghouse: "A", "Y", "M", "O" or "R", then change to "Y", else send "I" (for "N" or "I").	R	2300	CLM09	Titled Release of Information code in 837P.
13	Insured's Or Authorized Person's Signature		C	2300	CLM08	Titled Benefit Assignment Indicator in 837P.

CMS-1500 Claim Form

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
14	Date Of Current Illness Injury, Pregnancy (LMP)	<p>MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier to right of vertical dotted line. Qualifiers include:</p> <ul style="list-style-type: none"> • 431 – Onset of Current Symptoms or Illness • 439 – Accident Date • 484 – Last Menstrual Period (LMP) <p>Use the LMP for pregnancy. Example:</p> 	C	2300	DTP01 DTP03	Titled in the 837P: Date – Onset of Current Illness or Symptom Date – Last Menstrual Period
15	Other Date	<p>MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier between the left-hand set of vertical dotted lines. Qualifiers include:</p> <ul style="list-style-type: none"> • 454- Initial Treatment • 304 Latest Visit or Consultation • 453 – Acute Manifestation of a Chronic Condition • 439 – Accident • 455 – Last X-Ray • 471 – Prescription • 090 – Report Start (Assumed Care Date) • 091 – Report End (Relinquished Care Date) • 444 – First Visit or Consultation <p>Example:</p> 	C	2300	DTP01 DTP03	Titled in the 837P: Date – Initial Treatment Date – Last Seen Date Date – Acute Manifestation Date – Accident Date – Last X-ray Date Date – Hearing and Vision Prescription Date Date – Assumed and Relinquished Care Dates Date – Property and Casualty Date of First Contact
16	Dates Patient Unable to Work in Current Occupation		C	2300	DTP03	Titled Disability from Date and Work Return Date in 837P.
17	Name Of Referring Physician or Other Source	Enter applicable 2-digit qualifier to the left of vertical dotted line. If multiple providers are	R	2310A (Referring) 2310D	NM 101 NM103 NM104	

CMS-1500 Claim Form

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
		involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Qualifiers include: <ul style="list-style-type: none"> • DN - Referring Provider • DK - Ordering Provider • DQ - Supervising Provider Example: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> 17. NAME OF REFERRING PROVIDER OF DN Jane A Smith MD </div>		(Supervising) 2420E (Ordering)	NM105 NM107	
17a	Other I.D. Number of referring physician	Enter the 9-digit MA provider number for the attending, prescribing, or supervising physician. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. If the Other ID number is the Health Plan ID number, enter G2. If the Other ID number is another unique identifier, refer to the NUCC guidelines for the appropriate qualifier. The NUCC defines the following qualifiers: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.) Required if # 17 is completed.	C	2310A (referring) 2010D (supervising) 2420E (ordering)	REF01 REF02	Titled Referring Provider, Secondary Identified, Supervising Provider Secondary Identifier, and Ordering Provider Secondary Identifier in 837P.
17b	National Provider Identifier (NPI)	Enter the NPI number of the attending, prescribing, or supervising. Required if #17 is completed.	R	2310D	NM109	Titled Referring Provider Identifier, Supervising Provider Identifier, and Ordering Provider Identifier in 837P.

CMS-1500 Claim Form

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
18	Hospitalization Dates Related to Current Services	Required when place of service is inpatient. MMDDYY (indicate from and to date.)	C	2300	DPT01 DTP03	Titled Related Hospitalization Admission and Discharge Dates in 837P
19	Additional Claim Information (Designated by NUCC)	<p>Enter additional claim information with identifying qualifiers as appropriate.</p> <p>For multiple items, enter three blank spaces before entering the next qualifier and data combination.</p> <p>The NUCC defines the following qualifiers:</p> <ul style="list-style-type: none"> • OB State License • G2 Provider Commercial Number • LU Location Number <i>(This qualifier is used for Supervising Provider only.)</i> <p>Claim Attachment Report Type codes in 837P defines the following qualifiers</p> <p>03 - Itemized Bill M1 - Medical Records for HAC review 04 - Single Case Agreement (SCA)/ LOA 05 - Advanced Beneficiary Notice (ABN) CK - Consent Form 06 - Manufacturer Suggested Retail Price /Invoice 07 - Electric Breast Pump Request Form 08 - CME Checklist consent forms (Child Medical Eval) EB - EOBs - for 275 attachments should only be used for non-covered or exhausted benefit letter</p>	R	2300	NTE PWK	Titled Provider Taxonomy code 837P. Provider Additional Identifier in 837P.
	Additional Claim Information		Required	2310B 2300	PRV03 PRV01=P E PWK01	

CMS-1500 Claim Form						
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
		CT - Certification of the Decision to Terminate Pregnancy AM - Ambulance Trip Notes/ Run Sheet				
20	Outside Lab	If applicable, indicate, Yes. (If patient had outside lab work completed). Otherwise, leave blank.	C	2400	PS102	
21	Diagnosis Or Nature of Illness or Injury. (Relate To 24E)	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD diagnosis codes. Relate lines A – L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Note: Claims with invalid diagnosis codes will be denied for payment. External diagnosis or "E" codes are not acceptable as a primary diagnosis.	R	2300	HIXX-02 Where XX = 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12	
22	Resubmission Code and/or Original Ref. No	This field is required for resubmissions or corrected claims. Enter the appropriate bill frequency code (7 or 8 – see below) left justified in the Submission Code section, and the Claim ID# of the latest iteration of the original claim in the Original Ref.No. section of this field. 7- Replacement of Prior Claim 8- Void/cancel of Prior Claim	C Required for resubmitted or corrected claims.	2300 2300	CLM05-3 REF02 Where REF01 = F8	Titled Claim Frequency Code in the 837P. Titled Payer Claim Control Number in the 837P. Send the original claim number if this field is used.

CMS-1500 Claim Form						
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
23	Prior Authorization Number CLIA Number Locations	Enter the referral or authorization number. Refer to the Provider Manual to determine if services rendered require an authorization. Laboratory Service Providers must enter CLIA number here for the location. EDI claims: CLIA must be represented in the 2300 loop, REF02 element.	C	2300	REF02 Where REF01 – G1 REF02 Where REF01 = 9F REF02 Where REF01 = X4	Titled Prior Authorization Number in 837P. Titled Referral Number in 837P. Titled CLIA Number in 837P.
24A	Date(s) Of Service	“From” date: MMDDYY. If the service was performed on one day leave “To” blank or re-enter “From” Date. See below for Important Note (instructions) for completing the shaded portion of field 24.	R	2400	DTP01 DTP03	Titled Service Date in 837P.
24B	Place Of Service	Enter the CMS standard place of service code. “00” for place of service is not acceptable.	R	2300 2400	CLM05- 1 SV105	Titled Facility Code Value in 837P. Titled Place of Service Code in 837P.
24C	EMG	This is an emergency indicator field. Enter Y for “Yes” or leave blank for “No” in the bottom (unshaded area of the field).	N	2400	SV109	Titled Emergency Indicator in 837P.
24D	Procedures, Services or Supplies CPT/HCPCS Modifier	Procedure codes (5 digits) and modifiers (2 digits) must be valid for date of service. Note: Modifiers affecting reimbursement must be placed in the 1 st modifier position.	R	2400	SV101 (2-6)	Titled Product/Service ID and Procedure Modifier in 837P.

CMS-1500 Claim Form

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
24E	Diagnosis Pointer	Diagnosis Pointer - Indicate the associated diagnosis by referencing the pointers listed in field 21 (1, 2, 3, or 4). Diagnosis codes must be valid ICD-10 codes for the date of service and must be entered in field 21. Do not enter diagnosis codes in 24E. Note: The Plan can accept up to twelve (12) diagnosis pointers in this field. Diagnosis codes must be valid ICD codes for the date of service.	R	2400	SV107 (1-4)	Titled Diagnostic Code Pointer in 837P.
24F	Charges	Enter charges. A value must be entered. Enter zero (\$0.00) or actual charged amount. (This includes capitated services.)	R	2400	SV102	Titled Line-Item Charge Amount in 837P.
24G	Days Or Units	Enter quantity. Value entered must be greater than or equal to zero. Blank is not acceptable. (Field allows up to 3 digits)	R	2400	SV104	Titled Service Unit Count in 837P
24H	Family Plan	In Shaded area of field: <u>AV</u> - Patient refused referral. <u>S2</u> - Patient is currently under treatment for referred diagnostic or corrective health problems. <u>NU</u> - No referral given; or <u>ST</u> - Referral to another provider for diagnostic or corrective treatment. In unshaded area of field: "Y" for Yes – if service relates to a pregnancy or family planning "N" for No – if service does not relate to pregnancy or family planning	C	2300 2400	CRC SV111 SV112	

CMS-1500 Claim Form

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
24i	ID Qualifier	If there is rendering provider information listed in 24j this field is required, enter ZZ.	R	2310B	REF (01) NM108	Titled Reference Identification Qualifier in 837P XX Required for NPA in NM109
24j	Rendering Provider ID	The individual rendering the service is reported in 24j if different from billing provider in box 33. Enter the NPI number in the unshaded area of the field. Enter Taxonomy in shaded area. Note: For clinics/facilities this section should be blank.	R	2310B	REF02 NM109 PRV03	Optum/Change HealthCare, Availity, or other clearinghouse will pass this ID on the claim when present. NPI Rendering provider taxonomy
25	Federal Tax ID Number SSN/EIN	Physician or Supplier's Federal Tax ID numbers.	R	2010AA	REF01 REF02	Titled Reference Identification Qualifier and Billing Provider Tax Identification Number in the 837P. Where REF01 Qualifier EI=Tax ID Where REF01 Qualifier SY=SSN
26	Patient's Account No.	The provider's billing account number.	R	2300	CLM01	Titled Patient Control Number in 837P.
27	Accept Assignment	Always indicate Yes . Refer to the back of the CMS 1500 (08-05) form for the section pertaining to Medicaid Payments.	R	2300	CLM07	Titled Assignment or Plan Participation Code in 837P.

CMS-1500 Claim Form

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
28	Total Charge	Enter total charges of lines 1-4. A value must be entered. Enter zero (0.00) or actual charges (this includes capitated Services). Blank is not acceptable.	R	2300	CLM02	Titled Total Claim Charge Amount in the 837P May be \$0.
29	Amount Paid	Required when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Plan. Medicaid programs are always the payers of last resort.	C	2300 2320	AMT02 AMT02	Patient Paid Payer Paid
30	Reserved for NUCC Use		Not Required			
31	Signature Of Physician or Supplier Including Degrees or Credentials / Date	Actual signature is required.	R	2300	CLM06	Titled Provider or Supplier Signature Indicator on 837P.
32	Name and Address of Facility Where Services Were Rendered (If other than Home or Office)	Required unless #33 is the same information. Enter the physical location. (P.O. Box #'s are not acceptable here)	R	2310C	NM103 N301 N401 N402 N403	
32a.	NPI number	Required if box 32 is completed enter Service location NPI.	R	2310C	NM109	Titled Laboratory or Facility Primary Identifier in the 837P.
32b.	Other ID#	Required if box 32 is completed enter Service location Taxonomy.	C	2310C	REF01 REF02	Titled Reference Identification Qualifier

CMS-1500 Claim Form

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
33	Billing Provider Info & Ph. #	Required – Identifies the provider that is requesting to be paid for the services rendered and should always be completed. Enter physical location; P.O. Boxes are not acceptable	R	2010AA	NM103 NM104 NM105 NM107 N301 N401 N402 N403 PER04	
33a.	NPI number	Enter the billing provider's NPI.	R	2010AA	NM109	Titled Billing Provider Identifier in 837P.
33b.	Other ID#	Enter the ZZ qualifier followed by the billing provider's taxonomy code.	R	2010A	PRV03 PRV01="BI"	Titled Provider Taxonomy Code in 837P.
			Required Health Plan ID (Recommended)	2010AA	REF02 where REF01 = G2	Titled Reference Identification Qualifier and Billing Provider Additional Identifier in 837P.

UB-04 Claim Form							
			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
1	Unlabeled Field NUBC - Billing Provider Name, Address and Telephone Number	Service Location, no PO Boxes (Required) Left justified Line a: Enter the complete provider name. Line b: Enter the complete address Line c: City, State, and Zip code + 4 Line d: Enter the area code, telephone number.	R	R	2010AA	NM1/85 N3 N4	Billing Provider Name (NM102 should always be 2) Billing Provider Address
2	Unlabeled Field NUBC - Pay-to Name and Address	Enter Remit Address. No PO Boxes Enter the Facility PROMISE Provider ID (PPID) number. Left justified	R	R	2010AB	NM1/87 N3 N4	Pay-To Name Pay-To Address
3a	Patient Control No.	Provider's patient account/control number	R	R	2300	CLM01	Patient's Control Number
3b	Medical/Health Record Number	The number assigned to the patient's medical/health record by the provider	C	C	2300	REF02 where REF01 = EA	Medical Reference Number
4	Type Of Bill	Enter the appropriate three or four digit code.	R	R	2300	CLM05	If Adjustment or Replacement or Void claim, include

UB-04 Claim Form							
			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		1 st position is a leading zero – Do not include the leading zero on electronic claims. 2 nd position indicates type of facility. 3 rd position indicates type of care. 4 th position indicates billing sequence.					frequency code as the last digit. Include the frequency code by using bill type in loop 2300. Include the Original claim number in loop 2300, segment REF01=F8 and REF02=the original claim number. (No dashes or spaces.)
5	Fed. Tax No.	Enter the number assigned by the federal government for tax reporting purposes.	R	R		REF/EI/02 Where REF01 = EI	Pay to provider = Billing Provider use 2010AA
6	Statement Covers Period From/ Through	Enter dates for the full ranges of services being invoiced. MMDDYY	R	R	2300	DTP03 where DTP01 = 434	MMDDYY Statement Dates
7	Unlabeled Field	Not Used. Leave Blank.	N/A	N/A	N/A	N/A	N/A
8a	Patient Identifier	Recipient Medicaid ID Number. Enter the member's Medicaid ID number exactly as it appears on their ID card.	R	R	2010BA 2010CA	NM109 where NM101 = IL NM109 where NM101 = QC	Patient =Subscriber Use 2010BA Subscriber ID Patient is not =Subscriber, Use 2010CA Patient ID

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
8b	Patient Name	<p>Patient name is required. Last name, first name, and middle initial. Enter the patient name as it appears on the Health Plan ID card. Use a comma or space to separate the last and first names.</p> <p><u>Titles</u> (Mr., Mrs., etc.) should not be reported in this field.</p> <p><u>Prefix</u>: No space should be left after the prefix of a name e.g., McKendrick.</p> <p><u>Hyphenated names</u>: Both names should be capitalized and separated by a hyphen (no space).</p> <p><u>Suffix</u>: A space should separate a last name and suffix.</p>	R	R	2010BA 2010CA	NM103, NM104, NM107 where NM101=I L NM103, NM104, NM107 where NM101 = QC	<p>Patient =Subscriber Use 2010BA</p> <p>Subscriber Name Patient is Not =Subscriber, Use 2010CA</p> <p>Patient Name</p>

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
9a-e	Patient Address	The mailing address of the patient 9a. Street Address 9b. City 9c. State 9d. ZIP Code + 4 9e. Country Code (report if other than USA)	R	R	2010BA 2010CA	N301, N302 N401, 02, 03, 04 N301, N302 N401, 02, 03, 04	Patient =Subscriber, Use 2010BA Subscriber Address Patient is not =Subscriber, Use 2010CA Patient Address
10	Patient Birth Date	The date of birth of the patient Right justified; MMDDYYYY	R	R	2010BA 2010CA	DMG02 DMG02	Subscriber Demographic Info
11	Patient Sex	The sex of the patient recorded at admission, outpatient service, or start of care. M for male, F for female.	R	R	2010BA 2010CA	DMG03 DMG03	Subscriber Demographic Info
12	Admission Date	The start date for this episode of care. For inpatient services, this is the date of admission. Right Justified	R	R	2300	DTP03 where DTP01=4 35	Required on inpatient. Admission date/HR

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
13	Admission Hour	The code referring to the hour during which the patient was admitted for inpatient or outpatient care. Left Justified	R	R	2300	DTP03 where DTP/43/	Required on inpatient. Admission date/HR
14	Admission Type	A code indicating the priority of this admission/visit.	R	R	2300	CL101	Institutional Claim Code
15	Point of Origin for Admission or Visit	A code indicating the source of the referral for this admission or visit.	R	R	2300	CL102	Institutional Claim Code
16	Discharge Hour	Valid national NUBC Code indicating the discharge hour of the patient from inpatient care.	R	R	2300	DTP03 where DTP01=096	
17	Patient Discharge Status	A code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill, as reported	R	R	2300	CL103	Institutional Claim Code

UB-04 Claim Form							
			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		in Field 6.					
29	Accident State	The accident state field contains the two-digit state abbreviation where the accident occurred. Required when applicable.	R	R	2300	REF02 Where REF01 = LU	
30	Unlabeled Field	Leave Blank	N/A	N/A	N/A	N/A	N/A
31a, b - 34a, b	Occurrence Codes and Dates	Enter the appropriate occurrence code and date. Code must be 01 - 69, or A0-A9 or B1. Dates must be in YYYYMMDD format. Required when applicable.	R	C	2300	HIXX-2 Where XX = 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12	HIXX-1 = BH
35a, b - 36a, b	Occurrence Span Codes and Dates	A code and the related dates that identify an event that relates to the payment of the claim. Code must be 70 - 99 or M0-Z9. Dates must	R	C	2300	HIXX-2 Where XX = 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12	HIXX-1 = BI

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		be in MMDDYY format. Required when applicable.					
37a, b	Referral Code	Required when applicable.	N		2300	NTE	<p>NTE 01 position - input "ADD" Upper case/capital format.</p> <p>NTE 02 position - first six-character (input upper case/capital format where the sixth character will be the = sign.) Input applicable referral directly after "="</p> <p>For multiple code entries: Use "_"(underscore) to separate as follows: NTE*ADD*EPSD T=YD_YM_Y O~</p>
38	Responsible Party Name and Address	The name and address of the party responsible for the bill.	N	C	N/A	N/A	

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
39a,b, c, d - 41a, b, c, d	Value Codes and Amounts	<p>A Code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization Value Codes and amounts. If more than one value code applies, list in alphanumeric order.</p> <p>Required when applicable.</p> <p>Note: If value code is populated then value amount must also be populated and vice versa.</p> <p>Please see NUCC Specifications Manual Instructions for value codes and descriptions.</p> <p>Documenting covered and non-covered days: Value Code 81-non-covered</p>	C	C	2300	HIXX-2 HIXX-5 Where XX = 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12	HIXX-1 = BE

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		days; 82 to report co-insurance days; 83- Lifetime reserve days. Code in the code portion and the Number of Days in the "Dollar" portion of the "Amount" section. Enter "00" in the "Cents" field.					
42	Rev. Cd.	Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements	R	R	2400	SV201	Revenue Code
43	Revenue Description	The standard abbreviated Description of the related revenue code categories included on this bill. See NUBC instructions for Field 42 for description of each revenue code category.	R	R	N/A	N/A	Not mapped 8371

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
44	HCPCS/Accommodation Rates/HIPPS Rate Codes	<p>1. The Healthcare Common Procedure Coding system (HCPCS) applicable to ancillary service and outpatient bills.</p> <p>2. The accommodation rate for inpatient bills.</p> <p>3. Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems.</p>	C	R	2400	SV202-2	SV202-1=HC/HP

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		Enter the applicable rate, HCPCS or HIPPS code and modifier based on the Bill Type of Inpatient or Outpatient. HCPCS are required for all outpatient claims (Note: NDC numbers are required for all physician administered drugs.)					
45	Serv. Date	Service date (required for outpatient billing only; cannot be used for inpatient billing)	C	R	2400	DTP03 where DTP01=472	Date of Service
46	Serv. Units	Report units of services. A quantitative measure of services rendered by revenue category to the patient to include number of service days.	R	R	2400	SV205	Service Units

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
47	Total Charges	Total charges for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total Charges includes both covered and non-covered charges. Report grand total of submitted charges. Enter a zero (\$0.00) or actual charged amount.	R	R	2300	SV203	Total Charges
48	Non-Covered Charges	To reflect the non-covered charges for the destination payer as it pertains to the related revenue code. Required when Medicare is Primary.	C	C	2400	SV207	Non-Covered Charges

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
49	Unlabeled Field	N/A	Not required	Not required	N/A	N/A	Not Mapped
50	Payer	Enter the name for each Payer being invoiced. When the patient has other coverage, list the payers as indicated below. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R	2000B 2010BB 2320 2330B 2330B	SBR NM103 where NM101=P R SBR NM103 where NM101=P R	Other Payer Name
51	Health Plan Identification Number	The number used by the health plan to identify itself.	R	R	2330B 2010BB 2330B	NM109 where NM101=P R	Payer ID Other Plan Payer ID
52	Rel. Info	Release of Information Certification Indicator. This field is required on Paper and Electronic Invoices. Line A refers to the primary payer; B, secondary; and C, tertiary. It is Expected that the provider has all necessary release	R	R	2300	CLM09	Release of Information code

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		information on file. It is expected that all released invoices contain "Y"					
53	Asg. Ben.	Valid entries are "Y" (yes) and "N" (no). The A, B, C indicators refer to the information in Field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary.	R	R	2300	CLM08	Benefits Assignment Certification Indicator
54	Prior Payments	The A, B, C indicators refer to the information in Field 50. The A, B, C indicators refer to the information in Field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary.	C	C	2320	AMT02 where AMT01= D	Prior Payment Amounts

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
55	Est. Amount Due	Enter the estimated amount due (the difference between "Total Charges" and any deductions such as other coverage). The amount up to two decimal places in the format XXXXX.XX	N	N	2430	AMT02 where AMT01 =EAF	Payment Estimated Amount Due
56	National Provider Identifier - Billing Provider	The unique identification number assigned to the provider submitting the bill; NPI is the national provider identifier.	R	R	2010AA	NM109 where NM101 = 85	NPI

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
57 A, B, C	Other (Billing) Provider Identifier	A unique identification number assigned to the provider submitting the bill by the health plan. Required for providers not submitting NPI in field 56. Use this field to report other provider identifiers as assigned by the health plan listed in Field 50 A, B and C.	N	N	2010AA 2010BB	REF02 where REF01 = EI REF02 where REF01 = G2 REF02 where REF01 = 2U	Tax ID Only sent if needed to determine the Plan ID Legacy ID
58	Insured's Name	Information refers to the payers listed in field 50. In most cases this will be the patient name. When other coverage is available, the insured is indicated here.	R	R	2010BA 2330A	NM103, NM104, NM105 where NM101 = IL NM103, NM104, NM105 where NM101 = IL	Use 2010BA is insured is subscriber Other Insured Name

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
59	P. Rel	Enter the patient's relationship to insured. For Medicaid programs the patient is the insured. Code 01: Patient is Insured Code 18: Self	R	R	2000B	SBR02	Individual Relationship code
60	Insured's Unique Identifier	Enter the patient's Health Plan ID on the appropriate line, exactly as it appears on the patient's ID card on line B or C. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R	2010BA	NM109 where NM101= IL REF02 where REF01 = SY	Insured's Unique ID
61	Group Name	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B,	C	C	2000B	SBR04	

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		secondary; and C, tertiary.					
62	Insurance Group No.	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C	2000B	SBR03	Subscriber Group or Policy Number
63	Treatment Authorization Codes	Enter the Health Plan referral or authorization number. Line A refers to the Primary payer; B, secondary; and C, tertiary.	R	R	2300	REF02 where REF01 = G1	Prior Authorization Number

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
64	DCN	Document Control Number. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. Previously, field 64 contained the Employment Status Code. The ESC field has been eliminated. Note: Resubmitted claims must contain the original claim ID.	C	C	2320	REF02 where REF01 = F8	Original Claim Number
65	Employer Name	The name of the employer that provides health care coverage for the insured individual identified in field 58. Required when the employer of the insurer is known to potentially be involved	N	N	2320	SBR04	

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		in paying this claim. Line A refers to the primary payer; B, secondary; and C, tertiary.					
66	Diagnosis		R	R			
67	Prin. Diag. Cd. and Present on Admission (POA) Indicator	The appropriate ICD codes corresponding to all conditions that coexist at the time of service, that develop subsequently , or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital service.	R	R	2300	HIXX-2 HIXX-9 Where HI01-1 = ABK	Principal Diagnosis
67 A - Q	Other Diagnosis	The Appropriate	C	C	2300	HIXX-2 HIXX-9	Other Diagnosis Information

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
	Codes	ICD codes corresponding to all conditions that coexist at the time of service, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital service.				Where HI01-1 = ABF	
68	Unlabeled Field	N/A	N/A	N/A	N/A	N/A	Not mapped.
69	Admitting Diagnosis Code	The appropriate ICD code describing the patient's diagnosis at the time of admission as stated by the physician. Required for inpatient and outpatient. External diagnosis codes cannot	R	R	2300	HI01-2 Where HI01-1= ABJ	Admitting diagnosis

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		be submitted as the primary diagnosis.					
70	Patient's Reason for Visit	The appropriate ICD code(s) describing the patient's reason for visit at the time of outpatient registration. Required for all outpatient visits. Up to three ICD codes may be entered in fields A, B, and C.	C	R	2300	HIXX-2 Where HIXX-1=APR Where XX = 01, 02, 03	Patient reason for visit
71	Prospective Payment System (PPS) Code	The PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer. Required when the Health Plan/ Provider contract requires this information. Up to 4 digits.	C	C	2300	HI01-2 Where HI01-1 = DR	DIAGNOSIS Related Group (DRG) Information

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
72a-c	External Cause of Injury (ECI) Code	The appropriate ICD code(s) pertaining to external cause of injuries, poisoning, or adverse effect. External Cause of Injury diagnosis codes should not be billed as primary and/or admitting diagnosis. Required if applicable.	C	C	2300	HIXX-2 Where HIXX-1 = ABN	HIXX-1 = BN or ABN External Cause of Injury
73	Unlabeled Field	N/A	N/A	N/A	N/A	N/A	Not mapped.
74	Principal Procedure code and Date	Inpatient facility – Surgical procedure code is required if the operating room was used. Outpatient facility or Ambulatory Surgical Center – CPT, HCPCS or ICD code is required when a surgical procedure is performed.	C	R	2300	HI01-2 HI01-4 Where HI01-1 = BBR	

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
74a-e	Other Procedure Codes and Dates	The appropriate ICD codes identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed. Inpatient facility – Surgical procedure code is required when a surgical procedure is performed. Outpatient facility or Ambulatory Surgical Center – CPT, HCPCS or ICD code is required when a surgical procedure is performed.	C	C	2300	HIXX-2 Where HI01-1 = BBQ	Other Procedure Information
75	Unlabeled Field	N/A	N/A	N/A	N/A	N/A	Not mapped.
76	Attending Provider Name and Identifiers NPI#/Qualifier/Other	Enter the NPI of the physician who has primary responsibility for the patient's	R	R	2310A	NM109	REF01=G2/

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
77	Operating Physician Name and Identifiers NPI#/Qualifier/Other ID#	Enter the NPI of the physician who performed surgery on the patient in the upper line, and their name in the lower line, last name first. If the operating physician has another unique ID# enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the Attending physician when a surgical procedure code is listed.	R	R	2310B	NM103, NM104, NM107, NM109 where NM101 = 72 REF02 where REF01=G 2	
78 – 79	Other Provider (Individual) Names	Enter the NPI# of any physician, other than the attending	C	C	2310C 2310C	NM103, NM104, NM107, NM109 where	

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
	and Identifiers - NPI#/Qualifier/Other ID#	physician, who has responsibility for the patient's medical care or treatment in the upper line, and their name in the lower line, last name first. If the other physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#				NM101 = ZZ REF02where REF01 = G2	
80	Remarks Field	Area to capture additional information necessary to adjudicate the claim. Claim Attachment Report Type codes in 837I defines the following qualifiers 03 - Itemized Bill M1 - Medical Records for HAC review	C R	C R	2300 2300	NTE02 Where NTE01=ADD PWK01	Billing Note Claim Attachment Report Type codes in 837I

UB-04 Claim Form

			Inpatient, Bill Types 11X and 86X	Outpatient, Bill Type 013X			
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		04 - Single Case Agreement (SCA)/ LOA 05 - Advanced Beneficiary Notice (ABN) CK - Consent Form 06 - Manufacturer Suggested Retail Price/ Invoice 07 - Electric Breast Pump Request Form 08 - CME Checklist consent forms (Child Medical Eval) EB - EOBs - for 275 attachments should only be used for non-covered or exhausted benefit letter CT - Certification of the Decision to Terminate Pregnancy AM - Ambulance Trip Notes/ Run Sheet					
81CC, a-d	Code-Code Field	To report additional codes related to	C	C	2000A	PRV01 PRV03	

		(overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institution al data set. B3 Billing Provider Taxonomy					
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Special Instructions and Examples for CMS 1500, UB-04 and Electronic Claims Submissions

Supplemental Information

A. CMS 1500 Paper Claims –

Important Note: All unspecified Procedure or HCPCS codes require a narrative description be reported in the shaded portion of field 24. The shaded area of lines 1 through 6 allow for the entry of 61 characters from the beginning of 24A to the end of 24G.

B. EDI – Field 33b (Professional)

Field 33b – Other ID# - Professional: 2310B loop, REF01=G2, REF02= Plan's Provider Network Number. Less than 13 Digits Alphanumeric. Field is required. Note: do not send the provider on the 2400 loop. This loop is not used in determining the provider ID on the claims D. EDI – Field 45 and 51 (Institutional)

Field 45 – Service Date must not be earlier than the claim statement date. Service Line Loop 2400, DTP*472

Claim statement date Loop 2300, DTP*434

Field 51 – Health Plan ID – the number used by the health plan to identify itself. PerformCare EDI Payer ID# is 65371.

C. Reporting NDC on CMS-1500 and UB-04 and EDI

1. NDC on CMS 1500

- NDC must be entered in the shaded sections of item 24A through 24G.
- Do not submit any other information on the line with the NDC; drug name and drug strength should not be included on the line with the NDC.
- To enter NDC information, begin at 24A by entering the qualifier N4 and then the 11 digit NDC information.
 - Do not enter a space between the qualifier and the 11 digit NDC number.
 - Enter the 11 digit NDC number in the 5-4-2 format (no hyphens).
 - Do not use 9999999999 for a compound medication, bill each drug as a separate line item with its appropriate NDC
- Enter the NDC quantity unit qualifier
 - F2 – International Unit
 - GR – Gram
 - ML – Milliliter
 - UN – Unit
- Enter the NDC quantity
 - Do not use a space between the NDC quantity unit qualifier and the NDC quantity
 - Note: The NDC quantity is frequently different than the HCPC code quantity

Example of entering the identifier N4 and the NDC number on the CMS 1500 claim form:

The diagram shows a CMS 1500 claim form line item with the following data: N459148001665 UN1. Red boxes and arrows highlight the 'N459148001665' as the '11 digit NDC' and the 'UN1' as the 'N4 qualifier' and 'NDC Unit Qualifier'. The 'NDC Quantity' is indicated as '1' in the quantity field.

24. A. DATE(S) OF SERVICE				B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DUNS OR UNITS	H. EXPD Family Ref	I. ID QUAL	J. RENDERING PROVIDER ID #
From	To	MM	DD	YY		CPT	HCPCS	MODIFIER						
10	01	05	10	11		J0400			1	250 00	40	N	G2	12345678901
														0123456789

2. NDC on UB-04

- NDC must be entered in Form Locator 43 in the Revenue Description Field.
- Do not submit any other information on the line with the NDC; drug name and drug strength should not be included on the line with the NDC.
- Report the N4 qualifier in the first two (2) positions, left-justified.
 - Do not enter spaces
 - Enter the 11 character NDC number in the 5-4-2 format (no hyphens).
- Do not use 9999999999 for a compound medication, bill each drug as a separate line item with its appropriate NDC

Immediately following the last digit of the NDC (no delimiter), enter the Unit of Measurement Qualifier.

- F2 – International Unit
- GR – Gram
- ML – Milliliter
- UN – Unit
 - Immediately following the Unit of Measure Qualifier, enter the unit quantity with a floating decimal for fractional units limited to 3 digits (to the right of the decimal).
 - Any unused spaces for the quantity are left blank.

Note that the decision to make all data elements left-justified was made to accommodate the largest quantity possible. The description field on the UB-04 is 24 characters in length. An example of the methodology is illustrated below.

N	4	1	2	3	4	5	6	7	8	9	0	1	U	N	1	2	4	5	.	5	6	7	
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	--

3. NDC via EDI

The NDC is used to report prescribed drugs and biologics as required by government regulation.

EDI claims with NDC info must be reported in the LIN segment of Loop ID-2410. This segment is used to specify billing/reporting for drugs provided that may be part of the service(s) described in SV1. Please consult your EDI vendor if not submitting in X12 format for details on where to submit the NDC number to meet this specification.

When LIN02 equals N4, LIN03 contains the NDC number. This number should be 11 digits sent in the 5-4-2 format with no hyphens. Submit one occurrence of the LIN segment per claim line.

Claims requiring multiple NDC's sent at claim line level should be submitted using CMS-1500 or UB- 04 paper claim.

When submitting NDC in the LIN segment, the CTP segment is required. This segment is to be submitted with the Unit of Measure and the Quantity.

When submitting this segment, CTP03, Pricing; CTP04, Quantity; and CTP05, Unit of Measure are required.

Provider Preventable Conditions Payment Policy and Instructions for Submission of POA Indicators for Primary and Secondary Diagnoses

The Plan payment policy with respect to Provider Preventable Conditions (PPC) complies with the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA defines PPCs to include two distinct categories: Health Care Acquired Conditions; and Other Provider-Preventable Conditions. It is the Plan's policy to deny payment for PPCs.

Health Care Acquired Conditions (HCAC) apply to Medicaid inpatient hospital settings only. An HCAC is defined as "condition occurring in any inpatient hospital setting, identified currently or in the future, as a hospital-acquired condition by the Secretary of Health and Human Services under hospital acquired conditions, except for DVT/PE following total knee or hip replacement in pediatric and obstetric patients.

Other Provider-Preventable Conditions (OPPC) is more broadly defined to include inpatient and outpatient settings. An OPPC is a condition occurring in any health care setting that: (i) is identified in the Commonwealth of Pennsylvania State Medicaid Plan; (ii) has been found by the Commonwealth to be reasonably preventable through application of procedures supported by evidence-based guidelines; (iii) has a negative consequence for the Member; (iv) can be discovered through an audit; and (v) includes, at a minimum, three existing Medicare National Coverage Determinations for OPPCs (surgery on the wrong patient, wrong surgery on a patient and wrong site surgery).

For a list of PPCs for which the Plan will not provide reimbursement, please refer to the Appendix of the Provider Manual.

Submitting Claims Involving a PPC

In addition to broadening the definition of PPCs, the ACA requires payers to make *pre-payment* adjustments. That is, a PPC must be reported by the provider at the time a claim is submitted.

There are some circumstances under which a PPC adjustment will not be taken, or will be lessened. For example:

- No payment reduction will be imposed if the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by the provider. Please refer to the Reporting a Present on Admission section for details.
- Reductions in Provider payment may be limited to the extent that the identified PPC would otherwise result in an increase in payment; and the Plan can reasonably isolate for

nonpayment the portion of the payment directly related to treatment for, and related to the PPC.

Practitioners

- If a PPC occurs, providers must report the condition through the claims submission process. Note that this is required even if the provider does not intend to submit a claim for reimbursement for the services. The requirement applies to providers submitting claims on the CMS-1500 or 837-P forms, and dental providers billing via ADA claim form or 837D formats.
- For professional service claims, please use the following claim type and format:

Claim Format:

- Report the external cause of injury codes, such as Y65.51, Y65.52 or Y65.53 in field 21 [and/or] field 24E of the CMS 1500 claim form.

Inpatient/Outpatient Facilities

- Providers submitting claims for facility fees must report a PPC via the claim submission process. Note that this reporting is required even if the provider does not intend to submit a claim for reimbursement of the services. This requirement applies to providers who bill inpatient or outpatient services via UB-04 or 837I formats.

For Inpatient facilities

When a PPC is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital-acquired. When submitting a claim which includes treatment as a result of a PPC, facility providers are to include the appropriate ICD-10 diagnosis codes, including applicable external cause of injury on the claim in field 67 A – Q. Examples of ICD-10 and external cause of injury include:

- If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the Patient Status Code 20 “Expired”.

For per-diem or percent of charge-based hospital contracts, claims including a PPC must be submitted via paper claim with the patient’s medical record. These claims will be reviewed against the medical record and payment adjusted accordingly. Claims with PPC will be denied if the medical record is not submitted concurrent with the claim. All information, including the patient’s medical record and paper claim should be sent to:

PerformCare of Pennsylvania
Healthchoices
P.O. Box 7308
London, KY 40742

For DRG-based hospital contracts, claims with a PPC will be adjudicated systematically, and payment will be adjusted based on exclusion of the PPC DRG. Facilities need not submit copies of medical records for PPCs associated with this payment type.

UB-04 or 837I

Valid POA indicators are as follows:

- “Y” = Yes = present at the time of inpatient admission
- “N” = No = not present at the time of inpatient admission
- “U” = Unknown = documentation is insufficient to determine if condition was present at time of inpatient admission
- “W” = Clinically Undetermined = provider is unable to clinically determine whether condition was present at time of inpatient admission or not
- Exempt from POA reporting – leave blank

A. Reporting POA on the UB-04 Claim Form

Fields 67 A – Q:

- Valid primary and secondary diagnosis codes (up to 5 digits), are to be placed in the unshaded portion of 67 A – Q, followed by the applicable POA indicator (1 character) in the shaded portion of 67 A – Q.

Sample UB-04 populated with primary and secondary diagnosis codes, and POA indicators:

FL 67

	Primary Diagnosis Code	FL 67 POA	FL 67 A - Q Secondary Diagnosis Codes						
66 DX	2449 67	Y	25001A	N	29620 B	U	V1581 C	W	D
	I		J		K		L		M
69 Admit DX			70 Patient Reason DX	a	b		C		71 PPS CODE

**FL 67 A - Q
POA**

B. Reporting POA in Electronic 837I Format

Provider is to submit their POA data via the NTE segment on all 837I claims, (005010X223A2), for Pennsylvania.

- Although this segment can repeat, Plan requires provider submit POA data on a single NTE Segment. No additional K3 segments with the letters POA will be validated.
- NTE segment must contain POA as the first three characters or the POA data will not be picked up. NTE*ADD *POA~
- NTE02 Segment must only contain details pertaining to the Principal and Other Diagnosis found in the HI segment with qualifiers BK for Principal and BF for Other Diagnosis prior to the ending Z (or X).
- The POA indicator for the BN – External Cause of Injury on the NTE segment

with POA is entered following the ending Z (or X). This is required by Optum/Change Healthcare, Availity, or other clearinghouses for Medicare Claims as well.

- No POA Indicator is to be sent for the BJ/ZZ – Admitting Diagnosis Data. Following the letters POA in the NTE Segment is to be only those identified on the Medicare Bulletin. 1, Y, N, U, Ware valid, with ending characters of X or Z and E Code indicator.

Example:

1st claim:

1 Principal and 2 Other

Diagnosis

NTE*ADD*POAYNUZ~

2nd Claim:

1 Principal and 3 Other Diagnosis and an ECode

NTE*ADD*POAYNIZY~

Common Causes of Claim Processing Delays, Rejections or Denials

Authorization Invalid or Missing - A valid authorization number must be included on the claim form for all services requiring prior authorization.

Attending Physician ID Missing or Invalid – Inpatient claims must include the name of the physician who has primary responsibility for the patient's medical care or treatment, and the medical license number on the appropriate lines in field number 82 (Attending Physician ID) of the UB-04 (CMS 1450) claim form. A valid medical license number is formatted as 2 alpha, 6 numeric, and 1 alpha character (AANNNNNA) OR 2 alpha and 6 numeric characters (AANNNNNN).

Billed Charges Missing or Incomplete – A billed charge amount must be included for each service/procedure/supply on the claim form.

Diagnosis Code Missing Required Digits – Precise coding sequences must be used in order to accurately complete processing. Review the ICD-10-CM or ICD-10 manual for the appropriate categories, subcategories, and extensions. After October 1, 2015, three-digit category codes are required at a minimum. Refer to the coding manuals to determine when additional alpha or numeric digits are required. Use “X” as a place holder where fewer than seven digits are required. Submit the correct ICD qualifier to match the ICD code being submitted. Additional guidance can be found in [AD 25 118 ICD 10 Codes](#).

Diagnosis, Procedure or Modifier Codes Invalid or Missing Coding from the most current coding manuals (ICD-10-CM, CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure and modifier fields must be completed.

EOBs (Explanation of Benefits) from Primary Insurers Missing or Incomplete – A copy of the EOB from all third party insurers must be submitted with the original claim form. Include pages with run dates, coding explanations and messages. Payment from the previous payer may be submitted on the 837I or 837P. Besides the information supplied in this document, the line item details may be sent in the SVD segment. Include the adjudication date at the other payer in the DTP, qualifier 573. COB pertains to the other payer found in 2330B. For COB, the plan is considered the payer of last resort.

Handwritten Claims – Handwritten claims are strongly discouraged. Handwritten information often causes delays in processing or inaccurate payments due to reduced clarity.

Illegible Claim Information – Information on the claim form must be legible in order to avoid delays or inaccuracies in processing. Review billing processes to ensure that forms are typed or printed in black ink, that no fields are highlighted (this causes information to darken when scanned or filmed), and that spacing and alignment are appropriate.

Incomplete Forms – All required information must be included on the claim forms in order to ensure prompt and accurate processing.

Member Name Missing – The name of the Member must be present on the claim form and must match the information on file with the Plan.

Member Plan Identification Number Missing or Invalid – The Member's MAID/ recipient number

must be included on the claim form or electronic claim submitted for payment.

Member Date of Birth does not match Member ID Submitted – a newborn claim submitted with the mother’s ID number will be pended for manual processing causing delay in prompt payment.

Multiple-year claims- Providers must bill separate claims when the dates of service span over a calendar year. This rule applies to all primary claims.

Payer or Other Insurer Information Missing or Incomplete – Include the name, address and policy number for all insurers covering the Plan Member.

Place of Service Code Missing or Invalid – A valid and appropriate two-digit numeric code must be included on the claim form. Refer to CMS 1500 coding manuals for a complete list of place of service codes. The place of service code must be valid for the service and provider type/specialty for the **rendering** provider.

Provider Name Missing – The name of the provider of service must be present on the claim form and must match the service provider name and TIN on file with the Plan.

Provider NPI – The NPI listed on the claim form must be registered with the PROMISE Medicaid Enrollment Number (see OMAP Bulletin Number 99-0614 titled Instructions for Registering Your National Provider Identifier to DHS, Issued November 22, 2006).

- Billing Provider NPIs must be included on the claims form.
 - **CMS 1500:** The billing provider’s NPI must always be provided in box 33a; the qualifier ZZ and billing taxonomy code must be in box 33b.
 - **UB-04:** The billing provider’s NPI must always be provided in box 56; the qualifier B3 and taxonomy code must be in box 81.

Provider NPI Number Missing or Invalid – The individual NPI and group NPI numbers for the service provider must be included on the claim form.

Qualifier- The appropriate qualifier for a Taxonomy code is ZZ for CMS 1500 forms and B3 for UB 04 claims.

Revenue Codes Missing or Invalid – Facility claims must include a valid four-digit numeric revenue code. Refer to UB-04 coding manuals for a complete list of revenue codes.

Rendering provider- The rendering provider’s NPI and Taxonomy Code is required if the rendering provider is individually credentialed with PerformCare and payment is going to the group.

Spanning Dates of Service Do Not Match the Listed Days/Units – Span-dating is only allowed for services that are paid on a per diem basis (ie. SU Halfway House) for consecutive dates of service. Always enter the corresponding number of consecutive days in the days/unit field. Services which can be provided for multiple units per day like IBHS or Family-Based cannot span-date. Please refer to [AD 24 110: Claims Dates of Service Clarification](#).

Signature Missing – The signature of the practitioner or provider of service must be present on the claim form and must match the service provider name, NPI and TIN on file with the Plan.

Tax Identification Number (TIN) Missing or Invalid - The Tax I. D. number must be present and must match the service provider name and payment provider on file with the Plan. The Tax I.D. number must also be linked to the provider’s PROMISe Medicaid Enrollment Number. Providers should be sure to check SSN or EIN depending on which the provider is enrolled with.

Taxonomy –The provider’s taxonomy number is required wherever requested in claim submissions.

CMS-1500 field 24J (Rendering Taxonomy, as applicable) and 33b (Billing Taxonomy)

UB04 field 76 (Attending Taxonomy) and 81(Billing Taxonomy)

Third Party Liability (TPL) Information Missing or Incomplete – Any information indicating a work-related illness/injury, no-fault, or other liability condition must be included on the claim form. Additionally, a copy of the primary insurer’s explanation of benefits (EOB) or applicable documentation must be forwarded along with the claim form.

Reminder: When billing Electronic Data Interchange (EDI) 837 coordination of benefit services to PerformCare indicate the appropriate primary insurer. Claims submitted indicating the primary payer is a commercial carrier rather than Medicare may be delayed or processed incorrectly.

Correct EDI submission:

The claims filing indicator (located in Loop 2320, segment SBR09) identifies whether the primary payer is another commercial payer. Please ensure you are using the appropriate indicator on EDI claims as follows:

- Cl -the primary payer is commercial insurance (non-Medicare)

Type of Bill – A code indicating the specific type of bill (e.g., hospital inpatient, outpatient, replacements, voids, etc.). The first digit is a leading zero. Do not include the leading zero on electronic claims. Adjusted claims may be sent via paper or EDI.

IMPORTANT BILLING REMINDERS:

- Include all primary and secondary diagnosis codes on the claim. All primary and secondary diagnosis codes must have a corresponding POA indicator.
- Substance Use providers must bill with Substance Use diagnoses and Mental Health providers must bill with Mental Health diagnoses. If providers do not follow these guidelines, Z99 denial issues could be issued.
- Missing or invalid data elements or incomplete claim forms will cause claim processing delays, inaccurate payments, rejections or denials.
- Regardless of whether reimbursement is expected, the billed amount of the service must be documented on the claim. Missing charges will result in rejections or denials.
- PerformCare strongly suggests that providers bill their usual and customary charges rather than the rate indicated on the rate notice. In the event of a system or data entry error, this practice will help providers avoid the need to resubmit corrected claims when the issue is resolved.

- Providers must bill Medicaid codes and modifiers reimbursable by PerformCare. Allowable codes lists can be requested from Account Executives.
- All billed codes must be complete and valid for the time period in which the service is rendered. Incomplete, discontinued, or invalid codes will result in claim rejections or denials.
- The services billed on the claim form should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges or code appear different due to global coding requirements of the primary insurer, submit claim with the appropriate coding which matches the total charges on the EOB.
- Submitting the original copy of the claim form will assist in assuring claim information is legible.
- Reimbursement for all rendering network providers for claims subject to the ordering/referring/prescribing (ORP) requirement is determined by validating that participating ORP Practitioners have a valid Pennsylvania Medical Assistance (MA) Provider ID. For more information on claims subject to ORP requirements please refer to [AD 17 104 Ordering, Referring, and Prescribing Providers](#).
- Do not highlight any information on the claim form or accompanying documentation. Highlighted information will become illegible when scanned or filmed.
- Do not attach notes to the face of the claim. This will obscure information on the claim form or may become separated from the claim prior to scanning.
- The individual service provider name and NPI number must be indicated on all group claims. Using only the group NPI or billing entity name and number will result in rejections, denials, or inaccurate payments.
- When the provider or facility has more than one NPI number, use the NPI number that matches the services submitted on the claim form. Imprecise use of NPI numbers may result in inaccurate payments or denials.
- When submitting electronically, the provider NPI number must be entered at the claim level as opposed to the claim line level. Failure to enter the provider NPI number at the claim level will result in rejection. Please review the rejection report from the EDI software vendor each day.
- Claims without the provider signature will be rejected.
- Claims without a tax identification number (TIN) will be rejected.
- Any changes in a participating provider's name, address, NPI number, or tax identification number(s) must be reported to the Plan immediately. Contact your Provider Account Executive to assist in updating the Plan's records.
- Providers must verify whether an Member has insurance coverage in addition to PerformCare, providers can verify Member eligibility and benefits through any of the following methods:
 - EVS <https://promise.dhs.pa.gov/portal/provider/Home/tabid/135/Default.aspx>
 - NaviNet (<https://navinet.net>)
 - PerformCare – **1-888-700-7370**

Common Denial Codes

The following are common denial codes and how to resolve the issue.

Denial Code	Meaning	Resolution
Z99	Code not payable for Provider Specialty or there is no Provider agreement on file	May be due to invalid CPT, modifiers, POS, diagnosis, provider type/specialty, provider agreement on file for the service being billed (ex. SU diagnosis for MH service, providers can only point to the diagnoses that they are approved to treat).
ZH0	Duplicate, disallowed, or unbundled service	Member is being seen in a higher level of care. See AD 25 102 for more information.
ZK1/ Z95	Invalid/ Deleted Code, Modifier, Description	The modifier billed is most likely not valid for the service or the base code requires a modifier (ex. 90791 always requires a modifier).
ZR2	Please submit the correct original claim #	Reference numbers from rejected claims letters are <u>not</u> valid claim #s and cannot be used in box 22. Providers should be sure to use the last iteration of the last processed claim.
X96	EOB (Explanation of Benefits) attached illegible or incomplete	Member may have multiple active TPLs. The EOB must also outline the billed service and how much the primary did or did not bill out.
ZJ2	Modifier Combination Invalid	Modifiers billed on the claim are not billable.
ZH6/ N17	Invalid place of service	The place of service does not align with the code or type of provider billed.
Z48	Not a final denial	The primary insurance denial reason is not a final denial. Provider must submit a first level appeal with the primary insurer.
073	Deny All Claim Lines	This is not a stand-alone denial code. There will be an additional denial code listed on the remittance advice for a more detailed explanation.

Electronic Claims Submission

The following sections describe the procedures for electronic submission for claims. Included are a high-level description of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

Electronic Data Interchange (EDI) for Claims

Electronic Data Interchange (EDI) allows for faster, more efficient and cost-effective claim submission for providers. EDI, performed in accordance with nationally recognized standards, supports the health care industry's efforts to reduce administrative costs.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim

submission. It has also been proven to reduce claim re-work (adjustments).

- Receipt of clearinghouse reports makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim form. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are generally processed quicker. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

All the same requirements for paper claim filing apply to electronic claim filing.

Important: Please allow for normal processing time before resubmitting the claim either through EDI or paper claim. This will reduce the possibility of your claim being rejected as a duplicate claim.

Important: In order to verify satisfactory receipt and acceptance of submitted records, please review both the Optum/Change Healthcare, Availity, or other clearinghouse Acceptance report, and the R059 Plan Claim Status Report.

Refer to the Claim Filing section for general claim submission guidelines.

Hardware/Software Requirements

There are many different products that can be used to bill electronically. As long as you have the capability to send EDI claims to Optum/Change Healthcare, or Availity, whether through direct submission or through another clearinghouse/vendor, you can submit claims electronically.

Contracting with Optum/Change Healthcare, Availity, and Other Electronic Vendors

If you are a provider interested in submitting claims electronically to the Plan but do not currently have Optum/Change Healthcare EDI capabilities, you can contact the OptumChange Healthcare Provider Support Line at **1-800-527-8133, option 2** or Availity Client Services at **1-800-AVAILITY (282-4548)**. Assistance is available Monday through Friday from 8 a.m. to 8 p.m. ET. You may also choose to contract with another EDI clearinghouse or vendor who already has Optum/Change Healthcare capabilities.

Direct Submission

Providers can submit claims directly to Optum/Change Healthcare Connect Center or PCH Global. The Optum/Change Healthcare Connect Center provides two methods for submitting claims: key them in manually or import batches of claims.

There is no cost to manually key claims in using Connect Center, but claims must be entered one at a time, which may not be feasible for practices with high claim volume. Providers should call Optum/Change Healthcare **1-800-527-8133** and follow the appropriate prompts, or go to <https://support.changehealthcare.com/customer-resources/enrollment-services> to enroll for direct submission with Optum/Change Healthcare. Optum/Change Healthcare will also provide information on their various electronic solutions, the requirements for connectivity, and setup

instructions.

Contacting the EDI Technical Support Group

Providers interested in sending claims electronically may contact the EDI Technical Support Group for information and assistance in beginning electronic submissions.

When ready to proceed:

- Read over the instructions within this booklet carefully, with special attention to the information on exclusions, limitations, and especially, the rejection notification reports.
- Contact your EDI software vendor and/or Optum/Change Healthcare to inform them you wish to initiate electronic submissions to the Plan.
- Be prepared to inform the vendor of the Plan's electronic payer identification number.

Important: Contact EDI Technical Support by email at: DL-EDI-Team@amerihealthcaritas.com.

Important: Providers are responsible for arranging to have rejection reports forwarded to the appropriate billing or open receivable departments.

Important: The Payer ID for PerformCare is 65391.

Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within the Claim Filing section of this booklet. Any EDI clearinghouse or vendor may require additional data record requirements.

Electronic Claim Flow Description

In order to send claims electronically to the Plan, all EDI claims must first be forwarded to Optum/Change Healthcare or Availity. This can be completed via a direct submission or through another EDI clearinghouse or vendor.

Once the clearinghouse receives the transmitted claims, the claim is validated for HIPAA compliance and the Plan's Payer Edits as described in Exhibit 99 at Optum/Change Healthcare. Claims not meeting the requirements are immediately rejected and sent back to the sender via an Optum/Change Healthcare error report. The name of this report can vary based upon the provider's contract with their intermediate EDI vendor or clearinghouse. Accepted claims are passed to the Plan, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to the Plan by the clearinghouse are immediately validated against provider and Member eligibility records. Claims that do not meet this requirement are rejected and sent back to the clearinghouse, which also forwards this rejection to its trading partner – the intermediate EDI vendor or provider. Claims passing eligibility requirements are then passed to the claim processing queues. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or Member data.

Providers are responsible for verification of EDI claims receipts. Acknowledgments for accepted or rejected claims received from the clearinghouse or other contracted EDI software vendors, must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to the Plan.

- If you would like assistance in resolving submission issues reflected on either the Acceptance or R059 Plan Claim Status reports, contact the Optum/Change Healthcare Provider Support Line at **1-800-527-8133** or Availity Client Services at **1-800-AVAILITY (282-4548)**. Assistance is available Monday through Friday from 8 a.m. to 8 p.m. ET.
- If you need assistance in resolving submission issues identified on the R059 Plan Claim Status report, contact the EDI Technical Support by email at: edi.support@amerihealthcaritas.com

Important: Rejected electronic claims may be resubmitted electronically once the error has been corrected.

Important: The clearinghouse will produce an Acceptance report * and a R059 Plan Claim Status Report** for its trading partner whether that is the EDI vendor or provider. Providers are responsible for arranging to have these reports forwarded to the appropriate billing or open receivable departments.

* An Acceptance report verifies acceptance of each claim by the clearinghouse.

** A R059 Plan Claim Status Report is a list of claims that passed the clearinghouse's validation edits. However, when the claims were submitted to the Plan, they encountered provider or Member eligibility edits.

Important: Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or Member data.

Timely Filing Note: Your claims must be received by the EDI vendor by 9 p.m. in order to be transmitted to the Plan the next business day.

Important: Contact Optum/Change Healthcare Provider Support Line at **1-800-527-8133** or Availity Client Services at **1-800-AVAILITY (282-4548)**. Assistance is available Monday through Friday from 8 a.m. to 8 p.m ET.

Important: Claims submitted can only be verified using the Accept and/or Reject Reports. Contact your EDI software vendor or clearinghouse to verify you receive the reports necessary to obtain this information.

Important: When you receive the Rejection report from the clearinghouse or your EDI vendor, the plan does not receive a record of the rejected claim.

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to the Plan must first pass the clearinghouse HIPAA edits and Plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at the Plan. In these cases, the claim must be corrected and re-submitted within the required filing deadline of 60 calendar days from the date of service. It is important that you review the Acceptance or R059 Plan Claim Status reports received from the clearinghouse or your EDI software vendor in order to identify and re-submit these claims accurately.

Plan Specific Electronic Edit Requirements

The Plan currently has two specific edits for professional and institutional claims sent electronically.

837P -005010X222A1– Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.

837I - 005010X223A2 – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.

Submit a 275 claim attachment transaction

PerformCare is accepting ANSI 5010 ASC X12 275 unsolicited attachments via Optum/Change Healthcare, Availity, or other clearinghouse. Please contact your Practice Management System Vendor or EDI clearinghouse to inform them that you wish to initiate electronic 275 attachment submissions via the PerformCare EDI payer ID: 65391.

There are three ways that 275 attachments can be submitted.

- Batch: you may either connect to Optum/Change Healthcare or Availity directly or submit via your EDI clearinghouse.
- API via JSON: you may use Optum/Change Healthcare to submit an attachment for a single claim.
- Portal: individual providers can register at Availity <https://www.availity.com/Essentials-Portal-Registration> to submit attachments.

General guidelines:

- A maximum of 10 attachments are allowed per submission. Each attachment cannot exceed 10 megabytes (MB), and total file size cannot exceed 100MB.
- The acceptable supported formats are pdf, tif, tiff, jpeg, jpg, png, docx, rtf, doc, and txt.
- The 275 attachments must be submitted prior to the 837. After successfully submitting a 275 attachment, an Attachment Control Number will generate. The Attachment Control Number must be submitted in the 837 transactions as follows:

- **CMS 1500**
 - Field Number 19
 - Loop 2300
 - PWK segment
- **UB-04**
 - Field Number 80
 - Loop 2300
 - PWK01 segment

In addition, the following 275 claims attachment report codes have been added. When submitting an attachment, use the applicable code in field number 19 of the CMS 1500 or field number 80 of the UB04, as documented in the Claims Filing Instructions.

Attachment Type	Claim assignment attachment report code
Itemized Bill	03
Medical Records for HAC review	M1
Single Case Agreement (SCA)/LOA	04
Advanced Beneficiary Notice (ABN)	05
Consent Form	CK
Manufacturer Suggested Retail Price /Invoice	06
Electric Breast Pump Request Form	07
CME Checklist consent forms (Child Medical Eval)	08
EOBs — for 275 attachments should only be used for non-covered or exhausted benefit letter	EB
Certification of the Decision to Terminate Pregnancy	CT
Ambulance Trip Notes/Run Sheet	AM

Common Rejections

Invalid Electronic Claim Records – Common Rejections from Optum/Change Healthcare, Availity, or other clearinghouses
Claims with missing or invalid batch level records
Claim records with missing or invalid required fields
Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-10, etc.)
Claims without provider numbers
Claims without Member numbers
Claims in which the date of birth submitted does not match the Member ID.
Invalid Electronic Claim Records – Common Rejections from the Plan (EDI Edits within the Claim System)
Claims received with invalid provider numbers

Claims received with invalid Member numbers
Claims received with invalid Member date of birth
Claims without Billing Taxonomy IDs, Attending Taxonomy IDs, Rendering Taxonomy IDs

Electronic Claim Payment Options

ECHO Health, Inc. (ECHO Health), a leading innovator in electronic payment solutions, offers electronic payment options to our healthcare providers so that they can select the payment method that best suits their accounts receivable workflow.

Virtual Credit Card (VCC)

Echo Health offers Virtual Credit Cards as an optional payment method. Virtual Credit Cards are randomly generated, temporary credit card numbers that are either faxed or mailed to providers for claims reimbursement. Major advantages to VCC are that providers do not have to enroll or fill out multiple forms in order to receive VCC, and personal information, like practice bank account VCC is received. In the future, PerformCare providers who are not currently registered to receive payments electronically will receive VCC payments as their default payment method, instead of paper checks. Your office will receive either faxed or mailed VCC payments, each containing a VCC with a number unique to that payment transaction with an instruction page for processing the payment and a detailed Explanation of Payment /Remittance Advice (EOP/RA). **Normal transaction fees apply based on your merchant acquirer relationship.** If you do not wish to receive your claim payments through VCC, you can opt out by contacting ECHO Health directly at **1-888-492-5579**.

Electronic Funds Transfers (EFT)

Electronic funds transfers allow you to receive your payments directly in the bank account you designate rather than receiving them by VCC or paper check. When you enroll in EFT, you will automatically receive electronic remittance advices (ERAs) for those payments. All generated ERAs and a detailed explanation of payment for each transaction will also be accessible to download from the ECHO provider portal (<https://providerpayments.com>). If you are new to EFT, you will need to enroll with ECHO Health for EFT from PerformCare.

Please note: Payment will appear on your bank statement from PNC Bank and ECHO as “PNC — ECHO.”

To sign-up to receive EFT from PerformCare, visit <https://enrollments.ECHOhealthinc.com/efteradirect/enroll>. There is no fee for this service.

To sign-up to receive EFT from all of your payers processing payments on the ECHO platform, visit <https://enrollments.ECHOhealthinc.com>. **A fee for this service may be required to receive EFT if you select the all payers option.**

If you already receive payments from ECHO Health, you may be able to enroll for EFT with the Plan using your existing account. Please make sure you have an ECHO Health draft number and corresponding payment amount so your enrollment request can be validated.

A draft number is listed as the EPC draft number on ECHO Health's explanation of payments. If you need assistance locating an ECHO payment in order to register, contact ECHO at 1-800-946-4041, Monday through Friday, from 8 a.m. to 6 p.m. ET.

If you have questions regarding how to enroll in EFT, please reference the [PerformCare EFT](#)

[Enrollment Guide](#) located on our website.

Electronic Remittance Advice (ERA)/835 file

Electronic Remittance Advices (also referred to as an 835 file) are also available through ECHO Health. To receive ERAs from PerformCare, it is important to check with your practice management/hospital information system vendor to see if the system includes both PerformCare Payer ID 65391 and ECHO Payer ID 58379.

If you are not receiving any payer ERAs, please contact your current practice management/hospital information system vendor to ask if your software can process ERAs. Your software vendor is then responsible for contacting ECHO to enroll for ERAs under PerformCare Payer ID **65391** and ECHO Health Payer ID **58379**

If your software does not support ERAs or you continue to reconcile manually, and you would like to start receiving ERAs only, please contact the ECHO Health Enrollment team at **1-888-834-3511**.

For enrollment support, please contact ECHO Health Inc. at **1-888-834-3511**.

If you have additional questions regarding VCC, EFT, or ERAs, please reference our FAQ or call Echo Health Support team at 1-888-492-5579.

For additional detailed resources visit our website at: <https://pa.performcare.org/>

1099 Distribution

At the end of each year, all providers that receive reimbursement from PerformCare can expect a 1099 to be issued. This form is an informational tax form used to report income that is distributed to providers by ECHO. If providers have questions about the status of the 1099 form please outreach to ECHO.

Electronic Billing Inquiries

Action	Contact
If you would like to transmit claims electronically...	Contact Optum/Change Healthcare Provider Support Line at 1-800-527-8133
If you have general EDI questions ...	Contact EDI Technical Support via email: edi.support@amerihealthcaritas.com
If you have questions about specific claims transmissions or acceptance and R059 - Claim Status reports...	Contact your EDI Software Vendor or call the Optum/Change Healthcare Provider Support Line at 1-800-527-8133
If you have questions about claims that are reported on the Remittance Advice....	Contact Provider Claim Services at 1-800-521-6007
If you need to know your provider NPI number...	Contact Provider Claim Services at 1-800-521-6007
If you would like to update provider Payee information, NPI, tax ID number or payment address information...	Notify PerformCare Account Executive in writing.
For questions about changing or verifying provider information...	Contact Account Executive at PerformCare.

If you would like information on the 835 Remittance Advice:	Contact your EDI Vendor
Check the status of your claim:	Review the status of your submitted claims on NaviNet at https://navinet.net
Sign up for NaviNet	https://navinet.net Navinet Customer Service: 1-888-482-8057

Third-Party Liability (TPL) and Claims Submission

All Medicaid plans, including PerformCare, have a contractual obligation to ensure that a member's primary insurance is used first where applicable. All claims for members with Medicare or commercial insurance as the primary insurance must be billed with the EOB from that primary carrier attached (one EOB for one claim.) If no EOB is attached, the claim will be denied as "missing EOB."

We understand there are services not covered by Medicare or commercial insurances. The following services are generally not covered by Medicare or Medicare Advantage plans or are known to not be available for members under the primary insurers' networks but are state Medicaid plan services in HealthChoices and covered by PerformCare. These services are exempt from the requirements to bill the primary **Medicare** insurer.

- Assertive Community Treatment (ACT) and Community Treatment Team (CTT)
- Certified Recovery Services (CRS)
- Clozapine/ Clozaril support services
- Crisis Intervention services
- Family-Based mental health services (FBMHS)
- IBHS (except when Act 62 or ABA coverage applies)
- Non-hospital-based Partial Hospitalization Programs (PHP) (drug and alcohol and mental health)
- Mobile Mental Health Treatment
- Music Therapy
- Peer Support Services
- Residential treatment services (RTF) for children and adolescents
- Substance use non-hospital services including withdrawal management, residential services, and halfway house
- Substance Use Outpatient Services
- Substance Use Intensive Outpatient Services (IOP)
- Targeted Case Management (TCM)

Except in accordance with Act 62, which provides coverage for certain services to children with a diagnosis on the autism spectrum and ABA (discussed below), the following services are generally not covered by primary commercial insurances. Except for members who have a primary insurance and a diagnosis on the autism spectrum, these services are exempt from EOB requirements from the primary **commercial** insurer.

- Assertive Community Treatment (ACT) and Community Treatment Team (CTT)
- Certified Recovery Services (CRS)
- Clozapine/ Clozaril support services
- Crisis Intervention services
- Family-Based mental health services (FBMHS)
- IBHS (non-ABA)
- Methadone Maintenance
- Mobile Mental Health Treatment
- Music Therapy
- Peer Support Services
- Residential treatment services (RTF) for children and adolescents
- Substance use non-hospital services, halfway house only
- Targeted Case Management (TCM)

Note: Substance Use non-hospital withdrawal management and residential treatment services still require EOBs from the primary commercial insurer.

Please be aware that providers must be Medicare-enrolled or enrolled in the commercial insurance plans to bill PerformCare for non-exempt services provided to members with Medicare or commercial insurance as a primary payer. ***Do not accept members with Medicare or commercial insurance as primary coverage until you have qualified Medicare- or commercial insurance-enrolled clinicians available to provide treatment.***

We strongly encourage providers to become enrolled in the Medicare program or commercial insurance. Information about the enrollment process for Medicare is available online at, <https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/chain-ownership-system-pecos/enrollment-applications>.

Providers are expected to make all reasonable efforts as required per MA enrollment to secure payment from the primary source (§1101.64 MA Manual), including assignment of clinicians that meet the primary insurer's credentialing requirements. PerformCare will not override TPL requirements for services provided that would have been paid by the primary payer had it been provided by a clinician who met criteria of the primary payer, when the provider has available such certified clinicians on staff, because the provider is not in network or because the provider did not follow proper authorization requirements for the primary insurance. This expectation applies to all services rendered at either the primary clinic site, satellite sites, or any location that is recognized as a place of service by the provider.

Special consideration is given when Medicare is the primary payer and there is documented evidence that there is not a provider of the required service within HealthChoices access standards. Commercial insurance is subject to the same access standards under Pennsylvania Department of Health regulations as PerformCare; thus, the commercial insurer is expected to fulfill its obligation to make payment for services included in their plan. If there is clinical support to bypass the TPL process, providers will be instructed to submit all claims on paper with an attached document. Further instruction will be provided as needed.

When submitting claims to PerformCare as a secondary payer, the EOB from the primary insurer must be attached to the claim when billing paper. Whether billing paper or electronically, **claims must be received within 60 days of your notification of payment or denial by the primary insurance company and within 365 days from the date of service.**

When PerformCare processes claims as secondary, lesser of logic is applied to most services. Payment is based on:

1. The lesser of the patient's responsibility which is the total of the coinsurance, copay and deductible or,
2. The difference of the Medicaid allowable minus the primary's payment.

For more information providers can refer to FI-014 Third Party Liability and Coordination of Benefits.

The following services pay up to PerformCare's contracted amount minus primary's payment,

1. Best Practice Evaluations
2. IBHS claims billed with the Rural Rate (TN) modifier
3. Interpreter rate
4. Telepsychiatry claims billed with the GT modifier
5. DBT services

The payment will never be more than the PerformCare allowable in the above scenarios.

When Medicare is primary, and pays for Mental Health Inpatient services, PerformCare will pay the deductible amount, even if that amount is over the PerformCare allowable.

When PerformCare processes claims as secondary for Spravato, the patient's responsibility which is the total of the coinsurance, copay and deductible, will be paid.

Some claims will require an adjustment due to overpayment or underpayment of a prior claim. If an adjustment is required, the EOB will give a detailed explanation and include a description of the process for the adjustment. In most cases, PerformCare will make the adjustment to a future payment.

Act 62 and Third-Party Liability (TPL)

Background: Coverage for autism services has changed since PA implemented Act 62 in July of 2008. Previous Act 62 TPL rules for PerformCare included exemptions for certain federal and out-of-state plans as well as self-funded plans. However, those TPL exemptions are no longer applicable in all cases. The conversion to IBHS and the use of ABA codes for members with or without a diagnosis of autism requires coordination of benefits and billing primary insurance plans because many commercial insurance plans cover ABA services. Medicaid remains the payer of last resort for these services and requires coordination of benefits.

Providers billing any IBHS codes for a member with a diagnosis of autism that may be subject to ACT 62 requirements and/or providers billing any ABA codes regardless of diagnosis must coordinate benefits with the member's primary insurance plan, including attempting to come in-network with the insurance plan. As services have transitioned from BHRS to IBHS, providers should be working to ensure that they are credentialed with each member's primary insurance plan and working with families to develop a transition plan for any situations where they are unable to become credentialed. However, PerformCare expects that there will be no sudden interruptions in service and should notify the Clinical Care Manager in cases where a plan needs to be developed for a family to transition to a new provider covered by the primary plan.

For PerformCare to pay as the secondary payer, Providers must submit an EOB with each claim if the primary insurance(s) covers the services for the member. For primary insurers that do not cover the services, Providers must submit one denial or non-covered letter (NCL) per CPT code billed per calendar year.

PerformCare has seen instances where primary insurers issued providers a NCL that covers the entire duration of an episode of care or authorization for an IBHS/ABA service which may be for several years, rather than issuing a new NCL each calendar year. We have also seen instances where the primary insurer issued a provider a NCL that spans two calendar years, such as 7/1/22 to 6/30 2023. However, PerformCare must receive confirmation of non-covered services for each calendar year as we must update the member's record each calendar year.

For Act 62 and ABA non covered letters that span more than one calendar year, or the non-covered letter is used for the duration of an episode of care, providers must submit the non-covered letter AND one EOB denial for each CPT code billed per calendar year.

The claim with NCL and/or EOB can be submitted via paper claim submission or 275 attachments.

Tricare

Tricare covers autism services, so exemptions for ACT 62 are not applicable to Tricare. Providers should attempt to become credentialed by Tricare if serving members with Tricare as primary insurance.

<https://tricare.mil/CoveredServices/IsItCovered/AutismSpectrumDisorder>

Out-of-State Plans

Insurance plans in all 50 states offer coverage for autism services. While there are variations and limitations to that coverage, a blanket exemption for out-of-state plans for members with a diagnosis of autism as originally permitted under ACT 62 implementation is no longer applicable, and TPL coordination of benefits with primary payers must be explored even for out-of-state plans.

www.disabilitycoop.com/2019/10/01/autism-insurance-coverage-now-required-50-states/27223/
www.ncsl.org/research/health/autism-and-insurance-coverage-state-laws.aspx

Self-funded Plans

Self-funded insurance plans in Pennsylvania continue to be exempt from ACT 62, but may pay for ABA services <https://www.autismspeaks.org/health-insurance-coverage-autism>. Forty-five percent of companies with more than 500 employees include coverage for ABA or other intensive behavioral therapies, according to the Mercer National Survey of Employer-Sponsored Health Plans. Most companies of this size provide self-funded plans.

Members with private insurance being newly referred to a provider for ABA services should be directed to an in-plan provider with that private insurance for the service if ABA is a covered service.

Because of the unique requirements of Act 62, autism service providers must follow procedures for both MA and private insurers. For example, providers should request prior authorization from both PerformCare and the private insurance company (if prior authorization is required from the private insurer.) DHS did not create special rules for autism services. Therefore, for those members and services that are applicable, providers should follow the existing TPL regulation (Title 55 §1101.64 concerning third-party medical resources). The procedure codes covered as Act 62 services are subject to cost avoidance. This means that the MA program through PerformCare should not pay a provider for services unless the private insurer denies the service. More specifically, certain denial reasons are not acceptable for PerformCare to pay per the existing TPL regulations.

Common reasons for non-payment by PerformCare include but are not necessarily limited to the following:

- Failure to follow the proper authorization procedures of the primary insurer
- Failure to follow the proper billing procedures of the primary insurer
- Accepting a member and providing service when the provider is out-of-network and no out-of-network benefits are available through the primary carrier. If a provider refuses to join the private insurance network of the MA recipient, PerformCare is not required to pay the provider for the service. The MA recipient cannot refuse to use available private insurance to avoid a copayment, deductible, or coinsurance.
- Families should not intentionally disenroll from private insurance. By law, MA is a government program and is the designated payer of last resort. As a condition of MA eligibility, the Members are agreeing to use other available insurance resources first. Families that intentionally drop private insurance coverage are at risk of losing continued MA coverage.

Corrected Claims

Providers using electronic data interchange (EDI) can submit corrected claims* electronically rather than via paper to the Plan.

* A corrected claim is defined as a resubmission of a claim with a specific change that you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim. Any claim that is resubmitted must be billed as a corrected or replacement claim and must include the original claim number.

Your EDI clearinghouse or vendor needs to:

- Use “7” for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P)
- Include the original claim number in segment REF01=F8 and REF02=the original claim number; no dashes or spaces
- Do include the plan’s claim number in order to submit your claim with the 7
- Do use this indicator for claims that were previously processed (approved or denied)
- Do not use this indicator for claims that contained errors and were not processed (rejected upfront)
- Do not submit corrected claims electronically and via paper at the same time

For more information, please contact the EDI Hotline by email:

edi.support@amerihealthcaritas.com

Providers using our NaviNet portal, (<https://navinet.net>) can view their corrected claims faster than available with paper submission processing.

Important: Claims originally rejected for missing or invalid data elements must be corrected and resubmitted within 365 calendar days from the date of service. Rejected claims are not registered as received in the claim processing system. (Refer to the definitions of rejected and denied claims on page 5.)

Important: Before resubmitting claims, check the status of your submitted claims online at <https://navinet.net>

Important: Corrected Claims may be sent in on paper via CMS 1500 or via EDI. If sending paper, please use a 7 as the resubmission code in box 22 and reference the last processed claim as the original claim number. Mailed corrected claims must be sent to:

PerformCare
Healthchoices
P.O. Box 7308
London, KY 40742

Important: Corrected Institutional and Professional claims can be resubmitted electronically using the appropriate bill type to indicate that it is a corrected claim.

Contact Optum/Change Healthcare Provider Support Line at: **1-800-527-8133** or Availity Client Services at **1-800-AVAILITY (282-4548)**. Assistance is available Monday through Friday from 8 a.m. to 8 p.m. ET.

Contact EDI Technical Support by email: edi.support@amerihealthcaritas.com

Important: Provider NPI number validation is not performed by the clearinghouse. The clearinghouse will reject claims for provider NPI only if the provider number fields are empty.

Important: The Plan's Provider ID is recommended as follows: 837P – Loop 2310B, REF*G2[PIN] NPI Processing – The Plan's Provider Number is determined from the NPI number using the following criteria:

1. Plan ID, Tax ID and NPI number
2. If no single match is found, the Service Location's ZIP code is used
3. If no service location is included, the billing address ZIP code will be used
4. If no single match is found, the Taxonomy is used
5. If no single match is found, the required Taxonomy is used
6. If a plan provider ID is sent using the G2 qualifier, it is used as provider on the claim The legacy Plan ID is used as the primary ID on the claim
7. If you have submitted a claim, and you have not received a rejection report, but are unable to locate your claim via NaviNet, it is possible that your claim is in review by the Plan. Please check with provider services and update you NPI data as needed. It is essential that the service location of the claim match the NPI information sent on the claim in order to have your claim processed effectively.

Administrative Appeals (Administrative Claim Denials)

Providers must follow all authorization and billing requirements as defined in the [Provider Manual](#) and [provider notices](#). The Administrative Appeal policy, [FI-027 Appeals of Administrative Denials](#), is intended to apply to claims denials that are not approved because they do not meet contractual or administrative requirements. Administrative denials are **not** denied based on medical necessity guidelines.

Before submitting an administrative appeal, a claim must be billed, and a denial notification must be received by the provider. All appeal requests must include the claim numbers for all dates of service involved. All requests for review of an administrative denial must be submitted with the [Administrative Appeal Request form](#) and received within 60 days of receiving the administrative denial notification. No claims 365 days or older will be considered for payment unless an exception applies. Exceptions include,

- Improper rejections or denials, resulting from a claim error by PerformCare
- Secondary/ Third Party Liability (TPL) primary payor issue

Providers must have an internal auditing system to ensure claims and administrative appeal requests are submitted timely.

An appeal that is valued at less than \$10,000 and received within 365 days of the dates of service will be reviewed by the Administrative Appeal Committee and will be decided within 30 days of the receipt of the appeal submission. The committee is comprised of representatives from each department who research and review each request.

An appeal that is valued at \$10,000 or more and/or has dates of service that are older than 365 days will be reviewed by executive management and will be decided within 30 days of the receipt of the appeal submission.

Providers requesting review of an administrative denial must submit a completed [Administrative Appeal Request form](#), in which the following information must be provided,

- Member Name
- Provider Name
- Contact Name
- Contact's mailing address
- Claim number(s)

- Service/CPT code with modifier
- Dates(s) or service
- Explanation of circumstances
- Steps taken to correct and prevent future occurrences
- Value of expected reimbursement
- For IBHS, FBMHS, or RTF/CRR requests, all clinical notes for the month requested as well as the treatment plan and prescription/order/evaluation must be submitted.
- For MH IP/PHP requests, admitting and discharge evaluation and progress notes are required.
- For All SUD services, ASAM level of care 6-dimension/assessment is required.
- Whenever a service requiring pre-certification was provided without a medical necessity review, the medical record must be submitted with the request.
- Documentation relevant to the request:
 - Eligibility verification system (EVS) documentation verifying the eligibility was checked and wrongly indicated enrollment status
 - An explanation of benefits (EOB) must be included in cases where the member has other insurance in addition to PerformCare coverage
- Reasons for approval (reversal of the original claims denial) may include but are not limited to:
 - Documentation of eligibility verification issues beyond the control of the provider
 - Documentation of processing errors by PerformCare
 - Documentation of continued stay review issues beyond the control of the provider
 - Unavoidable delay caused by another provider
- Reasons to uphold the original claims denial may include but are not limited to:
 - Failure in authorization management by the provider
 - Failure in claims or billing management by provider
 - Failure to check a member's eligibility prior to service delivery
 - Submission of the request was beyond 60 days of the original claim's denial notice
 - Untimely filing- claims that are 365 days or more beyond the dates of service will not be considered for payment
- Reasons for rejection of an appeal request (which reserves the opportunity for the provider to resubmit the appeal within 30 days of the response letter) include:
 - A claim was not billed, and a denial notice was not received before the administrative appeal request was submitted to PerformCare.
 - The claim number(s) was missing
 - Incorrect and insufficient information was submitted
 - The requested dates of service have already been paid

All relevant information must be submitted with the appeal request. The decision of the review process is final.

**Singular administrative appeals can be mailed to:
 PerformCare Administrative Appeals
 P.O. Box 7301
 London, KY 40742**

Multiple Administrative Appeals (those involving 10 or more claims) or singular administrative appeals can be submitted via NaviNet. Providers should follow the Forms and Dashboards section of the [PerformCare's NaviNet Authorization Participant Guide](#).

Tips for Accurate Diagnosis Coding: How to Minimize Retrospective Chart Review

Why are retrospective chart reviews necessary?

Although the Plan captures information through claims data, certain diagnosis information is commonly contained in medical records but is not reported via claim submission. Complete and accurate diagnosis coding will minimize the need for retrospective chart reviews.

What is the significance of the ICD-10-CM Diagnosis code?

International Classification of Diseases-10th Edition-Clinical Modification (ICD-10-CM) codes are identified as 3 to 7 alpha-numeric codes used to describe the clinical reason for a patient's treatment and a description of the patient's medical condition or diagnosis (rather than the service performed).

- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
- Do not code conditions that were previously treated and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Per the ICD-10-CM Official Guidelines for Coding and Reporting, providers must code all documented conditions that were present at time of the encounter/visit and require or affect patient care treatment or management.

Have you coded for all chronic conditions for the Member?

Examples of disease conditions that should always be considered and included on the submission of the claim if they coexist at the time of the visit:

Amputation status	HIV/AIDS
Bipolar disorder	Hypertension
Cerebral vascular disease	Lung, other severe cancers
Chronic renal failure	Metastatic cancer, acute leukemia (Prostate, breast, etc.)
Congestive heart failure	Multiple sclerosis
CAD	Paraplegia
Depression	Quadriplegia
Diabetes mellitus	Renal failure
Dialysis status	Schizophrenia
Drug/alcohol psychosis	

What are your responsibilities?

Providers must accurately report the ICD-10-CM diagnosis codes to the highest level of specificity.

Accurate coding can be easily accomplished by keeping accurate and complete medical record documentation.

Documentation Guidelines

- Reported diagnoses must be supported with medical record documentation.
- Acceptable documentation is clear; concise, consistent, complete, and legible.

Provider Documentation Tips

- First list the ICD-10CM code for the diagnosis, condition, problem or other reason for the encounter visit shown in the medical record to be chiefly responsible for the services provided.
- Adhere to proper methods for appending (late entries) or correcting inaccurate data entries, such as lab or radiology results.
- Strike through, initial, and date. Do not obliterate.
- Use only standard abbreviations.
- Identify patient and date on each page of the record.
- Ensure provider signature and credentials are on each date of service documented.

Clinical Laboratory Improvement Amendments (CLIA)

Providers that perform laboratory testing are required to indicate their CLIA ID number when submitting professional claims. Professional claims submitted for laboratory services are validated for the following to be processed and paid:

- Is the lab code submitted subject to CLIA requirements?
- Is there an active CLIA number on the claim? (see below for correct fields)
- Is the lab code billed within the scope of the CLIA certification number submitted on the claim?

*Codes appearing on the CMS clinical waiver list should be billed with a QW modifier. Failure to do so will result in claim payment denials.

Please note that it is the responsibility of providers to make sure the laboratory tests performed are within the scope of their certification and that they have a valid (not expired) CLIA number.

For electronic and paper professional claims, enter your CLIA ID numbers in the fields indicated below:

- For the 837 professional electronic claim submission: Please enter your CLIA ID number in Loop ID 2300, segment/data element REF2
- For the CMS 1500 paper form, please enter your CLIA in field 23 (titled prior authorization number).
- It is not necessary to indicate your CLIA ID number on institutional claims.

Most Common Claims Errors

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
2	Patient's Name	" Member name is missing or illegible. " (If first and/or last name are missing or illegible, the claim will be rejected.)
3	Patient's Birth Date	" Member date of birth (DOB) is missing. " (If missing month and/or day and/or year, the claim will be rejected.)
3	Patient's Birth Sex	" Member's sex is required. " (If no box is checked, the claim will be
4	Insured's Name	" Insured's name missing or illegible. " (If first and/or last name is missing or illegible, the claim will be rejected.)
5	Patient's Address (number, street, city, state, zip) phone	" Patient address is missing. " (If street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)
6	Patient Relationship to Insured	" Patient relationship to insured is required. " (If none of the four boxes are selected, the claim will be rejected.)

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
7	Insured's Address (number, street, city, state, zip) phone	"Insured's address is missing." (If street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.) (If street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)
21	Information related to Diagnosis/Nature of Illness/Injury	"Diagnosis code is missing or illegible." (The claim will be rejected.)
24	Supplemental Information	"National Drug Code (NDC) data is missing/incomplete/invalid." (The claim will be rejected if NDC data is missing incomplete, or has an invalid unit/basis of measurement.)
24A	Date of Service	"Date of service (DOS) is missing or illegible." (The claim will be rejected if both the "From" and "To" DOS are missing. If both "From" and "To" DOS are illegible, the claim will be rejected. If only the "From" or "To" DOS is billed, the other DOS will be populated with the DOS that is present.)
24B	Place of Service	"Place of service is missing or illegible." (Claim will be rejected.)
24D	CPT Code	"Procedure code is missing or illegible." (Claim will be rejected.)
24E	Diagnosis Pointer	"Diagnosis (DX) pointer is required on line ___" [lines 1-6]. (For each service line with a "From" DOS, at least one diagnosis pointer is required. If the DX pointer is missing, the claim will be rejected.)
24F	Line item charge amount	"Line item charge amount is missing on line ___" [lines 1-6]. (If a value greater than or equal to zero is not present on each valid service line, claim will be rejected.)
24G	Days/Units	"Days/units are required on line ___" [lines 1-6]. (For each line with a "From" DOS, days/units are required. If a numeric value is not present on each valid service line, claim will be rejected.)
24J	Rendering provider identification	"National provider identifier (NPI) of the servicing/rendering provider is missing, or illegible." (If applicable.)
26	Patient Account/Control Number	"Patient Account/Control number is missing or illegible" (If missing or illegible, claim will reject)
27	Assignment Number	"Assignment acceptance must be indicated on the claim." (If "Yes" or "No" is not checked, the claim will be rejected.)
28	Total Claim Charge Amount	"Total charge amount is required." (If a value greater than or equal to zero is not present, the claim will be rejected.)

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
31	Signature of physician or supplier including degrees or credentials	" Provider name is missing or illegible. " (If the provider name, including degrees or credentials, and date is missing or illegible, the claim will be rejected.)
33	Billing Provider Information and Phone number	" Billing provider name and/or address is missing or incomplete. " (If the name and/or street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)

Appendix A: Frequently Asked Questions Provider Enrollment and Related Questions

How can I become a network provider?

All providers go through the credentialing process, which begins by completing an in-plan expansion application. Provider may obtain an application package by contacting Provider Relations at **1-888-700-7370**. All providers must be licensed and enrolled and in good standing within the Pennsylvania MA program.

How do I enroll with the Pennsylvania MA program?

All PerformCare HealthChoices providers must be enrolled in the Pennsylvania MA program. Providers can visit DHS' website at www.dhs.pa.gov or call the OMAP Enrollment Toll-Free Inquiry line at **1-800-537-8862** for more information on fee-for-service enrollments. When calling to check on the status of an application please allow 45 days from the date that the application was submitted. Please note that OMAP does not handle all types of enrollments. OMHSAS enrolls Targeted Case Management, Family-Based Mental Health and Crisis Intervention Services. For those enrollments, contact the behavioral health services line at **1-800-433-4459** or by email at RA-PWSERVICES@pa.gov.

What if I cannot accept any new referrals or other changes occur that affect my ability to see members?

It is important that you tell your Account Executive any new information that affects referrals so providers and members will not be inconvenienced. Please be sure to notify us of phone number and address changes as well. PerformCare will need the information in written form via fax **717-671-6522** or via email to your Account Executive. A [Provider Data Update Form](#) may be used. Temporary inability to accept referrals will not jeopardize network status.

Who do I notify when a site moves or a practitioner leaves/starts employment?

This information should be reported to your Account Executive in writing using the [Provider Data Update Form](#). Up-to-date information prevents inconvenience for members as well as providers.

If you are structured as a group practice, each new practitioner must complete an individual credentialing application for enrollment. Please contact the Account Executive to request an application. If you are a provider with a license from OMHSAS to provide behavioral health services or with a license from DDAP to provide drug and alcohol services, you are probably categorized as a facility provider. If you are an individual clinician who works exclusively for a facility, it is not necessary to complete the individual application for enrollment. Please be certain to notify PerformCare if you have a new prescribing practitioner. Failure to enroll new ordering, referring, and prescribing providers in Medicaid may lead to problems when members get prescriptions filled. Except in the case of a supplemental service, anytime there is a change, DHS must also be notified.

Clinical Operations and Authorization Questions

How do I request authorization?

All services except crisis intervention, targeted case management and outpatient (psychiatric evaluation, psychological evaluation, medication management, family, individual, and group therapy) and substance use hospital and non-hospital withdrawal management require approval from a Clinical Care Manager before they are provided. Hospital withdrawal management does not require prior approval; however, it is important to contact the Clinical Care Manager prior to discharge so that an authorization can be generated for billing these services. Current authorization request forms as well as instructions for completing forms can be found on the PerformCare website under **Forms**. Providers can also use the [Prior Authorization Lookup Tool](#) for more information. Inpatient psychiatric hospitalization and acute partial hospitalization require a phone call to PerformCare. You will have access to a live person 24 hours per day, seven days per week if you have questions or need to discuss a case.

When will I get the authorization?

Hard copies of authorizations will be mailed to you. You should receive a copy in approximately five business days, depending on mail service. If you have questions about the status of your authorization request, you may contact PerformCare at **1-888-700-7370** or check authorization status through NaviNet. If you do not receive the hard copy authorization, please call. In any circumstance, never hold your claims because you have not received hard copies of authorizations.

Should we stop services until we get an authorization even though we sent in the authorization request late?

Professional standards would indicate that services should not be discontinued based on late authorizations. The provider should work directly with the Clinical Care Manager to decide how to proceed. Providers should ensure that all authorization requests are submitted per PerformCare requirements so that there is minimal impact to the member's treatment.

How should we continue to provide services in the home and community when the member goes into Inpatient or Partial Hospitalization?

The lead clinician should contact the member's assigned Clinical Care Manager to discuss treatment concerns when members are in partial hospitalization or inpatient. Continuation of services should be part of that discussion.

How do I know who is the assigned Clinical Care Manager for a particular member?

Member Services Specialist staff can provide this information via a phone inquiry. Providers should be prepared with Member name and Medical Assistance identification number so that PerformCare can identify the Member.

What do I do if a member wants to go to a different provider?

As a provider, you are responsible for providing the member with other provider options and/or referring the member to PerformCare if they require additional information or experience any problems with transferring providers.

What if I do not agree with an administrative denial for authorization or claims payment?

If your authorization request or claim was denied due to administrative or procedural errors, you may request that PerformCare reconsider the decision. Reversal of administrative denials should be regarded as an exception and will not be routinely approved without compelling evidence that the provider did not follow protocol due to valid special circumstances as determined by PerformCare. An example of a valid special circumstance would be a conflict with EVS regarding an individual's eligibility, which can be proven by the provider in the form of EVS documentation.

All requests for review of administrative denial must be submitted via the Administrative Appeal process within 60 days of the authorization request denial or date of service denial.

How will I know about changes in authorization processes and other procedures at PerformCare?

PerformCare will share this information with providers through provider notices. Provider notices should be regarded as supplements and clarifications to the PerformCare Provider Manual and are considered incorporated by reference into the Provider Manual when they are issued. All such communications can be found on the website in the Providers section and are available for download.

What do I do if a member needs emergency services?

PerformCare expects the provider to take immediate action to ensure the safety of the member and others. PerformCare should be contacted for service authorization at **1-888-700-7370** after the situation is stabilized.

Emergencies should be considered as incidents/behaviors when member is a direct threat to self and/or others and is in need of a higher level of care due to safety. Emergency care is defined as: A medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

The lead clinician should be consulted first for an acute exacerbation of target behaviors that do not result in risk to self and/or others but still require immediate interventions for stabilization. The lead clinician should contact the member's assigned Clinical Care Manager within one business day to discuss the case. A team meeting may need to be convened to discuss any changes to current treatment interventions.

Claims and Eligibility Questions

When do I submit a claim for payment?

Claims must be received within 60 days from the date of service.

When will I get paid?

A minimum of 90% of all clean claims are paid within 30 days. All clean claims are paid within 45 days. A clean claim includes all of the information necessary to process your claim. Necessary information is listed in Chapter XII: Claims and Claims Disputes of this manual. If you have not heard from PerformCare within 30 days of the date you believe you submitted the claims, call the Help Desk immediately at **1-888-700-7370**, as this may be an indicator that PerformCare has not received your claim.

What if I have a question about my claim?

PerformCare has a Claims Help Desk that is staffed from 8 a.m. to 4:30 p.m. each weekday. The phone number is **1-888-700-7370**.

How do I check member eligibility?

PerformCare is responsible for behavioral health services for HealthChoices members residing in Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, and Perry counties.

Due to volatility of continuous membership, we strongly recommend providers check eligibility frequently. We recommend that eligibility checks occur at a minimum every two weeks but ideally before each appointment. PerformCare has no involvement with determining eligibility. Member files are downloaded to PerformCare on a daily basis from DHS. Further, authorization is not a guarantee of payment. The provider must verify the member continues to be eligible prior to rendering the service.

Providers should check the member's eligibility by using EVS at **1-800-766-5387** at no cost to you. When calling EVS, be prepared to supply your provider MAID # and the member's identification number and date of birth. You can check eligibility 24 hours per day, seven days per week using this phone number.

If you are interested in obtaining PROMISE ready eligibility verification devices, two vendors are available, Insurance Benefit Spot Check at **1-800-233-7768** and TES at **1-800-843-5237, ext. 5604**. PROMISE ready Provider Electronic Solutions Software is also available at the DHS website or by calling the Provider Assistance Center at **1-800-248-2152**.