

CLAIM PAYMENT PROCEDURES

Section X

I. HOW TO FILE A CLAIM

Paper Claims Process

A. If billing services on a Medical Claim Form, the following data must be included:

1. Member ID ----- Field 1a
2. Member Name ----- Field 2
3. Member Date of Birth & Gender ----- Field 3
4. Subscriber Name----- Field 4
5. Patient Condition Related ----- Field 10
6. Group Number ----- Field 11
7. ICD-9-CM Diagnosis Codes ----- Field 21
8. Date(s) of Service(s) ----- Field 24A
9. Place of Service----- Field 24B
10. Current CPT or HCPC Procedure Code(s) ----- Field 24D
11. Charges----- Field 24F
12. Units----- Field 24G
13. Provider Tax ID ----- Field 25
14. Total Charges----- Field 28
15. Provider Name ----- Field 31
16. Servicing Address ----- Field 32
(Name & Address of facility where services were rendered)
17. Provider ID ----- Field 33
18. Provider Billing Address----- Field 33
19. Provider Telephone Number ----- Field 33
20. NPI -----Field 33
 - If applicable, please include the following information:
 21. Other Insurance-----Field 9a-d
 22. Referring Physician-----Field 17
 23. Referral/Prior Authorization Number----- --Field 23
 24. Patient Account Number----- --Field 26
 25. National Drug Code (NDC) Number-----Field 19
 26. Primary Explanation of Benefits when CHP is secondary payor attached to claim form.

B. Bill your usual charges first. Community Health Plan will reimburse the maximum allowable fee or the provider's charge, whichever is less. Community Health Plan will subtract the appropriate co-payment, deductible, and co-insurance amount from the authorized amount and any applicable fee discount from your bill. You will receive a detailed Remittance Advice with payment explanation for each claim submitted.

C. Bill Community Health Plan within the timely filing provision of your contract. Billing after your contractual time frame will result in a timely filing denial.

D. If additional information is required to finalize the claim, a Suspend Letter will be sent to you requesting the specific information needed. If you receive a Suspend Letter requesting additional information, you will need to return the specific information that is requested in order to process your claim appropriately.

II. SUBMISSION OF CLAIMS

Upon submission of claims, provider agrees that, if it is determined by Community Health Plan that the patient is not entitled to benefits, then such claims may be denied and provider shall be entitled to collect billed charges from the patient. Provider may be required to repay amounts erroneously paid to provider by Community Health Plan, or amounts previously paid may be deducted by Community Health Plan from subsequent amounts due provider. Any additional amounts due to the provider by Community Health Plan shall be paid promptly.

1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 09/05

PCIA PCIA

| | | | |
|--|--|--|--|
| 1. MEDICARE <input type="checkbox"/> Medicare A <input type="checkbox"/> Medicare B <input type="checkbox"/> TRICARE CHAMPVA (Donor's SSA) <input type="checkbox"/> CHAMPVA (Member's CA) <input type="checkbox"/> OTHER HEALTH PLAN (OHP or OI) <input type="checkbox"/> COBRA (COBRA) <input type="checkbox"/> OTHER <input type="checkbox"/> | | 1a. INSURED'S I.D. NUMBER (For Programs in Item 1) | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | 3. PATIENT'S BIRTH DATE | |
| 5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code) | | 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | |
| 7. PATIENT'S STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Enrolled <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> | | 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code) | |
| 8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | 10. IS PATIENT'S CONDITION RELATED TO | |
| 9. OTHER INSURED'S POLICY OR GROUP NUMBER | | a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 10. OTHER INSURED'S DATE OF BIRTH (MM DD YY) M <input type="checkbox"/> F <input type="checkbox"/> | | b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 11. EMPLOYER'S NAME OR SCHOOL NAME | | c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 12. INSURANCE PLAN NAME OR PROGRAM NAME | | 13. RESERVED FOR LOCAL USE | |
| 14. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> (If Yes, return to and complete Item 5 a-c.) | | 15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for medical services below.) SIGNED: _____ DATE: _____ | |
| 16. DATE OF CURRENT ILLNESS (For injuries) OR INJURY (Accident or Pregnancy/Child) MM DD YY | | 17. IS PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY FIRST DATE MM DD YY | |
| 18. NAME OF REFERRING PROVIDER OR OTHER SOURCE TYPE: <input type="checkbox"/> YES <input type="checkbox"/> NO | | 19. DATED PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | |
| 20. RESERVED FOR LOCAL USE | | 21. HOSPITALIZATION CHARGE RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | |
| 22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Write items 1, 2, 3 or 4 to Item 24C by Line) 1. _____ 2. _____ 3. _____ 4. _____ | | 23. OUTSIDE LAB CHARGE YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 24. A. (DATE)S OF SERVICE From MM DD YY To MM DD YY B. ICD-9-CM PROCEDURE CODE C. ICD-9-CM DIAGNOSIS CODE D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) E. DIAGNOSIS POINTER F. CHARGES G. DRUG CODE (NDC) H. REFILL # I. CPT CODE J. REFERRING PROVIDER ID # | | 24. MEDICAD RESUBMISSION CODE ORIGINAL REF. NO. 25. PRIOR AUTHORIZATION NUMBER | |
| 25. FEDERAL TAX ID NUMBER SSN EIN | | 26. PATIENT'S ACCOUNT NO. | |
| 27. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDENTIALS (Verify that the statements on the reverse apply to the bill and are made in person.) | | 28. TOTAL CHARGE \$ | |
| 29. SERVICE FACILITY LOCATION INFORMATION | | 29. AMOUNT PAID \$ | |
| 30. BILLING PROVIDER INFO & PH # | | 30. BALANCE DUE \$ | |

NUCC Instruction Manual available at: www.nucc.org
SPE by Medicare Rate Plans

PLEASE PRINT OR TYPE

APPROVED CMB 09/06-09/05 FORM CMS-1500 (06-05)
474712 - MEDICAR 976 PMS

IV. ELECTRONIC CLAIMS PROCESS

- A. If a provider prefers to submit electronic claims, the provider must first contact Emdeon at 1-800-845-6592 or Gateway at (800) 969-3666 to receive instructions and requirements for sending an electronic file. The provider's office must use the provider identification number assigned by Community Health Plan in order to submit claims electronically. If you do not know your provider identification number, please contact your Community Health Plan Provider Representative.
- B. Electronic Validation Report reflects those claims submitted to Community Health Plan through Electronic Data Interchange (EDI) media. Community Health Plan mails an Electronic Validation Report to the provider within one business day after receipt of an electronic claim. When you receive an Electronic Validation Report and you have questions regarding any errors that have occurred, contact Community Health Plan for assistance.
- C. If an "Accepted" status is shown on the report, then the claim has interfaced to the system and you may expect finalization of this claim on your Provider Remittance Advice.
- D. If you receive a "Rejected" status, then you must resubmit the claim with correct information identified as shown in the Error Message section of the report. A claim with a "Rejected" status on your report will not interface to the system until errors are corrected. Therefore, Community Health Plan has not received the claim. These claims need your prompt attention in order to comply with the Timely Filing provision of your contract. The Electronic Validation Report will not be acceptable as proof of timely filing.
- E. If the member has other medical insurance as Primary Payor, you must enter the amount Paid, amount Allowed, and Member Responsibility such as Deductible, Co-insurance, and/or Co-payment or the claim may be denied needing Primary Explanation of Benefits.
- F. If additional information is required to finalize your claim, a Suspend Letter may be sent to you requesting the specific information needed. If you receive a Suspend Letter, return the specific information that is requested in order to process your claim appropriately.
- G. Community Health Plan complies with 835 and 837 HIPAA Standards. For more information, visit our website at www.mychp.com. Select the Provider button, and view our HIPAA Companion Guide. For additional information, please contact our Provider Relations Department at (816) 271-1273.
- H. If you have any questions regarding Provider Reports or Claims, please contact Community Health Plan at (816) 271-1247 Option #5 or (800) 990-9247 Option #5.
- I. The following pages are examples of Electronic Validation Reports noting acceptance and rejections. Acceptance report means your claim has interfaced with the system so you will expect your claim to process. Rejected report means your claim has not interfaced with the system and will require a correction of the electronic submission. Each example is provided with an explanation of your electronic claim submission.

- Example A:** An “accepted” status means Community Health Plan did receive your electronic claim submission and the claim is in process.



January 1, 2007
Page 1 of 1

Electronic Validation Report

Provider Group Name
Address
City, State, Zip Code

| GROUP ID/NAME: 12345678900 | | DOCTOR NAME | | | | |
|---|--------------------|--------------------|------------------|----------------|----------------|------------------------------------|
| CLAIM TYPE | CLAIM NO. | MEMBERID | FROM DATE | TO DATE | ACCOUNT | MEMBER NAME / ERROR MESSAGE |
| 12345678900 | Doctor Name | | | | | |
| HCFA | | | | | | |
| ACCEPTED | 010107000300 | 060101XXXX00 | 12/01/06 | 12/01/06 | 123456 | ABCDEF, GHIJKL |
| ACCEPTED | 010107000400 | 060101XXXX00 | 12/07/06 | 12/07/06 | 123456 | ABCDEF, GHIJKL |
| Total Claims rejected for Provider: | | 12345678900 | | 0 | | |
| Total Claims accepted for Provider: | | 12345678900 | | 2 | | |
| Total Claims rejected for TAX ID 123456789 | | | | 0 | | |
| Total Claims accepted for TAX ID 123456789 | | | | 2 | | |

2. **Example B:** A “rejected” claim status will need your **prompt** attention. The example below indicates the member’s Date of Birth entry is invalid. This claim did not make it to Community Health Plan’s electronic claims acceptance system because the Date of Birth does not match Community Health Plan’s system. Therefore, Community Health Plan did not receive this claim. The Date of Birth must be corrected and resubmit the claim electronically or on a Medical Paper Claims form.



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Electronic Validation Report

Provider Group Name
Address
City, State, Zip Code

GROUP ID/NAME: 12345678900

| CLAIM TYPE | CLAIM NO. | MEMBERID | FROM DATE | TO DATE | ACCOUNT | MEMBER NAME / ERROR MESSAGE |
|---------------------|--------------|-------------|-----------|----------|---------|---|
| Not Assigned | | | | | | |
| HCFA | | | | | | |
| ACCEPTED | 010106000600 | 060101XXX00 | 10/27/05 | 12/27/05 | 1234 | |
| ACCEPTED | 010106000700 | 060101XXX00 | 10/14/05 | 12/14/05 | 4567 | |
| REJECTED | 010106000800 | 060101XXX00 | 10/24/05 | 12/24/05 | 8910 | MEMBERID: 060101XXX00 Member Date of Birth: 10/24/2004 invalid |

Total Claims rejected for Provider: 12345678900 1
Total Claims accepted for Provider: 12345678900 2

Total Claims rejected for TAX ID 123456789 1
Total Claims accepted for TAX ID 123456789 2

3. **Example C:** A “rejected” status will need your **prompt** attention. The example below indicates the Provider ID entry is invalid. This claim did not make it to Community Health Plan’s electronic claims acceptance system because the Provider ID number does not match Community Health Plan’s system. Therefore, Community Health Plan did not receive this claim. The Provider ID number is assigned by Community Health Plan, and must be corrected then resubmitted electronically or on a Medical Paper Claims form.



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Electronic Validation Report

Provider Group Name
Address
City, State, Zip Code

GROUP ID/NAME: 12345678900

| CLAIM TYPE | CLAIM NO. | MEMBERID | FROM DATE | TO DATE | ACCOUNT | MEMBER NAME / ERROR MESSAGE |
|------------|-----------|----------|-----------|---------|---------|-----------------------------|
|------------|-----------|----------|-----------|---------|---------|-----------------------------|

**Not Assigned
HCFA**

| | | | | | | |
|-----------------|--------------|--------------|----------|----------|--------|---|
| REJECTED | 010107000500 | 060101XXXX00 | 12/01/06 | 12/01/06 | 123456 | ABC, DEF Provider ID: with “Provider Group Name” Not Valid Required Field: Provider ID missing |
|-----------------|--------------|--------------|----------|----------|--------|---|

Total Claims rejected for Provider: 12345678900 1
Total Claims accepted for Provider: 12345678900 0

Total Claims rejected for TAX ID 123456789 1
Total Claims accepted for TAX ID 123456789 0

V. Example of Provider Remittance Advice

- A. An electronic or paper claims submission will have a Provider Remittance Advice mailed to you. The Provider Remittance Advice is an explanation of benefits of the claim you have submitted to Community Health Plan. If you have any questions regarding your Provider Remittance Advice, please contact Community Health Plan for assistance.

PAYEE NO:

SAINT JOSEPH, MO 64506



137 N. Belt Hwy.
St. Joseph, MO 64506
(816) 271-1247

REPORT NO: FR0199A
RUN DATE: 5/17/2005
PAYMENT DATE: 5/16/2005

REMITTANCE ADVICE

| BEGINNING SERVICE DATE | UNITS | CPT & REV CODES | CAP SERVS | TOTAL CHARGE | ALLOWABLE AMOUNT (LESS W/H) | RISK W/H | OTHER CARRIER CONSIDER | DISALLOW * | SUBSCRIBER NON-COVER | DEDUCTIBLE | COPAY | CO-INSUR | PATIENT RESPNS. | PLAN PYMT | EXPLANATION CODE |
|------------------------|-------|-----------------|-----------|--------------|-----------------------------|----------|------------------------|------------|----------------------|------------|-------|----------|-----------------|-----------|------------------|
|------------------------|-------|-----------------|-----------|--------------|-----------------------------|----------|------------------------|------------|----------------------|------------|-------|----------|-----------------|-----------|------------------|

PROVIDER OF SERVICE:

| MEMBER NAME: REL: SUBSCRIBER | | | | DRG: MEMBER ID: | | | | CLAIM ID: INTEREST: \$0.00 | | | | ACCOUNT ID: | | | |
|---------------------------------|----------|---|---------|--------------------|----------|----------|--------|-------------------------------|---------|--------|--------|-------------|--------|---------|---------|
| 1 | 5/9/2005 | 1 | 9924325 | N | \$185.00 | \$144.17 | \$0.00 | \$0.00 | \$40.83 | \$0.00 | \$0.00 | \$50.00 | \$0.00 | \$50.00 | \$94.17 |
| TOTALS | | | | | \$185.00 | \$144.17 | \$0.00 | \$0.00 | \$40.83 | \$0.00 | \$0.00 | \$50.00 | \$0.00 | \$50.00 | \$94.17 |

| MEMBER NAME: REL: SUBSCRIBER | | | | DRG: MEMBER ID: | | | | CLAIM ID: INTEREST: \$0.00 | | | | ACCOUNT ID: | | | |
|---------------------------------|----------|---|---------|--------------------|----------|--------|--------|-------------------------------|----------|--------|--------|-------------|--------|--------|--------|
| 1 | 5/3/2004 | 1 | 9924425 | N | \$250.00 | \$0.00 | \$0.00 | \$0.00 | \$250.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | TF1 |
| TOTALS | | | | | \$250.00 | \$0.00 | \$0.00 | \$0.00 | \$250.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 |

PROVIDER TOTALS:

| CLAIM LINES | TOTAL BILL | PLAN PYMT | PRIOR PAYMENT | TOTAL PAYABLE |
|-------------|------------|-----------|---------------|---------------|
| 2 | \$435.00 | \$94.17 | \$0.00 | \$94.17 |

PAYEE TOTALS:

| CLAIM LINES | TOTAL BILL | PLAN PYMT | PRIOR PAYMENT | TOTAL PAYABLE | CHECK AMOUNT |
|-------------|------------|-----------|---------------|---------------|--------------|
| 2 | \$435.00 | \$94.17 | \$0.00 | \$94.17 | \$94.17 |

Explanation Codes

TF1 Claim submitted after filing limit

Payment Reduction Detail

| Payment Reference ID | Member Name | Account No. | Original Overpayment Amount | Type | Amount Recovered |
|----------------------|-------------|-------------|-----------------------------|------|------------------|
|----------------------|-------------|-------------|-----------------------------|------|------------------|

Total Payment Reductions:

Note: This member(s) is a participant in a fully insured (HMO) plan.

* Community Health Plan members obtaining services at the Point of Service level of benefits by an out of network provider may be billed charges in excess of Usual, Reasonable and Customary as determined by Community Health Plan.

Usual, Reasonable, and Customary (Disallow) does not apply to non-covered services.

VI. THIRD PARTY LIABILITY (TPL)

A. If the injury or illness corresponds with one of the following categories, third party liability should be pursued:

1. **Work Comp**

- Should a Community Health Plan Member sustain an injury or illness due to employment, the employer should be contacted immediately to initiate workers' compensation care. Community Health Plan and its providers cannot deny care to anyone who needs care.

2. **The following applies to ASO (self-insured) members:**

- **Auto Accident Related:** Should an ASO Member sustain an injury due to auto accident, the Auto Insurance Carrier should be contacted immediately to collect payment covered under the Auto Accident Policy. If or when these benefits are paid or exhausted, proof of benefit letter from the Auto Insurance Carrier is required to be attached to each claim submitted detailing the amount paid or denied. A paid benefit, denial letter or proof of benefit exhaustion will provide immediate assistance to Community Health Plan with timely finalization of your claim.

VII. COORDINATION OF BENEFITS

- A. This section explains basic Coordination of Benefit (COB) information and determination. COB rules are proposed by the National Association of Insurance Commissioners (NAIC) and then adopted into state law.
1. Plans use COB to decide which health care coverage should be the first-paying (primary) for the covered benefit.
 2. It is Community Health Plan's responsibility to collect complete COB information at the time of enrollment and periodically update information in order to accurately coordinate benefits. This is an important function due to the fact that over/underpayment of claims has a financial impact and creates rework.
 3. All participating providers are requested to maintain current patient additional insurance coverage information and to include this information with each claim submitted to Community Health Plan. Providers should always ask the member if other health insurance coverage exist.
 4. If other health insurance coverage exists, and Community Health Plan is secondary, the provider is required to submit a copy of the member's primary Explanation of Benefits (EOB), with each claim submission for appropriate finalization of your claim.
 5. Some claims prompt pay rules must be overlooked if Community Health Plan is awaiting information regarding a member's COB determination.
 6. If the primary Plan's payment is less than Allowable Expense, then the second paying (secondary) Plan will apply its Allowable Expense to the unpaid balance. Benefits payable under another Plan include the Benefits that would have been payable if you had filed a claim for them.
 7. Many rules exist outlining who pays first. Do not rely on "the birthday rule" as the rule of thumb. Many times the residency of the child, the marital status of the parents and existing court decrees must be taken into consideration when determining primary and secondary payer.
 8. Medicaid will always be secondary to Community Health Plan.
 9. Medicare Secondary Payer (MSP) rules are developed from federal regulations and are frequently updated due to changes in case law. The rules exist to determine who pays first. Rules also must exist to determine how much the secondary carrier must pay.
 10. Individuals who are age 65 or older and are covered by a group health plan (by self or spouse):
 - For the month before the month the disabled employee attains age 65, the individual was entitled to Social Security disability benefits; and
 - The individual was not receiving payment subject to Federal Insurance Contribution Act (FICA) tax.
 - This means that individuals over age 65 who are continuously disabled subsequent to the month in which disability began and the next six months, the group health plan may be secondary.

VIII. CLAIM PRE-EXISTING SUSPEND LETTER

1. The provider may receive a Claim Suspend Letter because additional information is needed in order to finalize your claim. Community Health Plan may request Medical Records for potential pre-existing conditions. If you receive a Claim Suspend Letter, please submit the requested information within 30 days of the letter date for appropriate finalization of your claim. If you have any questions regarding a Claim Suspend Letter that you have received, please feel free to contact Community Health Plan for assistance.
-



October 29, 2007

Provider Name:
Provider Address:

Re: Claim ID: 090507000100
 Group ID: 10010
 Member: JANE M DOE
 Member Date of Birth: 01/01/03
 Patient Account No.: 987654321

Dear Provider Name:

A claim for services rendered to JANE M DOE was received on Sep 5 2007. We require additional information in order to process this claim. Please provide us with a copy of the member's medical record, for a timeframe of 6 months prior to the member's effective date 04/01/2007 including date of service 08/05/2007, along with a copy of this letter within 30 days of the letter date listed above.

Thank you in advance for your prompt response and assistance in finalizing this claim. Should you have questions regarding this request, please contact Community Health Plan's Customer Service Department at 800-990-9247 or 816-271-1271 between the hours of 8:00 AM and 5:00 PM, Monday through Friday. Please have the Claim ID provided above available if you call.

Sincerely,

Pre-existing Condition Reviewer
Phone Number: (816) 271-7831
Fax Number: (816) 271-7275

CMR1LL01

137 North Belt / St. Joseph, Missouri 64506 / 816-271-1247 / FAX: 816-271-1248