

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.

E. Submit paper claims or requested Suspend Letter information to:

**Community Health Plan
Claims Department
137 North Belt
St. Joseph, MO 64506**

F. Acknowledgement Report

- The provider will receive an Acknowledgement Report for any claim that has not been paid or denied within 10 days of receipt of the claim. If the claim is paid or denied within 10 days, the provider will not receive an Acknowledgement Report. If the claim has not been paid or denied after 10 business days, the provider will receive an additional Acknowledgement Report indicating “*Claim In Process*”. The following is an example of the report:



Claims Acknowledgement / Status Report

PROVIDER NO: 12345678900
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
12345678900	DOCTOR NAME					
HCFA						
IN PROCESS	010107000100	060101XXXX00	12/01/06	12/01/06	123456	ABCDEF, GHIJKL
IN PROCESS	010107000200	060101XXXX00	12/07/06	12/07/06	123456	ABCDEF, GHIJKL
Total Claims for Provider:		12345678900	0			
Total Claims:		12345678900	2			

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.

III. Example of Medical Claim Forms

A. The highlighted areas are required fields for a claim submission to be accepted.

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMS-0938-0008

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSM) (ITEM 1)

2. PATIENT'S BIRTH DATE: MM DD YY M SEX F

3. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

4. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

5. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE)

6. PATIENT STATUS: Single Married Other

7. EMPLOYED Full-Time Part-Time

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. OTHER INSURED'S DATE OF BIRTH: MM DD YY M SEX F

11. EMPLOYER'S NAME OR SCHOOL NAME

12. INSURANCE PLAN NAME OR PROGRAM NAME

13. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 s-d.*

14. DATE OF CURRENT ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP): MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO \$ CHARGES

21. OR NATURE OF ILLNESS OR INJURY. (RELATE ITEM 14 TO ITEM 21E BY LINE)

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	DATE(S) OF SERVICE		Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	I EHS	J COB	K RESERVED FOR LOCAL USE
	From MM DD YY	To MM DD YY										
1												
2												
3												
4												
5												
6												

24. FEDERAL TAX I.D. NUMBER SSN EIN

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (including degrees or credentials) (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE #08) PLEASE PRINT OR TYPE FORM NCPA-1500 (12-90) FORM DWCP-1500 FORM RRB-1500

REORDER FROM STANDARD REGISTER FORM NO. HC0801-1

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC)

Medicare/Medicaid/Other Insurance/Other Health Plans/Other Health Plans/Other Health Plans/Other Health Plans

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (Tricare #) OTHER (Other #) OTHER (Other #) OTHER (Other #) OTHER (Other #)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX (M/F)

4. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

5. PATIENT RELATIONSHIP TO INSURED (Self/Spouse/Child/Other) 6. PATIENT STATUS (Single/ Married/ Other) 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) 9. OTHER INSURED'S POLICY OR GROUP NUMBER 10. IS PATIENT'S CONDITION RELATED TO (a. EMPLOYMENT? (Current or Previous) YES/NO b. AUTO ACCIDENT? YES/NO c. OTHER ACCIDENT? YES/NO) 11. INSURED'S POLICY GROUP OR POLICY NUMBER 12. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX (M/F) 13. EMPLOYER'S NAME OR SCHOOL NAME 14. INSURANCE PLAN NAME OR PROGRAM NAME 15. IS THERE ANOTHER HEALTH BENEFIT PLAN? (YES/NO) (If yes, return to cert complete form 9 etc.)

16. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I certify on the validity of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION CHIEF RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY) 19. RESERVED FOR LOCAL USE 20. OUTSIDE LIMIT? (YES/NO) 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer items 1, 2, 3 or 4 to item 21C by line) 22. MEDICARE RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE (From MM/DD/YY To MM/DD/YY) B. PLACE OF SERVICE (R/S) C. PROCEDURE, SERVICE, OR SUPPLY (Specify Usual or Extraordinary) D. DIAGNOSIS (ICD-9-CM) E. CHARGES (U. CHG. (U.S. DOLLARS) L. CHG. (L.S. DOLLARS)) F. HENDERSON PROVIDER ID #

25. FEDERAL TAX ID NUMBER (SSN/EIN) 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (YES/NO) 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including address or credentials (If only the fax statements on the reverse apply to the bill and are made a part thereof)) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH #

NUCC Instruction Manual available at: www.1500.org
MFA by Member Fax Press

PLEASE PRINT OR TYPE
Approved by Standard Carrier

APPROVED CMB 0938-0995 FORM CMS-1500 (08-05)
471710 - 08/05/04 474 FMS

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
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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 CHARGES	ALLOWABLE (URC) (LESS W/H)	DISALLOW * (charges above URC)	RISK W/H	OTHER CARRIER CONSIDER	SUBSCRIBER NON-COVER	DEDUCTIBLE	COPAY	CO-INSUR	PATIENT RESPONS.	PLAN PYMT	EXPLANATION CODE
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PROVIDER OF SERVICE:

MEMBER NAME:		REL: HUSBAND		DRG: MEMBER ID:		CLAIM ID: INTEREST:		ACCOUNT ID:							
1	4/25/2005	1	N	\$650.00	\$0.00	\$650.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	CDD
TOTALS				\$650.00	\$0.00	\$650.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

MEMBER NAME:		REL: HUSBAND		DRG: MEMBER ID:		CLAIM ID: INTEREST:		ACCOUNT ID:							
1	4/25/2005	1	N	\$650.00	\$650.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$650.00	L01
TOTALS				\$650.00	\$650.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$650.00	

PROVIDER TOTALS:

CLAIM LINES	TOTAL BILL	PLAN PYMT	PRIOR PAYMENT	TOTAL PAYABLE
2	\$1,300.00	\$650.00	\$0.00	\$650.00

PAYEE TOTALS:

CLAIM LINES	TOTAL BILL	PLAN PYMT	PRIOR PAYMENT	TOTAL PAYABLE	CHECK AMOUNT
2	\$1,300.00	\$650.00	\$0.00	\$650.00	\$650.00

Explanation Codes

CDD This claim is a duplicate of a previously submitted claim for this member
L01 Individual annual out of pocket maximum has been met

Payment Reduction Detail

Payment Reference ID	Member Name	Account No.	Original Overpayment Amount	Type	Amount Recovered
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Total Payment Reductions:

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

- * Community Health Plan members obtaining services by an out of network provider may be billed charges in excess of Usual, Reasonable and Customary (URC) as determined by Community Health Plan.
- * Usual, Reasonable, and Customary (URC) 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