

Beginner Billing Training: Institutional Claims (UB-04)

Health First Colorado
(Colorado's Medicaid Program)



Navigating This Presentation

- Underlined words or phrases often will link viewers to more information, such as web pages. If you are viewing this presentation in normal mode (not slideshow mode), you may need to press the Ctrl key while you click on the link in order to open it.
- Use color-coded table of contents slides to navigate to specific areas of interest in the presentation.
 - Use back arrows provided in the bottom right corner of some slides to return to table of contents slides.



Institutional Claim - Who Completes It?

Dialysis Centers

Federally Qualified
Health Centers

Home Health

Hospice

Indian Health
Services

Inpatient /
Outpatient Hospital

Nursing Facility

Private Duty
Nursing

Psychiatric
Residential
Treatment Facilities

Rural Health Clinics

Home Health vs. HCBS

- Home Health Care (Provider Type 10): Skilled care delivered directly in a patient's home. This type of care is provided by licensed medical professionals including nurses, therapists and aides for the purpose of *treating* or *managing* an **illness, injury or medical condition**. Uses form UB-04 for institutional claims.
- Home and Community-Based Services (HCBS) (Provider Type 36): Professional support services that allow patients to live independently and safely in their homes. Uses form CMS 1500 for professional claims. HCBS is only for members with that specific benefit plan. *It is not open to all members.*
 - Help with daily activities such as dressing and bathing
 - Assistance with managing routine tasks around the house
 - Companionship
 - Non-medical transportation

Training Overview

Program
Overview

Department
Website

Provider
Enrollment

Member
Eligibility

Prior
Authorizations

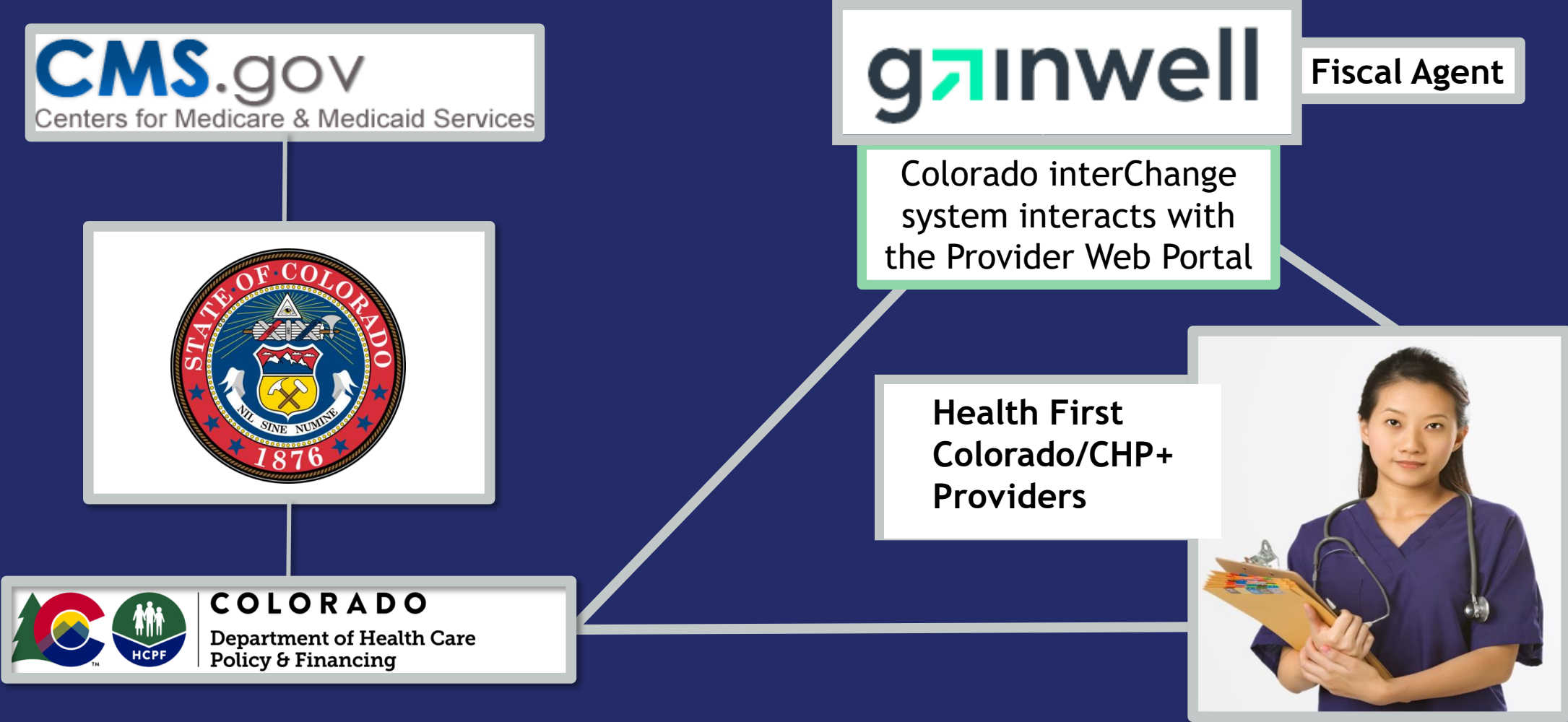
Billing and
Payment

Resources

Claim
Submission



Program Overview



Department Website



Department of Health Care Policy & Financing

Website

The screenshot shows the website's header and main navigation. A red box labeled '1' highlights the URL <https://hcpf.colorado.gov> in the browser's address bar. Another red box labeled '2' highlights the 'For Our Providers' link in the top navigation bar. Below the navigation bar, a dark blue bar contains links for 'For Our Members', 'For Our Providers', 'For Our Stakeholders', and 'About Us'. The 'For Our Providers' link is also highlighted with a red box. Below this bar, the text reads: 'We administer Health First Colorado (Colorado's Medicaid program), Child Health Plan Plus, and other health care programs.' Below this text are four blue buttons: 'Apply Now', 'Explore Programs', 'Find a Doctor', and 'Get Help'. At the bottom of the main content area, there is a white box with the 'Health First COLORADO' logo and the text 'Colorado's Medicaid Program', and a green banner with the text 'We can #KeepCOCovered'.

For Our Providers Home Page

Access to billing manuals, fee schedules, enrollment, revalidation, the Provider Web Portal, contacts and resources like Quick Guides

Contains important information regarding Health First Colorado (Colorado's Medicaid program) & other topics of interest to providers and billing professionals

Home > For Our Providers

For Our Providers

- Why should you become a provider?
- Provider enrollment
- Provider services: Forms, rates, & billing manuals
- What's new: Bulletins, updates & emails
- CBMS: CO Benefits Management System
- Long-Term Services and Supports
- Web portal
- Revalidation
- Provider contacts: Who to call for help
- Provider resources: Quick guides, known issues, EDI, & training

COVID-19 Provider Information | Resources for HCBS Providers

SAVE System | ColoradoPAR | DDDWeb

Provider Services

Forms, fee schedules and billing manuals can be found on the Provider Services web page

The General Provider Information billing manual is an overview of the program, including billing and policy information

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COVID-19 Provider Information | Resources for HCBS Providers

SAVE System | ColoradoPAR | DDDWeb

What's New: Bulletins, Updates & Emails

Sign up for publications



Weekly newsletters and monthly bulletins

Home > For Our Providers

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COVID-19 Provider Information | Resources for HCBS Providers

SAVE System | ColoradoPAR | DDDWeb

Provider Resources

Provider Web Portal Quick Guides, Electronic Data Information (EDI) for batch billing information, training presentations, field representatives and more

Home > For Our Providers

For Our Providers

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COVID-19 Provider Information | Resources for HCBS Providers

SAVE System | ColoradoPAR | DDDWeb

Provider Enrollment



Provider Enrollment

Website

- Who needs to enroll?
 - Any provider who provides services to Health First Colorado members
 - Any provider listed on a claim
- Some services require an Ordering, Prescribing or Referring (OPR) Provider:
 - Audiology
 - Durable Medical Equipment (DME)/Supply
 - Independent Laboratory
 - Occupational, Physical & Speech Therapy
 - X-Ray Facility

Provider Enrollment

Website

- The institutional claim requires attending and billing providers.

Attending Provider (Individual Within a Group)

Individual that provides services to a Health First Colorado member



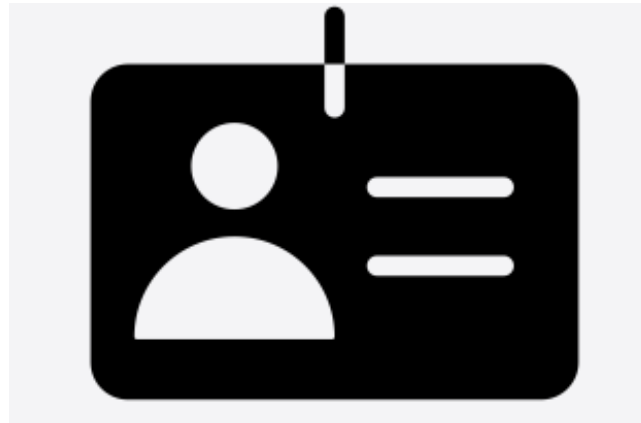
Billing Provider

Entity being reimbursed for service



National Provider Identifier (NPI)

- **Most providers require an NPI for billing transactions.**
- Non-medical providers, such as some Home and Community-Based Services (HCBS) and Non-Emergent Medical Transportation (NEMT) providers, do not need an NPI and use the Health First Colorado Provider ID for billing transactions.
- Providers who bill Medicare need to ensure each NPI for Health First Colorado is also enrolled with Medicare.



National Provider Identifier (NPI)

Individual Providers

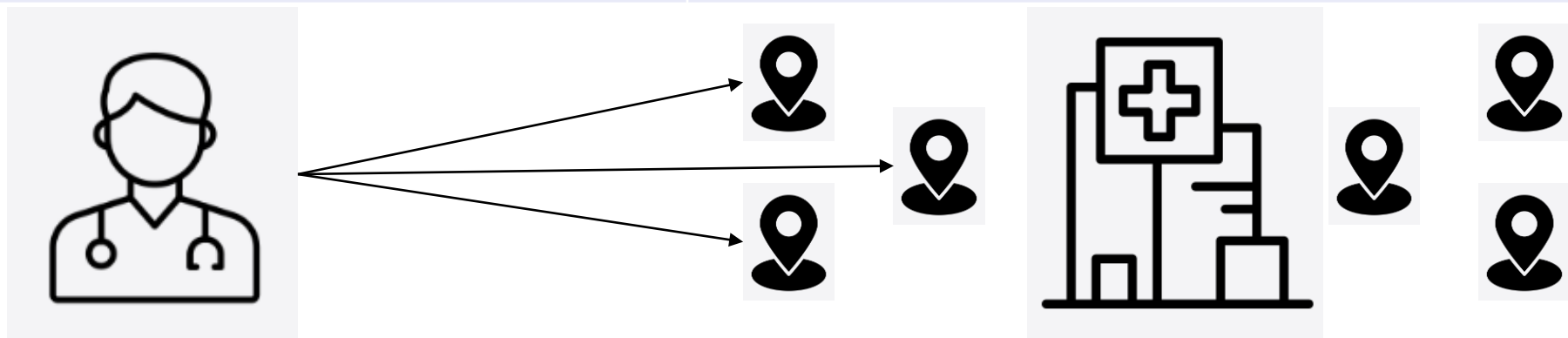
(Individuals Within a Group, Billing Individuals or Ordering/Prescribing/Referring)

- One NPI can be affiliated with multiple locations
- Tied to Social Security Number (SSN)

Organizational Providers

(Groups, Facilities)

- Separate NPI for each service location and provider type
- Tied to Taxpayer Identification Number (TIN)



Revalidation

- All Health First Colorado and Child Health Plan *Plus* (CHP+) providers must revalidate in the program at least every five (5) years to continue as a provider.
- **Providers who do not complete the revalidation process by their revalidation due date will be subject to claim denials and disenrollment.**
- Each provider will be notified via email six (6) months in advance of their revalidation deadline. The deadline is based on the date the enrollment application was approved.

Revalidation

- A spreadsheet with providers' revalidation dates can be found on the Department's Revalidation web page.

[Home](#) > [For Our Providers](#) > [Provider Enrollment](#) > [Revalidation](#)

Revalidation

Health First Colorado and CHP+ Provider Revalidation

Child Health Plan *Plus* (CHP+) and Health First Colorado (Colorado's Medicaid program) providers must revalidate in the program at least every five (5) years to continue as a provider. Organization Health Care Providers are required to obtain and use a unique National Provider Identifier (NPI) for each service location and provider type enrolled.

Attention: Download the Provider Revalidation Dates Spreadsheet to verify the next revalidation due date. Providers will be contacted via email approximately 6 months prior to their revalidation deadline with further instructions. **Attempting to revalidate by completing a new application before being notified will create duplicate enrollments and cause claim processing issues.**

Revalidation Resources

- [Provider Revalidation Manual](#)
- [Revalidation/NPI Law Fact Sheet](#)
- [Revalidation Quick Guide](#)
- [Provider Revalidation Dates Spreadsheet](#) (updated 10/02/2023)
- [Revalidation Information by Provider Type](#)
- [Revalidation Information for HCBS Providers](#)

Revalidation Newsletters

- [Provider News & Resources - Revalidation Special Newsletter - 09-29-2023](#)



Revalidation for Individual Providers

- Each individual provider within a group has a separate account for the Provider Web Portal.
 - Different from the group or facility account and login credentials
- Individuals, or their delegate(s), **must revalidate using the account for the individual provider.**
 - Refer to the [Delegates - Provider Web Portal Quick Guide](#) for more information on managing delegates.
- Even if the billing provider has revalidated, claims may suspend or deny if an individual provider has not revalidated.

Revalidation for Individual Providers

- All OPR providers indicated on a claim must be actively enrolled with Health First Colorado.
 - Groups are encouraged to coordinate with all Ordering, Prescribing and Referring (OPR) providers to ensure that those provider IDs have been revalidated.
 - Refer to the [Ordering, Prescribing and Referring Claim Identifier Project](#) for more information about OPR issues on claims.



Member Eligibility

Member Eligibility

Verifying Member Eligibility

Viewing Member Information

Health First Colorado Member ID Cards

Eligibility Types

Managed Care

Medicare

Third Party Liability

Co-Pay

Verifying Member Eligibility

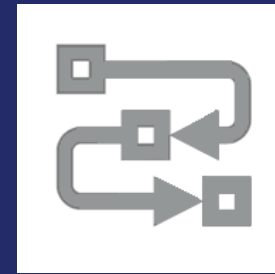
- Member's eligibility must be checked on each date of service.
 - Facilities that bill monthly: Eligibility can change throughout the month. Therefore, it is recommended that providers check eligibility more than once a month.
 - Ways to verify eligibility:



**Provider Web
Portal**



**Virtual Agent
1-844-235-2387**



Batch 270

Log In to View Member Information

Provider Web Portal

COLORADO
Department of Health Care
Policy & Financing

Health First
COLORADO
Colorado's Medicaid Program
[Contact Us](#) | [Logout](#)

Home **Eligibility** Claims Care Management Resources

Home Tuesday 10/03/2023 04:11 PM MST

Provider Name	MFCU PROVIDER	Provider ID	Providers - 1669775326 (NPI)	Location	MFCU PROVIDER
Taxonomy	261Q00000X				

User Details
Welcome 9000203639_PRIV
My Profile
Manage Accounts

Provider
Name MFCU PROVIDER
Provider ID 1669775326 (NPI)
Location ID
Revalidation Date 8/11/2027
Provider Maintenance
EFT/ERA (835) Enrollment
Disenroll

Provider Services
Member Focused Viewing
Search Payment History
Search Accounts Receivable
BIDM

Welcome Health Care Professional!

[Contact Us](#)
[Notify Me](#)
[Alerts](#)
[Secure Correspondence](#)

We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers.

Provider Portal News
You are connected to the UAT system

Providers with multiple locations should ensure that the correct location is being used. Having the incorrect location can impact whether a claim will adjudicate—or process a decision—correctly.

Providers with separate National Provider Identification (NPI) numbers are encouraged to verify their NPI before moving past this home page screen.

Viewing Member Information

Provider Web Portal

“CAPTCHA” verification is required to ensure the provider is not a robot. On the Search tab, enter the Member ID or Last Name, First Name and Birthdate.

Search tab -

Member Focus Search

Last Members Viewed Search

* Indicates a required field.
Enter the Member ID or Last Name, First Name and Birth Date.

Member ID

Last Name

City

First Name

Zip Code

Birth Date

Search **Reset**

Search Results

Click on the member name below to access the Member Focus View.

Total Records: 1

Member ID	Member	Gender	Birth Date	City	Zip Code
S700001	IMA_MEMBER	Female	07/15/1961	AURORA	80011-2506

Member in Focus: [Change](#) ID: S700001 [Close Member Focus](#)

Member Details

Member ID S700001
 Name Ima Member
 Birth Date 09/19/1919
 City NORTH
 State Connecticut
 Gender Female
 Primary English Language

Coverage Details

Coverage	Effective Date	End Date
Medicaid State Plan	01/01/2014	12/31/2299
Medicaid Behavioral Health Benefits	01/01/2014	12/31/2299

[View eligibility verification information](#)

Other Details

Secure Correspondence
Review previously sent messages or send new secure messages.

Your Member Claims

Medical/Dental

[Submit a Professional Claim](#) [Submit a Dental Claim](#)
[Submit an Institutional Claim](#)

Claim ID	Service Date	Claim Type	Claim Status
	01/01/2016 - 02/01/2016	LongTermCare	Denied
	03/15/2015 - 03/15/2015	Inpatient	Suspended

Your Member Authorizations

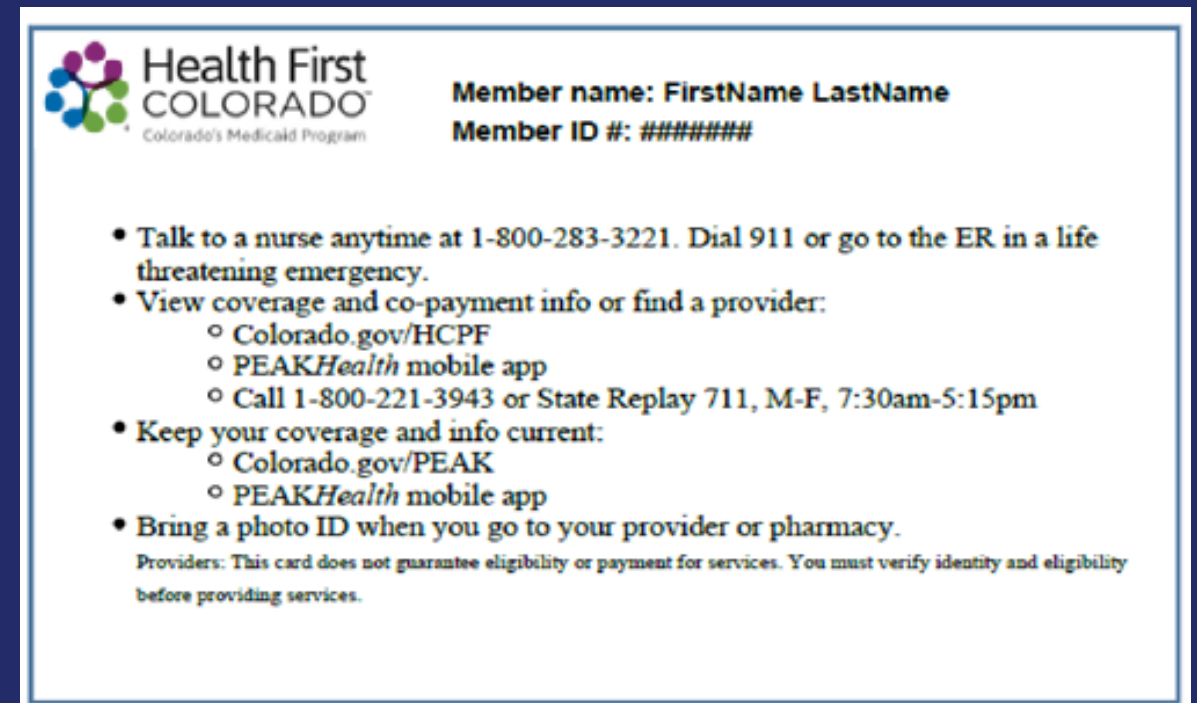
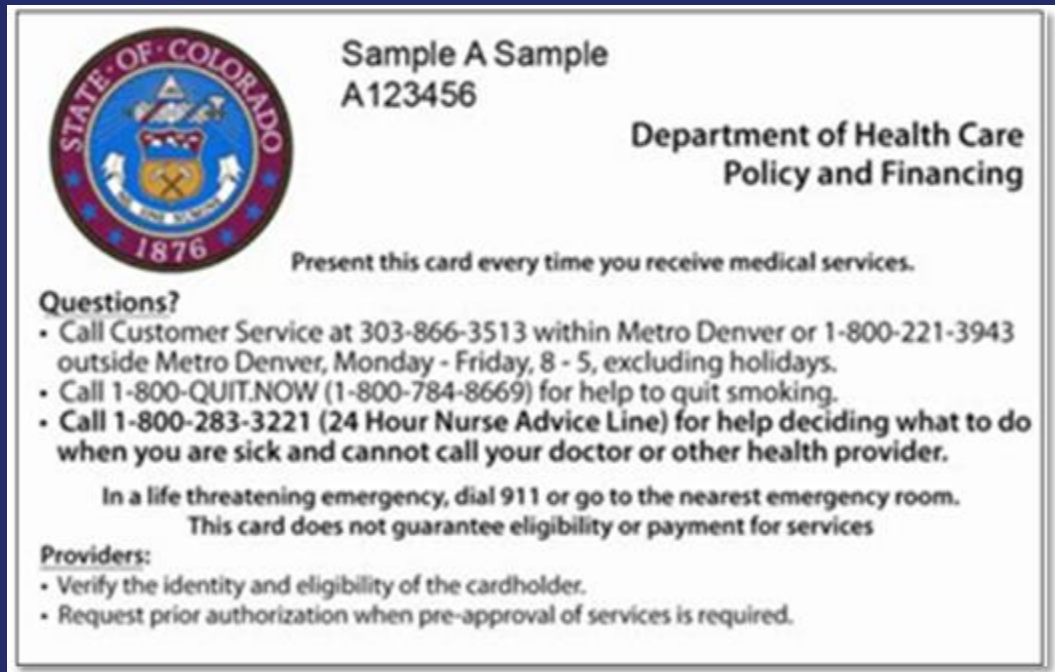
[Submit an Authorization](#)

There are no authorizations for this member.

This search will display the Member in Focus page which provides Member Details, Coverage Details and Member Claims and Authorizations.


Health First Colorado Identification Cards

- This page shows two older branded cards that are still valid.
- Identification card does not guarantee eligibility.
- Only the front is shown below:



Health First Colorado Identification Cards

- This page depicts newer branded cards in English and Spanish.
- Identification card does not guarantee eligibility.
- Only the front is shown below:





Member ID: Z999999
Name: Ima Member

Your PCP is available to help.
Primary Care Provider (PCP): (303) 555-1212
HEALTH COLORADO, INC. RAE 4

Emergencies or medical advice
If you aren't sure if it's an emergency, call your PCP or the Nurse Advice Line. If it's an emergency, call 911 or go to the emergency room.

24/7 Nurse Advice Line: 800-283-3221
24/7 Mental health crisis: 844-493-TALK (8255)
ColoradoCrisisServices.org text TALK to 38255


If you need help getting an appointment call 1-888-502-4185.
See if you're active on the  PEAK Health App



ID de miembro: Z999999
Nombre: Ima Member

Su PCP está a su disposición para ayudarle.
Médico de cabecera (Proveedor de atención primaria o PCP): 303-555-1212
DENTAQUEST USA

Emergencias o asesoramiento médico
Si no está seguro de si se trata de una emergencia, llame a su PCP o a la Línea de asesoramiento de enfermería. Si es una emergencia, llame al 911 o vaya al servicio de emergencias.

Línea de asesoramiento de enfermería las 24 horas del día, los siete días de la semana: 800-283-3221
Crisis de salud mental las 24 horas del día, los siete días de la semana: 844-493-TALK (8255)
ColoradoCrisisServices.org envíe TALK al 38255
Si necesita ayuda para hacer una cita, llame al 1-855-384-7926.
Consulte si está activo en la aplicación  PEAK Health

Eligibility Types

- Most members: Health First Colorado benefits (Title XIX)
- Some members have **different** eligibility types:
 - Old Age Pension, state only
 - Non-Citizens (individuals without documentation)
 - Child Health Plan *Plus* (CHP+)
 - Presumptive Eligibility
 - Behavioral Health Administration (BHA)
 - Managed Care
- Some members have **additional** benefits:
 - Medicare
 - Third-party commercial insurance



Eligibility Types

- Providers must confirm coverage types before rendering any Medicaid or CHP+ services or submitting claims.
- Eligibility coverage types listed in the Provider Web Portal (not an all-inclusive list):
 - Medicaid: "Medicaid State Plan" and "TXIX" (Title XIX)
 - Child Health Plan Plus: "CHP+B"
 - Behavioral Health Coverage through the Regional Accountable Entities (RAEs):
"Medicaid Behavioral Health Benefits" and "BHO+B"



Eligibility Verification Information for	
Member ID	Birth Da
Coverage	
Medicaid State Plan	
Medicaid Behavioral Health Benefits	
HCBS Elderly, Blind, & Disabled Waiver	

Eligibility Types

Old Age Pension (OAP) - State Only

- Members are not eligible for Title XIX due to income.
- Claims will have reduced reimbursement amounts since the program only gets state funds and no federal match.
- Providers cannot bill the member for the difference between the billed amount and the reimbursement amount.
- Does not cover:
 - Home and Community-Based Services (HCBS)
 - Inpatient, psychiatric or nursing facility services



Eligibility Types

Family Planning and Non-Citizens

- Family Planning Expansion
 - Applies to individuals with a higher income than the standard Medicaid limit (between 133%-260% of the federal poverty level [FPL])
 - Covers up to a 12-month supply of contraceptives
 - Family planning coverage for non-citizens available from July 1, 2022
- Non-Citizen Emergency Medicaid Services (EMS)
 - Eligibility type only covers emergency services, including labor and delivery
 - Claim must indicate emergency
 - Emergency services must be certified in writing by the provider and kept on file, but does not need to be submitted with the claim

Who Defines an Emergency?

- **The provider determines whether the service is considered an emergency** and marks the claim appropriately by writing a “1” in box 14 for Admission Type on the UB-04 paper claim or typing “1” for the Admission Type on the first screen in the Provider Web Portal.
- Health First Colorado does not determine emergency status based on diagnosis or procedure codes used on the claim. The box must be checked to indicate emergency.
- Examples of an emergency are:
 - Active labor and delivery
 - Sudden, urgent occurrences requiring immediate action
 - Acute symptoms of sufficient severity and severe pain in which the absence of medical attention might result in serious impairment to bodily functions and/or dysfunction of any bodily organ or part

The image shows a screenshot of a 'Claim Information' form. The form has a blue header with the text 'Claim Information'. Below the header, there are three fields: '* Covered Dates', '* Admission Date/Hour', and '* Admission Type'. The '* Admission Type' field is highlighted with a red rectangular box. The value '1' is entered in this field, and a dropdown menu is open below it, showing the option '1-Emergency'.

Eligibility Types

Child Health Plan *Plus* (CHP+)



- Members determined to be eligible are later assigned to one of the four CHP+ Managed Care Organizations (MCOs): Colorado Access, Denver Health, Kaiser Permanente or Rocky Mountain Health Plans.
 - Before MCO assignment: Services must be billed as fee-for-service to the Fiscal Agent, Gainwell Technologies (or Magellan for pharmacy services)
 - After MCO assignment: Services must be billed to the MCO



Eligibility Types

Child Health Plan *Plus* (CHP+)



- Providers should contact the MCO for further benefit details. Benefits through CHP+ may vary from the Title XIX (Medicaid) benefit plan.
 - Applied Behavior Analysis (ABA) therapy is not covered by CHP+.
 - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is not covered by CHP+.
 - CHP+ does not divide behavioral health from other services.



Eligibility Types

Presumptive Eligibility

- Temporary coverage of Health First Colorado or Child Health Plan *Plus* (CHP+) services until eligibility is determined
- Presumptive Eligibility (PE) is only available to:



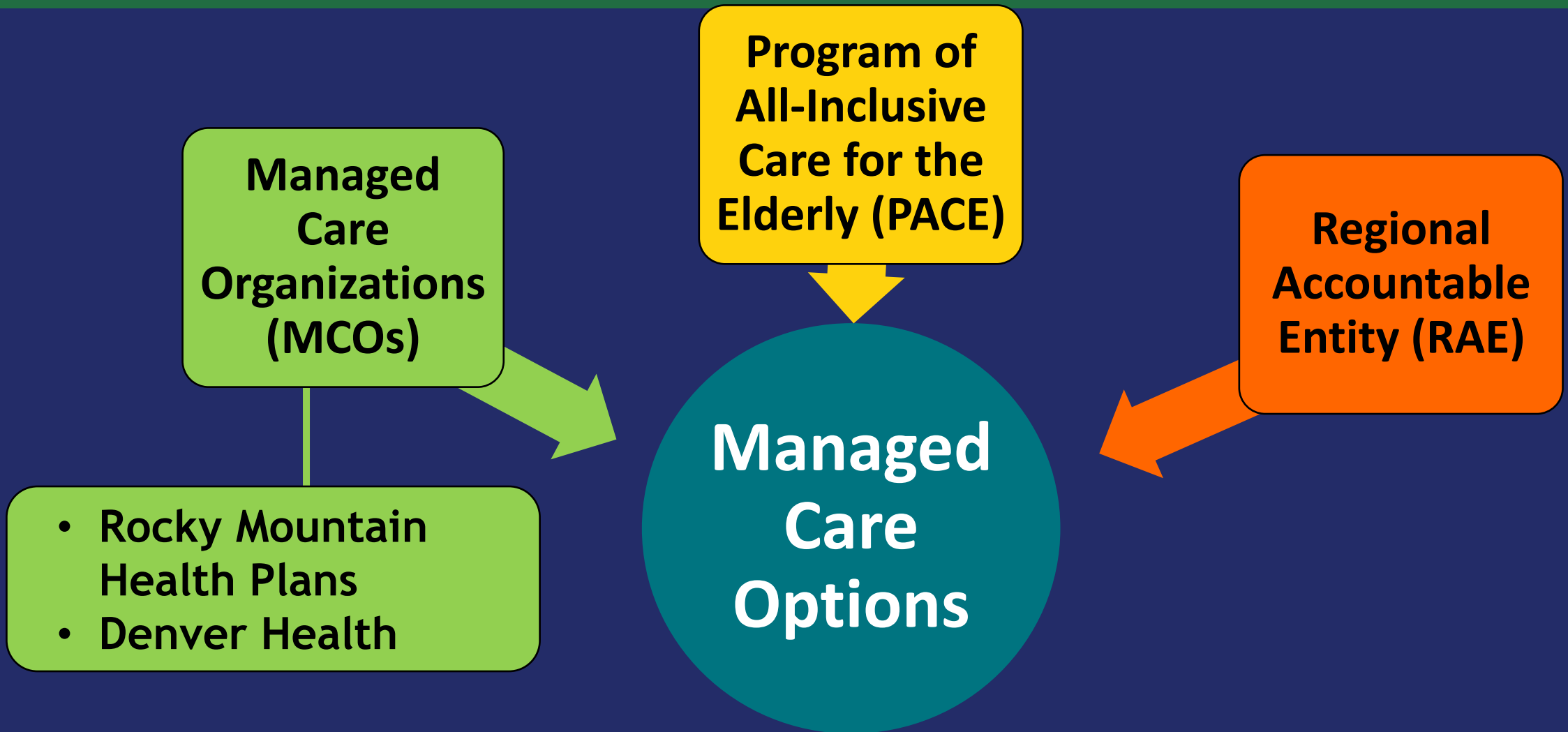
Population	Eligibility	Covered Benefits
Child or pregnant person that meets Health First Colorado PE requirements	<u>Health First Colorado Eligibility Criteria</u>	All <u>Health First Colorado benefits</u> : includes labor and delivery, excludes inpatient (hospital) care
Child or pregnant person that meets CHP+ PE requirements	<u>CHP+ Eligibility Criteria</u>	All <u>CHP+ benefits</u> excluding dental services
Family Planning Limited (FAMPL) Benefit	<u>FAMPL Eligibility Criteria</u>	Birth control, STI testing and treatment, Cervical cancer screening and prevention, Related counseling and preventative services
Breast and Cervical Cancer Program (BCCP)	<u>BCCP Eligibility Criteria</u>	All <u>Health First Colorado benefits</u>

Eligibility Types

Behavioral Health Administration (BHA)

- The Behavioral Health Administration (BHA) is an evolving entity that is addressing behavioral health needs of individuals not covered by other medical assistance programs. **This program is not part of Health First Colorado or Child Health Plan *Plus* (CHP+).**
 - In the Provider Web Portal, providers may see the “Coverage” type “BHA Benefit Plan” and “BHAB.”
 - “BHAB” is not the same as “BHO+B” benefits (Medicaid Behavioral Health Benefits through the Regional Accountable Entities [RAEs]).

Managed Care



Managed Care

Managed Care Organizations (MCOs)

- Some services are not included in the managed care contract for Rocky Mountain Health Plans or Denver Health.
 - Those fee-for-service claims can be billed directly to the Fiscal Agent (Gainwell Technologies).

Example:

- Denver Health does not pay for hospice. Hospice claims for a member with Denver Health enrollment would be billed directly to Gainwell Technologies.



Managed Care

Regional Accountable Entity (RAE)

- Members are assigned to the Regional Accountable Entity (RAE) for their geographic area for behavioral **health**.
 - Contact the RAE in your area to enroll as a Behavioral Health Provider.



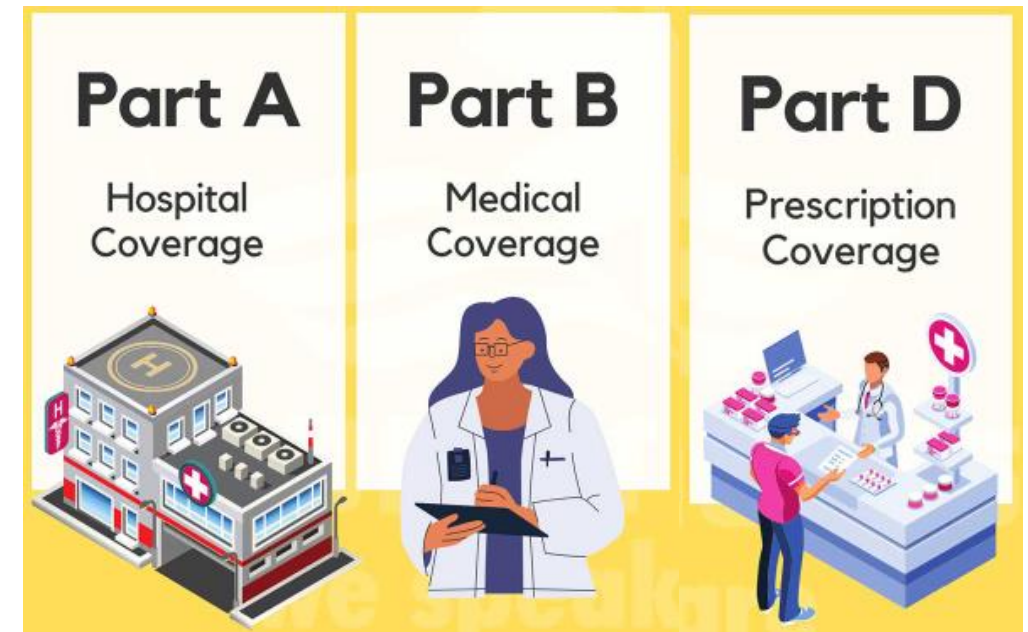
Dual Eligibility

- Members may be eligible for both Medicare and Health First Colorado.
- Health First Colorado is always the payer of last resort.
 - Bill Medicare first for members with Medicare and Health First Colorado.
- Retain proof of:
 - Submission to Medicare prior to Health First Colorado
 - Medicare denials(s) for seven (7) years
- Medicare Explanation of Benefits does not need to be attached to claim submission.



Medicare

- Medicare members may have:
 - Part A only covers institutional services
 - Hospital insurance
 - Part B only covers professional services
 - Medical insurance
 - Part A and B covers both services
 - Part D covers prescription drugs



<https://boomerbenefits.com/wp-content/uploads/2021/04/parts-of-medicare-1.png>

Medicare

Qualified Medicare Beneficiary (QMB)

- QMB programs cover any service covered by Medicare.
 - QMB Plus Medicaid (QMB+): Members also receive Health First Colorado benefits (Title XIX).
 - QMB Only: Members do not receive Health First Colorado benefits. Health First Colorado will only pay if Medicare pays primary.
- Members are only responsible for Health First Colorado co-pay.



Medicare

Qualified Medicare Beneficiary (QMB)

- Health First Colorado uses “lower of pricing” logic - either coinsurance and deductible or difference between Medicare paid amount and Health First Colorado allowed amount, whichever is lower.

$$\begin{array}{l} \text{Coinsurance} \\ + \text{Deductible} \\ = \end{array} \text{ [Yellow Box]}$$



$$\begin{array}{l} \text{What Medicare paid} \\ - \text{Health First Colorado} \\ \text{allowable} \\ = \end{array} \text{ [Yellow Box]}$$

Which side is lower? That's what is paid by Medicaid.

Third Party Liability

(Commercial Insurance)

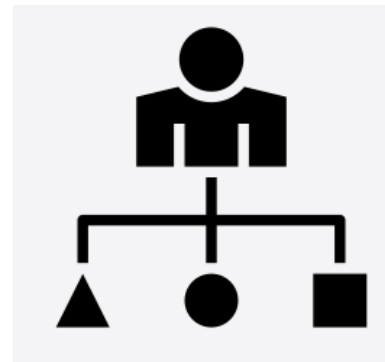
- **Health First Colorado is always the payer of last resort.**
 - Indicate the date the Third-Party Liability (Commercial Insurance) paid or denied on each claim.
 - The Explanation of Benefits (EOB) does not need to be attached to the claim.

Other Insurance for Service Detail					
Click the row number to edit the row. Click the Remove link to remove the entire row.					
#	Carrier ID	Paid Amount	Paid Date	Paid Units	Action
☐ Click to collapse.					
	*Other Carrier				
	*Paid Amount		*Paid Date		*Paid Units

Third Party Liability

(Commercial Insurance)

- When a provider agrees to render service to a member, they agree to work with all the member's forms of insurance. Providers working with Health First Colorado members cannot:
 - Bill the member the difference between the amount billed and the amount reimbursed
 - Bill the member for the co-pay or deductible assessed by the Third-Party Liability (Commercial Insurance)



Third Party Liability

(Commercial Insurance)

- Health First Colorado pays the difference between Third-Party Liability payment and Program Allowable.

Example 1:

Charge = \$500

Program allowable = \$400

TPL payment = \$300

Program allowable - TPL payment =

Reimbursement

$$\$400.00 - \$300.00 = \$100.00$$

Example 2:

Charge = \$500

Program allowable = \$400

TPL payment = \$400

Program allowable - TPL payment =

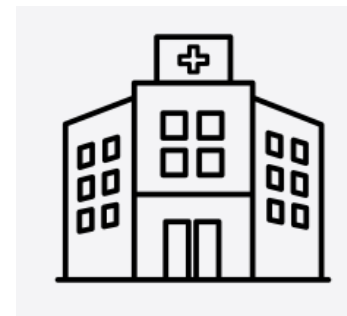
Reimbursement

$$\$400.00 - \$400.00 = \$0.00$$

Co-Pay

Website

- Effective July 1, 2023, most member co-pays were reduced to \$0.
 - Change effective for members eligible for Title XIX (Medicaid), the Alternative Benefits Plan and the Old Age Pension
 - Exceptions to this change are special programs administered by the Department, such as Child Health Plan *Plus* (CHP+)
- **Outpatient hospital non-emergent emergency room visits continue to carry an \$8 co-pay per visit.**



Co-Pay

Website

- Providers can check co-pay amounts when verifying member eligibility on the Provider Web Portal.
- A provider may not deny services to individuals when such members are unable to immediately pay the co-pay amount. However, the member remains liable for the co-pay at a later date. (8.754.6.B rule in 10 CCR 2505 volume 8.700)
- The co-pay maximum is 5% of the household monthly income.
 - The head of household will receive a letter showing the household has reached the monthly limit.



Co-Pay Exempt Members

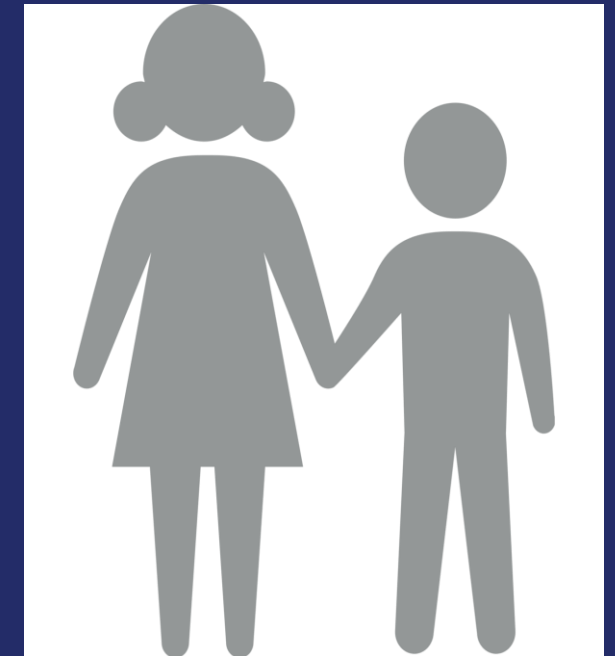
Full List



**Nursing Facility
Residents**



**Pregnant
Women**



**Children and Former
Foster Care Eligible**

Prior Authorizations

Prior Authorization Requests (PARs)

- The ColoradoPAR Program reviews Prior Authorization Requests (PARs) for the following services or supplies:

- Audiology
- Diagnostic imaging
- Durable medical equipment
- Some inpatient admissions (including out of state)
- Medical services (including transplant, back and bariatric surgery)
- Physical, occupational and speech therapy
- Physician Administered Drugs (PADs) from January 1, 2022
- Pediatric behavioral therapy
- Pediatric home health care
- Pediatric personal care
- Synagis (seasonal)



Prior Authorization Requests (PARs)

- PAR and PAR revisions processed by the ColoradoPAR Program must be submitted via the vendor utilization management portal managed by Acentra Health (formerly Kepro).
- Final Prior Authorization Request (PAR) determination letters are mailed to members. Letter inquiries should be directed to ColoradoPAR.
- Providers can review PARs via the Provider Web Portal.

Website:

ColoradoPAR website

Phone:

Phone: 1-888-801-9355

FAX: 1-866-940-4288

Prior Authorization Requests (PARs)

- All PARs for members ages 20 and under are reviewed according to Early Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. Even if it is not a covered service for an adult, it may be covered under EPSDT if deemed medically necessary for a child/youth.
- ColoradoPAR does not process Prior Authorization Requests (PARs) for adult home health, dental, pharmacy, transportation or behavioral health services covered by the Regional Accountable Entities (RAEs).



Billing and Payment

Billing and Payment

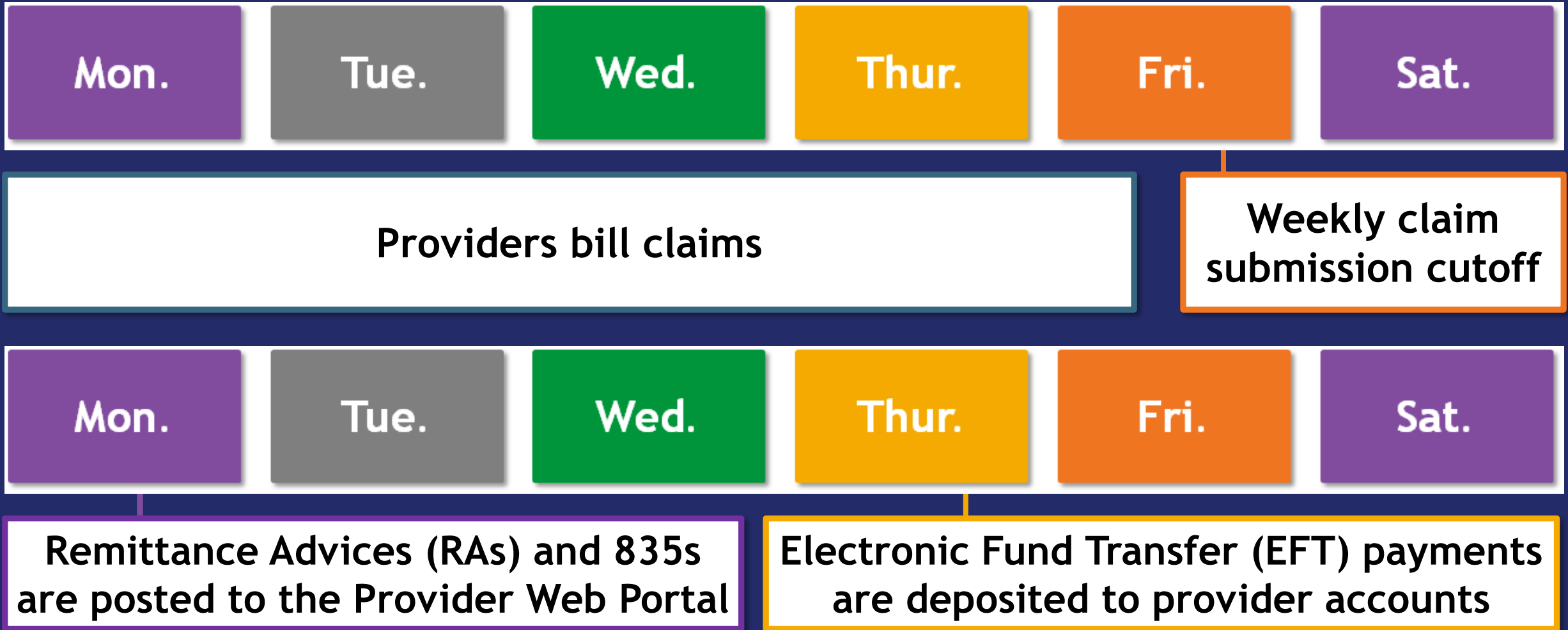
Record Retention

Payment Processing
and Remittance

Timely Filing

Extensions for
Timely Filing

Payment Processing Schedule



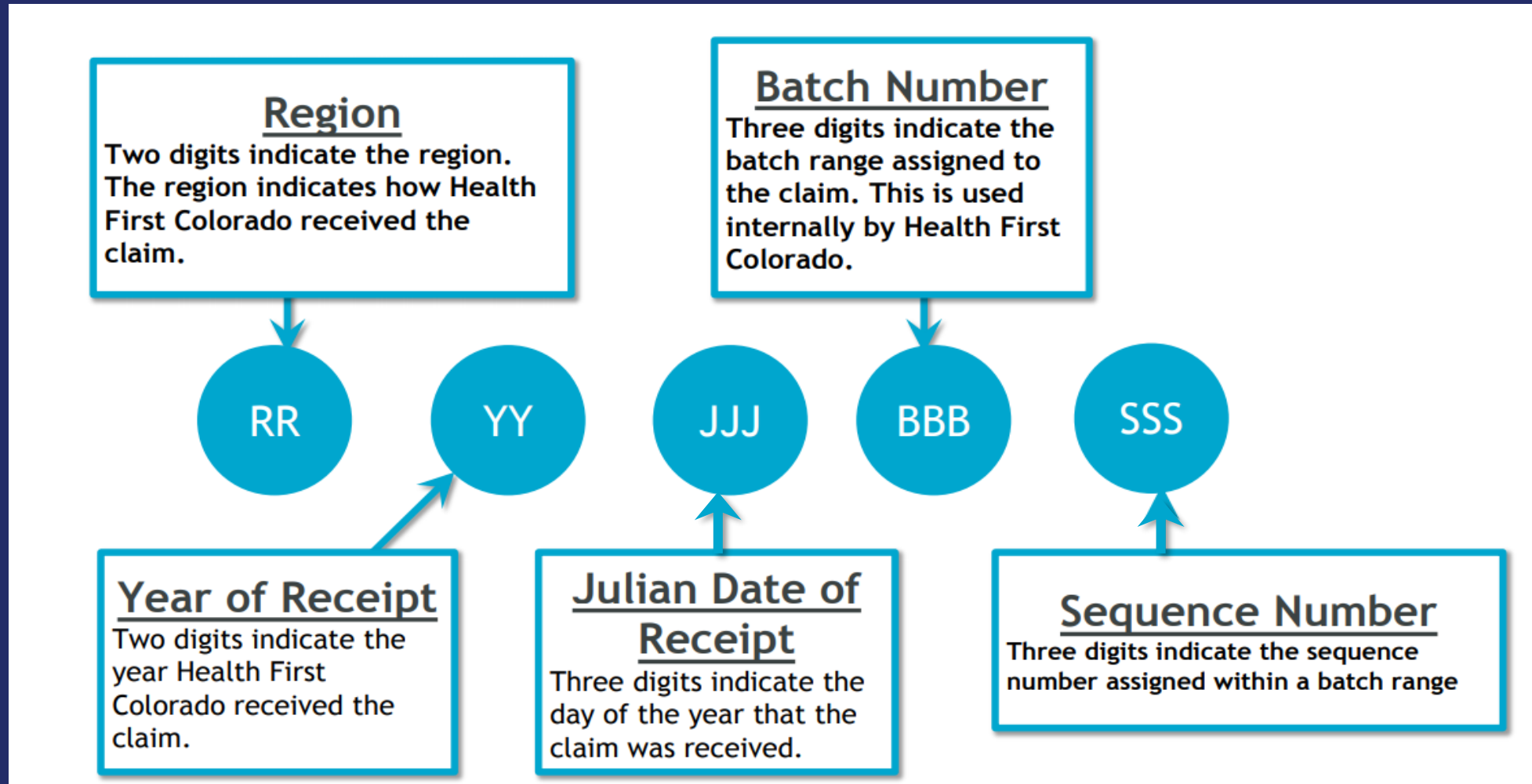
Remittance

Remittance Advice (RA)

- A Remittance Advice (RA) contains claims status and information about claim payments, as well as general announcements (banner messages) from the Department.
- Each week, providers should reconcile the RA by matching individual claims with the total payment received.
 - RAs are posted on Monday and the corresponding payment usually is deposited on the following Thursday.
 - The second page of the RA lists financial transactions that make up the total payment.
 - Denied claims will be listed with an Explanation of Benefits (EOB).

Remittance

Internal Control Number (ICN)



Remittance

Region Codes

The Region Code, the first two digits of the claim Internal Control Number (ICN), indicates how Health First Colorado received the claim.

- 10 - Paper Claims with No Attachments
- 11 - Paper Claim with Attachments
- 20, 21 - Batch Claim
- 22 - Web Portal Claim with No Attachments
- 23 - Web Portal Claim with Attachments
- 25 - PBM Pharmacy Claims
- 30, 31, 40 - Claims Converted from Old MMIS
- 50 - Provider Initiated Adjustment (via paper)
- 51, 52, 53, 55, 58 - System Initiated Adjustments
- 54 - Mass Void
- 56 - Mass Void Request or Single Claim Void
- 57 - Cash Void
- 59 - Provider Initiated Electronic Adjustment
- 67 - Cash Adjustments
- 80 - Claim Resubmission by Gainwell
- 92 - Batch Reconsideration Claims with Attachments
- 93 - Provider Initiated Batch Reconsideration Adjustment with Attachments
- 94 - Web Portal Reconsideration Claims with Attachments
- 95 - Provider Initiated Web Portal Reconsideration Adjustment with Attachments



Remittance

Retrieval of Remittance Advice or 835

- To pull a Remittance Advice (RA), log into the Provider Web Portal and click on Resources and then Report Download.
- To pull an Electronic Remittance Advice (ERA) X12 835, click on File Exchange and then Download Reports.
- Resources:
 - [Provider Web Portal Quick Guide - Reading the Remittance Advice \(RA\)](#)
 - [Provider Web Portal Quick Guide - Pulling Remittance Advice \(RA\)](#)
 - [Provider Web Portal Quick Guide - Linking the TPID and Pulling an 835](#)



Timely Filing

- 365 days from Date of Service (DOS) determined by date of receipt of the claim
- Circumstances that are **not** proof of timely filing include, but are not limited to:
 - Certified mail
 - Prior Authorization Requests (PARs)
 - Contacting the Fiscal Agent (Gainwell Technologies) or waiting for response to a verbal inquiry
 - Provider staffing changes
 - Issues between providers and their software vendors, billing agents or clearinghouses
 - Holidays, weekends and dates of business closure

Timely Filing

Dates of Service

Type of Service	Timely Filing Calculation
Nursing Facility; Home Health; Inpatient; Outpatient; all services filed on the UB-04	From the “through” (last) date of service
Dental; EPSDT; Supply; Pharmacy; All services filed on the CMS 1500	From the date of each service (line item)

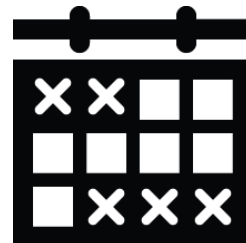
- Claims must be submitted to keep them within timely filing guidelines, even if the result is a denial.



Timely Filing

Provider Enrollment

- Providers must complete the enrollment process and submit claims within 365 days.
- Claims do not need to be submitted while waiting for provider enrollment to be approved.
- Backdated Approval
 - The Requested Enrollment Effective Date on the enrollment application can be entered as a previous date if services were previously rendered. Providers can be backdated up to 10 months from the enrollment approval date.



Timely Filing

Primary Payers: Commercial Insurance (Third Party Liability)

- Members who are enrolled with commercial insurance and Health First Colorado:
 - **Timely filing extensions cannot be given for claims including commercial insurance if the date of service is past 365 days** per state and federal regulation. (42 CFR § 447.45(d), 10 CCR 2505-10-8.043.01 and .02A)
 - Providers should submit these claims as soon as possible and then **follow up to ensure prompt response.**
 - Insurance companies are bound by the Prompt Pay Law (CRS § 10-16-106.5), which requires payment within certain timeframes.

Timely Filing Extensions

Primary Payers: Commercial Insurance (Third Party Liability)

- If a claim is denied, adjusted or voided because a third-party liability is primary:
 - **Providers may resubmit the claim within 60 days of the date of denial, adjustment or void by the fiscal agent**
 - Include commercial insurance information on claim
 - Reference the last Internal Control Number (ICN) of the claim that was denied, adjusted or voided
 - Do not attach copy of commercial insurance Explanation of Benefits (EOB) or the Remittance Advice (RA)



Timely Filing Extensions

Denials, Adjustments & Voids by Fiscal Agent

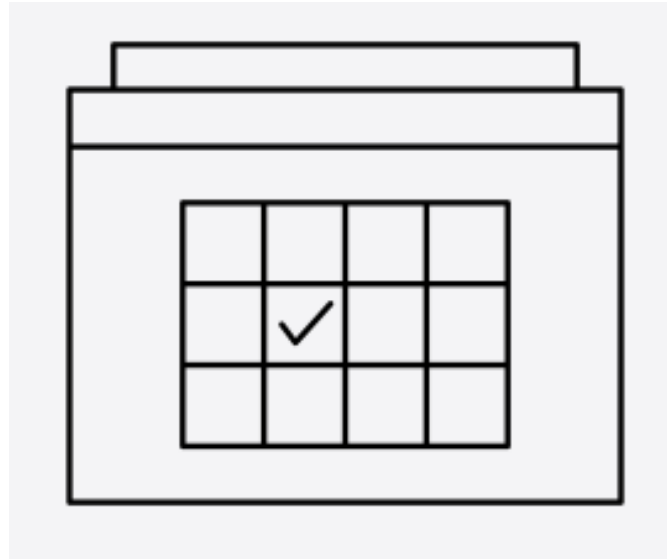
- If a claim is denied, adjusted or voided by the fiscal agent after the initial timely period of 365 days, providers have an additional 60 days from the date of the last Remittance Advice (RA) or returned paper claim to submit.
 - Reference the last Internal Control Number (ICN) from denied claims
 - Do not attach copy of Remittance Advice (RA) with claim
 - Keep supporting documentation
- Providers should continue submitting the claim every 60 days—even if the result is a denial—in order to keep it within timely filing.



Timely Filing Extensions

Primary Payers: Medicare

- Members who are enrolled with both Medicare and Health First Colorado:
 - Providers have an **additional 120 days from Medicare Explanation of Benefit (EOB) date.**



Timely Filing Extensions

Backdated Member Eligibility

- Backdated Member Eligibility
 - Providers can request load letters when a county backdates member eligibility farther than 365 days from date of service. Once a load letter is received, a **provider has 60 days from the load letter date to submit claims.**
 - Submit claims with copy of load letter via the Provider Web Portal.
- Delayed Notification of Member Eligibility
 - Providers are responsible for determining member eligibility within 365 days of date of service even if the member does not notify them of Health First Colorado eligibility. **No further extensions are given for delayed notification of eligibility.**

Timely Filing

Is the claim within 365 days of the (final) date of service?

Yes

Health First Colorado: Check member's eligibility (and continue checking in case of retroactive eligibility) and submit claim

Health First Colorado + Third-Party (Commercial Insurance): Bill commercial insurance as soon as possible and follow up to ensure prompt payment

Health First Colorado + Medicare: Bill Medicare first

No

✗ Claim cannot be submitted after 365 days from the date of service unless:

✓ **Member's eligibility backdated by county?** Request load letter and attach to claim submitted within 60 days of letter.

✗ **Delayed in submitting claim and just received Explanation of Benefits (EOB) from Third-Party (Commercial Insurance)?** Claim cannot be submitted after 365 days from the date of service.

✓ **Claim voided or adjusted by fiscal agent for Third-Party Liability?** Providers have 60 days from date of void or adjustment to resubmit claim.

✓ **Just received Explanation of Benefits (EOB) from Medicare?** Providers have 120 days from Medicare Explanation of Benefits (EOB) to submit claims to Health First Colorado

Claim Submission



Claim Submission

[Claim Submission Methods](#)

[Claim Submission Information](#)

[UB-04 Paper Claim Form & Example](#)

[Claim Status & Common Terms](#)

[Common Denial Reasons](#)

[Claim Adjustments, Voids and Refunds](#)

Claim Submission Methods

- Electronically through the Fiscal Agent's (Gainwell Technologies) Provider Web Portal (free of charge)
 - Interactive, one claim at a time, immediate response with claim status
- Electronically using a batch vendor, clearinghouse or software
 - Submitters must test batch transactions before approval to submit
- Paper
 - Only when pre-approved due to consistently submitting less than five (5) per month
 - Request form must be mailed to the Fiscal Agent (Gainwell Technologies) to request paper claim submission approval

Claim Submission Methods

Electronic Data Interchange (EDI)

- Providers do not need to obtain a trading partner ID/submitter ID to access the Provider Web Portal.
- Only a submitter who sends batch transactions or receives batch reports needs to enroll in the Electronic Data Interchange (EDI) for a trading partner ID.
- Visit the [EDI Support](#) web page for more information.



Claim Submission Methods

Medicare Crossovers

- **Automatic Medicare Crossover Process:**



- Claims not automatically crossed over must be submitted directly by the provider.
- Crossovers may not be processed by Health First Colorado if:
 - NPI used on Medicare claim does not match NPI enrollment with Health First Colorado
 - Member is a retired railroad employee
 - Member has incorrect or missing Medicare information on file

Claim Submission Information

Attending Provider (Individual Within a Group)

Individual that provides services to a Health First Colorado member



Billing Provider

Entity being reimbursed for service



UB-04 (Paper Claim)

UB-04 is the standard institutional claim form used by Health First Colorado and Medicare programs.

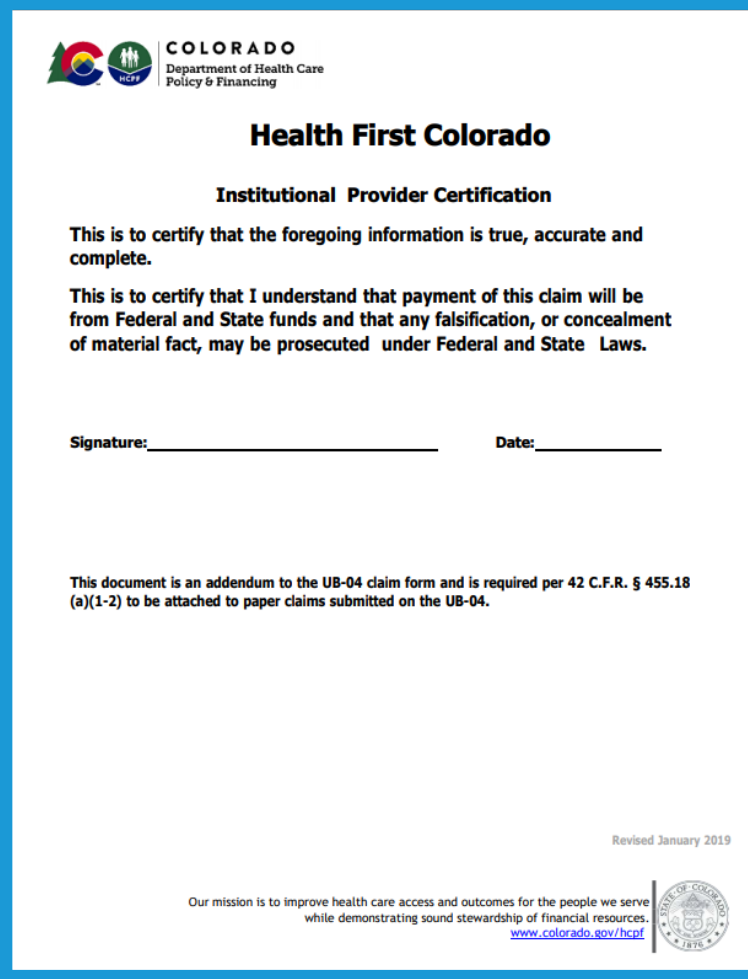
Where can a provider get the UB-04?


Information is available on the [Centers for Medicare and Medicaid Services website](#).

UB-04 (Paper Claim)

UB-04 certification must be completed and attached to all claims submitted on the paper UB-04.

Visit the [Provider Forms webpage](#) to print a [copy of the certification](#).



 **COLORADO**
Department of Health Care
Policy & Financing

Health First Colorado

Institutional Provider Certification

This is to certify that the foregoing information is true, accurate and complete.


This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature: _____ Date: _____

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. § 455.18 (a)(1-2) to be attached to paper claims submitted on the UB-04.

Revised January 2019

Our mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.
www.colorado.gov/hcpf



Paper Claim - Example 1

REQUIRED FIELDS
 CONDITIONAL FIELDS
 OPTIONAL FIELDS

1 ABC Hospice 1234 Alphabet Lane Anytown, CO 33333-9999 Phone: 999-999-9999										2 3a PAT. CNTL # 11111-000 b. MED. REC. # 123 5 FED. TAX NO. 999999999 6 STATEMENT COVERS PERIOD FROM 07012018 THROUGH 07312018										4 TYPE OF BILL 813							
8 PATIENT NAME a Doe, John					9 PATIENT ADDRESS a Greentown Nursing and Rehabilitation 123 Southern Rd, Room 555 b Greentown c CO d 11111-4444										7												
10 BIRTHDATE 02121950		11 SEX M	12 DATE 02132018		13 HR 12	14 TYPE 3	15 SRC 5	16 DHR	17 STAT 30	18 Z4	19 20 21 22 23 24 25 26 27 28 CONDITION CODES								29 ACDT STATE	30							
31 OCCURRENCE DATE 27 051418		32 OCCURRENCE DATE CODE DATE		33 OCCURRENCE DATE CODE DATE		34 OCCURRENCE DATE CODE DATE		35 OCCURRENCE SPAN FROM THROUGH CODE		36 OCCURRENCE SPAN FROM THROUGH CODE		37															
38 Field 31-34 - Required. Enter the appropriate code and the date on which it occurred. Enter the date using MMDDYY format.										Field 15 & 17 - Required. For field 15 enter source of admission. For field 17 enter client status as ongoing patient (code 30) or as of discharge date.										39 VALUE CODES AMOUNT a b c d				40 VALUE CODES AMOUNT CODE AMOUNT		41 VALUE CODES AMOUNT CODE AMOUNT	
42 REV. CD. 0651		43 DESCRIPTION Routine Low Days			44 HCPCS / RATE / HIPPS CODE			45 SERV. DATE 07012018		46 SERV. UNITS 31	47 TOTAL CHARGES 5410 : 12		48 NON-COVERED CHARGES 0 : 00		49												
Field 39-41 - Conditional. Enter appropriate codes and related dollar amounts to identify monetary data or number of days using whole numbers, necessary for the processing of this claim. If a value code is entered, a dollar amount or numeric value related to the code must always be entered.										Field 48 - Conditional. Enter incurred charges that are not payable by the Health First Colorado.																	

Paper Claim - Example 2

Field 50 & 51 - Required. For field 50 enter the payment source code followed by name of each payer organization from which the provider might expect payment. For field 51 enter the eight-digit Health First Colorado Program provider number assigned to the billing provider. This is the distinct number assigned to a provider during Health First Colorado enrollment.

Field 54 & 55 - Conditional. For field 54 enter third party and/or Medicare payments. For field 55 enter net amount due from Health First Colorado after provider has received other third party, Medicare or patient liability. For Medicare enter the sum of the Medicare coinsurance plus Medicare deductible less third party payments and patient liability.

Field 58 & 60 - Required. For field 58 enter the client's name on the first line for Health First Colorado. Complete additional lines when there is additional coverage. For field 60 enter the insured's unique identification number assigned by the payer organization. Complete additional lines when there is additional coverage.

Field 67 - Required. Enter the exact ICD-10-CM diagnosis code describing the principal diagnosis that exists at the time of admission or develops subsequently and affects the length of stay. Do not add extra zeros to the diagnosis code.

Field 63 - Conditional. Field is used to enter PAR number; however, PARs automatically link to the claim when there is a PAR on file for the service.

Field 61, 62, 65 - Conditional. Complete when there is third party coverage.

PAGE 1 OF 1		CREATION DATE 07312018		TOTALS		5410	12	0:00
50 PAYER NAME D Health First Colorado		51 HEALTH PLAN ID 12345678		52 REL INFO Y	53 ASG BEN. Y	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE
58 INSURED'S NAME Doe, John		59 P.REL.	60 INSURED'S UNIQUE ID A123456		61 GROUP NAME		62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES			64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME		
66 DX J441	R0902	R0600	R630	R634	E45	R5383	Z720	Z9981
68	70 PATIENT REASON DX		71 PPS CODE		72 ECI		73	



Paper Claim - Example 3

67										68										69										70										71										72										73																													
J441										R0902										R0600										R630										R634										E45										R5383										Z720										Z99									
68 ADMIT DX										70 PATIENT REASON DX										71 PPS CODE										72 ECI										73																																																	
74 PRINCIPAL PROCEDURE CODE										a. OTHER PROCEDURE CODE										b. OTHER PROCEDURE CODE										75										76 ATTENDING NPI										QUAL										LAST										FIRST																			
																																								1234567890																				Doe										Jane																			
c. OTHER PROCEDURE CODE										d. OTHER PROCEDURE CODE										e. OTHER PROCEDURE CODE										77 OPERATING NPI										QUAL										LAST										FIRST																													
80 REMARKS										81CC a										b										c										78 OTHER NPI										QUAL										LAST										FIRST																			
Field 74A - Conditional. Complete when there are additional significant procedure codes. Enter the date using MMDDYY format.																																																		0000000000																				Thomas										Doctor									

Field 76 - Required. Enter the 10 digit NPI assigned to the physician having primary responsibility for the member.

Field 78 & 79 - Conditional. Enter 10 digit NPI when attending physician is not the PCP or to identify additional physicians. Ordering, Prescribing, or Referring NPI - when applicable.


UB-04 CMS-1450 APPROVED OMB NO.

REQUIRED FIELDS

CONDITIONAL FIELDS

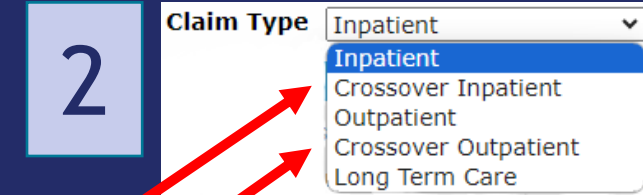
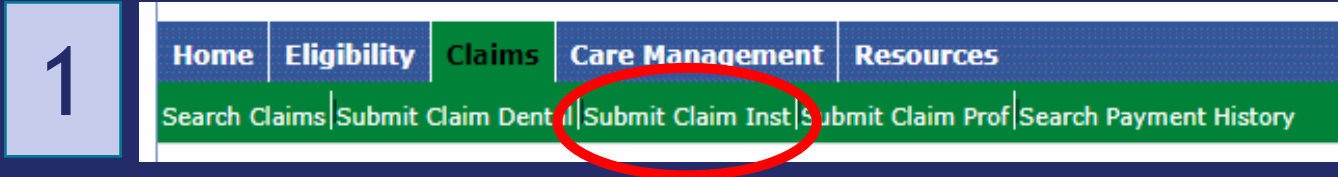
OPTIONAL FIELDS

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.


NUBC National Uniform Billing Committee
 LIC9213257

Provider Web Portal Demo

Step 1: Member and Claim Information



The Crossover Inpatient or Crossover Outpatient Institutional claim is used when Medicare is the primary payer.

3

Patient number can be any number the provider assigns for internal records.

Reference the original Internal Control Number (ICN) if you are resubmitting a claim after it has been denied.

Claim Information

*Covered Dates -

*Admission Date/Hour (hh:mm) Discharge Hour (hh:mm)

*Admission Type *Admission Source

*Admitting Diagnosis Type ICD-10-CM *Admitting Diagnosis

*Patient Status *Facility Type Code

*Patient Number

Previous Claim ICN

Note

Include Other Insurance

Total Charged Amount \$0.00

Check "Include Other Insurance" if there is a third-party liability (commercial insurance) that is the primary payer. This is NOT used for Medicare.

Provider Web Portal Demo

Step 2: Diagnosis Panel

Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	Action
<u>1</u>			

1 *Diagnosis Type *Diagnosis Code

Be sure to click "Add" after inputting the Diagnosis Code and before clicking "Continue."

Provider Web Portal Demo

Step 3: Service Details Panel

A revenue code is a four-digit code that identifies the specific accommodation or ancillary service provided.

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
<u>1</u>							

1 *Revenue Code HCPCS/Proc Code

Modifiers

From Date To Date *Units *Unit Type

*Charge Amount

NDCs for Svc. # 1

A procedure code is a catch-all term for codes used to identify what was done or given to a member.

Be sure to click "Add" after inputting the Diagnosis Code and before clicking "Continue."

Indicate the number of service units provided. Use whole numbers only.

Provider Web Portal Demo

Step 4: Correcting a Denied Claim

1

Adjudication Errors		
Header / Detail	EOB	Description
Service # 1	3314	Denied. Detail Dates Are Not Within Statement Covered Period.

Check the "Adjudication Errors" for information on why a claim denied.

2

Copy Outpatient Claim

Select the information you would like to have copied to the new claim. Press Copy to initiate the claim and continue entering claim information.

- Member Information**
 - Member ID
 - Last Name
 - First Name
 - Birth Date
 - Address
 - Condition Code(s)
- Service Information**
 - Admission Source
 - Admission Type
 - Admitting Diagnosis
 - Facility Type Code
 - Diagnosis Code(s)
 - Revenue Code(s)
 - HCPCS/Proc Code(s)
 - Modifier(s)
 - Detail Charge Amount(s)
 - Units
 - Unit Type(s)
 - NDC Code Type(s)
 - NDC Code(s)
 - NDC Quantity(s)
 - NDC Unit of Measure(s)
- Member and Service Information**
 - Copies data listed in previous 2 columns.
- Entire Claim**
 - Copies data listed in columns 1 and 2 PLUS:
 - All Providers
 - Admission Date/Hour
 - Discharge Hour
 - Patient Status
 - Occurrence Code(s)
 - Value Code(s)
 - Surgical Procedure Code(s)
 - Other Insurance
 - All Dates
 - All Amounts

Copy the entire claim to make necessary changes.

After copying the entire claim and making necessary changes, be sure to click "Save" before clicking "Continue."

3

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
1	0329-RADIOLOGY - DIAGNOSTIC OTHER RADIOLOGY - DIAGNOSTIC DX X-RAY/OTHER	77066-DX MAMMO INCL CAD BI	10/02/2023	10/02/2023	1.000 Unit	\$1,000.00	Remove

1 *Revenue Code 0329-RADIOLOGY - DIAGNOSTIC OTHER F HCPCS/Proc Code 77066-DX MAMMO INCL CAD BI

Modifiers

From Date 10/02/2023 To Date 10/02/2023 *Units 1.000 *Unit Type Unit

*Charge Amount 1,000.00

NDCs for Svc. # 1

Click on blue numbers to expand and change information within that panel.

UB-04

Resources

Billing Manuals (Provider-Specific)

- UB-04 Paper Claim Reference Table
 - Indicates which fields are required, conditional and optional (differ based on provider type)
- UB-04 Claim Example
 - Often show various scenarios, such as members with Medicare
- Codes and Modifiers
 - Often in the format of a code table

Provider Web Portal

- Red asterisks (*) will denote required fields

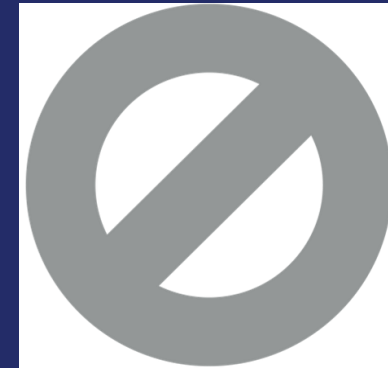
Claim Status

Common Terms



Paid

Claim processed & paid by claims processing system. Claims paid at zero due to lower of pricing are still considered paid.



Denied

Claim processed & denied by claims processing system. Denied claims may not be adjusted but may be resubmitted after corrections have been made.

Common Denial Reasons

Timely Filing

Claim was submitted more than 365 days without reference to a previous Internal Control Number (ICN).

Duplicate Claim

A subsequent claim was submitted after a claim for the same service had already been paid.

Bill Medicare or Other Insurance

Health First Colorado is always the payer of last resort. Provider should enroll with and bill all other appropriate carriers first. Primary information must be reported on the claim form.

Common Denial Reasons

Prior Authorization (PAR) Not on File

No approved prior authorization on file for services that are being submitted, OR modifiers, units or PAR type may not match.

Total Charges Invalid

Line-item charges do not match the claim total.

Type of Bill

Claim was submitted with an incorrect or invalid type of bill. Verify appropriate type of bill in billing manual.

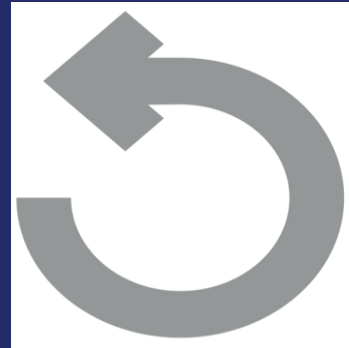
Claim Status

Common Terms



Adjustment

Correct a paid claim



Resubmit

Rebill a previously denied claim



Suspend

Claim must be manually reviewed before final decision



Void

Cancel a paid claim

Providers should only void claims if accidentally submitted OR there is an incorrect Member ID or Provider ID

Claim - Resubmissions

- Providers may resubmit, also known as rebill, claims that have been denied.
 - If the resubmitted claim is outside of timely filing, the original Internal Control Number (ICN) must be referenced.

Resubmit a claim when

- Claim was denied

Do not resubmit a claim when

- Claim was paid
- Claim is suspended

Resubmission Codes

Rebilled Claims: Date of Service Past 365 Days

Provider Web Portal:

- Search for original claim
- Click “Copy” at the bottom; include original ICN in “Previous Claim ICN” field

Batch:

- Qualify claim loop with F8 and use the previous Internal Control Number (ICN) as the Payer Claim Control Number along with 1 code in the 2300/CLM segment

Paper:

- Use code 1 as the third digit in box 4 (Type of Bill) and the original Internal Control Number (ICN) in box 64



Claim - Adjustments

- What is an adjustment?
 - Adjustments create a replacement claim.
 - Two step process: Credit & Repayment

Adjust a claim when

- Provider billed incorrect services or charges
- Claim paid incorrectly

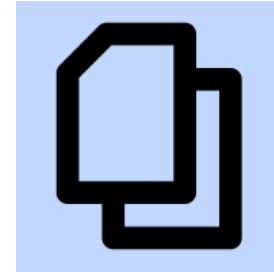
Do not adjust a claim when

- Claim was denied
- Claim is suspended

Adjustment & Void Codes

Provider Web Portal:

- Search for original claim and
 - Adjustment: Click “Adjust” at the bottom
 - Void: Click “Void” at the bottom



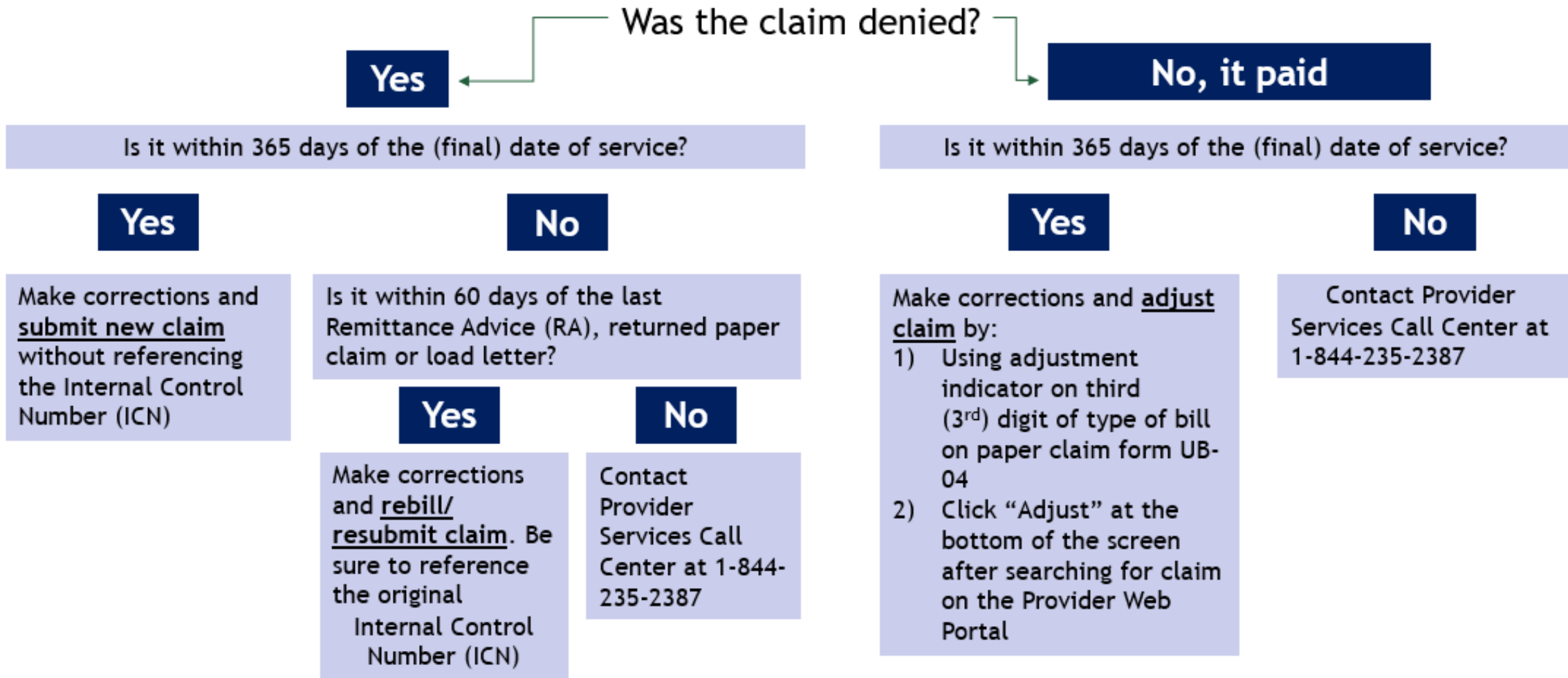
Batch:

- Qualify claim loop with F8 and use the previous Internal Control Number (ICN) as the Payer Claim Control Number along with
 - Adjustment: 7 code in the 2300/CLM segment
 - Void: 8 code in the 2300/CLM segment

Paper:

- Adjustment: Use code 7 as the third digit in box 4 (Type of Bill) and the original Internal Control Number (ICN) in box 64
- Void: Use code 8 as the third digit in box 4 (Type of Bill) and the original Internal Control Number (ICN) in box 64

Claim Submission: Resubmit or Adjust?



Quick Guides

- Copy, Adjust or Void a Claim
 - Pulling Remittance Advice (RA)
 - Reading the Remittance Advice (RA)
 - Submitting an Institutional Claim
- All Provider Web Portal Quick Guides can be found on the Department's Quick Guides web page



Resources

Billing Manuals web page

- General Provider Billing Manual
- Provider-Specific Billing Manuals
- Appendix R (for a detailed list of Explanation of Benefits [EOB] codes)

Provider Web Portal Quick Guides

- Technical help for the Provider Web Portal

Provider Training web page

- Training schedule and sign-up
- Training presentations and materials

Provider Contacts web page

- Contact information for Fiscal Agent (Gainwell Technologies) and Health First Colorado vendors
- Contact information for Regional Accountable Entities (RAEs)
- Virtual Agent Fact Sheet

Provider Services Call Center

1-844-235-2387



hcpf.colorado.gov/our-providers

Where can I find...?

For Our Providers

- Enrollment forms
- Revalidation dates spreadsheet
- National Provider Identifier (NPI) information
- Provider types

- Fee schedules
- General Provider Information manual
- Billing manuals & appendices
- Forms
 - Prior Authorization Requests (PARs)
 - Load letters
 - Request to use paper claims form

- Newsletters
- What's New?

Where can I...?

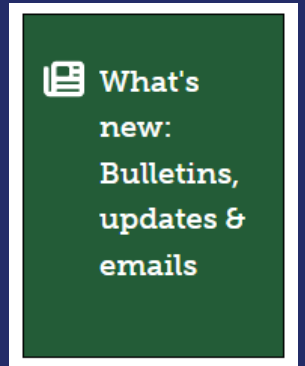
- Check member eligibility
- Submit claims
- Review Prior Authorization Requests (PARs)
- Receive Remittance Advices (RAs)
- Complete provider maintenance requests

- Quick Guides for Web Portal
- Known issues
- EDI Support
- Training registration
- Information about
 - Accountable Care Collaborative & RAEs
 - Co-Pays
 - EVV



Reminders

- Remember to sign up for Department of Health Care Policy & Financing communications by visiting the website and clicking “For Our Providers” and then “What’s new: Bulletins, updates & emails.”
- Interested in more training? Sign up by visiting the website and clicking “Provider Resources” and then “Provider Training.”



**Thank you for the services
you provide to Health First
Colorado members!**