Beginner Billing Workshop: Professional Claims (CMS 1500)

Health First Colorado

(Colorado's Medicaid Program)

Professional Claim - Who completes it?

- Home and Community Based Services
- Vision
- Physicians, Therapists and Practitioners
- Supply
- Surgeons
- Transportation

Training Overview

Program Overview

Department Website

Provider Enrollment

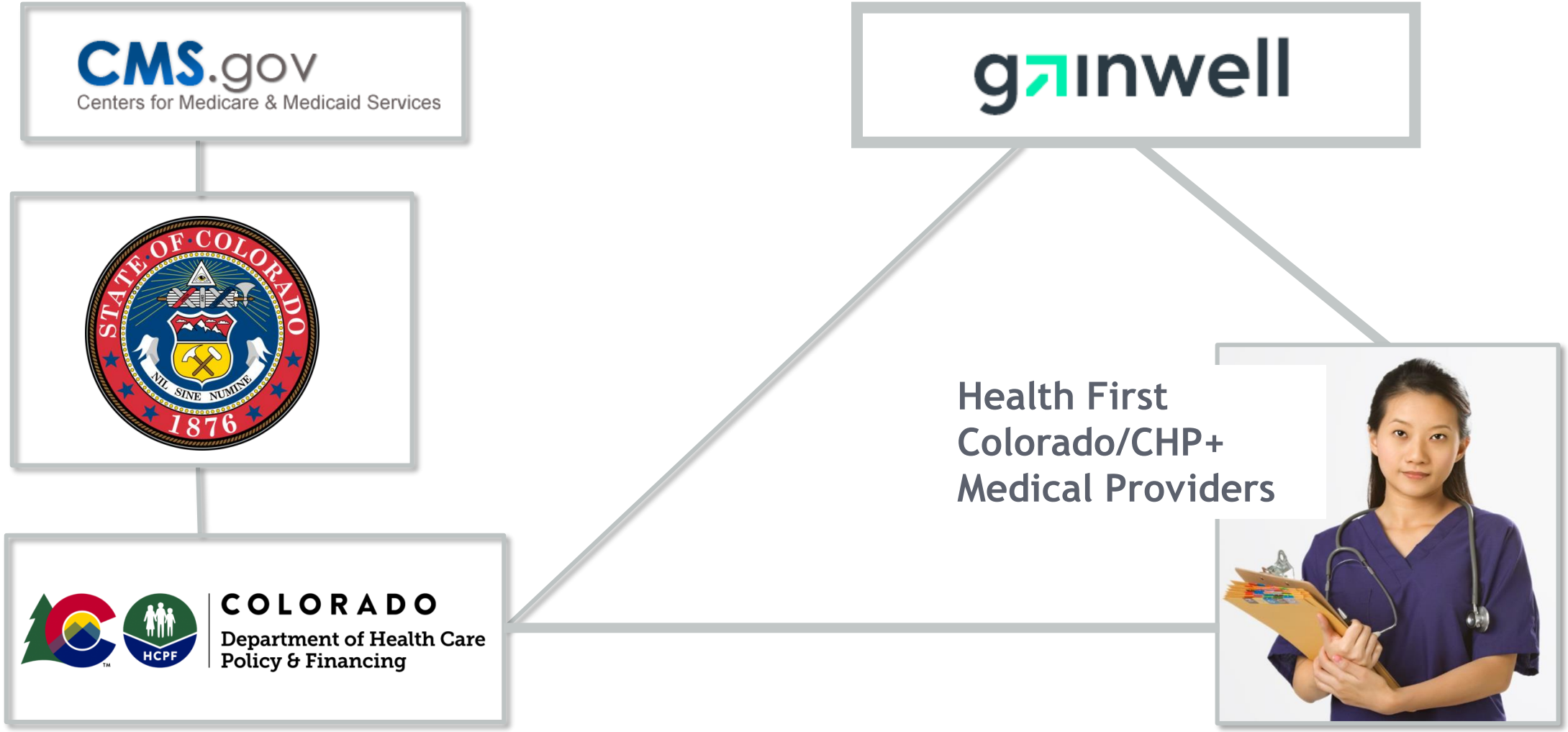
Eligibility Verification

Prior Authorizations

Billing and Payment

Claim Submission

Program Overview



Department Website

1

hcpf.colorado.gov

2

For Our Providers

https://hcpf.colorado.gov/

Visit "Where can I get vaccinated" or call 1-877-COVAXCO (1-877-268-2926) for vaccine information.

COLORADO
Department of Health Care Policy & Financing

Search

Home | For Our Members | For Our Providers | For Our Stakeholders

We administer Health First Colorado (Colorado's Medicaid program), Child Health Plan *Plus*, and other programs.

Apply Now | Explore Programs | Find a Doctor | Get Help

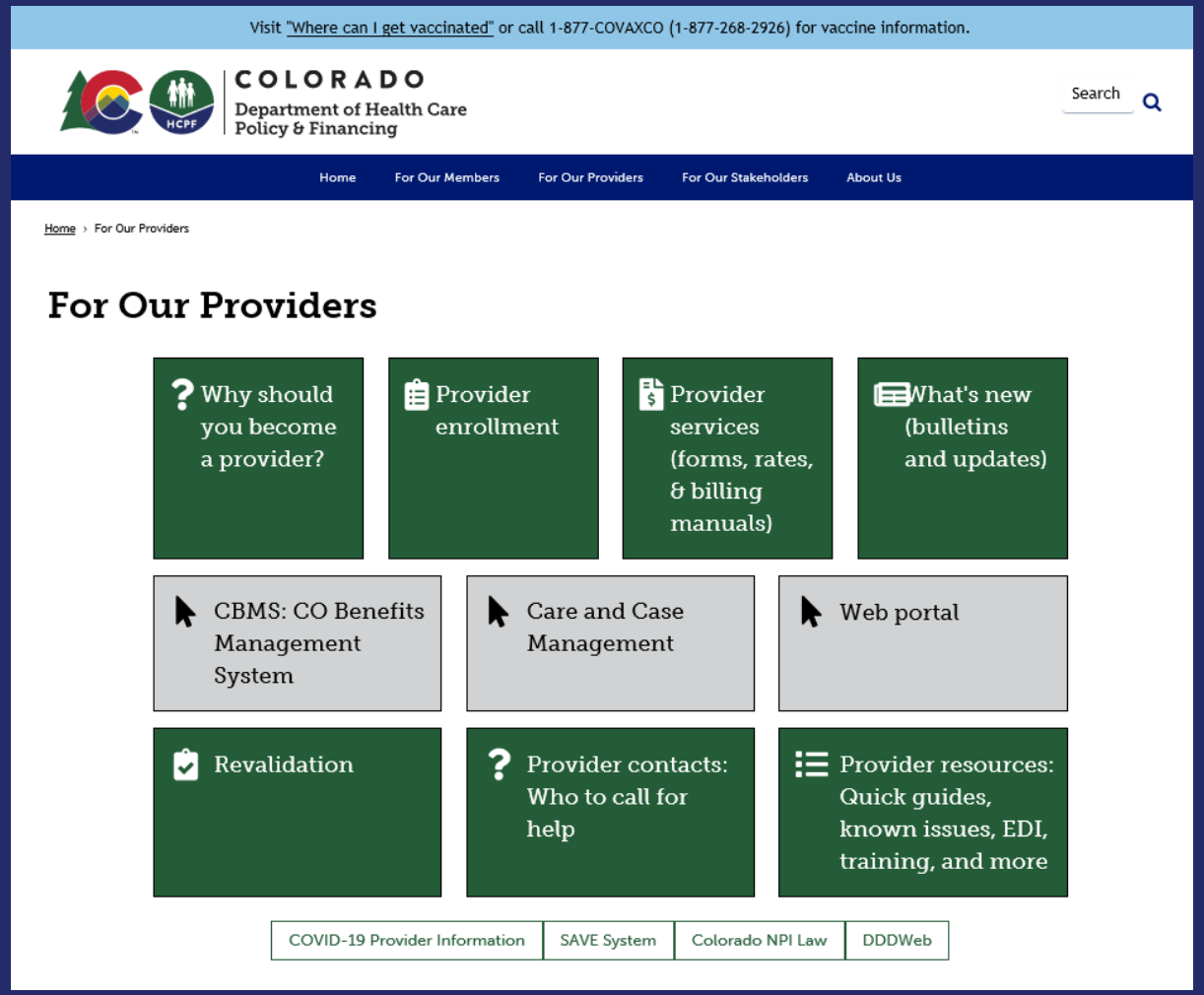
Health First COLORADO
Colorado's Medicaid Program

COVID-19 Information For Members, Providers and Stakeholders

Provider Home Page

Access to fee schedules, billing manuals, revalidation, enrollment, the provider web portal, contacts and resources

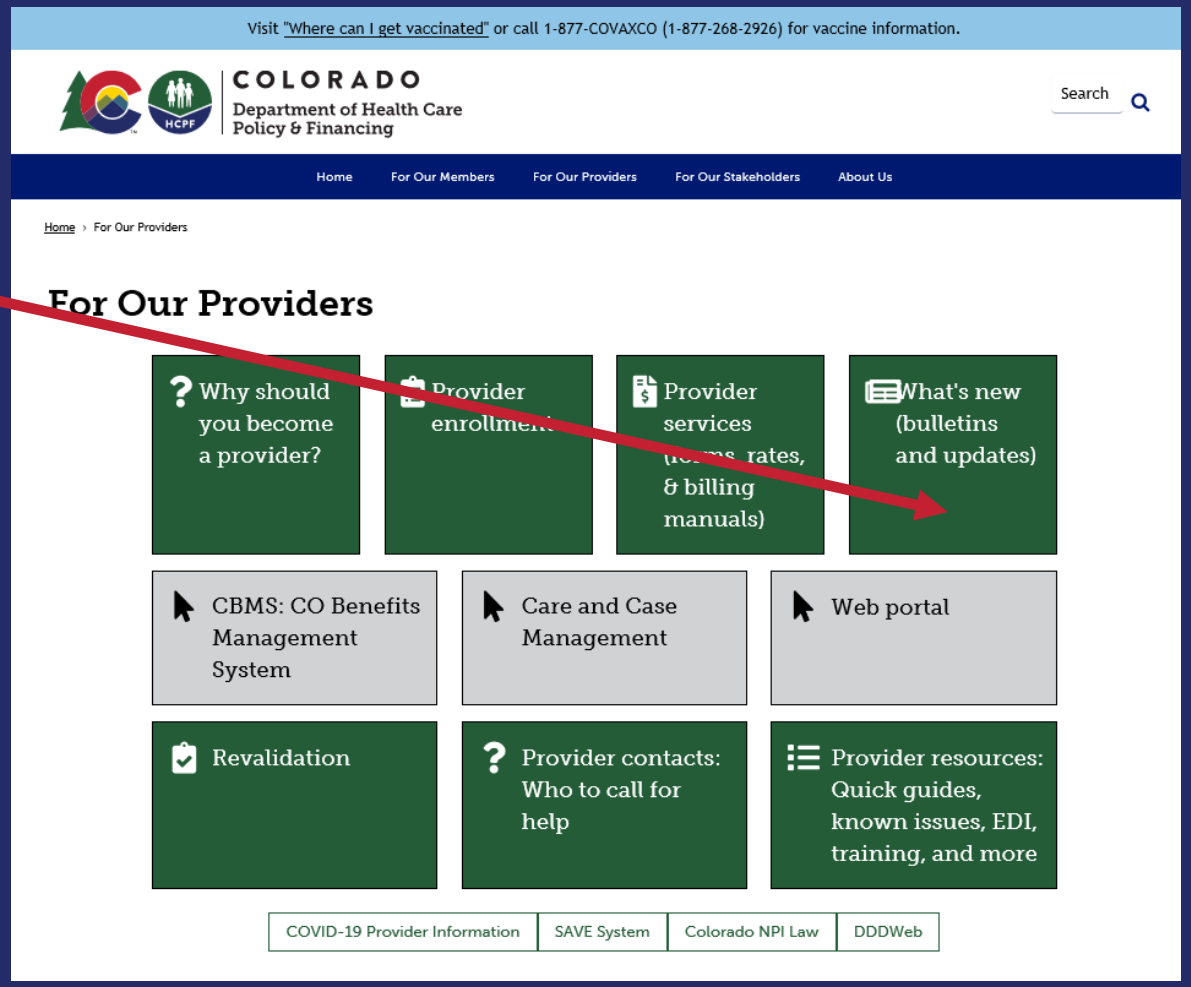
Contains important information regarding Health First Colorado (Colorado's Medicaid Program) & other topics of interest to providers and billing professionals



What's New, Bulletins, Newsletters

Sign up for publications

Weekly newsletters and bulletins



Provider Resources

Provider Resources

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

Visit "Where can I get vaccinated" or call 1-877-COVAXCO (1-877-268-2926) for vaccine information.

COLORADO
Department of Health Care Policy & Financing

Search

Home | For Our Members | For Our Providers | For Our Stakeholders | About Us

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 and updates)
- CBMS: CO Benefits Management System
- Care and Case Management
- Web portal
- Revalidation
- Provider contacts: Who to call for help
- Provider resources: Quick guides, known issues, EDI, training, and more

COVID-19 Provider Information | SAVE System | Colorado NPI Law | DDDWeb

Provider Resources

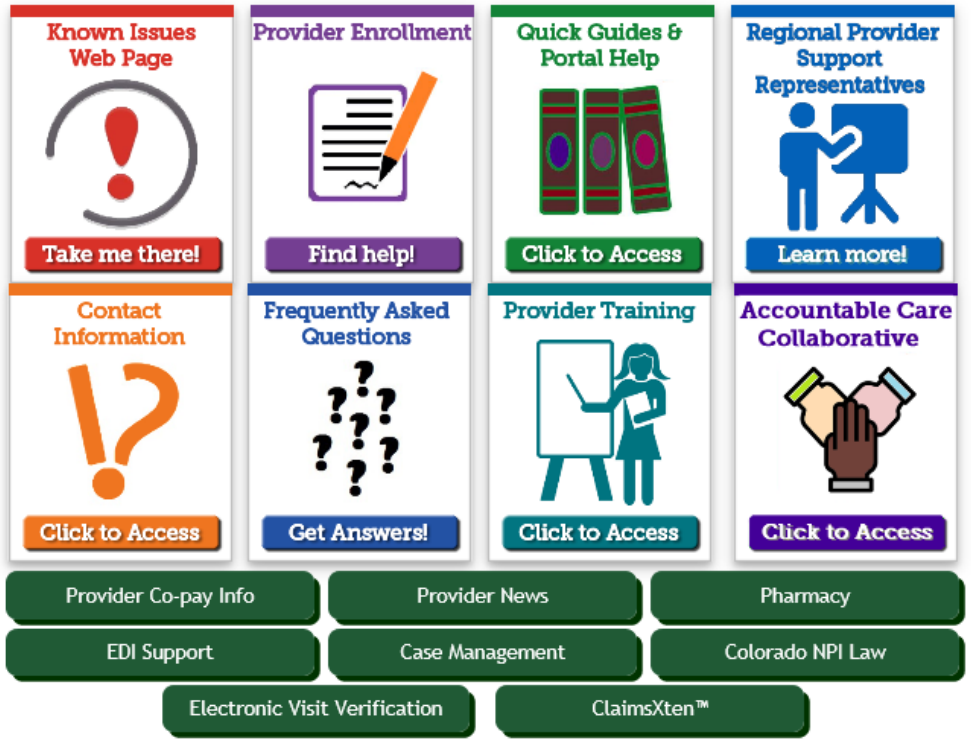
Provider Resources

Provider Services Call Center New Friday Hours: Effective February 5, 2021, the current fiscal agent (now referenced as Gainwell Technologies) extended the Friday hours of the Provider Services Call Center, with hours of operation Monday - Friday from 7:00 a.m. - 5:00 p.m. MT.

Upcoming Holidays

Memorial Day- Monday, May 31- State Offices, the ColoradoPAR Program, DentaQuest and Gainwell Technologies will be closed.

The receipt of warrants and EFTs may potentially be delayed due to the processing at the United State Postal Service or providers' individual banks.



National Provider Identifier

- A National Provider Identifier (NPI) is a unique 10-digit identification number issued to U.S. health care providers by CMS
- Non-medical providers such as home and community based services do not require an NPI
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions
- The Colorado interChange claims system will use the NPI to find the unique Health First Colorado Provider ID
- NPIs are permanent for individual providers regardless of rendering provider location or affiliation. Individuals should only have one NPI and one Health First Colorado ID

National Provider Identifier

- How to Obtain & Learn Additional Information:
  - CMS web page
  - National Plan and Provider Enumeration System (NPPES)-
    - 1-800-456-3203
    - 1-800-692-2326 TTY

NPI Law

- HB 18-1282 requires newly enrolling and currently enrolled organization health care providers (not individuals) to obtain and use a unique National Provider Identifier (NPI) for each service location and provider type enrolled in the Colorado interChange.

- Who Is Impacted by the Colorado NPI Law?
  Newly Enrolling Providers
  Organizational Health Care Providers (Facilities or Groups)
- Who Is **Not** Impacted by the Colorado NPI Law? Individual Practitioners
  Individual practitioners (Individuals Within a Group, Billing Individuals or Ordering/Prescribing/Referring), as individuals are limited to one enrollment and one NPI per person.
  Atypical (Non-Medical) Providers

- Providers who bill Medicare need to ensure each National Provider Identifier (NPI) for Health First Colorado is also enrolled with Medicare.

Provider Enrollment

Question:

What does Provider Enrollment do?

Answer:
Enrolls providers into Health First Colorado, not members

Question:

Who needs to enroll?

Answer:

Everyone who provides services for Health First Colorado members

Provider Enrollment

Provider Enrollment

ATTENTION: Some providers can now temporarily enroll in Health First Colorado (Colorado's Medicaid program) to provide services during the COVID-19 public health emergency. New applicants will be required to indicate whether they are enrolling temporarily due to the public health emergency or enrolling for the long-term. Refer to the drop-down section further down on this page, titled New Provider Specialties for COVID-19 Long-Term and Temporary Enrollment, for further details.

Revalidation Information | NPI Law Web Page

Enrollment Instructions & Application

Enrollment Resources

- Enrollment Best Practices
- Trading Partner Enrollment Information
- Enrollment and Web Portal Quick Guides
- Information for Ordering, Prescribing, Referring (OPR) Providers

Need to speak to a live agent for help with your enrollment? Please call the Provider Services Call Center at 1-844-235-2387, then select option 2 and then option 5.

Completed your application? Click here for next steps

- To prepare for enrollment as a new provider, go to the Provider Enrollment web page and click the Enrollment Instructions & Application button.
- There is a list of resources as well as forms for enrolling providers

Enrollment Forms

- Application Fee Refund Form
- Behavioral Therapy Provider Attestation Form
- Disclosure Instructions EIN
- Disclosure Instructions SSN
- EFT Exemption Instructions
- Enrollment Backdate Form
- Network Participation Verification Form
- Provider Participation Agreement
- SUD Clinic Supervisor Attestation Form

Revalidation

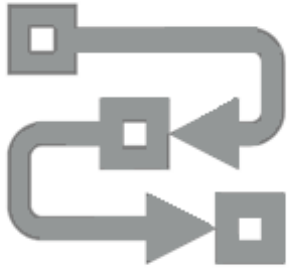
- Child Health Plan Plus (CHP+) and Health First Colorado (Colorado's Medicaid Program) providers must revalidate in the program at least every five (5) years to continue as a provider.
- Organization Health Care Providers are required to obtain and use a unique National Provider Identifier (NPI) for each service location and provider type enrolled.
- A spreadsheet with providers' revalidation dates can be found on the Department's Revalidation web page.

Verifying Member Eligibility

- Always save copies of eligibility verifications
- Keep member's eligibility information in member's file for auditing purposes
- Member's eligibility must be checked on each date of service
- Ways to verify eligibility:

Provider Web Portal

IVR 1-844-235-2387



Batch 270

Eligibility Response Information

- Web Portal
- Member ID Cards
- Eligibility Types
- Managed Care
- Medicare
- Third Party Liability
- Co-Pay

Viewing 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 — Monday 05/04/2020 01:32 PM MST

Provider Name	Provider ID	Location
	Taxonomy	

User Details

Welcome RevailProv1

- My Profile
- Manage Accounts

Provider

Name

Provider ID

Location ID

Revalidation Date

- Provider Maintenance
- EFT/ERA (835) Enrollment
- Disenroll

Revalidation

Provider Services

- Member Focused Viewing
- Search Payment History
- Search Accounts Receivable
- BIDM

Welcome Health Care Professional!

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 Model Office System

- Contact Us
- Notify Me
- Alerts
- Secure Correspondence

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

Member in Focus: FRIEDA FRANK Change ID: S700001 Close Member Focus

Member Details

Member ID S700001
Name Ima Member
Birth Date 07/15/1961
City NORTH
State Connecticut
Gender Female
Primary Language English

Coverage Details

Coverage	Effective Date	End Date
Medicaid State Plan	01/01/2014	12/31/2299
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
2216152001011	01/01/2016 - 02/01/2016	LongTermCare	Denied
2216109001026	03/15/2015 - 03/15/2015	Inpatient	Suspended

Your Member Authorizations

Submit an Authorization

There are no authorizations for this member.

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 S700001
Last Name
First Name
Birth Date
City
Zip Code

Search Reset

Search Results

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

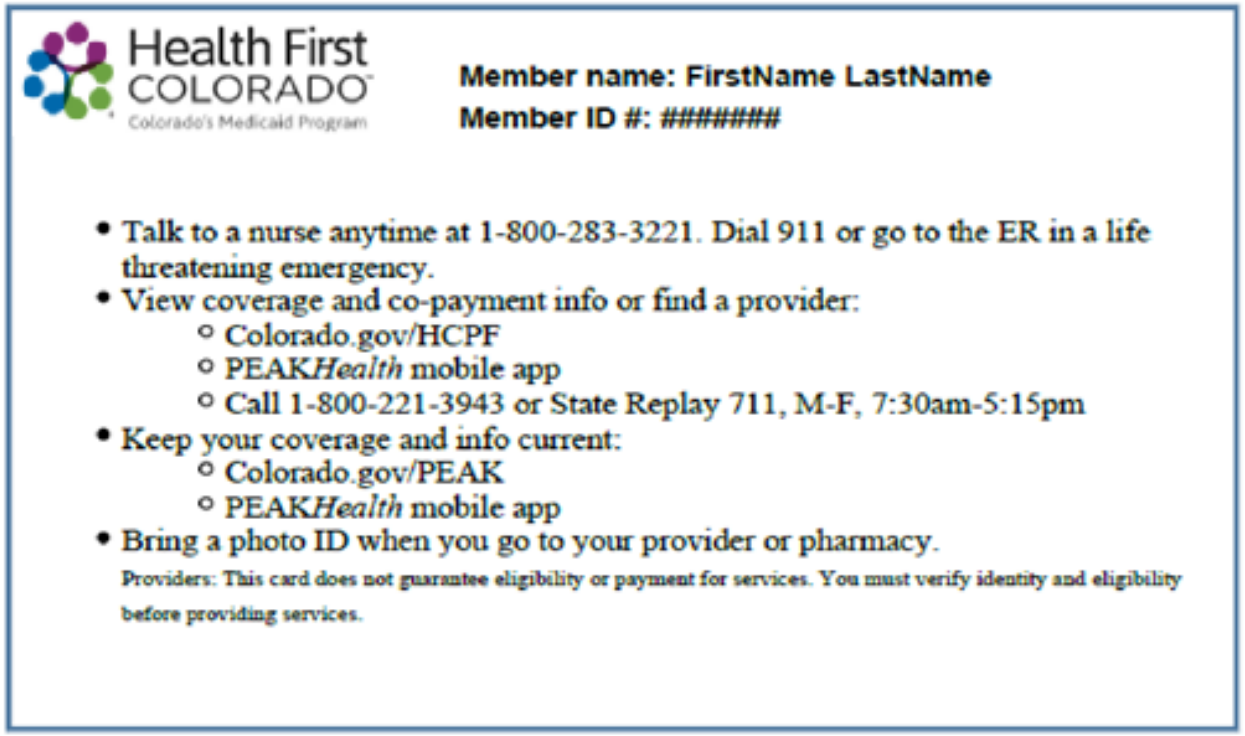
Total Records: 1

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

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

Health First Colorado Identification Cards

- This page depicts older branded cards. Older branded cards are 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 Spanish and English.
- Only the front is shown below.

Health First COLORADO
Colorado's Medicaid Program

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**

Health First COLORADO
Colorado's Medicaid Program

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
  - Presumptive Eligibility
  - Managed care
- Some members have additional benefits
  - Medicare
  - Third Party Insurance (Commercial Insurance)

Eligibility Types

Old Age Pension – 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.
- Maximum member co-pay for OAP-State is $300
- Does not cover:
  - Home Health
  - Home and Community Based Services (HCBS)
  - Inpatient, psychiatric or nursing facility services

Eligibility Types

Non-Citizens EMS or COVID-only EMS

- **Non-Citizen Emergency Medicaid Services**
  - Eligibility type only covers emergency services
  - Claim must indicate emergency
  - Emergency services must be certified in writing by provider and kept on file, but do not need to be submitted with the claim
- **COVID-only Emergency Medicaid Services (EMS)**
  - Eligibility type only covers COVID-19 testing

What Defines an "Emergency"?

- The provider determines whether or not the service is considered an emergency and marks the claim appropriately.
- Examples of an emergencies are:
  - Active labor and delivery
  - Sudden, urgent occurrences requiring immediate action
  - Acute symptoms of sufficient severity & severe pain in which the absence of medical attention might result in:
    - Serious impairment to bodily functions
    - Dysfunction of any bodily organ or part

Eligibility Types

Presumptive Eligibility

- Temporary coverage of Health First Colorado or Child Health Plans *Plus* (CHP+) services until eligibility is determined
- Health First Colorado Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers Durable Medical Equipment (DME) and other outpatient services
    - Covers labor and delivery, but does not cover any OTHER inpatient services
  - Children ages 18 and under
    - Covers all Health First Colorado covered services
- CHP+ Presumptive Eligibility
  - Covers all CHP+ covered services, except dental

Eligibility Types

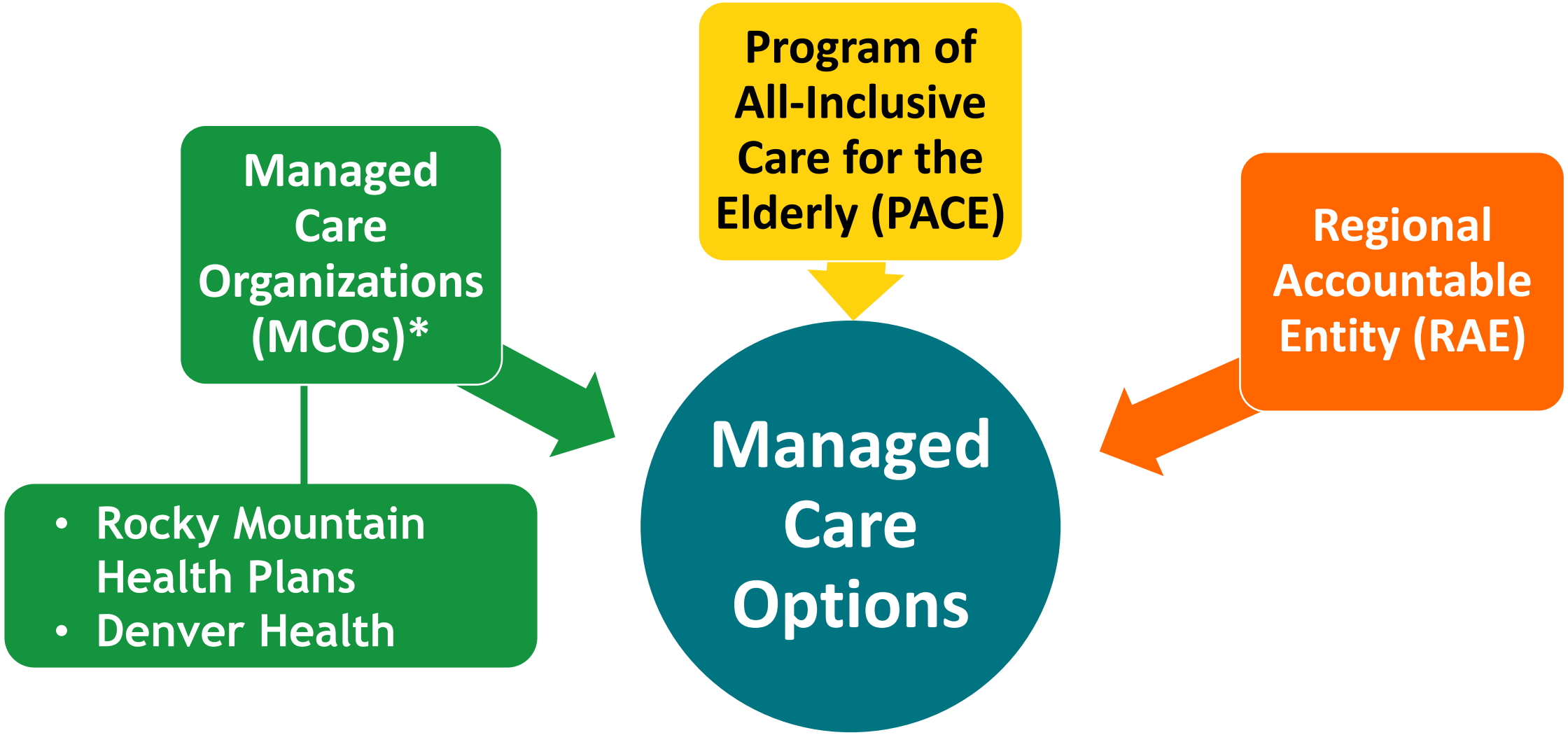
Presumptive Eligibility (cont.)

- Health First Colorado Presumptive Eligibility claims
  - ➢ Submit to the Fiscal Agent (Gainwell Technologies)

CHP+ Presumptive Eligibility and claims

  - ➢ Submit to Colorado Access or Denver Health

Managed Care



Managed Care

Managed Care Organization (MCO)

- Some services are not included in the managed care contract.
- Those fee-for-service claims can be billed directly to fiscal agent.

  - Example:
    - Denver Health does not pay for Hospice

Managed Care

Regional Accountable Entity

- Members are assigned to the Regional Accountable Entity (RAE) for their area
  - ➢ Contact the RAE in your area to enroll as a Behavioral Health Provider
- Regional Accountable Entities do not pay for pediatric behavioral therapy

Medicare

- Members may be eligible for both Medicare & Health First Colorado
- Health First Colorado is always payer of last resort
  - Bill Medicare first for Medicare-Health First Colorado members
- Retain proof of:
  - Submission to Medicare prior to Health First Colorado
  - Medicare denials(s) for six (6) years
  - Medicare EOB does not need to be attached to every 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

Medicare

Qualified Medicare Beneficiary (QMB)

- Covers 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.
- 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.
- Members are only responsible for Health First Colorado co-pay

Third Party Eligibility

- Health First Colorado is always 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
- Provider 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 (Colorado's Medicaid Program) pays the difference between Third Party Liability payment and Program Allowable

- Example:
  - Charge = $500
  - Program allowable = **$400**
  - TPL payment = **$300**
  - Program allowable – TPL payment = **Reimbursement**

	$400.00
-	$300.00
=	$100.00

Co-Pay

- **Auto-deducted during claims processing**
  - Do not deduct from charges billed on claim
- **A provider may not deny services to an individual 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)**
- **Children (Youth from birth to 18 years old) do not require a co-pay**
- **Services that do not require co-pay:**
  - Dental
  - Home Health
  - HCBS waiver services
  - Transportation
  - Emergency Services
  - Family Planning Services
  - Behavioral Health Services (mental health and substance use disorder)

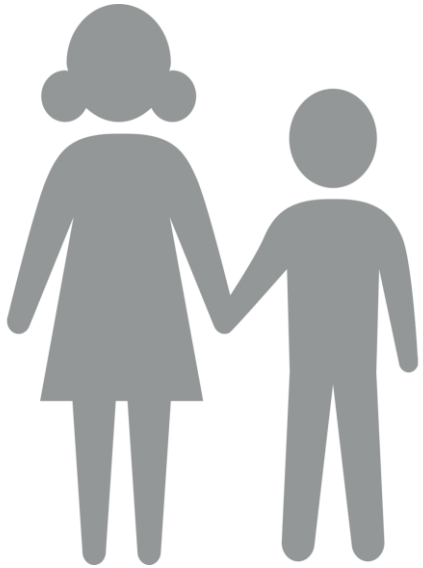
Co-Pay

- 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.
- Members who track their own co-pay amounts may claim they have reached their maximum for the month before the Provider Web Portal reflects this information. If Health First Colorado members state they have met their monthly co-pay maximum, but the Web Portal indicates they owe a co-pay amount at the time of their visit, it may be because the health care claims from other providers have not been submitted yet.
- Providers are encouraged to submit claims as soon as possible to ensure a co-pay does not need to be refunded to the member.

Co-Pay Exempt Members

Nursing Facility Residents

Pregnant Women



Children and Former Foster Care Eligible*

*former foster care eligible still has a pharmacy co-pay

From the Noun Project:
"Nursing-Home" by Iconathon
"Children" by OCHA Visual Information Unit
"Maternity-Cycle" by HCPF

Specialty Co-Pay

Practitioner, Optometrist, Speech Therapy, RHC / FQHC	$2.00
DME / Supply	$1.00 per date of service
Outpatient	$4.00
Inpatient	$10.00 per covered day or 50% of average allowable daily rate - whichever is less
State Plan Psych Services	.50 per unit of service, 1 unit = 15 minutes

Prior Authorization Requests (PAR)

- The ColoradoPAR Program reviews prior authorization requests (PARs) for the following services or supplies:
  - Diagnostic imaging
  - Durable medical equipment
  - Inpatient admissions
  - Medical services (including transplant, back and bariatric surgery)
  - Physical, occupational, and speech therapy
  - Pediatric behavioral therapy
  - Pediatric long-term home health
  - Pediatric Personal Care
- Adult long-term home health PARs are not submitted to eQHealth, but to the case management agency

Prior Authorization Requests (PAR)

- ColoradoPAR does not process prior authorization requests (PARs) for dental, transportation, pharmacy, or behavioral health services covered by the Regional Accountable Entities.
- All PARs for members age 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.
- Prior Authorizations and PAR revisions processed by the ColoradoPAR Program must be submitted via eQSuite®.
- The ColoradoPAR Program will process PARs submitted by paper only if provider fills out the eQSuite® Exception Request Form.

Website:

https://www.colorado.gov/hcpf/par

Phone:

Phone: 1.888.801.9355

FAX: 1.866.940.4288

Prior Authorization Requests (PAR)

- Final prior authorization request (PAR) determination letters
  - Mailed to members
  - Posted to Department's prior authorization vendor's web portal
  - Letter inquiries should be directed to ColoradoPAR
- Providers can review PARs via the utilization management portal

Prior Authorization Requests (PAR)

Home & Community Based Services (HCBS) Waiver

- Contact the community center board (CCB) or single entry point (SEP) case manager to obtain the member's service plan and prior authorization information before delivering services on behalf of the member.

Billing and Payment

Record Retention

Payment Processing and Remittance

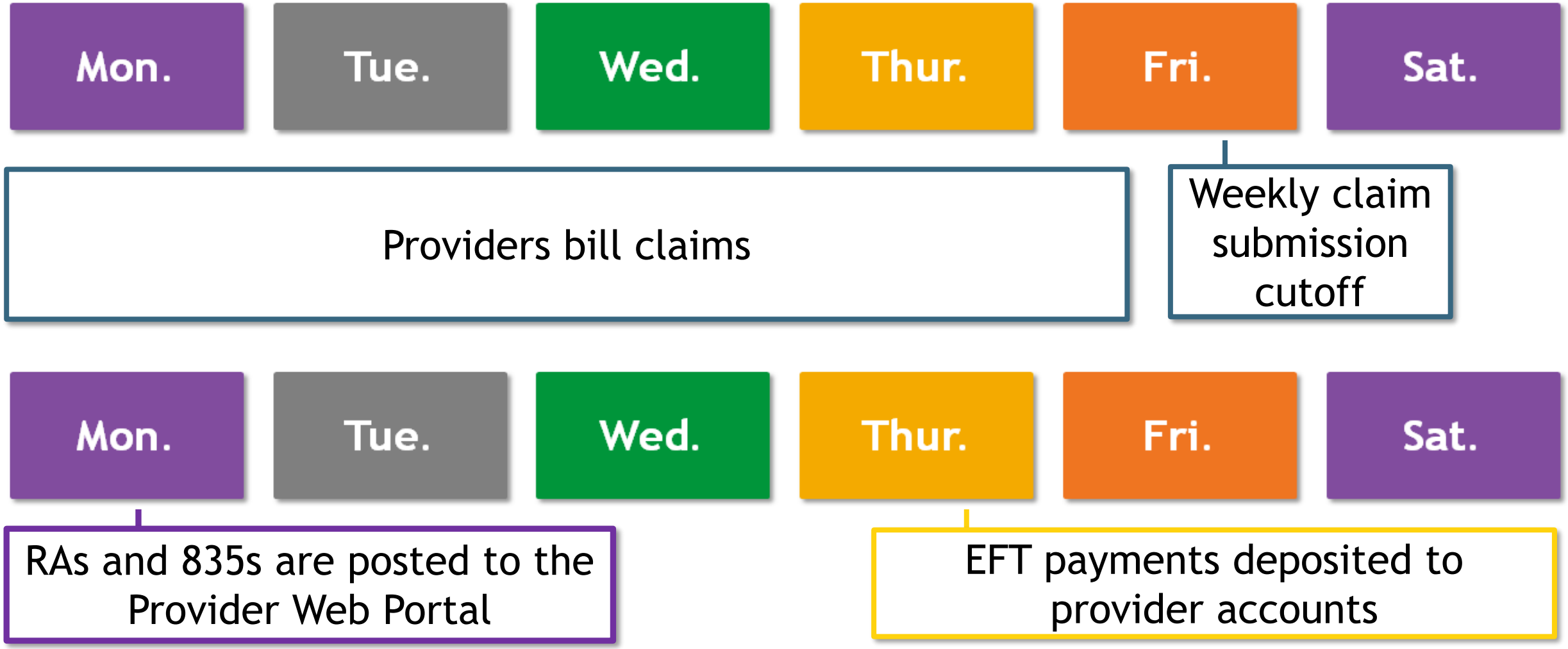
Timely Filing

Extensions for Timely Filing

Record Retention

- Providers must:
  - Maintain records for at least seven (7) years
    - Longer if required by specific contract between provider & Health First Colorado
  - Furnish information upon request about payments claimed for Health First Colorado services
- Medical records must:
  - Substantiate submitted claim information
  - Be signed & dated by person ordering & providing the service
    - Electronic record keeping is also allowed and encouraged

Payment Processing Schedule



Retrieving 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 – Pulling Remittance Advice (RA)
- Provider Web Portal Quick Guide – Linking the TPID and Pulling an 835

Timely Filing

- 365 days from Date of Service
  - Determined by date of receipt
  - Certified mail is not proof of timely filing
  - Prior authorization requests are not proof of timely filing
  - Contacting the fiscal agent or waiting for fiscal agent response to a verbal inquiry is not proof of timely filing

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

Timely Filing

Type of Service	Timely Filing Calculation
Nursing Facility; Home Health, Inpatient, Outpatient; all services filed on the UB-04	From the “through” date of service
Dental; EPSDT; Supply; Pharmacy; All services filed on the CMS 1500	From the date of each service (line item)
Home & Community Based Services	From the “through” date of service
Obstetrical services professional fees Global procedure codes: The service date must be the delivery date.	From the delivery date
Equipment rental - The service date must be the last day of the rental period	From the date of service

Timely Filing Extensions

Rebilled Claims

Providers always have the initial timely filing period of 365 days from the date of service to submit claims.

Providers have an additional 60 days from the date of the last remittance advice or returned paper claim to resubmit, if the initial 365-day period has expired. If the date of service is still within 365 days, providers do not need to refile every 60 days.

- Use last Internal Control Number (ICN). Do not attach copy of remittance advice with claim.

Keep supporting documentation.

Timely Filing Extensions

Primary Payers

- **Commercial Insurance/Third Party Liability (TPL)**
  - Claim can not be paid if over 365 days from date of service per federal statute
    - Per state and federal regulation (42 C.F.R. § 447.45(d), 10 CCR 2505-10 8.043.01 and .02A), all claims which include commercial insurance (third-party liability) information that are received more than 365 days from the date of service must be denied. The provider is responsible for pursuing available third-party resources in a timely manner.
- **Member who are enrolled with both Medicare and Health First Colorado**
  - Additional 120 days from Medicare explanation of benefit date

Timely Filing Extensions

Delayed Notification/Backdated Eligibility

Delayed Notification

- Providers are responsible for determining eligibility within 365 days, even if the member does not notify them of Health First Colorado eligibility. No further extensions are given for delayed notification of eligibility.

Load Letters

- 60 days from load letter
  - Used when county backdates eligibility farther than 365 days
- Bill electronically
  - Submit with copy of load letter via the Provider Web Portal

Timely Filing Extensions

Provider Enrollment

Providers have 365 days from enrollment approval to file a claim.

Providers do not need to submit claims while waiting for enrollment to be approved.

Claim Submission

- Claim Submission Methods
- CMS 1500 Paper Claim Form and Claim Number
- Paper Claim Examples
- Common Denial Reasons
- Claim Status
- Claim Adjustments, Voids and Refunds

Claim Submission Methods

Methods to submit:

- Electronically through Gainwell Technologies' Web Portal (free of charge)
  - Interactive, one claim at a time
- Electronically using Batch Vendor or Clearinghouse or software
  - Submitters must test batch transactions before approval to submit.
- Paper only when:
  - Pre-approved (consistently submits less than five (5) per month). Form must be mailed to the fiscal agent 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

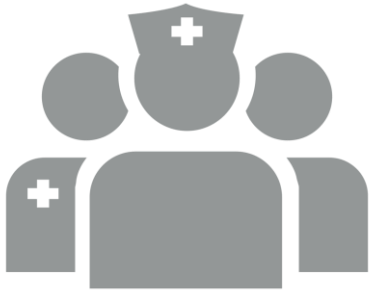
Automatic Medicare Crossover Process:

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

Claim Submission Information

Rendering Provider (Individual Within a Group)

Individual that provides services to a Health First Colorado member



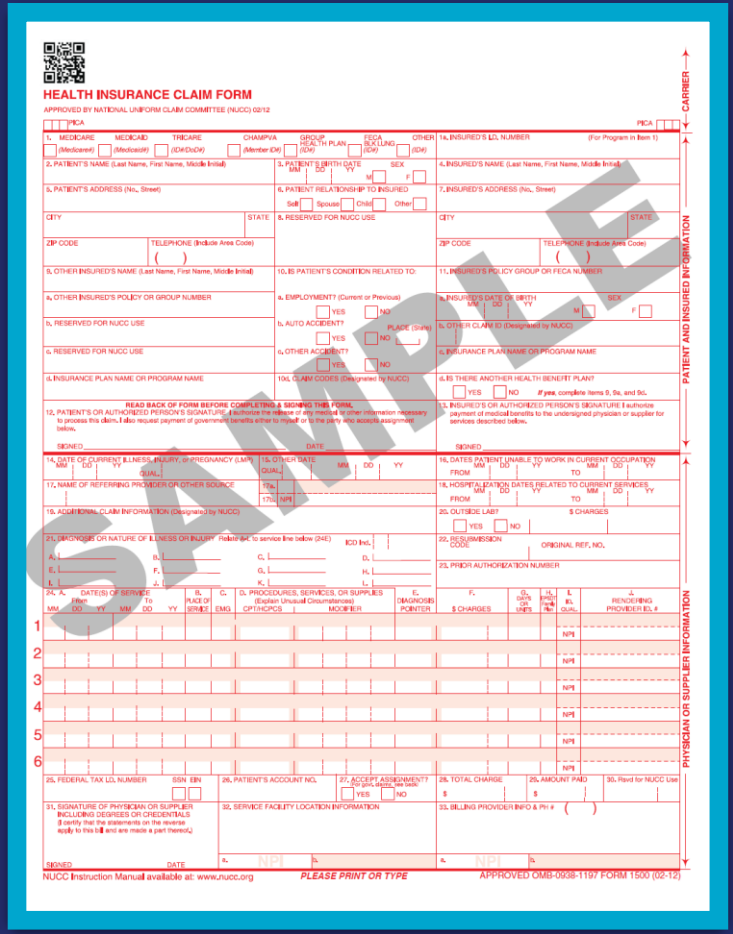
Billing Provider

Entity being reimbursed for service

CMS 1500

Where can a Colorado Medical Assistance provider get the CMS 1500?

Information available on https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.html

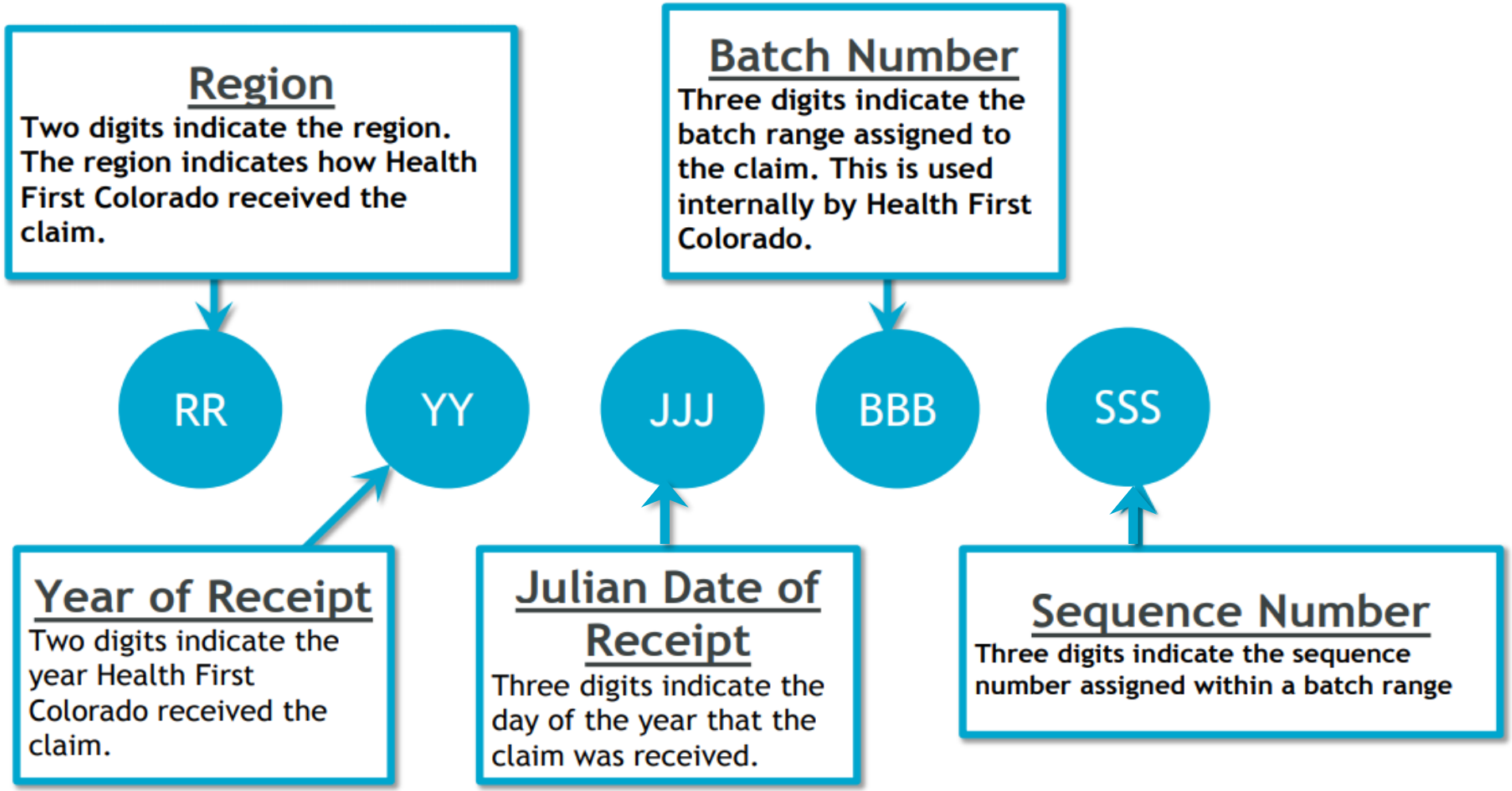

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SAMPLE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Internal Control Number (ICN)



Paper Claim - Example 1

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID [X] (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program In Item 1): Y123456

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John

3. PATIENT'S BIRTH DATE MM 04 DD 21 YY 1950 SEX M [X] F

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

5. PATIENT'S ADDRESS (No., Street): 555 Dandelion View

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: CO

8. RESERVED FOR NUCC USE

CITY

ZIP CODE: 11111 TELEPHONE (Include Area Code): (123) 222-3333

ZIP CODE TELEPHONE ( )

Field 11, 11a, 4 - **Conditional.** Complete if the member is covered by a **Medicare** health insurance policy.

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

a. OTHER INSURED'S POLICY OR GROUP NUMBER

Field 11d, 6, 9, 9a, 9d - **Conditional.** Complete if the member is covered by a **Third party liability/Commercial** insurance policy.

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) YES [X] NO

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

c. OTHER ACCIDENT? YES [X] NO

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release 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.

SIGNED SIGNATURE ON FILE DATE 061518

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

CARRIER

PATIENT AND INSURED INFOR

Paper Claim - Example 2

HEAD BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release 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.
SIGNED SIGNATURE ON FILE DATE 061518

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the un services described below.
SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Ima Doctor
17a.
17b. NPI 8888888888

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L
A. M50 222 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	06 15 18	06 15 18	22		00670	AA	A	2860 00	106	N	NPI	9999999999
2												
3												
4												

25. FEDERAL TAX I.D. NUMBER 954849652 SSN EIN [X]

26. PATIENT'S ACCOUNT NO. 4548941561

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE $ 2860 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. 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 092218

32. SERVICE FACILITY LOCATION INFORMATION
ABC Hospital
2222 Colorado Avenue
Anytown CO 11111-6666
a. 4444444444 b.

33. BILLING PROVIDER INFO & PH # (800) 866 6666
ABC Partners
P.O Box 44444
Anycity CO 88888-4444
a. 5555555555 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Field 18 - **Conditional.** Complete for services provided in an inpatient hospital setting in two digit format.

Field 20 - **Conditional.** Complete if all laboratory work was referred to and performed by an outside laboratory.

Field 22 - **Conditional.** 7-Replacement of prior claim. 8-Void/Cancel of prior claim. List ICN that needs to be voided/ adjusted in "Original Ref No." box.

Field 24C - **Conditional**. This field is used to indicate the service rendered is for a life threatening condition or one that requires immediate medical intervention. "Y" for YES.

Field 24E - **Required.** The "Diagnosis Pointer" refers to the line number from field 21 that relates to the reason the service(s) was performed. At least one diagnosis code reference letter must be entered.

Field 24J - Required. CMS-1500 providers must have a **billing** provider ID along with a **rendering** provider ID. An NPI must be used unless the provider is atypical. Atypical - providers that do not provide health care. I.e., taxi services, home modification, etc.

Field 31 - **Required.** A holographic/ rubber signature stamp may be used. An authorized agent or representative may sign the claim for the enrolled provider. May not be typed.

Field 32 - **Conditional.** Complete for services provided in a hospital or nursing facility.
Field 33 - **Required.** Enter the information of the individual or organization that will receive payment for the billed service.

Fields 26 - **Optional.** This number identifies the member or claim in the provider's billing system.

Field 29 - **Conditional.** Complete if **Medicare** or **Third party liability/ Commercial insurance** made payment.

Common Denial Reasons

Timely Filing	Claim was submitted more than 365 days without a reference to a previous Internal Control Number (ICN).
Duplicate Claim	A subsequent claim was submitted after a claim for the same service has 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 authorization on file for services that are being submitted. 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

Denied

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

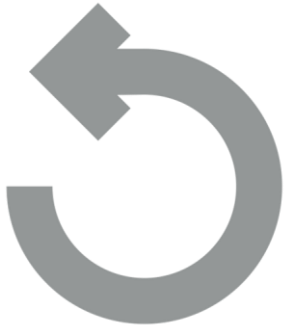
Paid

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

Claim Status – Common Terms

Adjustment

Correcting paid claims that are still within timely filing



Rebill

Re-bill previously denied claim

Suspend

Claim must be manually reviewed before adjudication

Void

Cancelling a paid claim

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 when

- Claim was denied
- Claim is suspended

Claim - Voids and Refunds

Web Portal or Batch

- Preferred method
- Easier to submit & track

Paper

- Use adjustment indicator on third digit of type of bill to indicate void.
- Refund check is not needed. Recoupment will show on the remittance advice.

Claim - Adjustment Methods

Web Portal or Batch

- Preferred method
- Easier to submit & track

Paper

- Use adjustment indicator on third digit of type of bill to indicate adjustment

Quick Guides

- Copy, Adjust or Void a Claim
- Pulling Remittance Advice (RA)
- Reading Remittance Advice Dated 1/9/2019 or Later
- Submitting a Professional Claim

- All Quick Guides can be found on the Department's Quick Guides web page.

Contact Info

Provider Services Call Center
1-844-235-2387

Download the Call Center Queue Guide

7 a.m. - 5 p.m. MT Monday - Friday

Thank you!