

Claims

A Quick Guide on the Importance and Process of Handling Claims and Encounter Submissions



Claims — Benefits of Using Electronic Claims and Payment Options

- Electronic claim submission has been proven to significantly reduce costs. Claims are processed faster, so payments arrive faster.
- Electronic funds transfer (EFT) or Virtual Credit Card (VCC):
 - ✓ Cash flow advantages knowing payments will be made automatically on specific dates.
 - ✓ Eliminates lost, stolen, or delayed checks sent in the mail.
 - ✓ Decreases administrative costs and increases convenience with no trips to the bank to make deposits during office hours.
 - ✓ EFT allows you to keep your preferred banking partner.
 - ✓ Safe and secure.
 - ✓ Reduces paper.
 - ✓ It's FREE.

Claims — How to Sign Up for Free Electronic Claim Processing



AmeriHealth Caritas VIP Care partners with Change Healthcare to provide free electronic claims submission.

- Claims can be submitted electronically through Change Healthcare, or another clearinghouse.
- Contact your Practice Management System Vendor or EDI clearinghouse to inform them that you wish to initiate electronic claim submissions to AmeriHealth Caritas VIP Care.
- Providers are not required to enroll with Change Healthcare to submit electronic claims if they are already using another EDI vendor to submit claims electronically.
- Change Healthcare's toll-free number is 1-877-363-3666.
- AmeriHealth Caritas VIP Care payer ID is **77062**.

Claims — Direct Entry Claims Submissions

Providers can submit claims directly to Change Healthcare through WebConnect. This service provides two methods for submitting claims:

- Key them in manually or import batches of claims.
- There is no cost to manually key claims in using WebConnect, but claims must be entered one at a time.
- For practices with high claim volume, batches of claims may be imported via WebConnect, but there is a one-time setup fee of \$300 for this service.
- Providers should call 1-877-667-1512 and follow the appropriate prompts, or go to [Change Healthcare ConnectCenter](#) to enroll for direct submission. Change Healthcare will also provide information on their various electronic solutions, the requirements for connectivity, and setup instructions.
- Providers may also access WebConnect from our website or NaviNet.

Electronic Payment Options

Change Healthcare is partnering with ECHO Health Inc. (ECHO Health), a leading innovator in electronic payment solutions, to offer more electronic payment options to our health care providers. You can select the payment method that best suits your accounts receivable workflow:

- **Virtual Credit Card (VCC)** - ECHO Health offers virtual credit cards as an optional payment method. Virtual credit cards are randomly generated, temporary credit card numbers that are either faxed or mailed to providers for claims reimbursement. VCC payments have a number of advantages for providers:
 - ✓ You do not have to enroll or fill out multiple forms in order to receive VCC.
 - ✓ We will never request personal information, such as practice bank account information.
 - ✓ You can access your payment the day you receive the VCC.
 - ✓ Your office will receive either faxed or mailed VCC payments, each containing a VCC with a number unique to that payment transaction, an instruction page for processing, and a detailed Explanation of Payment /Remittance Advice (EOP/RA).

Normal transaction fees apply based on your merchant acquirer relationship. If you do not wish to receive your claim payments through VCC, you can opt out by contacting ECHO Health at 1-888-492-5579.

Electronic Payment Options - Continued

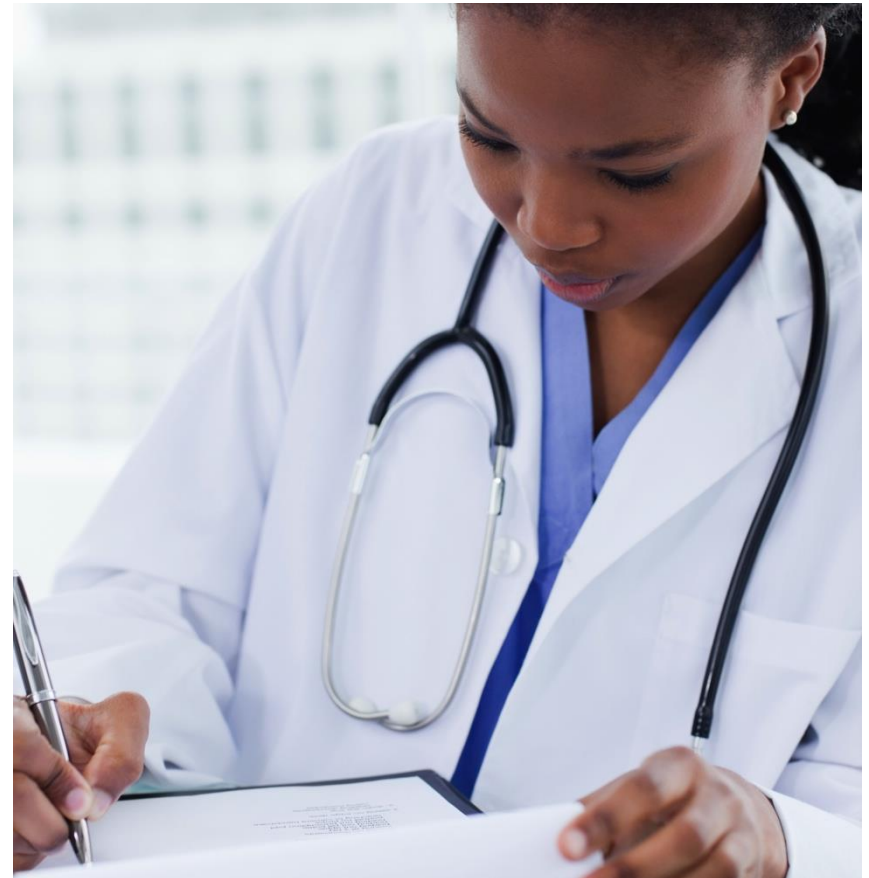
- **Electronic funds transfers (EFT)** allow you to receive your payments directly in the bank account you designate rather than receiving them by VCC or paper check. When you enroll in EFT, you will automatically receive electronic remittance advices (ERAs) for those payments. All generated ERAs and a detailed explanation of payment for each transaction will also be available on the ECHO provider portal (<http://www.providerpayments.com>). If you are new to EFT, you will need to enroll with ECHO Health for EFT from AmeriHealth Caritas VIP Care.
 - ✓ To sign up to receive EFT from AmeriHealth Caritas VIP Care, visit: <https://enrollments.ECHOhealthinc.com/afteradirect/enroll>. **There is no fee for this service.**
 - ✓ To sign up to receive EFT from all of your payers that process payments on the Settlement Advocate platform, visit <https://enrollments.ECHOhealthinc.com>. **A fee for this service may be required.**
 - ✓ Please note: Payment will appear on your bank statement from PNC Bank and ECHO as “PNC — ECHO.”

Claims — How to Submit Paper Claims

Provider may submit new and corrected paper claims to:

AmeriHealth Caritas VIP Care
Claims Processing Department
P.O. Box 7143
London, KY 40742-7143

Medicaid-only services and appropriate secondary payments (such as part A deductible and coinsurance) should be sent to Pennsylvania Medicaid or appropriate Community Health Choices plan.



Claims — Claims Processing Time Frames



- AmeriHealth Caritas VIP Care processes electronic claims in fourteen (14) calendar days and paper claims in thirty (30) calendar days.
- Providers have 365 days from the date of service to submit claims.
- Real-time claim status is available via NaviNet or by calling Provider Services at 1-800-521-6007.

Claims — Provider Claim Inquiry/Dispute

If a AmeriHealth Caritas VIP Care provider has an inquiry, such as claim status, or a dispute regarding the way a claim was processed or adjudicated, the provider should do the following:

- Inquires and disputes may be made by calling Provider Services.
- Disputes can also be submitted by completing a provider dispute form, which is located on the AmeriHealth Caritas VIP Care Plan website under the Provider Resources tab.
- If the form is not used, you must include the following:
 1. Submitter contact information (name, phone number)
 2. Provider information (name, phone number, NPI number, Tax ID number)
 3. Member information (name, DOB, member ID number)
 4. Claim information (claim number, DOS, billed amount)
 5. Reason for dispute
 6. Any documentation which supports your position that the plan's reimbursement is not correct
- Disputes should be submitted within 180 days of the initial remittance advice to:

AmeriHealth Caritas VIP Care
Claims Processing Department
P.O. Box 7143
London, KY 40742-7143

Claims — Provider Claim Inquiry/Disputes Form



Provider Claim Dispute Form

A dispute is a request from a health care provider to change a decision made by AmeriHealth Caritas VIP Care related to claim payment or denial for services already provided. A provider dispute is not a pre-service appeal of a denied or reduced authorization for services or an administrative complaint.

A provider may dispute the claim within **180 days** from the date of the denial or payment.

Submitter contact information	
Name (last, first): _____	Phone number: _____

Provider information	
Name (last, first): _____	Phone number: _____
NPI number: _____	Tax ID: _____
<input type="checkbox"/> I am an in-network provider	<input type="checkbox"/> I am an out-of-network provider

Member information	
Name (last, first): _____	Member date of birth: _____
Member ID: _____	

Claim information	
Claim number: _____	Billed amount: \$ _____
Dates of services: _____	

Payment — Balance Billing Requirements

- Per Section 1902(n)(3)(B) of the Social Security Act, as modified by 4714 of the Balanced Budget Act of 1997, Medicare providers cannot collect Medicare Parts A and B deductibles, coinsurance, or copays from members enrolled as a Qualified Medicare Beneficiary (QMB).
 - AmeriHealth Caritas VIP Care **members** will have no out-of-pocket responsibility for all Medicare services. Some traditional Medicaid services may require copayments, as determined by the State. Providers must accept payment for these services as payment in full and **may not balance-bill** the AmeriHealth Caritas VIP Care member.
 - AmeriHealth Caritas VIP Care **providers** will have deductibles and coinsurance applied to payments.
 - In the event of a balance from deductible or coinsurance, providers should submit appropriate claims to **Pennsylvania Medical Assistance**.
 - Providers may also not bill for contractual disallowances and non-covered services (unless a prior written agreement was signed by the member and provider).
 - All providers are encouraged to use the claims inquiry/disputes process to resolve any outstanding claims payment issues.
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More than
30 YEARS
of making
care the heart
of our **work.**

