



## Electronic Filing with Office Ally & ActivHealthCare



08/2018

# EDI Claims

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Electronic Data Interchange (EDI) is a transfer of data between two companies using the Internet.

AHC offers this service for electronic claims processing to you, FREE, through a partnership with Office Ally (OA).

**\*ActivHealthCare only accepts EDI claims through Office Ally!**



# EDI Claims - Benefits

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## Why consider Office Ally?

- \*No monthly fees
- Faster Payments
- Quick and easy
- Online access to claim status, history and summary reports
- Online claims correction capability
- Reduced costs for postage, printer cartridges and claim forms
- Improved accuracy in claims processing
- **Only acceptable proof for timely filing**

\*If 50% of your monthly electronic submittals are Medicare or Non-Par, Office Ally will charge \$19.95 for that month.

# EDI Enrollment

## Enrollment is easy!

- Download and complete the enrollment forms from [www.ActivHealthCare.com](http://www.ActivHealthCare.com):



- Mail the original and signed enrollment forms to **ActivHealthCare**:

ActivHealthCare  
Attn: EDI  
1926 Northlake Pkwy, suite 100  
Tucker, GA 30084

*Do not send forms  
to Office Ally!*

# EDI Enrollment (continued)

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Allow up to 30 days for enrollment. Office Ally will contact your office for training, uploading and with your username and password.

- OA will provide technical support in addition to training on how to upload claims
- AHC will work with OA and your office during the start-up phase

# Office Ally Online Tools

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- Patient Look-Up
- View Claim History
- Inventory Reporting
- Code Search
- Claim Fix
- Eligibility Request

# Claims Follow-Up

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## ***Critical Step – Checking Your Claim's Status!***

Within 24 hours of upload, your file summary is ready. This report lists the status of all claims received by OA. This acts as your receipt that your claims have been entered into the OA system.

- Log into [www.officeally.com](http://www.officeally.com) and click **DOWNLOAD FILE SUMMARY**
- Click the appropriate day on the calendar
- Below the calendar, click **VIEW** and then click **OPEN**

*Please note: ANSI 837 users may receive an ERR Report in place of their file summary. You should contact OA if you receive this report.*

# ID Card Example – MHP

**CORESOURCE**  
A Trademark Company

Questions?  
855.402.8831  
www.mycourcesource.com

<b>Employee</b> <b>Employer:</b> Gulfstream Aerospace Corp. <b>Group #:</b> GA0000 CS Savannah PPO <b>Employee:</b> <b>Employee ID:</b> E12345678	<b>Medical Plan</b> Dependent Coverage: Yes <b>Memorial</b> Aetna Signature Administrators' PPO By <b>aetna</b> www.memorialhealth.com www.aetna.com/acc 877.342.0280 855.402.8831  If you live in, or receive services in Bryan, Chatham, Effingham or Liberty counties you must utilize the MHP Network to receive in-network benefits. If you live outside of these four counties, and services are provided outside of these four counties, you will have access to the MHP and Aetna Signature Administrators Networks.
<b>Medical Claims Submission</b> EDI: Payer ID CB624 Mail: CoreSource, Inc. P.O. Box 105 Arnold, MD 21012  Aetna participating doctors and hospitals are independent providers and are neither agents nor employees of Aetna.	<b>Eligibility</b> To confirm eligibility, verify benefits or check the status of a claim, call CoreSource at 855.402.8831 or visit our website at www.mycourcesource.com.  This card does not guarantee eligibility or payment. <b>Care Management</b> Precertification is required for all hospital admissions and specified outpatient procedures. In an emergency, call within 48 hours or the next business day. For precertification, please call ActiveHealth at 855.698.3504.  Failure to precertify will result in a reduction in benefits.  MultiPlan Out of Network Only

Primary Network

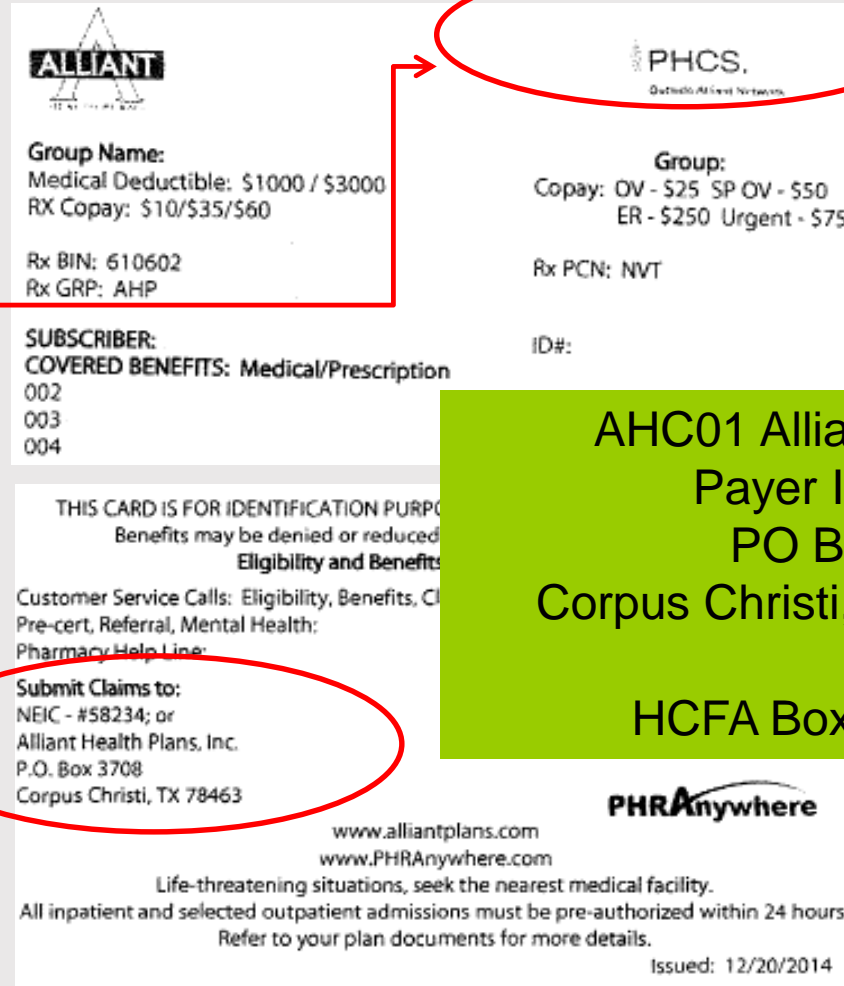
AHC01 CoreSource  
Payer ID# CB624  
PO Box 105  
Arnold, MD 21012

HCFA Box 11c: MHP

Payor or "Mail To" address



# ID Card Example – Alliant Health Plan/PHCS



Network name?

Payor?

Send claim through?

ActivHealthCare

AHC01 Alliant Health Plan  
Payer ID# 58234  
PO Box 3708  
Corpus Christi, TX 78463-3708  
HCFA Box 11c: PHCS

# NPI Numbers - required

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NPI numbers are not an option, they are required.

**NPI numbers must be placed** in the following locations of the CMS1500 form:

- Box 24.j (treating provider's NPI required)
- Box 32.a
- Box 33.a

Failure to properly place NPI numbers on claims may result on a denial, delay or return of the claim.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE (Medicare #) <input type="checkbox"/>		MEDICAID (Medicaid #) <input type="checkbox"/>		TRICARE (Sponsor's SSN) <input type="checkbox"/>		CHAMPVA (Member ID#) <input type="checkbox"/>		GROUP HEALTH PLAN (Sponsor ID) <input type="checkbox"/>		FECA BLK LUNG (SSN) <input type="checkbox"/>		OTHER (ID) <input type="checkbox"/>		12. INSURED'S PLAN NUMBER					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE (MM DD YY)				SEX (M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street, City, STATE, ZIP CODE)				6. PATIENT RELATIONSHIP TO INSURED (Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street, City, STATE, ZIP CODE)				TELEPHONE (Include Area Code)							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.							
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>				a. INSURED'S DATE OF BIRTH (MM DD YY)				SEX (M <input type="checkbox"/> F <input type="checkbox"/>							
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY)				b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)				b. EMPLOYER'S NAME OR SCHOOL NAME				c. INSURANCE PLAN NAME OR PROGRAM NAME							
c. EMPLOYER'S NAME OR SCHOOL NAME				c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.							
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.							
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		DATE		SIGNED		DATE	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES				20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES							
19. RESERVED FOR LOCAL USE				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				23. PRIOR AUTHORIZATION NUMBER							
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. PLACE OF SERVICE		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. ICD-9-CM		I. RENDERING PROVIDER ID#			
1																14322895876			
2																NPI			
3																NPI			
4																NPI			
5																NPI			
6																NPI			
25. FEDERAL TAX I.D. NUMBER TIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$			
31. SIGNATURE OF PROVIDER OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and receipt.)				32. SERVICE FACILITY INFORMATION				33. BILLING FACILITY INFORMATION				34. BILLING FACILITY INFORMATION		35. BILLING FACILITY INFORMATION		36. BILLING FACILITY INFORMATION			
SIGNED				John Chiropractic Center 4455 Highway 84 Tucker, GA 30084-7069 1932992610				John Chiropractic Center 4455 Highway 84 Tucker, GA 30084-7069 14322895876											

AHC01 Payor Name from ID Card  
Payor Address from ID Card  
Payor City, State, Zip

Patient's Information

Insured's Information

Network Name

Doctor's NPI Number

Service Address & NPI #

Service Provider

Address/NPI number for who checks are payable to

# If Mailing Paper Claims, Send Claims To:

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Coventry Health  
Care of GA Claims



ActivHealthCare  
1926 Northlake Pkwy,  
Suite 100  
Tucker, GA 30084

All Claims for  
Networks

(Alliant, Beech Street, First  
Health, etc)



ActivHealthCare  
1926 Northlake Pkwy,  
Suite 100  
Tucker, GA 30084

**Note: See Network Affiliate sheet. This applies to the networks that are to be submitted through Activ.**

## If Filing EDI through Office Ally, Address Claims using this format:

Coventry Health  
Care of GA Claims



AHCØ1 Coventry  
25133  
P.O. Box 7711  
London, KY 40742-7711

All Claims for  
Networks

(Alliant, MHP, First Health, etc)



AHCØ1 *"Name of Payor"*  
*"Insurance co. payer ID"*  
*Address*  
*City, State, Zip*

# Setting Up Payors

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Some payors may necessitate that you set up the payor *twice* in your management software. For example, Aetna will pay claims for AHC and non-AHC employer groups.

1 AHCØ1 Payor Name

2 (no prefix) Payor Name

Pay close attention to the network and payor information. Failure to properly identify the payor information at the top of the CMS-1500 will most likely result in your claim being processed out-of-network, creating additional work for your office staff and patients.

# Contact Information

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ActivHealthCare  
1926 Northlake Pkwy, suite 100  
Tucker, GA 30084  
Phone: 770-455-0040  
General Fax: 770-455-6188



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*We are here to help you and your doctors with any questions or problems.*

# Questions

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