



## Electronic Claims Submission (EDI) – Training

Part 1 – How to completed CMS1500 form

Contact Information  
[EDI@ActivHealthCare.com](mailto:EDI@ActivHealthCare.com)

866-374-9558

770-455-0040

# Two parts of Training

Part 1: How to complete CMS1500 form for Integrated-ActivHealthCare.

- » Understanding Network verses Payor
- » Understanding Network Affiliates
- » Preparing your office software & Completing the CMS-1500 Form
- » ID card Examples

Part 2: How to use Office Ally (done by Office Ally conference call).

# How to Enroll

## To Enroll:

1. Print enrollment forms from our website, [activhealthcare.com](http://activhealthcare.com).
2. Complete forms carefully and completely.
3. Return completed forms to:

Integrated-ActivHealthCare

P.O. Box 969

Lilburn, GA 30048

# IMPORTANT!!!

You **MUST** clearly understand the difference between the following two terms:

**Network** - the group of providers — First Health, Coventry National Network, Beech Street, etc...

**Payor** – the company listed on the insurance card to which claims are to be sent.

This is fundamental to EDI processing with AHC.

# Understanding Network Affiliates

To process EDI and I-AHC network claims, you need to understand how to determine if a claim should be filed as in-network.

The next slide will give you a list of your network affiliates which will require our Office Ally payor prefix AHCØ2.

# Network Affiliates



Alliant Health Plans



Galaxy Health Network



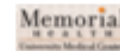
American PPO



Health One Alliance



Atlantic Integrated Health, Inc.



Memorial Health Partners



Beech Street Corp.  
(Owned by MultiPlan)



MultiPlan



Companion Workplace Health



NovaNet



CorVel Corporation



PHCS



Coventry Health Care of the Carolinas, Inc. (fka WellPath)  
(SC only)



Prime Health Services



Coventry National Network  
(South Carolina only)



Procura Management



Employers Choice Network



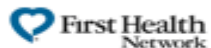
The Covenant Companies



Evolutions Healthcare Systems, Inc.



The Initial Group



First Health Network (SC only)



Fortified Provider Networks



TLC Advantage



Preparing your office  
software and completing  
the CMS-1500 form

# Office Software

It is not essential to have office billing software for our EDI. You can use the OA online tools.

However, it is necessary to fully understand the following slides whether you are uploading from your office software or using the OA online tools.

The OA training will explain the online tools and how to upload a file.



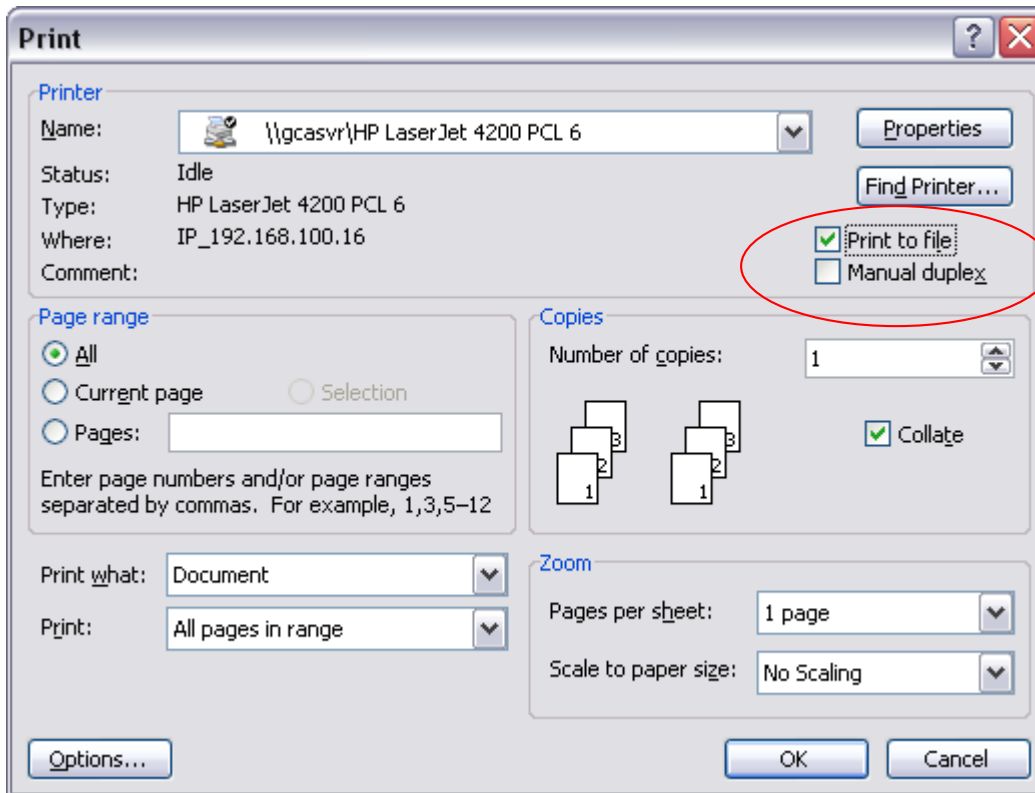
# Office Software (continued)

There are certain functions you need to be able to perform, such as:

- Printing to file
- Changing/adding carriers/payors
- Changing/adding plan names
- Having Internet access

If you have problems with your office software, you will need to contact your software vendor.

# Print to file function



Instead of printing paper CMS1500 forms, use the [Print to File Function](#) to create a file to upload to Office Ally

You will need to name the file as you create it. We suggest using a naming system to allow easy file recognition and sorting, i.e. 20090324 (yyyymmdd).

# Things You Must Communicate

1. Payor prefix, if applicable, at the top of the CMS-1500 form
2. Payor name and address at the top of the CMS-1500 form
3. Insurance plan name or program name, i.e. network affiliate in box 11c of the CMS-1500 form
4. All other pertinent insurance claim form information must be completed correctly

# Two Very Important Points

**Payor prefix** – The I-AHC payor prefix is **AHCØ2**. The payor prefix is used to identify claims that OA should send to I-AHC. This prefix (**AHCØ2**) must be used when the network logo shown on the patient's insurance ID card is on the AHC network affiliate list and the Term summary sheet instructs you to file the claim with i-AHC. The payor prefix, payor name and payor address will be placed at the top of the CMS-1500 form.

**Insurance plan name or program name** – for EDI and I-AHC purposes, you will need to use box 11c of the CMS-1500 form to identify the network, i.e. First Health, Beechstreet, etc... that applies to the patient. If not, the claim may be delayed or paid incorrectly. The network will be on the insurance card.

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

AHC02 prefix, then name and address from insurance id card.

**HEALTH INSURANCE CLAIM FORM**

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (PICA) (PICA)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM DD YY SEX M F 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other 7. INSURED'S ADDRESS (No., Street)

CITY STATE 8. PATIENT STATUS Single Married Other 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO b. AUTO ACCIDENT? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO 11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M F b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F b. EMPLOYER'S NAME OR SCHOOL NAME c. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO // yes, return to and complete item 9 a-d.

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 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

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? \$ CHARGES YES NO

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

1	A		B	C	D		E	F	G	H	I	J	K
	DATE(S) OF SERVICE From MM DD YY To MM DD YY	Place of Service			Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER							
1													
2													
3													
4													
5													
6													

24. FEDERAL TAX I.D. NUMBER SSN EIN 25. PATIENT'S ACCOUNT NO. 26. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO 27. TOTAL CHARGE \$ 28. AMOUNT PAID \$ 29. BALANCE DUE \$

30. 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 31. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 32. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Network name goes here.

# Preparing Your Software

For all I-AHC network affiliates, you will need to change the payor name in your database to include the I-AHC payor prefix, AHCØ2.

For example, if the patient is insured with Mail Handlers Plan, which is covered under an I-AHC network affiliate, First Health, as identified on their insurance identification card, then the payor would be entered on the CMS-1500 and updated in your database **with the AHCØ2 prefix in front of the payor name.**

AHCØ2 Mail Handlers  
P. O. Box 8402  
London, KY 40742

**INSURANCE CLAIM FORM**

PICA

CARRIER

# Address Format is Extremely Important!!!!

Correct Format -

**AHCØ2 Mail Handlers  
PO Box 8402  
London, KY 40742**

Incorrect Formats – Do not use the formats below.

~~AHCØ2  
Mail Handlers  
PO Box 8402  
London, KY 40742~~

~~Mail Handlers  
AHCØ2  
PO Box 8402  
London, KY 40742~~

~~AHC-Ø2 Mail Handlers  
PO Box 8402  
London, KY 40742~~

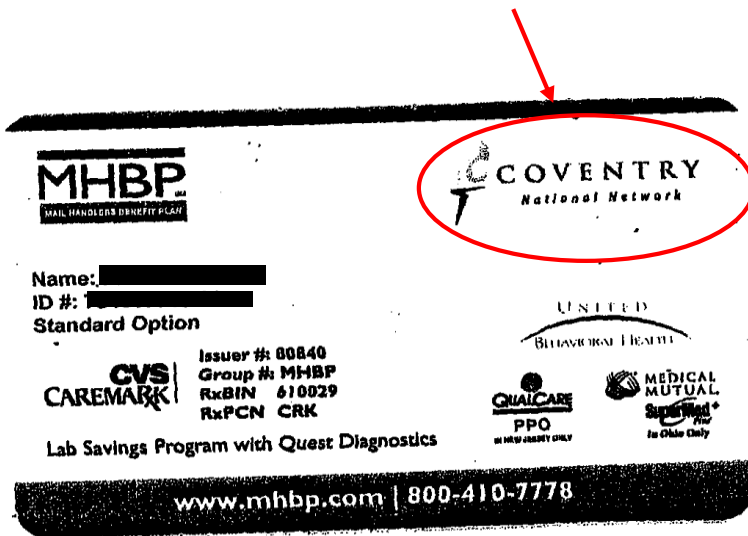
~~AHCØ2 / Mail Handlers  
PO Box 8402  
London, KY 40742~~

~~Mail Handlers AHCØ2  
PO Box 8402  
London, KY 40742~~

# Mail Handlers ID Card Example

Network Name

Payor Address



MHBP  
MAIL HANDLERS BENEFIT PLAN

COVENTRY  
National Network

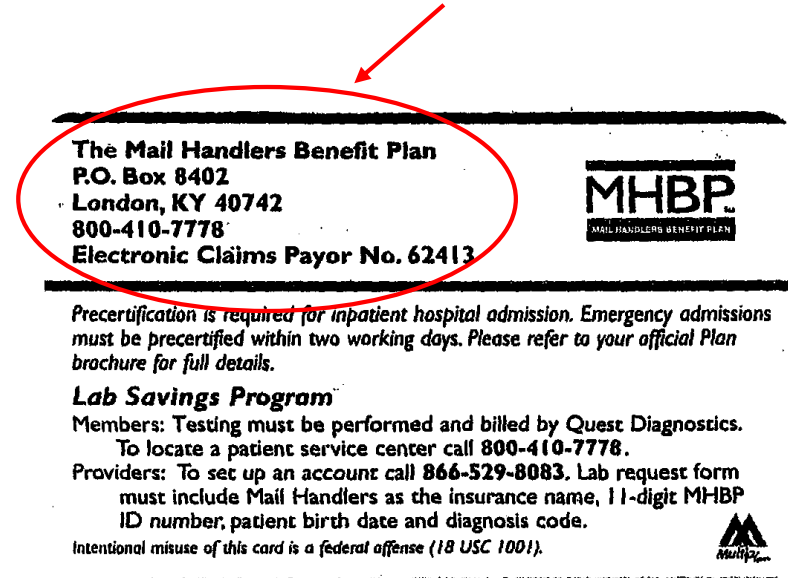
Name: [REDACTED]  
ID #: [REDACTED]  
Standard Option

CVS CAREMARK | Issuer #: 80840  
Group #: MHBP  
RxBIN 610029  
RxPCN CRK

Lab Savings Program with Quest Diagnostics

UNITED Behavioral Health  
QUALICARE PPO IN NEW JERSEY ONLY  
MEDICAL MUTUAL SuperMed+ In Ohio Only

www.mhbp.com | 800-410-7778




The Mail Handlers Benefit Plan  
P.O. Box 8402  
London, KY 40742  
800-410-7778  
Electronic Claims Payor No. 62413

MHBP  
MAIL HANDLERS BENEFIT PLAN

*Precertification is required for inpatient hospital admission. Emergency admissions must be precertified within two working days. Please refer to your official Plan brochure for full details.*

**Lab Savings Program**  
Members: Testing must be performed and billed by Quest Diagnostics.  
To locate a patient service center call 800-410-7778.  
Providers: To set up an account call 866-529-8083. Lab request form must include Mail Handlers as the insurance name, 11-digit MHBP ID number, patient birth date and diagnosis code.

Intentional misuse of this card is a federal offense (18 USC 1001).





In another example, Principal is the payor (from the back of the insurance ID card) for First Health (in box 11c), then the payor is identified on the top of the CMS-1500 as AHCØ2 First Health, with the mailing address from the insurance identification card.

AHCØ2 First Health Network PO Box 5319 Tampa, FL 33675-5319	CARRIER
<b>INSURANCE CLAIM FORM</b>	PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

It is critical to include the I-AHC network affiliate in box 11c of the CMS-1500.

11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH MM   DD   YY M <input type="checkbox"/> SE
b. EMPLOYER'S NAME OR SCHOOL NAME
c. INSURANCE PLAN NAME OR PROGRAM NAME First Health

# First Health ID Card Example

**SMITH AND DAVIS FABRIC**

Issuer (80840)

ID # [REDACTED]

Name [REDACTED]

Deps [REDACTED]

Payor # SEE BACK

Account # [REDACTED]

Eff 01/01/09



Care Type: Medical, Dental  
 Managed Care Network/Preferred Provider Organization  
 FIRST HEALTH NETWORK

Benefit Ph # 800-247-4695

Caremark  
 RX Group # H5GA1797

RXPCN:PCS

RX Bin# 0610415



Network Name

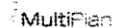
OUTPATIENT & CLINIC SURGERY-CAL YR DEDUCT & COINS  
 PREAPPROVAL REQUIRED FOR HOSPITAL ADMISSION  
 AND SOME OTHER SERVICES. SEE YOUR PLAN BOOKLET.  
 - 2 WORKING DAYS PRIOR TO NON-EMERGENCY SERVICES  
 - WITHIN 2 WORKING DAYS FOR EMERGENCY SERVICES  
 TO RECEIVE FULL BENEFITS, APPROVAL REQUIRED.  
 FOR AUTHORIZATION CALL THE PHONE # ON CARD FRONT.

SEND PPO CLAIMS TO:  
 FIRST HEALTH NETWORK  
 PO BOX 5319  
 TAMPA FL 33675-5319  
 ELECTRONICALLY: 73159

SEND ALL OTHER CLAIMS TO:  
 PRINCIPAL LIFE INSURANCE CO  
 PO BOX 39710  
 COLORADO SPGS CO  
 80949-3910  
 PAYOR # 61271



RX Help Desk, For Pharmacist Use Only 800-345-5413  
 MENTAL/NERVOUS/ALCOHOL/DRUG BENEFITS MAY DIFFER



REFER TO YOUR BOOKLET FOR FURTHER DETAILS  
 Visit us at [www.principal.com](http://www.principal.com) 12/25/2008

Payor Address

If the patient is insured with a company that is not an I-AHC network affiliate, then that payor is shown on the top of the CMS-1500 without the AHCØ2 prefix.

<p>BCBS P.O. Box 9907 Columbus, GA 31904</p>	<p>↑ CARRIER ↓</p>
<p><b>INSURANCE CLAIM FORM</b></p>	<p>PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>

Therefore, in this example, BCBS would be in your payor database without the AHCØ2 prefix.

<p>Identification Number</p>		<p>PCP Name:</p>	
<p>Benefits effective as of: 02/01/2008</p>		<p>PCP Number: 404 778-2700</p>	
<p>Rx Plan Code: 100 Rx Bin: 610053</p>		<p>QV/SP QV 20/30 AFTER HRS ADD 5 CHIRO 30 ER 100</p>	
<p>Group No/Name: 1007603501 CHILDRENS HEALTHCARE OF ATLAN</p>		<p>COINS% IN/OUT 90/70 M/S IN 90 MDED CAL YR 200</p>	
<p>BlueChoice Option </p>			

		<p>bebega.com</p>
<p><i>Possession of this card does not guarantee eligibility of benefits.</i></p>		
<p><b>Providers:</b> File all claims directly with your local Blue Cross Blue Shield plan. Please submit all claims with the 3 Digit Alpha prefix that precedes the member ID on the front of the card. Georgia providers submit claims to: Blue Cross Blue Shield Healthcare Plan of Georgia, P.O. Box 9907, Columbus, GA 31908-6007</p>		
<p><b>Dental:</b> File claims (if applicable) directly to: Blue Cross Dental Customer Service, P.O. Box 9201, Oxnard, CA 93031-9201</p>		
<p><b>Pharmacy:</b> Please submit to WellPoint NextRx using the Rx Bin and Plan Code displayed on the front of this card.</p>		
<p><i>*All hospital admissions require precertification. Benefits are reduced if you receive care from an out of network provider.</i></p>		
<p>Member Services 1-800-441-2273 24/7 NurseLine 1-888-724-2583 Behavioral Health 1-800-292-2879 Coverage While Traveling 1-800-810-2583 Pharmacy Services 1-800-962-7378 Pre Certification 1-800-662-9023 Dental Services 1-800-627-0004 Dental TDD 1-800-789-0084</p>		
<p><small>BlueChoice Option is administered by Blue Cross Blue Shield Healthcare Plan of Georgia (BCBSHP), an independent licensee of the Blue Cross Blue Shield Association. BCBSHP provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims.</small></p>		
<p>PSUM</p>		

# MultiPlan Exception

Sometimes the ID card may not show the name of the network affiliate.

MultiPlan serves as a 2<sup>nd</sup> tier network for:

Aetna

Humana

Cigna

Great West

United Healthcare

If you do not have a direct contract with the carrier, MultiPlan will apply.

It may not be mentioned on the ID card.

UnitedHealthcare<sup>SM</sup>

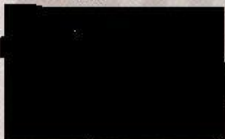


GENERAL BOARD OF  
PENSION AND HEALTH  
BENEFITS OF THE UNITED  
METHODIST CHURCH

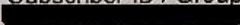
myuhc.com<sup>®</sup>

Company  
**GEN BD PENSION & HEALTH**

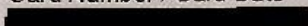
Name(s)



Subscriber ID / Group Number



Card Number / Card Date



Elect. Claim Payer ID#



PCPOV/UrgCare/ER Copays  
**\$30/\$50/\$50**

SpecOV Copay  
**\$50**

UnitedHealthcare Choice Plus – United HealthCare Insurance Company

Consumers – [www.myuhc.com](http://www.myuhc.com) ; Providers – [www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com) ; 75555662/01-8120

**AUTHORIZED SIGNATURE**

Date Issued 01/07/05



This card does not prove membership nor guarantee coverage.  
For verification of benefits, please call Member Services.

Member Services: 800-901-1939

Medco RX Bin #: [REDACTED] Medco RX Group #: [REDACTED]

\*Not affiliated with UnitedHealthcare

Claim Address: PO BOX 740800, Atlanta, GA 30374-0800



# Double Checking Claims

Make sure your claims include all required information **before** submission.

In other words be sure the CMS-1500 form is completed properly and completely with special attention to the following:

- Does the payor address require the AHCØ2 prefix?
- Did you include the name of the network in box 11c?
- Are the patient's name and date of birth correct?
- Are the insured's id number and name correct?
- Did you complete boxes 11, 11a and 11b of the CMS-1500?

# OA Training and Tools

The OA training will train you on how to upload claims and use their tools online.

Phone number is (866) 575-4120

Additional follow-up tools available from Office Ally include:

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

# Disclaimer

Integrated-ActivHealthCare (I-AHC) has arranged EDI processing for claims of I-AHC network affiliates through Office Ally (OA), a clearinghouse.

I-AHC staff will assist you in resolving any processing issues you experience on i-AHC in-network claims.

**I-AHC is NOT responsible for your relationship with Office Ally and the processing of Medicare, BCBS, Medicaid, and other non-AHC claims.**

You should contact OA at (866) 575-4120 with any questions regarding non-I-AHC claims. Neither I-AHC nor OA will make any corrections to claims. You are responsible for correct completion of the CMS1500 form.



# One last thing

If you have not already done so, please go to [ActivHealthCare.com](http://ActivHealthCare.com).

- Customer Service Center – download Term summary sheets
- Network Resources – print Network affiliates list