



# Electronic Claims Submission (EDI) – Training

## Part 1 – How to complete the CMS-1500 form

Contact Information:

[EDI@I-AHC.net](mailto:EDI@I-AHC.net)

866-374-9558

770-455-0040

# Two parts of Training

Part 1: How to complete CMS-1500 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, [www.ActivHealthCare.com](http://www.ActivHealthCare.com)
2. Complete forms carefully and completely.
3. Return completed forms to:  
ActivHealthCare, Inc.  
1926 Northlake Pkwy, Suite 100  
Tucker, GA 30084

# IMPORTANT!!!

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

**Network** - the group of providers – First Health Network, PHCS, MultiPlan, Memorial Health Partners, etc.

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

This is fundamental to EDI processing with I-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

Claims for the following networks should be:

- Sent electronically with the prefix AHC02 if you are enrolled with Office Ally through I-AHC OR
- Mailed to 1926 Northlake Parkway, Suite 100, Tucker, GA 30084
- To verify in-network benefits, use I-AHC TIN (do **NOT** put on claim)

	Alliant Health Plans		Memorial Health Partners (South Carolina only)
	Atlantic Integrated Health, Inc		MultiPlan
	Beech Street Corp. (Owned by MultiPlan)		PHCS
	Coventry National Network (South Carolina only)		SimpleCare (Alliant Health)
	Evolutions Healthcare Systems, Inc.		SoloCare (Alliant Health)
	First Health (SC only)		The Covenant Companies
	Galaxy Health Network		The Initial Group
	Health One Alliance		TLC Advantage

Claims for the following networks should be sent to the payer listed on the insurance card without the AHC02 prefix:

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



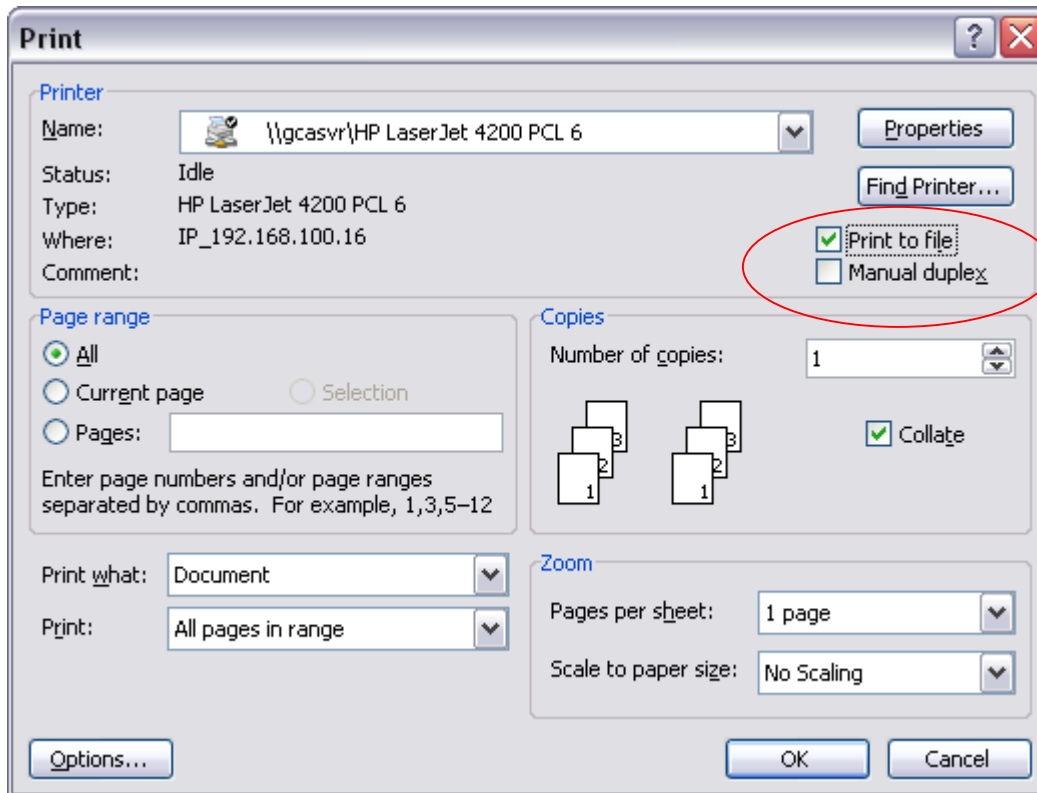
# Office Software (continued)

There are certain functions you will 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 CMS-1500 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

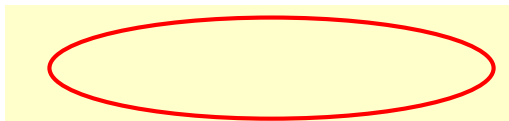
1. Payor prefix, if applicable, at the top of the CMS-1500 form
2. Payor name and address at the top of the CMS-1500 form
3. Insurance plan name or program name, i.e. network affiliate in box 11c of the CMS-1500 form
4. All other pertinent insurance claim form information must be completed correctly.

# Two Very Important Points

**Payor prefix** – The I-AHC payor prefix is **AHCØ2**. The payor prefix is used to identify claims that Office Ally 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 I-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, MultiPlan, PHCS, 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 (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)											
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		CITY		STATE		
ZIP CODE		TELEPHONE (Include Area Code)			Employed Full-Time Student Part-Time Student		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				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO		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. AUTO ACCIDENT? PLACE (State) YES NO		b. EMPLOYER'S NAME OR SCHOOL NAME				
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? YES NO		c. INSURANCE PLAN NAME OR PROGRAM NAME				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If 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 _____ DATE _____					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)				
21. 1. _____ 3. _____					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER				
21. 2. _____ 4. _____					24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPsDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE						
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO		28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. BALANCE DUE \$
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.)					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				
SIGNED _____ DATE _____					PIN# _____		GRP# _____				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Network  
name goes  
here.

5/21/2018

# Preparing Your Software

For all AHC network affiliates, you will need to change the Payor name in your database to include the I-AHC payor prefix, AHC02.

The image shows the header of an insurance claim form. The text "AHC02 First Health Network", "PO Box 5319", and "Tampa, FL 33675-5319" is circled in red. To the right of this text is a vertical label "CARRIER" with arrows pointing up and down. At the bottom left, it says "INSURANCE CLAIM FORM". At the bottom right, it says "FICA" followed by three empty boxes.

AHC02 First Health Network  
PO Box 5319  
Tampa, FL 33675-5319

CARRIER

**INSURANCE CLAIM FORM**

FICA

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.

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

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"/>
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.

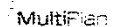
SEND PPO CLAIMS TO:  
 FIRST HEALTH NETWORK  
 PO BOX 5319  
 TAMPA FL 33675-5319  
 ELECTRONICALLY: 73159

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>██████████</p>		<p>PCP Name:</p> <p>██████████</p>	
<p>Benefits effective as of: 02/01/2008</p>		<p>PCP Number: 404 778-2700</p>	
<p>Rx Plan Code: 100</p> <p>Rx Bin: 610033</p>		<p>OV/SP OV 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 POS </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>Member Services</b> 1-800-441-2273</p> <p><b>24/7 NurseLine</b> 1-888-724-2583</p> <p><b>Behavioral Health</b> 1-800-292-2879</p> <p><b>Coverage While Traveling</b> 1-800-810-2583</p> <p><b>Pharmacy Services</b> 1-800-962-7378</p> <p><b>Pre Certification</b> 1-800-662-9023</p> <p><b>Dental Services</b> 1-800-627-0004</p> <p><b>Dental TDD</b> 1-800-789-0084</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><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

United Healthcare

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

*Note: 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

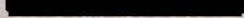
myuhc.com<sup>®</sup>

Name(s)

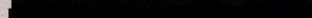


Company  
GEN BD PENSION & HEALTH

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) | 75550002/01/07/05

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



UnitedHealth  
Allies<sup>SM</sup>  
Not an insurance product.

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

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

**Neither I-AHC nor AHC is NOT responsible for your relationship with Office Ally and the processing of Medicare, BCBS, Medicaid, and other non-I-AHC claims.**

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