How to File Claims with ActivHealthCare

1. If the Primary Network is listed on our Network Affiliates sheet, the claim will come to ActivHealthCare.

2. The format on the HCFA must be correct regardless of how the claims are being filed. All claims should have AHC01 as the prefix, followed by the name and address of the Insurance Payor.

Example 1: AHC01 Peach State Health Plan Ambetter *(or name from ins. ID card)*
68069
PO Box 5010
Farmington, MO 63640

Example 2: AHC01 CareSource *(or name from ins. ID card)*
GACS1
PO Box 8730
Dayton, OH 45401-8730

Example 3: AHC01 Alliant Health Plan *(or name from ins ID card)*
58234
PO Box 2667
Dalton, GA 30722

3. There are two ways to file your claims.

1. EDI – Electronic claims can only be filed through Office Ally using an 837P file. If you do not use Office Ally, you must submit claims on paper.

2. Mail – Paper claims can be mailed to ActivHealthCare; however, we suggest filing them electronically to expedite the processing of your claims. Please mail paper claims to:

ActivHealthCare, Inc.
1926 Northlake Pkwy Ste. 100
Tucker, GA 30084

Claim form with instructions

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

AHCØ1 Payor Name from ID Card
Payor ID #
Payor Address from ID Card
Payor City, State, Zip

CARRIER

PICA PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

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

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

Patient's Information

Insured's Information

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? YES NO PLACE (State)

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

Network Name from ID card

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.

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 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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.
2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

9

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 111N00000X
NPI 14322895876
2 NPI
3 NPI
4 NPI
5 NPI
6 NPI

Service Address & NPI #

Taxonomy code and Doctor's NPI Number

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

Doctor TIN

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.)

Service Provider

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
John Chiropractic Center
4455 Highway 84
Tucker, GA 30084-7069
a. 1932992610 b.

33. BILLING PROVIDER INFO & PH #
John Chiropractic Center
4455 Highway 84
Tucker, GA 30084-7069
a. 14322895876

Address/NPI number for who checks are payable to

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

How to File a Corrected Claim with Ambetter

1. The format on the top of the HCFA should be:

   AHC01 Peach State Health Plan Ambetter
   68069
   P.O. Box 5010
   Farmington, MO 63640-5010

2. The ID number must include the prefix and the suffix.

   Incorrect number: 12345678
   Correct number: U1234567801

3. Patient's name should match what is on the ID card. Do not file with a nickname.

4. Timely filing is 180 days from the date of service.

5. To dispute a claim, a Reconsideration Request Form must be completed and sent to Ambetter. Do not send it to ActivHealthCare.

6. Corrected claims need to be submitted with the following information in Box 22.

CMS-1500 Example *(please use red and white claim form for official submission)*

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to servi
A. B. C. E. F. G. I. J. K.
YES NO
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

Box 22: Original claim number. Note: Not to be used if original claim was rejected

Box 22: Use resubmission code 7 for corrected claim

Claim # on Activ's EOB

```
ACTIV CLM #   19-293-0070-0
PAYER CLM #   U292MPEE9018
```

How it should look on the HCFA

22. RESUBMISSION CODE	ORIGINAL REF. NO
7	U292MPEE9018

2023-11-09

7. Please review the three examples on completing Section 24 of the CMS1500 form. If this is completed incorrectly, the previous payment may be deducted from your claims.

Example 1

The original claim was billed with 2 lines. Provider left out the 3rd line and submitted a Corrected Claim. This is NOT a Corrected Claim because the 3rd line was never billed. It should have been submitted as a regular claim.

24.	A. DATE(S) OF SERVICE From	To	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	11/01/21	11/01/21	11		98941					AB	50	¢	1		ZZ NPI	111N00000X 123456789
2	11/01/21	11/01/21	11		97530					AB	40	¢	1		ZZ NPI	111N00000X 123456789
3	MM/DD/YY	MM/DD/YY			CPT/HCPCS #					A - L	$	¢	#		NPI	Rendering's Non-NPI ID # Rendering's NPI #
4	MM/DD/YY	MM/DD/YY			CPT/HCPCS #					A - L	$	¢	#		NPI	Rendering's Non-NPI ID # Rendering's NPI #
5	MM/DD/YY	MM/DD/YY			CPT/HCPCS #					A - L	$	¢	#		NPI	Rendering's Non-NPI ID # Rendering's NPI #
6	MM/DD/YY	MM/DD/YY			CPT/HCPCS #					A - L	$	¢	#		NPI	Rendering's Non-NPI ID # Rendering's NPI #

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NUMBER	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
123456789		X	Patient Account # (Optional)	X YES NO	90 00	$ ¢	

Since the 97012 was never submitted, do not complete box 22. It is not a Corrected Claim. It is simply an additional charge. If you submit it as a Corrected Claim, Ambetter will back out the originally processed claim prior to processing the correction. In doing this, any potential payment to be made will be offset by the negative created when the claim was backed out.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY   ICD Ind.

A. M5412	B. M546	C. Diag Code C	D. Diag Code D
E. Diag Code E	F. Diag Code F	G. Diag Code G	H. Diag Code H
I. Diag Code I	J. Diag Code J	K. Diag Code K	L. Diag Code L

22. RESUBMISSION CODE	ORIGINAL REFERENCE NUMBER
7	U123MPE123456

23. PRIOR AUTHORIZATION NUMBER: Prior Authorization Number (Optional)

24.	A. DATE(S) OF SERVICE From	To	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	11/01/21	11/01/21	11		97012	GP				AB	50	¢	1		ZZ NPI	111N00000X 123456789
2	MM/DD/YY	MM/DD/YY			CPT/HCPCS #					A - L	0	¢	#		NPI	Rendering's Non-NPI ID # Rendering's NPI #
3	MM/DD/YY	MM/DD/YY			CPT/HCPCS #					A - L	0	¢	#		NPI	Rendering's Non-NPI ID # Rendering's NPI #
4	MM/DD/YY	MM/DD/YY			CPT/HCPCS #					A - L	0	¢	#		NPI	Rendering's Non-NPI ID # Rendering's NPI #
5	MM/DD/YY	MM/DD/YY			CPT/HCPCS #					A - L	0	¢	#		NPI	Rendering's Non-NPI ID # Rendering's NPI #
6	MM/DD/YY	MM/DD/YY			CPT/HCPCS #					A - L	0	¢	#		NPI	Rendering's Non-NPI ID # Rendering's NPI #

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NUMBER	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
123456789		X	Patient Account # (Optional)	X YES NO	50 00	$ ¢	

Example 2:

The original claim was billed with 4 lines. A Corrected Claim was sent in with the 2 lines that denied. The Corrected Claim is wrong. It should include all the lines submitted on the original claim, not just the 2 lines in question. Ambetter will back out the first claim as a negative before processing the Corrected Claim. This will cause the 2 lines that were previously processed correctly to be deducted from the payment for the second 2 lines. It will probably create an overpayment situation.

24.	A. DATE(S) OF SERVICE From	To	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	11/01/21	11/01/21	11		98940		AB	50 ¢	1		ZZ NPI	111N00000X 123456789
2	11/01/21	11/01/21	11		98943		AB	40 ¢	1		zz NPI	111N00000X 123456789
3	11/01/21	11/01/21	11		97012		AB	20 ¢	1		zz NPI	111N00000X 123456789
4	11/01/21	11/01/21	11		97110		AB	40 ¢	1		zz NPI	111N00000X 123456789
5	MM/DD/YY	MM/DD/YY			CPT/HCPCS #		A - L	$ ¢	#		NPI	Rendering's Non-NPI ID # Rendering's NPI #
6	MM/DD/YY	MM/DD/YY			CPT/HCPCS #		A - L	$ ¢	#		NPI	Rendering's Non-NPI ID # Rendering's NPI #

The Corrected Claim should include all 4 lines of charges, not just the 2 lines below.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY — ICD Ind. 0

A. M5412	B. M546	C. Diag Code C	D. Diag Code D
E. Diag Code E	F. Diag Code F	G. Diag Code G	H. Diag Code H
I. Diag Code I	J. Diag Code J	K. Diag Code K	L. Diag Code L

22. RESUBMISSION CODE: 7 — ORIGINAL REFERENCE NUMBER: U123MPE12345

23. PRIOR AUTHORIZATION NUMBER: Prior Authorization Number (Optional)

24.	A. DATE(S) OF SERVICE From	To	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	11/01/21	11/01/21	11		97012	GP	AB	20 ¢	1		ZZ NPI	111N00000X 123456789
2	11/01/21	11/01/21	11		97110	GP	AB	40 ¢	1		zz NPI	111N00000X 123456789
3	MM/DD/YY	MM/DD/YY			CPT/HCPCS #		A - L	0 ¢	#		NPI	Rendering's Non-NPI ID # Rendering's NPI #
4	MM/DD/YY	MM/DD/YY			CPT/HCPCS #		A - L	0 ¢	#		NPI	Rendering's Non-NPI ID # Rendering's NPI #
5	MM/DD/YY	MM/DD/YY			CPT/HCPCS #		A - L	0 ¢	#		NPI	Rendering's Non-NPI ID # Rendering's NPI #
6	MM/DD/YY	MM/DD/YY			CPT/HCPCS #		A - L	0 ¢	#		NPI	Rendering's Non-NPI ID # Rendering's NPI #

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NUMBER	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
123456789		X	Patient Account # (Optional)	YES / NO	60 00	$ ¢	

Example 3

Multiple dates of service were billed on multiple claims. Corrected claims were sent in with only the denied line for all the dates of service. This will create a big mess and an overpayment by Ambetter. Before Ambetter process the Corrected claim, they will back out the previous payment made on the original claims. The Corrected claim payment will be offset by the negative or back out of the original claim. When filing a Corrected claim, you must include all lines previously processed, even the lines processed correctly the first time.

24.	A. DATE(S) OF SERVICE From	To	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											ZZ	111N00000X
	11/01/21	11/01/21	11		98941		AB	50 ¢	1		NPI	123456789
2											ZZ	111N00000X
	11/01/21	11/01/21	11		97012		AB	50 ¢	1		NPI	123456789
3			Help								ZZ	111N00000X
	11/02/21	11/02/21	11		98941		AB	50 ¢	#		NPI	123456789
4											ZZ	111N00000X
	11/02/21	11/02/21	11		97012		AB	50 ¢	#		NPI	123456789
5											ZZ	111N00000X
	11/05/21	11/05/21	11		98941		AB	50 ¢	#		NPI	123456789
6											ZZ	111N00000X
	11/05/21	11/05/21	11		97012		AB	50 ¢	#		NPI	123456789

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NUMBER	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
123456789		X	Patient Account # (Optional)	YES NO	300 00	$ ¢	

If you only list the charges that need to be re-processed, you will create a problem. Ambetter will back out the 98941 codes prior to re-processing the 97012-GP codes. This will create a negative, which will be deducted from an unrelated claim. You must include all lines from the original claim, including those previously processed correctly.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY **ICD Ind.** 0

A.	M5412	B.	M546	C.	Diag Code C	D.	Diag Code D
E.	Diag Code E	F.	Diag Code F	G.	Diag Code G	H.	Diag Code H
I.	Diag Code I	J.	Diag Code J	K.	Diag Code K	L.	Diag Code L

22. RESUBMISSION CODE 7 **ORIGINAL REFERENCE NUMBER** U123MPE12345

23. PRIOR AUTHORIZATION NUMBER Prior Authorization Number (Optional)

24. A. DATE(S) OF SERVICE From	To	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														ZZ	111N00000X
11/01/21	11/01/21	11		97012	GP				AB	50	¢	1		NPI	123456789
2														zz	111N00000X
11/02/21	11/01/21	11		97012	GP				AB	50	¢	1		NPI	123456789
3														zz	111N00000X
11/05/21	11/02/21	11		97012	GP				AB	50	¢	#		NPI	123456789
4														zz	111N00000X
11/08/21	11/02/21	11		97012	GP				AB	50	¢	#		NPI	123456789
5														zz	111N00000X
11/11/21	11/05/21	11		97012	GP				AB	50	¢	#		NPI	123456789
6														zz	111N00000X
11/15/21	11/05/21	11		97012	GP				AB	50	¢	#		NPI	123456789

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NUMBER	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
123456789		X	Patient Account # (Optional)	YES NO	300 00	$ ¢	