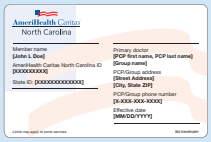
AmeriHealth Caritas North Carolina

Claims and Billing Quick Reference Guide

Electronic data interchange (EDI) payer ID# for AmeriHealth Caritas North Carolina (ACNC) is **81671**.

Your claims. Paid right. The first time.



Verify member eligibility.

- Use the NaviNet provider portal (www.amerihealthcaritasnc.com/provider/resources/navinet.aspx).
- Automated real-time eligibility service: Call Provider Services **1-888-738-0004**.
- Ask to see the member's plan ID card.

Visit the Claims and Billing webpage for additional information and links to other resources and support.

To avoid pending claims, delay of payment, rejections and denials, submit claims as soon as reasonably possible, and **remember to attach documentation**. Accuracy throughout the following steps will help ensure your claims are clean and ready for submission.

Enroll in electronic funds transfer (EFT).

Do you already receive payments from ECHO Health?

- Enroll using your existing account.
- Locate your ECHO Health draft number in ECHO Health's explanation of payments document.

If new to ECHO Health...

- Have your first check stub handy.
- There are no fees for single-payer agreements. If you encounter a fee, please contact your Provider Network Account Executive.

For assistance during registration, contact ECHO at **1-800-946-4041**, Monday through Friday, 8 a.m. to 6 p.m. ET.

Clean claims

- Using the attachment section on page 2 for options, include the Explanation of Benefits (EOBs) from the primary insurance carrier.
- If required, obtain prior authorization for the service or product and include the authorization number in your claim submission.
- Provider taxonomy codes must match the NCDHHS/NCTracks file for the date of service on the claim.
- Utilize current CPT, HCPCS and ICD codes.
- Submit claims within 365 days from the original date of service.
- DO NOT SUBMIT duplicate claims. (See **Corrected claims.**)

Corrected claims

- Check the claim status in NaviNet, and wait for the original claim to be processed.
- Locate the original claim number from the 835 Electronic Remittance Advice (ERA) or visit NaviNet, our provider portal, to submit an inquiry. The original claim number must be included on your corrected claim.
- On the corrected claim, submit all services that were on the original claim PLUS the corrected information.
- If submitting EOBs, do so within 180 calendar days of the date on the primary insurer's EOB.
- DO NOT write or stamp the words "corrected, resubmitted or voided" on a paper claim. This will not process your claim as corrected.
- Submit Professional corrected claims on the 1500 paper form. Use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P).
- Submit Institutional corrected claims on the UB-04 paper form. Use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P).
- Use Field 22 for paper claim on HCFA 1500 and Field 64A for UB04 paper claim
- Paid in 30 days.

Three attachment types

Electronic 275 unsolicited
Availity Intelligent Gateway Connectivity

- After logging in, providers can access training demos for the submission process.
- A maximum of 10 attachments, each not to exceed 10 megabytes (MB), are allowed per submission.
- A complete submission of 10 attachments cannot exceed 100 MB.

Solicited 277 RFAI in NaviNet

Should ACNC require additional information for a claim, providers will receive a pend notification by letter and in NaviNet requesting the information. Attachments can be uploaded through the NaviNet pend notice.

Send paper claims to:

AmeriHealth Caritas North Carolina
Attn: Claims Processing Department
P.O. Box 7380
London, KY 40742-7380

File an inquiry to ask questions about a submitted claim.

The deadline to inquire on a claim payment is no later than 365 days from the date of service OR 60 calendar days after the payment, denial, or recoupment, whichever is later.

- Record the call reference number provided by the Provider Services Representative for additional follow-up.
- Open a claims investigation under adjustment inquiry by visiting the NaviNet provider portal webpage: www.amerihealthcaritasnc.com/provider/resources/navinet.aspx
- Connect with your Account Executive to discuss any claims issues, or call Provider Services **1-888-738-0004** to discuss up to five separate claims.

Definitions		Timelines	
Term	**Key information**	**Submission**	**Payment**
Denied medical claim	A claim that is either partially paid or denied in full. The most common reasons for denials are other insurance, eligibility, and not following clinical policy or correct coding guidelines.	Denied claims can sometimes be corrected and resubmitted. See corrected claim process on page 1.	Paid or denied within **30** calendar days of submission.
Rejected medical electronic claim	• These claims have missing or invalid data elements, such as the provider tax identification number (TIN) or member ID number. These are returned to the submitter or electronic data interchange (EDI) by the clearinghouse source without being processed or adjudicated. • Rejected claims are not registered in the claim processing system and are an exchange between the clearinghouse and provider.	Resubmission of a rejected claim must be submitted as an original claim. See **Clean claim** on page 1. Submit no later than **365** days from the original date of service (or discharge).	N/A
Rejected medical paper claim	• Rejected paper claims have a letter attached with a document control number (DCN). • A DCN is not an ACNC claim number.	Rebilling of a rejected claim should be done as an original claim. See **Clean claim** on page 1.	Paid or denied within **30** calendar days of submission. ACNC will notify you within **18** days of submission about whether the claim is clean or has been pended.