

How to submit corrected claims

An original claim or “new claim” is the first submission that has not been previously billed or processed and does not reference another claim.

Duplicate claims and corrections

Duplicate claim submission is a significant obstacle during the claims process, often resulting in incorrect claims processing. Some service lines may be paid, and other service lines denied as duplicates, or the entire claim may be denied as a duplicate.

If a provider is unsure a claim has been filed, they should view claim status on the Availity provider portal or call provider services to inquire on the status of the claim.

Sentara Health Plans checks for duplicate claims by comparing:

- member number
- vendor identification number
- date of service
- procedure code
- total charges of the current claim to claims that are stored in the member’s history.

Electronic corrections are accepted in a claim file through a clearinghouse or software vendor. Claims sent through a clearinghouse or software vendor must have a seven- frequency code in the CLM05-3 segment of the 2300 loop of the 5010 A1 837 professional guides. If a claim is resubmitted without the “resubmit” code, the claim will be denied as duplicate. Providers should contact their software vendor or clearinghouse with questions about how to send this code.

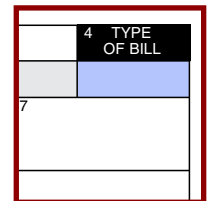
Sentara Health Plans accepts the following corrections electronically:

- Patient payment
- Service periods/dates
- Procedure/service codes
- Charges
- Units/visits/studies/procedures
- Hospitalization dates
- Name or ID number of the referring provider
- Provider ID
- Wrong member ID number or birth date

Corrected claim submission of a previously billed claim

UB-04 claims

- Bill type is a key indicator to determine whether a claim has been previously submitted and processed.
- The first digit of the bill type indicates the type of facility.
- The second digit indicates the type of care provided.
- The third digit indicates the frequency of the bill.
- Billing type is important for interim billing or a replacement/resubmission bill.
- "Resubmission" should be indicated in block 80 or any other unoccupied block of the UB-04.



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| 8 PATIENT NAME | | 9 PATIENT ADDRESS | | 10 PATIENT PHONE | | 11 SEX | | 12 DATE | | 13 HR | | 14 TYPE | | 15 SPC | | 16 DHR | | 17 STAT | | 18 | | 19 | | 20 | | 21 | | 22 | | 23 | | 24 | | 25 | | 26 | | 27 | | 28 | | 29 | | 30 | | 31 | | 32 | | 33 | | 34 | | 35 | | 36 | | 37 | | 38 | | 39 | | 40 | | 41 | | 42 | | 43 | | 44 | | 45 | | 46 | | 47 | | 48 | | 49 | | 50 | | 51 | | 52 | | 53 | | 54 | | 55 | | 56 | | 57 | | 58 | | 59 | | 60 | | 61 | | 62 | | 63 | | 64 | | 65 | | 66 | | 67 | | 68 | | 69 | | 70 | | 71 | | 72 | | 73 | | 74 | | 75 | | 76 | | 77 | | 78 | | 79 | | 80 | | 81 | | 82 | | 83 | | 84 | | 85 | | 86 | | 87 | | 88 | | 89 | | 90 | | 91 | | 92 | | 93 | | 94 | | 95 | | 96 | | 97 | | 98 | | 99 | | 100 | | | | | | | | | | | | | | | |
| 69 ADMIT DX | | 70 PATIENT REASON DX | | 71 PRINCIPAL PROCEDURE CODE | | 72 OTHER PROCEDURE CODE | | 73 OTHER PROCEDURE CODE | | 74 OTHER PROCEDURE CODE | | 75 OTHER PROCEDURE CODE | | 76 OTHER PROCEDURE CODE | | 77 OTHER PROCEDURE CODE | | 78 OTHER PROCEDURE CODE | | 79 OTHER PROCEDURE CODE | | 80 OTHER PROCEDURE CODE | | 81 OTHER PROCEDURE CODE | | 82 OTHER PROCEDURE CODE | | 83 OTHER PROCEDURE CODE | | 84 OTHER PROCEDURE CODE | | 85 OTHER PROCEDURE CODE | | 86 OTHER PROCEDURE CODE | | 87 OTHER PROCEDURE CODE | | 88 OTHER PROCEDURE CODE | | 89 OTHER PROCEDURE CODE | | 90 OTHER PROCEDURE CODE | | 91 OTHER PROCEDURE CODE | | 92 OTHER PROCEDURE CODE | | 93 OTHER PROCEDURE CODE | | 94 OTHER PROCEDURE CODE | | 95 OTHER PROCEDURE CODE | | 96 OTHER PROCEDURE CODE | | 97 OTHER PROCEDURE CODE | | 98 OTHER PROCEDURE CODE | | 99 OTHER PROCEDURE CODE | | 100 OTHER PROCEDURE CODE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 80 REMARKS | | 81 CC | | 82 | | 83 | | 84 | | 85 | | 86 | | 87 | | 88 | | 89 | | 90 | | 91 | | 92 | | 93 | | 94 | | 95 | | 96 | | 97 | | 98 | | 99 | | 100 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| 80 REMARKS | | 81 CC | | 82 | | 83 | | 84 | | 85 | | 86 | | 87 | | 88 | | 89 | | 90 | | 91 | | 92 | | 93 | | 94 | | 95 | | 96 | | 97 | | 98 | | 99 | | 100 | | | | | | | | | | | | | | | | | | | | | | | |

Corrected claim submission of a previously billed claim

CMS-1500 claims

- Claims submitted for correction require a "7" in box 22.
- Claims that need to be voided require an "8" in box 22.
- Enter the original claim number of the claim you are replacing in the right side of item 22.

HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER
 Medicare# Medicaid# (ID#) (ID#) (Member ID#) (ID#) (ID#) (ID#) (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) CITY STATE ZIP CODE TELEPHONE (Include Area Code) 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

8. RESERVED FOR NUCC USE 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? YES NO c. OTHER ACCIDENT? YES NO 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO # yes, complete items 9, 9a.

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 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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM/DD/YY) QUAL. 15. OTHER 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? YES NO \$ CHARGES _____

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____ 22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____

23. PRIOR AUTHORIZATION NUMBER _____

24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS F. G. H. I. J. \$ CHARGES DAYS OR UNITS EPSTDT Family Plan ID. QUAL. RENDERING PROVIDER ID. #

| | From | To | Place of Service | EMG | Diagnosis | Modifier | Diagnosis Pointer | \$ Charges | Days or Units | EPSTDT Family Plan | ID. Qual. | Rendering Provider ID. # |
|---|------|----|------------------|-----|-----------|----------|-------------------|------------|---------------|--------------------|-----------|--------------------------|
| 1 | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | |
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| 5 | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | |

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Rev'd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PI # ()

SIGNED _____ DATE _____ a. NPI _____ b. _____ a. NPI _____ b. _____

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Definitions

1. Clean Claim is a claim that does all of the following:
 - a. Identifies the provider that provided the service with industry-standard identification criteria, including billing and rendering provider names, identification numbers, and addresses;
 - b. Identifies the patient with a carrier-assigned identification number so the carrier can verify the patient was an enrollee at the time of service;
 - c. Identifies the service rendered using an industry-standard system of procedure or service coding, or, if applicable, a methodology required under the provider contract. The claim shall include a complete listing of all relevant diagnoses, procedures, and service codes, as well as any applicable modifiers;
 - d. Specifies the date and place of service;
 - e. If prior authorization is required for the services listed in the claim, contains verification that prior authorization was obtained in accordance with the provider contract for those services; and
 - f. Includes additional documentation specific to the services rendered as required by the carrier in its provider contract. Notwithstanding the above criteria, a claim shall be considered a clean claim if a carrier has failed timely to notify the person submitting the claim of any defect or impropriety in accordance with this section
2. Corrected Claim - A "re-billed" or "corrected claim" is a claim being resubmitted by the provider to correct or change a previous submission for the same patient, date of service, and/or procedures.
3. Reconsideration - A claim reconsideration is defined as a written dispute for further consideration when a claim does not process as expected (paid or denied). Applies to an original, unmodified claim.