Sentara® Health Plans

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.

A "corrected claim" is a resubmission of a previously adjudicated claim to correct or update information. Corrected claims should be submitted with the appropriate indicator or bill type to avoid being denied as duplicate.

Duplicate claims

Duplicate claim submissions are a common occurrence during the claims adjudication process. If a provider is uncertain if a claim has been filed, they should view claim status on the Availity provider portal or call Provider Services to inquire about the status of the claim. Some service lines may be paid, and other service lines denied as duplicates, or the entire claim may be denied as a duplicate.

Corrected claim submission of a previously billed claim

A corrected claim is a complete replacement of a previously submitted claim that requires changes such as updates to diagnosis codes, procedure codes, modifiers, charges, member information, or provider information. Corrected claims must include all services provided.

If multiple corrected claims are submitted and services are split across those claims, only the services billed on the most recent corrected claim will be considered. Upon receipt of a corrected claim, Sentara Health Plans will reverse the original claim and replace it with the corrected submission.

Corrected claims must be submitted within the original timely filing limit.

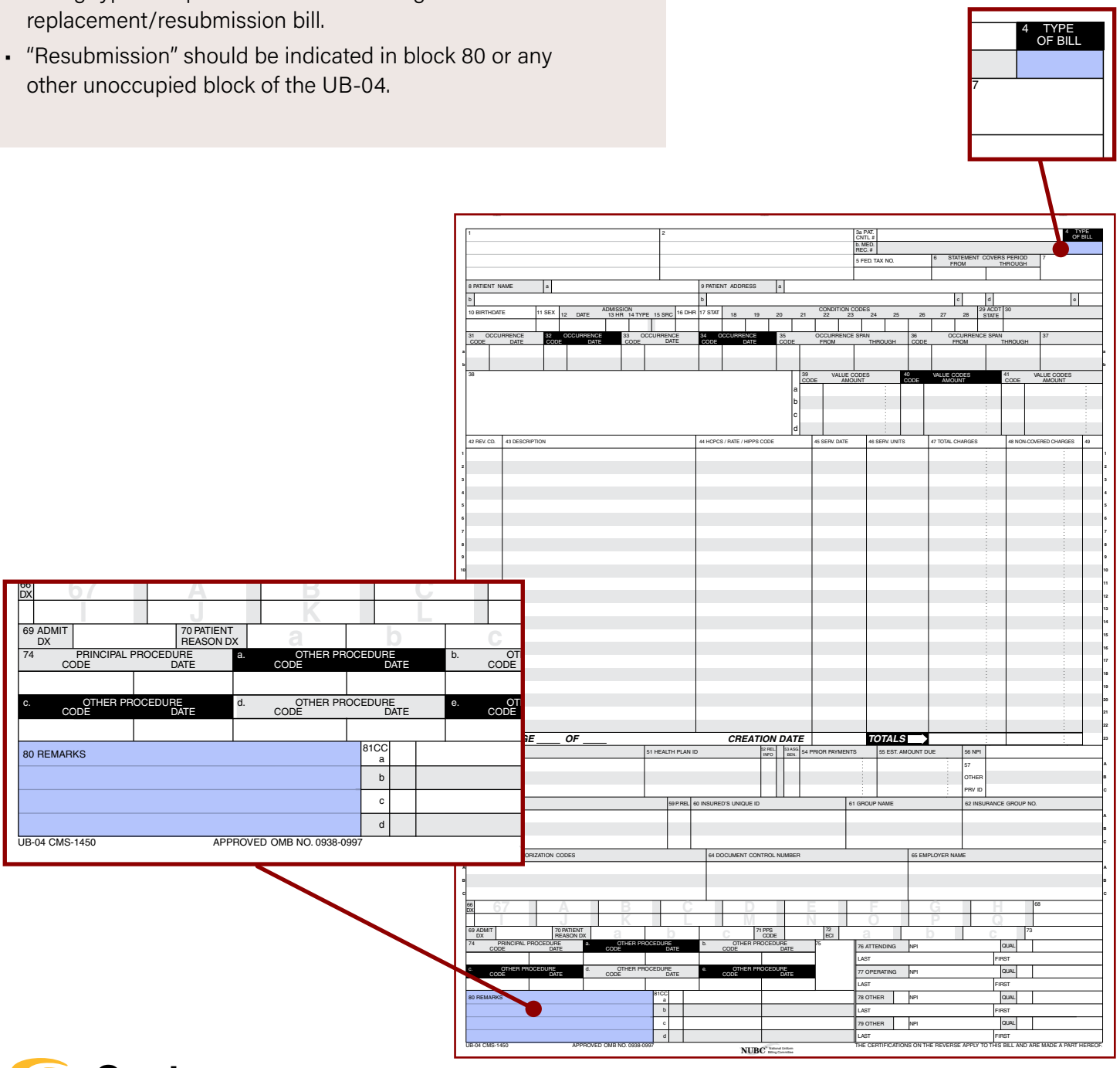
To avoid denial as a duplicate claim, all corrected claims must include the required indicators or codes identifying the submission as a correction or replacement of a prior claim. See section "Corrected Claim Submission of a Previously Billed Claim (Replacement of Prior Claim)" in the **Provider Manual** for more information.

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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.

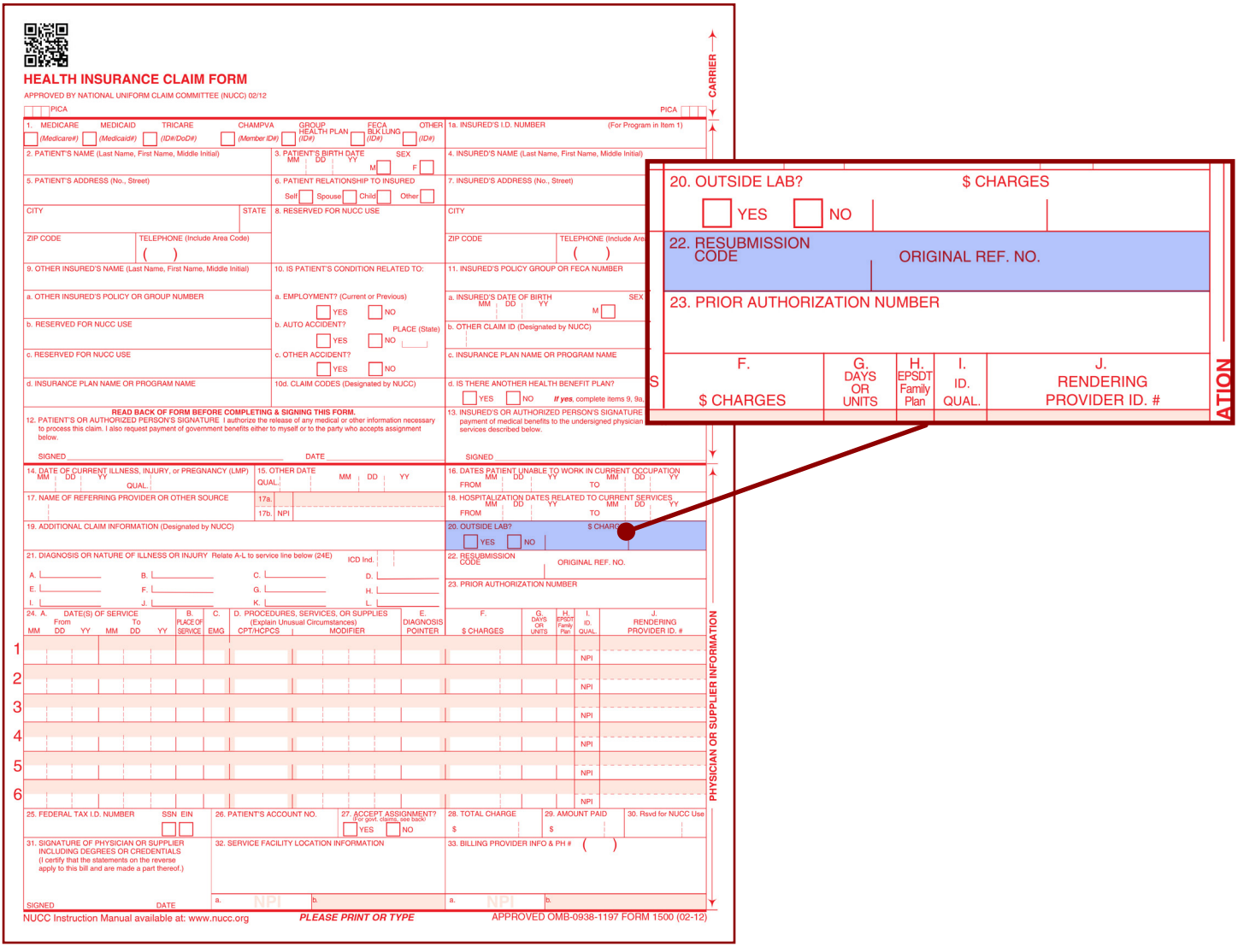


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Corrected claim submission of a previously billed claim

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.



Sentara® Health Plans

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 resubmission of a previously adjudicated claim to correct or update information. Corrected claims should be submitted with the appropriate indicator or bill type to avoid being denied as duplicate.

3. Reconsideration - Distinct from a claim correction and distinct from an appeal of an Adverse Benefit Determination—is a written request submitted by the provider seeking a review of how a claim was adjudicated. It is important to note that a reconsideration does not involve any changes to the original claim.