## Avoiding Common Claim Submission Errors



## Please ensure claims contain:

- **1. Correct member name** the patient name on the claim must match the patient name as listed on the member ID card.
- 2. Correct date of birth.
- 3. Member ID number, including:
  - member suffix: member number on claim must contain the correct two-digit suffix that identifies the patient
  - complete member ID number
  - no asterisk or spaces
- **4. Providers offering multiple services and multiple provider setups**, must bill the appropriate NPI/ Tax ID on the claim to eliminate assignment logic delays.
- **5. Rendering/Individual NPI** should be listed in box **24J**, "Rendering Provider ID #," in the bottom unshaded portion of the box labeled "NPI."
- **6. Taxonomy code** should be listed in the top shaded portion of box **24J**. Claims submitted without the correct taxonomy code will be rejected or denied.
- 7. Billing/Group NPI should be listed in box 33a, "Billing Provider Info & PH #."
- **8.** Services requiring pre-authorization can be found on sentarahealthplans.com/providers. If unsure, contact provider services at **757-552-7474** or **1-800-229-8822**.
- **9. Coordination of Benefits, Sentara Health Plans as secondary carrier.** Claims must be submitted with Explanations of Benefits (EOBs) attached and the identical information included on the original claim.
  - Providers may not bill one insurance carrier for one charge amount and Sentara Health Plans for a different charge amount.
  - If a claim is filed for a member whose primary insurance is not Sentara Health Plans, the provider must submit an EOB for the claims within 18 months of the date of service.
- **10. Non par provider.** After the Coordination of Care period, providers must secure a dually executed contract to participate with Sentara Health Plans and service Sentara Health Plans members. For more information on joining the network, please visit: **sentarahealthplans.com/providers/join-our-network**.

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Please note: Timely filing deadline on all claims is 365 days from the date of service. This includes any corrections, reconsiderations, and/or appeals.

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|--|--|---|---------------------------------|--|------------------------------------|--|-------------|--------------------------------|
|  | CAPE CHAM                                    | 140 At The Rt. 812 19 4   | Luca Chen                       | IA PISURED'S LO. NUM                           | DER                                | For Program in Item 1)                         | 4           |                                |
| (Medicerer) (Nedicardr) (Cel<br>2. PATIENT'S NAME Cast Name, First Name                        | (CuCir) (Marrie                              | 2 PATIENTS SWITH DATE   | SEX (CV)                        | 4 PASUMED S NAME QUE                           | of States Plant States Adv         | and a facility                                 | - 1         |                                |
|  |  | NW DO VY  | 7 .                             | a proportion a second firm                     |                                    | and security                                   |             |                                |
| 5. PATIENTS ADDRESS (No. Street) 6. PATIEN   |  | 6. PATIENT RELATIONSHIP TO  | PATIENT RELATIONSHIP TO INSURED |  | 7 INSURED'S ACCINESS (No., Street) |  |             |                                |
| OTY  |  | Self Spoute Child   | Other                           |  |                                    |  |             |                                |
| CITY   | STAR   | E & RESERVED FOR HUCC USE   |                                 | City   |                                    | STATE  | S S         |                                |
| ZP CODE TELEPHO  | NE (Include Area Code)                       |   |                                 | ZP 0006  | TELEPHONE (I                       | Include Area Code)                             | OFMATION    |                                |
| (  | )  |   |                                 |  | ( )                                |  | OPS         |                                |
| 9 OTHER INSURED'S NAME (Less Name, Fo  | rși Nome, Middle Initel)                     | 18. IS PATIENT'S CONDITION AS                                       | ELATED TO                       | II. INSURED'S POLICY (                         | POUP OR FECA HUM                   | ICA .  | 2           |                                |
| a. OTHER INSURED'S POLICY OR GROUP   | KANDEN                                       | a EMPLOYMENT? (Current or Pr  | minut)                          | · BOURSON S DATE OF                            | NATA .                             | SEX  | AND INSURED |                                |
|  |  | -   | NO                              | A PASUPED S DATE OF                            | YY M                               | П، п   | 50          |                                |
| B. RESERVED FOR NUCC USE   |  | b. AUTO ACCIDENT?   | PLACE (Store)                   | S. OTHER CLAM ID (OH                           | ignated by NJCC)                   |  | 6           |                                |
| e RESERVED FOR NUCC USE  |  |   | NO                              |  |                                    |  | T AN        |                                |
| C HEALTHED FOR MOCC USE  |  | e OTHER ACCIDENTY   | NO                              | E INSURANCE PLAN NA                            | ME OF PROGRAM NAM                  |  | ENT         |                                |
| 6. INSURANCE PLAN NAME OR PROGRAM  | NAME   | 100 CLAM CODES (Designated)   |                                 | E IS THERE ANOTHER I                           | GALTH BENEFIT PLAN                 | 9  | -PAT        |                                |
|  |  |   |                                 | VES NO   | If year, complete it               | ens R. Sa, and Sd.                             | T.          |                                |
| 12 PATIENTS OR AUTHORIZED PERSONS  | ORM BEFORE COMPLETS<br>SIGNATURE I BURNIUS D | NG & SIGNING THIS FORM.<br>Is referse of any medical or other Inlum | nation necessary                | 13. INSURED'S OR AUTH<br>payment of medical be | ORIZED PERSONS SIG                 | SATURE Lauthoriza<br>physicien or supplier for |             |                                |
| to process this claim. I also request paymen<br>below  | of government benefits with                  | or to myself or to the party who occupies                           | assignment                      | services described bet                         | Del.                               |  |             |                                |
| SIGNEO   |  | DATE  |                                 | SONED  |                                    |  | +           |                                |
| 14. DATE OF CURRENT SUMESS, BUSINEY, O   | W PREGNANCY (LMP) 10                         | LOTHER DATE NAM , DO  | **                              | IS DATES PATIENT UNIX                          | BLE TO WORK IN CUIT                | HENT OCCUPATION                                | 4           |                                |
| 17. NAME OF REFERRING PROVIDER OR C  |  | UAL   |                                 | FROM   | 10                                 |  |             |                                |
| 17. INVIECO PER EINING PROPERTIES  |  | Tis. NAPE   |                                 | A HOSPITALIZATION OF                           | TO TO                              | M CO YY  |             |                                |
| 19. ADDITIONAL CLASS INFORMATION (Des  |  | alasi -   |                                 | 20 OUTSIDE LAB?                                | \$ CHW                             | oes  | - 1         |                                |
|  |  |   |                                 | VES NO   |                                    |  |             |                                |
| 21. DIAGNOSIS OR NATURE OF ILLNESS O   | R DULISHY Relate A-L to be                   | rice ine betw (24E) ICD Ind.  |                                 | ZZ RESUBHISSION                                | OPIGNAL REF.                       | NO.  |             |                                |
| A  | c  |   |                                 | 23 PRIOR AUTHORIZATI                           | ON NUMBER                          |  |             |                                |
| EL   | 0  | M.L.  |                                 |  |                                    |  |             |                                |
| 24. A. DATE(S) OF SERVICE  |  | EDUALS, SERVICES, ON SUPPLIES                                       | DIAGNOSIS                       | F  | G H I                              | RENDERING                                      | ×           |                                |
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|  |  |   |                                 |  | - THE                              |  | 12          | •                              |
|  |  | 4 1 1 1   |                                 |  | NPI                                |  | 8           | Box 24J                        |
|  |  |   | 1 1                             |  | MPI                                |  | 8           |                                |
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| 25 FEDERAL TAX LD MARKER SIST  | EN 25 PATIENTS                               | ACCOUNT NO 27 ACCEPT.   | ASSIGNMENT?                     | IS TOTAL CHARGE                                | 29. AMOUNT PAID                    | 36. Revel for NUCC L                           |             | Group NPI,                     |
|  |  | YES   | NO                              | 1  | 5                                  |  |             | Box 33a                        |
| 21. SIGNATURE OF PHYSICIAN OR SUPPLE<br>INCLUDING DEGREES OR CREDENTIAL                        | 5  | ACILITY LOCATION INFORMATION  |                                 | IS BILLING PROVIDER IN                         | WOAPH#                             | )  |             | טטע טטמ                        |
| () certify that the statements on the reverse<br>apply to this bill and are made a part thereo | ()   |   |                                 |  |                                    |  |             |                                |
|  |  |   |                                 |  |                                    |  |             |                                |
|  |  |   |                                 |  |                                    |  |             |                                |