HNS Crib Sheet - Paper Claims

This crib sheet provides important information regarding secondary, corrected and voided claims, as well as helpful information regarding what information is required in the various boxes of a claim form.

Prior to submitting paper claims, please carefully check your completed claim form against this checklist.

Please contact your HNS Service Representative if you have any questions regarding the information on this form. The name, phone number and email address for your Service Rep can be found on the home page of the secure portal (the dashboard) of the HNS Website.

I. Paper Claims:

Which Claims Should be Sent by Paper?
With few exceptions, ALL primary claims must be sent to HNS electronically (either via HNSConnect® or Office Ally®).

Information regarding primary claims which must be sent by paper can be found in the Quick Reference Guides provided for each HNS contracted payor, which are located under the Billing/Solutions section of the HNS Website.

CMS 1500 Claim Form
When it is necessary to submit a paper claims, paper claims must be submitted on the revised CMS 1500 Claim Form, version 2/12.

The following claims must be submitted as paper claims to HNS (and must be submitted on the revised CMS 1500 Claim Form, version 2/12).

- Corrected Claims
- Secondary claims
- Voided Claims
- Claims with attachments

A. Corrected Claims
A corrected claim must be filed when you need to correct information provided on the original claim submitted. In other words, a corrected claim is a claim which includes information different from the information included on the original claim.
A corrected claim may ONLY be submitted once the payor has already adjudicated the original claim and you have received the EOB associated with that claim.

1. Requirements for Submission of All Corrected Claims:

- When creating a corrected claim, you must include ALL services lines/codes which were correctly included on the original claim, then add or remove any service lines which were not or should not have been submitted on the original claim.

- All corrected claims must be submitted by paper on the CMS 1500 claim form.

- All corrected claims must have the words “Corrected Claim” at the top of the claim form, in large bold letters.

- In addition to the above requirements, you must follow each payor’s specific requirements for corrected claims (below).

2. Payor-specific Requirements for Corrected Claims:

a. BCBS – Box 22
For BCBSNC claims (NC Providers), corrected claims must include BOTH the number 7 and the original claim number in box 22. The original claim number can be obtained in the provider’s remittances on the Electronic Explanation of Payment (EOP) and will be displayed on the EOP as "BCBS Claim Reference #".

b. HealthSpring – Box 22
For HealthSpring claims (for NC & SC providers), corrected claims must include BOTH the number 7 and the original claim ID in box 22. The original claim number can be obtained by contacting your HNS Representative.

c. Select Health- Box 22
For Select Health claims (SC providers), in box 22, corrected claims must include BOTH the number 7 and the claim number of the most recently processed claim. The claim number can be obtained by contacting your HNS Representative.

If the corrected claim is for a Select Health First Choice (Medicaid), you must include the preauthorization number submitted on the original claim in box 23.

d. Other Payors
For all other corrected claims, the claims must include BOTH the number **7** and the word “Corrected” in box 22, and the word “Corrected” at the top of the claim in large bold letters.

**B. Claims for Members with Primary & Secondary Coverage**

For ALL claims for members with 2 insurance plans, (both the primary and the secondary claims), the following boxes must always be completed.

- Box 11d
- Box 9a
- Box 9d
- Box 14

If you are filing to the **primary health care plan**, (primary claim), 11d must be marked “YES”, and boxes 9, 9a, and 9d must be completed with relevant information regarding the secondary plan.

If you are filing to the **secondary health care plan**, (secondary claim), 11d must marked “YES”, and boxes 9, 9a, 9d must be completed with relevant information regarding the primary plan, and box 14 (date of current illness/injury) must be completed.

**C. Secondary Claims**

1. Requirements for ALL Secondary Claims

   If the claim is a secondary claim:

   - Box 11d must be marked “Yes”.
   - Box 9, box 9a and box 9d must be completed with information regarding the **primary insurance** and the insured.
   - Box 14 (date of current illness/injury) must be completed.

   The **original** primary EOB must always be attached to the secondary claims.

   The claim should be clearly marked “Secondary” at the top of the page.

   The dates of service, charges, CPT codes and modifiers reported on the secondary claim must be **identical** to those shown on the primary EOB.

2. Medicare Crossovers
For most major payors, when Medicare receives a primary claim from a provider, Medicare processes the claim and systematically sends the EOB associated with the claim to the secondary healthcare plan (“crossover claims”).

When a provider submits a claim to Medicare, he/she correctly submits this under his/her own EIN. However, all health care plans which contract with HNS list each HNS Provider under the HNS EIN in their databases, and it is the HNS EIN that identifies the provider as an ‘in-network’ provider.

As a result, when Medicare crosses over a primary claim to an HNS contracted payor, the payor does not recognize the provider as an ‘in-network’ provider. As a result, you will receive either a claim rejection notification or an EOB from the secondary health plan showing the denial of the claim. If you receive a claim rejection notification, you must then file a secondary claim through HNS with the primary EOB denial attached.

If you receive an EOB denial or an EOB showing the crossover claim was processed as out of network, you will need to contact that payor and follow their directions on how to void the crossover claim. Once it is voided, you can submit the secondary claim to HNS, as normal.

3. Medicare primary / BCBS secondary
For NC providers, if BCBS (or another HNS contracted plan) is secondary and Medicare is primary:

If the provider has previously treated the patient for the same condition, then Box 15 also must be completed. In Box 15, use “Qual” code 454, and in the date field, enter the patient’s initial date of treatment.

D. Voided Claims
To direct a payor to void a previously submitted (and adjudicated) claim, please follow the directions below:

1. BCBS
For BCBSNC claims (NC Providers), voided claims must include BOTH the number “8” and the original claim number in box 22. The original claim number can be obtained in the provider’s remittances on the Electronic Explanation of Payment (EOP) and will be displayed on the EOP as "BCBS Claim Reference #". Please also include the word “Voided” at the top of the claim in large bold letters. Please remember, the services and charges listed on the “Void” claim must exactly match the original claim submitted.

2. Select Health
For Select Health claims (SC providers), voided claims must include BOTH the number 8 and the original claim number in box 22. The original claim number can be obtained by contacting your HNS Representative. Please also include the word “Voided” at the top of the claim in large bold letters.

3. All Other Voided Claims
For voided claims for ALL other payors (for both NC and SC providers), the word “Void” must be at the top of the claim form in large bold letters.

E. Claims with Attachments
For claims with any type of attachment, including but not limited to, office notes, subscriber ID card, etc., always write the word “ATTACHMENT” at the top of the claim form so that the payors (and HNS) know that there are additional pages attached to the claim.

II. Checklist - CMS 1500 Claim Form
While many boxes on the CMS 1500 Form require no explanation, prior to submitting paper claims, please carefully check your completed claim form against the information provided below.

1. Box 1a (subscriber ID number)
For primary claims, Box 1a must include the subscriber ID number for the primary insurance.

For secondary claims, Box 1a must include the subscriber ID number for the secondary insurance.

Important Note:
An incorrect member ID number in box 1a of the claim form is the primary reason claims are returned for correction.

- At each visit, ask your patient if there has been any change to their insurance information, and if so, make a copy of their new ID card and promptly update your software with the new ID number.

- Make sure the member ID number in Box 1a is exactly as it appears on the member’s current ID card.

- When applicable (most BCBSNC plans), the member ID must include the relationship suffix. (Example: 01)

2. Box 2 (Name of patient)
Always complete box 2 with the name of the patient exactly as it appears on the subscriber ID card.

3. Box 4 (Name of insured)
Box 4 must include the name of the insured exactly as it appears in the payor’s database. If the patient is the insured, always put the name in box 4. (i.e. – you cannot use the word “same”)

4. **Box 6 (Patient relationship to insured)**
The relationship shown in box 6 must correlate to the names in boxes 4 and 2.

5. **Box 9, 9a and 9d (Other Insured’s Information)**
If the claim is a **secondary claim**, box 9, box 9a and box 9d must be completed with information regarding the primary insurance holder and the primary insurance. (Box 11d must also be marked “YES”.)

6. **Box 11 (Group number)**
All claims must have information in box 11. (HNSConnect® will reject claims which do not include a group number in Box 11 (Insured’s Policy Group Number). If the subscriber ID card does not show a group number:

- Except as noted below, use the alpha prefix of the subscriber’s ID number for the group number.

- If the plan is a **CIGNA TPA** plan, use the name of the TPA as the group number.

7. **Box 11c (Insurance Plan name)**
Box 11c must include the name of the insurance plan to whom the claim is to be sent (example: BCBS, CIGNA, HealthSpring, etc.)

**Important Note:**
If the claim is for a **CIGNA TPA** plan (third party administrator):
- HNS/CIGNA must be at the top of the claim form; and
- The name of the TPA must be in box 11c.

8. **Box 11d (Other health benefit plan)**
If the patient has more than one insurance, you must complete box 11d by marking “Yes”.

9. **Box 10a, 10b and 10c (Patient’s Condition is related to)**
Box 10a, 10b, and 10c must be completed on each claim form.

If Box 10b is marked “yes”, then “state” (NC, SC, etc.) must be provided on the claim form.

If box 10a, 10b or 10c is marked “yes”, then you must complete box 14 (date of current illness).

10. **Box 14 (Date of Current Illness/injury)**
If box 10a, 10b or 10c is marked “yes” box 14 must include the date of current illness/injury.
Date of current illness/injury cannot be after the date of service shown on the claim form).

Note: If the claim is a secondary claim and Medicare is primary, box 14 (date of current illness/injury) is required.

11. Box 15 (Other Date/Qual)
If box 10a, 10b or 10c is marked “yes”, Box 15 “Qual” must be completed with Qualifier “439” (accident) as well as the date of the accident/injury (the same date as the date in box 14)

If Medicare is Primary:
For NC providers, if BCBS (or another HNS contracted plan) is secondary and Medicare is primary, if the provider has previously treated the patient for the same or similar issue, then Box 15 also must be completed. In Box 15, use “Qual” code 454, then in the date field, enter the patient’s initial date of treatment.

12. Box 17 (Referring Provider)
HealthSpring claims must include the name of the referring provider in Box 17 and the referring provider’s NPI number in box 17b.

13. Box 21 (a-l) Diagnoses
Diagnoses must be listed in order of importance.

Important Note: If the diagnosis code is 800 or greater,

- Box 10 (Patient condition) must reflect an accident or injury, AND
- Box 14 (Date of Current Illness/Injury) must be completed AND
- Box 15 (Qual) must be completed including the date and qualifier 439 (accident).

Important Note: For ICD-10 codes, if the diagnosis code indicates an injury:

- Box 10 (Patient condition) must reflect an accident or injury, AND
- Box 14 (Date of Current Illness/Injury) must be completed AND
- Box 15 (Qualifier “439 (accident)” must be included, as well as the date of the accident/injury.)

14. Box 22 (Resubmission code/claim reference number)
Please see requirements for box 22 in Sections 1A and 1D of this document (corrected and voided claims) for information regarding the resubmission code and original reference number.

15. Box 23 (Prior Authorization Number)
Select Health First Choice (Medicaid) claims must include prior authorization number in box 23.
16. **Box 24A (Date of Service)**
Claims can only include dates from the same calendar year. Separate claims must be submitted if the dates of service include different years.

17. **Box 24E (Diagnosis Pointer)**
Alpha diagnosis pointers are required (numbers are no longer accepted). Make sure the pointers correctly reference only those diagnosis codes shown in box 21.

18. **Box 24F (Charges)**
The claim must include a charge for each service line, including G codes. (For G codes, enter $00.00.)

19. **Box 24G (Units)**
While the correct number of units must be accurately reported in box 24G, for each service line on the claim, box 24G must show a minimum of 1 unit. (This includes G codes.)

20. **Box 24J (Rendering Provider ID #)**
For each line on the claim form for which a service is reported, the Type 1 NPI number of the provider who rendered the service must be in Box 24J on the claim form.

   Exception: if services were provided by a locum tenens (fill-in) provider, box 24J must reflect the Type 1 NPI of the HNS participating provider who hired/contracted with the locum tenens doctor.

21. **Box 25 (Provider's Federal tax number)**
Box 25 must include the provider’s federal tax number (EIN). This number must be the same EIN that is linked to the practice location reported in box 32 on the claim form. Please do not use the HNS EIN in box 25.

22. **Box 26 (Patient account number)**
The patient account number must be included in box 26. (The account number is required to produce the HIPAA 835 file for auto-posting of payments and must be included on the claim form, regardless of whether your practice utilizes the 835 auto-posting file.)

23. **Box 28 (Total charges)**
As a general rule, total charges in box 28 must be the sum of all charges reflected under column 24F on each claim form.

   Exception: for BCBS claims, if the number of services you are reporting exceed the maximum of 6 service lines allowed per claim, and are for multiple dates of service, additional services must be listed on a second claim. In such cases, do not put the total charges in box 28 on the 1st claim; instead, write the word “Continued” in box 28, and put the total charges for both claims in box 28 on the
second claim. Additionally, mark the first claim “page 1 of 2” and mark the second claim “page 2 of 2”.

24. Box 31 (Provider’s name)
The name of the rendering provider must be included in box 31 (cannot use “signature on file”).

Exception: if services were provided by a locum tenens (fill-in) provider, then box 31 must reflect the name of the HNS participating provider for whom the locum tenens doctor is working.

25. Box 32 (Service Facility Location Information)
The name and address of the practice location where the services were provided must be included in box 32.

For providers with more than one location and more than one federal tax number, the EIN reported in Box 25 must be specific to the location shown in Box 32.

26. Box 32a (NPI number)
If the provider has a Type 2 NPI number, enter the Type 2 number here, if no Type 2 NPI, enter the provider’s Type 1 NPI number here.

27. Box 33 (Billing Provider Information)
The name and address of the billing provider must be included in box 33, even when it is the same information as the information in box 32.