HNSConnect®

User Manual

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I. About HNSConnect®

HNSConnect® is the secure portal of the HNS Website and access to it is limited to HNS Providers and those individuals to whom the provider has given access.

This section of the website includes HNS' state-of-the-art web-based application that allows HNS to securely receive claims and deliver remittance information 100% electronically. HNSConnect® also includes contact information for your HNS Service Representative, payor fee schedules, board certified online continuing education, and much more.

The HNSConnect® User Manual is intended to help you easily navigate this section of the HNS website with particular emphasis on the submission of electronic claim files via HNSConnect®.

A. Accessing HNSConnect®

You must enter your specific username and password to access the secure portal. To do so:

1. Open your Internet Browser and navigate to https://www.healthnetworksolutions.net/.

2. Click on **Secure Portal**.

3. Enter your unique username and password.
   (If you have not created your username and password, please contact your HNS Service Representative.)

   Please Note: usernames and passwords are case sensitive.

4. In order to be HIPAA compliant, always exit the program by clicking **Logout** and closing the browser window when you are finished using HNSConnect®.

B. Forgot Username and/or Password

If you have forgotten your username or password, please follow the instructions below:

1. Open your Internet Browser and navigate to https://www.healthnetworksolutions.net/.

2. Click on **Secure Portal**.

Username:
If you have forgotten your username, click the Forgot username? link on the Provider Login screen. When prompted, enter the ***Provider Email Address*** on file with HNS and your Type I NPI number, then click Submit.

An email will be sent to the ***Provider Email Address*** on file with HNS. Within the email will be the username associated with your HNSConnect® provider account.

Password
If you have forgotten your password, click the Forgot password? link on the Provider Login screen. When prompted, enter the username associated with your HNSConnect® provider account and click **Reset Password**.

An email will be sent to the ***Provider Email Address*** on file with HNS. Within the email will be a link to reset the password for your account. Click on the link, and it will walk you through the process.

3. Once reset, please attempt to login with your existing username and newly created password.

4. If you are unable to gain access to HNSConnect® using these instructions, please contact your HNS Service Representative.

II. Dashboard Options

Logging in to HNSConnect® takes you to the "**Provider Dashboard**". Created for your convenience, the dashboard provides quick links and menu options for easy access to information and workflow processes you will frequently need.

Here is some helpful information regarding the dashboard:

1. **Send Claims:**
   This option allows the user to upload a 5010 837p claim file created by your practice management software.

2. **HNS Service Representative (Questions?):**
   This section includes the name of your personal HNS Service Representative and his/her contact information, including a quick link for sending an email to him/her.

3. **Fee Schedules:**
   All current HNS contracted payer fee schedules can be accessed by clicking on the links within this section.

4. **Claim Status:**
   This section offers users a quick glance at the status of the most recent claim files submitted to HNS, and displays a status of either "Received, Processing or Error". **Claims that show "Error" should be promptly corrected and resubmitted.**

   Whether the file includes only 1 claim or many, claim files are referred to as "batch files", and each claim file submitted to HNS is assigned a batch ID number. Clicking on the Batch ID for any file listed here will navigate the user to the File Summary page for that file allowing you to quickly make corrections and resubmit claims in error.

5. **Recent HNS Remittance:**
   Details for the most recent HNS Remittance are displayed in this section with quick links to print the associated EOB, HNS Provider Statement or to download the associated 835 file for auto-posting.

6. **Search Claims:**
   This section offers users the ability to quickly search for submitted claims using basic search criteria. There is also an Advanced Search link in this section to quickly navigate to the Search Claims page where more search criteria may be entered.

7. **HNSConnect® Logo:**
   Clicking on the HNSConnect® logo in the upper, left-hand corner of the screen will return the user to the dashboard. This logo is present throughout the Secure HNS Portal for your convenience.

III. Main Menu Options

The main menu options are displayed in the red bar across the top of the page and can be accessed from all pages throughout the Secure HNS Portal.

Below is an overview of the information accessible throughout these menu options:

1. **Provider Home:**
   Clicking on this menu item will allow the user to leave HNSConnect® and return to the Provider homepage of the HNS website.

2. **Claims:**
   Items in this drop-down menu allow the user to send, search, and check status of claims submitted via HNSConnect®.

3. **Remittances:**
   Clicking on this menu item takes the user to a complete list of HNS Remittances with quick links to print the HNS Provider Statements/HNS Summary and EOBs or download the 835 files for auto-posting for each remittance.

4. **Fee Schedules:**
   All HNS contracted payer fee schedules can be accessed via this drop-down menu.

5. **Education:**
   This menu provides access to the online Continuing Education courses offered by HNS. Note: You must be logged in using PHYSICIAN username & password to receive credit for the quizzes.

6. **Initial Training:**
   This menu provides access to the online training modules required of all newly credentialed physicians. Note: You must be logged in using PHYSICIAN username & password to receive credit for the quizzes.

7. **Annual Compliance Training:**
   This menu provides access to the Annual Compliance Training required of all contracted physicians each year. Note: You must be logged in using PHYSICIAN username & password to receive credit for the quizzes.

8. **Account Management:**
   By clicking the profile icon in the upper, right-hand corner of the dashboard, a drop-down menu offers the provider the ability to view and/or make changes to his/her HNSConnect® physician account, including:

   - Viewing Current Account Info (changing/adding email addresses)
   - Changing password

- Changing bank account information for EFT
- Adding additional users
- Changing profile picture if desired
- Logging out

IV. Filing Claims to HNS

All claims, both paper and electronic, must be identified in the address section at the top of the claim form, with HNS, *the name of the specific healthcare plan*, and the HNS address, and *must be displayed exactly as shown in the examples below*.

HNS/BCBS
PO Box 2368
Cornelius, NC 28031

HNS/Select Health
PO Box 2368
Cornelius, NC 28031

With few exceptions, all claims must be submitted *electronically* to HNS.

The following claims **must be sent by paper** to HNS using the CMS 1500 claim form:

- Tertiary claims
- Corrected/Voided secondary claims
- Corrected/Voided tertiary claims
- Claims with attachments (such as office notes)
- Claims for specific CIGNA TPA Plans
  (Please refer to the list of TPA plans in the CIGNA Quick Reference Guide on the HNS Website under 'Billing/Claims Support', which must be sent via paper claims.)
- Claims rejected for invalid first name
  (Claims submitted electronically to HNS for which the provider received an HNS Electronic Error Report indicating the first name was not valid.)

All claims for all covered services provided to members whose healthcare plans contract with HNS must be filed through HNS. *Filing claims directly to a payor will result in the rejection and/or denial of the claims.*

All payors have timely filing policies regarding when claims must be filed. To prevent denials for timely filing, it is essential that providers become familiar with each payor's timely filing policies. These are posted on the public-facing section of the website, under **HNS/Payor Policies**, then "**Timely Filing**".

For claims that may be filed electronically, HNS accepts them via the following methods:

1. **HNSConnect®**
   HNSConnect® was designed to allow providers to submit 837p electronic claim files created by their software system, and to upload those files to HNSConnect®.

   The 837p electronic claim file format is dictated by Electronic Data Interchange (EDI) and Health Insurance Portability and Accountability Act (HIPAA) regulations. One of these regulations require the healthcare industry to use standard formats for electronic transactions, including the HIPAA-compliant 5010 837p claim file.

   With few exceptions, all claims must be filed electronically to HNS.
   (Exceptions can be found under Billing/Claim Support on the public-facing HNS Website. From this section, review each healthcare plan's Quick Reference Guide.)

2. **Office Ally™**
   As a general rule, HNS requires all providers to submit claims electronically to HNS via submission of the 837p claim file to HNSConnect®.

   Only those providers whose practice management software cannot produce the required 837p claim file for upload to HNS are allowed to submit claims to HNS via Office Ally™ and doing so requires express permission from HNS.
   (HNS does not accept claims from any other clearinghouse.)

3. **Manual Entry**
   This menu option allows the user to create a new claim using a blank form similar to the CMS 1500 for submission through the HNSConnect® secure portal. While you may file claims to HNS by manually entering claim data in HNSConnect®, this option was designed for use when a practice management software is temporarily unavailable and is not an efficient method for the routine submission of claims.

V.Manual Entry (CMS 1500)

This option allows the user to create and submit a claim using a blank form similar to the CMS 1500 for submission through the HNSConnect® secure portal. While you may file claims to HNS by manually entering claim data in HNSConnect®, this option was designed for use when a practice management software is temporarily unavailable and is not an efficient method for the routine submission of claims.

Filing Manual Claims via HNSConnect®:

1. Click on **Manual Entry (CMS 1500)** from the Claims drop-down menu.

2. On the New Claim page, complete all required fields based on the insurance plan of the patient.

3. When all claim information has been successfully entered, click **Submit Claim**.

4. Print out confirmation page.

VI. Electronic Claim Files (837 Files)

This section of the *HNSConnect® User Manual* will focus on the submission of 837 claim files via HNSConnect®.

A. Getting Started

Before you get started submitting your 5010 837p claim file through HNSConnect®, HNS recommends that you do the following:

1. Make sure your billing software has a current listing of CPT and ICD codes.

2. Make sure your computer system has a current version of security software and anti-virus software.

3. Make sure you have appropriate back-up systems in place which will allow you to restore data should it be lost.

4. Make sure your system does not include the use of special characters. Special characters will result in an error back to the provider if any of the following are used:

    - slashes or dashes in dates (date of birth, date of onset, date of service, etc.)

    - invalid characters in either patient name or name of insured (last, first, and MI)

    - ! @ # $ % ^ & * ( ) + = {} [] ; : " < > ? /\ | ~

5. Only claims for services provided to patients whose health care plans contract with HNS should be uploaded to HNS. A complete list of current contracts ("HNS Contracts") is available under **Services/Solutions** on the public-facing HNS website.

B. Information required to Provide your Software Vendor

Please ensure you have a *complete list of all HNS Payor Contracts*. For each payor, set up is as follows:

- For the "**receiver**" or the "**Payor ID**", use the HNS EIN, which is **561971088.** (If the field only allows 5 digits, use first 5 digits of HNS' EIN…)

- If your software requires an "**Identifier Qualifier**" or "**Primary Identifier**" always use HNS' EIN (56-1971088).

- Further, if your software requires "**specialty"** code (or **taxonomy code**, for all Chiropractors, that number is **111N00000X**

C. Testing

After you (or your software vendor have completed setting up your software, then:

Print out a paper claim
Before beginning to transmit claims, first test your billing software (practice management software) by printing out a paper claim and ensure that all data is properly located in each field. If your paper claim data is not correct, most likely your electronic claim data will not be correct.

Submit a "test" file
Before you begin the routine submission of claim files to HNSConnect®, and prior to submitting a large claim file, HNS recommends you submit a "test" claim file, with only 1-3 claims in the file. Within 24 hours of submission, log on to the secure portal, and on the dashboard page, check under "**Claim Status**" to see if the claim(s) came through, and shows "Received, Processed or Error". If so, you should be able to proceed with routine submission of your claim files. If NOT, please contact your software vendor for assistance. Once they have resolved the issue, then submit another test file to confirm.

D. Submitting 837 Files via HNSConnect®

First, as previously noted, make sure you only create batch files for the insurance companies with whom you participate through Health Network Solutions, Inc. Your software vendor should assist your office in setting up custom filters in your practice management software in order to create batch files for HNS payers.

When ready to submit claims, please follow these steps:

1. Open your Internet Browser and navigate to https://www.healthnetworksolutions.net/.

2. Click on **Secure Portal**.

3. Enter your username and password and click **Log in**.

4. Either on the dashboard or from the Claims drop-down menu, click **Send Claims**.

5. On the Send Claims page, click **Choose File**.

6. Navigate to the location of the file you wish to submit. If unsure of this location, contact your software vendor for assistance.

7. Select the desired file and click **Open.**

8. Locate the claim file you wish to submit.

9. On the Send Claims page, click **Upload**.

Please wait until the confirmation page appears. If you close the window before this, you will lose connection with HNSConnect® and the file may not be uploaded.

E. Claim File Confirmation

Once the claim file is uploaded successfully, a confirmation page is displayed. HNS strongly recommends that you print and save this page for future reference.

Please allow 24 hours before checking file status.

After you have successfully uploaded a claim file, you can start over and send another claim file or check the claim status page to see previous claim files for errors. You may also search claims or enter individual claims. Please use your Claims drop-down menu to navigate through this section.

F. HNSConnect® Edits

HNSConnect® includes numerous advanced data validations (edits) to facilitate the submission of “clean claims”, resulting in fewer denials, and improved cash flow.

Customized edits identify claims with certain missing or incorrect information, allowing you to quickly correct errors and resubmit the claim. (When a claim does not meet the data validations, the claims will appear in “Error” status.)

G. Electronic Corrected Primary Claims

A corrected claim is a claim which includes information different from the information included on the original claim.

A corrected claim must be filed when you need to correct information provided on the original claim submitted *after that claim has been adjudicated by the payor*.

A corrected claim may ONLY be submitted once the payor has adjudicated the original claim and you have received the EOB associated with that claim.

Requirements & Edits for Electronic Corrected Primary Claims:

- When submitting a corrected primary claim, **you may only submit one date of service per claim.**

- When creating a corrected primary claim, you must include ALL service lines/codes *for the specific date of service*, 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.

- Electronic corrected primary claims must include BOTH the number **7** and the original claim reference number in box 22. The original claim reference number can be obtained in the provider's remittances on the Electronic Explanation of Payment (EOP) as "***Payor* Claim Reference #**".

H. Electronic Voided Primary Claims

A voided claim is a claim which was submitted in error and needs to be eliminated in its entirety.

A voided claim may ONLY be submitted once the payor has adjudicated the original claim and you have received the EOB associated with that claim.

Requirements & Edits for Electronic Voided Primary Claims:

- When submitting a voided primary claim, **you may only submit one date of service per claim**.

- The services and charges listed on the voided claim must exactly match the services and charges on the original claim submitted.

- Electronic voided primary claims must include BOTH the number **8** and the original claim reference number in box 22. The original claim reference number can be obtained in the provider's remittances on the Electronic Explanation of Payment (EOP) as "***Payor* Claim Reference #**".

I. Electronic Secondary Claims

1. Requirements for submission of Secondary Claims

To submit your secondary claims electronically, please ensure you meet the following submission guidelines:

- Box 9, box 9a and box 9d must be completed with information regarding the *primary insurance* and the insured.

- Box 11c must show the name of the healthcare plan to which the claim is to be sent.
- Box 11d must be marked “Yes”.
- Box 14 (date of current illness/injury) must be completed.
- The original primary EOB must always be attached to the secondary claims.
- The dates of service, charges, CPT codes and modifiers reported on the secondary claim must be *identical* to those shown on the primary EOB.
- Always choose the ***most appropriate*** primary insurance type/payor.
- Remember to include the date the primary claim was paid.

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 be 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.

2. About 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”).

While some out-of- state plans will correctly process these crossover claims, many healthcare plans which contract with HNS will deny these crossover claims or will process them incorrectly.

This is why:
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, often when Medicare crosses over a primary claim to an HNS contracted payor, the payor does not recognize the provider as an ‘in-network’ provider. When this occurs, the payor will either reject, deny, or process the claim as ‘out-of-network’.

- If the payor rejects or denies the claim, you must then file a secondary claim through HNS with the primary EOB denial attached. **(See Section F.1 above (Secondary Claims).**

- If the payor processes the claim as *out-of-network*, you must contact that payor and follow their directions on how to void the crossover claim. Once it is voided, you must submit the secondary claim to HNS, as normal.

3. Medicare primary / HNS Plan is Secondary

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

- Box 9, box 9a and box 9d must be completed with information regarding the *primary insurance* and the insured.
- Box 11d must be marked "Yes".
- Box 14 (date of current illness/injury) must be completed.
- The original Medicare primary EOB must always be attached to the secondary claim.
- The dates of service, charges, CPT codes and modifiers reported on the secondary claim must be *identical* to those shown on the primary EOB.
- 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.
- Always choose the ***most appropriate*** primary insurance type/payor.
- Remember to include the date the primary claim was paid.

J. Duplicate Claim Edit

In addition to other edits, HNSConnect® has edits intended to prevent the submission of a claim which was previously submitted. HNS refers to this as a "duplicate edit".

Once we identify claims that have previously been submitted through HNSConnect®, those claims will appear as errors and will not be transmitted to payers. The following information is used to determine if a claim is a duplicate:

1. Payer
2. Insured's ID
3. Patient Date of Birth
4. Date of Service
5. CPT code
6. CPT modifier
7. Diagnosis

If a claim is in error for "**Duplicate Claim**", the current claim cannot be submitted

electronically unless the previous submission is located and deleted.

To remove the current claim in error (or the previously submitted claim), click **Delete Claim** and click **OK** to confirm.

Notes:

- Some claims that have errored back on HNSConnect® may have to be submitted to HNS via a paper claim. If unsure, contact your HNS Service Representative.

- As applicable, in order to prevent the same errors from occurring again on future claims for the patient, please correct the error in your practice management software as well as on HNSConnect®.

K. Group Number Edit

HNSConnect® will reject claims which do not include a group number in Box 11 (Insured's Policy Group Number).

Should the subscriber ID card not show a group number, as a first step, HNS recommends that you contact the plan and ask if there is a group number. If so, enter the number provided to you.

If the plan states there is NO group number, please do the following:

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

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

L. Status of Each Claim File

To help providers know the status of claim files submitted to HNS, and whether the claim file included any claims with errors, HNS assigns a "status" to each claim file (batch).

Each batch is assigned one of the following statuses.

- **Received**
  A status of "received" is assigned once the batch has been successfully uploaded to HNSConnect®, but it is still in the processing stage.

- **Processed**
  A status of "processed" is assigned when all claims submitted within a batch are error free and have been processed successfully.

- **Error**
  A status of “error” is assigned if there are ANY claims within the claim file with an error. (Claims with errors should be promptly corrected and resubmitted.)

M. When to Check Claim Status

Always allow 24 hours after the submission of a claim file BEFORE checking claim status.

Claims in error status will not be transmitted to the applicable payor until the error has been corrected and the claim has been successfully resubmitted to HNSConnect®.

N. How to Check Claim Status

While the “Check Status” tab on the dashboard allows you to view the status of the 3 most recently submitted claim files, to view and check status of any claim file, from the main menu, click on **Claims**, and from the dropdown box, click on **Check Status**.

On the Check Status page, all batches submitted through HNSConnect® are listed with batch details including batch ID, date received, status, number of correct claims, number of claims in error, and total number of claims in the batch.

Click on the Batch ID number to view the batch details for the selected batch.

The batch detail screen consists of three sections:

- **File Summary** – an overview of the batch details including the batch ID, the date sent, the practice name, the total batch amount, the batch status, the total number of claims in the batch, the number of correct claims, and the number of claims in error.

- **Claims with Errors** – details of all claims within the batch which are pending processing due to errors including patient name, date of service, payer, claim total, and the option to correct the claim.

- **Patients in Current File** – details of all claims within the batch including the claim ID, date of service, payer, patient account number, insured name, patient name, and claim total.

O. Correcting Claims

When you find you have claims with errors, those claims must be corrected in order to be transmitted to the insurance company. Use the following steps to correct and resubmit your claims with errors:

1. Click on **Check Status** from the Claims drop-down menu.

2. To view only batches containing errors awaiting correction, click the **View Batches with Errors** box.

3. Click on the Batch ID number of a batch containing errors to view the batch details for the selected batch.

4. In the Claims with Errors section, click on the **Correct This Claim** button to pull up the Claim Details page for the first claim in error.

5. In the Claim Errors section of the Correct Claim page, review the Error Description. For many errors, you can click on the red/underlined Error, and you will be taken directly to the field containing the invalid information.

6. Correct the claim by providing the required information.

7. Once corrected, click **Submit Claim**.

8. Repeat this process for all Claims with Errors within the batch.

9. If the claim is in error for "**Duplicate Claim**", the current claim cannot be submitted unless the previous submission is located and deleted. To remove the current claim in error (or the previously submitted claim), click **Delete Claim** and click **OK** to confirm.

Note: In order to prevent the same errors from occurring again on future claims, please correct the error in your practice management software as well as on HNSConnect®.

P. Search Claims

This option allows users to search for claims that have been submitted to HNSConnect®.

Note: If claims are submitted to HNS via Office Ally™, those claims will not be in HNSConnect®. However, remittances associated with those claims WILL be in HNSConnect®.

1. Click on **Search Claims** from the Claims drop-down menu.

2. The following fields can be used in any combination to search for claims:

    - Provider
    - Patient Last Name
    - Patient First Name

- Date of Service (mm/dd/yyyy)
- Patient DOB (mm/dd/yyyy)
- Insured's ID Number
- Claim ID
- Batch ID
- Date Submitted (mm/dd/yyyy)

3. Enter search criteria and click the **Search** button to apply the criteria to execute the search.

Q. Search Results

This section displays the claims found with the search criteria applied.

1. Claims Results are displayed in a table with claim submission information including claim ID, batch ID, insured last name, insured first name, patient last name, received date, and date of service.

2. Click on the **Claim ID** to view the Claim Details for the selected claim.

3. Within the View Claim screen, no information can be changed, but you can confirm what was submitted on the claim.

VII. Paper Claims

All claims, both paper and electronic, must be identified in the address section at the top of the claim, with "HNS" *the name of the specific healthcare plan*, and the HNS address, and *must be displayed exactly as shown in the examples below*.

Examples:

HNS/BCBS
PO Box 2368
Cornelius, NC 28031

HNS/Select Health
PO Box 2368
Cornelius, NC 28031

A. Which Claims Should be Sent by Paper?

With few exceptions, **ALL** claims must be sent to HNS electronically (either via HNSConnect® or Office Ally™). HNS accepts primary, secondary, and corrected/voided primary claims electronically.

The following claims **must be sent by paper** to HNS using the CMS 1500 claim form:

- Tertiary claims
- Corrected/Voided secondary claims
- Corrected/Voided tertiary claims
- Claims with attachments (such as office notes)
- Claims for specific CIGNA TPA Plans
  (Please refer to the list of TPA plans in the CIGNA Quick Reference Guide on the HNS Website under 'Billing/Claims Support', which must be sent via paper claims.)
- Claims rejected for invalid first name
  (Claims submitted electronically to HNS for which the provider received an HNS Electronic Error Report indicating the first name was not valid.)

B. Requirements for Paper Claims

1. All paper claims must be submitted on the CMS 1500 Claim form.

2. All paper claims must be typed (do not hand write).

3. Claims must be formatted properly to fit in the space or blank shown on the form.

4. Number of Services Listed on a Paper Claim:

   The CMS 1500 claim form allows for a total of 6 services per claim. If more than 6 services are performed on a single visit, the remaining services must be listed on a separate claim form. However, importantly, on the first claim form (which shows 6 services) in **box 28 (total charges), you must write in "Continued".** *Do not list the total of the charges shown on the claim in box 28 on this claim.* Then on the 2nd claim form in box 28 you must write the total of all charges shown on both claim forms.

   Further, at the top of the first claim, write "Claim #1 of 2" and at the top of the 2nd claim form, write "Claim 2 of 2".

C. Payor-specific Requirements for Paper Claims

Absolute Total Care (ATC)

ATC will only accept paper claims which are typed, and which are submitted on the red/white CMS 1500 Claim Form. (ATC will deny all claims which are handwritten, or which are not submitted on the red/white CMS 1500 form.)

The taxonomy qualifier, **ZZ**, must appear in Box 24I. The taxonomy code, **111N00000X**, must be present in Box 24J, just above the rendering provider's NPI.

Additionally, Box 32 must contain the physical address of the practice, along with the group NPI number in Box 32a (if no group NPI, enter the provider's individual NPI). The taxonomy qualifier, **ZZ**, and the taxonomy code, **111N00000X**, must appear in Box 33b.

BlueCross BlueShield NC (BCBSNC)

Effective 08/08/2023, for the claims shown below, BCBSNC will only accept paper claims which are submitted on the **red/white CMS 1500 Claim Form. Effective 08/08/23,** BCBSNC will only accept paper claims submitted on an original red/white claim form. **No copied or scanned forms will be accepted.**

- Claims with Attachments, such as claims with office notes or subscriber ID cards
- Tertiary Claims
- Corrected Secondary or Corrected Tertiary Claims

These claims should be typed and must be mailed to HNS.

Just as you do now, you may continue to fax, email or mail to HNS your BCBS Secondary Claims, Corrected Primary Claims, and Voided Primary Claims if they cannot be sent electronically. Since those claims do not fall within one of the three categories shown above, you are not required to send those on a red/white CMS claim form.

Select Health

The taxonomy qualifier, **ZZ**, must appear in Box 24I. The taxonomy code, **111N00000X**, must be present in Box 24J, just above the rendering provider's NPI.

Additionally, Box 32 must contain the physical address of the practice, along with the group NPI number in Box 32a (if no group NPI, enter the provider's individual NPI). The taxonomy qualifier, **ZZ**, and the taxonomy code, **111N00000X**, must appear in Box 33b.

WellCare Medicare Advantage

WellCare will only accept paper claims which are typed, and which are submitted on the red/white CMS 1500 Claim Form. (WellCare will deny all claims which are handwritten, or which are not submitted on the red/white CMS 1500 form.)

The taxonomy qualifier, **ZZ**, must appear in Box 24I. The taxonomy code, **111N00000X**, must be present in Box 24J, just above the rendering provider's NPI.

Additionally, Box 32 must contain the physical address of the practice, along with the group NPI number in Box 32a (if no group NPI, enter the provider's individual NPI). The taxonomy qualifier, **ZZ**, and the taxonomy code, **111N00000X**, must appear in Box 33b.

D. CMS 1500 Claim Form

Please refer to **Section VIII** in this manual (***Checklist -CMS 1500 Claim Form***), regarding what information is required in the boxes on the form.)

E. Paper Corrected Claims

A corrected claim is a claim which includes information different from the information included on the original claim.

A corrected claim must be filed when you need to correct information provided on the original claim submitted *after that claim has been adjudicated by the payor*.

A corrected claim may ONLY be submitted once the payor has adjudicated the original claim and you have received the EOB associated with that claim.

1. Requirements for Submission of Corrected Claims:

- When submitting a corrected claim, **you may only submit one date of service per claim**.

- When creating a corrected claim, you must include ALL services lines/codes *for the specific date of service*, 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 which must be submitted by paper, must be submitted on the CMS 1500 claim form and must be typed.
- All paper corrected claims must have the words "**Corrected Claim**" at the top of the claim form, in large bold letters.

  Exception: claims which must be submitted on the red and white CMS Claim form cannot include any handwritten words, so do not include "Corrected" at the top of those claims.

- 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 (NC Providers), corrected claims must include BOTH the number **7** and the original claim reference number in box 22. The original claim reference 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. MedCost – Box 22

For MedCost (NC & SC Providers), corrected claims must include BOTH the number **7** and the original claim reference number in box 22. The original claim reference number can be obtained in the provider's remittances on the Electronic Explanation of Payment (EOP) and will be displayed on the EOP as "**MedCost Claim Reference #**".

c. HealthSpring – Box 22

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

d. Select Health – Box 22

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

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

The taxonomy qualifier, **ZZ**, must appear in Box 24 I. The taxonomy code, **111N00000X**, must appear in Box 24J, just above the rendering provider's NPI.

Additionally, Box 32 must contain the physical address of the practice, along with the group NPI number in Box 32a (if no group NPI, enter the provider's individual NPI). The taxonomy qualifier, **ZZ**, and the taxonomy code, **111N00000X**, must appear in Box 33b.

e. HealthTeam Advantage (HTA) – Box 22

For HTA (NC providers), corrected claims must include BOTH the number **7** and the original claim reference number in box 22. *The original claim reference number can be obtained by contacting your HNS Service Representative*.

f. Absolute Total Care (ATC) – Box 22

For ATC (SC providers), corrected claims must include BOTH the number **7** and the original claim reference number in box 22. The original claim reference number can be obtained in the provider's remittances on the Electronic Explanation of Payment (EOP) and will be displayed on the EOP as "**ATC Claim Reference #**".

Note: ATC will only accept corrected claims which are typed and *submitted on the red/white CMS 1500 claim form.* (ATC will deny corrected claims which are handwritten, or which are not submitted on the red/white CMS 1500 claim form.)

The taxonomy qualifier, **ZZ**, must appear in Box 24 I. The taxonomy code, **111N00000X**, must appear in Box 24J, just above the rendering provider's NPI.

Additionally, Box 32 must contain the physical address of the practice, along with the group NPI number in Box 32a (if no group NPI, enter the provider's individual NPI). The taxonomy qualifier, **ZZ**, and the taxonomy code, **111N00000X**, must appear in Box 33b.

g. WellCare Medicare Advantage – Box 22

For WellCare MA (SC providers), corrected claims must include BOTH the number **7** and the original claim reference number in box 22. *The original claim reference number can be obtained by contacting your HNS Service Representative.*

Note: WellCare will only accept corrected claims which are typed and *submitted on the red/white CMS 1500 claim form*. (WellCare will deny corrected claims which are handwritten, or which are not submitted on the red/white CMS 1500 claim form.)

The taxonomy qualifier, **ZZ**, must appear in Box 24 I. The taxonomy code, **111N00000X**, must appear in Box 24J, just above the rendering provider's NPI.

Additionally, Box 32 must contain the physical address of the practice, along with the group NPI number in Box 32a (if no group NPI, enter the provider's individual NPI). The taxonomy qualifier, **ZZ**, and the taxonomy code, **111N00000X**, must appear in Box 33b.

h. Other Payors – Box 22

For all other payors, corrected claims must include BOTH the number **7** and the word "Corrected" in box 22.

F. Paper Voided Claims

A voided claim is a claim which was submitted in error and needs to be eliminated in its entirety.

A voided claim may ONLY be submitted once the payor has adjudicated the original claim and you have received the EOB associated with that claim.

1. Requirements for Submission of Paper Voided Claims:

- When submitting a voided claim, **you may only submit one date of service per claim**.
- The services and charges listed on the voided claim must exactly match the services and charges on the original claim submitted.
- All voided claims which must be submitted by paper, must be submitted on the CMS 1500 claim form and must be typed.
- All paper voided claims must have the words "**Voided Claim**" at the top of the claim form, in large bold letters.

  Exception: claims which must be submitted on the red and white CMS Claim form cannot include any handwritten words, so do not include "Voided" at the top of those claims.

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

2. Payor-Specific Requirements for Voided Claims:

a. BCBS – Box 22

For BCBSNC (NC Providers), voided claims must include BOTH the number **8** and the original claim reference number in box 22. The original claim reference 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. MedCost – Box 22

For MedCost (NC & SC Providers), voided claims must include BOTH the number **8** and the original claim reference number in box 22. The original claim reference number can be obtained in the provider's remittances on the Electronic Explanation of Payment (EOP) and will be displayed on the EOP as "**MedCost Claim Reference #**".

c. HealthSpring – Box 22

For HealthSpring (NC & SC providers), voided claims must include BOTH the number **8** and the original claim reference number in box 22. *The original claim reference number can be obtained by contacting your HNS Service Representative.*

d. Select Health – Box 22

For Select Health (SC providers), voided claims must include BOTH the number **8** and the claim reference number *of the most recently processed claim* in box 22. *The claim reference number can be obtained by contacting your HNS Service Representative*.

If the voided claim is for a **Select Health First Choice (Medicaid), or a Select Health First Choice Next Plan that requires preauthorization,** you must include the preauthorization number submitted on the original claim in **box 23**.

The taxonomy qualifier, **ZZ**, must appear in Box 24 I. The taxonomy code, **111N00000X**, must appear in Box 24J, just above the rendering provider's NPI.

Additionally, Box 32 must contain the physical address of the practice, along with the group NPI number in Box 32a (if no group NPI, enter the provider's individual NPI). The taxonomy qualifier, **ZZ**, and the taxonomy code, **111N00000X**, must appear in Box 33b.

e. HealthTeam Advantage (HTA) – Box 22

For HTA (NC providers), voided claims must include BOTH the number **8** and the original claim reference number in box 22. *The original claim reference number can be obtained by contacting your HNS Service Representative*.

f. Absolute Total Care (ATC) – Box 22

For ATC (SC providers), voided claims must include BOTH the number **8** and the original claim reference number in box 22. The original claim reference number can be obtained in the provider's remittances on the Electronic Explanation of Payment (EOP) and will be displayed on the EOP as "**ATC Claim Reference #**".

Note: ATC will only accept voided claims which are typed and *submitted on the red/white CMS 1500 claim form.* (ATC will deny voided claims which are handwritten, or which are not submitted on the red/white CMS 1500 claim form.)

The taxonomy qualifier, **ZZ**, must appear in Box 24 I. The taxonomy code, **111N00000X**, must appear in Box 24J, just above the rendering provider's NPI.

Additionally, Box 32 must contain the physical address of the practice, along with the group NPI number in Box 32a (if no group NPI, enter the provider's individual NPI). The taxonomy qualifier, **ZZ**, and the taxonomy code, **111N00000X**, must appear in Box 33b.

g. WellCare Medicare Advantage – Box 22

For WellCare MA (SC providers), voided claims must include BOTH the number **8** and the original claim reference number in box 22. *The original claim reference number can be obtained by contacting your HNS Service Representative.*

Note: WellCare will only accept voided claims which are typed and *submitted on the red/white CMS 1500 claim form*. (WellCare will deny voided claims which are handwritten, or which are not submitted on the red/white CMS 1500 claim form.)

The taxonomy qualifier, **ZZ**, must appear in Box 24 I. The taxonomy code, **111N00000X**, must appear in Box 24J, just above the rendering provider's NPI.

Additionally, Box 32 must contain the physical address of the practice, along with the group NPI number in Box 32a (if no group NPI, enter the provider's individual NPI). The taxonomy qualifier, **ZZ**, and the taxonomy code, **111N00000X**, must appear in Box 33b.

h. Other Payors – Box 22

For all other payors, voided claims must include BOTH the number **8** and the word "Voided" in box 22.

G. Paper Secondary Claims

1. Requirements for submission of Secondary Claims

If a secondary claim must be submitted by paper:

- It must be submitted to HNS using the CMS 1500 claim form.
- It must be typed (not handwritten).
- It must be clearly marked "**Secondar**y" at the top of the page. **Exception:** for claims which must be submitted only on a red and white CMS 1500 claim form, do NOT write 'Secondary' on the top of the form.
- Box 9, box 9a and box 9d must be completed with information regarding the *primary insurance* and the insured.
- Box 11c must show the name of the healthcare plan to which the claim is to be sent.
- Box 11d must be marked "Yes".
- Box 14 (date of current illness/injury) must be completed.
- The original primary EOB must always be attached to the secondary claims.
- The dates of service, charges, CPT codes and modifiers reported on the secondary claim must be *identical* to those shown on the primary EOB.

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 be 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.

2. About 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").

While some out-of- state plans will correctly process these crossover claims, many healthcare plans which contract with HNS will deny these crossover claims or will process them incorrectly.

This is why:
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, often when Medicare crosses over a primary claim to an HNS contracted payor, the payor does not recognize the provider as an 'in-network' provider. When this occurs, the payor will either reject, deny, or process the claim as 'out-of-network'.

- If the payor rejects or denies the claim, you must then file a secondary claim through HNS with the primary EOB denial attached. **(See Section F.1 above (Secondary Claims).**

- If the payor processes the claim as *out-of-network*, you must contact that payor and follow their directions on how to void the crossover claim. Once it is voided, you must submit the secondary claim to HNS, as normal.

3. Medicare primary / HNS Plan is Secondary

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

- Box 9, box 9a and box 9d must be completed with information regarding the *primary insurance* and the insured.
- Box 11d must be marked "Yes".
- Box 14 (date of current illness/injury) must be completed.
- The original Medicare primary EOB must always be attached to the secondary claim.
- The dates of service, charges, CPT codes and modifiers reported on the secondary claim must be *identical* to those shown on the primary EOB.
- 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.

H. 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.

VIII.Checklist - CMS 1500 Claim Form

For all claims: In the address section at the top of each claim, "HNS" and *the name of the specific healthcare plan to whom the claim should be sent*, and the HNS address *must be displayed exactly as shown in the examples below*.

HNS/BCBS
PO Box 2368
Cornelius, NC 28031

HNS/Select Health
PO Box 2368
Cornelius, NC 28031

Formatting:
Claims must be formatted properly to fit in the space or blank shown on the 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.

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

For **secondary claim**s, Box 1a must include the subscriber ID number for the secondary insurance.

BCBS patients:
For most BCBSNC plans, the member ID must be a 14-digit number, which includes the 2-digit relationship suffix. (Example: 01)

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.

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

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")

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

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".)

Box 10a, 10b and10c (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).

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 either the alpha prefix of the subscriber's ID number OR the first 3 characters of the subscriber ID number.

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

- If the plan is a **WellCare Medicare Advantage** plan, use the word "WellCare" as the group number.

Box 11a
Box 11a must include the date of birth and sex of the insured.

Box 11b
You are not required to complete box 11b.

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.

Box 11d (Other health benefit plan)
If the patient has more than one insurance, you must complete box 11d by marking "Yes", and boxes 9, 9a, and 9d must be completed with the secondary insurance information. You also must indicate the most appropriate primary insurance type/payer and include the date the primary claim was paid/processed.

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.

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.

Box 17 (Referring Provider)
If a healthcare plan requires a referral from the patient's primary care provider (PCP), the claim must include the name of the *referring* provider in Box 17 and the referring provider's NPI number in box 17b.

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.)

Box 22 (Resubmission code/claim reference number)
Please see requirements for box 22 in the Electronic Corrected/Voided Primary Claims (pp. 15-16) and Paper Corrected/Voided Claims (pp. 24-28) sections of this manual for information regarding the resubmission code and original claim reference number.

Box 23 (Prior Authorization Number)
Select Health First Choice (Medicaid) claims and Select Health First Choice Next claims that require it, must include prior authorization number in box 23.

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.

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*.

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

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.)

Box 24I (Taxonomy Qualifier)
FOR SELECT HEALTH, ATC, ATC WELLCARE PAPER CLAIMS ONLY- Enter the taxonomy qualifier, **ZZ**.

Box 24J (Taxonomy Code)
FOR SELECT HEALTH, ATC, ATC WELLCARE PAPER CLAIMS ONLY- In the line just above the rendering provider NPI, the taxonomy code, **111N00000X**, must be present.

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.)

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.

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.)

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.

If there were more than 6 services provided, then the extra services must be listed on a second claim form. If this occurs, you must write "Continued" in box 28 instead of the total charges, and on the 2nd claim form, in box 28, you show the total charges for both claims.

Exception: for **BCBS** claims, if the number of services you are reporting exceeds 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".

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.)

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.

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.

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.

Box 33b (Taxonomy Qualifier and Taxonomy Code)
FOR SELECT HEALTH, ATC, ATC WELLCARE PAPER CLAIMS ONLY- Enter the taxonomy qualifier, **ZZ**, and the Chiropractic taxonomy code, **111N00000X**.

IX. Sending Claims to Payors

A. Claims Submitted Electronically

Once successfully processed by HNSConnect®, claims are imported into HNS internal systems for transmission to contracted health care payers. This process occurs every thirty minutes throughout the day.

All claims which are successfully imported to HNS internal systems prior to 12 midnight each day are transmitted to payers on the following business day. Once transmitted to the various payors, HNS confirms the successful transmission of the claim files via individual payer confirmation/audit reports.

B. Health Plan Front-end Edits

Similar to the edits on HNSConnect®, contracted health care plans have various front-end edits which are intended to identify "problem" claims BEFORE the payor accepts the claim for processing. When HNS attempts to transmit claims each day, and the payor's system identifies a problem claim, the payor rejects the claim.

When this occurs, HNS will notify the provider via the *HNS Electronic Error Report*. (See below, Section VII C).

Below are the most common reasons the payor rejects a claim when HNS attempts to transmit it:

1. **Invalid or Incomplete Member ID Number** – submitting claims with an incorrect or incomplete member identification number in box 1A on the CMS 1500 claim form is the number ONE reason that insurance companies reject your claims when HNS attempts to transmit your claims. There can be several reasons for denials associated with a member's ID number such as:

    - Failing to include any suffix (such as "01") that appears on a member's ID card.
    - Incorrectly entering the member's ID.
    - Transposing numbers when completing box 1A.
    - Failing to include alpha prefixes.
    - Member presents with an invalid insurance card.

2. **Member ID number not valid *for date of service*** – many front-end edits are because the member has no coverage on the dates of service shown on the claim.

Remember: Insurance plans are renewed and change throughout the year, not just in January.

You can reduce the number of these denials by taking the following actions:

- Obtain a current insurance card on every visit.
- Check effective dates of coverage for each member.
- Update your software with current insurance information.

3. **Incorrect Patient Date of Birth** – it is very important to check ALL information on a claim prior to submitting the claim. If the DOB on the claim is inconsistent with the DOB in the payor's database, the claim will be rejected when HNS attempts to transmit it.

4. **Incorrect Patient Name** –When the first name, middle initial and last name on the claim is not identical to the information in the payor's database, the payer cannot recognize the patient, and the claim will be rejected when HNS attempts to transmit it.

C. HNS Electronic Claim Error Reports

Claims submitted electronically which are rejected by payer front-end edits are returned to HNS providers accompanied by the ***HNS Electronic Claim Error Report.***

Each error report includes details of the rejected claim including rendering provider and location, patient account number, member ID number, last name, first name, date of service, total charges, the information the payer deemed incorrect and an explanation of the rejection.

Claims returned to providers via HNS Electronic Claim Error Reports have NOT been successfully submitted to payers and will not be until errors have been corrected, and the revised claim has been received by HNS.

HNS Electronic Claim Error Reports are returned to the rendering provider/location via fax or email on the next business day following notification of the rejection from the payer.

Claims returned to providers via HNS Electronic Claim Error Reports should be corrected and resubmitted immediately to prevent issues with timely filing. While some claims can be resubmitted electronically to HNS, some claims must be submitted via a paper claim.

- If you receive an error report which indicates the payor rejected the claim due to **invalid patient name**, first, please make the necessary changes in your billing software, then **print a paper claim, attach the error report,** and submit to HNS via email or fax, and HNS will forward for processing.

- If you receive an error report which indicates the payor rejected the claim due to **invalid DOB or Member ID#**, first, please make the necessary changes in your billing software, and then resubmit the claim **electronically through HNSConnect or as applicable, Office Ally**.

Note: In order to prevent the same errors from occurring again on future claims, please correct the error in your practice management software.

D. Claims Submitted by Paper

The following claims cannot be submitted electronically and must be submitted via the CMS 1500 paper claim form:

- Tertiary claims
- Corrected/Voided secondary claims
- Corrected/Voided tertiary claims
- Claims with attachments (member ID cards, medical records, etc.)
- Claims which resulted in an HNS Electronic Error Report due to incorrect first name of the member. After updating your billing software with the correct name, you must submit the claim to HNS via paper.
- A few CIGNA Third Party Administrator (TPA) claims – for more information regarding which TPA claims must be submitted via a paper claim form, please refer to the CIGNA Healthcare Guide under “Billing/Claims Support”.

Claims must be identified by the HNS contract name in the address section at the top of the CMS 1500 claim form (HNS/BCBS is an acceptable format). Be sure to use the HNS mailing address for sending paper claims, not the address listed on the insurance card.

HNS
PO Box 2368
Cornelius, NC 28031

Claims requiring special handling and all claims with attachments (secondary claims with primary EOBs attached, claims with medical records attached, etc.) are keyed into HNS internal systems and sent by paper via US Mail directly to the insurance company

for adjudication. HNS has no more involvement in the processing of paper claims until the claim is adjudicated by the payer.

E. HNS Notice of Claim Rejection

Paper claims submitted to HNS via the CMS 1500 claim form are also checked for issues that could cause the claim to deny. Such claims are returned to the rendering provider/location via fax on the next business day accompanied by the HNS Notice of Claim Rejection form. The HNS Notice of Claim Rejection form will include the issue(s) specific to the claim.

Claims returned to providers via HNS Notice of Claim Rejection forms should be corrected and resubmitted immediately to prevent issues with timely filing.

Note: Claims returned to providers via HNS Notice of Claim Rejection forms have not been successfully submitted to payers and will not be until all errors have been corrected. Also, in order to prevent the same errors from occurring again on future claims, please correct the error in your practice management software.

X. Payments from HNS

Payments for services provided (remittance) are sent from the payer directly to HNS. HNS issues those payments to providers via electronic fund transfers (EFT) to the provider's business bank account.

A. When are Payments Issued?

HNS issues bulk provider payments on the 10th, 20th (or next business day), and again on the last business day of each month.

With few exceptions, all monies received by HNS during the check cut periods are sent to the provider via electronic fund transfers (EFT) on the next scheduled bulk provider payment date.

As soon as HNS has completed the bulk provider payment process, HNS sends an email to providers to notify them that HNS has electronically transferred funds received from payors since the last provider payment date to HNS' bank.

It may take up to **24 hours for HNSConnect® to reflect this payment.**

It may take up to **3 business days** for payments to appear in the provider's checking account.

For each bulk provider payment date, always check HNSConnect® to determine if you have received an EFT from HNS for this payment period. If HNSConnect® does not indicate a remittance amount, then HNS did not receive any funds on your behalf during this payment period.

B. Change to EIN

Your bank account information and EFT are directly linked to the EIN you have on file with HNS.

If you change your EIN, you must immediately notify your HNS Service Rep who will assist you with registering your new EIN with HNS and ensuring you continue to receive EFTs from HNS.

C. Changing Bank Accounts

Should you change bank accounts, you must immediately update your banking information on HNSConnect®. (In the secure portal, click the profile icon in the upper, right-hand corner of the dashboard. From the drop-down menu, choose "EFT Registration", then "Click Here to Register".

XI. Remittances

For each EFT, HNS provides the associated EOBs (remittances) so that patient accounts may be properly updated.

For easy reference, each HNS remittance is assigned a specific remittance number.

On each bulk provider payment date, remittances are uploaded to HNSConnect® and are provided in 2 formats:

- PDF ("**Print EOB**")
  For printing and manual posting

- EDI ("**Download 835 File**")
  For auto-payment posting

A. 835 ERA Auto-Posting Files

An ERA file is an Electronic Remittance Advice file for auto-posting of payments to your patient accounts. The 835 file is an electronic version of the paper EOB that you are accustomed to receiving. Also called an 'ANSI 835' file, it includes all information normally provided in an EOB, including remark (reason) codes.

ERAs can be imported directly into your billing software and will automatically post payments to your patient accounts. Utilizing ERAs saves valuable staff time, increases efficiency, and reduces the costs of health care administration.

All information received on the paper EOB, including remark codes, is included in the ERA file.

Most practice management software systems can import the ANSI 835 ERA for auto-posting of payments to your patient accounts. Contact your software vendor to inquire if your software version has the ability to import an auto-posting ERA/835 file and to assist you with the initial set-up. Your software vendor will "map" the information in this file so it can be correctly imported to your software.

Please be aware that HNS cannot provide assistance should your software not be able to import an 835 file. **You will need to contact your software vendor if you need assistance regarding importing any 835 files for posting.**

B. Accessing HNS Remittances

Recent HNS Remittance:
The Dashboard in HNSConnect® shows the most recent HNS Remittance and includes the:

- Remittance number
- The amount of the remittance
- The date of the remittance

This section includes quick links to print the associated EOB, HNS Provider Statement or to download the associated 835 file for auto-posting.

Remittances:
The main menu bar takes the user to a complete list of HNS Remittances with quick links to print the HNS Provider Statements/HNS Summary and EOBs or download the 835 files for auto-posting for each remittance.

C. HNS Provider Statement

For each bulk provider payment, in addition to the EOBs/835 auto-posting file, HNS provides the *HNS Provider Statement.*

The HNS Provider Statement displays the remittance number, the payment date, and the amount paid from each contracted healthcare plan during the payment period, and the total net amount paid to the provider ("Net Amount Due Provider"). **The *net amount due to the provider* shown on this statement should be the same as the EFT shown in the provider's bank account.**

D. HNS Remittance Summaries

For each bulk provider payment, in addition to the EOBs/835 auto-posting file, HNS also provides the *HNS Remittance Summaries.*

HNS Remittance Summaries are a breakdown, by payor, of the total amount paid for each patient during the payment period. For each payor, the summary includes:

- Patient Name
- Allowables
- Patient Responsibility
- Amount Paid by Insurance
- HNS Administrative Fee
- Amount Paid to the Provider

E. Posting Remittances

To ensure that your patients' accounts are current, and your accounts receivable figures are accurate, **all EOBs should be posted within 15 days of receipt**.

Below is important information regarding posting your HNS remittances.

1. The HNS Admin Fee should NEVER be posted to your patients' accounts.

2. Only use the information included on the EOB to post to your patients' accounts. The "Amount Paid" shown on the EOB is the amount to be posted to your patient accounts.

3. Don't forget to post ZERO-dollar payments ($0.00 dollar amounts paid) when no payment was made by the insurance company and, as applicable, write off the charge or transfer the amount to "patient responsibility".

4. The difference between the "Billed Charges" and the "Contracted Charges" on the EOB should be adjusted from each patient's account as a contractual adjustment/write-off, and the amount that must be written off as a contractual adjustment should never appear in your system as an amount owed by the member. And as a reminder, you cannot "balance bill" the patient for this amount. The correct amount to write off as your contractual adjustment can usually be found in the "Disallowed Amount" column on the EOB.

5. Once you have finished posting each EOB, check to make sure the total amount you have just posted to each of your patients' accounts in your practice management software system is equal to the total amount of the EOB.

6. Always compare the amount you posted to your patients' accounts in your practice management software to the TOTAL column of the "Paid by Ins Co" section on the Remittance Summary that accompanies each EOB. If you correctly posted to your patients' accounts, these two numbers will be the same.

7. Contact HNS immediately if you receive a payment for a member that is not your patient. Notify your HNS Service Representative via email, and HNS will adjust at the next scheduled HNS bulk provider payment date.

8. If there are ANY inconsistencies in the amount actually paid by HNS, and the amount shown on your EOB/NOP as the amount actually due you from the payer, OR if the amount shown on your provider statement does not match the amount of your HNS payment, you must notify HNS within 10 days.

If you are new to the HNS network and have questions regarding how to post your HNS EOBs, contact your HNS Service Representative and he/she will gladly assist you.

F. Retention of HNS Remittances

As a reminder, HNS providers must retain complete patient health care records **(including all EOBs)** for a minimum of 10 years from the last date of service OR, if

the patient is a minor, for 10 years after the minor patient reaches age 19. Once the patient reaches 19 and is still under care, the provider should retain the patient's health care record for 10 years from the last date of service.

XII. Claims Adjudication

The information below is provided to help you understand HNS' role in claims/payment processing and to address some of the questions HNS frequently receives.

1. HNS does not adjudicate or "process" your claims. HNS forwards all claims to the applicable payor, and payors adjudicate the claims.

2. HNS makes no decisions regarding the payment or denial of any services submitted to the payers through HNS.

3. HNS has no role in applying co-payments, co-insurance, and/or deductibles when your claims are adjudicated. The insurance companies/payers verify benefit and coverage information on each member before processing claims and adjudicate claims based on relevant policies as well as each member's coverage.

4. All decisions are made by the insurance company/managed care organization and are subject to member eligibility, payer corporate medical policies, and plan limitations.

5. Only the insurance company/payor determines whether services submitted on your claim are denied or paid. If a service or procedure is denied, the basis for the payer's denial is shown on the EOB/NOP via the remark/reason code.

6. HNS has no information regarding WHY a claim may be denied or paid by a payor, but we will gladly assist with understanding the reason codes on the EOB/NOP and, if applicable, will contact the payor for clarification and assistance.

7. Generally, providers can expect most claims to be adjudicated by payors within 30-45 days from the date the claim was filed.

8. When verifying eligibility or benefits for patients whose healthcare plans contract with HNS, always provide the HNS EIN/HNS NPI (not your own)!

    - **HNS EIN is 56-1971088**

    - **HNS NPI number is 1093773392**

For questions regarding claim status, non-payment of claims, etc., please refer to **Section XII** (Assistance from HNS) in this manual.

XIII.HNS Service Representatives

Our provider service representatives and health care executives understand your market, your business, and its challenges and are here to support you and your team in the constantly changing world of health care.

HNS' Claims and Billing Support program connects you and your staff to HNS Service Representatives to assist in resolving claims/billing and other administrative issues, saving you time, money, and frustration - while simplifying health care administration.

Our service representatives are experts at problem solving and can resolve even the most confusing claim/EOB issues... and will work with you to ensure claims submitted through HNS are correctly adjudicated.

A. CA Training:

HNS offers free training for new billing CAs and refresher training for existing staff. Training is designed to improve efficiency and productivity in your practice and to help you improve compliance to policies, laws, and regulations, reduce your claim denials and improve cash flow. **Just contact your HNS Service Representative to schedule.**

Email is the most efficient and preferable method of communicating with your Representative. So that we may better serve you, please include the patient's name, subscriber ID number, date of birth, and date of service with all inquiries. While we do our best to respond to all inquiries the same, or next business day, please allow up to 72 hours for your Representative to respond.

Voicemail: HNS Service Reps spend a significant portion of their time on the telephone with contracted payors working to resolve your claims issues. As such, when calling your Service Rep, you will often reach his/her voicemail. If so, please consider emailing your Service Rep, or if the issue requires a telephone call to resolve, please leave your name and phone number, and he/she will return your call as soon as possible (or send an email).

Not sure who your personal HNS Service Representative is or how to reach him/her?

From the public-facing HNS Website, click "**Secure Portal**" and log in. This will take you to the dashboard, which includes the name of your personal HNS Service Representative, his/her contact information, as well as a link to his/her email address.

XIV. Assistance from HNS (Claim Inquires)

As noted, your personal HNS Service Representative is here to assist you in any way possible.

A. How to Request Assistance

Please submit all requests to HNS to check claims status (or to otherwise request assistance) via **email to your HNS Service Rep**. **(Please do NOT fax.)** As a reminder, the dashboard page of the Secure HNS Portal shows the name of your HNS Service Rep and includes a link to his/her email address.

B. Before Requesting Claim Status

Prior to requesting claim status, HNS requires that you do the following:

1. **Post all HNS Remittances**
   Ensure all HNS Remittances, including the most recent one, have been posted to your patient accounts.

2. **Ensure the claim has been submitted to HNS.**

   - **HNSConnect® Users:**
     Before requesting claim status, use the "Search" feature on HNSConnect® to ensure the claim (or claims) in question were successfully transmitted to HNS. (Check "errors" on HNSConnect®.)

   - **Office Ally™ Users:**
     Before requesting claim status, check your Office Ally™ account and ensure the claim was transmitted to HNS, under the applicable HNS Payor ID number.

3. **Verify the date the claim was filed to HNS.**
   As a general rule, most health care plans adjudicate "clean" claims within 30-45 days. While your HNS Service Representative will be glad to assist your office with checking claim status, we cannot respond to inquiries for claims which were submitted less than 30 days ago.

4. **HNS Error Reports**
   Verify the claim in question was not returned to you via an HNS Error Report, and if so, confirm it has been correctly resubmitted to HNS.

C. Claim Inquiries (Information Required by HNS)

In order to check claims status and/or to properly research your issue, for each inquiry, always provide your Service Rep with ALL of the following information:

- Patient Name and Insured’s Name (if applicable)
- Patient Date of Birth
- Insurance Plan
- Member ID Number
- Date of Service

XV. Changing Billing Software

A. Always Notify HNS

There is specific information you must provide to your software vendor related to the submission of claims to HNS, so it is imperative that you promptly notify HNS if you plan to change your billing software.

While your software vendor must set up your new software, HNS will provide you with the information the vendor needs to ensure your HNS claim files include all required information.

B. Considerations – New Software

Prior to purchasing a new billing software, please contact HNS to confirm that it is compatible with HNSConnect®.

Considerations for practice management software:

1. Confirm the practice management software can create the HIPAA compliant ANSI 5010 837p claim file.

2. Confirm the practice management software can process the HIPAA compliant ANSI 835 file for auto-posting.