healthfirst®
Health Insurance for New Yorkers

Frequently Asked Questions

Corrected Claims Submissions

1. **What is a corrected claim?**
   If a claim was submitted to and accepted by Healthfirst but was later found to have incorrect information, certain data elements on the claim can be corrected and/or added and the claim can be resubmitted to Healthfirst either by mail or electronically. The resubmitted claim is a corrected claim. Examples of data elements that may be corrected and/or added are:

- Diagnosis code
- Number of units
- Date(s) of service
- Procedure code(s) and/or modifiers
- Place of service (POS)
- Revenue code
- Total charges
- Late charges
- Member or provider information

2. **What are the different ways in which corrected claims can be submitted?**
   Corrected claims can be submitted through an Electronic Data Interchange (EDI) or sent manually.

- **EDI** transactions are the computer-to-computer transfer of business-to-business document transactions and information between trading partners. Many healthcare partners, payers, vendors, and fiscal intermediaries choose to submit corrected claims via EDI as a fast and inexpensive method for automating business processes.

- **Manual (non-EDI)** corrected claims submitted on the CMS-1500 (professional) and UB-04 (institutional) claim forms can be mailed into Healthfirst.

Corrected claims must include the original claim number. Failure to provide the original claim number on the corrected claim will result in the claim being rejected or denied as a duplicate.

3. **When did Healthfirst begin accepting corrected claims via EDI?**
   Healthfirst began accepting EDI corrected claim submissions on June 1, 2016.

4. **What are the benefits of corrected claims via EDI?**
   Corrected claims submitted via EDI are fast, reliable, and secure, simplifying the claims management process. Healthfirst encourages providers to submit initial and corrected claims electronically and accepts both institutional and professional claims this way.

5. **How are EDI corrected claims different from manual (non-EDI) corrected claims?**
EDI corrected claims are submitted electronically on **837P** or **837I** transactions and must be in the following data file format:

- The claim type (segment **CLM05-03**) must list the number **'7'**
  Example: CLM*8084*96.98***11>B>7*Y*A*W*I*P~

- The **original Healthfirst claim ID** from the explanation of payment (EOP) or 835 file must be included in the **REF*F8** segment in the **2300 loop** of the EDI transaction
  Example: REF*F8***9999999999999~**

Manual (non-EDI) corrected claims are submitted on the **CMS-1500** or **UB-04** claim forms that are mailed into Healthfirst **within 180 days** from the date of service. These claims must be submitted as follows:

Claims must be marked "**Corrected,**" and the original claim number must be referenced, as shown in the three examples below.

2 Corrected Claim clm #999999999999

1500 Corrected Claim #999999999999
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05
PICA

CORRECTED CLAIM

CMS-1500 forms should:
- List the number **'7' in Box 22** of the claim form
- Reference the **original claim number in Box 22**
- Include a copy of the original EOP

CMS-1500 Example *(please use red and white claim form for official submission)*

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to servi
A. B. C.
E. F. G.
I. J. K.
Box 22: Use resubmission code 7 for corrected claim
Box 22: Original claim number. Note: Not to be used if original claim was rejected
YES NO
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

UB-04 forms should:
- List the number **'7' in the third digit of the bill type**
- Reference the **original claim number in Box 64**
- Include a copy of the original EOP

UB-04 Example

63 TREATMENT AUTHORIZATION CODES
Box 64: Original claim number
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

6. **How can I start submitting electronic EDI claims to Healthfirst?**
Providers who don't have claims submission software may sign up for an account with **ABILITY** (formerly MD On-Line) to begin filing electronically at www.abilitynetwork.com.

Providers may also contact their software vendor or clearinghouse and request that their Healthfirst claims be submitted through Emdeon at www.emdeon.com/claims.

7. **How do I ask to receive electronic remittance advices (ERA) and electronic funds transfer (EFT)?**

For new enrollment or modification of existing ERA/EFT account information, providers must submit a completed ERA/EFT form.

- To obtain a copy of the ERA/EFT form, please speak with your Network Management representative. If you do not have an account, you will need to create one.
- In-network providers should submit the completed documentation to their Network Relationship Manager.
- Out-of-network providers may submit their completed documentation via email to HFEFTERA@healthfirst.org.

For general questions regarding EFT set-up, you may contact Provider Services at 1-888-801-1660.

8. **Why was my EDI claim rejected, and what do I need to do to correct it?**
The following will provide you with the appropriate guidance, based on the claim status category and code that you received, so that you may take the necessary action to submit the claim(s) for reprocessing.

Claim Status Category	QA4	QA3	QA5	QA8
Claim Status Code	A3	A3	A3	A3
Claim Status Code Description	Submitted original claim ID is not valid	Original claim ID not supplied	Submitted original claim ID has already been adjusted	Submitted original claim ID has not been finalized; wait for the remittance then resubmit
Corrective Action	The claim number is incorrect; resubmit claim with a valid claim number	The original claim number must be provided when submitting a corrected claim	The original claim was already adjusted. If additional corrections are needed, indicate changes and resubmit	Upon receipt of the EOP, resubmit a corrected claim and provide the original claim number

Claim Status Category	A7	A3	A3
Claim Status Code	464	78	54
Claim Status Code Description	Payer Assigned Claim Control Number	Duplicate of an existing claim/line; awaiting processing	Duplicate of a previously processed claim/line
Corrective Action	The claim number is incorrect; resubmit claim with a valid claim number	Upon receipt of EOP, resubmit a corrected claim and provide the original claim number	The original claim was already adjusted. If additional corrections are needed, indicate changes and resubmit

9. **What should I do if I disagree with the determination of the claim?**
Providers who are dissatisfied with a claim determination made by Healthfirst must submit a request for review and reconsideration with all supporting documentation to Healthfirst within **90 days** from the paid date on the EOP.

Requests for review and reconsideration of a claim determination, including attachments, are accepted via the secure Healthfirst Provider Portal at www.healthfirst.org or can be mailed to the following addresses, as applicable:

Healthfirst	Claims and Claims Correspondence	P.O. Box 958438 Lake Mary, FL 32795-8438	1-888-801-1660
Senior Health Partners	Claims and Claims Correspondence	P.O. Box 958439 Lake Mary, FL 32795-8439	1-877-737-2693

Requests for review and reconsideration should include the following information:

- A written statement explaining why you disagree with the determination of the claim
- Provider name, address, telephone number, and Healthfirst provider ID number
- Member name and Healthfirst ID number
- Date(s) of service
- Healthfirst claim number
- A copy of the original claim or corrected claim
- A copy of the Healthfirst EOP
- Documentation that supports the request for claim reconsideration, such as the examples listed below (where applicable):
  - Evidence of member eligibility verification
  - Copy of the authorization issued by Medical Management
  - A copy of the EOP from another insurer or carrier (e.g., Medicare), along with supporting medical records to demonstrate medical necessity
  - Contract rate sheet to support payment rate or fee schedule
  - RO59 Report (Insurance Carrier Rejection Report) or Emdeon Vision "Claim for Review"/"Claim Summary" Report to show evidence of timely filing
    - ***Please note:*** *Healthfirst does not accept copies of certified mail or overnight mail receipts, or documentation from internal billing practice software, as proof of timely filing.*

Healthfirst will investigate all written requests for review and reconsideration and within 30 days from the date of receipt will issue a response indicating whether the denial has been upheld or is being reprocessed.

Healthfirst will not review or reconsider claims determinations which are not appealed according to the procedures above. If a provider submits a request for review and reconsideration after the ninety (90) day time frame, the request is deemed ineligible and will be dismissed. Providers will not be paid for any services, irrespective of the merits of the underlying dispute, if the request for review and reconsideration is not filed timely. In such cases, providers may not bill members for services rendered.

All questions concerning requests for review and reconsideration should be directed to:

- Healthfirst Provider Services 1-888-801-1660
  Monday to Friday, 8:30am–5:30pm

10. Are other resources available?

Healthfirst Provider Website	Provider Alerts	www.healthfirst.org/alerts
	Claims & Billing	www.healthfirst.org/providers/claims-billing
	Provider Forms	www.healthfirst.org/providerforms
	ICD-10 Tools & Information	www.healthfirst.org/icd10

Healthfirst Provider Portal	Verify Member Eligibility	www.healthfirst.org/providers
	View Member Cost Sharing	
	Look Up Authorizations	
	View Claims Status and Detail	
	Submit Requests for Claims Review and Reconsideration	

Provider Services	Provider Inquiries	**1-888-801-1660**
	Claims Inquiries	

Utilization Management	Authorizations	**1-800-238-7828**

Ancillary Authorizations		
CVS Caremark	Pharmacy Prior Authorization	**1-877-433-7643 – Medicaid 1-855-344-0930 – Medicare 1-855-582-2022 – Leaf Plans Essential Plans**
	Specialty Pharmacy	**1-800-238-7828**
Davis Vision	Routine Vision Care/Eyewear	**1-800-773-2847**
Superior Vision	Surgical Procedures of the Eye	**1-888-273-2121**
DentaQuest	Routine Dental Care	**1-888-308-2508**
eviCore	Radiology Prior Authorization	**1-877-773-6964**
ASH	Chiropractic Services	**1-800-972-4226**
OrthoNet	PT, OT, ST Services	**1-844-641-5629**
	Pain Management, Spinal and Foot Surgery	**1-844-504-8091**

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