Claims Filing Tips and Guidelines

Providers should submit properly filed claims electronically via Blue *e*SM, or if necessary, using either the CMS-1500 or the UB-04 paper claims form.

All information necessary to adjudicate the claim, including appropriate codes, must be provided.

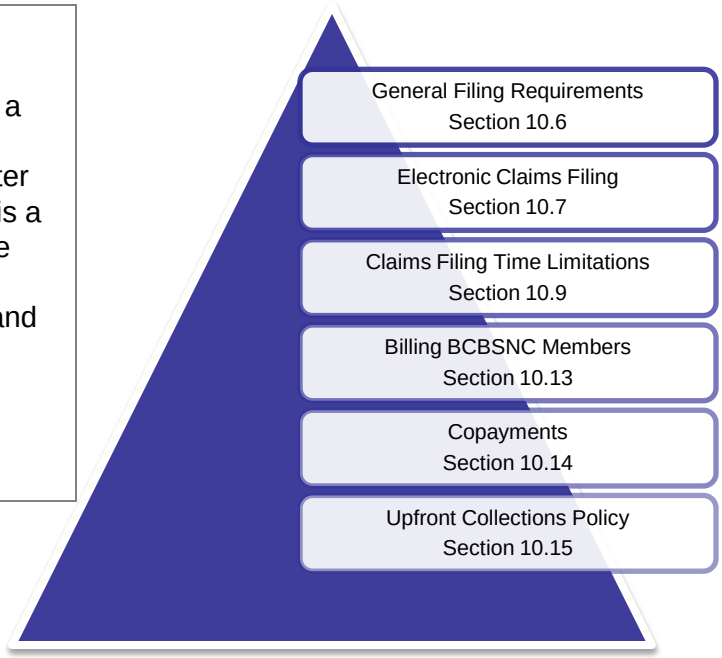
Duplicate claims can be very costly for health care providers and health insurers, as every time a duplicate claim is filed, it must be processed. This can be counterproductive in the following ways:

- Time is taken in the claims processing system that could be used to process claims already loaded to the system.
- Valuable staff time is used to track duplicate claims and reconcile the system for Blue Cross and Blue Shield of North Carolina (BCBSNC).
- Provider office staff loses office time completing and submitting the second claim.
- Providers may be paying a billing service to resubmit a claim that was already in process to pay within a few days.

Blue *e* provides details regarding how claims were adjudicated by BCBSNC, including claim payment disposition along with any denial reasons, and a description of the denial reasons for each claim.

Provider eManual

The Provider eManual is a Web-based provider reference manual (Chapter 10 addresses claims). It is a comprehensive reference guide for our products, value-added programs, and services.



Provider Filing Hints and Tips

Defining a "Corrected Claim"

The corrected claims process begins when you receive a notification of payment (NOP) or explanation of payment (EOP) from BCBSNC detailing the claims processing results. A corrected claim should only be submitted for a claim that has already paid, was applied to the patient's deductible/copayment or was denied by the Plan, or for which you need to correct information on the original submission.

File a New Claim …When		File a Corrected Claim When …	
1	Claim never billed	1	NOP received with claim disposition code ECN
2	Receive a claim mail back form (except mail back code M039)	2	NOP received and corrections required for originally billed charges
3	NOP received with claim disposition codes M1 – M9 or EM0 – EM9		
4	Additional information requested. File new claim with requested correspondence.		

Best Practices for Corrected Claim Filing

Adhering to the following claims filing best practices may reduce duplicate service denials and other unexpected processing results.

1. Allow 30 days for claim processing to be completed before resubmitting a claim.
2. When filing multiple-page paper claims:
   - Number pages (i.e., Page 1 of 3, Page 2 of 3, etc.)
   - Do not place the total charges for all services billed in the total charge field on each claim form. Only indicate the claim total charge on the last page.
3. File all services for a particular date of service on the same claim form.
4. Do not mark claim "corrected" if additional information is requested, such as medical records or primary carrier EOB, **UNLESS** a change is made to the original claim submission.
5. Include **ALL** services to be considered for payment when submitting a corrected claim. This includes services that may have already paid on the original claim submission.
6. When changing a member ID number (base 9) or date of service for a processed claim:
   - Submit a **corrected claim** canceling charges for the original claim, **AND**
   - Submit a **new claim** with the correct member ID number or date of service
7. Refer to the Provider eManual (section 10.12.3) for additional corrected claim tips.