

How to File Claims with ActivHealthCare

1. If the Primary Network is listed on our Network Affiliates sheet, the claim will come to ActivHealthCare.
2. The format on the HCFA must be correct regardless of how the claims are being filed. All claims should have AHC01 as the prefix, followed by the name and address of the Insurance Payor.

Example 1 for GA: AHC01 Peach State Health Plan Ambetter *(or name from ins. ID card)*
68069
PO Box 5010
Farmington, MO 63640

Example 2 for SC: AHC01 Absolute Total Care Ambetter *(or name from ins. ID card)*
68069
PO Box 5010
Farmington, MO 63640

Example 3 for TN: AHC01 Ambetter of TN *(or name from ins ID card)*
68069
PO Box 5010
Farmington, MO 63640

3. There are two ways to file your claims.
 1. EDI – Electronic claims can only be filed through Office Ally using an 837P file. If you do not use Office Ally, you must submit claims on paper.
 2. Mail – Paper claims can be mailed to ActivHealthCare; however, we suggest filing them electronically to expedite the processing of your claims. Please mail paper claims to:

ActivHealthCare, Inc.
1926 Northlake Pkwy Ste. 100
Tucker, GA 30084

Claim form with instructions

1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Carrier Information:
AHC01 Payor Name from ID Card
Payor ID #
Payor Address from ID Card
Payor City, State, Zip

Patient Information:
Patient's Information

Insured Information:
Insured's Information

Network Information:
Network Name from ID card

Physician/Supplier Information:
11 Taxonomy code and Doctor's NPI Number
Address/NPI number to whom checks are payable

24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES	E. DIAGNOSIS	F. CHARGES	G. DAYS OR UNITS	H. RATE PER UNIT	I. ID. QUAL.	J. RENDERING PHYSICIAN'S NPI #
1										111N00000X
2										14322895876
3										
4										
5										
6										

25. FEDERAL TAX I.D. # TTN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? YES NO
28. TOTAL CHARGE \$
29. AMOUNT PAID \$
30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS
32. SERVICE ADDRESS AND CITY, STATE, ZIP CODE
33. BILLING ADDRESS AND CITY, STATE, ZIP CODE

Service Provider:
John Chiropractic Center
4455 Highway 84
Tucker, GA 30084-7069
1932992610

Service Provider:
John Chiropractic Center
4455 Highway 84
Tucker, GA 30084-7069
14322895876

NUCC Instruction Manual available at: www.nucc.org
APPROVED OMB 0938-0099 Form CMS-1500 (08-05)

How to File a Claim and a Corrected Claim with Ambetter

1. The format on the top of the HCFA should be:

AHC01 Ambetter (or name from insurance ID card)
 68069
 P.O. Box 5010
 Farmington, MO 63640-5010

2. The ID number must include the prefix and the suffix.

Incorrect number: 12345678
 Correct number: U1234567801

3. Patient's name should match what is on the ID card. Do not file with a nickname.

3. Timely filing is 180 days from the date of service.

4. To dispute a claim, a Reconsideration Request Form must be completed and sent to Ambetter. Do not send it to ActivHealthCare.

5. Corrected claims need to be submitted with the following information.

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			16. ICD-9-CM CODE		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						18. ICD-9-CM CODE		
17a. NAME						18a. ICD-9-CM CODE		
17b. NPI						18b. ICD-9-CM CODE		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. YES NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service						22. RESUBMISSION CODE ORIGINAL REF. NO.		
A. _____	B. _____	C. _____	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> Box 22: Use resubmission code 7 for corrected claim </div>			23. PRIOR AUTHORIZATION NUMBER		
E. _____	F. _____	G. _____						
I. _____	J. _____	K. _____						
L. _____	M. _____	N. _____						

Box 22: Original claim number.
 Note: Not to be used if original claim was rejected