

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 (NUCC)

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Patient's Information

3. PATIENT'S BIRTHDATE (MM/DD/YY) SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Insured's Information

5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) () ()

6. PATIENT RELATIONSHIP TO INSURED
 Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) () ()

8. PATIENT STATUS
 Single Married Other
 Employed Full-time Part-time Student

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
 a. OTHER INSURED'S POLICY OR GROUP NUMBER
 b. OTHER INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M F
 c. EMPLOYER'S NAME OR SCHOOL NAME
 d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO:
 a. EMPLOYMENT? (Current or Previous) YES NO
 b. AUTO ACCIDENT? YES NO PLACE (State)
 c. OTHER ACCIDENT? YES NO
 10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER
 a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M F
 b. EMPLOYER'S NAME OR SCHOOL NAME
 c. INSURANCE PLAN NAME OR PROGRAM NAME
 d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO **#yes**, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
 SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
 SIGNED _____ DATE _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (MM/DD/YY)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM/DD/YY)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (MM/DD/YY) TO (MM/DD/YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM (MM/DD/YY) TO (MM/DD/YY)

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
 1. _____ 2. _____ 3. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. **9**

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE FROM (MM/DD/YY) TO (MM/DD/YY) B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) MODIFIER E. DIAGNOSIS PORTER F. \$ CHARGES G. DAYS OR UNITS H. PROFIT (Only for Fee) I. D. CHARGE J. PROVIDER ID

1
 2
 3
 4
 5
 6

25. FEDERAL TAX ID NUMBER (Doctor TIN) SSN EIN
Service Provider

26. PATIENT'S ACCOUNT NO.
Service Address & NPI #

27. ACCEPT ASSIGNMENT? YES NO
John Chiropactic Center
4455 Highway 84
Tucker, GA 30084-7069
1932992610

28. TOTAL CHARGE \$
John Chiropactic Center
4455 Highway 84
Tucker, GA 30084-7069
14322895876

29. AMOUNT PAID \$

30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING CREDENTIALS (Verify that the statements on this invoice apply to this service as part thereof)
111N00000X
14322895876

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

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

Patient's Information

Insured's Information

Network Name from ID card

Taxonomy code and Doctor's NPI Number

Address/NPI number for who checks are payable to

How to File 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.

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

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

6. 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. DATE OF SERVICE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NAME 17b. NPI	18. ICD-9-CM CODE 18a. PRIMARY 18b. SECONDARY 18c. TERTIARY	19. ICD-9-CM CODE 19a. PRIMARY 19b. SECONDARY 19c. TERTIARY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. YES <input type="checkbox"/> NO <input type="checkbox"/>
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service A. _____ B. _____ C. _____ E. _____ F. _____ G. _____ I. _____ J. _____ K. _____		22. RESUBMISSION CODE ORIGINAL REF. NO.
<div style="border: 1px solid black; padding: 5px; display: inline-block;"> Box 22: Use resubmission code 7 for corrected claim </div>		<div style="border: 1px solid black; padding: 5px; display: inline-block;"> Box 22: Original claim number. Note: Not to be used if original claim was rejected </div>
23. PRIOR AUTHORIZATION NUMBER		

Claim # on Activ's EOB

ACTIV CLM # 19-293-0070-0
 PAYER CLM # U292MPEE9018

How it should look on the HCFA

22. RESUBMISSION CODE 7	ORIGINAL REF. NO U292MPEE9018
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7. Please review the three examples on completing Section 24 of the CMS1500 form. If this is completed incorrectly, the previous payment may be deducted from your claims.

Example 1

The original claim was billed with 2 lines. Provider left out the 3rd line and submitted a Corrected Claim. This is NOT a Corrected Claim because the 3rd line was never billed. It should have been submitted as a regular claim.

24. A. DATE(S) OF SERVICE		B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E.	F.	G.	H.	I.	J.
From	To	PLACE OF SERVICE	EMG	CPT/HCPCS	MODIFIER			DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
▶ 1	11/01/21	11/01/21	11	98941				AB	50	¢	1	ZZ	111N00000X
												NPI	123456789
▶ 2	11/01/21	11/01/21	11	97530				AB	40	¢	1	ZZ	111N00000X
												NPI	123456789
▶ 3	MM/DD/YY	MM/DD/YY		CPT/HCPCS #				A - L	\$	¢	#		Rendering's Non-NPI ID #
												NPI	Rendering's NPI #
▶ 4	MM/DD/YY	MM/DD/YY		CPT/HCPCS #				A - L	\$	¢	#		Rendering's Non-NPI ID #
												NPI	Rendering's NPI #
▶ 5	MM/DD/YY	MM/DD/YY		CPT/HCPCS #				A - L	\$	¢	#		Rendering's Non-NPI ID #
												NPI	Rendering's NPI #
▶ 6	MM/DD/YY	MM/DD/YY		CPT/HCPCS #				A - L	\$	¢	#		Rendering's Non-NPI ID #
												NPI	Rendering's NPI #

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NUMBER	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
123456789		X	Patient Account # (Optional)	X YES <input type="checkbox"/> NO	90 00	\$	

Since the 97012 was never submitted, do not complete box 22. It is not a Corrected Claim. It is simply an additional charge. If you submit it as a Corrected Claim, Ambetter will back out the originally processed claim prior to processing the correction. In doing this, any potential payment to be made will be offset by the negative created when the claim was backed out.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY				ICD Ind.	22. RESUBMISSION CODE	ORIGINAL REFERENCE NUMBER
A. M5412	B. M546	C. Diag Code C	D. Diag Code D		7	U123MPB123456
E. Diag Code E	F. Diag Code F	G. Diag Code G	H. Diag Code H		23. PRIOR AUTHORIZATION NUMBER	
I. Diag Code I	J. Diag Code J	K. Diag Code K	L. Diag Code L		Prior Authorization Number (Optional)	

24. A. DATE(S) OF SERVICE		B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E.	F.	G.	H.	I.	J.
From	To	PLACE OF SERVICE	EMG	CPT/HCPCS	MODIFIER			DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
▶ 1	11/01/21	11/01/21	11	97012	GP			AB	50	¢	1	ZZ	111N00000X
												NPI	123456789
▶ 2	MM/DD/YY	MM/DD/YY		CPT/HCPCS #				A - L	0	¢	#		Rendering's Non-NPI ID #
												NPI	Rendering's NPI #
▶ 3	MM/DD/YY	MM/DD/YY		CPT/HCPCS #				A - L	0	¢	#		Rendering's Non-NPI ID #
												NPI	Rendering's NPI #
▶ 4	MM/DD/YY	MM/DD/YY		CPT/HCPCS #				A - L	0	¢	#		Rendering's Non-NPI ID #
												NPI	Rendering's NPI #
▶ 5	MM/DD/YY	MM/DD/YY		CPT/HCPCS #				A - L	0	¢	#		Rendering's Non-NPI ID #
												NPI	Rendering's NPI #
▶ 6	MM/DD/YY	MM/DD/YY		CPT/HCPCS #				A - L	0	¢	#		Rendering's Non-NPI ID #
												NPI	Rendering's NPI #

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NUMBER	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
123456789		X	Patient Account # (Optional)	X YES <input type="checkbox"/> NO	50 00	\$	

Example 2:

The original claim was billed with 4 lines. A Corrected Claim was sent in with the 2 lines that denied. The Corrected Claim is wrong. It should include all the lines submitted on the original claim, not just the 2 lines in question. Ambetter will back out the first claim as a negative before processing the Corrected Claim. This will cause the 2 lines that were previously processed correctly to be deducted from the payment for the second 2 lines. It will probably create an overpayment situation.

24.	A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	From	To			CPT/HCPCS	MODIFIER							
▶	11/01/21	11/01/21	11		98940			AB	50	¢	1	ZZ NPI	111N00000X 123456789
▶	11/01/21	11/01/21	11		98943			AB	40	¢	1	zz NPI	111N00000X 123456789
▶	11/01/21	11/01/21	11		97012			AB	20	¢	1	zz NPI	111N00000X 123456789
▶	11/01/21	11/01/21	11		97110			AB	40	¢	1	zz NPI	111N00000X 123456789
▶	MM/DD/YY	MM/DD/YY			CPT/HCPCS #			A - L	\$	¢	#	NPI	Rendering's Non-NPI ID # Rendering's NPI #
▶	MM/DD/YY	MM/DD/YY			CPT/HCPCS #			A - L	\$	¢	#	NPI	Rendering's Non-NPI ID # Rendering's NPI #

The Corrected Claim should include all 4 lines of charges, not just the 2 lines below.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY										ICD Ind. 0		22. RESUBMISSION CODE 7		ORIGINAL REFERENCE NUMBER U123MPE12345														
A. M5412		B. M546		C. Diag Code C		D. Diag Code D		E. Diag Code E		F. Diag Code F		G. Diag Code G		H. Diag Code H		I. Diag Code I		J. Diag Code J		K. Diag Code K		L. Diag Code L						
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
▶	11/01/21	11/01/21	11		97012	GP		AB	20	¢	1	ZZ NPI	111N00000X 123456789															
▶	11/01/21	11/01/21	11		97110	GP		AB	40	¢	1	zz NPI	111N00000X 123456789															
▶	MM/DD/YY	MM/DD/YY			CPT/HCPCS #			A - L	0	¢	#	NPI	Rendering's Non-NPI ID # Rendering's NPI #															
▶	MM/DD/YY	MM/DD/YY			CPT/HCPCS #			A - L	0	¢	#	NPI	Rendering's Non-NPI ID # Rendering's NPI #															
▶	MM/DD/YY	MM/DD/YY			CPT/HCPCS #			A - L	0	¢	#	NPI	Rendering's Non-NPI ID # Rendering's NPI #															
▶	MM/DD/YY	MM/DD/YY			CPT/HCPCS #			A - L	0	¢	#	NPI	Rendering's Non-NPI ID # Rendering's NPI #															
25. FEDERAL TAX I.D. NUMBER 123456789		SSN	EIN X	26. PATIENT ACCOUNT NUMBER Patient Account # (Optional)		27. ACCEPT ASSIGNMENT? YES NO		28. TOTAL CHARGE 60 00		29. AMOUNT PAID \$ ¢		30. Rsvd for NUCC Use																

Example 3

Multiple dates of service were billed on multiple claims. Corrected claims were sent in with only the denied line for all the dates of service. This will create a big mess and an overpayment by Ambetter. Before Ambetter process the Corrected claim, they will back out the previous payment made on the original claims. The Corrected claim payment will

be offset by the negative or back out of the original claim. When filing a Corrected claim, you must include all lines previously processed, even the lines processed correctly the first time.

24. A. DATE(S) OF SERVICE		B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E.	F.	G.	H.	I.	J.
From	To	PLACE OF SERVICE	EMG	CPT/HCPCS	MODIFIER			DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
▶	1	11/01/21	11/01/21	11	98941				AB	50	¢	1	ZZ 111N00000X NPI 123456789
▶	2	11/01/21	11/01/21	11	97012				AB	50	¢	1	zz 111N00000X NPI 123456789
▶	3	11/02/21	11/02/21	11	98941				AB	50	¢	#	zz 111N00000X NPI 123456789
▶	4	11/02/21	11/02/21	11	97012				AB	50	¢	#	zz 111N00000X NPI 123456789
▶	5	11/05/21	11/05/21	11	98941				AB	50	¢	#	zz 111N00000X NPI 123456789
▶	6	11/05/21	11/05/21	11	97012				AB	50	¢	#	zz 111N00000X NPI 123456789

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NUMBER	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
123456789		X	Patient Account # (Optional)	YES NO	300 00	\$ ¢	

If you only list the charges that need to be re-processed, you will create a problem. Ambetter will back out the 98941 codes prior to re-processing the 97012-GP codes. This will create a negative, which will be deducted from an unrelated claim. You must include all lines from the original claim, including those previously processed correctly.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY				ICD Ind.	22. RESUBMISSION CODE	ORIGINAL REFERENCE NUMBER
A. M5412	B. M546	C. Diag Code C	D. Diag Code D	0	7	U123MPE12345
E. Diag Code E	F. Diag Code F	G. Diag Code G	H. Diag Code H			
I. Diag Code I	J. Diag Code J	K. Diag Code K	L. Diag Code L			
				23. PRIOR AUTHORIZATION NUMBER		
				Prior Authorization Number (Optional)		

24. A. DATE(S) OF SERVICE		B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E.	F.	G.	H.	I.	J.
From	To	PLACE OF SERVICE	EMG	CPT/HCPCS	MODIFIER			DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
▶	1	11/01/21	11/01/21	11	97012	GP			AB	50	¢	1	ZZ 111N00000X NPI 123456789
▶	2	11/02/21	11/01/21	11	97012	GP			AB	50	¢	1	zz 111N00000X NPI 123456789
▶	3	11/05/21	11/02/21	11	97012	GP			AB	50	¢	#	zz 111N00000X NPI 123456789
▶	4	11/08/21	11/02/21	11	97012	GP			AB	50	¢	#	zz 111N00000X NPI 123456789
▶	5	11/11/21	11/05/21	11	97012	GP			AB	50	¢	#	zz 111N00000X NPI 123456789
▶	6	11/15/21	11/05/21	11	97012	GP			AB	50	¢	#	zz 111N00000X NPI 123456789

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NUMBER	27. ACCEPT ASSIGNMENT?	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
123456789		X	Patient Account # (Optional)	YES NO	300 00	\$ ¢	