



Avoiding Common Claim Submission Errors

www.optimahealth.com/providers

PLEASE ensure claims contain:

- 1) **Correct member name** – the patient name on the claim must match the patient name as listed on the Member ID Card.
- 2) **Correct date of birth.**
- 3) **Member ID Number, including:**
 - a) Member suffix – the member number on the claim must contain the correct two-digit suffix that identifies the patient.
 - b) Complete Member ID Number: total of nine (9) characters.
 - c) No asterisk or spaces
- 4) **Providers offering multiple services and multiple provider setups**, must bill the appropriate NPI/Taxonomy/Tax ID on the claim to eliminate assignment logic delays.
- 5) **Claims requiring pre-authorization** must include the correct authorization code on the claim form, box **23**.
- 6) **Individual NPI** should be listed in box **24J**, “Rendering Provider ID #,” in the bottom unshaded portion of the box labeled “NPI”.
- 7) **Group NPI** should be listed in box **33a**, “Billing Provider Info & PH #”.
- 8) **Services requiring pre-authorization can be found on [optimahealth.com/providers](http://www.optimahealth.com/providers).** If unsure contact Provider Relations at 757-552-7474 or 1-800-229-8822.
- 9) **Coordination of Benefits, Optima Health as secondary carrier.** Claims must be submitted with EOB’s attached and the identical information included on the original claim.
 - a) Providers may not bill one insurance carrier for one charge amount and Optima Health for a different charge amount.
 - b) If a claim is filed for a member whose primary insurance is not Optima Health, the provider must submit an EOB with the claims within 18 months of the date of service.
- 10) **Non par provider.** After the Coordination of Care period, Providers must secure a dually executed contract to participate with Optima Health and service Optima Health members. For more information on joining the network, please visit www.optimahealth.com/providers/join-our-network.

11) Duplicate Denials on Corrected Claim. Please submit “Corrected Claim” in Box 19 of the HCFA 1500 claim form. **Note:** Include the claim number.

PLEASE NOTE: Timely filing deadline on all claims is 365 days from the Date of Service. This includes any corrections, reconsiderations, and/or appeals.

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PATIENT AND INSURED INFORMATION

1. MEDICARE (Member ID#) MEDICAID (Medical ID#) TRICARE (IDA/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BOX/LUNG (ICM) OTHER (ID#) 1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F) 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED (Self Spouse Child Other) 7. INSURED'S ADDRESS (No., Street)

CITY STATE CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER b. EMPLOYMENT? (Current or Previous) YES NO a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)

b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? YES NO PLACE (State) b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? YES NO c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME 10c. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO # yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 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. 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 SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) (MM DD YY) QUAL 15. OTHER 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 17a. QUAL 17b. NPI 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) **CORRECTED CLAIM, BOX 19** 19. OUTSIDE LAB? YES NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service the below (24E)) ICD Inc. 22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

A. DATE(S) OF SERVICE (From MM DD YY To MM DD YY) B. PLACE OF SERVICE (EMG) C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) (CPT/HCPCS) D. MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD QUAL I. RENDERING PROVIDER ID # J. NPI

1 2 3 4 5 6

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov't items, see back) YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Rvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If certly that the statements on the reverse apply to this bill and are made a part thereof) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()

SIGNED DATE a. b. a. b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Pre-authorization Number Box 23

Individual NPI, Box 24J

Group NPI, Box 33a