Claims Tips

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✓ **Do Give Complete Information on the Member and Policy Holder**

Please provide complete information, such as the name, birth date and sex of the patient and give the policy holder name, relationship to the patient and policy information. Verify that this information matches the patient's insurance card; also, membership can be verified through the Magellan provider website. Watch out for name variations and changes. Errors and omissions of these items can cause an unnecessary delay in processing the claim.

✓ ***Do Give Complete Information on You, the Provider***

Please provide your complete provider information, including the names of both the rendering provider and the billing entity. The Taxpayer Identification Number (TIN) or Social Security Number and National Provider Identifier (NPI) must be included for the rendering provider in order to process and report claims accurately. In addition, the TIN and the NPI for the billing entity must be provided for the claim to be processed correctly. The billing or remittance address must be accurate for the check and/or Explanation of Benefits to be sent to the correct party. And the degree level of the provider of service is needed to determine reimbursement amounts.

✓ **Do Include Any Other Carrier's Payment Information**

If another health plan is the primary insurer and benefits have been provided or denied, include primary insurer's payment information in compliance with Coordination of Benefits rules.

✓ **Do Include the Complete Diagnosis Information**

If the patient has more than one diagnosis, please be sure to report all diagnoses on the claim. In addition, the Diagnosis Pointer field on the CMS-1500 form is required to indicate which billed diagnosis code relates to the service. Submitted diagnosis codes must be HIPAA-compliant, including the additional 5-7 digits, when required.

✓ **Do Obtain Authorization for Services**

Most benefit plans require authorization prior to rendering services. Please verify with the members benefit plan if you are not sure if authorization is required. Billed services must match the authorization in order for the claim to be eligible for payment.

✓ **Do Show Your Entire Charge**

Always show your full charge on the claim. The amount that is reimbursed is based on the lesser of billed charges or the applicable reimbursement schedule.

✓ **Do Submit Your Claims Electronically and Within Timely Filing Guidelines**

Submit your claims in HIPAA compliant ASC X12 837 format within 60 days of the Covered Service directly to Magellan or through a Magellan preferred clearinghouse.

✓ **Do Monitor Your EDI Transaction Reports**

Monitor your EDI transaction reports on a regular and timely basis and correct rejected claims.