289 LaClair St. | Coos Bay, OR 97420
Main: 541-269-7400
Toll Free: 800-264-0014
TTY: 711 / 800-735-1232

# Claims FAQ:

1. Do In-network specialists need an auth for office visits?
    i) No In-Network Specialists do not require prior authorization for office visits, but they do require a valid referring provider (typically PCP) on the CMS1500/837P claim form in box 17.
        (1) Behavioral Health and A&D providers do not require a referring provider as members are able to self-refer for those services.
2. How do we submit a corrected claim?
    i) For CMS1500/837P claims, we require box 22 to be completed with a code 7 (replacement) and the original claim number (ICN) to indicate that it is a correction. No other claim notations are accepted as corrections.
    ii) For UB04/837I claims, a corrected claim needs to have the appropriate bill type.
    iii) Duplicate claim submissions will be systematically denied unless submitted as a corrected claim as indicated above.
3. My claim was rejected, now what?
    i) Please make sure your clearinghouse is set up to receive rejection logs.
    ii) Rejected claims are claims that were NOT accepted into Advanced Health's claim system for processing.
    iii) Claim rejections are not denials and will not show up in an Explanation of Payment (EOP) or an 835 claim remittance file. They cannot be appealed. You must correct the issue and resubmit until the claim is officially accepted.
4. How long do I have to file a claim?
    i) Initial submissions must be received within 120 days from date of service.
    ii) Corrected claims must be received within 1 year from date of service.
    iii) Initial claims may be submitted within 12 months of the date of service under the following circumstances:
        (1) Pregnancy
        (2) Secondary Claims (Medicare, commercial insurance, etc.)
        (3) Billing is delayed due to eligibility issues (retroactive eligibility initiated by the State)
        (4) Cases involving Third Party Recovery
    iv) Claims received more than 12 months from the date of service will be systematically denied.
5. How do I submit a claim appeal?
    i) Appeals can be sent in a variety of ways:
        (1) The Provider Appeal Request Form and Process can be found on the Advanced Health website at https://advancedhealth.com/providers/claims/ labeled New Advanced Health Claims Appeal Form
        (2) Appeals should be submitted within 45 days from date of the original claim denial and will not be reviewed if sent over 1 year from date of service on the claim.
        (3) Email the appeal form above and all supporting documents to the confidential address Claim.appeals@advancedhealth.com
        (4) Fax the appeal form and all supporting documents to 541-266-0141 Attn Claim Appeals
        (5) Do Not mail appeal information to the claims mailing address as this will just create a duplicate claim and the appeal will not be submitted for proper review.
        (6) If needed, please mail the appeal form and all supporting documents to the Advanced Health main office at:

            Advanced Health – Provider Appeals
            289 LaClair Street
            Coos Bay, OR 97420

6. What do the different benefit plans mean?
   i) Be advised that not all members have the same benefits through Advanced Health. The following explains what benefits are available to which members:
      (1) CCOA - Medical, Mental Health, Dental, Non-Emergent Medical Transportation (NEMT).
      (2) CCOB - Medical, Mental Health, NEMT
      (3) CCOE - Mental Health, NEMT
      (4) CCOG - Mental Health, Dental, NEMT
      (5) CCOF – Dental, NEMT
7. Where can we send claim documentation?
   i) Please add Member ID, Date of Service, and Claim # (if claim has already been submitted) to all submitted correspondences.
   ii) We DO NOT accept faxed claim submissions.
   iii) Documentation that may need to be submitted includes but is not limited to:
      (1) Sterilization Consent (required prior to payment for all sterilization related claims)
      (2) Invoices for hearing aids, Drug codes (J codes), etc
      (3) Medical records that have been requested by the claims team or that are required for claims processing due to modifiers or unlisted procedure codes
   iv) Please send documentation to Jackie Bohannon at Jackie.bohannon@advancedhealth.com or fax it to 541-266-0141 ATTN Jackie in Claims.
   v) If required paperwork is not received prior to claim processing, the claim may be denied.
8. Why was my claim denied for no/invalid authorization?
   i) Please make sure the completed authorization # was on the claim in the correct field.
   ii) Please verify that the correct auth was on the claim and matches what is being billed (CPT codes, DX codes, POS, DOS, etc)
   iii) Please check the current Authorization Grid for full Authorization requirements
9. Did you receive my claims?
   i) Providers can access the portal for status information. If they do not already have a password, they can get started on obtaining one with assistance from Emilie in Finance. Provider portal information can be found on the Advanced Health website or https://www.visibiledi.com/advancedhealth.
   ii) Please note that the portal is very sensitive to information entered. Be specific and accurate with member ID, billed amount and all the dates of service listed on the claim.
10. Why is my Medicare claim denied as a duplicate?
   i) We receive crossovers directly from Medicare. It is not necessary to send Medicare prime claims unless you have not received a claim from us after 45-60 days from the Medicare EOP paid date. Sending those claims earlier than that may result in claim denials. Please check the provider portal prior to submission to see if Advanced Health received your claim via a Medicare crossover.
   ii) Currently Medicare Advantage plans, commercial insurance and supplemental plans do not automatically crossover. Please send those electronically as secondary or tertiary claims. The EOP should be entered exactly as the primary insurance processed the claim. Please be mindful to correctly enter group codes, CARCs, and RARCs as listed on the primary EOP.
   iii) If the services are never covered by Medicare and Medicare is the primary payer, please submit those claims directly to Advanced Health. Please make sure to add the authorization number, if required, to the claim prior to submission.
11. Why is my Medicare or other primary insurance claim denied for needing an auth?
   i) When Medicare/Medicare Advantage is the primary payer and the service is covered by Medicare/Medicare Advantage, those services do not need prior authorization.

ii) When services are not covered by Medicare/Medicare Advantage, Advanced Health's Prior Authorization Grid must be followed as Advanced Health would be become the primary payer for those services.
iii) Members with a commercial insurance as primary payer need to follow Advanced Health's Prior Authorization Grid and request authorization when required.

12. What can I do to verify the Coordination of Benefit (COB) information on file with Advanced Health?
    i) Please email COB@advancedhealth.com with all Coordination of Benefit inquiries or updates.
    ii) Please send as much of the following information as possible if you have updated COB information:
        (1) Member ID, name, date of birth, primary insurance name & policy number, start & end date, policy holder information (if different from the member)
    iii) If you believe the information Advanced Health has on file is inaccurate, please email the inquiry to COB@advancedhealth.com and the COB team will verify all information by calling the other insurance in question or utilizing our electronic verification system to verify coverage.
13. An overpayment was identified, what do we do next?
    i) Advanced Health will either mail a refund letter or process a recoupment when an overpayment has been identified by either Advanced Health or by a Provider's office.
    ii) Refund checks should be mail to Advanced Health main office at:

        Advanced Health – Attn Finance
        289 LaClair Street
        Coos Bay, OR 97420

    iii) Please include necessary identifying information like member ID, claim number, date of service, and the reason for the refund and attach it to all refund checks. Attach any additional documentation to the refund check that would aid in the processing of that refund. Checks without proper documentation may be returned to sender unprocessed.
    iv) Providers can call and request a recoupment that would be offset on a future payment. Recoupments are not available in all circumstances and a refund check may still be required.