BILLING AND CLAIMS

Instructions for Submitting Claims
The physician's office should prepare and electronically submit a CMS–1500 claim form. Hospitals should prepare and electronically submit a UB04 claim form.

Electronic Claims Submission
Fidelis Care receives electronic claims submission. For a complete list of vendors, visit the Fidelis Care Web site at www.fideliscare.org. The unique payer ID for Fidelis Care is 11315 and is used for all submissions.

Timely Filing
All claims must be submitted to Fidelis Care within the timeframes specified by your Fidelis Care provider contract. Claims for services provided to Medicaid, CHP and FHP enrollees must be submitted within 90 days. Acceptable reasons for a claim to be submitted late are: litigation, primary insurance processing delays, retro-active eligibility determination, and rejection of the original claim for reason(s) other than timely filing. Claims that are submitted must be accompanied by proof of prior billing to another insurance carrier or a letter that specifies an acceptable reason for the delay.

Mailing Addresses For Direct Claims Submission

UB04	Fidelis Care New York Corporate Claims Department P.O. Box 806 Amherst, New York 14226-0806
CMS 1500	Fidelis Care New York Corporate Claims Department P.O. Box 898 Amherst, New York 14226-0898

NOTE:
Participating providers may not under any circumstances bill a Fidelis Care member for any services rendered under an agreement with Fidelis Care unless the provider has advised the member, prior to initiating service, that the service is not covered by Fidelis Care for that specific member's product line of business, and has obtained the member's written consent agreeing to personally pay for the service.

Claim Forms

Physician Services
Claims can be submitted electronically; please refer to section 12.1. Providers must submit claims and encounter information for services within ninety (90) calendar days of the date of service using the CMS-1500 claim.

Hospital Providers
Claims can be submitted electronically, refer to section 12.1. Claims for hospital services must be submitted on a UB04 claim form within ninety (90) calendar days of the date of service or the date of discharge.

Ancillary Providers
Claims can be submitted electronically; please refer to section 12.1. Providers must submit claims for home healthcare services, durable medical equipment (DME), respiratory care, physical, occupational and speech therapies on a CMS-1500 or UB04 claim form within ninety (90) calendar days of the date of service.

For the following services, please attach the appropriate documentation to the claims:

- Ambulance Services – Claims must include a Run Report.
- Supplies and DME – Claims must include the manufacturer's invoice for HCPC codes that require a report.
- Hysterectomies - Claims should include a copy of the consent form.

Claims Procedures
Claims are processed Mondays through Fridays and clean claims are scheduled to be paid in accordance with New York State Insurance Law §3224-a. A **"Clean Claim"** is a claim for healthcare services that contains all the data elements required by Fidelis Care to process and adjudicate the claim including, but not limited to, all the data elements contained on Form 1500 published by CMS.

Please follow the guidelines below in completing and submitting claim forms for services rendered:

- Always include the National Provider Identifier and Tax Identification number on each claim.
- Complete a single claim form for each patient encounter.
- Submit a separate claim form for each Provider and for each site where services were rendered.

Provide all the information requested, including:
- Member name
- Date of birth
- Fidelis Care member ID number
- Accident or injury related indicator
- Authorization number on form
- All valid Diagnosis Codes by number (ICD-9)
- Present on Admission (POA)
- Date(s) of service
- Place of service
- Quantity/Units
- Valid Procedure Code (CPT 4 and HCPC)
- Charges
- Treating physician's name, address, telephone number
- National Provider Identifier (NPI)
- Taxonomy Codes
- COB information
- Federal Tax Identification Number (TIN)

Please note the following applicable place of service codes:

11	Office Services	12	Home Services	15	Mobile Unit
20	Urgent Care	21	Inpatient Hospital	22	Outpatient Hospital
23	Emergency Room	24	Ambulatory Surgical Center	25	Birthing Center
26	Military Treatment Ctr.	31	Skilled Nursing Facility (SNF)	32	Nursing Facility
33	Custodial Care	34	Hospice	41	Ambulance (Land)
42	Ambulance (Air or Water)	51	Inpatient Psych Facility	52	Day Care Facility (Psych)
53	CMHC Facility	54	Intermediate Care Facility	55	Residential SA Trtmt Ctr
56	Psych Res Trtmt Ctr	61	Comprehensive IP Rehab Fac	62	Comprehensive OP Rehab
65	Independent Kidney Disease Trtmt Ctr	71	State or Local Public Health Center	72	Rural Health Clinic
81	Independent Lab	99	Other		

Coordination of Benefits (COB)
If a Fidelis Care member has more than one health plan, Fidelis Care will coordinate the benefits with the other carrier(s) to ensure that Fidelis Care's liability does not exceed more than 100% of Fidelis Care's allowable expenses. This effort involves coordinating coverage and benefits for illnesses, injuries, and accidents covered by:

- Personal Automobile coverage
- Worker's Compensation
- Veteran's Administration
- No Fault
- Other Health Insurance Plans

Payments Involving COB
In the event a claim is initially filed with Fidelis Care for which another carrier is determined to be the primary payer, the provider will be notified on a remittance advice to file with the primary insurer.

All participating providers agree to provide Fidelis Care with the necessary information for the collection and coordination of benefits when a member has other coverage. The provider will be required to do the following:

- Determine if there is duplicate coverage for the service provided;
- Recover the value of services rendered to the extent such services are provided by any other plan; and

- File the claim with Fidelis Care along with the primary carrier's Explanation of Benefits (EOB) attached for reconsideration within ninety (90) calendar days of receiving the primary carrier's explanation of benefits.

Fidelis Care will coordinate benefits up to Fidelis Care's allowable as secondary payer. Fidelis Care is not responsible for payment of benefits determined to be the responsibility of another primary insurer.

Payments and Reimbursements
Fidelis Care reimburses providers for services that are billed correctly to Fidelis Care on a weekly basis. Clean claims are paid within the guidelines stipulated by Section 3224-a of the New York State Insurance Law.

Payments to Primary Care Providers
Each PCP or group with a Capitation Agreement will receive capitation payments for enrolled members. Capitation payments are made at the beginning of each month in accordance with a schedule which is published and distributed to providers on an annual basis. All encounter data must be submitted to Fidelis Care as described on 12.3

Payments to Specialty Providers
Each specialist provider will receive a check reflecting payment for covered services provided to eligible members and correctly billed to Fidelis Care. The check may be made payable to the individual provider or to a designated medical or professional group. Dual Providers should submit taxonomy code when submitting claim forms.

NOTE:
Any changes in a provider's status, address, corporate name, or other changes should be reported to Fidelis Care immediately to ensure prompt and accurate reimbursement.

Remittance Advice
Electronic Remittance Advice and 835 are available. For providers who have a user ID/password on the Secure File Delivery system, a Remittance Advice should be obtained by going to www.fideliscare.org. Click on the Quick Navigation Link and search for Provider Access Online or go to the site's Provider section and locate the link for Provider Access Online. Providers may also connect directly to https://secure.fideliscare.org/files/logon.aspx. For providers who have not established a user id/password, please contact your local provider relations representative for assistance.

The Remittance advice identifies which members and services are covered by a particular check. Claims are listed in alphabetical order according to the member’s last name. Each item in the listing includes the following:

- Fidelis Care claim number as assigned by Fidelis Care
- Member's name
- Member's Fidelis Care ID number
- Provider's name
- Date of service
- Procedure code
- Patient account number
- Denied amount
- Allowed amount

The Remittance Advice should be examined to reconcile payments from Fidelis Care with accounts receivable records.

Suggestions To Expedite Claims

- Have correct and complete information on the claim form.
- Verify member eligibility before filing claim.
- Do not submit duplicate claims. Initiate an inquiry if payment is not received within forty-five (45) days after billing date.
- Provide Coordination of Benefits information before claim is filed.
- Include your NPI and TIN on all claims submitted.
- Electronic submission is the best way to expedite claims (refer to section 12.1 in this manual). However, if you must submit paper claims, please mail claims routinely. By mailing claims routinely throughout the month, you will assure faster turnaround and avoid an end of the month backlog.
- Include the Authorization Number on the claim and/or attach authorization claims form.

Fidelis Care Claim Inquiry
To status claims submitted over thirty-five (35) days please go to www.fideliscare.org to access Provider Access Online. You can also contact the Provider Call Center at 1-888-FIDELIS (1-888-343-3547) Monday through Friday, 8:30 AM to 5:00 PM.

Stop payment and reissue of checks
To request a stop payment and reissue of a check, the request must be sent in writing to the following address:

Attn: Finance Department
Fidelis Care New York
480 CrossPoint Parkway
Getzville, New York 14068
The written request must have the following information:

- A completed and notarized affidavit (affidavit form, refer to Section 12B of this manual)
- The contact person and phone number
- Verification of the correct remittance address for the check
- Who the check was made payable to, if known

Please note that if the check has been cashed, an additional Affidavit form will need to be obtained, signed, and notarized.

Overpayments/Underpayments
If your claim is overpaid/underpaid, please request an adjustment by submitting an Administrative Review Form(Section 12A) and a copy of the payment voucher that indicates the payment. If Fidelis Care agrees with your request for adjustment due to an overpayment, the overpayment will be withdrawn from a future payment. Do not return the check containing the overpayment.

If Fidelis Care identifies that an overpayment has been made to a provider, Fidelis Care shall provide a thirty (30) calendar days written notice to physicians (unless otherwise noted) before engaging in additional overpayment recovery efforts. Such notice will state the member name, service date, payment amount, proposed adjustment, and a reasonable specific explanation of the proposed adjustment.

If a provider disagrees with the payment determination, please attach documentation supporting additional payment along with an Administrative Review form (Section 12A) and submit your request within 60 days of the remittance advice.

No payment
If a provider disagrees with the no payment determination, please attach documentation supporting payment along with an Administrative Review form (Section 12A).

Coding
Billing with the appropriate procedure and diagnosis codes aids in accurate and timely payment reimbursement.

Quick Guide To Claims Processing

QUESTION	PROFESSIONAL SERVICES	FACILITY SERVICES
Where do I direct billing questions?	1-888-FIDELIS Provider Services Department	1-888- FIDELIS Provider Services Department
Where do I submit claims?	Refer to the Fidelis Care Web site at www.fideliscare.org for information about submitting claims electronically	Refer to the Fidelis Care Web site at www.fideliscare.org for information about submitting claims electronically
Which forms may be used for billing?	CMS 1500	UB04
Which patient identifier(s) should be used?	Medicaid Number (CIN) or Fidelis Care Identification Number	Medicaid Number (CIN) or Fidelis Care Identification Number
What is the time frame for submitting the claim?	see Section 12.1	see Section 12.1
What is the time frame for payment of a completed and clean claim?	30 days after receipt of a clean claim submitted electronically 45 days after receipt of a clean claim submitted via paper (In accordance with NY Insurance Law Section 3224-a)	30 days after receipt of a clean claim submitted electronically 45 days after receipt of a clean claim submitted via paper (In accordance with NY Insurance Law Section 3224-a)
What is the appeal process if you believe a claim has been underpaid or wish to appeal a denied claim?	Please refer to Section 13, PROVIDER APPEALS	Please refer to Section 13, PROVIDER APPEALS

HOW DO I CHECK ON THE STATUS OF A CLAIM?	
What do I do?	1. To status claims please go www.fideliscare.org to access our secure Provider Portal
What do I ask?	Request a claims status check.
What information does Fidelis Care need?	1. Name of member and Fidelis Care ID# or CIN number 2. Name and Provider NPI and TIN of Physician 3. Date (s) of service 4. Amount of claim 5. Fidelis Care claim number, if available 6. Copy of original claim or voucher
To whom do I direct a claims inquiry?	Call 1-888-FIDELIS (1-888-343-3547)