Provider Administrative Manual

Patient Choice Provider Manual
Quick Reference Contact List
Effective February 1, 2005

Claim Services

Customer Service	1-877-233-1800
Referral Fax Number	1-877-392-7711

Fiserv Health Online

www.fiservhealthservices.com

Technical Support	1-866-922-8266

Claim Submission

EDI Payer Number	39026
Mailing Address	PO Box 8013 - Wausau, WI 54402-8013

Internet Forms

www.fiservhealthservices.com
Online Services
Providers
Forms
PC

- In just 60 seconds providers have access to Eligibility, Benefits and Claim Status.
- Just call and providers will receive a fax with a patient's
    - Claim status and payment detail
    - Benefits information
    - Eligibility information
    - Claim submission information
    - Deductible and out-of-pocket status
    - Pre-certification information

- **To receive Eligibility and Benefits information**
    1. .Press "1" for Medical
    2. .Enter the Employee's Member ID or Social Security Number
    3. .Choose and confirm the correct dependent
    4. .Press "1" for Eligibility and Benefits information
    5. .Enter and confirm you fax number
- To receive Eligibility and Benefits information on multiple patient…
    1. After you hear "Your fax is on its way"
    2. .Press "2"
    3. .Repeat steps 2 through 5
- **To Receive Claim Status Information**
    1. .Press "1" for Medical
    2. .Enter the Employee's Member ID or Social Security Number
    3. .Choose and confirm the correct dependent
    4. .Press "2" for Claim Status
    5. .Enter your 9-digit Tax Identification Number (TIN)
    6. .Enter the date of service (XX/XX/XX)
    7. .Enter and confirm you fax number
- To receive Claim Status on multiple patients…
    1. After you hear "Your fax is on its way"
    2. .Press "3"
    3. .Repeat steps 2 through 7

Fiserv Health employs more than 200 CSR's with our Wausau, Wisconsin; and Des Moines, Iowa claim operation locations. Medical claim Customer Service Representatives (CSRs), complete a meticulous 10-week training program prior to processing claims. Fiserv Health is one of the largest Third party Administrators in the United States, processing more than 9 million claims annually, from more than 1.9 million enrollees from over 400 employers.

Headquartered in Wausau, Wisconsin, Fiserv Health employs more than 1100 professionals between our claim processing offices in Wausau, WI and Des Moines, IA as well as in field offices throughout the country.

A High-Touch Company

- Dedicated 800 numbers for all Patient Choice Plans
- Dedicated teams for Patient choice Plans
- Customer Service Representatives handle both claims and telephone inquiries
- Experienced CSRs average more than 5 years (industry average is 2)
- Formalized training for new CSRs; ongoing, monthly training for experienced CSRs
- 90% of all information needed is kept on CSR desktop
- CSRs use a database that holds plan design information for every Fiserv Health book of business
- All CSR's have image retrieval capability on their desktop, allowing them to view every claim document received with the click of a button.

Fiserv Health offers self-funded customers a single source for benefit plan administration, including

- Health — *URAC Accredited Claim Processing*
- Disability
- Flexible Spending accounts
- Stop Loss
- Pharmacy Benefits
- COBRA
- HIPAA
- Dental
- Vision
- Medical Management — *URAC Accredited Case and Disease Management*
- Population Health Management Programs

As a matter of time-sensitivity, Fiserv Health sets very high performance standards including:

Claim Turnaround	>90% in 10 days
Auto Adjudication	>75%
Call Response Rate	>85% in 30 seconds or less
Abandon Call Rate	<3%
Enrollment Accuracy	>98%
Electronic Enrollment	>72%
Financial Quality	>99.3 %
First Call Resolution	>90.0%

Fiserv Health strives to be a leader in the technological age with the information it handles, both internally and externally.

- Imaging system electronically captures and delivers over 30,000 paper documents, daily.
- OCR / ICR software converts paper claims to electronic files.
- Extensive disaster recovery plans
- Highly automated Problem Service Management system to track problems from start to finish.

Patient Choice Provider Manual
Claim Filing Continued - Mailing Claims and Minnesota Care Tax
Effective February 1, 2005

Paper Submission of Claims
Submit all claims on a standard HCFA-1500, or UB92 to:

Fiserv Health
PO Box 8013
Wausau, Wisconsin 54402-8013

Make sure that all information is legible, preferably type-written, and at a minimum that the following information is included on the form:

- Full name, address, and Member ID of the employee
- Employee's employer or sponsor name and/or plan number
- Patient's name and date of birth
- ICD-9 diagnosis code(s)
- Itemization of charges, including:
  - Date of Service
  - CPT procedure code(s), HCPCS
  - Facility or Provider Tax ID Number
  - Information regarding pre-certification requirements, if applicable
  - Physician Name, if bill is from a clinic

The address for bill submission is located on the reverse side of the employee's identification card, as well as on the Fiserv Health's website, www.fiservhealthservices.com. The next two pages are an example of an ID card.

BENEFITS ADMINISTERED BY

PATIENT NAME/COVERAGE

CARE SYSTEM/PRIMARY CARE

NAME:

ID:

EMPLR:

GROUP:

OFFICE COPAY:

CUSTOMER SERVICE:
PROVIDERS - CALL 1(877) 233-1800
MEMBERS - CALL 1(877) 390-7632

Print Date

This card must be presented each time services are requested.

MAIL ALL CLAIMS TO: UMR
PO BOX 450
PUEBLO CO 81002-0450
EDI PAYER ID # 39026

CUSTOMER SERVICE

1(877) 390-7632 — **Notice to Providers, Physicians and Facilities:** You are required to call for all inpatient admissions.
Notice to Members: You are required to call for any plan required certifications and any admission not directed by your care system physician.

1(800) 678-PHCS — For out of area participating PHCS providers when traveling contact **PHCS,** provider information line or www.umr.com

Patient Choice Web Site:
Your source for the most up-to-date information
www.patientchoicesignature.com

Sometimes a CSR cannot process a claim without further review from a support unit within the department.

When this occurs the CSR electronically pends the claim, with notes indicating the information to be reviewed to the support area, these notes can be viewed by any CSR that receives a telephone call questioning the status of a claim.

Situations that may require review by a support area *(this is not an all-inclusive list):*

Provider Add: The information pertaining to the medical provider on the claim contradicts the information in our files. The CSR forwards the claim to the Provider Add unit to have the information reviewed and confirmed.

Subrogation: Claims identified as having the potential for a third-party liability, (Worker's Compensation, Auto-Carriers) are sent to our Subrogation Unit for further review.

Fiserv Health normal workflow for these claims is to process the charges and then recoup employer funds. If a third party liability exists (excpet for worker comp claims which are always denied).

Medical Management: Claims with procedures or complications that require medical necessity review are forwarded to the Medical Management unit for review.

Quality Review: Approximately 2% of all processed claims are randomly selected for quality review.

Additionally all high-dollar claims are reviewed by the claim unit Supervisors. CSRs check limits on a graduated scale ranging from $0.00 to $10,000.00, based on their quality performance.

All CSRs must exceed the following performance requirements for all claims reviewed:

95% procedural accuracy
98% payment accuracy
99% financial accuracy

CSRs sometimes need to request further information from sources outside of Fiserv Health in order to process a claim. In these situations the claim is suspended and an Explanation of Benefits is sent to the employee indicating the claim cannot be considered for payment until additional information is provided. The following are examples of some of these situations:

Other Insurance Updates
Student Status Updates
Accident Detail / Subrogation Inquiry
Explanation of Medicare Benefits / Other Insurance Explanation of Benefits requests.
Medical Records Request
Independent Medical Review

When any of these situations occur, the patient has an unlimited amount of time to provide the information without penalty. In many cases the employee can either return the requested information (for other insurance, student status, or accident details) by mail or provide it by phone. Primary carrier information must always be received on paper. Once the additional information is received we review all suspended charges and immediately process the claim in accordance with all plan benefits.

The next few pages provide a short synopsis of how the Claim Payment System work flow for these cases.

Other Insurance updates

(herein referred to as OI)
verification is requested upon initial

- OI updates are enrollment of a new group plan.
- OI updates are only requested at time of claim when online information is older them 13 months
- CSRs update the employee's entire family unit when information is received. System logic reads the date of entry to flag for the next verification date.
- CSR's are able to pull all claims, update the OI field and reprocess in one step once the updated information is received.
- Provider should bill the patient at time of suspension because the claim will not be reviewed until the requested information is received.

Student Status Information

- *(herein referred to as SS)*
- Student Status is updated for all children age 18 and over listed as dependent(s) under the employee's plan. The information is checked every six months, running concurrently with the beginning of the spring and fall semesters.
- Student status updates work much in the same fashion as the OI update process. If information on file is not current, the system suspends claims and generates an Explanation of Benefits to the employee, requesting that they call and provide an update.
- CSR's are able to pull all claims, update student status, and reprocess in one step.
- Provider should bill the patient at time of the initial suspension because the claim will not be reviewed again until the requested information is received
- Beginning late May 2005 members have the ability to update their OI information through the IVR or web.

Medical Records

Medical Records are requested for a number of reasons including:

- Prior-Authorization Requests (Pre-Estimates
- Medical Review for Medical Necessity
- Appeal of Denial of Benefits
- Special Investigation Review
- Outside Medical Reviews *(herein referred to as OMR)*
  - OMRs are usually conducted during the final steps of an appeal process.
  - Medical records are requested from the appropriate providers. If they have not already been gathered through our investigation, and all information is forwarded to an independent medical reviewer.
  - The opinion of the independent reviewer is held as Fiserv Health's final decision.

- Providers are given two, 28-day periods to supply the medical records to our offices. All requests are made in writing with all pertinent information attached for quick reference. If the information is not received within the 28-day periods the claim(s) is denied for lack of information.

Accident Details / Subrogation Investigation

- Box 10 of the HCFA-1500 form is reviewd for indication that the visit may have been accident related. The list of diagnosis codes are compared to a list of codes likely to be subrogatable.
- If the billed diagnosis falls into one of the above criteria, we determine, if we have already investigated accident detail on the diagonsis:
  - If we have, and found it to be subrogatable, charges the claim is pended to the Subrogation Unit
    If we have and found it not to be subrogatable the claim is processed.
- If we have not checked already, the claim suspends generating a letter to the enrollee for accident detail information.
- Provider should bill the patient at time of the initial suspension because the claim will not be reviewed again until the requested information is received.

Primary Carrier Explanation of Benefits

When a claim is received and no primary payer information is attached, the information we have on file indicates the member has OI coverage:

- If OI is primary the claim is suspended and an Explanation of Benefits is sent requesting the primary payor EOB.
- Employee, patient or provider can supply the other insurance primary payor information to Fiserv Health
- A Physical copy of the EOB is required or the provider can send a print-out of the electronic payment information they receive.

Coordination of Benefits

- *see workflow on Page 30*

Patient Choice Provider Manual
Referral Processing
Effective September 01, 2002

Care Systems may submit referrals via:

- Fax 1-877-392-7711
- EDI (via Claim Lynx) Payor Number 39026
- Paper Mail PO Box 8013 - Wausau, WI 54402-8013

Care System indicators are required for all referrals. Referrals received without the indication are not considered calid and are not entered.

Once received, Fiserv Health assigns an Authorization Number to each referral. This is a unique number that will be provided to callers upon request and which can be used to reference their referral. This number is assigned within 24 hours of receipt.

In-Care System Referrals

Referrals are matched to incoming claims by:

- Demographics of Patient
- Provider TIN
- Date of Service

Out-of-Care System Referrals

- Demographics of Patient
- Billing Provider TIN
- Date of Service span
- Occurrences
- Type of Service

All referral information is kept indefinitely in electronic form.

Letters are sent only for denied referrals. If an appeal is requested, Fiserv Health communicates the appeal process based on the plan sponsors specific guidelines.

Providers may write referrals for:

- C - Consultation
  Physician visit only
- CRXT - Consult, Test and Treatment
  Physician visit plus any testing, diagnostic testing, labs, x-rays and
  chemotherapy
- A - Consult, Test, Treatment, and Surgery
  Physician visit plus any testing, diagnostic testing, labs, x-rays and
  chemotherapy, plus surgery and follow-up visits

Referrals are not needed for:

- Radiologists
- Anesthesiologists
- Pathologists
- Laboratory

Referrals are required to Out-of-Care System providers such as:

- Chiropractors
- Mental Health Providers
- DME Suppliers

Indicates required field.

Referral Authorization Request

Please PRINT or TYPE

Care System Identifier ____

Patient Name:_____ DOB:_____

Employee Name:_____ Member ID#:_____

Group Number: _____ Employer Name: _____

Referred To: _____ OR _____

Provider Name (Last,First) Entity / Facility Name

Preferred, if Known → _____

Tax Identification Number

☐ In Network ☐ Out of Network

ICD9 Code: _____ (must be the ICD9 code, and not a text translation of the code)

Referral Requested For:

Consultation Consultation, Test, Treatment All Services

Dates of Service: _____ to _____ → Number of Visits: _____

Referred By: _____,

Please Print Physician's Name

_____ And _____

Office Contact Phone Number

Has service already occurred? Yes ☐ No ☐

Date:_____

Approved ☐ Denied ☐

Denial Reason:

☐ Care available in Care System

☐ Other : _____

_____

Please send form to:

FISERV HEALTH Attn: DE Referral / Nancy Zinda
P.O. Box 8046
Wausau, WI 54402-8046
Fax Number: 1-877-392-7711

In-Network Precert

Each Care System hospital is responsible for their own In-Network Precert, however Fiserv Health requires notification of hospital stays from the providers because of Reinsurer requirements.

Out-of-Network Precert

Required for all Patient Choice members.

For all inpatient stays the member, or the provider's billing office, must call Fiserv Health for precertification.

Fiserv Health works with the appropriate Care System Coordinator to redirect the care back into the Care System.

Pre-Authorization

Outpatient

For all Patient Choice Care Systems, the employer specifies what will and will not require pre-authorization. This information is contained in the Employer Summary Plan Document.

For catastrophic case management phone calls are made daily to the Care System contact, informing them of potential cases. At time of call a decision is made if the Care System or Fiserv Health will handle the case management for each case.

Fiserv Health criteria for identification of a catastrophic case is either:

- $30,000 inpatient charges
- $10,000 outpatient charges
- ICD-9 codes known to predominantly be high dollar
  - Examples: (HIV, Cancer, Transplant, Pre-Mature and Multiple Births...)
- Care System Requested
- Employer Requested

For self-funded plans, the employer chooses what services require pre-authorization. It is the members responsibility to know their plan design and be responsible to ensure required services are pre-authorized. Providers should work with members to submit information to Fiserv Health's Medical Management for pre-authorization.
Just because a plan doesn't require a service to be pre-authorized, doesn't mean the service will be covered, but only covered if medically necessary. Some services may be covered under specific circumstances, or not covered (excluded) regardless of circumstance. Services that are completely excluded under a plan are not covered regardless of medical necessity. Members are responsible for knowing their plan exclusions. When in doubt the pre-determination process should be followed. The pre-determination request provides prudent members/ providers with a process for requesting a benefit determination prior to the services being performed. For example, cosmetic surgeries are typically excluded completely from plan coverage, or covered only if approved as medically necessary in accordance with specific guidelines. As such members/ providers should consider requesting a pre-determination for any cosmetic procedure that may not be covered.

This manual provides an abbreviated list of procedures or services that are commonly excluded from benefits or only covered if determined to be medicallly necessary.
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- Blepharoplasty / Levator Resection / Eyelid Surgery
- Septoplasty - Nasal / Sinus Surgery
- Rhinoplasty - Nasal Surgery
- Obesity / Morbid Obesity
- Gastric Bypass Surgery/ Roux-en-Y jejunostomy / Stomach Staple
- Panniculectomy / Abdominoplasty / Tummy Tuck
- Breast Reduction / Reduction Mammoplasty / Gynecomastia
- Speech Therapy (except for initial evaluation, as it is diagnostic)
- Orthoptic Training / Vision Therapy
- Prolotherapy
- Biofeedback
- Acupuncture
- IDET - Intradiscal Electrothermal Treatment (outpatient)
- Scar Revision
- Reconstructive Surgery
- Cosmetic Procedures
- Experimental Procedures
- UPPP / UP3 / Uvulopalatoplasty
- LAUP / Laser Assisted Uvulopalatoplasty
- Somnoplasty / Tongue Reduction - often done for snoring
- Some implanted devices (morphine pump, nerve stimulator, etc.)
- Injections - Ex. Botox, Synvisc (also called Hyalgan) Depo-Provera, and Depot Lupron
- Remicade Infusions
- IVIG (Intravenous immunoglobin)
- Clinical Trials
  (Note, this list is not all
  inclusive list)

A list of more comprehensive procedures and services can be found by visiting www.fiservhealthservices.com. Reference the Online Services section, select Provider Information Center, then select Forms.

The pre-determination requires review of all medical information from the servicing providers.
Once a decision is made, a letter with the approval, partial approval, or denial of the services is sent to both the medical provider and the patient.

Request for Review

If a provider feels that our processing of claims was not considered correctly due to a lack of information or the situation regarding the charges was not fully explained, they may request a formal inquiry review of the charges. This review may only be requested after a remittance advice, explanation of benefits, or pre-authorization determination letter has been received by the provider.

To initiate an inquiry, please describe in writing, the specific reason(s) for requesting the review. Include with the request all applicable documentation including new information not provided during the initial review and forward to:

Claim Appeals Unit
Fiserv Health
P.O. Box 8086
Wausau, WI 54402-8086

The review determination will be sent in writing to both the provider and the employee/ member.

FiserV Health
PO Box 8013 Wausau WI 54402-8013
1-800-826-9781
www.fiservhealthservices.com

SAMPLE

(1)

Employee	Joe Patient
Member Number	999999999
Patient	Joe Patient
Notice Date	09-01-05
Employer Name	Customer Inc.
Employer Number	7670-00-999999

EXPLANATION OF BENEFITS NOTICE - THIS IS NOT A BILL

(2) **Provider: Physician,Joe,MD**

(3) **Patient Account: 05050505aa**

(4) **Claim Control Number: 05171769999**

Service Description (5)	Dates of Service From: (6)	To:	Amount Billed (7)	Amount Not Payable (8)	See Note Section (9)	Less Deductible (10)	Allowable Amount (11)	% (12)	Plan Benefit Amount (13)	Amount Paid (14)	Provider May Bill You (15)
99283 - Emergency Care	01-01-05	01-01-05	$100.00	$25.00	908	$50.00	$25.00	80	$20.00	$20.00	$55.00
		TOTALS	$100.00			$50.00	$25.00		$20.00	$20.00	$55.00

Note Section (16)

908 Provider negotiated reduction. You are not responsible for this amount.

(17)

Payment To: XYZ Clinic

Payment Date: 09-01-05 **Payment Amount:** $20.00

Benefit Period	Benefit Level (18)	Applied To Date
	$1,000,000 Lifetime Maximum	$1,000,000.00 Met
01-01-05	$200 Ind Cal Yr Deductible	$50.00
01-01-05	$400 Fam Cal Yr Deductible	$50.00
01-01-05	$400 Ind Out-Of-Pocket	$50.00
01-01-05	$800 Fam Out-Of-Pocket	$50.00

EOB Field Explanations:

1. Fields include member information under which the claim was processed.
2. Hospital, physician or other health care provider that performed the services.
3. Account number assigned by the hospital, physician or other health care provider.
4. Fiserv Health assigns a unique claim control number to each claim received.
5. Services and/or procedures that were performed by the hospital, physician or other health care provider.
   Service description T9999 will print if dollars are available to be reimbursed from HRA.
6. Date(s) services were performed by the hospital, physician or other health care provider.
7. Amount charged for the services by the hospital, physician or other health care provider.
8. Charges not allowed according to the Plan - see comment code.
9. Refers to codes used to explain charges that were not allowed - see Note Section
10. Amount applied to the deductible.
11. Charges allowed for payment - this is the difference between the "Amount Billed" and the "Amount Not Payable" and/or "Less Deductible" columns
12. Percentage at which the Allowable charges are paid.
13. Amount actually payable by the Plan.
14. Amount that Fiserv Health paid the provider.
15. Only amount you are responsible to pay to the hospital, physician or other health care provider, if applicable.
16. Explains codes provided in the "See Note Section" column. Lists the specific code and its definition.
17. List of individuals or organizations to whom checks were issued.
18. Provides benefit period and benefit levels, amounts applied to individual/family deductibles, out-of-pocket and lifetime maximums, if applicable.

(1) **Remittance Advice for Period Ending 02-01-06**

(2) **FISERV HEALTH** 1-866-299-9090

(3) PO BOX 8077 WAUSAU WI 54402-8077
FISERV HEALTH PLAN
FISERV, INC.

(4)

SAMPLE

(32) Visit our web-site at **www.FiservHealthServices.com** to obtain eligiblity, benefit and claim information on behalf of your patients 24 hours/day, 7 days/week

(5) MEDICAL CENTER
111 ANYSTREET
SUITE 999
ANYCITY WI 53400-0001

(6) **Federal Tax ID NO. 55-5555555**

(7) Dates From/To	(8) Service Code	(9) Charged Amount	(10) Allowed Amount	(11) Deductible	(12) Copay	(13) Coinsurance	(14) Discount Managed Care Adjust	(15) Ineligible	(16) Withheld	(17) OC	(18) ANSI Code	(19) Paid	(20) Patient Responsibility
EMPLOYEE: JOE PATIENT (21)				(22) **PATIENT: JANE PATIENT**				(23)	**CERT NO. 999999999**				
ACCOUNT NUMBER: 12354678 (24)				**CLAIM NUMBER: 05001000001** (25)									
011506	99204	179.00	152.15	.00	.00	.00	26.85-		.00	01		152.15	26.85
							FEE EXCESS				41		
011506	99212	180.00	153.15	.00	.00	.00	26.85-		.00	01		153.15	26.85
											41		
TOTAL (26)		359.00	305.30	.00	.00	.00	53.70-		.00			305.30	53.70
					NETWORK SERVICES								
EMPLOYEE: JACK MEMBER					**PATIENT: JILL MEMBER**				**CERT NO. 499999990**				
ACCOUNT NUMBER: 12354678				**CLAIM NUMBER: 05001000002**									
011706	99214	110.00	110.00	100.00	10.00	.00	.00		.00			.00	110.00
TOTAL		110.00	0.00	100.00	10.00	.00	.00		.00			.00	110.00
					NETWORK SERVICES		(27)						
(28) SUB TOTAL:		469.00	415.30	100.00	10.00	0.00	53.70-	0.00	0.00			305.30	110.00
PROVIDER TOTAL:		469.00	415.30	100.00	10.00	0.00	53.70-	0.00	0.00			305.30	110.00

(29)

CD999 01000000001

CF0038 12-93

(30) (31)

Detail for Coding on Fiserv Health's Remittance Advice

01 Last day of the week for period covering the claims listed on this particular remittance advice.

02 Header identifying the organizational plan the patients are associated with. Header includes name, address, and return phone call number.

03 Indicates the plan name or plan holder the patients are covered under.

04 Provider of services and address.

05 Indicates the Federal Tax ID number of the provider.

06 The date of service range the services were provided are listed in this column.

07 The services' charges are listed in this column. If the charges submitted are processed at a per diem level, provider will only see one line with total charges and total payments.

08 Column shows amount charged per service.

09 Column shows the amount allowed per service line.

10 Column shows the amount of deductible applied per service line.

11 Column shows if any copays are applicable per plan benefits.

12 Column shows the amount of co-insurance the patient is responsible for per service line.

13 Column shows the amount of discount taken for each line of service. If column shows a negative number, Fiserv Health is paying greater than the billed amount, amount should be added to Allowed Amount for final calculation of payment.

14 Column will show dollars and short description of ineligible amounts.

15 Column shows the amount of withhold applicable to each service line per negotiated rates.

16 Column indicates the number of occurrences processed for each service line.

17 Column indicates the American National Standards Institute (ANSI) code applicable to ineligible codes.

18 Column shows actual amounts paid to the provider. This amount may differ from the Explanation of Benefits due to withhold amounts.

19 Column indicates the patient responsibility per service line.

20 Indicates the employee covered under the plan.

21 Indicates the patient for whom the charges were processed.

22 Indicates the social security number the charges were processed under.

23 Indicates the provider's account number for the patient (as indicated on bill).

24 Indicates Fiserv Health's internal identification number for the claim (Claim Control Number).

25 If a contract amount allows Fiserv Health to pay greater than billed, the variance will show on the RA as a negative dollar amount.

26 The total of all applicable columns for the claim processed.

27 The subtotal for the page if more pages are to follow for the same provider.

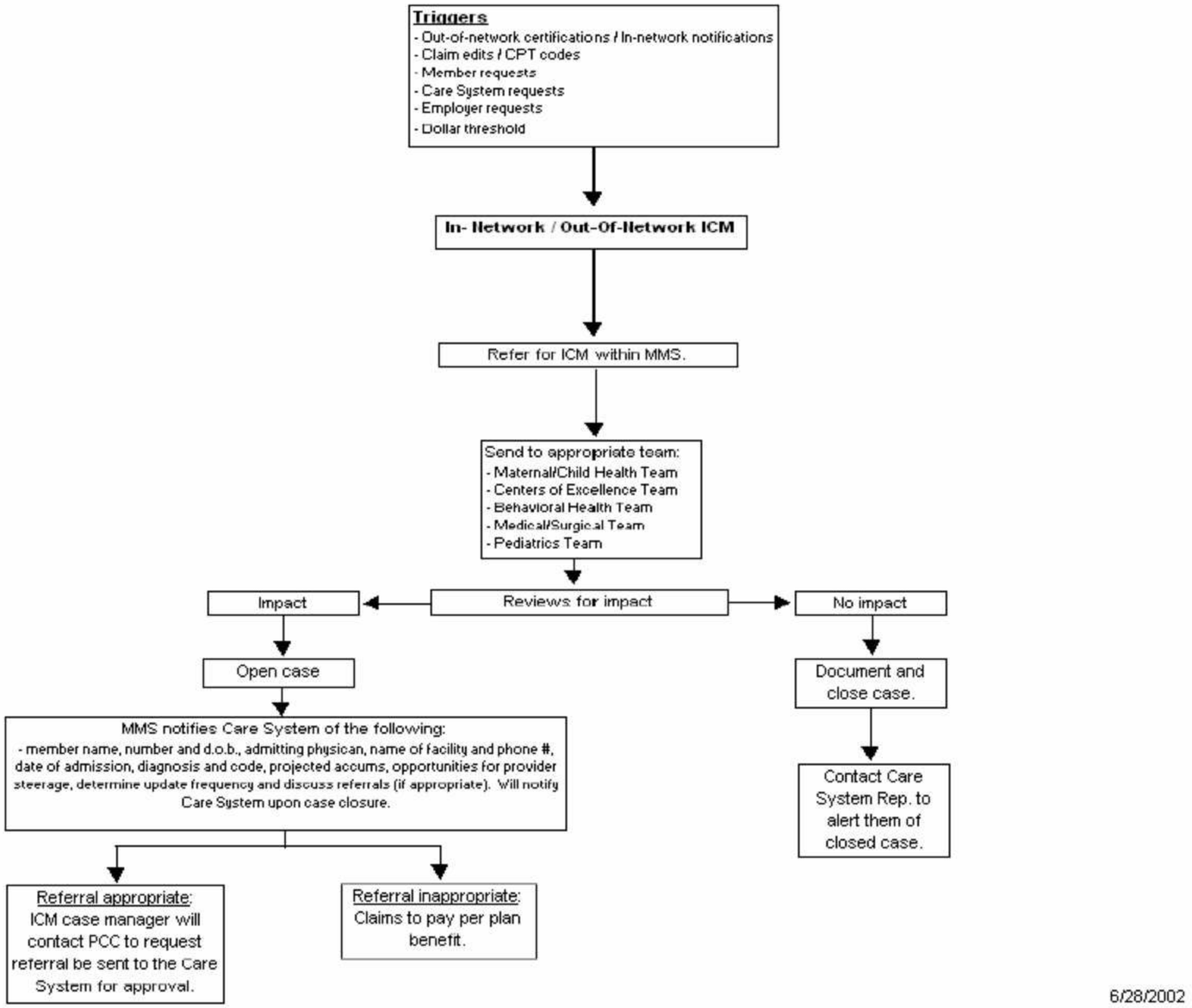
28 The total of all applicable columns for the provider. Will only show on the final page.

29 Care Tax

CARE SYSTEM NAME

Fiserv Health Medical Management Services (MMS) Individual Case Management Procedure

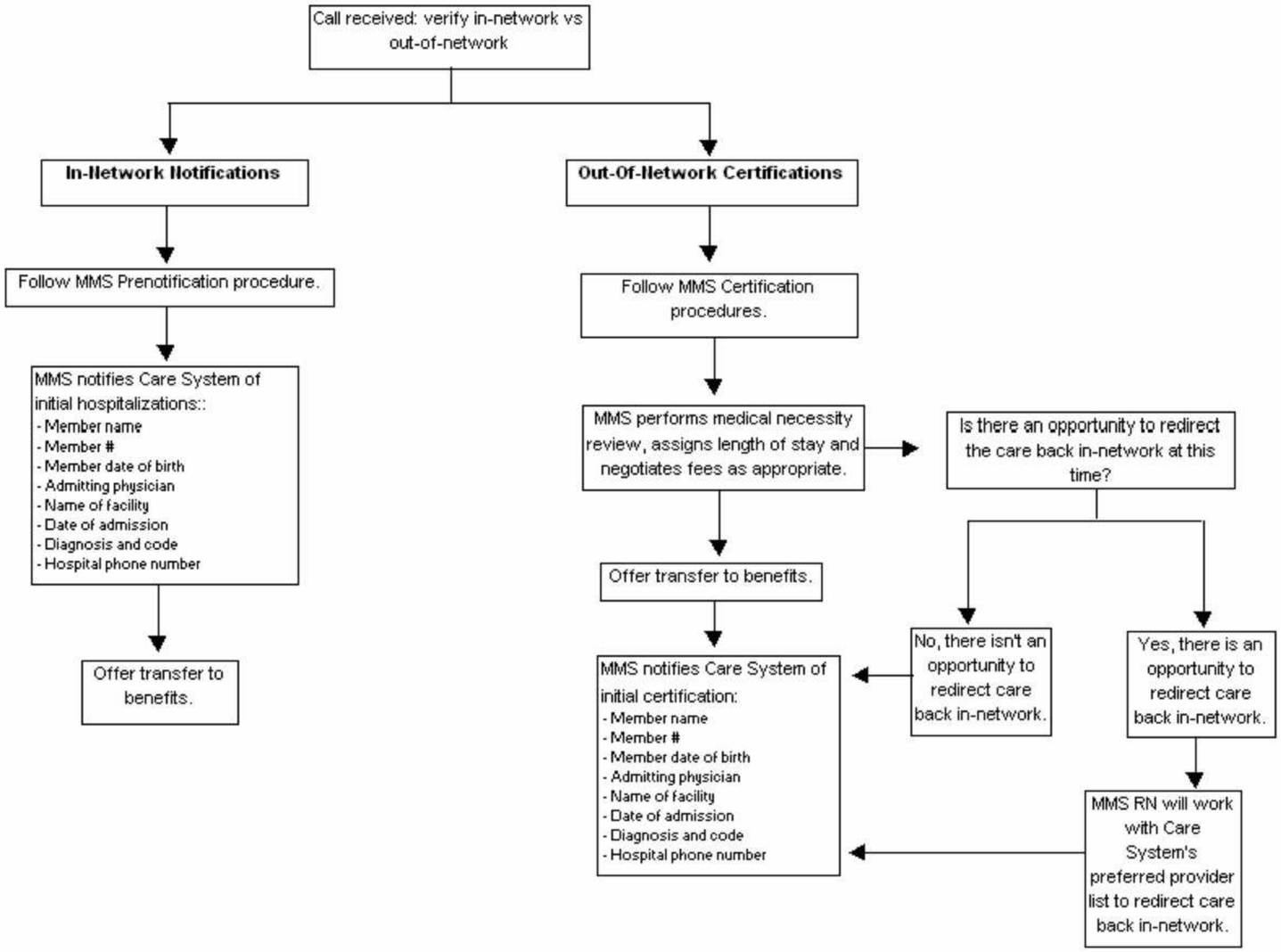
Definition: **Individual Case Management (ICM)** - Identified through potential high dollar cases and/or catastrophic cases as early as possible. Provides direct communication with patient, family and care providers to ensure appropriate quality care.



6/28/2002

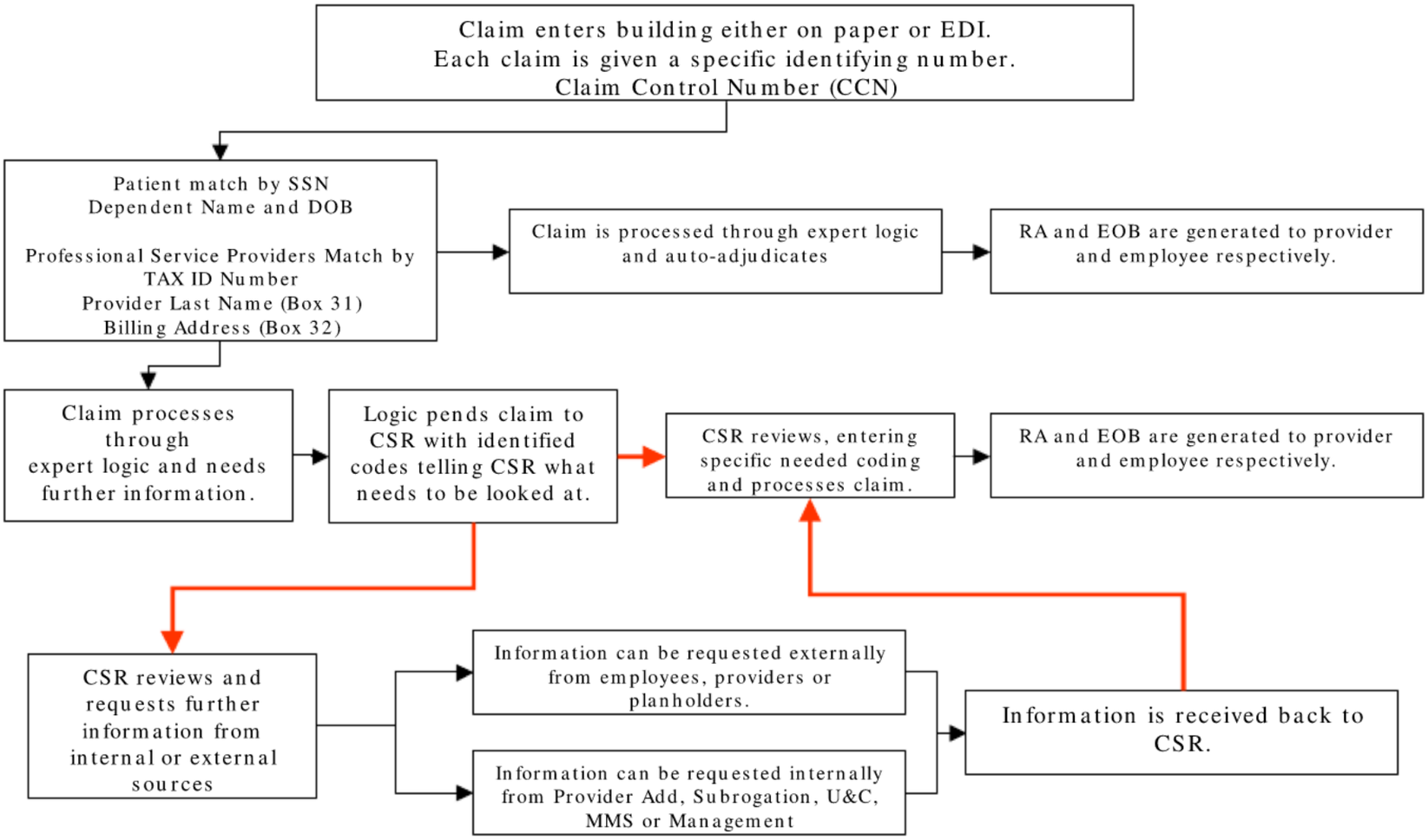
CARE SYSTEM NAME

Fiserv Health **Medical Management Services (MMS) Certification/Notification Procedure**

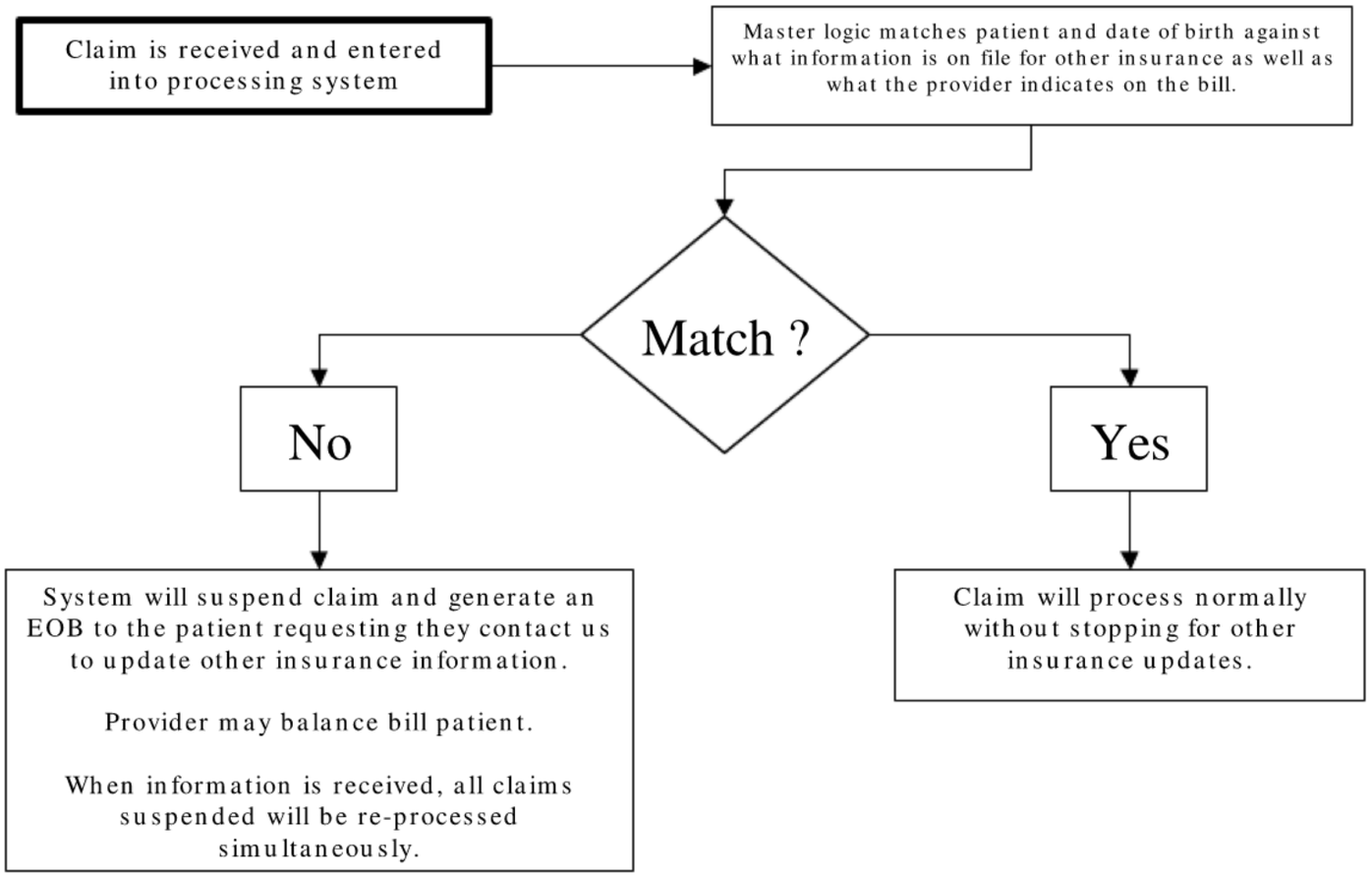


6/28/2002

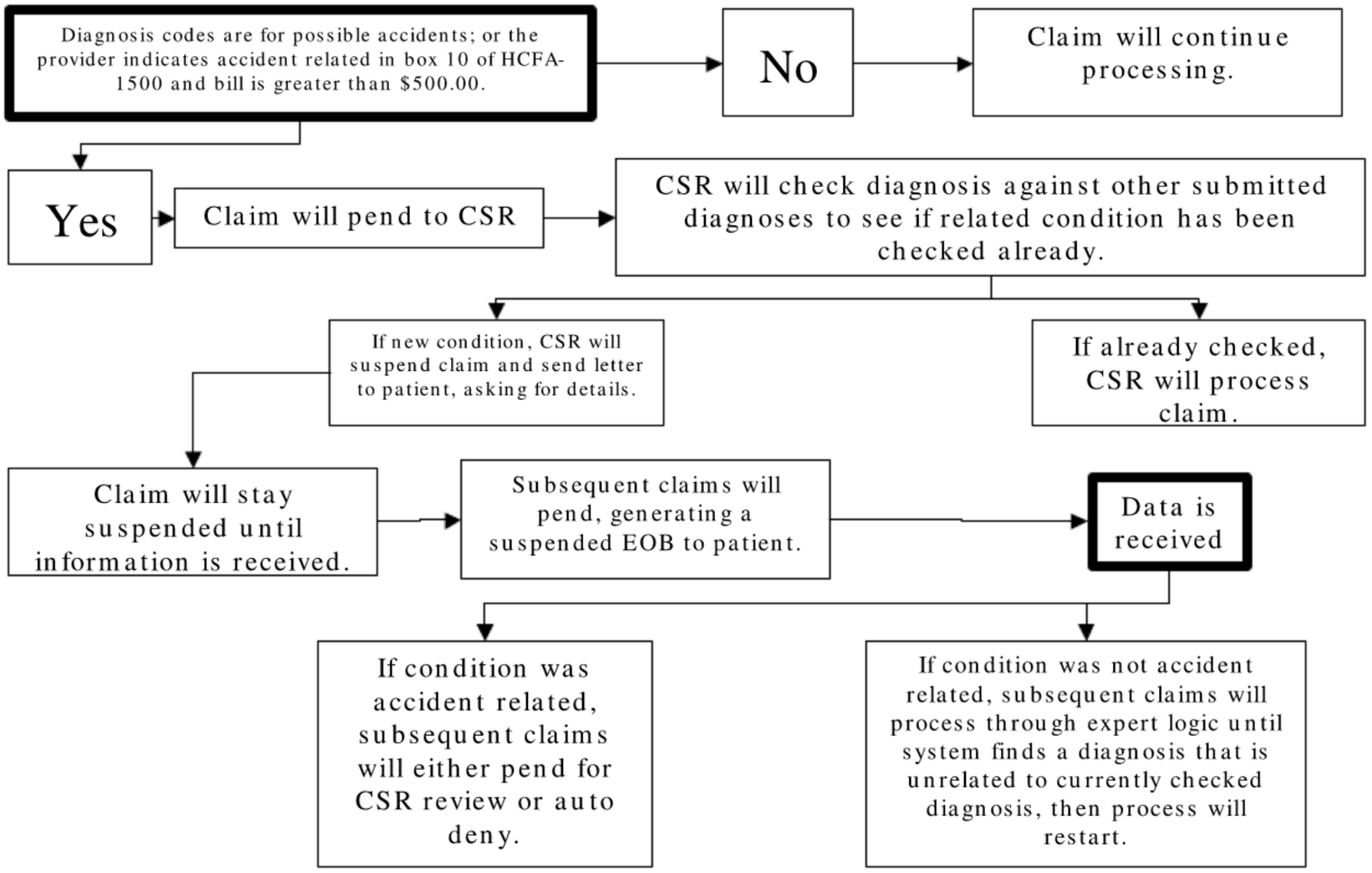
Claim Processing Flow



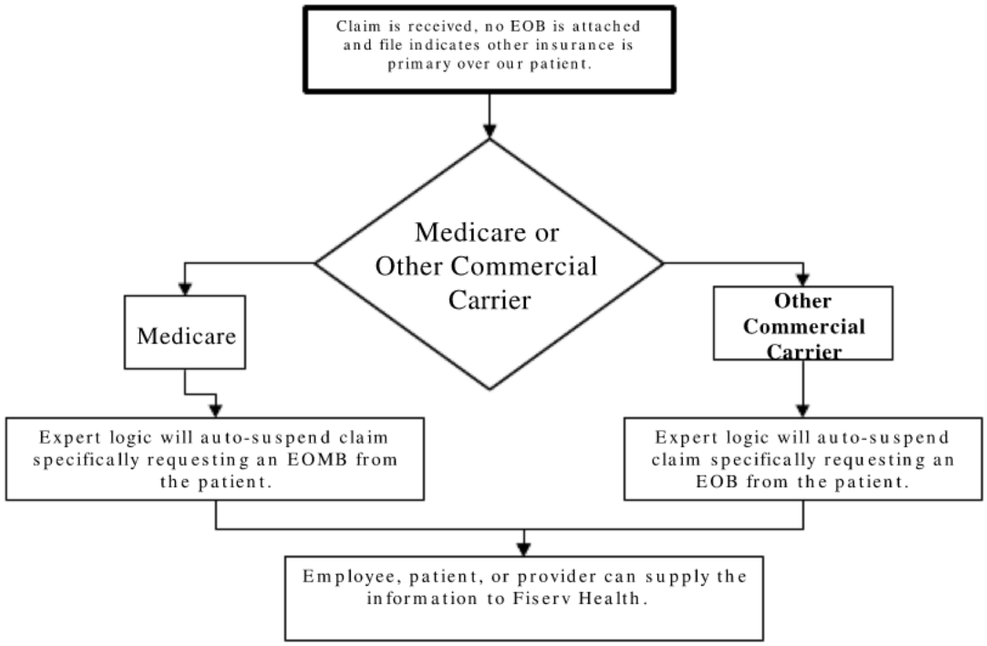
Other Insurance Requests



Accident Details / Subrogation Inquiry



Primary Carrier EOB Requests (OI)



Coordination of Benefits Information

In order to most successfully process a claim with coordination of benefits, Fiserv Health requests a full, original billing with the following information. Information can be received by fax, mail, or EDI.