

Claims Payment/Management

Claims Submission Policy: a claim should be submitted for payment subsequent to services being rendered. Providers are responsible for submitting claims for reimbursement.

Required Forms: Appropriate claim forms must be used. See Sample Claim Forms for a sample of these forms.

- Health Insurance Claim Form-HCFA-1500.
- UB-92 (Universal Institutional Billing Form).

Completing Claims Forms

1. Facilities must complete all required information on claim forms. See Sample Claim Forms for a sample UB-92 Form and instructions.
2. Providers must complete all required information on the claim form. See Sample Claim Forms, for sample HCFA 1500 form and instructions.

Primary Diagnosis (DSM-IV): The diagnoses covered by the Mental Health Capitation Program are listed in Section XII of this manual. If the primary diagnosis is not on this list then the provider should bill Colorado Medicaid Fee-For-Service Program. When submitting a claim to BHI for professional fees, make sure that the primary diagnosis is listed in Section XII, primary diagnosis. Facilities filling a claim must use the billing service codes listed on their individual facility agreements and the primary diagnosis that is listed in Section XII.

Insured/Consumer Signatures on Provider Submitted Claims:

Outpatient: The provider should maintain in his/her files on Health Insurance Claim Form HCFA - 1500, filled out and signed by the insured consumer. This form is good for one year from the signature date and should be renewed at least annually. At BHI's request, copies of signatures must be supplied for auditing purposes to ensure compliance.

Inpatient: Upon admission, the facility/institution should maintain in the consumer's file the appropriate registration filled out and signed by the insured/consumer. At each admission the institution is required to obtain an updated registration filled out and signed by the insured/consumer. At BHI's request, copies of signatures must be supplied for auditing purposes to ensure compliance.

Claims Submission Requirements: All claims for care must be submitted on an approved claim form and must contain the actual address, including zip code, where services were provided, regardless of the provider's preferred billing address.

Claims for services submitted by BHI Network providers must be received no later than 60 days after the services were delivered.

In cases where BHI is the secondary payer, the network provider is required to submit claims for services no later than 30 days after all primary payments are made or finally denied.

Corrected Billings: Claims submitted as corrected billings for the following must have clinical documentation attached supporting the correction. To expedite handling, please indicate " ReBill" across the top of the claim form.

- Change of diagnosis code--why is diagnosis code being changed?
- Change of date of service--why is date of service being changed?
- Change of service code--why is service code being changed?
- Change of place of service--why is place of service being changed?

Corrected billings received without the documentation will be returned unprocessed.

Claim Submission:

Please send claims or written claims appeals to:

BHI Claims
PO Box 17448
Denver, CO 80217

Billing the Consumer: Providers may not bill consumers

Coordination of Benefits: BHI will coordinate benefits with a consumer's primary health insurance carrier. A copy of the primary carrier's Explanation of Benefits (EOB) or denial should be sent with each claim submitted.

BHI's referral and utilization management procedures must be observed in order to receive benefit reimbursement (even if BHI is the secondary insurance carrier). The provider has 30 days from the date of receipt of the primary insurance carrier's EOB to submit the claim to BHI.

Clinical Assessment/Concurrent Review Form Copies Not Needed With Claims: Providers do not need to submit copies of their clinical paperwork each time a claim is submitted.

Time Limit of Payment: Provided all necessary information is received to process the claim, claims shall be paid or denied within 45 days of the receipt date and 30 days if claims are submitted in electronic format.

Questions About Claims Procedures: BHI/Provider Relations staff is available to answer any question you may have about the preceding claims procedures. Please call (720) 490-4413.