Billing Requirements

All claims must be submitted on an original red/white CMS-1500 Claim Form via mail. Claims must be mailed, faxes are not accepted.

The sample CMS-1500 claim form at the end of this section demonstrates how you and your staff must complete a CMS-1500 claim form.

The following steps must be adhered to ensure prompt claims payment:

1. Claims must be received by eviCore healthcare within **120 calendar days** of the date of service.

2. Claims must be submitted with a valid CPT and ICD-10 code.
   a. The appropriate/required diagnosis code for EAP services is Z00.00.
   b. Valid CPT codes for EAP services are:

Code	Description
X8001	Initial Assessment
X8002	Session
X8003	Training
X8004	Crisis Incident Stress Debriefing
X8005	Grief Counseling
X8006	Anger Management

   c. All services billed must authorized by eviCore EAP. To receive authorization for service, please contact the EAP directly at 716-712-2777.

3. Bill for treatment rendered.

4. Box 31 on the CMS-1500 billing form must indicate the practitioner that rendered the service, including their NPI (National Provider Identifier) number.

Benefit Guidelines

- EAP services are not subject to member copays.
- Eligibility and benefits limitations should be verified by the practitioner prior to services being rendered. All billed services require an authorization from eviCore EAP. To obtain an authorization, providers may call the EAP department at (716)712-2777 or 1-888-276-6632.

Claims Payment

Payment for services will be sent to the practitioner. Each check will have a check detail explaining payment. The check detail will identify the member(s) treated and a breakdown of that member's benefit. See the completed check detail at the end of this section.

Claims will be paid via paper check or EFT. Providers who wish to apply for EFT payment must complete the form at the end of this packet, and submit the information to the eviCore Network Management Department.

When inquiring on the status of a claim please contact Jill Campbell at 716-712-2700, Ext 26916 or Theresa Wojcicki at 716-712-2700 Ext 26911.

Note: Please keep in mind when checking the status of a claim you should allow thirty (30) processing days from the original submission date.

How to Complete a CMS-1500 Claim Form

Claims must be submitted on an original red/white CMS-1500 claim form.

Claims must be submitted within 120 days of the date of service or they will be denied for timely filing. The information on the CMS-1500 claim form must be complete. The following fields are **critical** to claims processing. If information is missing, eviCore healthcare will not be able to process the claim and the claim will be returned to the practitioner. Please see example claim form below. All highlighted fields are necessary fields.

- Box 1a ID number, including Alpha Prefix – this can be obtained by contacting Palladian EAP.
- Box 2 Patient's Name
- Box 3 Patient's Date of Birth
- Box 5 Patient's Address
- Box 12 Patient's Release of Medical Information
- Box 14 Date of Injury/Illness
- Box 21 ICD10/Diagnosis Code – all EAP claims must use Z00.00
- Box 24A Date(s) of Service – each date of service should be billed with its own line.
- Box 24B Place of Service - this code should refer to the office setting.
- Box 24D CPT Procedure Code – codes should relate to CPT codes listed above in this document.
- Box 24E Diagnosis Pointer – should always refer to diagnosis 1
- Box 24F Billed Charges
- Box 24G Billed Units – should default to '1'
- Box 24J Rendering provider NPI number
- Box 25 Practitioner's Tax Identification Number
- Box 28 Total Billed Charges
- Box 31 Practitioner's Signature with Date

- Box 32 Practitioner's Name & Address Where Services were Rendered
- Box32a Practitioner NPI number
- Box 33 Practitioners billing address
- Box 33a Billing office NPI number – may be the same as the practitioner NPI number, depending on provider set up

1-1/3"

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

CARRIER

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, complete items 9, 9a, and 9d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? For govt. claims, see back YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

How to Interpret a Provider Voucher

The practitioner will receive a Provider Voucher/Check Detail for every claim eviCore processes. If the provider opts to use EFT payment instead of paper check, eviCore will mail the provider their voucher. The following information is contained on the Provider Voucher **(see next page).**

- Field 1 Practitioner's Name and Address
- Field 2 Check/EFT Number
- Field 3 Date of the Provider Voucher
- Field 4 Member's last name, first name and identification number
- Field 5 Claim Number – please note – if the provider submits several claims – this information will repeat (the example on the following page contains several claims for the same provider).
- Field 6 Date of Service
- Field 7 CPT Code
- Field 8 Billed Amount with totals
- Field 9 Contracted Allowed Amount with totals
- Field 10 Total Benefits
- Field 11 Member Co-pay (which will be zero)
- Field 12 Total Net Payment to provider – sum of all claims payments

730 Cool Springs Blvd, Suite 800
Franklin, TN 37067

PROVIDER VOUCHER

Important Plan Information

1

Vendor Number:

2

Check/EFT No.:
Check/EFT Date

3

4

Date Of Service	Code	Procedure Description	Total Charges	Allowed Amount	Total Benefits	Member Responsibility
PATIENT:		PLAN: Palladian EAP			CLAIM:	
OFFICE INFO: OFFICE:						
1	X8001	EAP Initi... ent	65.00	65.00	65.00	0.00
	X8002	EAP Sess...	65.00	65.00	65.00	0.00
		CLAIM TOTALS:	130.00	130.00	130.00	$0.00

5 6 7 8 9 10 11

Service Line Explanation

12

NET PAYMENT FOR CLAIM $130.00

TOTAL NET PAYMENT TO PROVIDER 130.00

Palladian Health 730 Cool Springs Blvd, Suite 800 Franklin, TN 37067

ELECTRONIC PAYMENT PROGRAM ENROLLMENT FORM

Provider Information (Information must match your W-9 tax forms)

Provider Name ______________________________

Legal Name ______________________________

Tax Id Number ______________________________

Address ______________________________

City ______________________________

State ______________________________

Zip ______________________________

Phone ______________________________

Fax ______________________________

Designated Email ______________________________

Banking Information

Routing Number ______________________________

Account Number ______________________________

Bank Name ______________________________

I (we) hereby authorize eviCore healthcare, hereinafter called eviCore, to initiate credit entries to the checking account indicated on the attached voided check, hereinafter called DEPOSITORY, and to credit the same to such account. I (we) acknowledge that the origination transactions to my (our) account must comply with the provisions of U.S. law.

This authorization is to remain in effect until eviCore has received written notification indicating such. I understand t at the termination is effective thirty- (30) days from the date that the notification i s received.

Please attach a voided check from the authorized financial institution to this document.

Signature ______________________________

Date ______________________________

This form can be emailed to the Network Management Team at: PHNet.Management@evicore.com or returned with your (re)credentialing documents. Please allow 30 days processing time.

Palladian Health 400 Buckwalter Place Blvd, Bluffton, SC 29910