



How to File a Claim for Professional Services Tier 1 Providers

The criteria for submitting professional claim forms for a Tier 1 participating provider is summarized in the table below:

Who:	When:	Where:	How:
<ul style="list-style-type: none"> • All SmartHealth Tier 1 participating providers • All Medicare supplemental claims 	Claim form must be received by ABS within 24 months from the date of service. Claims submitted for secondary payment must be received 6 months from the date the primary payer processed the claim.	Submit all claims to: ABS for SmartPlan P.O. Box 37705 Oak Park, MI 48237-7705	All claims must be typed on HCFA 1500 claim forms. Electronic submission of claims available under Payer ID 38259**

**Vendors to process electronic claims: CAREVU, Web MD/Envoy, THIN, MCSI, ENS, ProxyMed, claimsnet.com, McKesson and NDC.

To avoid rejected claims, please be sure to include the following data elements:

- Member ID #
- Patient's name
- Patient's birth date and sex
- Insured's Group #
- Indication of Auto - Employment - Emergency related condition (when applicable)
- Authorization Number - include referral or authorization when applicable
- Name of Referring Physician. If the patient self-referred, type "self"
- Diagnosis code
- Date of Service
- Procedure Code (CPT or HCPCS when applicable, with appropriate modifiers)
- Billed Charges
- # of units
- Total Charges
- Provider Tax ID #
- Provider NPI #
- Provider's billing address and phone number

Claims received missing any of the above referenced data elements will be returned to the provider for completion.

Provider Reimbursement Rules

- Tier 1 Claims are processed and paid by Automated Benefit Services (ABS)
- Claims submitted with all required data elements will be processed within 45 days from receipt of the claim.
- An explanation of payment (EOP) will accompany payment for each service billed.

- Here's a sample of a Tier 1 EOP:

EXPLANATION OF BENEFITS Date: Page: EOB No: EOB No: Ident:																					
Provider Name: Provider Address: Attn: (Provider Name)																					
This is an explanation of payment for services rendered.																					
Claim/Patient Breakdown																					
Claim Number	Acct # / Patient Name	Date of Birth	Date of Service	Proc	Charge	Ded/Coins	Inelig	Paid	Ref												
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 15%;">Ref</th> <th style="width: 85%;">Explanation</th> </tr> <tr> <td> </td> <td> </td> </tr> </table>		Ref	Explanation																		
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Provider Payment Inquiry Process

Payment inquiries are welcomed for claims that have been submitted for dates of service that are greater than 60 days old.

The process to contact ABS concerning Tier 1 claim issues is as follows:

When:	How:	What's Needed:	When can a response be expected:
60 days after the date of service	By Phone: 888-492-6811	A copy of the outstanding claim for reference. Please limit call to 4 claims.	Immediate
60 days after the date of service	By Fax Recall: 888-492-6811	Follow prompts; enter contract number, tax ID number and fax number	Within 2-3 minutes, a return fax will detail the 6 mos claims history for your tax id.
60 days after the date of service	By Mail: ABS PO Box 37705 Oak Park, MI 48237	An original claim form stamped "status inquiry" in red ink in the upper right hand corner.	Within 21 days from receipt of the inquiry.

ABS is committed to resolving all claim inquiries in an efficient manner. In the event a provider is unable to finalize a payment inquiry after 30 days from the initial request, please contact the ABS Customer Service Supervisor. Documentation of the original request is required in order to address the service delay. Resolution can be expected within 10 business days.

Please have the following information available when calling the claims manager:

Type of Inquiry:	Information Required:
Written	A copy of the status inquiry claim
Phone	The date of the original inquiry Name of the assisting ABS service representative Status of the claim at the time of the call Expected outcome

* A member may not be billed for covered services (other than a co-pay) until after the provider has received an explanation of payment from ABS.

Provider Requests for Adjustment to Processed Claims

Processed claims will be considered for a payment adjustment for the circumstances listed below:

- Original claim was submitted with incorrect information
- Payment was made to the incorrect provider
- Payment was made at the incorrect contracted amount
- Payment was not made due to a processing error
- Coordination of Benefits was calculated incorrectly
- Provider received a duplicate payment

Follow these steps to initiate an adjustment request:

What's needed:	How to initiate:		Timeframe to submit:	Timeframe to process:
1. Copy of EOP 2. Reason for request 3. Supporting documentation 4. Copy of original claim (if applicable)	By phone: Processing errors may be handled over the phone. Call provider service for assistance.	Written: Fill out request form and attach the required data. Mail to ABS	Requests for adjustments will only be considered up to 180 days from the date the claim was processed.	Adjustment requests will be processed within 30 days from receipt of all necessary information. A final copy of the adjustment request will be returned to the requesting provider when completed.

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