Replacement Claim Billing

UB-04 and CMS-1500

Policy

Health Options accepts replacement (a.k.a. corrected) claims to allow specific claims to be restated in their entirety, exclusive of identifying information. Once a replacement claim is submitted, the original claim is considered null and void, as the replacement claim submission replaces the prior version of the claim submission.

Replacement claim billing is for submission of corrections needed to professional (CMS-1500) or institutional (UB-04) claims. Late charges and interim billing should not use the replacement claim process; please refer to policies for late charges and interim billing separately. If identifying information (i.e. patient demographic information) was incorrectly presented, resulting in charges billed to an incorrect patient, a void claim request is required, and replacement claim functionality should not be used.

Replacement claims are accepted only when submitted within timely filing requirements: Health Options timely filing limit is 120 days from the date of service or admission date. Corrected claims received outside of timely filing limits will result in claim denial.

Provider Billing Guidelines: UB-04 / Institutional Replacement Claims

Replacement institutional claims may be submitted electronically or on paper within the timely filing limits outlined above.

Electronic replacement institutional claims must include a Claim Frequency Type 7 in the Claim Frequency Type Code segment (Element CLM05-3), and the original Health Options claim number in the Payer Claim Control Number segment (enter F8 in REF01 and the claim number in REF02).

Paper replacement institutional claims must include a Claim Frequency Type 7 in the last position of the “Type of Bill” code in Form Locator 04, and the original Health Options claim number in Form Locator 64, “Document Control Number (DCN)”, on the UB-04 claim form.

Provider Billing Guidelines: CMS-1500 / Professional Replacement Claims

Replacement professional claims may be submitted electronically or on paper within the timely filing limits outlined above.

Electronic replacement professional claims must include a Claim Frequency Type 7 in the Claim Frequency Type Code segment (Element CLM05-3), and the original Health Options claim number in the Payer Claim Control Number segment (enter F8 in REF01 and the claim number in REF02).

Paper replacement professional claims must include a Claim Frequency Type 7 in Item 22 under “Resubmission Code”, and the original Health Options claim number in Item 22 under “Original Ref. No.”

Other Considerations

Health Options claim numbers for claims received on or after December 17, 2017, are 16 digits in length. Please carefully review entry of the claim number on a replacement claim as inaccurate data will lead to processing delays, claim rejections, or other unexpected results.

Please refer to our Paper Claims Policy for additional details regarding submission of professional and institutional claims on paper forms.

Document Publication History

05/01/19 Original documentation

This policy provides information on Community Health Options' claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, adherence to plan policies and procedures, and claims editing logic. Community Health Options reserves the right to amend a payment policy at its discretion.