Paper Claims Submission Standards

Reimbursement Policy

Policy and General Information

Community Health Options ("Health Options") utilizes high resolution scanning, plus optical character recognition (OCR) technology to convert paper claim submissions into an electronic format. To ensure accurate and timely processing, and electronic conversion, providers must follow the National Uniform Claim Committee (NUCC) and National Uniform Billing Committee (NUBC) guidelines, as well as the requirements further detailed in this policy when submitting paper claims. Failure to do so may result in a claim being rejected, returned for correction, or denied in its entirety.

Claim Submission Addresses

Claim Type	Address
Medical & Behavioral	Community Health Options PO Box 1121, Mail Stop 200 Lewiston, ME 04243
Dental	Northeast Delta Dental PO Box 2002 Concord, NH 03302-2002

Paper Claim Submission Requirements

For medical and behavioral claims, Health Options accepts the following standard claim forms accepted by the Centers for Medicare & Medicaid Services:

CMS-1500 Professional Services
CMS-1450 / UB04 Institutional Services

Paper claims must be submitted to the appropriate PO Box noted above; medical and behavioral claims must be sent to Mail Stop 200.

A clean claim submission includes typed input fields and the following (minimum) data elements:

- Patient name
- Patient date of birth
- Member identification number
- Service level information [industry standard code(s) where applicable]
    - date of service
    - diagnosis code(s)
    - place of service code(s)
    - procedure code(s) (CPT/HCPCS, ICD-10 CM, etc.)

    - charge information with applicable units
- Servicing provider's name, address and National Provider Identifier (NPI)
- Servicing provider's federal tax identification number (TIN)

Missing or incomplete information will result in a claim being rejected, returned for correction, or denied in its entirety. As a reminder, a rejected or returned claim does not constitute a successful original claim submission with respect to Community Health Options' timely filing requirements. All rejected or returned claims must be remedied and resubmitted within one hundred and twenty (120) days from the original date of service (all claim types) or date of discharge/ending statement date (institutional claims only).

Rejection Criteria

The following examples will result in a claim rejection that will require a resubmission (this is not an exhaustive list):

- Handwritten claim forms
- Printed claim forms amended with handwriting
- Claim forms filled out using red ink
- Extraneous information found on a claim not related to any field on the form
- Using a colored highlighter on any claim form field
- Utilizing photocopied claim forms
- Claim forms submitted by fax

Related Policies

Replacement Claims

Document Publication History

11/28/2022 Annual review: no changes
12/28/2021 Annual review: added "Health Options" and CMS 1450 language
10/23/2020 Policy reviewed; added related policy and timely filing clarification
1/29/2020 Policy reviewed; clarified language around acceptable claim forms
7/1/2019 Policy Effective Date
4/24/2019 Initial document created
