Replacement Claim Billing

Reimbursement Policy

Policy

Community Health Options ("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/CMS-1450) 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 claim billing is restricted to the original submission format (professional/CMS-1500 or institutional/UB-04) only. Replacement claims that are for claims originally billed in a different format (i.e. professional replacement claim for services originally billed on an institutional claim) will not be accepted.

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 discharge 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.

Related Policies

Interim Billing & Split Claim
Paper Claims Submission

Document Publication History

11/28/22	Annual review: no changes
12/28/21	Annual review: added “Health Options” and CMS-1450 language, added Related Policies
10/28/20	Annual review: clarified claim format requirements for replacement claim billing
10/14/19	Clarified timely submission of replacement claims is 120 days from date of service or discharge date
05/01/19	Original documentation
