



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

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

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. Policies are enforced unless underpinning direction stated otherwise.