

## Policy

Community Health Options accepts replacement, or 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 (e.g., 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 (e.g., 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: Community 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 CLMOS-3), and the original Community 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 Community 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 CLMOS-3), and the original Community 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 the "Resubmission Code", and the original Community Health Options claim number in Item 22 under "Original Ref. No."

## Other Considerations

Community Health Options claim numbers are 16 digits in length. Please carefully review the 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 the 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 the date of service or discharge date
- 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. Policies are enforced unless the underpinning direction stated otherwise.*