FILING NOTICE: Revisions to this policy require filing with the CA Department of Managed Healthcare. Notify the Compliance Department of any edits made to this policy.

CLAIMS	ASPIRE HEALTH PLAN	**Effective Date** 01/01/2018	
		Policy # AHP ASO - CL002	
	RECEIPT AND ACKNOWLEDGEMENT OF CLAIMS	**Review Date** 05/09/2023	**Applicable to:** ☐ Medicare Advantage ☐ Commercial ☑ Anthem HMO ☑ Blue Shield Trio
	Approver's Name & Title	Elisabeth Fagan, Director of Health Plan Operations	

1.1 PURPOSE

1.1 To outline the process regarding the receipt and acknowledgement of claims.

2.0 POLICY

2.1 Date of receipt means the working day when a claim, by physical or electronic means, is first delivered to either delegate's specified claims payment office, post office box, or designated claims processor or to delegate's capitated provider for that claim.

2.2 In the situation where a claim is sent to the incorrect party, the "date of receipt" is the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim.

2.3 Providers must submit claims, either electronically or on paper, using current industry-standard claim forms – UB-04 and CMS-1500.

2.3.1 The standard claim form shall include the following statement: "NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."

2.3.2 If mandated information is not contained on a received claim, or the claim is received from a provider using a non-standard form, the claim will be returned to the provider.

2.4 Claims submitted electronically via EDI can be acknowledged via phone call to Customer Service within 2 business days of receipt.

2.5 Claims submitted on paper claims are scanned and converted to an electronic claim and

can be acknowledged via phone call to Customer Service within 15 business days of receipt.

2.6 Paper claims that are not scannable are manually entered.

2.6.1 These paper claims must be manually entered into the claim system within 15 business days of receipt.

3.0 DEFINITIONS

3.1 Refer to the Definitions Manual.

4.0 PROCEDURE

4.1 Every incoming claim is stamped or dated with the date of receipt. Paper and electronic claims received by 5:00 PM local time are considered as received on that date.

4.1.1 Paper claims are hand stamped on the day they are received in the office and are converted to an electronic claim upon receipt.

4.1.2 Electronic claims are dated by the clearinghouse upon receipt.

4.2 Claims are assigned a document control number (DCN) upon receipt and this is the claim identification throughout pre-processing.

4.3 Once the claim is loaded into the claims system, it is assigned a claim number in addition to the DCN.

4.4 Claims that are received on paper but not scannable, either due to poor ink quality or form type used, are batched for manual data entry. Those claims are manually entered into the claims system.

4.5 Claims submitted without the required mandatory information will be sent back to the provider:

4.5.1 Paper claims will be returned with a coversheet notating the required information.

4.5.2 Electronic claims will be rejected by the clearinghouse.

5.0 TRAINING

5.1 Training for employees will occur within 90 days of hire, and upon updates to the policy.

6.0 REVIEW PERIOD

6.1 Annually.

7.0 REGULATORY REQUIREMENTS AND REFERENCES

7.1 Health and Safety Code Section 1371

7.2 Title 28 California Code of Regulations (CCR) Rule 1300.71

8.0 POLICY VIOLATION

8.1 Any AHP associate or contractor who fails to abide by this policy may be subject to disciplinary action, up to, and including termination. Please refer to AHP's Disciplinary Guidelines and Enforcement Policy for further details.