Table of Contents
General Information

Member eligibility

It is important to properly identify the Member's type of coverage. All Member ID cards contain information such as name, ID number, alpha prefix, coverage type, and copayments. The information on the card may vary based on the Member's benefits plan. Eligibility is not a guarantee of payment. In some instances, the Member's coverage may have been terminated.

How to check Member eligibility

- Always check the Member's ID card before providing service.
- If a Member is unable to produce his or her ID card, ask if the Member has a copy of his or her Enrollment/Change Form or temporary insurance information printed from the amerihealthexpress.com Member portal. This form provides Members temporary identification and can be used as an accepted proof of coverage until the actual ID card is issued.
- Participating facilities are encouraged to use either the NaviNet® portal or the Interactive Voice Response (IVR) system for all Member eligibility inquiries.

AmeriHealth has no obligation to pay for services provided to individuals who are not eligible Members on the date of service.

AmeriHealth New Jersey products

Please refer to the Eligibility Detail screen on NaviNet to obtain Member eligibility information. You may also call Customer Service for specific product information. The following tables outline the products offered through AmeriHealth. The alpha prefix found on the Member's ID card will assist you in quickly identifying our Members.

AmeriHealth New Jersey

Products	Alpha prefix
Point-of-Service (POS) and Small Employer Health (SEH) POS	Any of the following prefixes: ▪ Q1A ▪ Q1P
Preferred Provider Organization (PPO)	Q1B
Health Maintenance Organization (HMO) and SEH HMO	Q1C
SEH Comprehensive Major Medical (CMM)	Q1H
AmeriHealth 65® HMO (Medicare Advantage)	Q1N
AmeriHealth 65® POS (Medicare Advantage)	Q1N
SEH PPO	Q1S
Traditional Medical	Q1T

Note: AmeriHealth Administrators uses the suffix TPA. It does not use an alpha prefix.

Capitation

Under the HMO benefits program, select services are capitated for HMO Members. The following specialties include a capitated program:

- laboratory
- radiology*
- rehabilitative therapy*
- behavioral health

Members must be referred to their Primary Care Physician's (PCP) designated site for these capitated services. If the PCP's capitated site cannot perform a capitated study/service, that site is responsible for subcontracting with a participating AmeriHealth provider. To use a site other than the designated site or their subcontractor, the PCP must Precertify the service, which includes providing a clear medical rationale for selection of a site other than the designated site.

Hospitals that are contracted as a capitated provider should only accept Referrals from those PCPs that have selected their facility as their designated site for capitated services. Hospitals that are not contracted as a capitated provider should accept Referrals for capitated services only if the Referral has a subcontracting confirmation or per the Member's request with a valid Referral from AmeriHealth. Hospitals contracted as a capitated provider will be compensated in accordance with their Agreement.

**These services apply to southern New Jersey only which includes the following counties: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Salem, and Ocean.*

The northern New Jersey counties include the following: Bergen, Essex, Hudson, Hunterdon, Middlesex, Monmouth, Morris, Passaic, Somerset, Sussex, Union, and Warren.

Behavioral health services

Behavioral health services are capitated to Magellan Behavioral Health, Inc. However, PCPs do not have designated behavioral health providers. Eligible members can self-refer to any Magellan Behavioral Health, Inc. contracted provider.

Preapproval/Precertification

Preapproval/Precertification is required for certain services prior to services being performed. Examples of these services include planned or elective Inpatient Admissions and select Outpatient procedures. Preapproval/Precertification requirements vary by benefits plan; please reference *Appendix A* for specific requirements.

Note: Preapproval/Precertification is not required for Emergency Services.

For detailed information on Preapproval/Precertification, please see the *Care Management and Coordination* section of this Manual.

eConnectivity

The NaviNet® portal

The NaviNet portal is the HIPAA*-compliant, web-based connectivity solution (offered by NaviMedix®, Inc.) that streamlines administrative tasks, provides a wealth of time-saving electronic transactions, and provides you with news, announcements, and other valuable communications.

** HIPAA, the Health Insurance Portability and Accountability Act, was enacted by the U.S. Congress in 1996, and became effective July 1, 1997. This act is a grouping of regulations that work to combat waste, fraud, and abuse in health care delivery and health insurance. The intention of HIPAA is also to improve the effectiveness and efficiency of the health care system; portability and continuity of health insurance coverage in the group and individual markets; and the ability to provide consequences to those that do not apply with the regulations stated within the Act.*

Plan Central

"Plan Central" is AmeriHealth's dedicated news and information section, designed to keep you up to date with publications, important effective dates, product details, new programs, administrative tools and resources, and much more.

Plan Central content and links

- provider news
- *Partners in Health Update*
- NaviNet billing tips
- contact information
- third-party links

Inquiries and submissions

The NaviNet portal provides connectivity for both transaction inquiries and submissions. The following transactions apply to hospitals, ancillary facilities, and ancillary providers. Exceptions are indicated using the following key: Hospital (H); Ancillary (A).

Inquiries

- Accepted Claims Status Inquiry
- Authorization Status Inquiry
- Claims INFO Adjustment Inquiry
- Diagnosis Code Inquiry
- Eligibility and Benefits Inquiry
- ePayment – Online SOR Inquiry
- Procedure Code Inquiry
- Referral Inquiry
- Rejected Claim Status Inquiry
- Report Inquiry
- View A/R Aging Report

Submissions

- Cardiac Rehab Authorization – Facility-based (H)
- Chemotherapy/Infusion Authorization
- Request A/R Aging Report
- Claims INFO Adjustment Submission
- DME Authorization (A)
- ER Admission Notification (H)

- Home Health Authorization (A)
- Home Infusion Authorization (A)
- Drug Preauthorization
- EFT Registration
- Encounter Submission
- Medical/Surgical Authorization – Acute Care and Ambulatory Surgery Centers
- OB/GYN Referral Submission
- Provider Change Form
- Pulmonary Rehab Authorization – Hospital-based (H)
- Referral Submission
- Sleep Studies
- Speech Therapy – Speech Therapy providers and Facility-based Speech Therapy departments
- User Permission Manager (Security Officer Only) – EFT and SOR Registration

Featured resources

The following information is available to all NaviNet-enabled providers:

- **Access to Medical Policy via NaviNet** – View medical, claim payment, and pharmacy policies.
- **American Imaging Management, Inc. (AIM) Radiology Precertification** – Follow the NaviNet link to AIM's website to view online Precertification requests, or call AIM at 1-800-859-5288. *Note:* All providers must register with AIM prior to using the AIM website.
- **Authorization – Authorization Status Inquiry** – View Inpatient, Outpatient, and concurrent authorizations. When applicable, edit admission or service dates for approved authorizations.
- **Authorization Submission** – Submit authorization requests for selected services. You can authorize medical or surgical procedures at an acute-care facility or ambulatory surgical center.
- **Benefits Snapshot** – View a summary of benefits with copayments.
- **Claims A/R Aging –** Retrieve claims data in a report format, which can be exported to Microsoft® Excel, for service dates up to two years prior to the date of your search. You may retrieve claims data by using your provider number or tax identification number (TIN).
- **Claim INFO Adjustment Submission** – View existing claim detail for service dates up to two years prior to the date of your search and submit requests to AmeriHealth for claim adjustments, retractions, and late charges.
- **Claim Inquiry and Maintenance** – Search for and retrieve up to two years of historic claims data (including paid, rejected, denied, remit cycle, and in-process/pended claims) by using your TIN or group provider ID number.
- **Drug Formulary** – Obtain the list of the U.S. Food and Drug Administration-approved medications chosen for their medical effectiveness, safety, and value.
- **ePayment – Electronic Fund Transfer (EFT) and Online Statement of Remittance (SOR)** – Register and maintain your EFT account and receive claim payments electronically by viewing the ePayments screen. Once registered, use this feature to view all remittances issued to you and to search for an SOR using your facility's internal patient account number. SOR information can be viewed for a 13-month rolling calendar. *Note:* The NaviNet portal security officer can enable the above options by using the user permissions manager.
- **Member Eligibility and Benefits Inquiry** – Confirm Member ID, product, date of birth, relationship to the insured, coverage status, copayment, and Coordination of Benefits (COB) information.
- **Referral Inquiry** – View all Referrals (generated via NaviNet or the IVR system) to your facility.

- **Referral Submission** – PCPs and OB/GYNs must submit Referrals electronically to AmeriHealth and to NaviNet-enabled facilities and specialists. There are also fax and print options available via NaviNet.
- **Additional functionality** – View aging reports, procedure and diagnosis code inquiries, report inquiries, and user permissions manager.

Electronic Data Interchange claims submission

Electronic Data Interchange (EDI) claims submission is the most effective way to submit your claims. EDI claims submission reduces payor rejections and administrative concerns and increases the speed of claims payment by submitting HMO, PPO, and POS claims electronically. For information and inquiries about electronic submissions, please contact the eBusiness Help Desk at 215-241-2305 or through email at *claims.edi-admin@amerihealth.com*. Additional EDI billing information can be viewed online at *www.amerihealth.com/providers/claims_and_billing/edi/forms.html*. Providers without electronic connectivity should contact Customer Service at 1-800-275-2583, prompt 2 for Provider Services.

Contact information

In addition to NaviNet and *www.amerihealth.com*, the list of resources provided below is available for your reference.

Important telephone numbers

American Imaging Management Call for CT/CTA, MRI/MRA, PET, and nuclear cardiology Precertification requests	1-800-859-5288
AmeriHealth Administrators **Provider Relations** (Direct all inquiries or issues directly to AmeriHealth Administrators)	1-800-841-5328 *provrelations@amerihealth-tpa.com*
Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707
Baby FootSteps® Perinatal case management Nurse on call 24 hours a day	1-800-598-BABY
Care Management and Coordination Case Management (For Precertification/Preapproval, please see "Health Resource Center") HMO/PPO (Medicare Advantage and commercial) Hours: Mon. – Fri., 8 a.m. – 5 p.m.	1-800-313-8628 or 856-778-6374
Connections℠ Health Management Programs Call for disease management and decision support Connections℠ Health Management Program Connections℠ AccordantCare™ Program	 1-866-866-4694 1-866-398-8761
Credentialing violation hotline	215-988-1413

Customer Service AmeriHealth HMO/PPO Hours: Mon. – Fri., 8 a.m. – 6 p.m. AmeriHealth 65 Hours: Mon. – Sun., 8 a.m. – 8 p.m. TTY/TDD	1-800-275-2583 1-800-645-3965 1-888-857-4816
Electronic Data Interchange (EDI)	215-241-2305 *claims.edi-admin@amerihealth.com*
FutureScripts® Prescription drug Preauthorization Hours: Mon. – Fri., 9 a.m. – 5 p.m. **FutureScripts® Secure** Medicare Part D prescription drug Preauthorization Hours: Mon. – Fri., 8 a.m. – 5 p.m. Pharmacy appeals Blood glucose meter hotline	1-888-678-7012 1-888-678-7015 Toll-free fax: 1-888-671-5285 NJ appeals: 1-877-585-5731, prompt 2 1-877-585-5731 (prompt 2) 1-888-678-7012 (prompt 2)
Health Resource Center AmeriHealth Healthy Lifestyles℠ Hours: Mon. – Fri., 8 a.m. – 6 p.m. Precertification Hours: Mon. – Fri., 8 a.m. – 5 p.m.	1-800-275-2583
Interactive Voice Response (IVR) system	1-800-275-2583, prompt 2
Mental Health/Substance Abuse Magellan Behavioral Health, Inc. Member Services/Precertification Hours: 24 hours a day, 7 days a week	1-800-809-9954
NaviMedix®	1-888-482-8057
NaviNet® portal registration and questions	856-638-2701
Provider Services	1-800-275-2583, prompt 2
Provider Supply Line	1-800-858-4728

Claims mailing addresses

AmeriHealth Administrators
720 Blair Mill Road
Horsham, PA 19044

Note: Submit AmeriHealth Administrators new claims or adjustment requests directly to AmeriHealth Administrators. Do not submit AmeriHealth Administrators claims to the AmeriHealth HMO/POS, PPO claims addresses. Reference the back of the member ID card for specific claim mailing instructions.

AmeriHealth Processing Center
P.O. Box 41574
Philadelphia, PA 19101-1574

This address is for all HMO/POS and PPO claims and Magellan Behavioral Health, Inc. claims for the following products: Self-Referred (Out-of-Network) POS, New Jersey without the National Access Rider Standard and Flex PPO, and CMM.

Magellan Behavioral Health Claims Submission
Magellan Behavioral Health, Inc.
P.O. Box 1958
Maryland Heights, MO 63043-1958

This address is for the following claims: HMO/Referred (In-Network) POS, POS Plus with the National Access Rider, and New Jersey with the National Access Rider (In-Network and Out-of-Network).

Appeals mailing addresses

Member Medical Necessity Appeals – NJ
AmeriHealth New Jersey Appeals Unit
8000 Midlantic Drive, Suite 333 North
Mount Laurel, NJ 08054-1560

Member Administrative Appeals – NJ
Member Appeals Department
8000 Midlantic Drive, Suite 333 North
Mount Laurel, NJ 08054-1560

Inpatient Facility Appeals – NJ
P.O. Box 13985
Philadelphia, PA 19101-3985

Medicare Advantage HMO Member Appeals
Medicare Member Appeals Unit
P.O. Box 13652
Philadelphia, PA 19101-3652

Provider Claims Appeals – NJ (HMO/PPO)
Claims Payment Appeals Unit
P.O. Box 7218
Philadelphia, PA 19101

General mailing addresses

Claim Payment/Overpayment Refunds (AmeriHealth HMO and PPO)
P.O. Box 15075
Newark, NJ 07192-5075

Provider Services

Provider Services can serve as a valuable resource to you. The role of Provider Services is to:

- educate providers;
- facilitate effective communications by providing timely, accurate responses to telephone inquiries;
- identify service problems and their root causes and develop solutions.

To reach Provider Services, please call Customer Service at 1-800-275-2583, prompt 2.

Hospital and Ancillary Service Coordinators

Hospital and Ancillary Service Coordinators play an important role in educating our participating providers on policies, procedures, and specific billing processes. In an effort to build and sustain a strong working relationship with you, these coordinators will contact you regularly to:

- resolve issues
- review clinical and claim payment policies
- discuss new policy implementation
- explain new products and programs
- investigate and assist in resolution of inquiries

If you are unsure who your coordinator is, please contact Customer Service at 1-800-275-2583, prompt 2 for Provider Services, to obtain the name and contact information for your Hospital and Ancillary Service Coordinator.

Claims submissions

Clean Claim: A Clean Claim is a claim for payment for a Covered Service that has no defect or impropriety. A defect or impropriety includes, without limitation, lack of data fields required by AmeriHealth or substantiating documentation or a particular circumstance requiring special handling or treatment, which prevents timely payment on the claim.

The following information is generally required for a Clean Claim:

- patient's full name
- patient's date of birth
- valid Member ID number including prefix
- statement "from" and "to" dates
- diagnosis codes
- facility bill type
- revenue codes
- procedure codes (e.g., CPT® at the line level for outpatient claims, ICD-9 CM at the claim level for Inpatient claims)
- charge information and units
- service provider's name, address, and National Provider Identifier (NPI)
- provider's TIN

Missing or incomplete information will result in a claim being returned to you. Returned claims must be corrected and resubmitted within the time frame specified in your Agreement with AmeriHealth in order to be eligible for payment.

Claims submission requirements

Institutional and Professional Loop and Data Elements

For information on Institutional and Professional Loop and Data Elements, refer to the NPI Toolkit located at *www.amerihealth.com/providers/npi*. To view our 837P and 837I companion guides, visit *www.amerihealth.com/providers/claims_and_billing/edi/forms.html*. AmeriHealth recommends that you share our electronic billing requirements and updates with your billing vendor.

UB-04 data field requirements

A description of how to complete a paper UB-04 form can be found at *www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf*. Providers who bill electronically should bill according to their specifications. Failure to use the UB-04 form will result in the claim being returned to you or claim denial.

CMS-1500 field requirements

The CMS-1500 form should only be used by ancillary providers, such as home infusion, durable medical equipment, ambulance, and private duty nursing.

Providers who bill electronically should bill according to their specifications. Failure to use the CMS-1500 form will result in the claim being returned to you or claim denial. A description of how to complete a paper CMS-1500 form can be found at *www.amerihealth.com/providers/claims_and_billing/claim_requirements.html*.

Coordination of benefits/Other party liability

Where AmeriHealth is determined to be the secondary Payor, AmeriHealth will reimburse for any *remaining* patient liability, not paid by the primary carrier, *only* up to and including its own fee schedule or contracted rate, excluding applicable deductibles, copayments, and coinsurance. As a result, the total of the primary carrier's payment plus any balance paid by AmeriHealth will never exceed the contracted rate of payment.

Motor vehicle accident

All claims, up to the appropriate auto benefits amount related to the motor vehicle accident (MVA), are coordinated with the auto insurance carrier.

- To expedite payment, the provider should bill the auto insurance carrier first.
- When the auto insurance carrier sends notice that the applicable auto benefits have been exhausted, the provider should submit an exhaust letter with each claim form that is submitted to ensure prompt payment and to avoid a timely filing denial.
- Members should not be billed or be required to pay before MVA-related services are rendered.

Workers' compensation

If a claim is related to a workers' compensation accident, the provider must bill the workers' compensation carrier first. If the workers' compensation carrier denies the claim, the provider should submit the bill to AmeriHealth with a copy of the denial letter attached to the claim.

To expedite payment, include the following information when filing a workers' compensation claim:

- Member's name
- Member's ID number
- date of accident
- name and address of workers' compensation carrier

Coordination of benefits for dependents

AmeriHealth processes COB claims for dependents of Members with different coverage plans according to the "birthday rule." If both parents have family coverage with two different health plans, the parent whose birthday falls nearest to January 1 is the primary insurance carrier.

Example: If the mother's birthday is January 30 and the father's birthday is March 1, the mother's plan is primary.

Exceptions to the "birthday rule" may apply under certain conditions, including but not limited to, where required by divorce decree, child custody, or other court order.

Claims inquiries and follow-up

NaviNet is an available resource for claims status and adjustment requests. This option is outlined in detail in the *eConnectivity* section. If NaviNet is unavailable, you should contact Customer Service. The unit's hours of operation are 8 a.m. to 5 p.m., Monday through Friday. Inquiries regarding claims status should be directed to 1-800-275-2583, prompt 2 for Provider Services.