Indian Health Service

Medicare Billing Basics

Disclaimer

This presentation is a summary, is subject to change, and does not purport to be complete. It is prepared as a guide to assist billing and other staff, and is not intended to grant rights or impose obligations. Please follow your policies and procedures and seek assistance when needed. Any opinions expressed in this presentation are those of the author and do not necessarily reflect the views of the Indian Health Service.

CMS

Federal agency that provides health coverage through Medicare, Medicaid, CHIP, and the Health Insurance Marketplace.

Founded 1965 (Medicare enacted)

Originally designated the Health Care Finance Administration (HCFA)

Formed 1977 (Established as a subagency under HHS)

Created to administer oversight of the Medicare Program and the federal portion of the Medicaid Program.

The CMS, under the Department of Health and Human Services, has primary responsibility for the Medicare program.

Medicare Parts

Part A – Hospital Care

Part B – Medical Insurance

Part C – Medicare Advantage

Part D – Prescription Drug Coverage

Medicare Beneficiary Identifier (MBI)

The Beneficiary Medicare Card identifies:

- Beneficiary name
- MBI
- Hospital insurance (Part A) effective dates
- Medical insurance (Part B) effective dates

It is extremely important that the beneficiary's name and MBI are entered on the claim as they appear on the health insurance card

Mandatory electronic claim submission

Medicare is prohibited from covering claims submitted to Medicare on paper except in limited situations.

- Small provider (fewer than 25 full-time employees)
- >2 day disruption in electricity or communication systems.
- Any provider that submits fewer than 10 Medicare claims per month (<120 claims per year).

Timely Filing Requirement

1 (one) year from the date of service

Medicare IHS Payment Rates

Annual notice of CY Rates Published to the Federal Register

Fee For Service (FFS)

Facility Types

Hospital – Inpatient, Emergency Department, Outpatient, Ancillary

Freestanding Clinic – Outpatient, Ancillary

Critical Access Hospital (CAH) – Inpatient (not more than 25 beds), Emergency Department, Outpatient, Ancillary

FQHC (Tribal only) – Outpatient, Ancillary

- ✓ Must be certified as an FQHC during the facility enrollment process

Provider Enrollment

A critical function

Process (best practice – work closely with the Credentialing Specialist)

Facility enrollment – 855A/855B (may require application fee)

Provider enrollment – 855I/855R

PECOS

Novitas - Medicare Administrative Contractor (MAC)

Private health care insurer that has been awarded a geographic jurisdiction to process Medicare on behalf of CMS. IHS is under jurisdiction JH.

Process Medicare claims

Process Medicare payments

Enroll providers into Medicare

Handle provider reimbursement services and audit provider cost reports

Handle redetermination requests (1st stage appeals process)

Respond to provider inquiries

Educate about Medicare

EDI – Novitasphere Portal

Free and secure

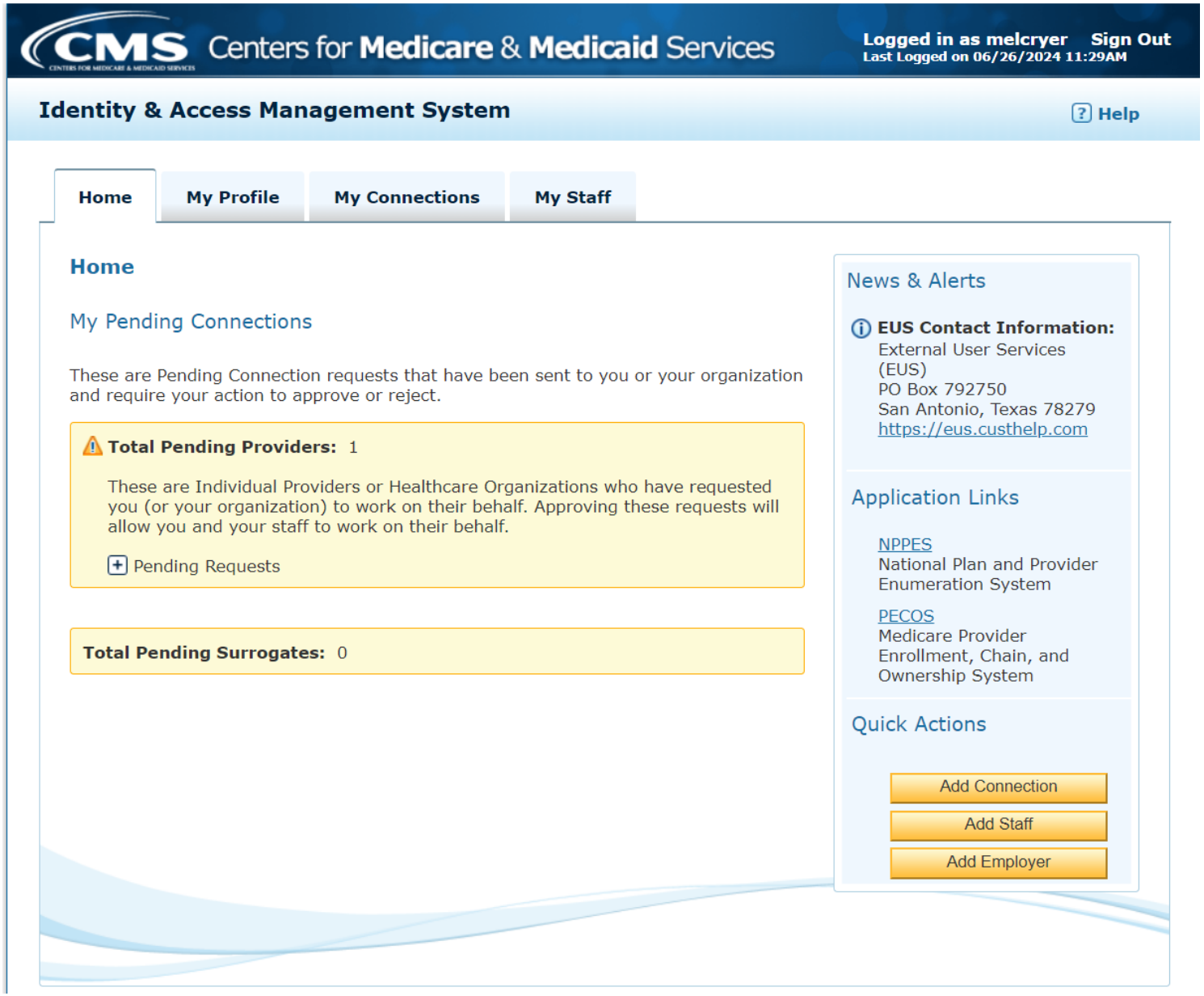
Claim file upload

Direct Data Entry (DDE) for corrections to uploaded claims

Electronic Remittance Advice (ERA)

https://nppes.cms.hhs.gov/IAWeb/login.do

The FIRST step in enrolling a provider in Medicare is having an account on I&A. The user name and password you set up here will be the same that you use on PECOS.


CMS Centers for Medicare & Medicaid Services
Logged in as melcryer Sign Out
Last Logged on 06/26/2024 11:29AM
Identity & Access Management System
Help
Home
My Profile
My Connections
My Staff
Home
My Pending Connections
These are Pending Connection requests that have been sent to you or your organization and require your action to approve or reject.
Total Pending Providers: 1
These are Individual Providers or Healthcare Organizations who have requested you (or your organization) to work on their behalf. Approving these requests will allow you and your staff to work on their behalf.
Pending Requests
Total Pending Surrogates: 0
News & Alerts
EUS Contact Information:
External User Services (EUS)
PO Box 792750
San Antonio, Texas 78279
https://eus.custhelp.com
Application Links
NPPES
National Plan and Provider Enumeration System
PECOS
Medicare Provider Enrollment, Chain, and Ownership System
Quick Actions
Add Connection
Add Staff
Add Employer

Employer Information

The Employer Information table displays your role and status with the employers you are associated with. If you are an Individual provider, your NPI will be listed below as an employer with a role of Authorized Official.

Show:

- (●) **All Employers**
- ( ) **Only Approved Employers**
- ( ) **Only Approved and Pending Employers**
- ( ) **Only Cancelled, Disassociated, and Rejected Employers**

Search By: ***Employer Name** [ ] Search Clear

Employer	My Role with this Employer	My Status with this Employer	PECOS	NPPES
ANADARKO INDIAN HEALTH CENTER	Access Manager	Approved	YES	YES
CARNEGIE INDIAN HEALTH CENTER	Access Manager	Approved	YES	YES
CLAREMORE INDIAN HOSPITAL	Access Manager	Approved	YES	YES
CLINTON INDIAN HEALTH CENTER	Access Manager	Approved	YES	YES
DEPT OF HEALTH AND HUMAN SERVICES	Access Manager	Approved	YES	YES
EL RENO INDIAN HEALTH CENTER	Access Manager	Approved	YES	YES
Haskell Indian Health Center	Access Manager	Approved	YES	YES
LAWTON INDIAN HOSPITAL	Access Manager	Approved	YES	YES
Pawnee Indian Health Center	Access Manager	Approved	YES	YES
Scott, Travis	Access Manager	Approved	YES	YES

Displaying records 1 - 10 out of approximately 13.

1 2 Next >

If you wish to add an employer, click "Add an Employer". Add an Employer

My Connections

Connections will allow you to create surrogate relationships between Providers and individuals or organizations that work on the Providers' behalf.

Select the name of a Connection to update or view more information about that connection.

New You can generate a report containing all your employer connections or all connections for a single employer. Generate

Search By: *Employer Name Search Clear

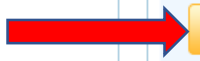
ANADARKO INDIAN HEALTH CENTER

ANADARKO INDIAN HEALTH CENTER is a surrogate for the following providers:

ANADARKO INDIAN HEALTH CENTER has been authorized to work on behalf of the Individual Provider(s) or Healthcare Organization(s) listed below.

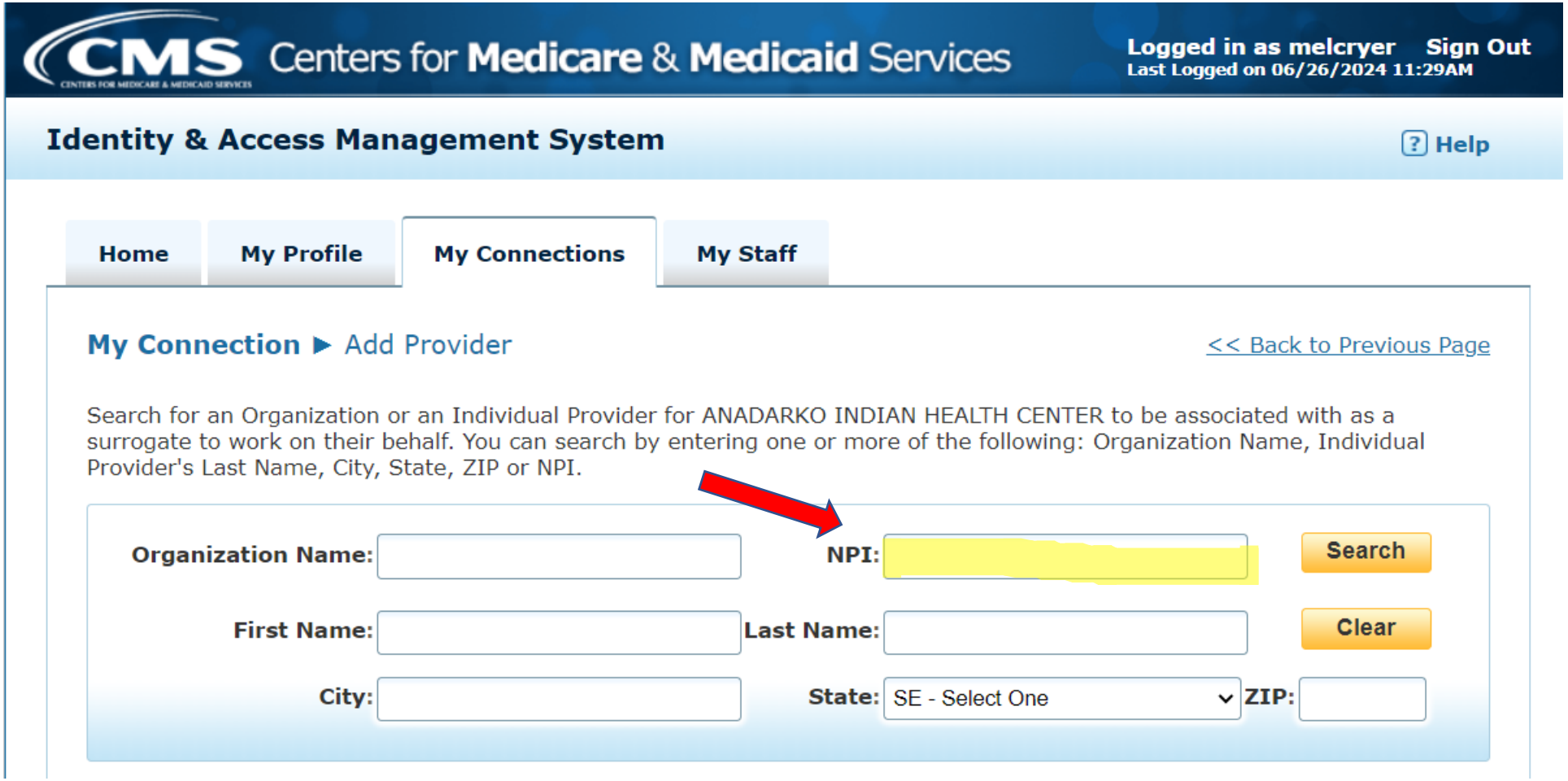
Use the **Find Provider** button below to initiate a request to have ANADARKO INDIAN HEALTH CENTER work on behalf of a Provider or Organization not already reflected in the list below.

Use the **Multiple Connections** button below to initiate a request to add or disable multiple provider connections (not already included in the list below) using bulk upload.



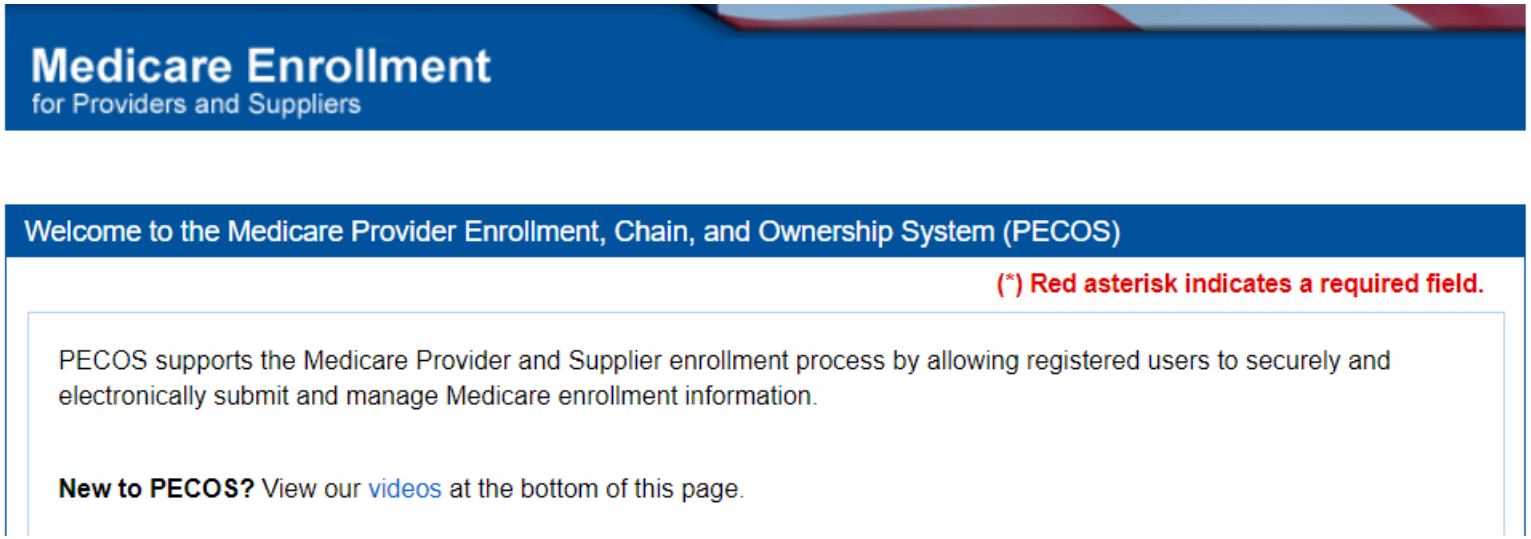
Find Provider Multiple Connections

Name	NPI	Tracking ID	Business Function	Access Status
Allen, Barbara				



Once you've found your provider and selected what applications you want to work on (NPPES, PECOS, etc), and hit submit, the system will send an email to the provider to approve your application to work on his/her behalf.

AFTER you have registered at I & A, and requested to make a connection between your facility and the provider, and it's been approved, then you can log into PECOS to make an initial enrollment (if need be), or complete reassignments to your facilities.



https://pecos.cms.hhs.gov/pecos/login.do#headingLv1

Welcome Gemma Morrow

Release Notes

Want to learn what's new in the latest PECOS release? Please review the Release Notes[PDF].

System Notifications

Note: JavaScript must be enabled in your internet browser for PECOS to work properly. If JavaScript is currently disabled in your browser, refer to the Accessibility section in PECOS Help for instructions on enabling JavaScript.

Details

- PECOS users are no longer able to mail documents that require a signature. When submitting your application, be prepared to provide an e-signature or upload your documents that require a signature.

Manage Medicare and Account Information

MY ASSOCIATES

- Enroll in Medicare for the first time
- View and update existing Medicare information
- Continue working on saved applications

ACCOUNT MANAGEMENT

- Update your user account information, request or remove access to organizations
- Manage access to Medicare enrollments

REVALIDATION NOTIFICATION CENTER

- View All Applications requiring revalidation
- Start or continue revalidation application

Manage Signatures

Applications Requiring Signatures

You currently have no pending signatures.

Help

- User Account
- Manage Access

Additional Resources

New! Medicare ID Search Tool

- How to Guides
- FAQs
- Glossary
- Who Should I Call? [PDF, 214 KB]
- Application Status Kiosk
- Additional Links

INITIAL Enrollment – This is for providers who have never been enrolled in Medicare at all, OR have changed their specialties, OR have been been enrolled in Texas (as part of Indian Health Service).

All IHS facilities are enrolled under Texas, no matter what state they are in. If the provider has worked in Kansas, Oklahoma, Washington, etc, but never worked in Texas, you have to create an Initial Enrollment for that provider!

My Associates

Initial Enrollment

Create an application for initial enrollment **ONLY** if you are:

- Enrolling in Medicare for the first time
- Enrolling in a new state, or
- Enrolling with a new specialty

IMPORTANT:

If you are responding to a **request for Revalidation**, **do not** create an initial enrollment application. Instead, select a provider from the "Existing Associates" section below then select from the list of existing enrollments.

Please Note: If your organization is currently enrolled in Medicare but you do not see your enrollment, please take the following steps to confirm your access to the enrollment.

- If you are a Staff End User of the organization, please contact the organization's Authorized/Delegated Official to ensure your account has access to PECOS.
- If you are an Authorized/Delegated Official of the organization, please confirm your role with the organization and ensure access to PECOS is active. To verify your account status, select the Account Management button on the Home Page and then choose Update user account information option.

The following checklists will help you gather the information needed to enroll via Internet-based PECOS:

- Checklist for Sole Proprietor or Solely Owned Organizations (eg. LLC, PC) using PECOS
- Checklist for Individual Physician and Non-Physician Practitioners using PECOS
- Checklist for Provider or Supplier Organization using PECOS

Select the Create Initial Enrollment Application button **ONLY** if you are enrolling for the first time, or enrolling in a new state or specialty.

CREATE INITIAL ENROLLMENT APPLICATION

Help

- Medicare Part A Services
- Medicare Part B Services
- Legal Business Name
- National Provider Identifier (NPI)

Additional Resources

- How to Guides
- FAQs
- Glossary
- Who Should I Call? [PDF, 214 KB]
- Application Status Kiosk
- Additional Links

Application Questionnaire

(*) Red asterisk indicates a required field.

Healthcare Services Rendered

* Please select the option that best represents the healthcare service rendered for this application.

- ○ Institutional Provider (e.g., Hospital, Skilled Nursing Facility, Hospice, Home Health Agency)
- ○ Clinics/Group Practices and Certain Other Suppliers (e.g., Ambulance Service Supplier, Clinic, Independent Diagnostic Testing Facility, Sole Owner of a Professional Association (PA), Professional Corporation (PC), or Limited Liability Corporation (LLC))
- ○ Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- ○ Medicare Diabetes Prevention Program Supplier (MDPP)
- ○ Individual Physician or Non-Physician Practitioner (including Sole Owner of a Professional Association (PA), Professional Corporation (PC), or Limited Liability Corporation (LLC))
- ○ Eligible Ordering, Certifying, and Prescribing Physicians, and Other Eligible Professionals

Note: Select this option only if any of the following applies to the applicant:

1. The applicant, or any organization employing the applicant, will not send claims to a Medicare contractor for any service furnished by the applicant.
2. The applicant, or any organization employing the applicant, sends claims through a Medicare managed care plan.

NEXT PAGE

CANCEL

Application Questionnaire

(*) Red asterisk indicates a required field.

Applicant Description

Please read through all the descriptions and then choose the one that best matches your situation.

* I am applying as a:

- ○ **Sole Owner of a PA, PC or LLC**
  - You are the only owner of a business, set up as a corporation, through which you give healthcare services.
  - Your business is *legally separate* from your personal assets.
- ○ **Self-Employed/Sole Proprietor**
  - You give *all* your healthcare services from a facility that you own, lease or rent.
  - You are the only owner of a business that gives healthcare services.
  - You and your business are *legally one and the same*. You are personally responsible for any of the business's financial obligations.
  - You report the business's income and losses on your personal tax return.
- ○ **Group Member Only**
  - You give *all* your healthcare services as an employee of a group practice or clinic.
  - You have an arrangement with your employer to send in Medicare claims and get paid for the services you have given.
- ○ **Group Member and is Self-Employed**
  - You give *some* healthcare services as an employee of a group practice or clinic.
  - You have an arrangement with your employer to send in Medicare claims and get paid for the services you have given.
  - You also give *some* healthcare services from a facility that you own, lease or rent.
  - The income you make through self-employment is part of your personal assets.
- ○ **Disregarded Entity**
  - You are the only owner of a business, set up as a corporation, through which you give healthcare services.
  - You and your business are considered *legally one and the same*.

Help

- Sole Owner
- Professional Corporation (PC)
- Professional Association (PA)
- Limited Liability Company (LLC)
- Disregarded Entity

Additional Resources

New! **Medicare ID Search Tool**

How to Guides

FAQs

Glossary

Who Should I Call? [PDF, 214 KB]

Application Status Kiosk

Additional Links

Topic View | Fast Track View | Error/Warning Check 9

Enrollment ID: I06302024000417
PacID: A011457164I06302024000417
Web Tracking ID: T063020240000356
Individual Provider NPI:

Reason for Application

Practitioner is Enrolling in Medicare for the First Time

Reports

Select the hyperlink to view the Application being edited:
View Application being edited

Topics

The data required for this enrollment application is grouped into topics. In order to electronically submit this enrollment application, you must complete all of the following topics.

You may view and print this enrollment application at any time during the enrollment process by clicking the View and Print button below.

This application is collecting the following topics:

Completed	Topics

Completed	Topics
—	**Personal Identifying Information** more information about Personal Identifying Information
✓	**Practitioner Specialty** more information about Practitioner Specialty
—	**Reassignment** more information about Reassignment
—	**Resident Status** more information about Resident Status
—	**Mailing Address** more information about Mailing Address
—	**License, Certification, and DEA Information** more information about License and Certification Information
—	**Final Adverse Legal Actions** more information about Final Adverse Legal Actions
—	**Organization Control** more information about Organization Control
✓	**Contact Person** more information about Contact Person
—	**Required and/or Supporting Documentation** more information about Required and/or Supporting Documentation

Note:

- Once you have completed all the topics and no errors are present, the 'Begin Submission' button will be enabled. You may review errors at any time by clicking the 'Error Check' tab. Clicking 'Begin Submission' will initiate the Submission Process.

BEGIN SUBMISSION

NEXT PAGE

Medicare Enrollment
for Providers and Suppliers

Home | Help | Log Out

Home > My Associates

My Associates

Initial Enrollment

Create an application for initial enrollment **ONLY** if you are:

- Enrolling in Medicare for the first time
- Enrolling in a new state, or
- Enrolling with a new specialty

IMPORTANT:

If you are responding to a **request for Revalidation**, **do not** create an initial enrollment application. Instead, select a provider from the "Existing Associates" section below then select from the list of existing enrollments.

Please Note: If your organization is currently enrolled in Medicare but you do not see your enrollment, please take the following steps to confirm your access to the enrollment.

- If you are a Staff End User of the organization, please contact the organization's Authorized/Delegated Official to ensure your account has access to PECOS.
- If you are an Authorized/Delegated Official of the organization, please confirm your role with the organization and ensure access to PECOS is active. To verify your account status, select the Account Management button on the Home Page and then choose Update user account information option.

The following checklists will help you gather the information needed to enroll via Internet-based PECOS:

Help

- Medicare Part A Services
- Medicare Part B Services
- Legal Business Name
- National Provider Identifier (NPI)

Additional Resources

New! **Medicare ID Search Tool**

- How to Guides
- FAQs
- Glossary
- Who Should I Call? [PDF, 214 KB]
- Application Status Kiosk
- Additional Links

Existing Associates

Please provide one or more of the following options to filter your associates. Selecting the reset button will clear the options selected and load the full list of associates.

Enrollment Type
All Types SELECT

Provider/Supplier Type
All Provider/Supplier Types

Associate Legal Business Name

TIN
XXX-XX-XXXX

Associate Last Name

NPI
10 Digits

Associate First Name

State
All States

FILTER RESET

In order to view Medicare applications and enrollments for an associate, please select the "View Enrollments" button next to an associate listed below.

Individuals 322

Records per page
250 SELECT

Records 1 - 250 of 322 1 2

Name: ABULFARAJ, MOAZ	**NPI:** [redacted]	VIEW ENROLLMENTS
Name: ACOSTA-VAN DEN BERG, JESSICA	**NPI:** [redacted]	VIEW ENROLLMENTS
Name: ADINARO, DAVID	**NPI:** [redacted]	VIEW ENROLLMENTS

Existing Enrollments

Contractor: NATIONAL GOVERNMENT SERVICES, INC.
State: NEW YORK
Type/Specialty: PSYCHIATRY

VIEW
MORE OPTIONS

Enrollment Type: 855I
Medicare ID: View Medicare ID Report
Status: DEACTIVATED View Deactivated Enrollment Record

Current ADI Accreditation?: No

Existing Reassignments: 1
Pending Reassignments Applications: 0
View/Manage Reassignments

Contractor: NOVITAS SOLUTIONS, INC.
State: OKLAHOMA
Type/Specialty: PSYCHIATRY

VIEW
REVALIDATE
MORE OPTIONS

Enrollment Type: 855I
Medicare ID: 2I0435 View Medicare ID Report
Status: APPROVED View Approved Enrollment Record

Current ADI Accreditation?: No

Existing Reassignments: 1
Pending Reassignments Applications: 0
View/Manage Reassignments

Contractor: NOVITAS SOLUTIONS, INC.
State: TEXAS
Type/Specialty: PSYCHIATRY

VIEW
REVALIDATE
MORE OPTIONS

Enrollment Type: 855I
Medicare ID: HSZ8SB, HSZ8SC...more View Medicare ID Report
Status: APPROVED View Approved Enrollment Record

Current ADI Accreditation?: No

Existing Reassignments: 10
Pending Reassignments Applications: 0
View/Manage Reassignments

View/Manage Reassignments

Pending Reassignments Applications

You currently do not have any Pending Reassignments.

Reassignments Report

Filter Reassignment Records

Please provide one or more of the following options to filter the enrollments. Selecting the reset button will clear the options selected and load the full list of enrollments.

Reassignment Status: All Statuses

Enrollment Status: All Statuses

Relationship Status: All Relationships

FILTER RESET

Records 1 - 10 of 10

The table below displays Reassignment Information for Approved, Deactivated, Revoked, and Rejected enrollment records. Any changes that you submit will display here only after the Medicare Administrative Contractor has processed the submitted enrollment.

Reassignments Report Details

Relationship	Provider Name/LBN	NPI	Current Enrollment Status	Reassigning Medicare ID	Receiving Medicare ID	Effective Date	Reassignment End Date	Revalidation Due Date
Reassigning Benefits to	ANADARKO INDIAN HEALTH CENTER	[redacted]	APPROVED	HSZ8SE	HSZ014	06/04/2023	N/A	N/A
Reassigning Benefits to	CARNEGIE INDIAN HEALTH CENTER	[redacted]	APPROVED	HSZ8SF	HSZ013	06/04/2023	N/A	N/A
Reassigning Benefits to	CLINTON INDIAN HEALTH CENTER	[redacted]	APPROVED	HSZ8UR	HSZ015	06/04/2023	N/A	05/31/2023
Reassigning Benefits to	DEPT OF HEALTH AND HUMAN SERVICES PHS INDIAN HEALTH SERVICE	[redacted]	APPROVED	HSZ8SD	HSZ25U	06/04/2023	N/A	N/A
Reassigning Benefits to	EL RENO INDIAN HEALTH CENTER	[redacted]	APPROVED	HSZ8UM	HSZ031	06/04/2023	N/A	02/29/2024
Reassigning Benefits to	HASKELL INDIAN HEALTH CENTER	[redacted]	APPROVED	HSZ8UU	HSZ008	06/04/2023	N/A	N/A
Reassigning Benefits to	LAWTON INDIAN HOSPITAL	[redacted]	APPROVED	HSZ8SC	HSZ012	06/04/2023	N/A	N/A
Reassigning Benefits to	PAWNEE INDIAN HEALTH CENTER	[redacted]	APPROVED	HSZ8SB	HSZ000	06/04/2023	N/A	02/29/2024
Reassigning Benefits to	WATONGA INDIAN HEALTH CENTER	[redacted]	APPROVED	HSZ8UQ	HSZ030	06/04/2023	N/A	02/28/2023
Reassigning Benefits to	WEWOKA INDIAN HEALTH	[redacted]	APPROVED	HSZ8SG	HSZ016	06/04/2023	N/A	N/A

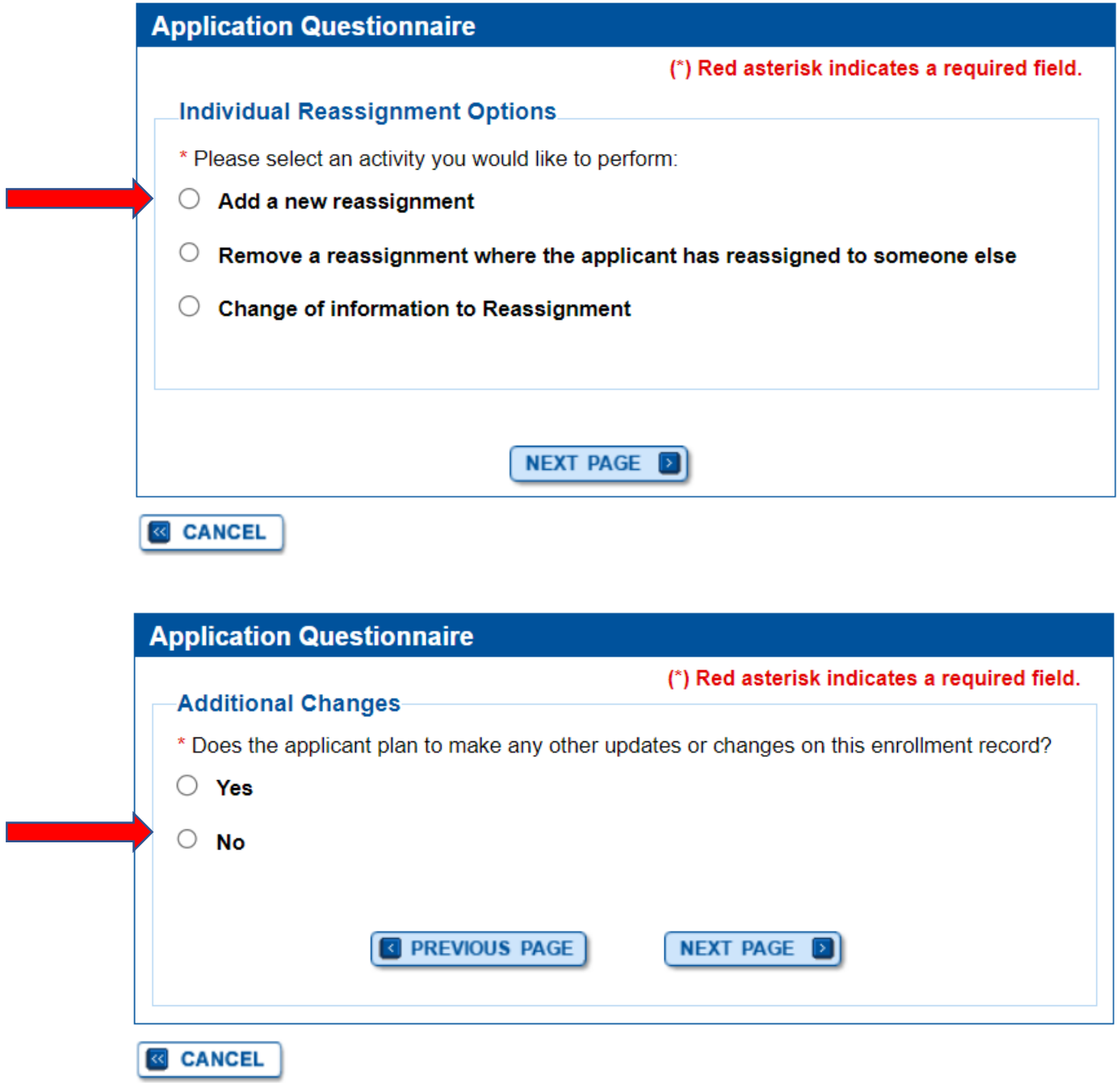
Records 1 - 10 of 10

Note: Please select on the "Download Report" button to download this report in CSV format.

PRINT DOWNLOAD REPORT

RETURN TO MY ENROLLMENTS

MANAGE REASSIGNMENTS


Application Questionnaire
(*) Red asterisk indicates a required field.
Individual Reassignment Options
* Please select an activity you would like to perform:
Add a new reassignment
Remove a reassignment where the applicant has reassigned to someone else
Change of information to Reassignment
NEXT PAGE
CANCEL
Application Questionnaire
(*) Red asterisk indicates a required field.
Additional Changes
* Does the applicant plan to make any other updates or changes on this enrollment record?
Yes
No
PREVIOUS PAGE
NEXT PAGE
CANCEL

Topic View | Fast Track View | Error/Warning Check 2

Enrollment ID: X06302024000495
PacID: 1951571736X06302024000495
Web Tracking ID: T063020240000429
Individual Provider NPI:

Reason for Application

Reassignment of Benefits Between an Enrolled Practitioner and another Enrolled Practitioner(s), Supplier(s), or Provider(s)

Reports

Select the hyperlink to view the Application being edited:
View Application being edited

Select the hyperlink to view the Medicare ID Report:
View Medicare ID Report

Topics

The data required for this enrollment application is grouped into topics. In order to electronically submit this enrollment application, you must complete all of the following topics.

You may view and print this enrollment application at any time during the enrollment process by clicking the View and Print button below.

This application is collecting the following topics:

Completed	Topics
—	Reassignment more information about Reassignment
✓	Contact Person more information about Contact Person

Reassignment of Benefits

Topic Summary

This topic captures information to identify Medicare providers with whom the applicant will establish a reassignment of benefits. (more information about Reassignment of Benefits)

Filter Reassignment of Benefits

Please provide one or more of the following options to filter your enrollments. Selecting on the Clear Filter button will clear the options and load the full list of enrollments.

Advanced Search

ADD INFORMATION

Reassignment Information

Records 1 - 10 of 10

Reassignment to: ANADARKO INDIAN HEALTH CENTER

Effective Date of Information: 06/04/2023 **Medicare ID(s) of Individual/Group**

Help

Reassignment

Additional Resources

New! Medicare ID Search Tool

How to Guides

FAQs

Glossary

Who Should I Call? [PDF, 214 KB]

Application Status Kiosk

Additional Links

Reassignment of Benefits (Group/Organization)

(*) Red asterisk indicates a required field.

Information of Group/Organization Receiving Benefits from Applicant

* **Effective Date of Information**

MM/DD/YYYY

* **Legal Business Name**

* **Tax Identification Number (TIN)**

XX-XXXXXXX

* **National Provider Identifier (NPI)**

10 Digits

PREVIOUS PAGE NEXT PAGE

CANCEL

Help

- Legal Business Name
- Tax Identification Number (TIN)
- National Provider Identifier (NPI)

Additional Resources

New! **Medicare ID Search Tool**

- How to Guides
- FAQs
- Glossary
- Who Should I Call? [PDF, 214 KB]
- Application Status Kiosk
- Additional Links

Reassignment of Benefits

Medicare Identification Numbers

Legal Business Name: Claremore Indian Hospital

National Provider Identifier (NPI): 1073527842

Please provide any Medicare Identification numbers that apply to the group/provider that you are reassigning your benefits.

Note: Use the Add More button to add more than one Medicare Identification number.

Medicare Identification Number

ADD MORE

PREVIOUS PAGE NEXT PAGE

CANCEL

Reassignment of Benefits

(*) Red asterisk indicates a required field.

Reassignment Practice Location Choice

* Please indicate what Practice Location information you would like to enter:

- **Primary Practice location**
- **Primary and Secondary Practice location**
- **None**

PREVIOUS PAGE NEXT PAGE

Topic View | Fast Track View | Error/Warning Check 1

Enrollment Submission

Note: Your application is ready for submission with warning messages. Please review the warning messages and select the Begin Submission button.

BEGIN SUBMISSION

Enrollment ID: X06302024000495
PacID: 1951571736X06302024000495
Web Tracking ID: T063020240000429
Individual Provider NPI:

Errors for this Enrollment

No Errors were found for this enrollment application.

Warnings for this Enrollment

Warnings were found for this enrollment application. Please review the warnings listed below and verify that the information entered is correct.

Verification of this information is optional; the submission process may continue without verification of this information.

Topic	Warning
Reassignment	Reassignment of Benefits exist that are missing a primary and/or secondary practice location. It is recommended that a primary and secondary practice location be specified, but are not required.

Both the I & A website and the PECOS website offer training PDFs and videos to walk you through the enrollment process. Your MAC will also offer training videos and live webinars to help you with provider enrollment.

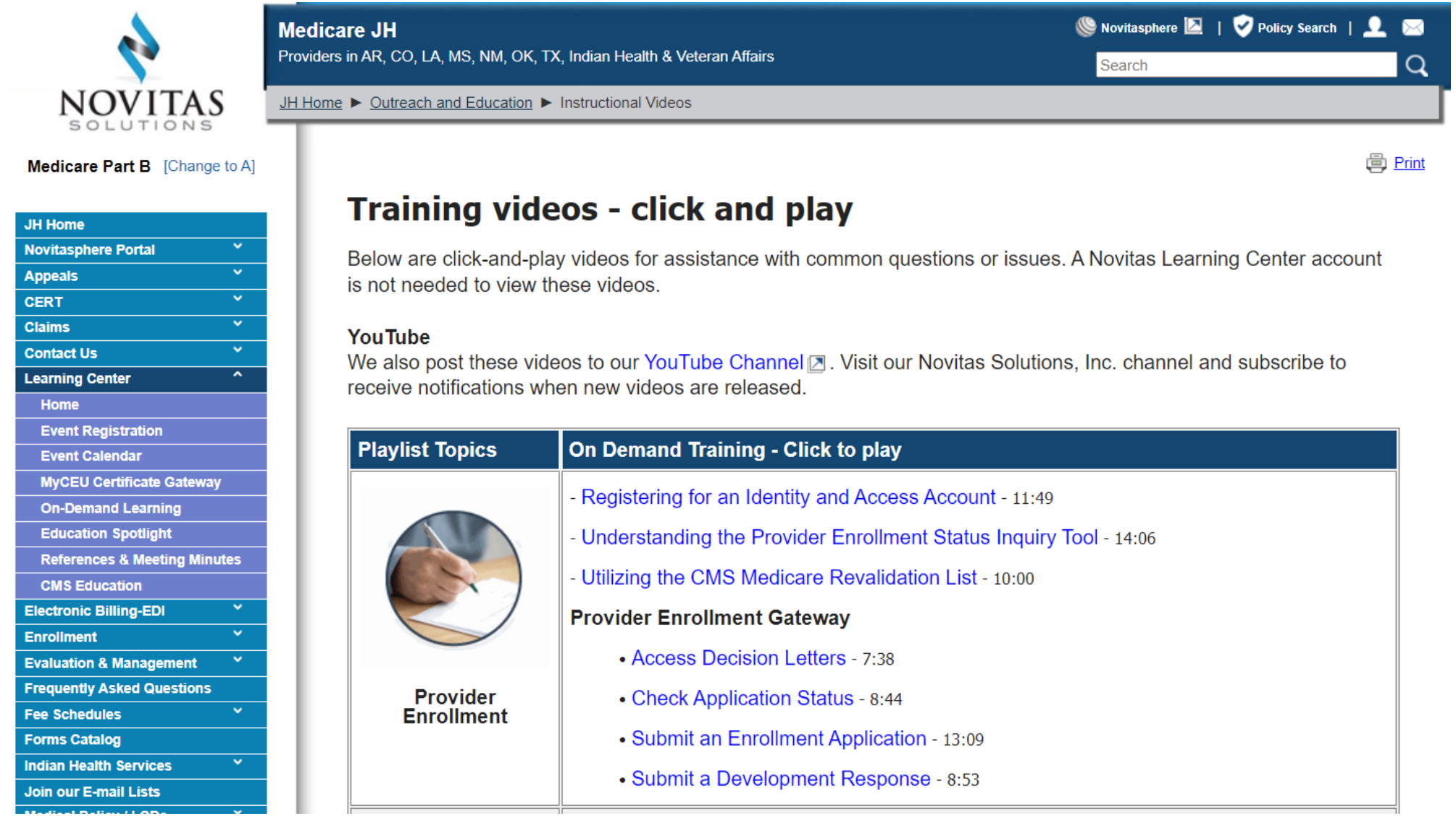
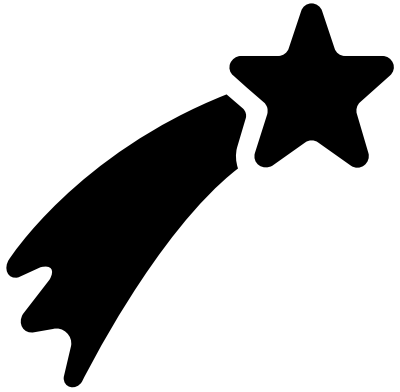


Table Maintenance Slides

Table Maintenance Slides



Provider Form

New Provider Contracts Required Information

Full Legal Name: _____

Name in NPPES: _____

Date-of-birth: _____

SSN: _____

NPI: _____

University/College graduated from: _____

Graduation Date: _____

Have you worked in IHS before?	YES	NO	
Is your NPI and taxonomy information up-to-date in NPPES?	YES	NO	
Do you have an active Oklahoma Medicaid Provider ID?	YES	NO	
Do you have an active Medicaid Provider ID in another state? (Please provide a letter from that state's Medicaid program that states you have been inactivated.)	YES	NO	
Does the state you are licensed in require your profession to have a DEA registration or a Controlled Substance Abuse registration?	YES	NO	N/A
Have you ever had your license revoked or has there been a gap? (If yes, please provide documentation.)	YES	NO	
Do you have an active Medicare PTAN under the Texas Region?	YES	NO	
In the past 10 years, have you had any adverse legal action brought against you, including malpractice? (If yes, please provide documenation.)	YES	NO	
Have you ever been a BC/BS OK Participating Provider before?	YES	NO	
Do you currently have malpractice insurance of at least $1 million for physicians OR $500,000/$1 million for health care providers?	YES	NO	
Has your professional liability insurance carrier excluded any specific procedures or imposed other restrictions on your coverage? (If yes, please list the procedures which have been excluded with an explanation.)	YES	NO	
Have you ever been subjected to actions by a utilization and quality control Peer Review Organization (PRO)?	YES	NO	
Has there been a gap OR six (6) months or greater in your academic or professional career for the previous 5 years?	YES	NO	

If you answered yes to the previous three questions, please provide an explanation.

Medicare Adminstrative Contractors (MACs)

Novitas Solutions (JH)

Noridian Healthcare Solutions

CGS Administrators

Wisconsin Physicians Service

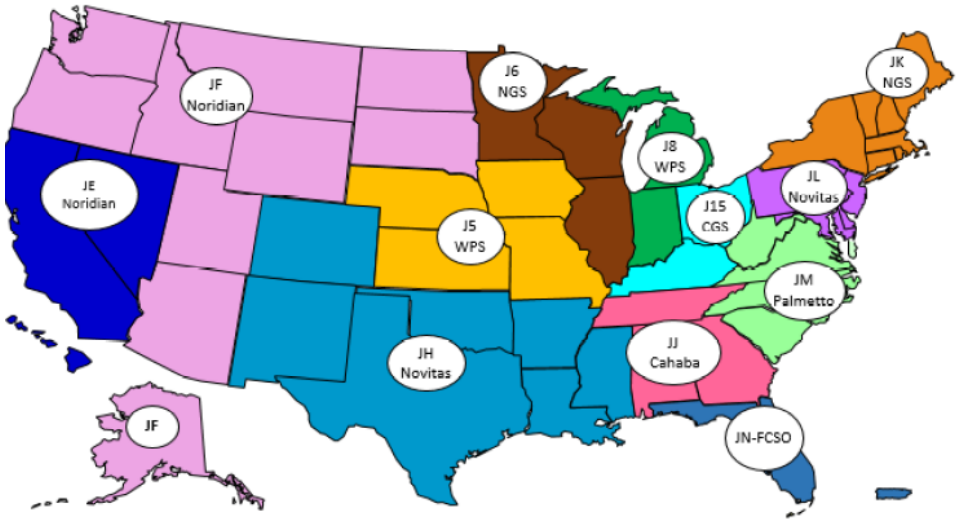
National Government Services

GS Administrators

Cahaba Government Benefit Admin

Palmetto GBA (DME)

A/B Jurisdiction Map
as of December 2015



Medicare and Railroad Retirement

PART A

Inpatient

Outpatient (hospital based)

Home Health Care

Skilled Nursing

Type	Billed	Reimbursed
Inpatient	All-Inclusive Rate	DRG
Outpatient	All-Inclusive Rate	All-Inclusive Rate

PART B

Professional Component

Durable Medical Equipment (DME)

Ambulatory Surgery

Therapeutic Services

Diagnostic Services

Type	Billed	Reimbursed
Outpatient	Itemized	Fee-for-service

Medicare

PART C

Medicare Advantage Plans

Replaces traditional Medicare

Most services covered and are not paid under Medicare

Offers prescription drug coverage

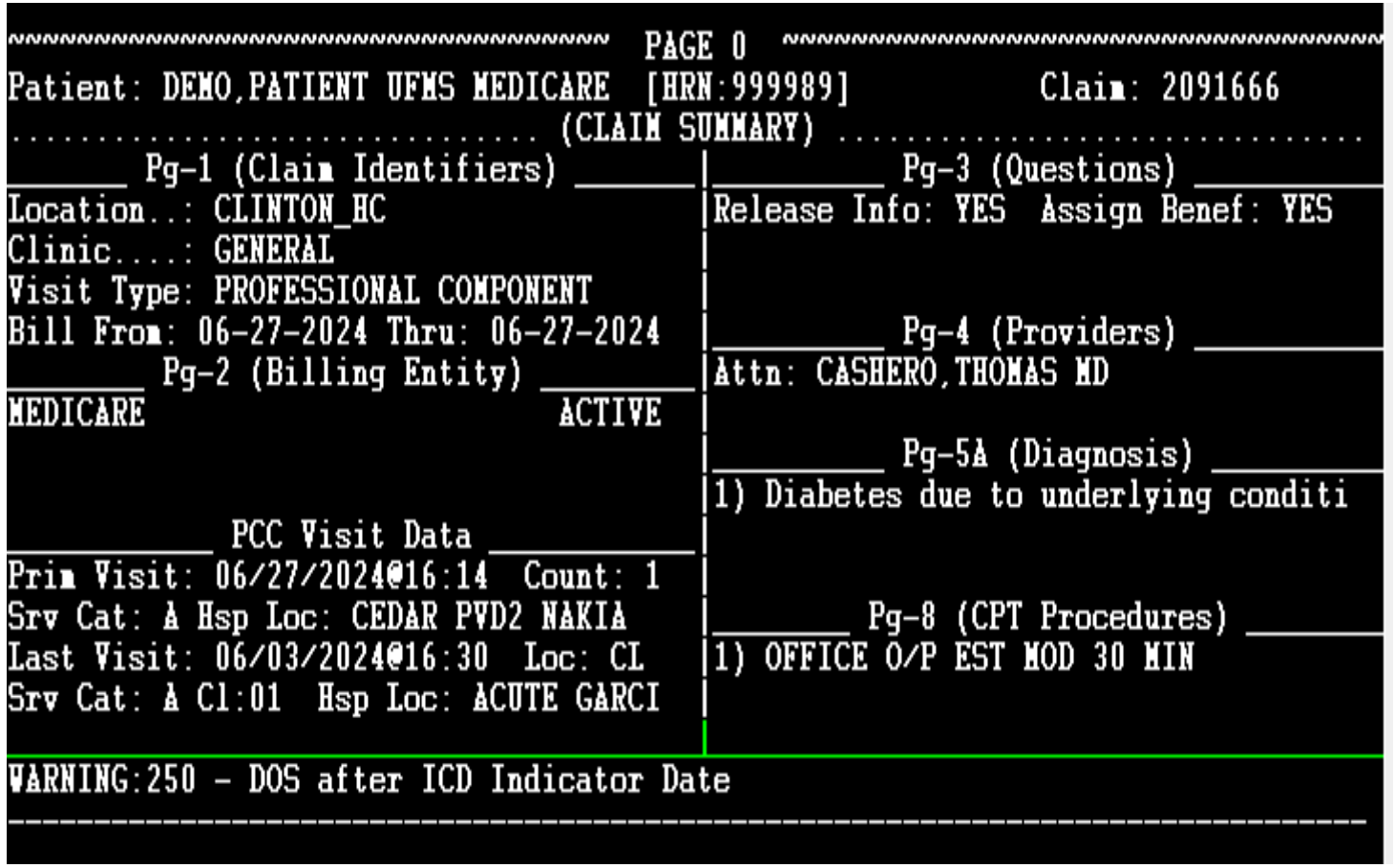
Entered as Private Insurance

PART D

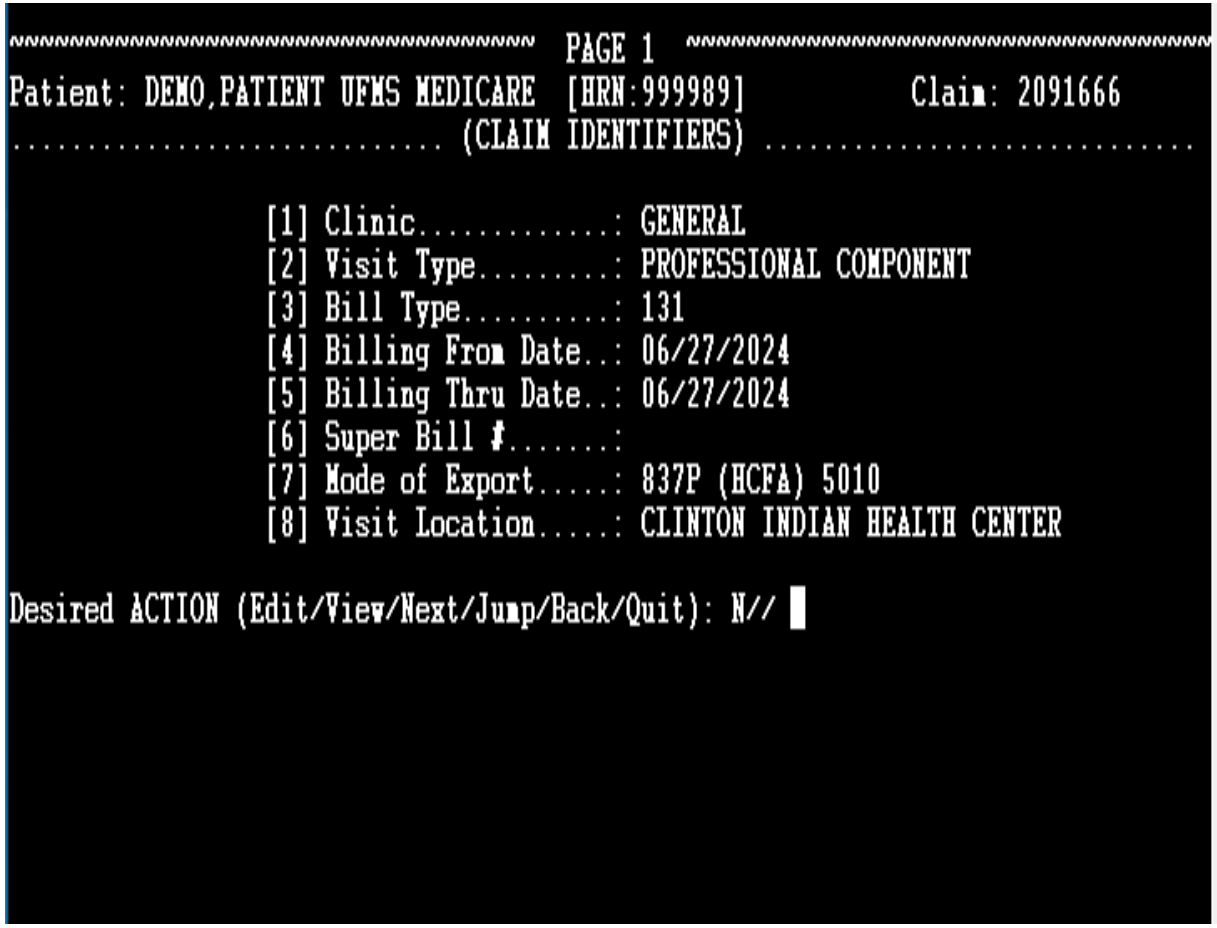
Prescription Drug Coverage

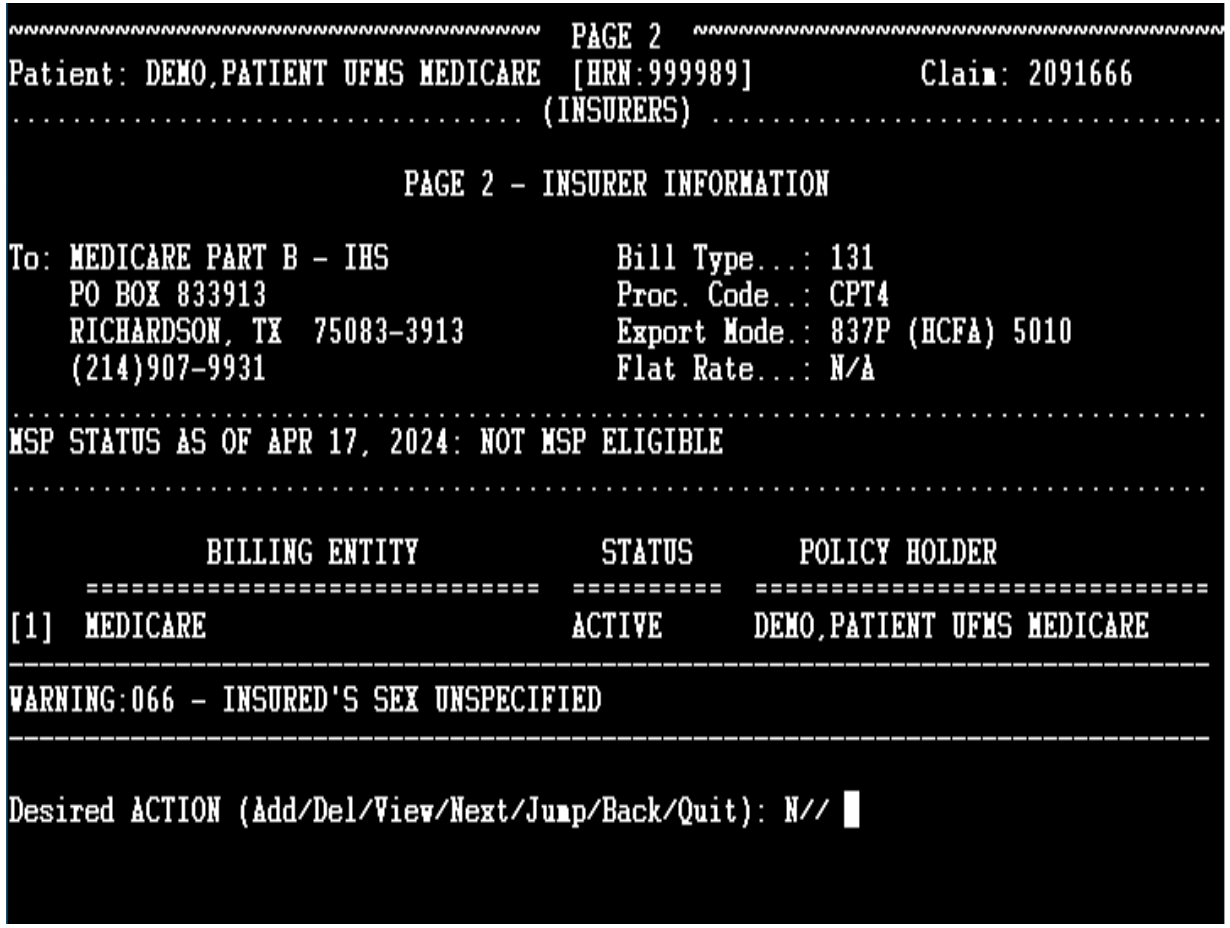
Entered under Medicare or Railroad Retirement as Part D

Medicare Part B Billing Example

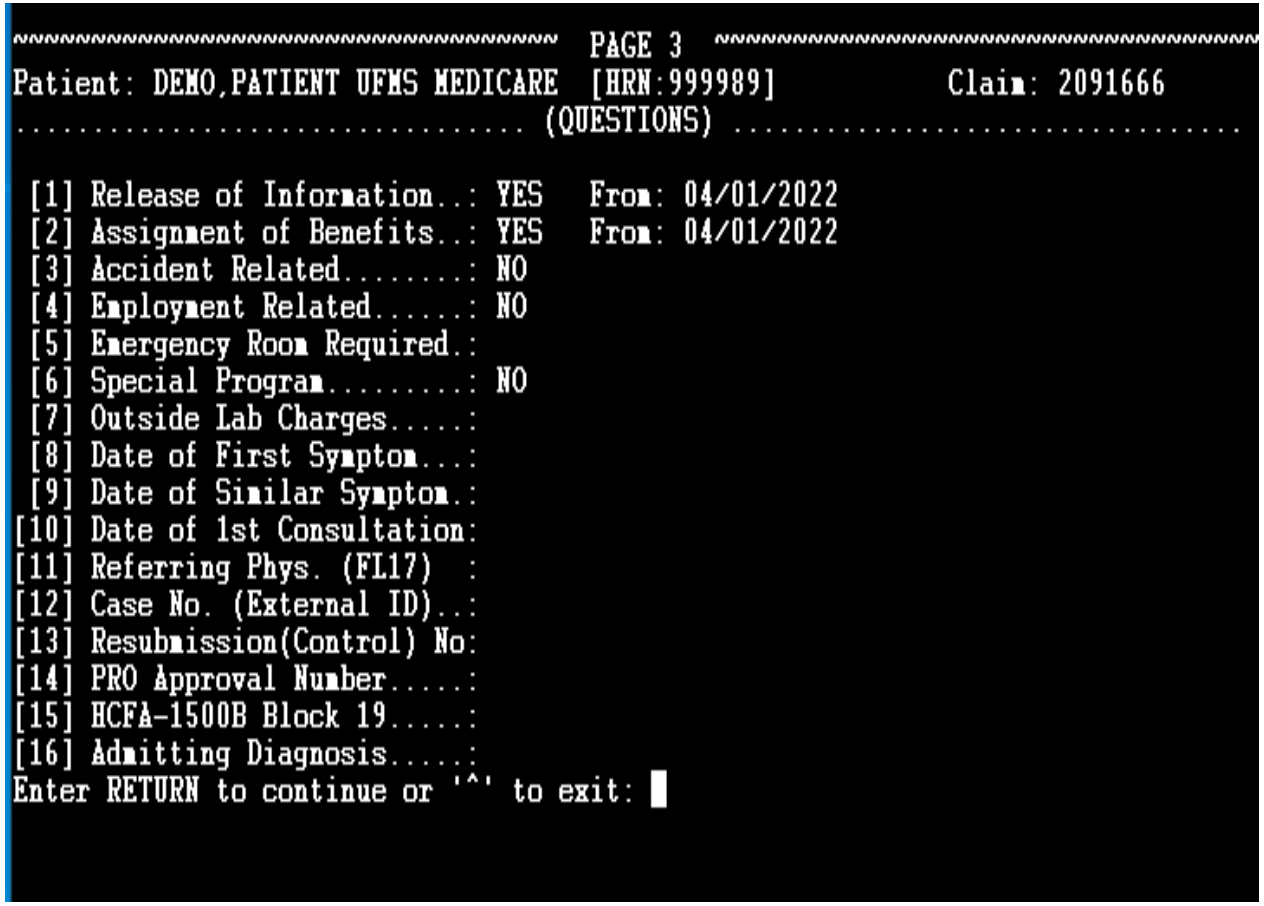


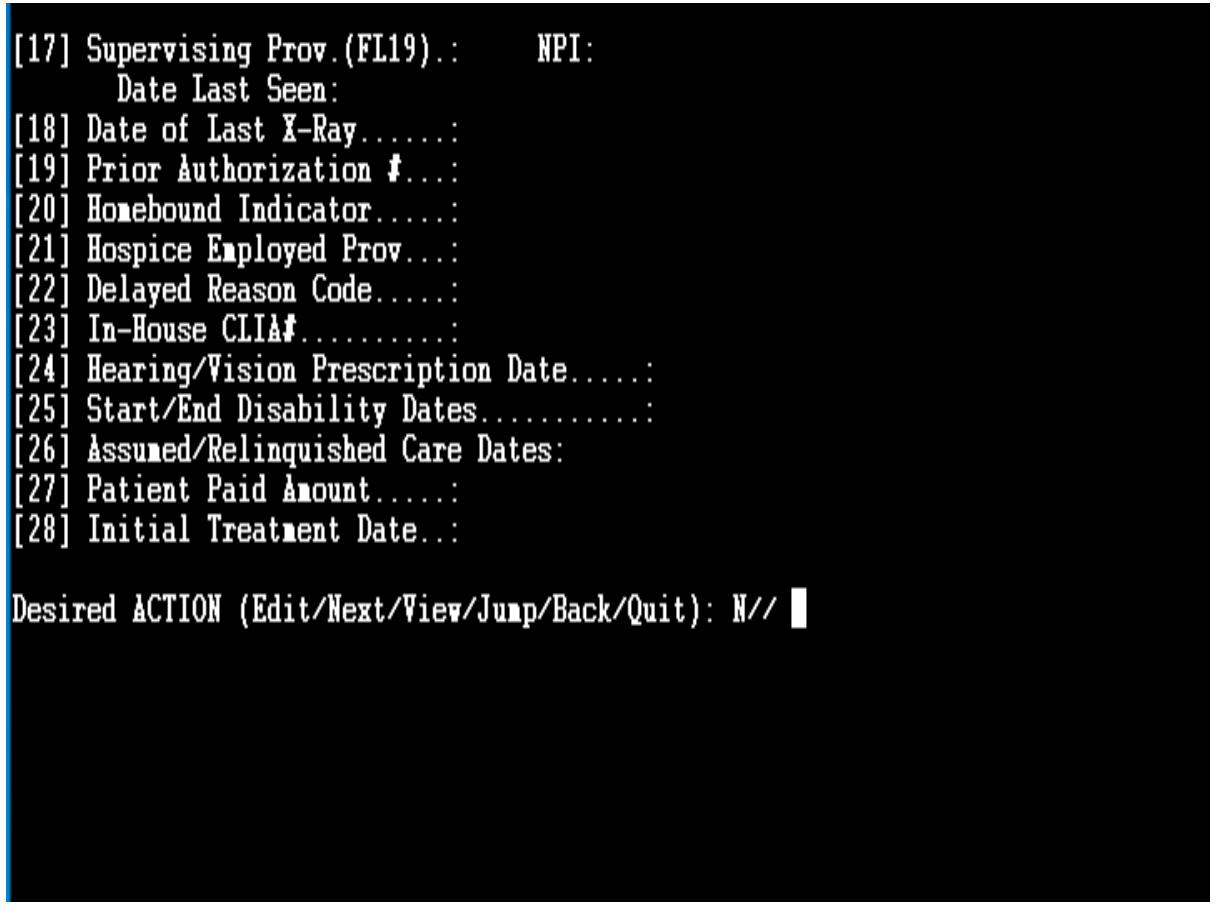
Pages 1 and 2


PAGE 1
Patient: DEMO,PATIENT UFMS MEDICARE [HRN:999989] Claim: 2091666
(CLAIM IDENTIFIERS)
[1] Clinic.....: GENERAL
[2] Visit Type.....: PROFESSIONAL COMPONENT
[3] Bill Type.....: 131
[4] Billing From Date..: 06/27/2024
[5] Billing Thru Date..: 06/27/2024
[6] Super Bill #.....:
[7] Mode of Export.....: 837P (HCFA) 5010
[8] Visit Location.....: CLINTON INDIAN HEALTH CENTER
Desired ACTION (Edit/View/Next/Jump/Back/Quit): N//

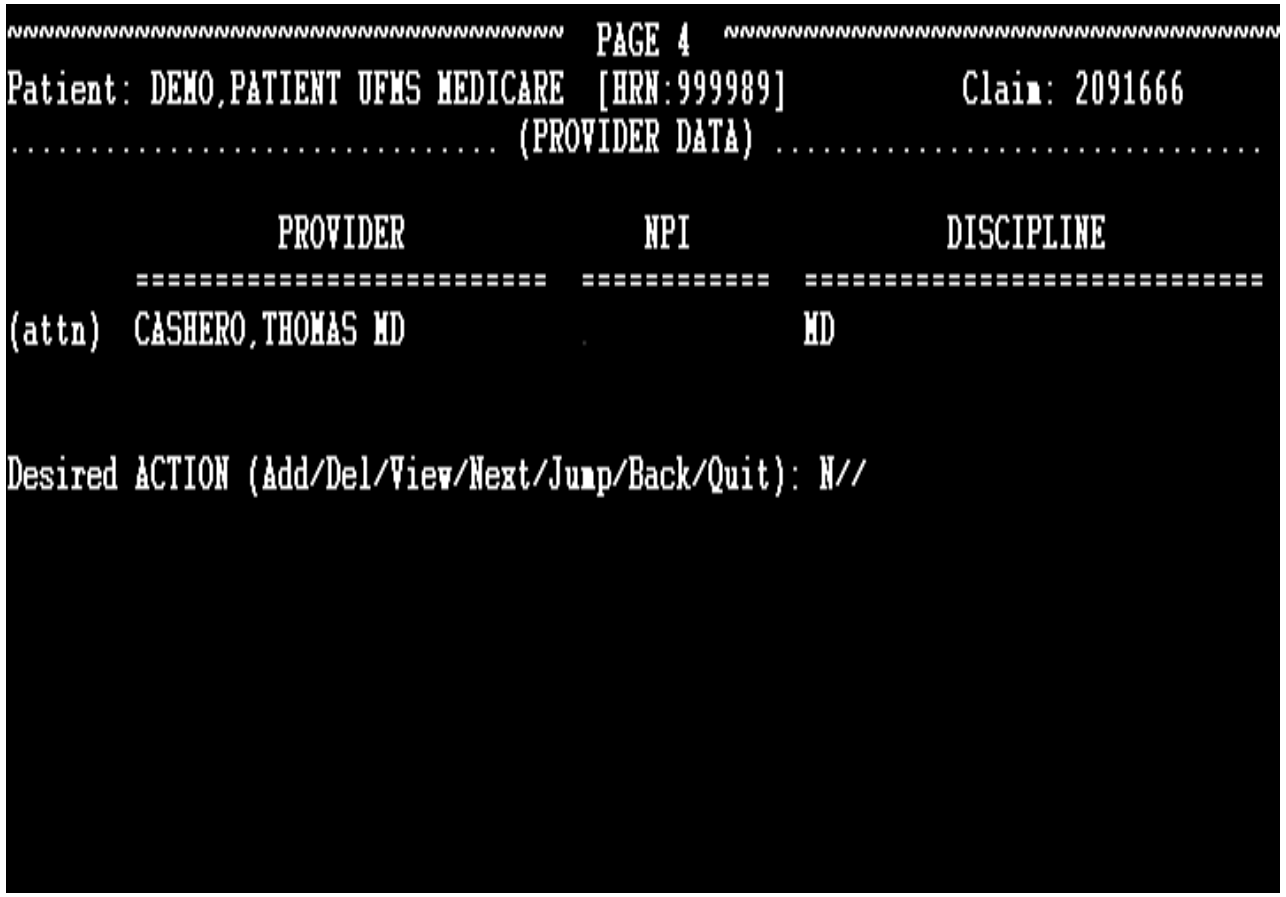

PAGE 2
Patient: DEMO,PATIENT UFMS MEDICARE [HRN:999989] Claim: 2091666
(INSURERS)
PAGE 2 - INSURER INFORMATION
To: MEDICARE PART B - IHS
PO BOX 833913
RICHARDSON, TX 75083-3913
(214)907-9931
Bill Type...: 131
Proc. Code..: CPT4
Export Mode.: 837P (HCFA) 5010
Flat Rate...: N/A
MSP STATUS AS OF APR 17, 2024: NOT MSP ELIGIBLE
BILLING ENTITY STATUS POLICY HOLDER
[1] MEDICARE ACTIVE DEMO,PATIENT UFMS MEDICARE
WARNING:066 - INSURED'S SEX UNSPECIFIED
Desired ACTION (Add/Del/View/Next/Jump/Back/Quit): N//

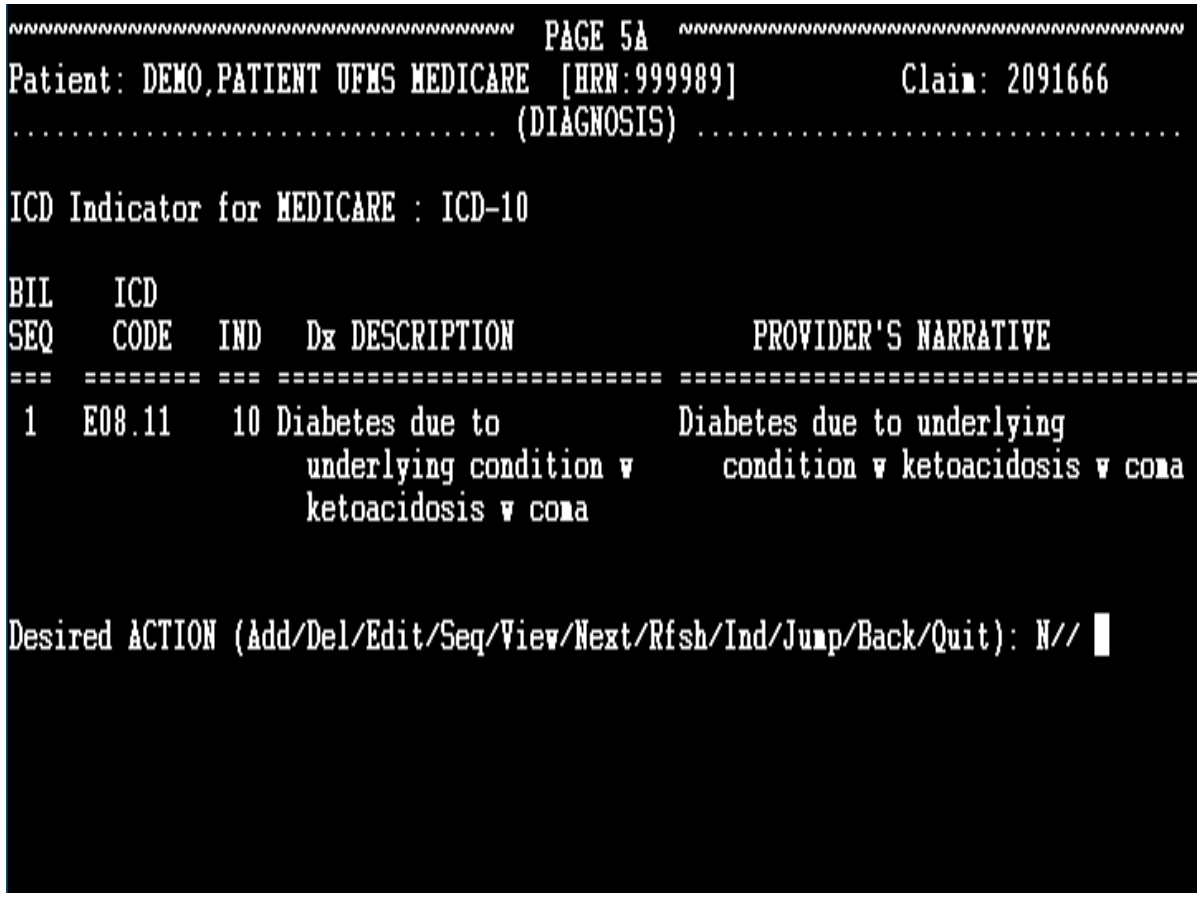
Page 3


PAGE 3
Patient: DEMO,PATIENT UFMS MEDICARE [HRN:999989] Claim: 2091666
(QUESTIONS)
[1] Release of Information..: YES From: 04/01/2022
[2] Assignment of Benefits..: YES From: 04/01/2022
[3] Accident Related.....: NO
[4] Employment Related.....: NO
[5] Emergency Room Required.:
[6] Special Program.....: NO
[7] Outside Lab Charges.....:
[8] Date of First Symptom...:
[9] Date of Similar Symptom.:
[10] Date of 1st Consultation:
[11] Referring Phys. (FL17) :
[12] Case No. (External ID)..:
[13] Resubmission(Control) No:
[14] PRO Approval Number.....:
[15] HCFA-1500B Block 19.....:
[16] Admitting Diagnosis.....:
Enter RETURN to continue or '^' to exit:

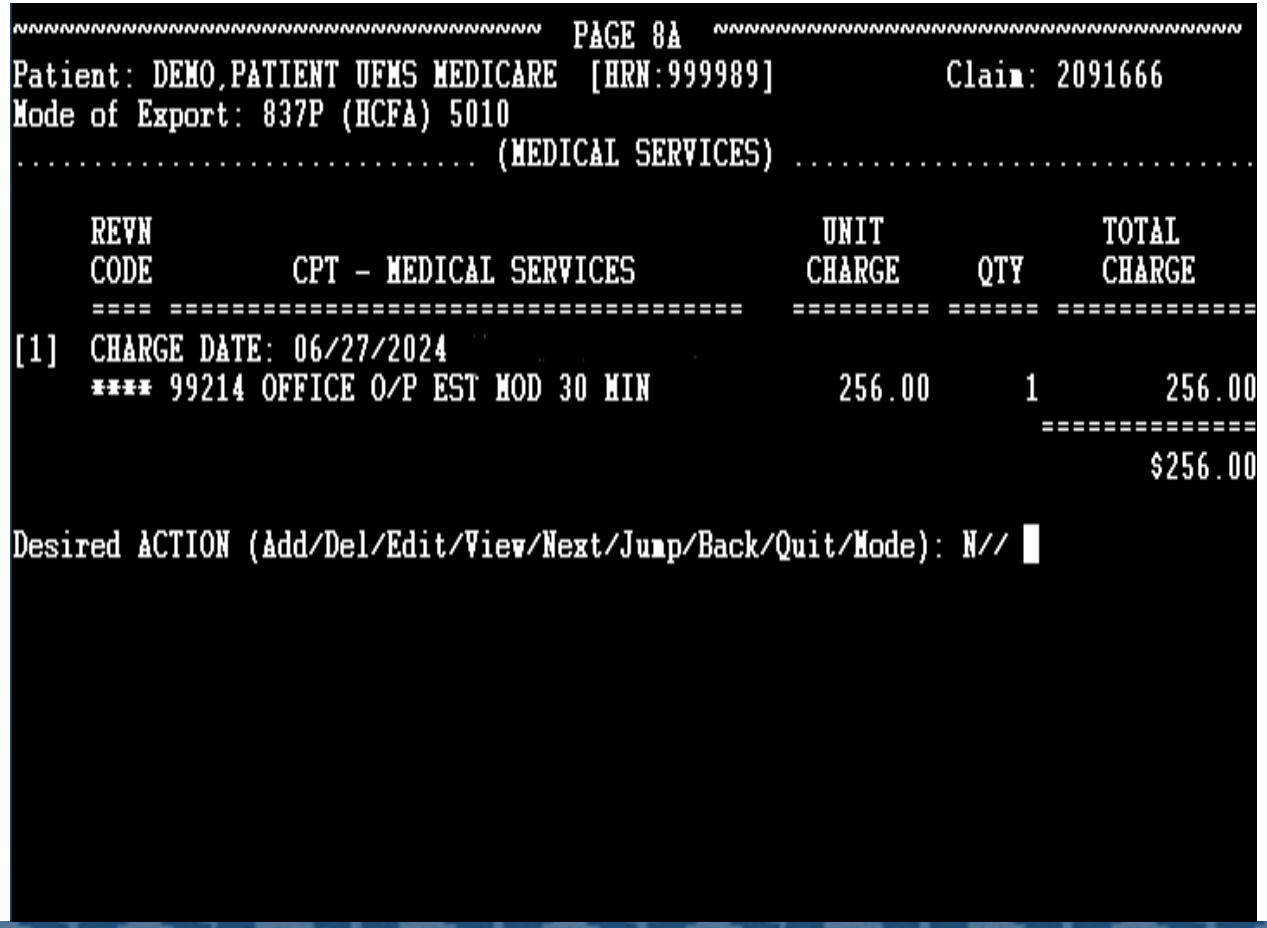

[17] Supervising Prov.(FL19).: NPI:
Date Last Seen:
[18] Date of Last X-Ray.....:
[19] Prior Authorization #...:
[20] Homebound Indicator.....:
[21] Hospice Employed Prov...:
[22] Delayed Reason Code.....:
[23] In-House CLIA#.....:
[24] Hearing/Vision Prescription Date.....:
[25] Start/End Disability Dates.....:
[26] Assumed/Relinquished Care Dates:
[27] Patient Paid Amount.....:
[28] Initial Treatment Date..:
Desired ACTION (Edit/Next/View/Jump/Back/Quit): N//

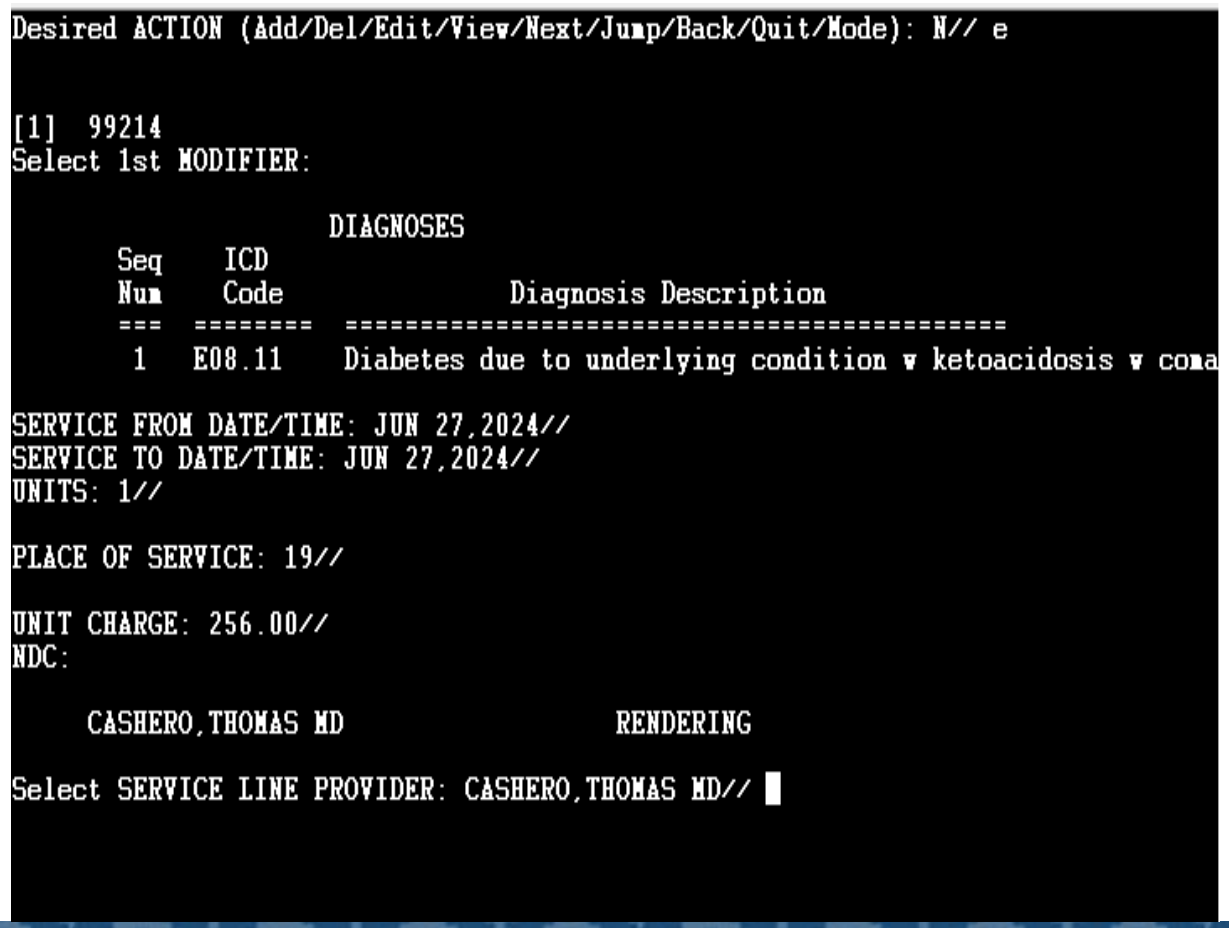
Page 4 and 5


PAGE 4
Patient: DEMO,PATIENT UFMS MEDICARE [HRN:999989] Claim: 2091666
(PROVIDER DATA)
PROVIDER
NPI
DISCIPLINE
(attn) CASHERO,THOMAS MD
MD
Desired ACTION (Add/Del/View/Next/Jump/Back/Quit): N//


PAGE 5A
Patient: DEMO,PATIENT UFMS MEDICARE [HRN:999989] Claim: 2091666
(DIAGNOSIS)
ICD Indicator for MEDICARE : ICD-10
BIL SEQ
ICD CODE
IND
Dx DESCRIPTION
PROVIDER'S NARRATIVE
1 E08.11 10 Diabetes due to underlying condition w ketoacidosis w coma
Diabetes due to underlying condition w ketoacidosis w coma
Desired ACTION (Add/Del/Edit/Seq/View/Next/Rfsh/Ind/Jump/Back/Quit): N//

Pages 8A


PAGE 8A
Patient: DEMO,PATIENT UFMS MEDICARE [HRN:999989] Claim: 2091666
Mode of Export: 837P (HCFA) 5010
(MEDICAL SERVICES)
REVN CODE
CPT - MEDICAL SERVICES
UNIT CHARGE
QTY
TOTAL CHARGE
[1] CHARGE DATE: 06/27/2024
**** 99214 OFFICE O/P EST MOD 30 MIN 256.00 1 256.00
$256.00
Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N//

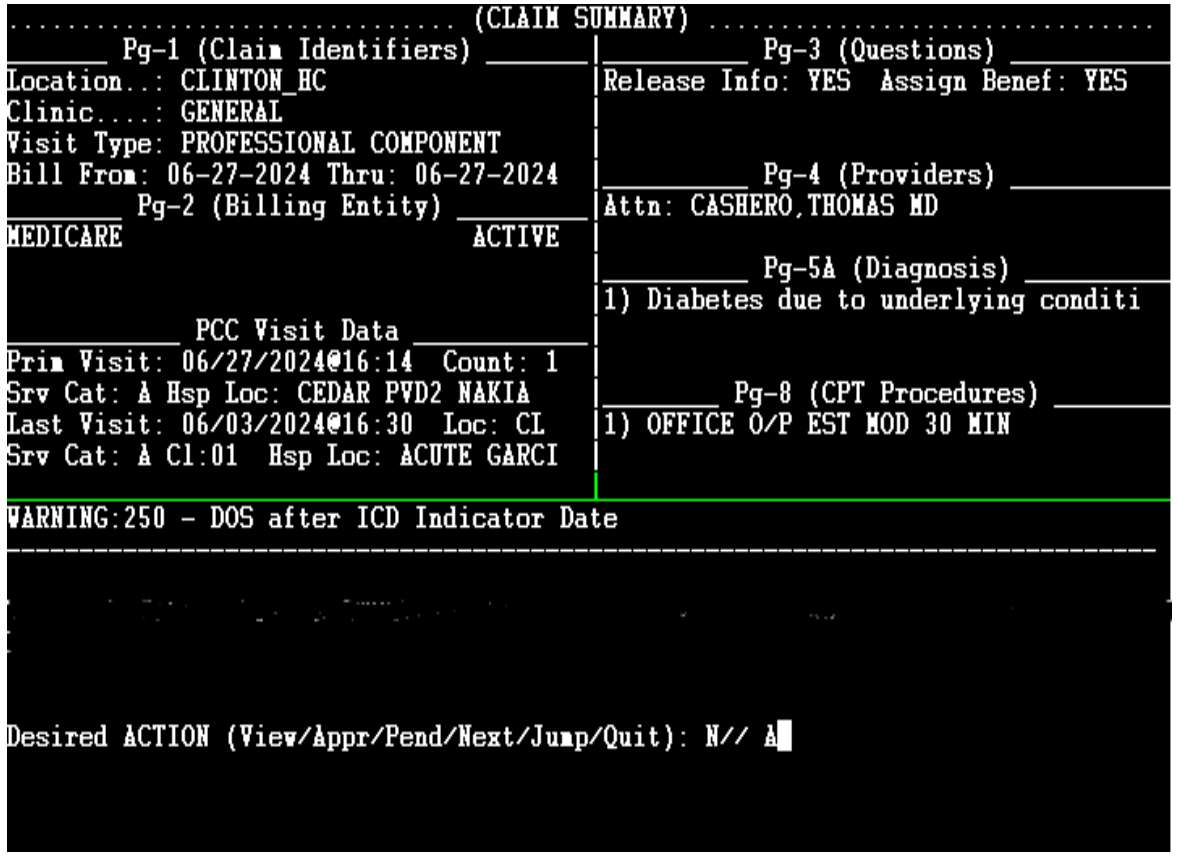

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N// e
[1] 99214
Select 1st MODIFIER:
DIAGNOSES
Seq Num
ICD Code
Diagnosis Description
1 E08.11 Diabetes due to underlying condition w ketoacidosis w coma
SERVICE FROM DATE/TIME: JUN 27,2024//
SERVICE TO DATE/TIME: JUN 27,2024//
UNITS: 1//
PLACE OF SERVICE: 19//
UNIT CHARGE: 256.00//
NDC:
CASHERO,THOMAS MD RENDERING
Select SERVICE LINE PROVIDER: CASHERO,THOMAS MD//

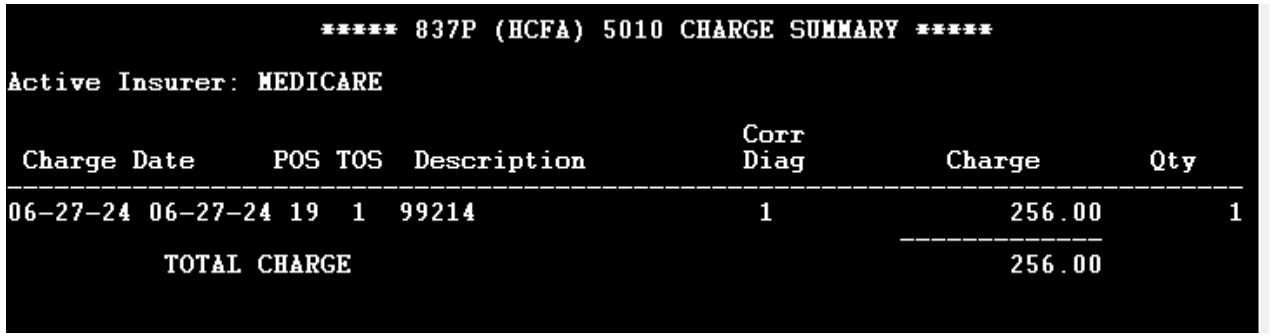
Page 8A

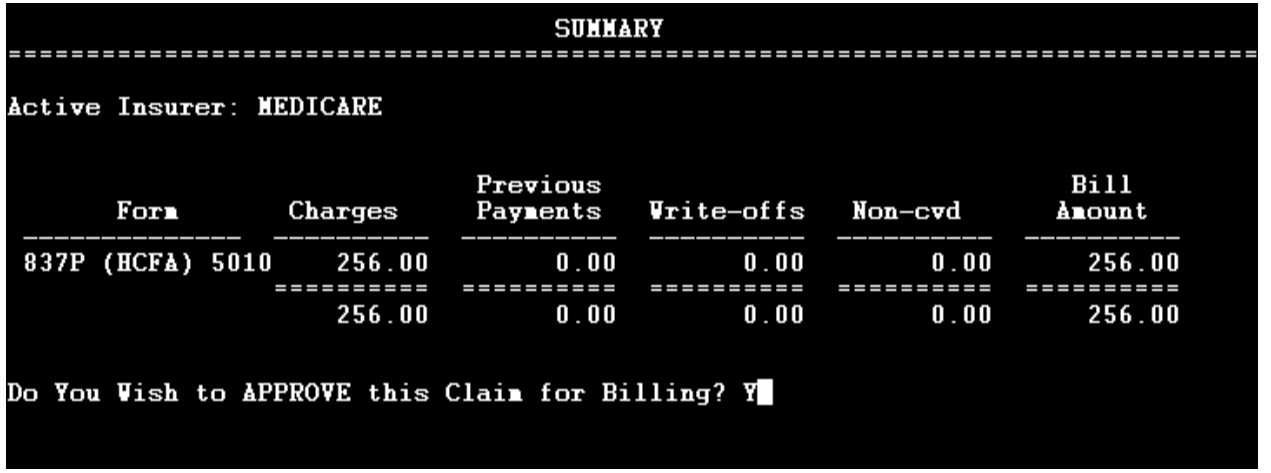
```
Select SERVICE LINE PROVIDER: CASHERO,THOMAS MD//      TEC       PHYSICIAN
       ...OK? Yes//  (Yes)
       RENDERING
SERVICE LINE PROVIDER: CASHERO,THOMAS MD//
```

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 8A  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT UFMS MEDICARE  [HRN:999989]          Claim: 2091666
Mode of Export: 837P (HCFA) 5010
.............................. (MEDICAL SERVICES) ..............................

     REVN                                                 UNIT                TOTAL
     CODE        CPT - MEDICAL SERVICES                  CHARGE     QTY      CHARGE
     ==== ===================================   ========= ====== ============
[1]  CHARGE DATE: 06/27/2024 (CASHERO,THOMAS MD-R)
     **** 99214 OFFICE O/P EST MOD 30 MIN           256.00      1        256.00
                                                                  ============
                                                                       $256.00

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N//
```

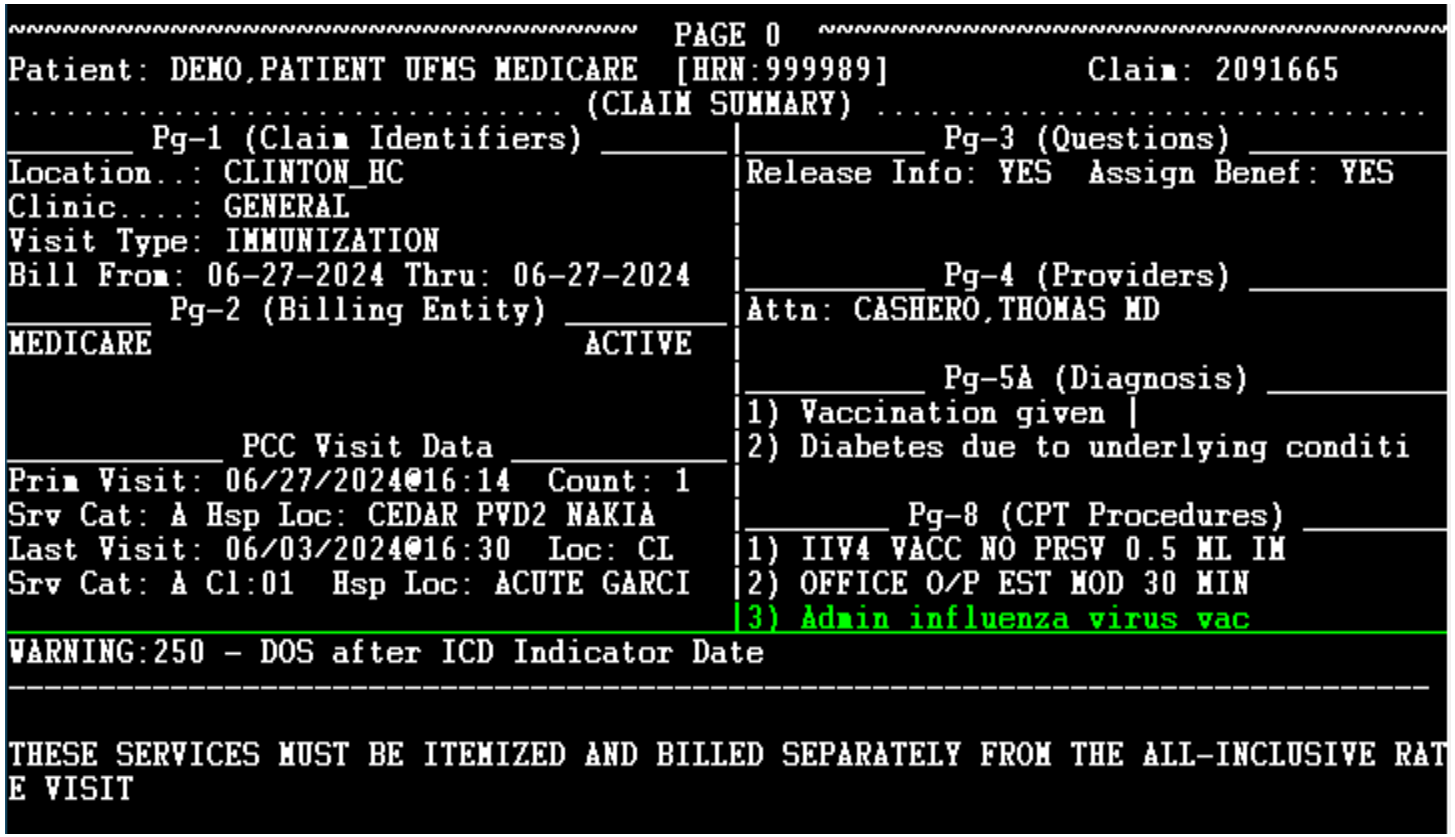
Approving the claim



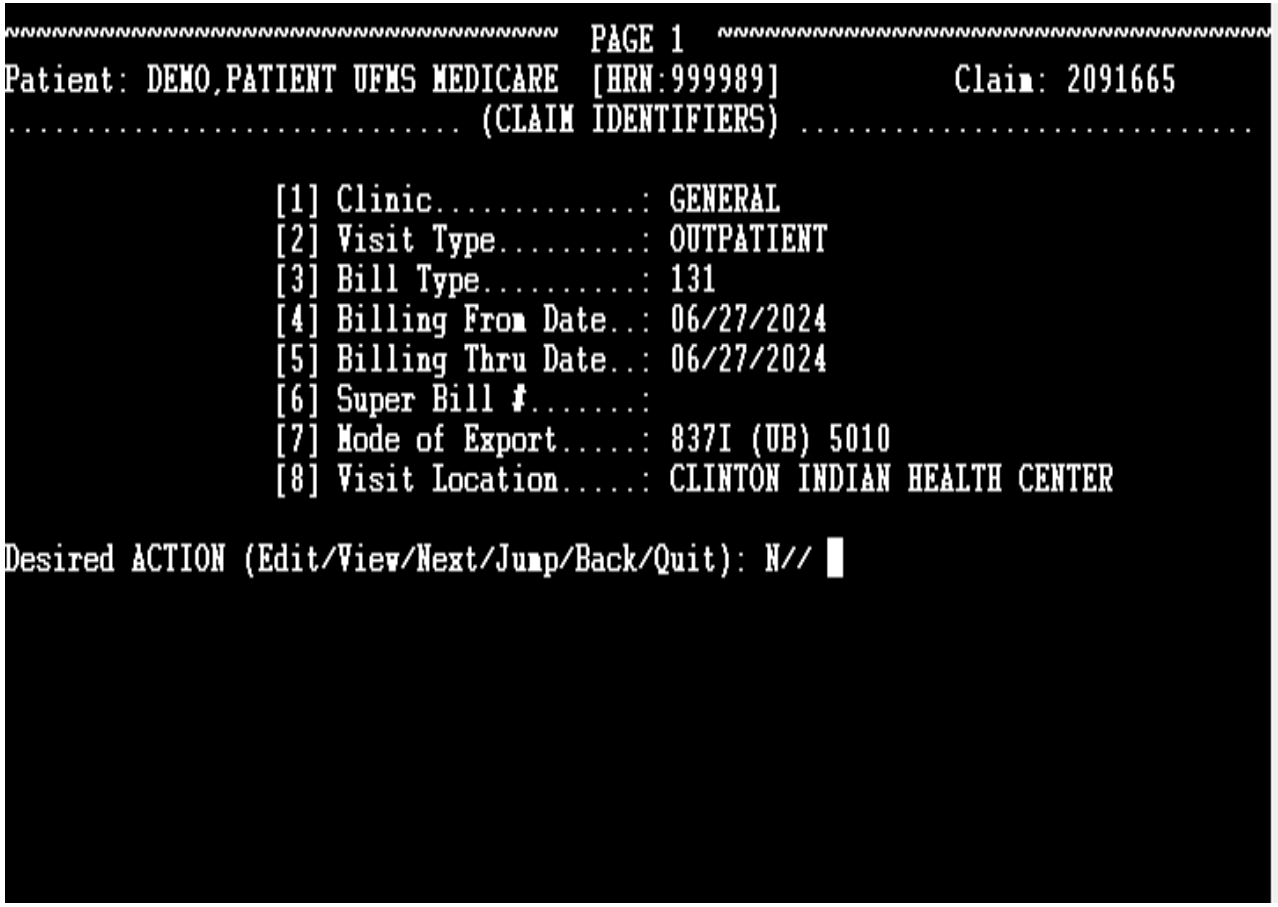


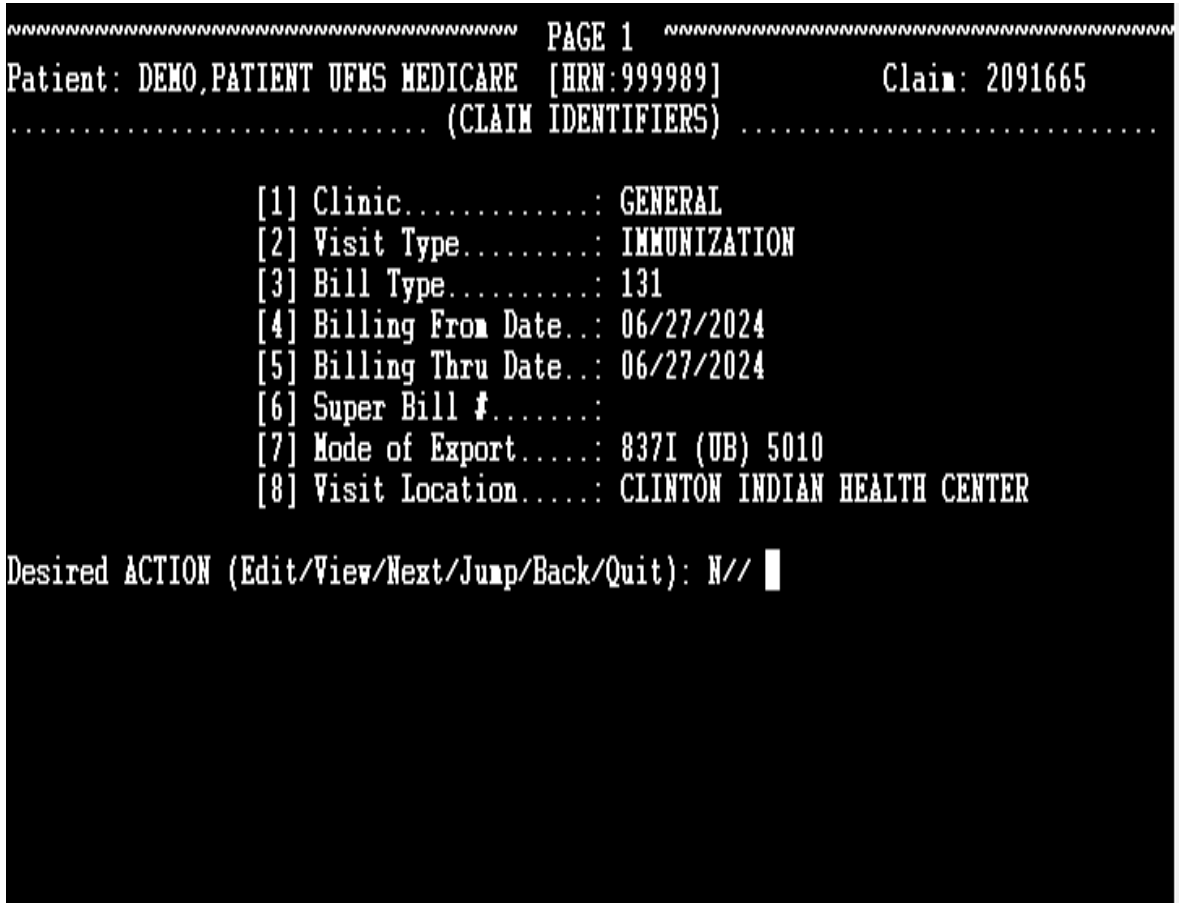


Medicare Part A Billing Example

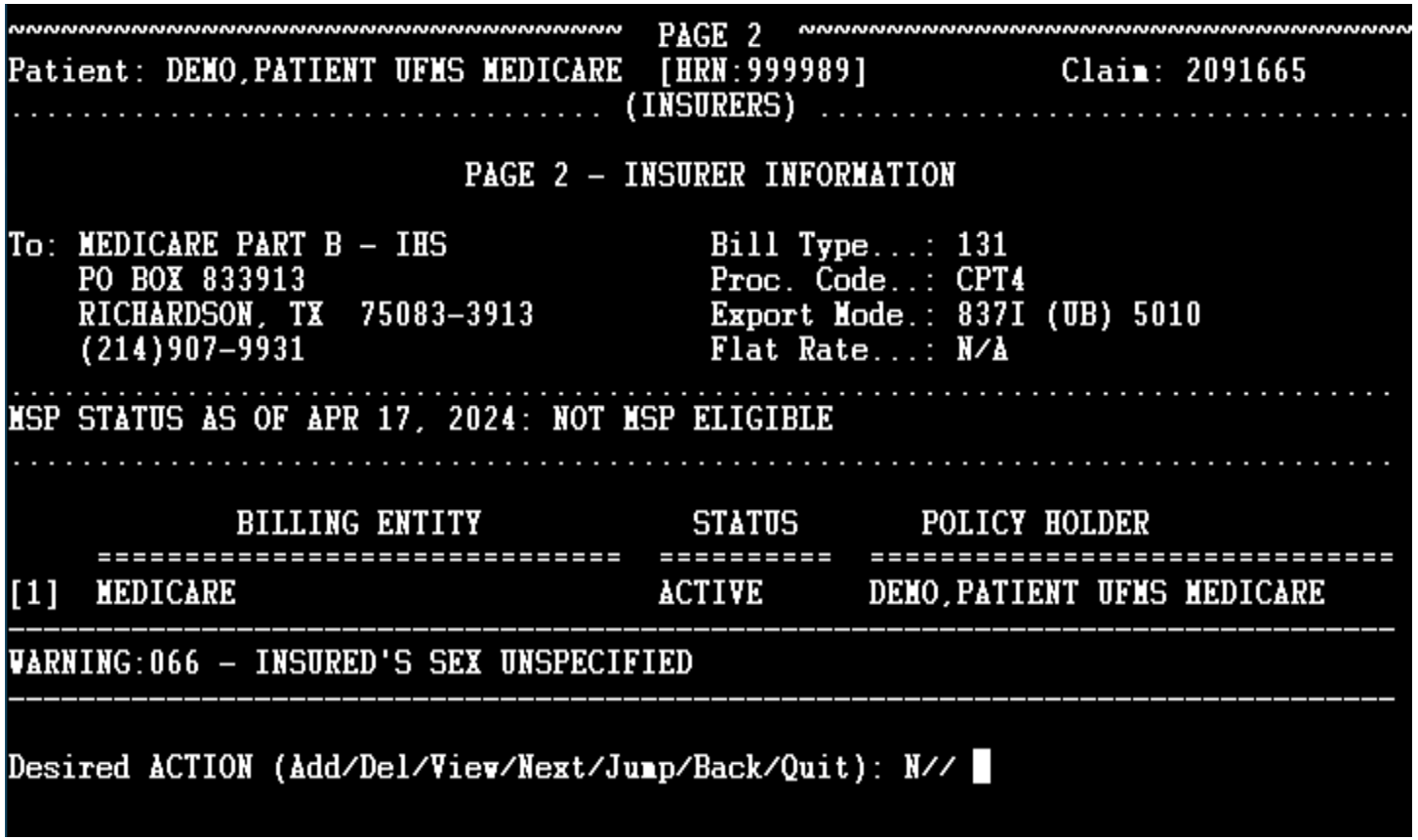


Page 1

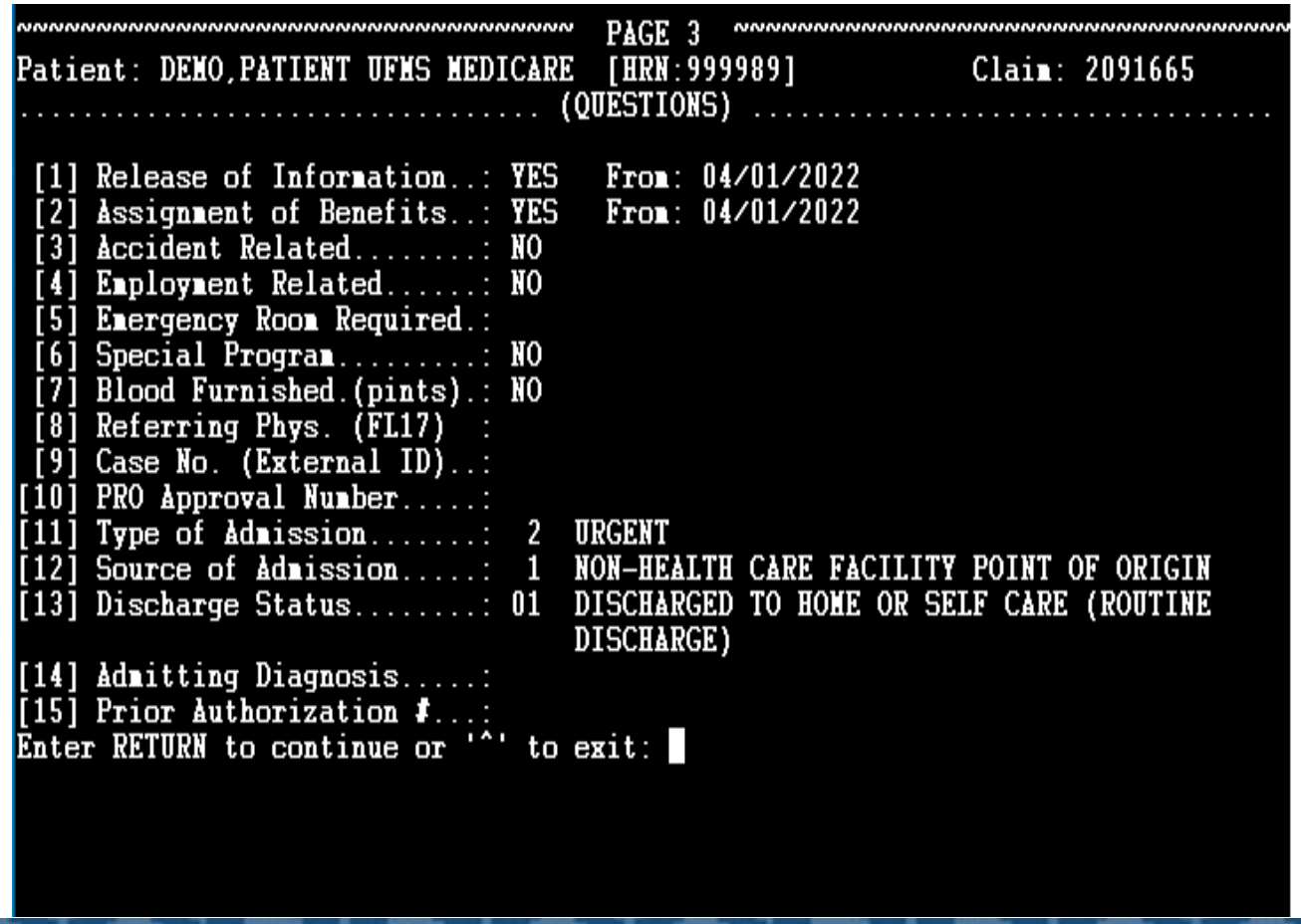

PAGE 1
Patient: DEMO,PATIENT UFMS MEDICARE [HRN:999989] Claim: 2091665
(CLAIM IDENTIFIERS)
[1] Clinic.....: GENERAL
[2] Visit Type.....: OUTPATIENT
[3] Bill Type.....: 131
[4] Billing From Date..: 06/27/2024
[5] Billing Thru Date..: 06/27/2024
[6] Super Bill #.....:
[7] Mode of Export.....: 837I (UB) 5010
[8] Visit Location.....: CLINTON INDIAN HEALTH CENTER
Desired ACTION (Edit/View/Next/Jump/Back/Quit): N//

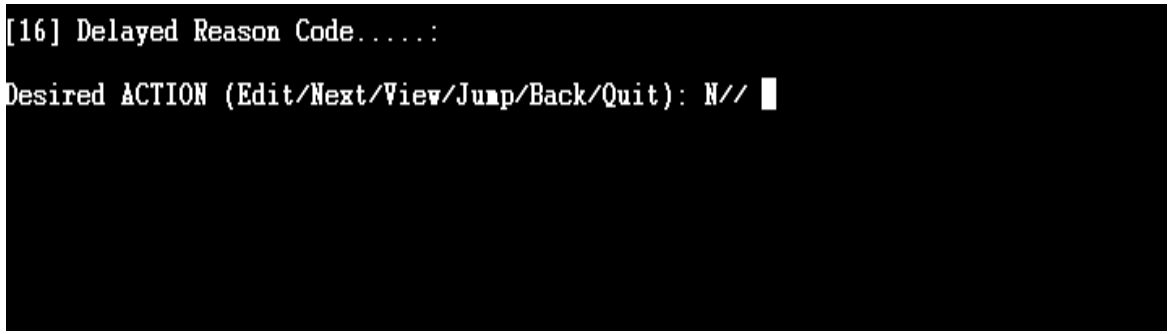

PAGE 1
Patient: DEMO,PATIENT UFMS MEDICARE [HRN:999989] Claim: 2091665
(CLAIM IDENTIFIERS)
[1] Clinic.....: GENERAL
[2] Visit Type.....: IMMUNIZATION
[3] Bill Type.....: 131
[4] Billing From Date..: 06/27/2024
[5] Billing Thru Date..: 06/27/2024
[6] Super Bill #.....:
[7] Mode of Export.....: 837I (UB) 5010
[8] Visit Location.....: CLINTON INDIAN HEALTH CENTER
Desired ACTION (Edit/View/Next/Jump/Back/Quit): N//

Page 2


PAGE 2
Patient: DEMO,PATIENT UFMS MEDICARE [HRN:999989] Claim: 2091665
(INSURERS)
PAGE 2 - INSURER INFORMATION
To: MEDICARE PART B - IHS
PO BOX 833913
RICHARDSON, TX 75083-3913
(214)907-9931
Bill Type...: 131
Proc. Code..: CPT4
Export Mode.: 837I (UB) 5010
Flat Rate...: N/A
MSP STATUS AS OF APR 17, 2024: NOT MSP ELIGIBLE
BILLING ENTITY
STATUS
POLICY HOLDER
[1] MEDICARE
ACTIVE
DEMO,PATIENT UFMS MEDICARE
WARNING:066 - INSURED'S SEX UNSPECIFIED
Desired ACTION (Add/Del/View/Next/Jump/Back/Quit): N//

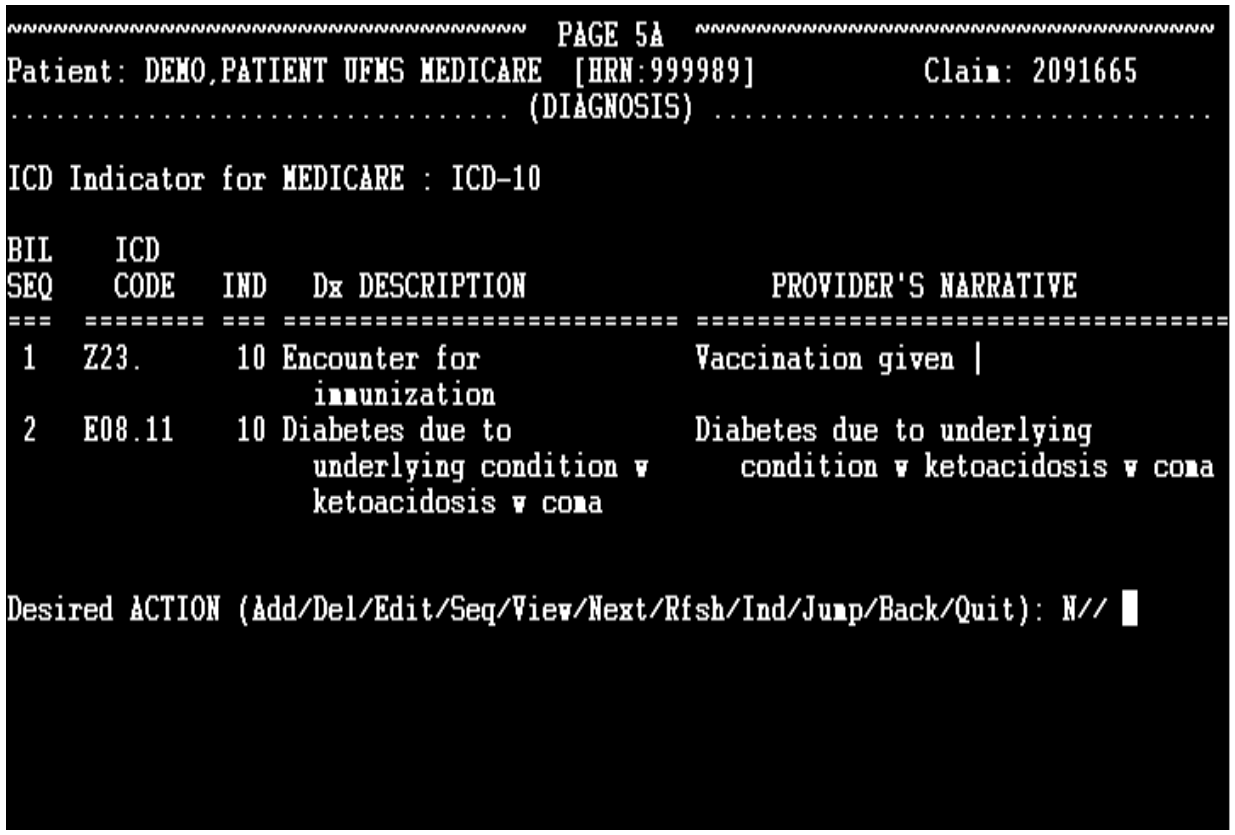
Page 3


PAGE 3
Patient: DEMO,PATIENT UFMS MEDICARE [HRN:999989] Claim: 2091665
(QUESTIONS)
[1] Release of Information..: YES From: 04/01/2022
[2] Assignment of Benefits..: YES From: 04/01/2022
[3] Accident Related.....: NO
[4] Employment Related.....: NO
[5] Emergency Room Required.:
[6] Special Program.....: NO
[7] Blood Furnished.(pints).: NO
[8] Referring Phys. (FL17) :
[9] Case No. (External ID)..:
[10] PRO Approval Number.....:
[11] Type of Admission.....: 2 URGENT
[12] Source of Admission.....: 1 NON-HEALTH CARE FACILITY POINT OF ORIGIN
[13] Discharge Status.....: 01 DISCHARGED TO HOME OR SELF CARE (ROUTINE DISCHARGE)
[14] Admitting Diagnosis.....:
[15] Prior Authorization #...:
Enter RETURN to continue or '^' to exit:


[16] Delayed Reason Code.....:
Desired ACTION (Edit/Next/View/Jump/Back/Quit): N//

Pages 4 and 5


PAGE 4
Patient: DEMO,PATIENT UFMS MEDICARE [HRN:999989] Claim: 2091665
(PROVIDER DATA)
PROVIDER
NPI
DISCIPLINE
(attn) CASHERO,THOMAS MD
MD
Desired ACTION (Add/Del/View/Next/Jump/Back/Quit): N//

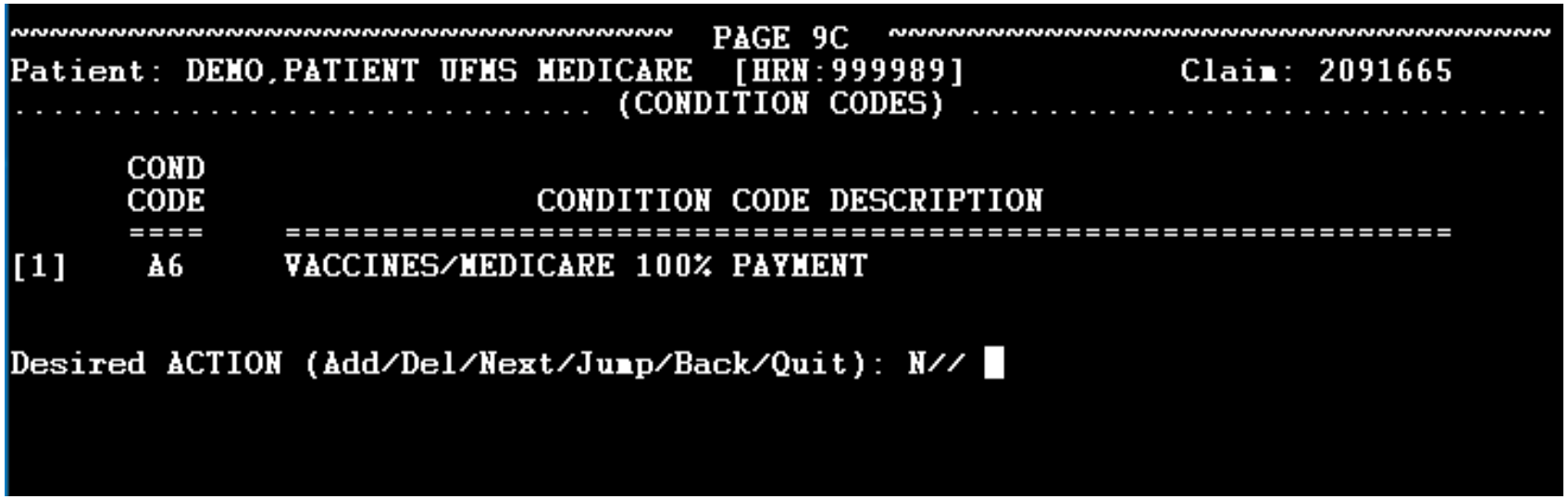

PAGE 5A
Patient: DEMO,PATIENT UFMS MEDICARE [HRN:999989] Claim: 2091665
(DIAGNOSIS)
ICD Indicator for MEDICARE : ICD-10
BIL SEQ
ICD CODE
IND
Dx DESCRIPTION
PROVIDER'S NARRATIVE
1 Z23. 10 Encounter for immunization
Vaccination given
2 E08.11 10 Diabetes due to underlying condition w ketoacidosis w coma
Diabetes due to underlying condition w ketoacidosis w coma
Desired ACTION (Add/Del/Edit/Seq/View/Next/Rfsh/Ind/Jump/Back/Quit): N//

Pages 8A and 8H

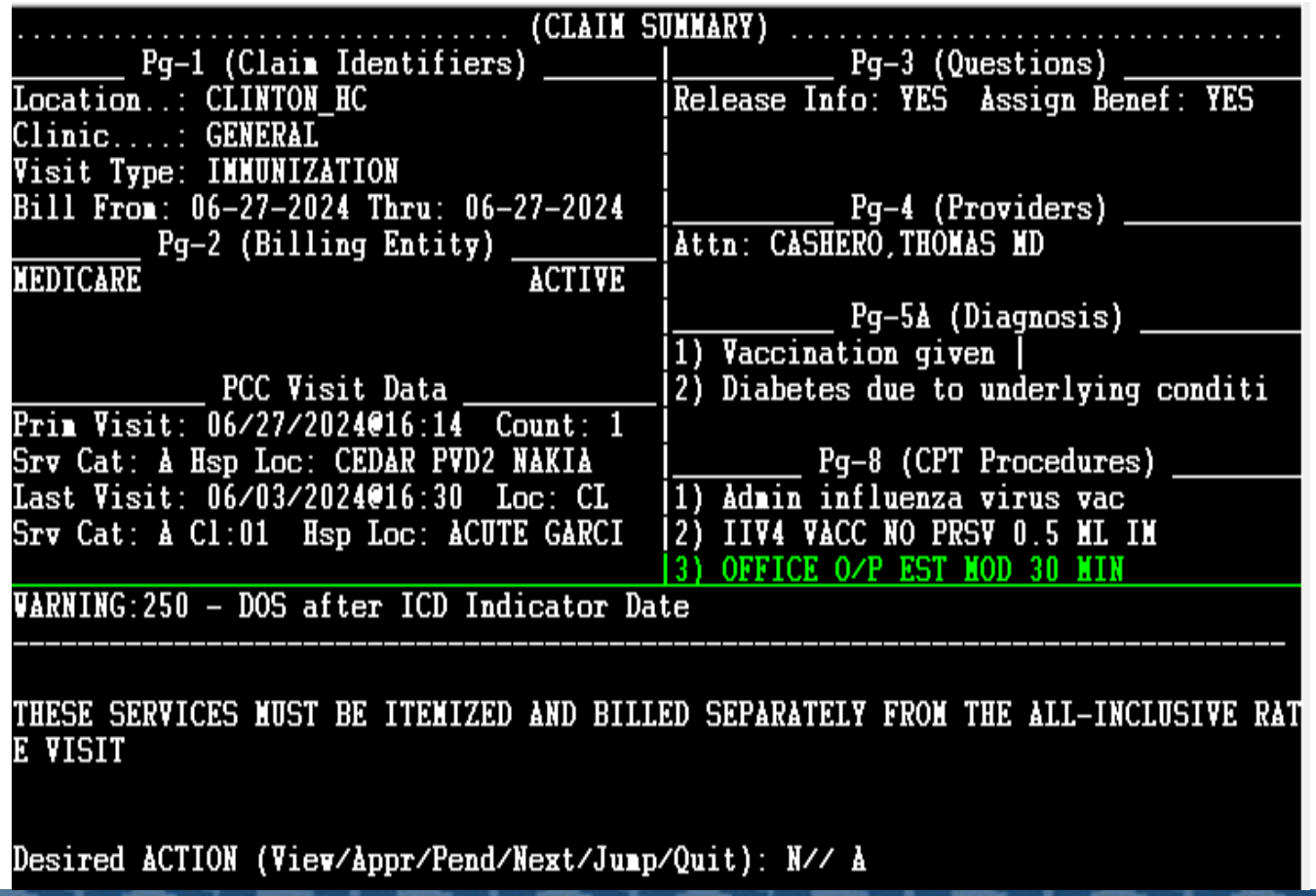
```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 8A ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT UFMS MEDICARE  [HRN:999989]          Claim: 2091665
Mode of Export: 837I (UB) 5010
.............................. (MEDICAL SERVICES) ..............................

     REVN                                             UNIT              TOTAL
     CODE        CPT - MEDICAL SERVICES              CHARGE    QTY     CHARGE
     ==== ====================================== ========= ====== =============
[1]  CHARGE DATE: 06/27/2024@16:14
     0510 90686 IIV4 VACC NO PRSV 0.5 ML IM             51.00      1         51.00
[2]  CHARGE DATE: 06/27/2024
     0510 99214 OFFICE O/P EST MOD 30 MIN              256.00      1        256.00
                                                                     =============
                                                                           $307.00

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N//
```

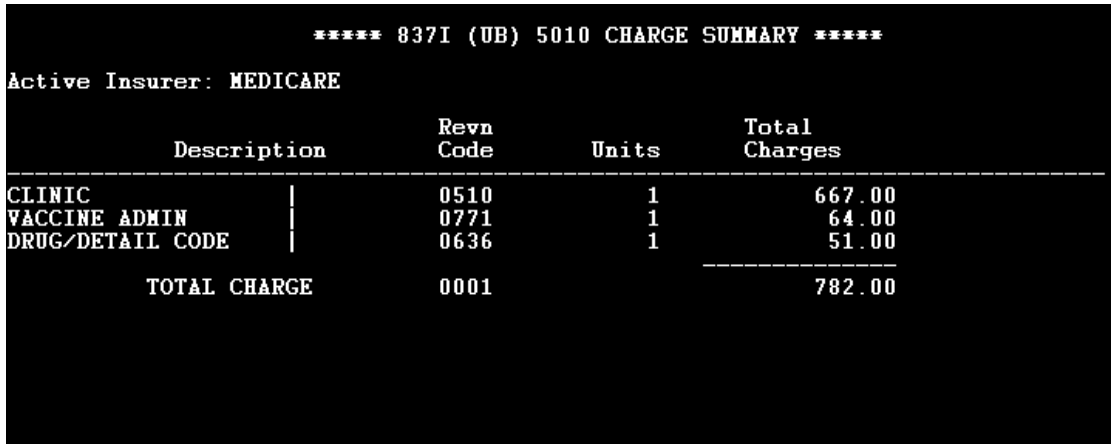
```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 8H ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: DEMO,PATIENT UFMS MEDICARE  [HRN:999989]          Claim: 2091665
Mode of Export: 837I (UB) 5010
.............................. (MISC. SERVICES) ..............................

     REVN                                            UNIT                TOTAL
     CODE      HCPCS - MISC. SERVICES               CHARGE    QTY       CHARGE
     ==== ====================================== ======== ======= ============
[1]  CHARGE DATE: 06/27/2024@16:14-06/27/2024
     0771 G0008 Admin influenza virus                 64.00       1        64.00
                vac
[2]  CHARGE DATE: 06/27/2024
     0636 90686 IIV4 VACC NO PRSV 0.5 ML              51.00       1        51.00
                IM
[3]  CHARGE DATE: 06/27/2024
     0510 99214 OFFICE O/P EST MOD 30                667.00       1       667.00
                MIN
                                                              ==============
                                                                     $782.00

Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit/Mode): N//
```

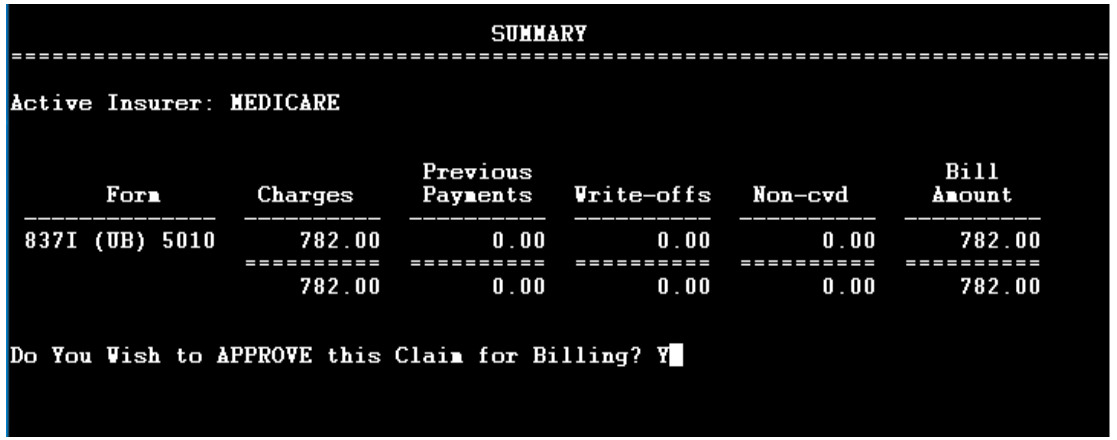
Page 9C


PAGE 9C
Patient: DEMO,PATIENT UFMS MEDICARE [HRN:999989] Claim: 2091665
(CONDITION CODES)
COND CODE
CONDITION CODE DESCRIPTION
[1] A6 VACCINES/MEDICARE 100% PAYMENT
Desired ACTION (Add/Del/Next/Jump/Back/Quit): N//

Approving the claim







Medicare Part C Billing Example

Medicare Requirements

Important Message from Medicare

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. This includes IHS hospitals.

The Important Message from Medicare (IM) must be delivered no later than two calendar days after admission. The initial copy may be given as part of the preadmission process, but no earlier than seven days prior to admission. If the notice is given more than two calendar days prior to admission, a follow-up copy must be delivered.

Patient Signatures

The patient's signature authorizes the release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service and (or) supplier, when the provider of service and (or) supplier accepts assignment on the claim.

All claims must have item 12 completed. Failure to include an appropriate signature and six-digit, eight-digit date or a "signature on file" statement will result in a claim rejection. A Medigap authorization signature in item 13 does not satisfy the Block 12 signature requirement.

Medicare Requirements

Release of Information

Providers of service and (or) suppliers are permitted to obtain and retain on file a lifetime authorization from the beneficiary. This authorization allows the provider of service and (or) supplier to submit assigned and non-assigned claims on the beneficiary's behalf

(Name of Beneficiary) (Medicare Beneficiary ID Number)

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier.

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service."

(Beneficiary Signature) (Date)

Medicare Requirements

Assignment of Benefits

Authorizes payment of medical benefits to the provider

Name of Beneficiary) (Medicare Beneficiary ID Number) (Medigap Policy Number)

"I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by that the provider of service and (or) supplier.

I authorize any holder of Medicare information about me to release to (Name of Medigap Insurer) any information needed to determine these benefits payable for related services."

(Beneficiary Signature) (Date)

Medicare Requirements

Coordination of Benefits

They must ask questions to secure employment and insurance information. They have a responsibility to identify payers other than Medicare so that incorrect billing and overpayments are minimized. Providers must determine if Medicare is the primary or secondary payer; therefore, the beneficiary must be queried about other possible coverage that may be primary to Medicare. Failure to maintain a system of identifying other payers is viewed as a violation of the provider agreement with Medicare.

As a Part A institutional provider (i.e. hospitals), you should:

- Obtain billing information prior to providing hospital services. It is recommended that you use the *CMS Questionnaire* (available in the Downloads section below), or a questionnaire that asks similar types of questions; and
- Submit any MSP information to the intermediary using condition and occurrence codes on the claim.

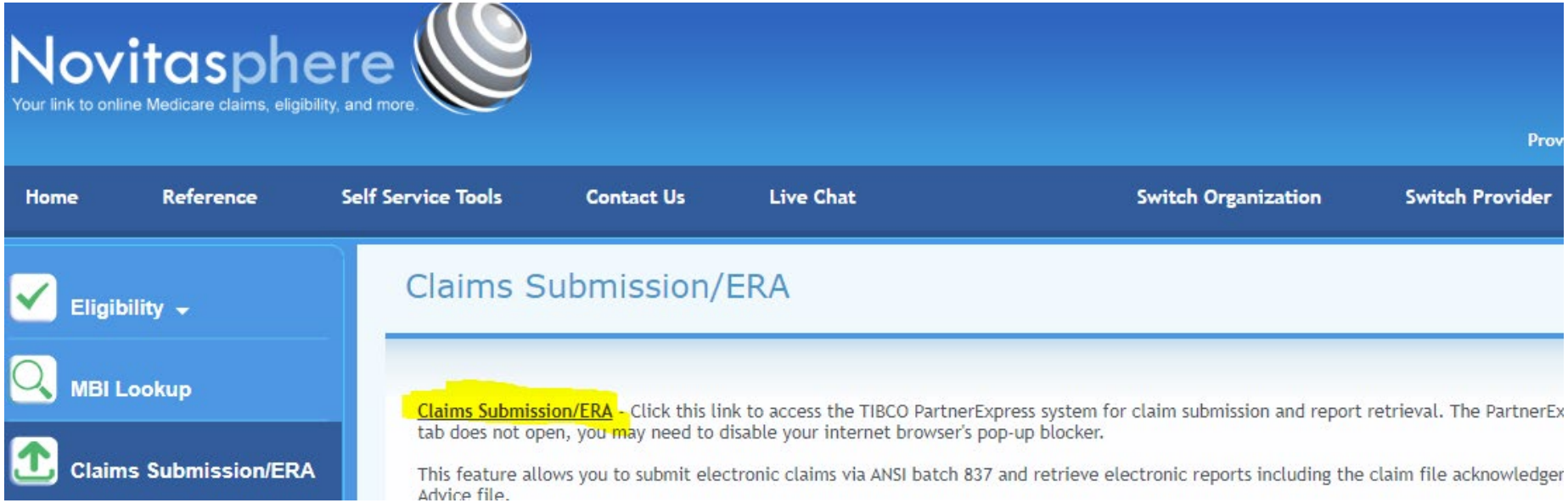
As a Part B provider (i.e. physicians and suppliers), you should:

- Obtain billing information at the time the service is rendered. It is recommended that you use the *CMS Questionnaire* (available in the Downloads section below), or a questionnaire that asks similar types of questions; and
- Submit an Explanation of Benefits (EOB) form with all appropriate MSP information to the designated carrier. If submitting an electronic claim, provide the necessary fields, loops and segments needed to process an MSP claim.

Novitasphere

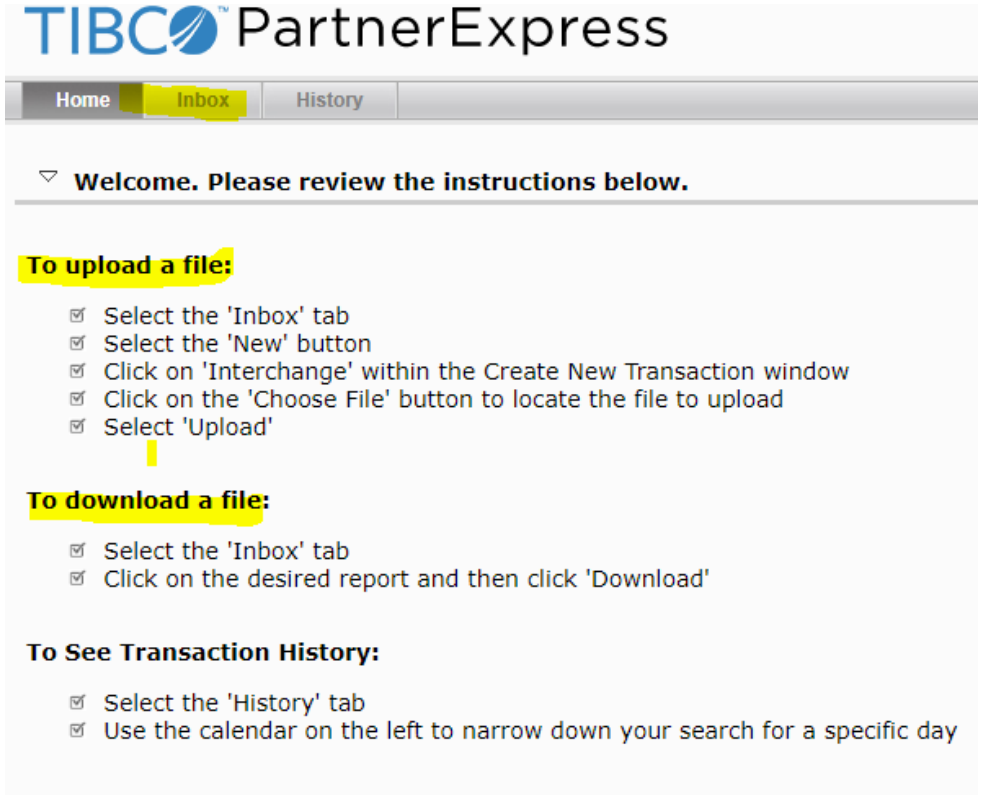
Log into Novitasphere and select the Organization that you need to upload files to.

Under the Claims Submission/ERA option, select New Claims Submission/ERA



Novitasphere

This will open the TIBC PartnerExpress Inbox. Click on Inbox.



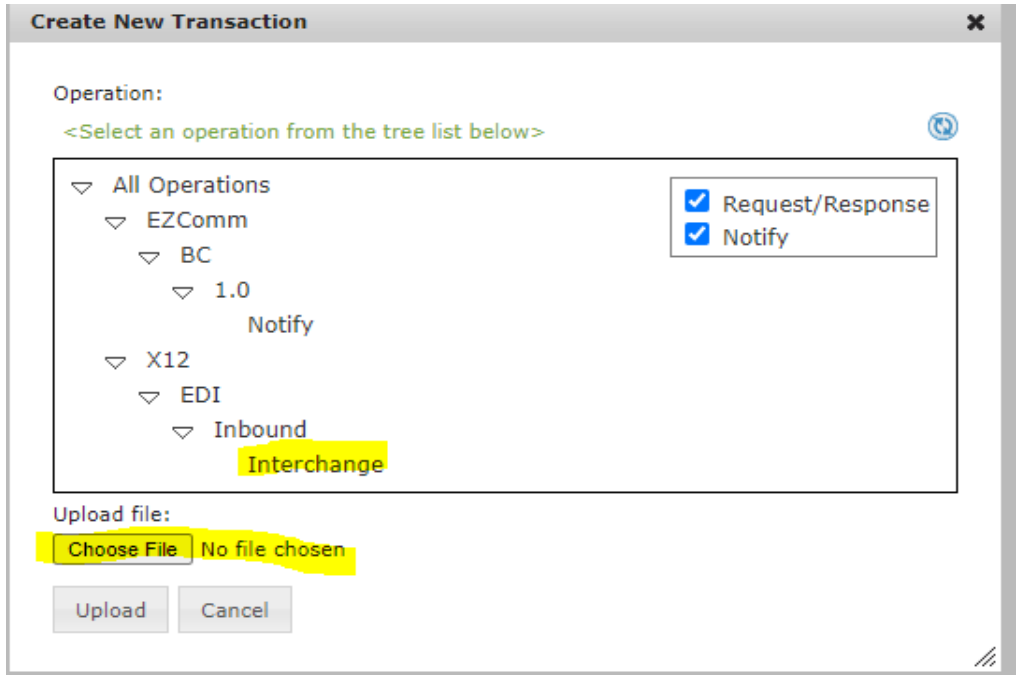
Novitasphere

Click New to create a new transmission (upload file)

Novitasphere

Click on Interchange, then Choose File

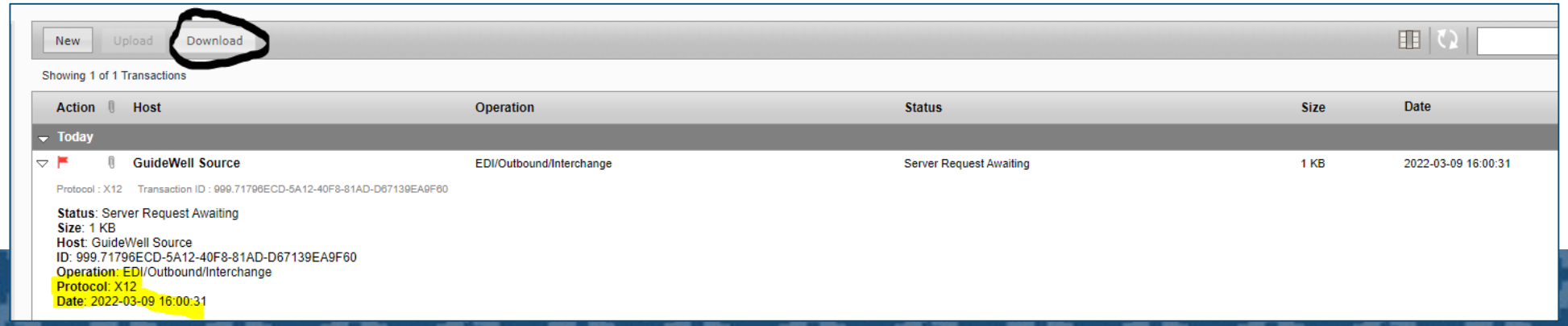
Once you have chosen your file, click Upload



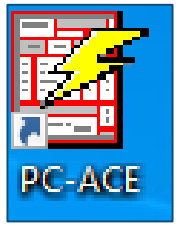
Novitasphere

Once the file has been received, you will receive an email with the file information.

Click on the 999 file and Download to a folder. This will be the one chance you have to download/save the file. Drop the file in the PC-ACE mailbox to view. This will also be the process for the 277 files.



PC-ACE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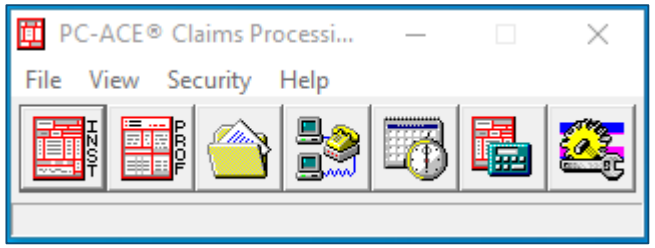

PC-ACE® Claims Processi...
File
View
Security
Help


Institutional Claims Menu
File
View
Attachments
Maintain
Import Claims
Enter Claims
List Claims
Process Claims
Prepare Claims

999

PC-ACE® ANSI-997/999 ACKNOWLEDGMENT REPORT

File Date/Time: 01/11/2024 16:13:00 Serial No: 000000

Acknowledgment Created (GS04/05):	01/11/2024 16:13
Sender Code (GS02):	[redacted]
Receiver Code (GS03):	[redacted]
Ack Transaction Set Control No (ST02):	0001
Group Control Number (AK102):	140581
Version/Release/Industry Code (AK103):	005010X223A2
Transaction Set Control Number (AK202):	0001
Implementation Convention Ref (AK203):	005010X223A2
Transaction Set Status (IK501):	A - Accepted
Functional Group Status (AK901):	A - Accepted
Transaction Sets Included (AK902):	1
Transaction Sets Received (AK903):	1
Transaction Sets Accepted (AK904):	1

277 and BSEM

PC-ACE® ANSI-277 CLAIM ACKNOWLEDGMENT REPORT

File Date/Time: 01/11/2024 16:15:00

Acknowledgement Created (GS04/05): 01/11/2024 16:15
Sender Code (GS02): [redacted]
Receiver Code (GS03):

*** Transmission Acknowledgement # 1 ***

Information Source ID: 04411 Name: MEDICARE

Transmission Receipt Control #: 044112024011l000001
Receipt Date: 01/11/2024
Process Date: 01/11/2024

*** Information Receiver Acknowledgement # 1 ***

Information Source ID: [redacted] Name: MEDICARE

Receiver Name: CLINTON INDIAN HEALTH CENTER ID: [redacted]

Receiver Info:
Receiver Trace #: 140581
Total Accepted Quantity: 2
Total Accepted Amount: $1,240.00

Receiver Status:
Status Date: 01/11/2024
Total Submitted Charges: $1,240.00

BATCH SUMMARY Page: 1

BATCH DATE: JAN 11, 2024@08:27:52
INSURER: MEDICARE
FORMAT: 837 5010 INSTITUTIONAL
EMC FILE NAME: CMCR131011020242 GROUP CONTROL #: 140581

BILL #	HRN	PATIENT	SERVICE DATE FROM	AMOUNT
SITE: CLINTON_HC			BILL TYPE: 131	
[redacted]		[redacted]	JAN 11, 2023	620.00
			JAN 26, 2023	620.00
		Insurer total:	2 bills	1,240.00
BATCH TOTAL:			2 bills	1,240.00

E N D O F R E P O R T

Enter RETURN to continue or '^' to exit:

999 and 277 Rejections

PC-ACE® ANSI-997/999 ACKNOWLEDGMENT REPORT

File Date/Time: 03/09/2024 15:39:00 Serial No: 000000

Acknowledgment Created (GS04/05): 03/09/2024 15:39
Sender Code (GS02): [redacted]
Receiver Code (GS03): [redacted]

Ack Transaction Set Control No (ST02): 0001

Group Control Number (AK102): 141262
Version/Release/Industry Code (AK103): 005010X223A2

Transaction Set Control Number (AK202): 0001
Implementation Convention Ref (AK203): 005010X223A2

Segment In Error (IK301): CL1 Occurrence: 26 Loop: 2300
Segment Error Code: 8 - Segment Has Data Element Errors
Business Unit Identifier (CTX01): CLM01: [redacted] (ANSI-837)
Field In Error (IK401): CL102
Data Element Reference Number (IK402): 1314
Data Element Error: 1 - Required data element missing

Transaction Set Status (IK501): R - Rejected
Transaction Set Syntax Errors (IK502-IK506):
5 - One or More Segments in Error

Functional Group Status (AK901): R - Rejected

Transaction Sets Included (AK902): 1
Transaction Sets Received (AK903): 1
Transaction Sets Accepted (AK904): 0

PC-ACE® ANSI-277 CLAIM ACKNOWLEDGMENT REPORT

File Date/Time: 03/07/2024 09:31:00

Acknowledgement Created (GS04/05): 03/07/2024 09:31
Sender Code (GS02): [redacted]
Receiver Code (GS03): [redacted]

*** Transmission Acknowledgement # 1 ***

Information Source ID: [redacted] Name: NOVITAS SOLUTIONS TEXAS

Transmission Receipt Control #: 0441220240307000001
Receipt Date: 03/07/2024
Process Date: 03/07/2024

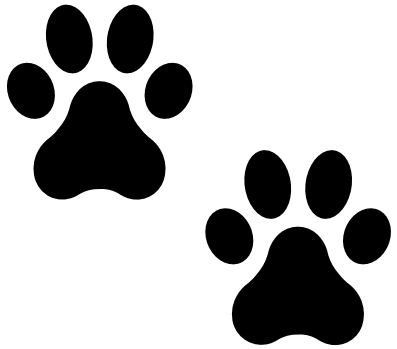
*** Information Receiver Acknowledgement # 1 ***

Information Source ID: [redacted] Name: NOVITAS SOLUTIONS TEXAS

Receiver Name: CLINTON INDIAN HEALTH CENTER ID: [redacted]

Receiver Info:
Receiver Trace #: 141197
Total Accepted Quantity: 47
Total Rejected Quantity: 1
Total Accepted Amount: $16,726.76
Total Rejected Amount: $2,810.00

Receiver Status:
Status Date: 03/07/2024
Total Submitted Charges: $19,536.76



Medicare Advantage Part C Plan

Definition:

- Medicare Advantage plans (Part C) provide all of your Part A (hospital) and Part B (medical) coverage and must cover all medically necessary services. Many plans also offer prescription drug coverage and additional programs not covered by Original Medicare. To enroll in a Medicare Advantage Plan, you must be eligible and enrolled in Original Medicare Part A and B and live within the plan's service area..

Medicare Advantage Part C Plan

- Part A Hospital + Part B Medical + Part D Prescription

- Combines Original Medicare, Part A and Part B, in 1 plan
- Often also includes Medicare Part D prescription drug coverage
- May come with additional programs and services not offered by Original Medicare
- These plans are part of the government's Medicare program, but are offered and managed through private insurers, like Cigna Healthcare. Medicare Advantage Plans may include plan extras not found in Original Medicare. **You must be enrolled in Medicare Part A and Part B to join.**

What are the pros and cons of a Part C Medicare Advantage plan?

Pros of Medicare Advantage Plans

- With Medicare Advantage plans, you can get personalized, coordinated medical care at a lower cost, depending on your plan. There are many advantages of enrolling in a Medicare Advantage plan. You can get:
- All of your coverage bundled together in 1 convenient plan.
- Costs that may be lower than Original Medicare.
- Extra benefits such as coverage for vision, hearing, dental, wellness programs, and discounts on health-related items.
- Prescription drug coverage (if it's included as part of the plan).
- All the rights and protections offered through the Medicare program.
- Help paying for premiums (subsidies), if you qualify.
- All the benefits of Medicare Part A and Part B plans, without buying supplemental insurance.

Cons of Medicare Advantage Plans

- The following are some disadvantages of Medicare Advantage plans:
- If you select an HMO Medicare Advantage plan, you may have a small selection of providers to choose from. If you see a provider out-of-network, it can cost you more. However, other plan options will offer a wider provider network.
- With certain plans, you may see additional costs for things like drug deductibles and specialist visit copays.
- If you travel a lot, your plan may not cover services outside your service area.

What types of Medicare Advantage plans are available?

- There are various kinds of Medicare Advantage plans, such as HMO, PPO, and Private Fee-for-Service plans. HMOs and PPOs each have certain characteristics, whether they are part of a Medicare plan or part of a regular health plan.
- For example, an HMO plan typically comes with lower costs but requires you to see providers within a network and get referrals before you see a specialist. A PPO plan typically costs more, but offers more flexible options for seeing providers and may not require any referrals to see specialists.

What does a Medicare Advantage plan cost?

- Depending on your Medicare Advantage plan, the costs you pay out-of-pocket can vary:
- You may pay a deductible, a certain amount you must meet before your plan begins to pay.
- There may be copays for doctor visits—this is a flat fee usually due at the time of the visit.
- You may have to pay a share for lab services and medical equipment.
- You will pay a monthly plan premium if there is one.
- You will continue to pay the Original Medicare Part B monthly premium, as well.
- Additional coinsurance or copays if you see providers outside your plan network.
- To help control your costs, make sure you understand the terms of your plan and the out-of-pocket costs you may be required to pay.

How do I choose a Medicare Advantage plan?

- It's important to compare the benefits between your current coverage and the different types of Medicare Advantage plans (Part C). Be sure that you understand the additional benefits and any benefits (or freedoms) that you may lose.
- You may want to consider:
- If you can change your current doctors
- If your medications are covered under the plan's drug list formulary (if prescription drug coverage is provided)
- The monthly premium
- The cost of coverage. This could include annual deductible, copays, and coinsurance.
- What additional services are offered (i.e. preventive care, vision, dental, health club membership)
- Any treatments you need that aren't covered by the plan

How do I enroll in a Medicare Advantage plan?

- If you want to enroll in a Medicare Advantage plan, you must:
- Be eligible for Medicare
- Be enrolled in both Medicare Part A and Medicare Part B (you can check this by referring to your red, white, and blue Medicare card)
- Live within the plan's service area (which is based on the county you live in–not your state of residence)
- Not have end-stage renal disease (ESRD)
- **Want more information about enrollment?** Visit Medicare Part C Eligibility and Enrollment Information

Can I change my Medicare Advantage plan?

- There are a few times during the year that you may be eligible to change your Medicare Advantage (MA) plan:

Annual Enrollment Periods

- The **Medicare Annual Enrollment Period (AEP)** occurs every year from October 15-December 7. Anyone who is eligible for Medicare can change plans during this time. You can make as many changes to your plan as you'd like before December 7, and your new coverage begins January 1.
- **Medicare Advantage Open Enrollment** occurs every year from January 1-March 31. This period is for Medicare Advantage customers only and is your opportunity to:
- Switch to another Medicare Advantage plan that better fits your needs, with or without drug coverage
- Switch to Original Medicare Part A and Part B, and add a standalone Part D prescription drug plan if you'd like one. Learn more about Original Medicare
- You can only make one change to your Medicare Advantage plan during this period. Your new coverage will begin the first of the month after you make the switch.
-

Special Enrollment Periods

- If you need to change your MA plan outside of the standard enrollment periods described above, you may be eligible for a Special Enrollment Period (SEP) for these qualifying events:
- Moving outside your plan's coverage area
- New Medicare or Part D plans are available due to a move to a new permanent location
- Recently released from prison
- Your plan is not renewing its contract with the Centers for Medicare & Medicaid Services (CMS) or will stop offering benefits in your area at the end of the year
- CMS may also establish SEPs for certain "exceptional conditions" such as:
- If you make an MA enrollment request into or out of an employer-sponsored MA plan
- If you want to disenroll from an MA plan in order to enroll in the Program of All-inclusive Care for the Elderly (PACE).
- If you dropped a Medicare Supplement (Medigap) insurance plan when you enrolled for the first time in an MA plan and you're still in the federally mandated "trial period" 12 months after the purchase of your MA plan
- If you enrolled in a Special Needs Plan (SNP) but are no longer eligible
- If you were a non-U.S. citizen and have become "lawfully present" as a "qualified non-citizen" without a waiting period in the United States
- To confirm if you're eligible for a SEP, contact us.

What does Medicare Advantage cover: benefits

- Medicare coverage is determined by federal and state laws, as well as national coverage decisions about whether something is covered.

What does Medicare Advantage provide?

- Medicare Advantage plans must provide the same coverage as Original Medicare, including hospital insurance (Part A) and medical insurance (Part 8). In addition, Medicare Advantage plans often include additional benefits such as prescription drug coverage, vision care, hearing care, and dental care. Some plans may also offer wellness programs and fitness benefits.

What is always covered in a Medicare Advantage plan?

- Medicare Advantage plans must provide the same coverage as Original Medicare, including hospital insurance (Part A) and medical insurance (Part 8).

What is excluded from a Medicare Advantage plan?

- Medicare Advantage plans may have different rules, costs, and restrictions, and may not cover all of the same services as Original Medicare. Some Medicare Advantage plans may require referrals to see specialists, limit coverage for certain medical services, or only cover care received from doctors in their network.

Medicare Advantage plans cover medical costs covered by Medicare Part 8, such as:

- • Doctor visits
- • Laboratory tests and x-rays
- • Emergency ambulance services
- • Mental health services (inpatient and outpatient)
- • Durable medical equipment such as wheelchairs and walkers
- • Preventative care including vaccines
- • Rehabilitative services including physical therapy, occupational therapy, and speech-language pathology

Medicare Advantage plans, also cover hospital costs covered by Medicare Part A, such as:

- • Hospital care
- • Skilled nursing facility care
- • Nursing home care as long as custodial care isn't the only care you need
- • Home health services

- If you have Medicare Advantage, hospice care is still covered by Medicare Part A.
- All Medicare Advantage plans cover emergency and urgent care.

What is the biggest disadvantage of Medicare Advantage?

- The biggest disadvantage of Medicare Advantage is the potential for more limited provider networks, which can result in higher out-ofpocket costs if you need care from a provider outside of the network. Additionally, Medicare Advantage plans may have more restrictions on coverage for certain medical services or prescription drugs compared to Original Medicare.

What does Medicare Advantage cover: supplemental benefits

- Medicare Advantage plans may offer benefits for services not typically covered by Original Medicare alone. These benefits may vary from plan to plan but this coverage could include:

- Prescription drugs coverage
- Routine Dental
- Routine vision
- Inpatient hospital acute or psychiatric
- Skilled nursing facility
- Podiatry
- Routine hearing
- Wellness benefits

- The coverage of specific prescription drugs may vary from plan to plan. To find out if your medications are covered, check the plan's formulary or list of covered prescription drugs. Prescription drugs that Medicare Advantage plans are required to cover: certain vaccines including pneumococcal and influenza certain oral anti-cancer drugs hemophilia clotting factors immunosuppressive drugs some antigens Injectable drugs for osteoporosis.
- Cleanings X-rays Annual exams Extractions Fillings Root canals Gum disease treatment Crowns, bridges, dentures
- Routine eye exams Contact lenses Eye glasses Lenses, frames, upgrades
- Additional days
- Additional days
- Routine care
- Routine hearing exams Fitting evaluation for hearing aids Hearing aids
- Gym memberships Fitness programs

What should I do if my Medicare Advantage plan doesn't cover something I need?

If your Medicare Advantage plan denies

- •A request for a health care service, item, or prescription drug you think you should get
- •A request for payment for a health care service, item, or prescription drug you already got OR
- •A request to change the amount you must pay for a health care service, item, or prescription drug

You have the right to appeal this decision.

Coverage options of Medicare Advantage

Medicare Advantage (MA) plans, also known as Medicare Part C, are offered by private insurance companies approved by Medicare. These plans provide an alternative way to receive Medicare benefits, combining coverage for hospital care (Part A) and medical services (Part B) into a single plan. Here's an overview of what Medicare Advantage plans cover and how the options may differ across plans and carriers:

- • Basic Coverage: Medicare Advantage plans must provide the same coverage as Original Medicare (Part A and Part B). This includes hospital stays, doctor visits, outpatient care, and medically necessary services. Many MA plans also include prescription drug coverage (Part D) as part of their basic benefits.
- • Additional Benefits: Medicare Advantage plans often offer additional benefits beyond what Original Medicare provides. These can include coverage for dental care, vision care, hearing aids, fitness programs, transportation services, and more. However, the specific additional benefits and their extent can vary between plans and carriers.
- • Network Limitations: Medicare Advantage plans typically have a network of healthcare providers with whom they have contracts. It's important to review the plan's network and confirm if your preferred doctors, hospitals, or specialists are included. Some plans may require you to use in-network providers, except for emergency or urgent care situations.
- • Cost-Sharing: Medicare Advantage plans may have different cost-sharing structures compared to Original Medicare. This can include copayments, deductibles, and coinsurance for various services. It's crucial to review and compare the costs associated with different plans, considering premiums, out-of-pocket maximums, and any limitations on cost-sharing.
- • Plan Types: Medicare Advantage plans come in different types, such as Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and Special Needs Plans (SNPs). Each plan type has specific rules and restrictions regarding accessing healthcare services, referrals to specialists, and out-of-network coverage. It's important to understand the rules of the plan type you choose.
- • Geographic Variations: Coverage options and plan availability can vary based on your location. Different Medicare Advantage plans may be offered by different insurance carriers in specific areas. Therefore, it's essential to research and compare the plans available in your geographic region to find the options that best suit your needs.

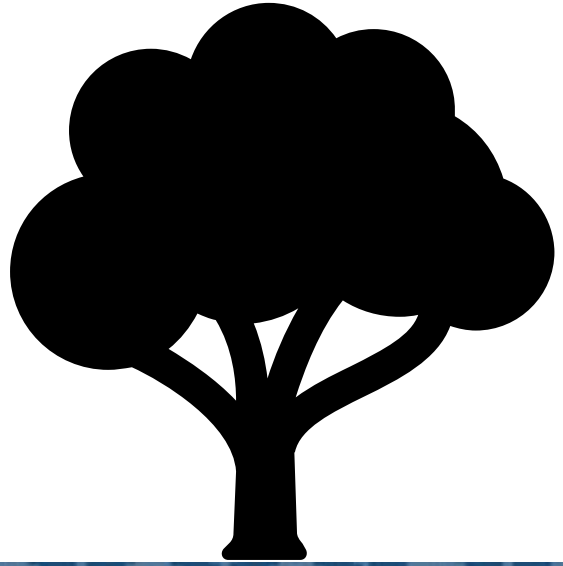
Eligibility requirements of Medicare Advantage

- Medicare Advantage plan eligibility is based on your eligibility for Original Medicare, Part A and Part B (except if you have ESRD). Generally, if you have Medicare Part A and Part B, you are eligible for Medicare Part C. However, you must live in the service area for the Medicare Advantage plan that you're considering.

- If you have other health insurance coverage, for example through an employer or union, ask your plan administrator about that plan's rules before you enroll in a Medicare Advantage plan. In some cases, you may lose your other coverage if you enroll in the Medicare Advantage plan and you may be unable to get it back if you change your mind later.

Thank you!!!

??? Questions ???

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