Creating Secondary Claims In Service Center

To find payers who accept secondary claims, go to the Resource Center> Payer List, and look for the indicator "Y" in the "SEC" column. This indicates that you can send secondary claims electronically to that payer.

For all methods of claim submission, you will need to bill the primary payer as usual. Once you receive the EOB or ERA from the primary insurance, you may then bill the secondary payer electronically.

PRINT IMAGE USERS ONLY

Note: If you are not submitting a print image, skip this section.

Upload your print image secondary claim, just as you would a primary claim, EXCEPT the payer name in the top right of the CMS 1500 form must contain the secondary payer name, plus the word, "secondary." We will recognize this as a secondary claim and send the claim to your claim fix so that you can key in the information from the primary EOB or ERA.

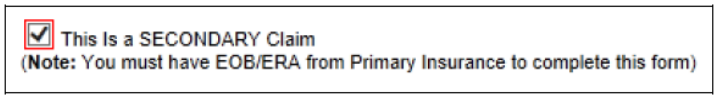
Example:
Medicare Northern CA Secondary
PO Box 1051
Augusta, GA 30903

Example:
Blue Shield of CA Secondary
PO Box 272540
Chico, CA 95927

HOW TO CREATE A SECONDARY CLAIM

1. Create a new claim if you are an Online Entry (OLE) user, or if you are a print image user, locate the rejected secondary claim in your claim fix.

2. At the top of the claim, check the box "This is a SECONDARY Claim."



3. Payer Information block
- Enter the information for the Secondary Payer. This is where the claim will be sent.

4. Boxes 2, 3, 5
- Enter the patient demographics.

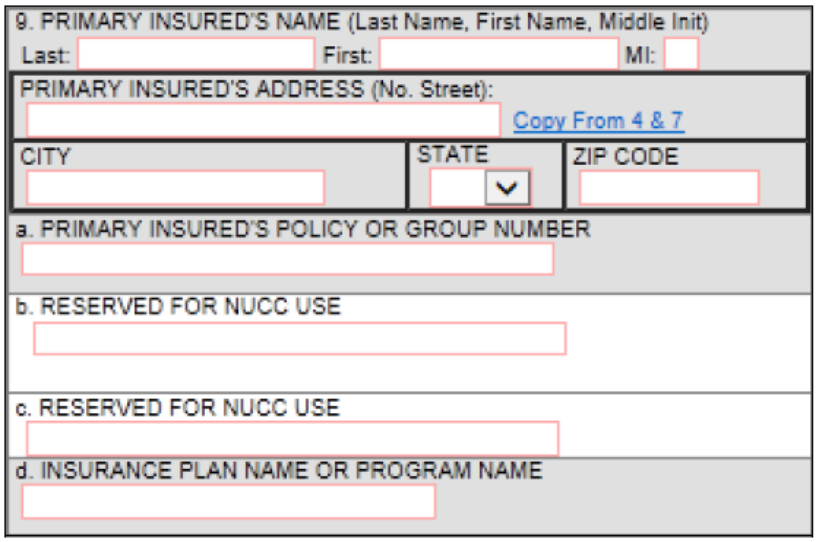
5. Boxes 4, 7, 11, 11a-c
- Enter the data of the policy holder of the Secondary Insurance payer.
  - This is the payer that the secondary claim is being sent to.

6. Box 11d

- Choose **YES**.
  - Since this is a secondary claim, there must have been another health benefit plan (the Primary Insurance).

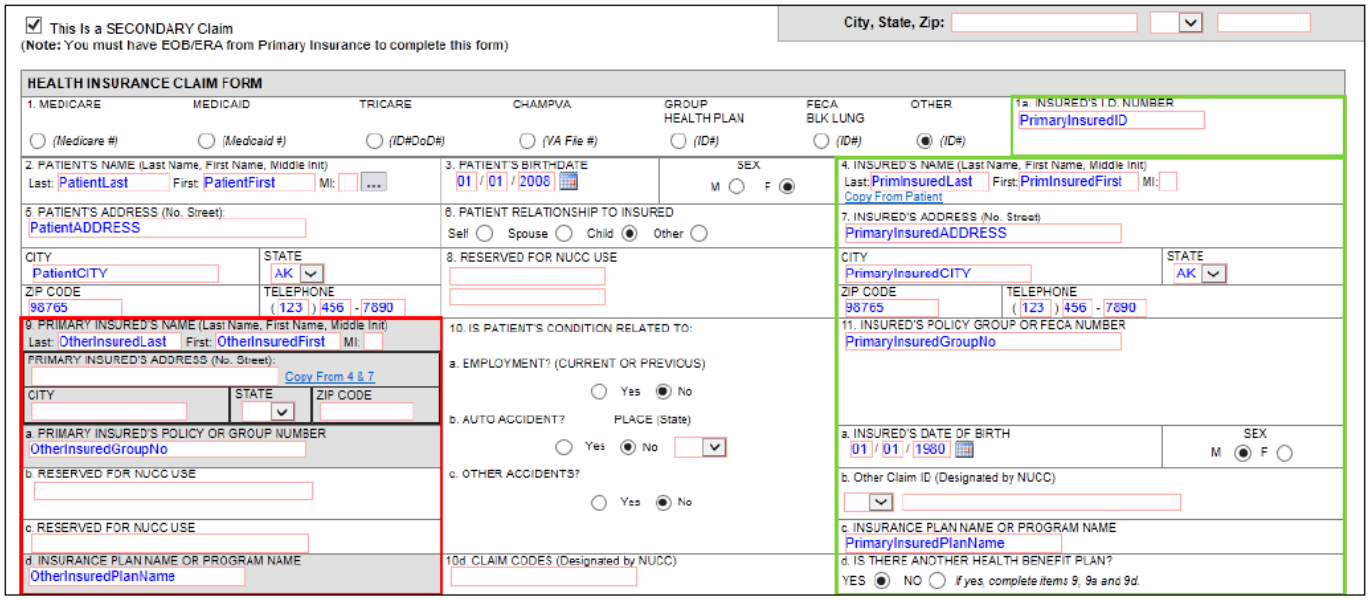
7. Boxes 9, 9a-d

- Enter the data of the policy holder of the Primary Insurance payer. This is the payer that the primary claim has already been billed to.

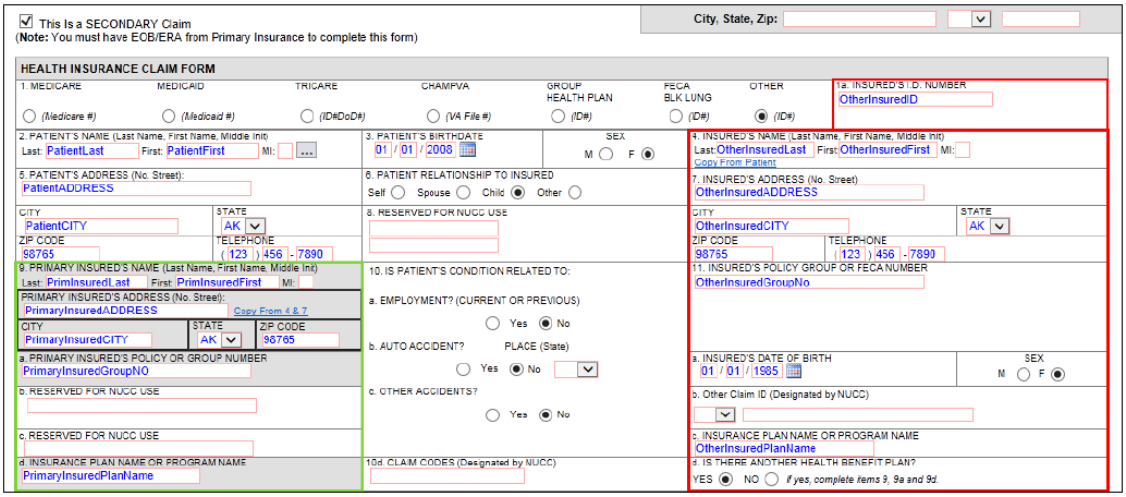


Note: If you are using a stored patient record from Manage HCFA Stored Information, you MUST manually update/edit the data so they are populated in the appropriate fields after checking the "This is a SECONDARY Claim" box. See examples below.

Example:
This is the claim using a stored information record, after checking the "This is a SECONDARY Claim" box.
(**Note**: The Primary Insured data gets loaded in 1a, 4, 7, 11, and Other Insured data gets loaded in 9a-d.)



This is what the secondary claim should look like once data is manually edited for the appropriate fields. (Note: The **Other Insured** data is now in 1a, 4, 7, and 11, and the **Primary Insured** data is now in 9a-d)



This Is a SECONDARY Claim
(Note: You must have EOB/ERA from Primary Insurance to complete this form)

City, State, Zip:

HEALTH INSURANCE CLAIM FORM

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER
1a. INSURED'S I.D. NUMBER: OtherInsuredID

2. PATIENT'S NAME (Last Name, First Name, Middle Init): Last: PatientLast First: PatientFirst
3. PATIENT'S BIRTHDATE: 01 / 01 / 2008 SEX: M F
4. INSURED'S NAME (Last Name, First Name, Middle Init): Last: OtherInsuredLast First: OtherInsuredFirst Copy From Patient

5. PATIENT'S ADDRESS (No. Street): PatientADDRESS
6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
7. INSURED'S ADDRESS (No. Street): OtherInsuredADDRESS

CITY: PatientCITY STATE: AK
ZIP CODE: 98765 TELEPHONE: (123) 456 - 7890
8. RESERVED FOR NUCC USE
CITY: OtherInsuredCITY STATE: AK
ZIP CODE: 98765 TELEPHONE: (123) 456 - 7890

9. PRIMARY INSURED'S NAME (Last Name, First Name, Middle Init): Last: PrimInsuredLast First: PrimInsuredFirst
PRIMARY INSURED'S ADDRESS (No. Street): PrimaryInsuredADDRESS Copy From 4 & 7
CITY: PrimaryInsuredCITY STATE: AK ZIP CODE: 98765
a. PRIMARY INSURED'S POLICY OR GROUP NUMBER: PrimaryInsuredGroupNO
b. RESERVED FOR NUCC USE
c. RESERVED FOR NUCC USE
d. INSURANCE PLAN NAME OR PROGRAM NAME: PrimaryInsuredPlanName

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) Yes No
b. AUTO ACCIDENT? PLACE (State) Yes No
c. OTHER ACCIDENTS? Yes No
10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER: OtherInsuredGroupNo
a. INSURED'S DATE OF BIRTH: 01 / 01 / 1985 SEX: M F
b. Other Claim ID (Designated by NUCC)
c. INSURANCE PLAN NAME OR PROGRAM NAME: OtherInsuredPlanName
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, complete items 9, 9a and 9d.*

Note: IMPORTANT LINE ITEM INFORMATION – When filling out the line item information in box 24 make sure that the CPT codes and the charges are EXACTLY the same as the primary claim. The charges should NOT be the amount that is unpaid by the primary insurance. That information will be covered in the next few steps.

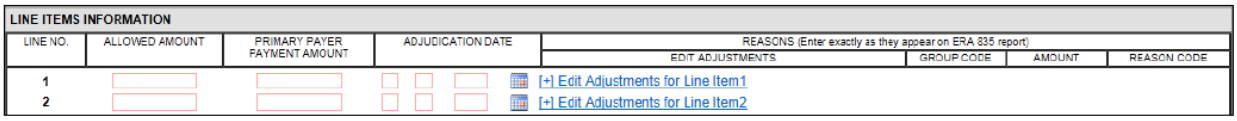
24. A. DATE(S) OF SERVICE From:	To:	B. Place Of Service	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER A	B	C	D	E. DIAGNOSIS POINTER	F. $ CHARGES	G. Days Or Units	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID. #
1 Note		Anest Start:		Stop	NDCQual:	NDC Code:		NDC U.Price:		NDC Qty:	NDC QtyQual:			
01 01 2014	01 01 2014	11		90806					12	125.00	1		NPI:	1234567890
2 Note		Anest Start:		Stop	NDCQual:	NDC Code:		NDC U.Price:		NDC Qty:	NDC QtyQual:			
01 02 2014	01 02 2014	11		90806					12	125.00	1		NPI:	
3 Note		Anest Start:		Stop	NDCQual:	NDC Code:		NDC U.Price:		NDC Qty:	NDC QtyQual:			
01 12 2014	01 12 2014			90806					12	125.00	1		NPI:	

Keying in the Information from the Primary EOB

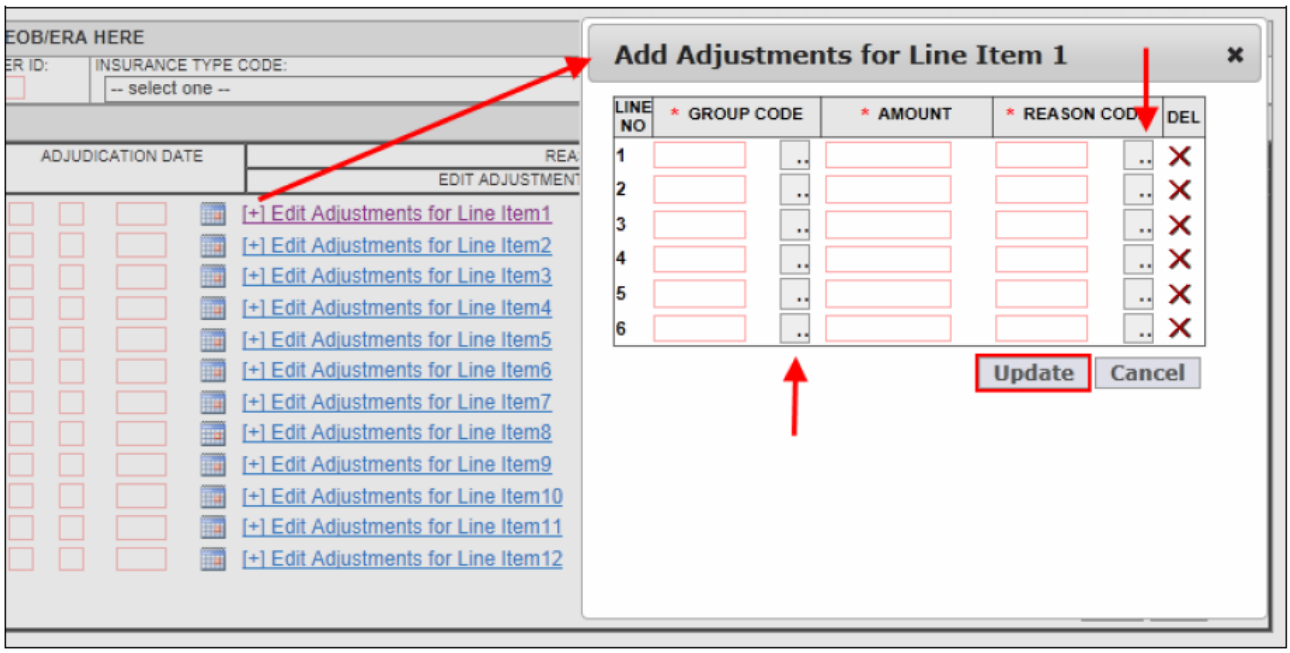
You will need to key in all the information from the primary EOB or ERA for each line item. This includes:

- Allowed Amount
- Primary Payer Payment Amount
- Adjudication Date
- Adjustment Reasons and Group Codes
- Adjustment Amounts
  - Co-insurance amount
  - Deductible amount
  - Co-payment amount
  - Patient responsibility
  - Other applicable charges, credits, payments, or adjustments which relate to the CPT code

ALL OF THESE AMOUNTS AND REASONS MUST BE KEYED IN FOR EACH LINE ITEM!



- **Allowed Amount**
  - In the first column of Line No. 1, under ALLOWED AMOUNT, enter the amount the Primary Payer allowed for the CPT code listed in line item 1 of box 24.
- **Primary Payer Payment Amount**
  - List the amount the Primary Payer actually paid for the CPT code in line item 1 of box 24
- **Adjudication Date**
  - Enter the date the Primary Payer processed the claim.
- **Reasons (Adjustments)**
  - Under the "Reasons" section you must key in everything the Primary Payer did not pay for that CPT code. This includes keying in any adjustments, contractual obligations, co-pay amounts, amounts applied to the deductible, and co-insurance amounts which are listed on the EOB.
  - Click " Edit Adjustments for Line Item X" to edit the Group Codes, Amount, and Reason Codes for the line.
    - **Group Code** – This is the general reason for the adjustment. Click the two dot box, , to get a list of possible group codes and their meanings to select from.
    - **Amount** – Enter the amount of the adjustment associated with that group code.
    - **Reason Code** – Select the Reason Code listed on the EOB for the adjustment amount you have entered. Click the two dot box, , to get a list of possible Reason Codes and their meanings to select from.
  - Click Update when you've completed all the adjustments for this line.



Please Note: If using Online Claim Entry, when Medicare is the destination/secondary payer, the MSP or Insurance Type Code must be selected from the dropdown in the Primary EOB section.

A Good Rule of Thumb to Follow Is

- Everything that the insurance company did pay should be typed in under PAYMENT AMOUNT
- Everything that the insurance company did not pay should be typed in under REASONS
- The ALLOWED AMOUNT does not factor in to the amount paid reason codes.

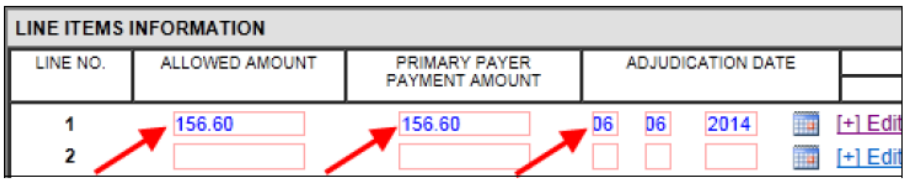
	PAID AMOUNT	(Primary Payer Payment Amount)
+ (plus)	AMOUNT NOT PAID	(Sum of Adjustment Amounts)
= (equals)	ORIGINAL BILLED AMOUNT	(Line Item Charge in 24)

Example:

You had billed $425.00 for the first CPT code and the payment information from the primary EOB is as follows:

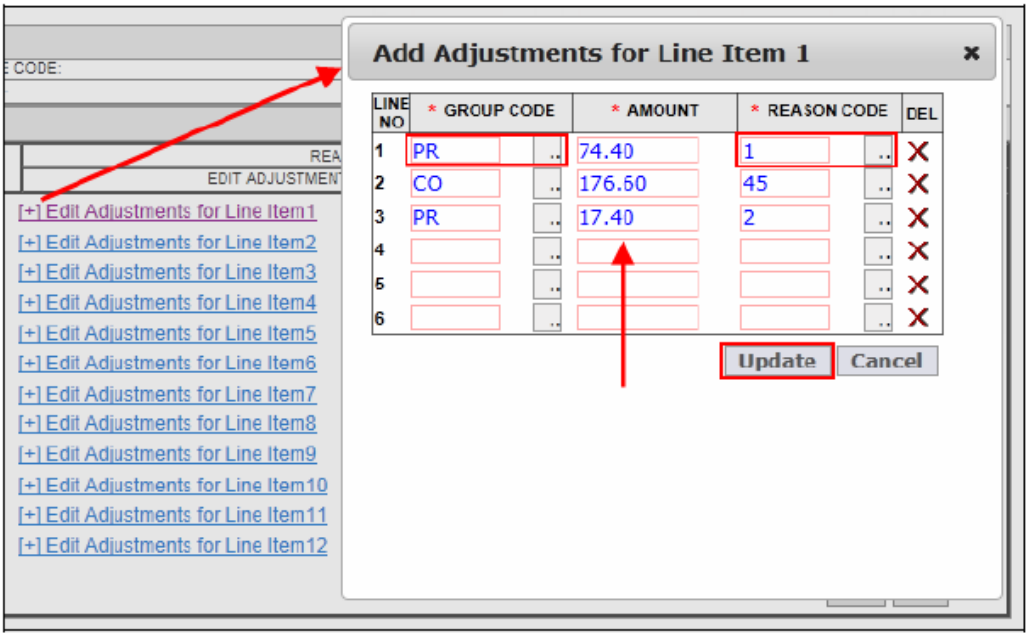
The primary insurance ALLOWED	$156.60	
The primary insurance PAID	$156.60	
Adjudication Date	06/06/2014	
Patient Responsibility (Grp Code: PR)	$74.40	Deductible amount (Reason Code: 1)
Contractual Obligations (Grp Code: CO)	$176.60	Charges exceed your contracted fee arrangement (Reason Code: 45)
Patient Responsibility (Grp Code: PR)	$17.40	Co-insurance amount (Reason Code: 2)

1. Type in the allowed amount, payment amount, and adjudication date.



2. Click "[+] Edit Adjustments for Line Item X" to enter the Group Codes, Amounts, and Reason Codes for what the Primary Payer did not pay.

Group Code	Amount	Reason Code
PR (Patient Responsibility)	$74.40	1 (Deductible amount)
CO (Contractual Obligations)	$176.60	45 (Charges exceed your contracted fee arrangement)
PR (Patient Responsibility)	$17.40	2 (Co-insurance amount)



3. Click Update when finished adding the adjustments.

Your claim should look like this:

You will notice the sum of what the payer did pay (156.60) plus what they did not pay (74.40 + 176.60 + 17.40) equals the billed amount for that line item (425.00).

- When you have finished entering all the payment and adjustment amounts for th4e first CPT Code, you may move onto filling in the same information for any remaining CPT codes billed on that claim.
- When you have entered all the information, click Update at the bottom of the form.

After clicking Update, you will see a message on your screen saying that the claim has been updated successfully. Office ally will automatically pick up the claim that night and process it for you. You will receive a file summary on your claim the following day.

IF YOU HAVE ANY QUESTIONS PLEASE CONTACT CUSTOMER SUPPORT:
support@officeally.com / (360) 975-7000 Option 1