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across the full continuum of care in the most appropriate and cost effective settings.
6. To be recognized as the industry leader in these areas:
   - Member services
   - Provider network and relationships
   - Care delivery outcomes
   - Health benefits financing
   - Health benefits administration

Values
Avera Health Plans adheres to three important values that guide the actions of our participating providers and staff.

Compassion
The compassion of Jesus, especially for the poor and the sick of body and spirit, shapes the manner in which health care is delivered by Avera's employees, physicians, administrators, volunteers and sponsors. Compassionate caring is expressed through sensitive listening and responding, understanding, support, patience and healing touch. Compassion is the extra element that makes Avera Health Plans the plan of choice.

Hospitality
The encounters of Jesus with each person were typified by openness and mutuality. A welcoming presence, an attentiveness to needs, a gracious manner seasoned with a sense of humor are expressions of hospitality in and by the Avera Health Plans community.

Stewardship
Threaded through the mission of Jesus, was the restoration of all the world to right its relationship with its Creator. In that same spirit, the members of Avera Health Plans treat persons, organizational power and the earth's resources with justice and responsibility. Respect, truth and integrity are the foundation to a right relationship among those who serve and those who are served.

Guiding Principles

- To maximize the quality of care delivered with continuous evaluation for opportunities for improvement.
- To provide for the most efficient use of resources.
- To provide an approach to medical diagnosis and treatment that is based on medical necessity.
- To require the involvement, input and support of the medical staff for the preservation of clinical judgment.
- To recognize the value of prevention and health maintenance through programs and services.
- To implement methods and tools of systems thinking and systems approach to problem solving.
- To support operations that receive the highest satisfaction rate from customers, members, providers and employees.

1.3 Provider Rights and Responsibilities

Rights:

1. To join Avera Health Plans subject to our credentialing plan
2. To receive notice of revisions to our policies
3. To receive claims payments directly, based on the provider's contractual agreement with Avera Health Plans.
4. To receive information, education, and support from our Provider Relations department regarding plan policies and operations as well as for problem resolution

Provider Responsibilities:

1. To utilize our participating specialty providers, hospitals and facilities unless otherwise approved by Avera Health Plans.
2. To provide services to our members in the same manner and quality as those services provided to patients who are not our members.
3. To close enrollment, if applicable, to new members with 60 days notice to Avera Health Plans.
4. To accept our reimbursement as payment in full (minus any Co-pays, Deductibles, or Coinsurance) for each covered service under the member's contract.
5. To recognize all payments are subject to the Coordination of Benefits provisions of Avera Health Plans.
6. To keep all member medical record information complete and confidential.
7. To open medical and administrative records with notice from Avera Health Plans regarding the member, for a review by our staff for the purpose of performing medical management, quality improvement, credentialing, and/or peer review activities.
8. To cooperate with Avera Health Plans to provide precertification, case management, quality improvement and peer review as requested.
9. To comply with all policies and procedures as outlined in Provider Agreement.
10. To provide the necessary information and documentation regarding any appeal.
11. To promptly notify Avera Health Plans regarding the following occurrences:
    - A change in status of license, certification, specialty board status or DEA registration.
    - Any circumstance that is required to be reported to the National Practitioner Data Bank, The Health Protection and Integrity Data Bank or any other reporting agency.
    - If a provider is no longer employed, contracted. or otherwise affiliated with a clinic or facility.
    - Any change or loss of liability insurance coverage.
    - If a provider is no longer compliant with our credentialing criteria.
    - Any circumstance in which a provider is sanctioned (examples: to be suspended, debarred, or excluded from participation in/or convicted of any criminal offense related to the delivery of health care).
    - Any situation where a provider is charged with a felony or is under formal investigation for fraud or felony.

12. To notify us of a change in address, ownership, tax identification number or network participation.
13. To notify our members in a timely manner if provider no longer participates with our network.
14. To maintain adequate medical records incorporating medical record standards.

Registered nurses make calls to eligible members and perform the following:

- Thorough assessment
- Development of an individualized care plan
- Weekly documented interactions
- Education for condition management
- Follow-up and track progress made toward goals including collaboration with the member's provider team.

Providers can refer members to Complex Case Management by contact our Medical Management department.

7.4 Disease Management

This program helps members regain optimum health or improved functional capability. Disease Management is offered to members diagnosed with the following diseases:

- Asthma (includes adult and pediatric patients)
- Chronic obstructive pulmonary disease
- Coronary artery disease
- Diabetes (includes adult and pediatric patients)
- Heart failure

Participants are assigned to a registered nurse team that conducts a comprehensive assessment of the participant's disease status, contributing co-morbid conditions, medication regimen and treatment plan approved by the primary care physician. Individualized intervention strategies and goals are developed with each participant.

Providers can refer members to Disease Management by contacting our Medical Management Department.

7.5 Non-Participating Provider Referrals

Avera Health Plans may allow in-network benefits for non-emergency services provided by out-of-network providers when Avera Health Plans determines network inadequacy exists for the service requested. If network inadequacy exists, covered services specific to the condition are covered at the member's in-network benefit level. Emergency situations are addressed by member coverage documents.

7.6 Avera Health Plans Advanced Outpatient Diagnostic Imaging Preauthorization Requirements Managed by eviCore

Avera Health Plans has a utilization and quality management relationship with eviCore. All participating providers are required to obtain a preauthorization for certain advanced

outpatient diagnostic imaging services provided to select Avera Health Plans members. The ordering provider is contractually responsible for obtaining the authorization on a pre-service basis and the rendering provider is responsible for ensuring a preauthorization is in place before rendering the service. Failure to obtain and verify the preauthorization could result in the denial of services as a provider liability under the Provider Agreement.

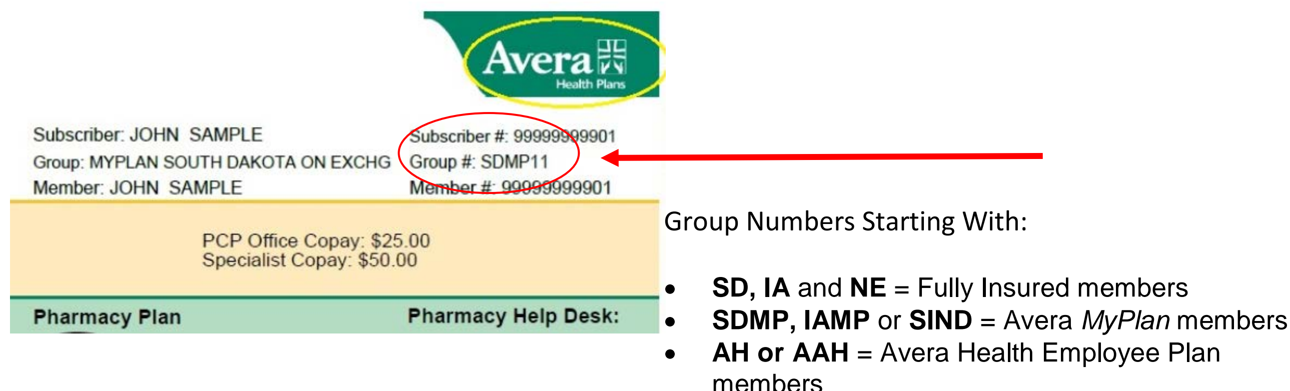
Some self-funded clients of Avera Health Plans Benefit Administrators may have their own radiology authorization requirements not managed by eviCore and providers are encouraged to inquire when checking eligibility and benefits.

Please refer to our outpatient radiology preauthorization list for a full listing of CPT codes with procedure descriptions that require preauthorization. This reference listing can be found on our website on the Provider page.

eviCore Radiology Preauthorization Requirements Apply to these Avera Health Plans Members

- Avera Health Plans' fully insured employer group members
- Avera *MyPlan* individual members
- Avera Health Employee Plan members

How Can These Members Be Identified by Their ID Cards?
When reviewing the Avera Health Plans' member ID card, look at their Group Number.



Group Numbers Starting With:

- **SD, IA** and **NE** = Fully Insured members
- **SDMP, IAMP** or **SIND** = Avera *MyPlan* members
- **AH or AAH** = Avera Health Employee Plan members

What if the member ID card is not available?
eviCore can be verified online at www.CareCoreNational.com. You will need the member's ID number and date of birth for eviCore to determine the eligibility for management of the imaging preauthorization process.

7.7 Obtaining and Verifying A Preauthorization with eviCore

The ordering provider or designee (a member of the ordering provider's office staff) is responsible for obtaining the preauthorization either online at www.CareCoreNational.com or by calling eviCore at 1 (866) 668-8295, 7 a.m. to 7 p.m. CT., Monday through Friday.

Patient Waivers
In the event of an adverse determination on a preauthorization request for imaging services, the rendering provider is entitled to present the patient with an opportunity to sign an Outpatient Imaging Informed Consent Waiver Form to preserve their rights to balance bill. As the name implies, the waiver process requires informed consent and therefore is only valid when signed on a pre service basis and with complete disclosure of the adverse determination.

Patient waivers do not need to be submitted to Avera Health Plans and should be kept in the patients file for documentation in the event of the need substantiate the balance billing of a patient in a dispute. Patient waivers must be presented to Avera Health Plans upon request if necessary to resolve any balance billing disputes. We recommend you use the Outpatient Imaging Informed Consent Waiver Form located on our website by clicking on the CareCore link on the Provider page. If you prefer to use your own form for this waiver process, you are encouraged to talk with your Provider Relations Representative to review the form to ensure adequacy.

7.8 Obtaining Utilization Management Criteria

Providers have the right to access copies of utilization management guidelines, criteria, policies or protocols used in utilization management decisions. All internally developed policies and guidelines are available on the provider portal of the Avera Health Plans website. If a provider would like copies of the utilization management guidelines, criteria, policies or protocols used in utilization management decisions, contact our Medical Management department.

7.9 Affirmative Statement about Incentives

Avera Health Plans makes utilization management decisions based only on appropriateness of care and service and existence of coverage. Avera Health Plans does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

Section 8: Pharmacy Management Guidelines

8.1 Pharmacy Overview

Avera Health Plans utilize pharmacy benefits managers for all members. Check each members' member identification card to determine which pharmacy benefit manager is assigned to each member.

8.2 Drug Formulary

To view the most current formularies and pharmacy information, login to access the Pharmacy Benefits for Members link.

8.3 Preauthorization

Avera Health Plans requires preauthorization for certain medications. The current preauthorization lists can by clicking the Preauthorization link on the provider page, logging in and clicking on the Pharmacy tab to view the preauthorization requirements.

8.4 Step Therapy

Step Therapy is designed to promote the use of lower cost alternatives to the newer medications within a therapeutic class.

To view the most current step therapy information, login and access the Pharmacy Benefits for Members link.

8.5 Mail Order

If the member would like to use mail order, new prescriptions can be ordered by calling the pharmacy benefit manager listed on the member's identification card.

Section 9: Claims

9.1 Claims Overview

Claims must be submitted on the standard UB-04 or CMS 1500 forms or electronically in those formats. In order to process a claim within the regulatory requirements the claim must be submitted as a clean claim. Submitted claims must include all required fields, claims that are not complete will be denied. The denial code on the provider's Explanation of Payment will indicate what information is necessary to reprocess the claim.

Providers must also ascertain from the patient at the time of the initial visit whether an injury is work-related or caused by a third party, such as an automobile accident. If an injury is work related or caused by a third party, the provider agrees to relay this information to Avera Health Plans as soon as possible. This information is required to determine if workers' compensation insurance applies and if coordination of benefits or subrogation rights should be invoked.

Electronic Claims Submission

Avera Health Plans uses clearinghouses for electronic claim submission. In order to receive electronic remittance advice, you must be able to submit claims to e-Provider Solutions. Our payer ID Number is 46045. The payer ID number assigned for John Morrell and Curley's claims is 38310.

Manual Claims Submission

Avera Health Plans encourages electronic claims submission for more timely and accurate processing. Avera Health Plans uses optical character recognition (OCR) technology when processing manually submitted claims. OCR allows for a more automated process, resulting in shorter claims turnaround and improved quality; however, electronic claims submission remains the industry standard for fastest and most accurate form of claims submission.

If you must submit a manual claim, submit claims to the following address:

Avera Health Plans
P.O. Box 381506
Birmingham AL 35238

When a claim is returned to providers or denied by Avera Health Plans, please resubmit corrected claims to the following address:

Avera Health Plans
P.O. Box 381506
Birmingham AL 35238

Required Information on the UB-04 and CMS 1500

Uniform Bill Form (UB-04), page 1

SAMPLE—Do not use.

Avera Health Plans

Form locator	Requirement
1	Required
3a PAT. CNTL #	Required
4 TYPE OF BILL	Required
6 STATEMENT COVERS PERIOD FROM / THROUGH	Required
8 PATIENT NAME	Required
9 PATIENT ADDRESS	Required
10 BIRTHDATE / 11 SEX	Required
14 TYPE / 17 STAT	14 Type & 17 Stat required
18-28 CONDITION CODES	18-28 Conditionally required
31-34 OCCURRENCE CODE / DATE	Conditionally Required
35-36 OCCURRENCE SPAN CODE / FROM / THROUGH	Required if inpatient
39-41 VALUE CODES CODE / AMOUNT	Required
42 REV. CD.	Required
44 HCPCS / RATE / HIPPS CODE	Required
45 SERV. DATE	Required
46 SERV. UNITS	Required
47 TOTAL CHARGES	Required
48 NON-COVERED CHARGES	Required
50 PAYER NAME	Required
51 HEALTH PLAN ID	Required
54 PRIOR PAYMENTS	Conditionally Required
56 NPI	Required
58 INSURED'S NAME / 59 P. REL / 60 INSURED'S UNIQUE ID / 61 GROUP NAME / 62 INSURANCE GROUP NO.	Required
63 TREATMENT AUTHORIZATION CODES / 64 DOCUMENT CONTROL NUMBER / 65 EMPLOYER NAME	Conditionally Required
66 DX	66 Required
69 ADMIT DX	69 Required
76 ATTENDING NPI / QUAL	Required
77 OPERATING / 78 OTHER	Conditionally Required
80 REMARKS	Conditionally Required

PAGE ____ OF ____ CREATION DATE TOTALS

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

UB-04 Required Field Information		
Field No.	**Field Name**	**Explanation**
1	None	Enter the facility's name and address.
3a	Pat. CNTL#	
3b	Med Rec. #	*Conditionally required:*
4	Type of Bill	Enter the appropriate four-digit code (e.g., 011X) as specified in the *UB-04 Data Specifications Manual.* 1st digit Leading zero (0) 2nd digit Type of facility 3rd digit Type of care 4th digit Indicates the sequence of the bill for a specific episode of care
5	Federal Tax Number	Enter your facility's nine-digit number for the type of bill you are submitting (e.g., NN-NNNNNNN)
6	Statement Covers Period (From-Through)	Enter dates in the MM/DD/YY format.
8a	Patient Name	Enter the patient's last name, first name and middle initial.
8b	Patient ID Number	Enter the patient's ID number if different from the policyholder's ID number.
9a-d	Patient Address	Enter the patient's full address, even if the patient's address is the same as the policyholder's.
10	Patient Birth Date	Enter the correct date of birth (MM/DD/YYYY).
11	Sex	Enter the sex of the patient.
12	Admission/ Start of Care Date	Enter the date the patient was admitted for inpatient care.
13	HR	*Conditionally required:*
14	Priority (Type) of Admission or Visit	Required on inpatient only. This code indicates priority of admission (e.g., emergency=1, urgent=2, elective=3, etc.) Refer to the *UB-04 Data Specifications Manual* for a listing of codes.
Field	**Field Name**	**Explanation**

No.		
15	Point of Origin for Admission or Visit (formerly Source of Admission)	*Conditionally required:* The point of origin is where the patient came from before presenting to the health care facility. Refer to the *UB-04 Data Specifications Manual* for a listing of codes.
17	Patient Discharge Status	The patient status code indicates the patient's status as of the "Through" date of the billing period (FL 6).
18-28	Condition Codes	*Conditionally required:* refer to the *UB-04 Data Specifications Manual* on how to complete FLs 18-28.
31-34	Occurrence Codes and Dates	*Conditionally required:* occurrence codes are required when there is a condition code that applies to the claim. Refer to the *UB-04 Data Specifications Manual* for a list of occurrence codes.
35-36	Occurrence Span Codes and Dates	*Conditionally required:* Enter event codes and a beginning and ending date that define a specific event relating to the billing period. Refer to the *UB-04 Data Specifications Manual* for a list of value codes.
39-41	Value Codes and Amounts	Enter the two-digit value code(s) and dollar or unit amount(s) necessary to process the claim. Refer to the *UB-04 Data Specifications Manual* for a list of value codes.
42	Revenue Code	Enter the four-digit revenue code that represents a specific accommodation, ancillary service, or billing calculation. Reven codes must be valid for the Type of Bill (FL 4) indicated on the claim form.
44	HCPCS/Rate/HIPPS Codes	
45	Service Date	You must provide a specific date for each service billed on a line.
46	Service Units	This field identifies the number of services the patient received or the time required to provide a specific service. To calculate units round up to the nearest whole number.
47	Total Charges	Submit a charge for each revenue code billed. Even if there is no charge, you must either enter 0.00 or N/C on the line item or

		the claim will be returned.
Field No.	**Field Name**	**Explanation**
48	Non-Covered Charges	
49		
50	Payer Name	
51	Health Plan ID	
52		
54	Prior Payments	*Conditionally required:* enter any amount the facility has received toward payment of this bill prior to the billing date by the indicated payer in FL 50.
56	National Provider ID (NPI)	Enter the facility's NPI number.
58	Insured's Name	Enter the last and first name of the policyholder.
59	Patient's Relationship	Enter a code that indicates the relationship of the patient to the policyholder. Refer to the *UB-04 Data Specifications Manual* for a complete list of appropriate codes you should use to complete this field.
60	Insured's Unique ID	Enter the alpha prefix and identification (ID) number as it appears on the patient's ID card.
61	Group Name	
62	Insurance Group Number	
63	Treatment Authorization	*Conditionally required:* enter the authorization numbers. Line A: Procedure authorization number Line B: Facility authorization number
64	Document Control Number	*Conditionally required:*
65	Employer Name	*Conditionally required:*
Field No.	**Field Name**	**Explanation**

67	Principal Diagnosis	Enter the principal ICD-9-CM diagnosis for the condition established, after study, as responsible for the patient's admission.
67a-q	Other Diagnosis Codes Present on Admission Indicator (POA)	Enter the full ICD-9-CM codes for additional conditions if they co-exist at the time of admission, or develop subsequently and have an effect on treatment or length of stay.
69		
70		*Conditionally required:*
71	PPS Code	*Conditionally required:*
74	Principal Procedure Code and Date	*Conditionally required:* On inpatient claims, submit a valid principal ICD-9-CM Volume 3 procedure code when revenue codes 0360-0369, 0490-0499, and 0750-0759 are billed.
76	Attending Physician Name and Identifiers	Enter the name and NPI number of the licensed physician who normally would be expected to certify and rectify the medical necessity of the services provided, and/or who has primary responsibility for the patient's medical care and treatment during an inpatient stay.
77	Operation Physician Name and Identifiers	*Conditionally required:* required when a surgical procedure code is listed on the claim.
80	Remarks	*Conditionally required:*

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1) **Required**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) **Required**

3. PATIENT'S BIRTH DATE MM DD YY SEX F **Required**

4. INSURED'S NAME (Last Name, First Name, Middle Initial) **Required**

5. PATIENT'S ADDRESS (No., Street) **Required**

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

6. PATIENT RELATIONSHIP TO INSURED Self Sp **Conditional** Other

8. RESERVED FOR NUCC USE

7. INSURED'S ADDRESS (No., Street)

CITY

ZIP CODE

Enter the complete address of the policyholder

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) **9a-d Conditional**

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO: **Required**

a. EMPLOYMENT? (Current or Previous) YES NO

b. AUTO ACCIDENT? PLACE (State) YES NO

c. OTHER ACCIDENT? YES NO

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER **Required**

a. INSURED'S DATE OF BIRTH MM DD YY SEX F **Required**

b. OTHER CLAIM ID (Designated by NUCC) **Required**

c. INSURANCE PLAN NAME OR PROGRAM NAME **Required**

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED **Required** DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED **Required**

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY **Required**

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE **Conditional**

17a. 17b. NPI **Required if you fill out #17**

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) **Conditional**

20. OUTSIDE LAB? $ CHARGES **Conditional**

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. **Required**

A. B. C. D. E. F. G. H. I. J. K. L. **Required**

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER **Conditional**

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #

1 2 3 4 5 6 NPI NPI NPI

All fields required except C. and H.

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN **Required**

26. PATIENT'S ACCOUNT NO. **Required**

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ **Required**

29. AMOUNT PAID $ **Required**

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED **Required** DATE

32. SERVICE FACILITY LOCATION INFORMATION **Required**

a. b.

33. BILLING PROVIDER INFO & PH # ( ) **Required**

a. b.

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

CMS-1500 Required Field Information		
Field No.	**Field Name**	**Explanation**
1a	Insured's ID Number	Enter the policyholder's alpha prefix and ID number as shown on his/her identification card.
2	Patient's Name	Enter the patient's full given name (no nicknames).
3	Patient's Date of Birth	Enter the correct date of birth (MM/DD/YYYY) and sex of the patient.
4	Insured's Name	Enter the policyholder's name.
5	Patient's Address	Required if it is not the same as the policyholder's address
6	Patient Relationship to Insured	*Conditionally required:*
7	Insured's Address	Enter the complete address of the policyholder.
9	Other Insurance Information	Required if 11d is marked "yes". If you determine the patient has other coverage, please enter the name of the other insured.
9a	Other Insured's Policy or Group Number	*Conditionally required:* Enter the other insured's policy or group number in this field.
9b	Reserved for NUCC use	*Conditionally required*
9c	Reserved for NUCC use	*Conditionally required*
9d	Insurance Plan Name or Program Name	*Conditionally required* : Enter the insurance plan name or program.
10	Is Patient's Condition Related To	Check the appropriate box if the patient's condition is related to employment or an auto accident or check "other."
11	Insured's Policy Group or FECA Number	
11a	Insured's Date of Birth	Enter the correct date of birth (MM/DD/YYYY) and sex of the insured.
11b	Other Claim ID	Designated by NUCC
11c	Insurance Plan Name or Program Name	
11d	Is There Another Health Benefit Plan?	Request this information from the member. If the answer is "yes" go back and complete blocks 9-9d.

Field No.	Field Name	Explanation
12	Patient's or Authorized Person's Signature	Signature on file okay
13	Insured's or Authorized Person's Signature	
17b	ID Number of Referring Physician (NPI)	*Conditionally required:* if you fill out field 17.
19	Additional Claim Information	*Conditionally required:*
20	Outside Lab? Charges	*Conditionally required:* Check the appropriate box if an outside lab was used. If "yes" list the charges.
21	Diagnosis or Nature of Illness or Injury	For dates of service through September 30, 2014 enter an ICD-9-CM code. For dates of service starting October 1, 2014 enter ICD-10 codes.
23	Prior Authorization Number	*Conditionally required*
24a	Dates of Service	If you submit office or hospital outpatient services, submit each service and/or each date of service on a separate lime with the same "from" and "to" dates.
24b	Place of Service	Enter the place of service code.
24d	Procedures, Services or Supplies	Submit valid CPT or HCPCS codes. Enter a current two-digit CPT or HCPCS modifier when applicable.
24e	Diagnosis Pointer	When there is more than one diagnosis on a claim, enter the primary diagnosis reference number from field 21 that relates to the reason each service was performed. If more than one diagnosis is appropriate for a service, the first number (letter) listed in 24e must be the primary diagnosis for that service.
24f	Charges	Submit a charge for each service billed on a line.
24g	Days or Units	Enter the appropriate number of services (in whole numbers) based on the time period or amount designated by the procedure code. You must enter at least one unit.

Field No.	Field Name	Explanation
24i	ID Qual	
24j	Rendering Provider ID	Enter the practitioner's individual rendering/performing NPI number.
25	Federal Tax ID Number	Enter your practitioner/supplier federal taxpayer identification number (TIN).
26	Patient's Account Number	Enter the patient's account number.
28	Total Charge	Enter the total of all charges from 24f. The line items submitted must equal the Total Charge in field 28 or the claim will be returned.
29	Amount Paid	
31	Signature of Physician or Supplier	The physician's signature, a computer-printed name, a stamp facsimile, "signature on file", or the signature of an authorized person is acceptable.
32	Service Facility Location Information	Enter the facility's NPI number.
33	Billing Provider Information	Enter the provider's or supplier's billing name, address, zip code, and phone number.
33a	NPI	If you have a group/organization NPI number, enter it in this field. If you do not have a group/organization NPI, enter your individual practitioner's/supplier's NPI number in this area.

9.2 Timely Filing Guidelines

Providers have one year from the date of service to submit, process, and pay claims*. This time schedule includes any corrected claims, provider requests for reconsiderations, and payment adjustments. Claims submitted more than one year from the date of service will be denied as provider liability. The full text of the Claims Adjustment and Time Limitations Reimbursement Policy can be found in the Policies section after logging into the Provider Portal at AveraHealthPlans.com.

*Exception: Providers have 180 days from the date of service to submit claims for members of the John Morrell network, and have until one year from the date of service to dispute claims for those members. For members of the Behavior Management Systems (BMS) group, providers have 182 days or 6 months to file a claim.

9.3 Explanation of Payment

Avera Health Plans uses many Explanation of Payment (EOP) codes to communicate with providers. These codes assist the provider in identifying what information is needed to process the claim or why a claim was denied. These codes are listed on the last page of each EOP. Avera Health Plans has adopted the standard transaction sets for EOP codes in order to comply with HIPAA regulations.

9.4 Overpayment of a Provider

Refund Process

If Avera Health Plans processes a claim and determines that it was initially overpaid to the provider, that amount will be automatically deducted from the provider's next payment. For providers who have already requested that overpayments be automatically deducted from their next payment, there will be no charge. If you find a situation where a claim has been overpaid and the overpayment has not automatically been deducted from your next payment, you can contact our Provider Relations Department to assist you in refunding the overpayment.

Recoupment Process

Recoupment involves offsetting the amount owed against future claim payments. Future claim payments will be reduced until the full amount of the overpayment is recovered by Avera Health Plans. Recoupment may also be used initially if the provider has requested this as their preferred recovery procedure. If you are interested in being set up for automatic recoupment, please contact our Service Center or email providers@averahealthplans.com.

9.5 Denied Claims – Request for Reconsideration

When submitting your request for reconsideration, the Provider Request for Reconsideration Form is required to be attached and our Provider Reconsideration Guidelines will help you expedite the dispute process. The form will ensure all pertinent information is included with the initial request and reduce delay within the review process.

9.6 Coordination of Benefits

Coordination of Benefits (COB) means a provision establishing an order in which plans pay their claims permit secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable charges. Coordination of Benefits helps eliminate duplicate payments when a member has healthcare coverage under more than one plan. Coordination of Benefits is designed to protect members and their employers from higher premiums that result when two insurance companies make duplicate reimbursements.