

75 Vanderbilt Avenue, Staten Island NY 10304 1-844-CPHL-CARES

To our Provider Partners:

As you well know, the cyber-attack on Change Healthcare has impacted healthcare systems nationwide. As many of you navigate your own contingency plans, we are sharing information related to the impact on CPHL and offering direction for any of you that may be affected.

For CPHL, the only direct impact is regarding how provider claims are received. All other processes are fully operational without impact. With regard to claim submission, there are three general options for providers to submit their claims to CPHL.

1) Electronic Submission – Clearinghouse:

Submit electronic claims via a clearinghouse, or network of clearinghouses, with the **Payer ID of CPHL1** to be received by CPHL through one of the following clearinghouses:

A. Change Healthcare Clearinghouse

B. Smart Data Solutions (SDS) Clearinghouse

2) Electronic Submission – Direct via a Portal:

Register with one of the following EDI vendors to submit claims directly to CPHL:

- A. Payer Connectivity Services (PCS), a Change Healthcare Company
- B. Smart Data Solutions (SDS)

3) Paper Submission:

Submit paper claims by mail to: Centers Plan for Healthy Living P.O. Box 21033 Eagan, MN 55121

As highlighted above, until Change Healthcare brings their systems back, the Change Healthcare paths are unavailable. However, as indicated above, each of the electronic options can be fully supported by our alternate clearinghouse, Smart Data Solutions, as follows.

If you are submitting electronic claims via a clearinghouse (Option #1), direct your practice management system vendor and/or clearinghouse to channel their claims to Smart Data Solutions.

CPHL's **Payer ID of CPHL1** is listed with Smart Data Solutions so claims with that Payer ID received by them will be received by CPHL.

- If you would like to submit electronic claims directly (Option #2), which may be the quickest path, follow these few steps to register and submit your electronic claims to CPHL.
 - 1) Go to Smart Data Solution's website at <u>sdata.us</u>
 - 2) On the right side of the top banner click on "Provider Portal"
 - 3) Select Register
 - 4) Complete the registration form to create an account [Note: Click on the radio button under Account Confirmation to ensure the verification is sent to the phone number provided in the form]
 - 5) Once registration is verified, follow instructions for submitting claims to CPHL (also included below)

If you have any questions regarding this process, please contact Smart Data Systems support Mon-Fri 9-5 CST at <u>stream.support@sdata.us</u> or 855-297-4436.

We hope you'll find this information helpful in successfully navigating around any obstacles created by this cyber-attack.

For any other claims related questions, please contact the CPHL Claims Dept. Mon-Fri 9-5 ET at 844-292-4211, Option 2.

Thank you, Provider Services Dept.





SUBMITTING A CLAIM

• There are two options to submit a claim through the Smart Data Stream Clearinghouse Portal. You can either upload a claim file or you can do Direct Data Entry and key in a new claim.

SMARTDATASTREAM Clearinghouse Porto										
Home Cla	ims Remits	Eligibility	Claim Status	Account Managemen	t Help				Logout	
Claims										
This page allows you to manage your past 90 days of claims. You can edit rejected claims, upload a new claim file, key a new claim, view unsubmitted claims, and view claim files using the button(s) below.										
This page is also searchable by a number of criteria. You may enter a reference number or an export name to search for documents within the current batch. To search for a document, enter the search criteria into the 'Search' box to the left of the table.										
Manage Rejects	Upload	Claims	N	lew Claim	Unsubmitte	ed Claims	Claim F	Files	Update Pa	ayers

UPLOAD CLAIMS

• If you selected "Upload Claims", this screen will appear:

Claim Upload								
Use this interface to upload claims in EDI format. Once the claims have been uploaded and checked for basic compliance, they will appear below. Please review and add any additional attachments to the claims by clicking the upload button underneath the claim. Once this has been completed please click the release button and the claims will be routed to the payer along with the attachment.								
Uploaded Documents								
Please drop your file here or								
Choose File No file chosen								

• This feature allows you to upload claims in batches to portal. As long as it's a valid 837 file and has a payer ID in the REFO2 segment, SDS will successfully route your claims on to the payer.





NEW CLAIM

• If you selected "**New Claim**", this screen will appear. From here you can either choose a Professional/CMS1500 claim form, an Institutional/UB04 claim form, or a Dental claim form.

New Document										
This data entry page will allow you to key an empty form for processing. To being entering information, please select a destination and a form to key. Once a form is selected you will be automatically redirected to the appropriate page to enter any data. Note that no data is saved until the submit button at the bottom of the page is selected. Once the entry has been completed, there may be a short delay before the entry appears on the history page while the system is processing it.										
Please select the appropriate route and form type to begin.										
5 <i>a a</i>										
Destination	Document Type									
Amerigroup ▼	Select a Type ▼ Select a Type Professional Institutional Dental									

• Once the claim type has been selected, it will bring up a template for the claim information to be typed into. The various document types are shown below:





PROFESSIONAL

More													
1. Type								la INSURED'S I.D. NUMBER					
OTHER V													
2. PATIENT'S NAME (Last Name Last First	3. PATIENT'S BIRTH DATE				4. INSURED'S NAME (Last Name, First Name, Middle Initial) Last First Middle								
5. PATIENT'S ADDRESS (No. Street)			6. PATIENT RELAT		7. INSURED'S ADDRESS (No. Street)								
ITY STATE			8. RESERVED FOR		СІТҮ			STATE					
ZIP CODE	TELEPHONE		_		ZIP CODE			TELEPHONE					
9. OTHER INSURED's NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: Employment? No.				11. INSURED'S POLICY GROUP OR FECA NUMBER						
a. OTHER INSURED'S POLICY OR GROUP NUMBER							a. INSURED'S BIRTH DATE						
b. RESERVED FOR NUCC USE			Auto Accident? No Other Accident? No		b. OTHER CLAIM ID (Designated by NUCC)								
c. RESERVED FOR NUCC USE			_				C. INSURANCE PLAN NAME OR PROGRAM NAME						
d. INSURANCE PLAN NAME O	R PROGRAM NAME	8	10d. CLAIM CODE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?								
12 PATIENT'S OR AUTHORIZE Signed			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Signed										
14. DATE OF CURRENT ILLNE (LMP) YYYY/MM/DD QUAL	15. OTHER DATE QUAL VYYY/MM/DD				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION YYYY/MM/DD TO YYYY/MM/DD								
17. NAME OF REFERRING PRO	17a.				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES								
Last F	170. NPI				YYYY/MM/DD TO YYYY/MM/DD								
19. RESERVED FOR LOCAL US					20. OUTSIDE I	.AB?	\$ C	HARGES 0					
21. DIAGNOSIS OR NATURE O	ICD Ind. 1CD-10 V C. D.				22. RESUBMIS	SION COI		IGINAL REF. NO.					
E I	G H K L				23. PRIOR AUTHORIZATION NUMBER								
24. A. DATES OF S	ERVICE B. P	OS C. EMO	D PROC M	ODIFIER	R E DIAG	E CHAR	G. DU PE	H STDT I Q	UAL J	PROVIDER ID			
Add Line						CITATO							
25. FEDERAL TAX I.D. NUMBER			T'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?				28. TOTAL 29. AMOUNT PAID 30. RSVD for NUCC CHARGE \$ 0.00 \$						
Name			CE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFORMATION Name						
Last Address					Address								
Middle Credential							City						
City													
		Zip Phone		1			Zip Phone			1			
				J 2									
		a. NPI		b.			a. NPI			b.			
Save Progress						ormation	tion Submit Document						





INSTITUTIONAL

More													
Name	Name					:	3a				4 81	LL TYPE	
Addr	Addr					:	Зь.						
Cay AA Y	City			V]	FED TAX NO.		6 STATEMEN	T COVERS			
Phone - Fax	1							/	MM/DD	YYYY/MM/DD	5 1		
8 Patient Name		9 Patient Adv	tress										
							7	-	▼] (_		
ADMISSION						CONDITION CO	DES			29 ACDT			
10 BIRTHDATE 11 SEX 12 DATE 13 HR	14 TYP 15 SRC 18 D	HR 17 STAT	19	20	21	22 23	24	25 28	27	28 29 ACD1	STATE	30	
YYYY/MM/DD M YYYY/MM/DD											¥		
31 OCCURRENCE S2 OCCURRENCE	33 OCCURRENCE		COURRENCE		5	OCCURRENCE SF		38		IRENCE SPAN		37	
CODE DATE CODE DATE	CODE DATE	CODE	DATE		CODE	FROM	THROUGH	CODE	FROM	THR	DUGH		
				╡┼╞	=								
					39	VALUE CODES	40		CODES	41	VALUE CODE	0	
Name					CODE	AMOUNT			AMOUNT	CODE	AMOU		
Address													
City													
Zip												_	
42 REV CD 43 DESCRIPTION		44 HOPOSIRATE/H	IPPS CODE	45	SERV. DATE	46 SERV. U	NITS 47 TOT	AL CHARGES	48 NON-CO	VERED CHARGES	49		
Add Line													
	(CREATION DATE			TO	TALS >	0.0	0	[0.00			
50 PAYER NAME	51 HEALTH PLAN ID		52 REL 53 INFO BE	ASG 4	4 PRIOR PAYMER	VTS 55 EST	AMT DUE	58 NPI					
Ameriqroup	81237		Y		0.00	0.00		57					
					0.00	0.00		ОТН					
					0.00	0.00		PRVID					
58 INSURED's NAME	59 P.REL 60 INS	URED's UNIQUE ID			0.00	61 GROUP NA	ME		62 INSURANC	E GROUP NO			
												More	
			-					-				11	
												More	
												More	
63 TREATMENT AUTHORIZATION CODES	1	54 DOCUMENT CONTRO	LNUMBER				65 EMPLOY	YER NAME					
66 DX 67 A B	c			E		F	G		н		68		
				N		0	P		0				
es admit dx 70 Pat res dx		71 PPS C	2006		72 ECI							1	
74 PROC DATE PROC	DATE	6 PROC	DATE		75	76					1	1	
							NPI		-				
						LAST			1 1	IRST			
e PROC DATE d PROC	DATE	e PROC	DATE				NPI		QUAL				
						LAST				FIRST			
а						78 OTH	NPI		QUAL [
ь	1					LAST				FIRST			
						79 OTH							
c													
d [LAST			1	FIRST			
Save Document Progress							Submit Document						