

Provider Tips



Top 5 Denial Reasons and Reminders to Reduce Denials:

1. **Duplicate Billing:**
 - Use the Care1st Web portal to confirm claim status at any time
 - Allow 45-60 days from the initial claim submission prior to resubmitting
 - Contact Claims Customer Service to assist with questions prior to submitting duplicates
2. **Primary Insurance on file-Bill Primary Insurance:**
 - Verify coverage at each appointment
 - Use AHCCCS online to verify other coverage
3. **Patient Not Eligible on Date of Service:**
 - Confirm eligibility on AHCCCS online or with Care1st Customer Service prior to claims submission
4. **Provider Not Contracted – Auth Required:**
 - Refer all laboratory services to Sonora Quest (our exclusive lab)
 - Refer to the Prior Authorization Guidelines on our website
5. **Exceeds Timely Filing Guidelines:**
 - Initial claim submission must be received no later than 6 months from the date of service, or eligibility posting date, whichever is greater
 - Care1st secondary claims must be received within 6 months from the date of service/eligibility posting date, or within 60 days of the primary carrier's processing date as indicated on the EOB, whichever is greater
 - Resubmissions must be received within 12 months of the date of service, or eligibility posting date, whichever is greater



Care1st
432 N 44th Street
Suite 100
Phoenix, AZ 85008
Phone: 602.778.1800
Toll Free: (866).560.4042

Our goal is to help you reduce claims submission denials!

Dual members covered by WellCare Liberty (Formerly ONECare) and Care1st Medicaid

Coordination of Benefits on Dual Members

Please confirm that the WellCare Liberty ID located on the member's card is correct on primary claim submissions. We have identified WellCare Liberty claims billed with the members Care1st Medicaid ID, which results in a denial.

Services billed on a CMS1500 for dual eligible members covered by both WellCare Liberty and Care1st do not require a secondary billing with a copy of the WellCare Liberty explanation of benefits. These claims are crossed-over internally for secondary processing with the following exceptions:

- Durable Medical Equipment
- Orthotics & Prosthetics
- Home Health Care
- FQHC/RHC services
- MSIC/Integrated Clinic services

After benefits are adjudicated under the WellCare Liberty plan the claim payment information is forwarded to the Care1st Medicaid plan for secondary handling. Please allow up to 45 days from the receipt of the WellCare Liberty Explanation of Benefits for completion of the secondary claim.

For all other services involving traditional Medicare or commercial insurance as the primary payer, you will continue to submit a secondary billing.

Resubmission and Void Requirements

Corrected claim resubmissions and voids must be billed using the format below:

- Resubmissions on CMS1500 forms: include indicator 7 and the original claim number in field 22 (EDI Loop 2300)
- Voided claims on CMS1500 forms: include indicator 8 and the original claim number in field 22 (EDI Loop 2300)
- UB04 forms: include bill type XX7 (replacement) or XX8 (void) with the original claim number in field 64 (Loop 2300)

Note: Failure to include the original claim number will result in a duplicate or timely filing denial. The original claim number must be provided for the claim to be reconsidered.

Documenting the Prior Authorization number on WellCare Liberty claims

When submitting claims the prior authorization number, if applicable, is required on the claim. Failure to include this information will result in a denial for WellCare Liberty claims.

- CMS1500 –populate the authorization number in field 23 (EDI Loop 2300)
- UB04 –populate the authorization number in field 63 (EDI Loop 2300)