Magellan Claims Settlement Practices and Dispute Resolution

Notice to Providers Contracted with
California Subsidiaries of Magellan Health, Inc.*

Revised June 2026

*Human Affairs International of California and Magellan Health Services of California, Inc. – Employer Services

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Magellan HEALTHCARE®

Submission of Claims under Blue Shield of California, Positive Healthcare, Sharp Health Plan and Scripps Health Plan Benefit Plans

Please use the appropriate address below for mail and physical delivery of managed care claims.

Blue Shield of California	**Positive Healthcare**
Blue Shield of California MHSA P.O. Box 710400 San Diego, CA 92171-0400 Claims Customer Service: • DMHC and DOI plans: 1-877-263-9952 • ASO BSC Buy-Up Product plans: 1-800-378-1109 • CalPERS plans: 1-866-505-3409 • City and County of San Francisco plan: 1-866-830-0328 • Medicare Advantage plan: 1-800-985-2398	Magellan Healthcare P.O. Box 2246 Maryland Heights, MO 63043 Claims Customer Service: 1-800-480-4464
Sharp Health Plan	**Scripps Health Plan**
Human Affairs International of California Sharp Health Plan P.O. Box 710430 San Diego, CA 92171 Claims Customer Service: 1-866-512-6190	Human Affairs International of California Scripps Health Plan Services, Inc. P.O. Box 710220 San Diego, CA 92171 Claims Customer Service: 1-866-272-4084

For all other benefit plans managed by a Magellan company, obtain specific contact information for claims from the member's benefit card or summary plan description.

To submit an **electronic claim**, please log on to www.MagellanProvider.com and click on *Getting Paid* for instructions.

For claims inquiries and filing information and to confirm our receipt of a claim, please use the appropriate telephone number, above, for claims customer service. Or, log on to www.MagellanProvider.com. Information about how to use these claims look-up features is available to providers on the same website.

Within 15 working days of receipt of a clean claim for the plans named above, we will either pay or deny your claim and send you an Explanation of Payment (EOP) or send you an acknowledgement of receipt of your claim. If you submit your claim electronically through a clearinghouse, you will receive an electronic acknowledgement of receipt from your clearinghouse; receipt by the clearinghouse does

not signify that we have received and accepted your claim for processing. **We strongly recommend that you check back with the clearinghouse after a couple of days to see if the claim was returned due to various reasons and or incomplete information.** Doing so will expedite our processing and payment of your claim. See below for description of process for claims under self-insured benefit plans.

Following are our claim filing requirements:

Submit all claims, paper or electronic, within ninety (90) days of the date of service. Claims submitted after 90 days will be denied payment except when delay is caused by extraordinary circumstances. Answers to frequently asked questions about timely claim submissions are available on the MagellanProvider.com website. For additional information on timely filing requirements, you may also call the appropriate Claims Customer Service number identified above.

Collect applicable co-payments from members.

Submit a *clean claim* on an accurately completed electronic or paper claim form and attach an itemized bill.

Service	**Claim Form**
Non-facility based professional services	CMS-1500
Professional outpatient services provided by the staff of a facility that are not part of a structured outpatient program when a facility per diem is exclusive of professional charges	CMS-1500
Partial hospitalization or IOP services	UB-04
Facility-based services and programs	UB-04

A **clean claim** for OUTPATIENT services is a claim that includes all of the following:

Subscriber name

Subscriber/patient plan ID number

Patient name

Patient date of birth

Patient address

Diagnosis code (current ICD-code)

National Provider Identifier (NPI) Number

Provider name (including both treating provider and billing entity, if different)

Provider Taxpayer Identification Number (TIN)

Provider credentials

Provider mailing address for payment and coordination of benefits information, if applicable

Coordination of benefits information -- Whether or not the patient has other health

coverage, and if so, the effective date of coverage, the carrier/plan name, and who else is covered.

CPT code

Date of service

Billed amount

A clean claim for INPATIENT and alternative levels of care is a claim that includes all of the following:

Subscriber/Patient plan ID number

Patient name

Patient date of birth

Patient address

Diagnosis code

Type of bill code

Dates of service

CPT code

Billed amount

Rates

Total charges

Revenue code

Taxpayer Identification Number (TIN) of billing entity

Provider name (both treating provider and billing entity, if different)

Provider credentials

Provider mailing address for payment

Attending physician's name

Coordination of benefits information – Whether or not the patient has other health coverage, and if so, the effective date of coverage, the carrier/plan name, and who else is covered.

Include your National Provider Identification (NPI) or the NPI of the group or organization that is contracted with us on all claims. Although the NPI is required only on electronic claims at this time, it provides information that helps locate your provider record in our claim system process and therefore helps us process paper claims more quickly and accurately.

- On the CMS-1500 form (version 08/05), insert billing Type 2 NPI in Box 33a; insert service facility Type 2 NPI (if different from billing NPI) in Box 32a; insert Type 1 NPIs for rendering providers in Box 24J.

- For an overview and additional information on NPI, visit the CMS website. See also our website at www.MagellanProvider.com under *Getting Paid*. Our NPI Claims Tips provide specific details on how to prepare and submit HIPAA-compliant claims.

Use only current code sets (ICD-10, CPT, HCPCS, procedural code modifiers, revenue code, type of bill, and place of service). Select the procedure code and diagnosis that most fully describes the service provided. Do not use DSM-IV codes for diagnoses on your claim.

If the patient has more than one Axis I diagnosis, be sure to report all diagnoses on the claim (using ICD-10 codes to report). The diagnosis must match your authorization and the Revenue Codes (for facilities) or CPT codes (for professional services) and the services on the claim must match the services authorized.

Use only HIPAA-compliant codes on all claim forms, whether electronic (EDI) or hard copy. Invalid or noncompliant codes may result in claim processing delays, a request to resubmit the claim with current compliant codes or denial of the claim. Your clearinghouse may reject non-HIPAA compliant codes on electronic claims.

For information on HIPAA-compliant codes for both electronic and hard copy claims, please see the HIPAA Standard Code Sets section in the Magellan National Provider Handbook or on MagellanProvider.com.

Accurately indicate the license and degree level of the provider of services on each professional service claim.

Show your full charge on the claim. The amount reimbursed is based on the lesser of the provider's reported charge or the applicable fee schedule. Do not reduce charges by the co-payment or co-insurance amounts paid by the patient.

Provide all information required on the claim form. In consideration of patient confidentiality, claims examiners do not have access to treatment plans; therefore, it is necessary to give information on the claim that may have been previously provided. Do not submit treatment plans with claim forms. Treatment plans are to be mailed to the service center that authorized the services.

If another benefit plan is the primary plan and benefits have been provided or denied, submit a copy of the Explanation of Benefits (EOB) from the other plan along with your claim submission.

Do not bill for the same service twice in one day.

List each date of service for each procedure code. Because we link the dates of care authorized with the dates given on the claim, we cannot accept dates of service lumped together under "from" and "through" dates (e.g., "from 12/1/11 through 12/8/11" and number of days/units of "3"). More than two dates of service on one line will delay processing.

Be sure the treating provider signs the claim form verifying that the services performed are accurately reflected in the services reported. The treating provider is legally responsible for the contents of the claim once it is signed. Please do not give a signed claim form to the member to complete.

Claims for professional services (those services submitted currently on a Form CMS-1500) can be submitted through Magellan-approved claims clearinghouses. For current information on clearinghouses, go to www.MagellanProvider.com and view the **Clearinghouse Information** under *Getting Paid/Electronic Transactions*. Professional service claims may also be submitted directly to us online through www.MagellanProvider.com (in-network only).

For faster electronic submission and fewer claim denials due to inaccurate member information, use the member search function on Magellan's Claims Courier online claim submission tool that auto-populates member data on claims. To use Claims Courier, sign in to www.MagellanProvider.com with your secure username and password and follow the instructions to "Submit a Claim Online." Search by entering a first name and last name and the member's state. The feature is available when entering a new claim but is not available for claim corrections.

For faster, more reliable receipt of payments on claims, take advantage of Electronic Funds Transfer (EFT) for claims payments. You can request to have certain claims payments directly deposited to your business bank account. See the *Getting Paid* area of www.MagellanProvider.com for more information.

To avoid delay, be sure you are submitting the claim to the correct payer and specific mailing address. Obtain a photocopy of the member's benefit card (front and back) to retain important claims/billing information.

Respond to requests for additional information or other corrective action in a timely manner.

Please remember that in-network providers are prohibited from billing or collecting from Magellan members for services determined by Magellan to lack medical necessity, unless the member agrees in writing to pay for the services after learning of Magellan's determination.

Make sure to keep all records documenting when you submit your claim, to the payer Magellan (MHSA) for use in the event your claim is denied for failing to meet applicable timely filing requirements.

Timely Filing Evidence would represent one of the following:

- Copy of a Magellan EOP with a date within the filing standard.
- Copy of a letter/correspondence from Magellan with a date within the filing standard.
- Certified or overnight mail receipts dated within the filing standard.
- Facsimile confirmation showing the provider faxed the claim to the correct claims address with imprinted dates within the filing standard.
- Copies of the microfilmed claim with Magellan's date stamp within the filing standard.
- Copy of 2nd level EDI 277 acceptance reports. 997 acknowledgements are not acceptable because they are only given when the claim goes through the HIPAA and companion guide

edits. The claim may be rejected before it is accepted into the claim system (CAPS). The 277 response is issued when the claim is actually accepted into the system.

- Copy of EOP from the medical/health plan vendor substantiating their denial date. Use the medical/health plan EOP denial date to calculate the timely filing requirement.

Claims under Self-Insured Plans (other than Blue Shield of California Self-Insured Plans)

If you have claims for services to a member of a self-insured benefit plan [i.e., a plan other than an HMO or insured plan] that is managed by a Magellan company, there are several differences in the claims processing:

You need to submit the claims per the specific contact information for claims on the member's benefit card or in the summary plan description. DO NOT submit claims to either of the addresses identified above on page 1. Submitting claims for self-insured plans to those addresses may result in the claim getting lost and will result in delay in processing. If you have questions about submitting claims, please call the member's toll-free Magellan access number.

Claims will be paid or denied within 30 calendar days of receipt of a clean claim.

Please note that all other filing requirements are the same for these plans as described above in connection with Blue Shield of California and Positive Healthcare plans. The type of plan only affects the procedural differences specifically noted here under "Claims under Self-Insured Plans."

Submission of Provider Disputes* under Blue Shield of California, Positive Healthcare, Sharp Health Plan and Scripps Health Plan Benefit Plans to our Provider Dispute Resolution Mechanism

Our Provider Dispute Mechanism is available to help resolve provider disputes in relation to services to members of **Blue Shield of California, Positive Healthcare, Sharp Health Plan and Scripps Health Plan** plans. A "provider dispute" is a provider's challenge, appeal, or request for reconsideration of a claim denial or adjustment; a request for resolution of a billing determination; a dispute regarding an overpayment reimbursement request; or other contract dispute made by a provider in writing on his/her/its own behalf.

For all appeals or grievances that do not meet the above definition of "provider dispute" and for all disputes under other plans, please call us at 1-800-788-4005.

Please use the appropriate address below for mail, physical delivery, or fax of provider disputes:

Blue Shield of California	**Positive Healthcare**
Blue Shield of California Mental Health Service Administrator P.O. Box 719002 San Diego, CA 92171-9002 • DMHC and DOI plans: 1-877-263-9952 • ASO BSC Buy-Up Product plans: 1-800-378-1109CalPERS plan: 1-866-505-3409 • City and County of San Francisco plan: 1-866-830-0328 • Medicare Advantage plan: 1-800-985-2398	*Medicare Provider Claims Disputes* Magellan Healthcare P.O. Box 1718 Maryland Heights, MO 63043 *Medicaid Provider Claims Disputes* PHC California P.O. Box 46160 Los Angeles, CA 90046 Customer Service: 1-800-480-4464
Sharp Health Plan	**Scripps Health Plan**
Human Affairs International of California Sharp Health Plan, Attn: Appeals P.O. Box 710430 San Diego, CA 92171 Customer Service: 1-866-512-6190	Magellan Healthcare P.O. Box 710190 San Diego, CA 92171 Customer Service: 1-866-272-4084 Fax: 1-888-656-2209

A written provider dispute must include the following information:

- **All disputes:** The provider's name, identification number, and contact information.

- **Claims appeals and disputes relating to a request for reimbursement of overpayment:** Original claim number; clear identification of the disputed item; the date of service; and a clear explanation of the basis upon which the provider believes our determination or other action or inaction is incorrect.

- **Disputes involving a member or group of members:** The name and identification number(s) of the member(s); clear explanation of the disputed item, including the date of service; and the provider's position on the dispute.

- **Disputes involving provider contract:** Clear explanation of the issue and the provider's position on the issue.

Please also submit any documents relevant to supporting your position.

We will acknowledge receipt of your dispute in writing within 15 business days of receipt and issue a written determination within 45 business days of receipt.

If we do not receive enough information to address your dispute, we will request additional information from you within 45 business days. We will suspend the process until you provide us the requested information. We will make a final determination within 45 business days of receipt of your amended dispute (the additional information). If we do not receive the requested additional information within 30 business days of the request, we will close the dispute for lack of necessary information and so notify you.

If you have questions about a dispute or how to file a dispute, please call us at the appropriate number indicated on the previous page.

Submission for Reimbursement for EAP Services

We reimburse providers for EAP services upon submission of an Employee Assistance Service Information (EASI) Form.

Please use the online EASI Form via www.MagellanProvider.com (available after sign-in) to submit the EAP request for reimbursement. Alternately you may complete the hardcopy EASI Form and mail or fax it to the appropriate address on the EAP Reimbursement Contact Information sheet, available online at www.MagellanProvider.com/EAP.

Here are our filing requirements for reimbursement for EAP services:

- Submit an accurately completed, appropriate EASI Form within ninety (90) days of the date of service.
- Fully complete the EASI Form. Incomplete items on a form may result in delay in payment.
- Do not bill for more than one EAP session for a member in one day.
- Respond to requests for additional information or other corrective action in a timely manner.
- Do not charge members or collect co-payments, co-insurance or deductibles from members unless specifically otherwise instructed by us. As a rule, members have NO financial responsibility for EAP services.

You can expect to receive payment for EAP services within 30 days of our receipt of a complete EASI Form. If you do not receive payment within 30 days, contact us at the appropriate number above.

Submission of EAP Provider Disputes

Our Provider Dispute Mechanism is available to help resolve provider disputes in relation to services to members of EAPs *other* than federal government EAPs and certain EAPs covering three sessions or fewer that are exempt from the Knox-Keene law.

A "provider dispute" is a provider's challenge, appeal, or request for reconsideration of a claim denial or adjustment; a request for resolution of a billing determination; a dispute regarding an overpayment reimbursement request, or other contract dispute made by a provider in writing on his/her/its own behalf.

Please use the appropriate address below for mail, physical delivery, or fax of EAP provider disputes:

Magellan Health Services of California–Employer Services
Provider Dispute Dept.
P.O. Box 710430
San Diego, CA 92171

Phone Number: 1-800-288-0558
Fax: 1-888-656-5366

For all EAP-related disputes that do not meet the above definition of "provider dispute," please call us at 1-800-424-1565, or at 1-800-274-2477 in connection with disputes relating to the FOH EAP.

A written EAP provider dispute must include the following information:

- **All disputes:** The provider's name, identification number, and contact information.

- **Appeals and disputes relating to payment request or a request for reimbursement of overpayment:** Case number; clear identification of the disputed item; the date of service; and a clear explanation of the basis upon which the provider believes our determination or other action or inaction is incorrect.

- **Disputes involving a member or group of members:** The name and identification number(s) of the member(s); clear explanation of the disputed item, including the date of service; and the provider's position on the dispute.

- **Disputes involving provider contract:** Clear explanation of the issue and the provider's position on the issue.

Please also submit any documents relevant to supporting your position.
We will acknowledge receipt of your dispute in writing within 15 business days of receipt and issue a written determination within 45 business days of receipt.

If we do not receive enough information to address your dispute, we will request additional information from you within 45 business days. We will suspend the process until you provide us the requested information. We will make a final determination within 45 business days of receipt of your amended dispute (the additional information). If we do not receive the requested additional information within 30 calendar days of the request, we will close the dispute for lack of necessary information and so notify you.

If you have questions about a dispute or how to file a dispute, please call us at the appropriate number on the previous page.

Posting of Information about Claims Settlement Practices and Provider Dispute Resolution

For your convenience, this information about reimbursement for managed care and EAP services and submission of provider disputes is posted on MagellanProvider.com. Please check the website for notices of changes to this information.