Transforming Lives

Trillium HEALTH RESOURCES

Claims Request Form Purpose

What is the Purpose of the Claims Request Form?

1. Inquire about a Claim

The claims staff will review the details of the claim and send the Provider Agency the results.

- I submitted a claim that passed the first level and have not seen a payment or denial. Can you tell me the status of this claim?

2. Void a Claim (unpaid claims submitted with errors)

This choice can be selected by an Out-of-Network Provider Agency to void a claim sent in with errors (see examples below). Contracted Provider Agencies should void the claim in Provider Direct (see Replacement/Voided Claim Instructions).

Examples:

- The claim submitted was for the wrong date of service
- The claim submitted was for the incorrect number of units
- The claim submitted was for the wrong consumer
- The claim submitted has the incorrect service code
- The claim was submitted with the wrong charges
- The incorrect NPI number was used on the claim
- The diagnosis billed was incorrect
- The wrong service facility location was chosen

3. Adjustment Request

This choice can be selected by an Out-of-Network Provider Agency to adjust a claim sent in with errors (see examples below). Contracted Provider Agencies should adjust the claim in Provider Direct (see Replacement/Voided Claim Instructions).

- I was paid for the incorrect number of units
- The date of service was incorrect
- I was paid the wrong amount (Over Payment and/or Under Payment)

4. Time Limit Override

Trillium Health Resources has a "Billing Window" for the Provider Agency to submit claims in a timely manner. The timeframe for entering claims is ninety (90) days from the date of service. Professional claims can be replaced when the claim is within 180 days from the date of service, as long as the original claim is submitted within the 90 day billing window.

Institutional claims can be replaced when the claim is within 180 days from the date of service, as long as the original claim was submitted within the 90 day billing window. If the Provider Agency has passed this window of time for unforeseen circumstances, the agency may use the Claims Request Form to request an extension of time to enter the claim. This request will be reviewed by the Review Team to determine if the request will be approved or denied. All decisions made on a request to have the billing window opened are final. The denial of a billing window request is non-appealable.

5. Third Party Liability/Medicare Coverage *(Coordination of Benefits)*

When an enrollee has third party insurance coverage and/or Medicare coverage, the Provider Agency will be required to submit an Explanation of Benefits (EOB) from the third party payer and/or Medicare as proof of payment and/or denial. The Provider Agency will use the Claims Request Form to submit this documentation to Trillium Health Resources. The Provider Agency will provide the details on the Claims Request Form and attach a copy of the EOB and mail to the Claims Department at Trillium Health Resources at the address on the bottom of the Claims Request Form.

6. Full Recoupment

This choice can be selected by an Out-of-Network Provider Agency to void a claim sent in with errors. Contracted Provider Agencies should void the claim in Provider Direct (see Replacement/Voided Claim Instructions).