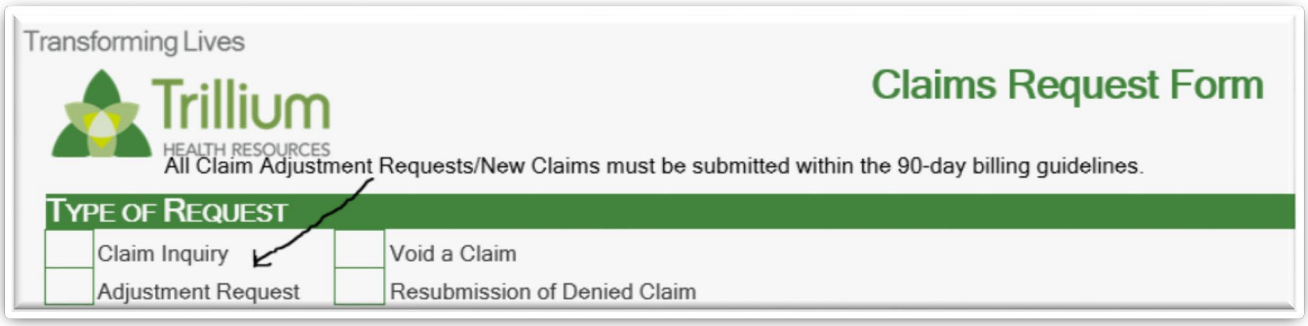
Transforming Lives

Trillium HEALTH RESOURCES

Claims Request Form Instruction

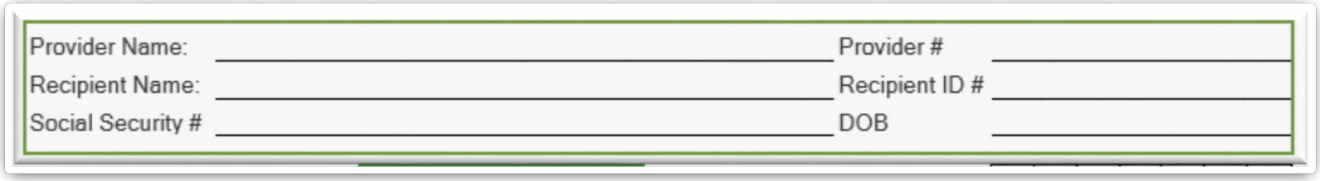
HOW DO I FILL OUT THE CLAIMS REQUEST FORM?

1. PLEASE CHECK THE REASON YOU ARE FILLING OUT THE REQUEST.



2. PLEASE FILL IN THE FIRST SECTION (AS FOLLOWS):

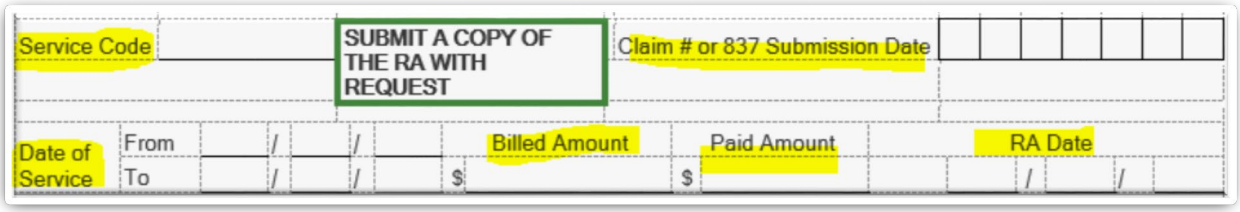
- Provider Agency Name
- Provider ID number assigned by Trillium Health Resources. This is available on the RA and Claims Status Report.
- Recipient's Name
- Recipient's ID Number (use the Medicaid number if applicable – if the enrollee does not have Medicaid, use the internal Trillium Client ID number).
- Recipient's Social Security Number
- Recipient's Date of Birth



3. PLEASE FILL IN THE SECOND SECTION (AS FOLLOWS):

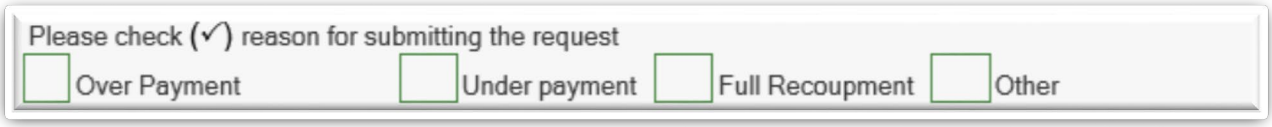
- Fill in the service code submitted on the claim
- Fill in the Claim ID number. This is located on the RA, the Claims Status Report (column I) or by using Claim Search in Provider Direct.
- If the claim was on an 837 uploaded from your agency, provide the date of the 837 in this block
- Fill in the date(s) of service being inquired about

- Fill in the billed amount submitted on the claim
- If inquiring about a paid claim, fill in the amount paid by Trillium – if inquiring about an unpaid claim, enter $0.00
- If this claim is paid and/or unpaid and is listed on an RA, please fill in the date of the



Please fill in the third section (as follows):

- If inquiring about an Over Payment, please check this block.
  - An overpayment can be the result of i.e., too many units submitted on the claim
- If inquiring about an Under Payment, please check this block.
  - The under payment could be a result of not billing the correct number of units or the correct rate was not billed.
- If a Full Recoupment is needed, please check this block.
  - A Full Recoupment of a claim could be the result of discovering a claim billed in error.
- Please check the "Other" block when one of the above reasons does not explain the inquiry.

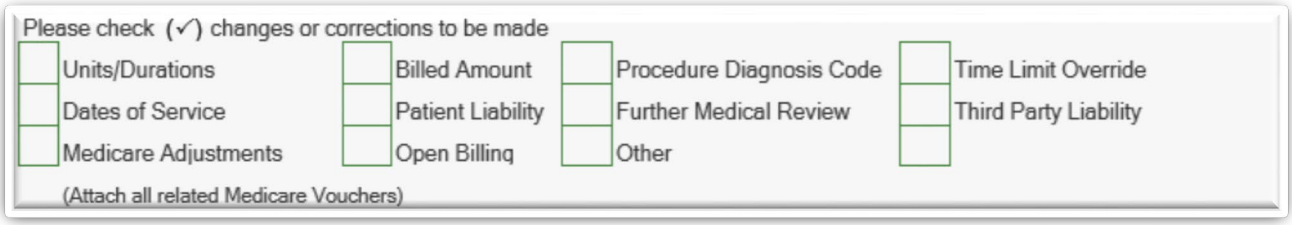


Once the reason above for submitting the request is selected, please provide further details of the request in this section.

4. Please fill in the fourth section (as follows):

- Check the Units/Duration block if the request is to change the Units/Duration submitted on the claim
- Check the Billed Amount if the request is to increase/decrease the amount submitted on the claim
- Check the Procedure Diagnosis Code if you are requesting to change the Procedure/Diagnosis Code submitted on the claim

- Check the Time Limit Override block if you are requesting an extension for claims submission
- Check the dates of service block if you are requesting to change the date(s) of service
- Check the Patient Liability block if you are reporting a payment made to the provider agency by the enrollee not originally submitted on the claim
- Check the Further Medical Review block if the claim submitted to the Clinical Department is being reviewed.
- Check the Third Party Liability block if submitting an Explanation of Benefits (EOB) from a third party insurance
- Check the Medicare Adjustments block if submitting an Explanation of Benefits (EOB) from Medicare
- Check the Open Billing Window block if an extension of time to bill this claim is being requested.
- Other – Please check this block if one of the above reasons does not apply to this request.



5. PLEASE FILL IN THE FIFTH SECTION (AS FOLLOWS):

Provide an explanation in detail as to why this request is being submitted for the reasons selected above. Please give as much as detail as possible so the Claims Specialist can understand your request.

Example: I submitted 3 units on this claim and should have submitted 5 units. This caused our agency to be underpaid. We were paid $16.92 and should have been paid $28.20. Please consider this request for the additional payment based on the correct number of units

6. PLEASE FILL IN THE LAST SECTION (AS FOLLOWS):

- Signature of Sender - The staff member submitting the request
- Print the Staff Member's name
- The Position the Staff member holds in your agency
- The Date this request is submitted
- The Phone Number of the staff member who completed this request
- The Fax number at the Provider agency
- The Email Address of the staff member submitting this request