FREQUENTLY ASKED QUESTIONS

I have a question about claims. Who should I contact?

- Call Provider Service at 1.844.424.7253 - opt. 2; Mon - Fri 9:00 a.m. - 5:00 p.m. for all claims questions.

How can I schedule transportation for a member?

- Please contact Member Services at 1.844.694.2273 8:00 a.m. - 5:30 p.m.

How do I become a provider?

- Visit our website at https://icirclecarecny.org/ProvidersPartners/ProviderForms/tabid/246/Default.aspx and complete the appropriate Credentialing Application.

Where can I submit my claims?

- Paper claims can be submitted to:
  - iCircle Care
    P.O. Box 1320
    Webster, NY 14580
    ATTN: Claims Department
- Electronic claims can also be submitted via Change Healthcare (formerly known as Emdeon)
  - Clearinghouse: Change Healthcare
  - Payer Name: iCircle
  - Payer ID: 33884
  - Authorization Number: Provided on Authorization from iCircle
  - Member Account Number: Provided on Authorization from iCircle

I have questions about a member's vision benefits.

- We use Davis Vision for our member's vision benefits. Providers may contact Davis Vision at 1.800.773.2847.

I have questions about a member's dental benefits.

- We use Healthplex for our member's dental benefits. Providers may contact Healthplex at 1.888.468.5175.

I've never submitted a health insurance claim before, what do I do?

- If you provided a service (such as construction of a ramp) and are not a medical facility you will need complete a CMS 1500 (must be version 2/12) form in order to be paid. The form can be purchased here: http://bookstore.gpo.gov
- Most of the information needed to complete this form will be found on the authorization that you received from iCircle.
- If you need a guide to filling out the form please click here

How long will it take for my clean claim to process?

- Electronic claims are processed within 30 days of receipt.
- Paper claims are processed within 45 days of receipt.
  - http://www.dfs.ny.gov/insurance/ogco2002/rg207242.htm

What is a Front-end Rejection (see definition below)? Why was my claim sent back?

- Claims with missing or incorrect information will be sent back to the provider without being entered into the system. The provider will receive a letter advising them of the reason for the rejection. After correcting the information, the claim may be sent back to:

iCircle Care
PO Box 1320
Webster, NY 14580
ATTN: Claims Department

FREQUENTLY ASKED QUESTIONS

How do I file an appeal for a denied claim?

- You'll need to complete an appeal form & supply all necessary documentation. The form can be found here: http://icirclecarecny.org/Portals/1/iCircle%20Claim%20Appeal%20and%20Adjustment%20Form%20(2).pdf
  - Please be sure to indicate reason for appeal
- If you have a large number of denied claims, errors or questions please contact Provider Service at 844-424-7253 opt. 2

What is your timely filing limit?

- If you are filing as primary: it is **120 days from the last date of service**
  - Example: dates of service on claim are 1/1/2019 – 1/31/2019, the calculation starts on 1/31/2019
- If you are filing as secondary: it is **120 days from receipt of the primary EOB**
- If you are filing as corrected claim (see definition below): it is **12 months from the date of service (effective 6/1/2019 – any claim with an original date of service 6/1/2019 and after)**
- If you are filing an appeal/reconsideration (see definition below): it is **90 days from date of denial/payment**
  - Claim must be finalized/paid in order to file an appeal

How can I email you?

- Contact Provider Services at ProviderService@icirclecny.org

What is your fax number?

- Our fax number is: 888.519.2816. Be sure to add the name of the recipient to the cover sheet or mark it for Provider Relations.

Definitions and Examples

Corrected

- **Definition**: A corrected claim is a claim that requires changes be made to the original claim previously processed (a corrected claim is NOT a rejected claim). For rejected claims please see Front-end Rejection.
- **Example**: An error with the way the original claim was billed (i.e., # of units billed, date of service, diagnosis, procedure codes, modifiers, bill amount)

Front-end Rejection

- **Definition**: A front-end rejection is a claim that has been rejected and needs to be resubmitted (meaning it is not recorded in our system).
- **Example**: Provider receives a rejection letter identifying the reason for rejection. (i.e., claim not on file, invalid claim number, NPI not on file, W-9 not on file, whiteout was used on claim). New claim submission is required.

Appeals

- **Definition**: An appeal is a type of dispute you make when you want a reconsideration of a decision (determination) that was made regarding a service.
- **Example**: All denials (i.e., authorization related denials, rate issues and timely filing).