Billing Workshop
Vision
Colorado Medicaid
2014
Training Objectives

• Billing Pre-Requisites
  ➤ National Provider Identifier (NPI)
    ▪ What it is and how to obtain one
  ➤ Eligibility
    ▪ How to verify
    ▪ Know the different types

• Billing Basics
  ➤ How to ensure your claims are timely
  ➤ When to use the CMS 1500 paper claim form
  ➤ How to bill when other payers are involved
What is an NPI?

• National Provider Identifier
• Unique 10-digit identification number issued to U.S. health care providers by CMS
• All HIPAA covered health care providers/organizations must use NPI in all billing transactions
• Are permanent once assigned
  ➤ Regardless of job/location changes
What is an NPI?

• How to Obtain & Learn Additional Information:
  ➤ CMS web page (paper copy)-
    ▪ www.dms.hhs.gov/nationalproldentstand/
  ➤ National Plan and Provider Enumeration System (NPPES)-
    ▪ www.nppes.cms.hhs.gov
  ➤ Enumerator-
    ▪ 1-800-456-3203
    ▪ 1-800-692-2326 TTY
NEW! Department Website

1. https://www.colorado.gov/hcpf

2. For Our Providers
NEW! Provider Home Page

Find what you need here

Contains important information regarding Colorado Medicaid & other topics of interest to providers & billing professionals
Provider Enrollment

Question: What does Provider Enrollment do?
Answer: Enrolls providers into the Colorado Medical Assistance Program, not members.

Question: Who needs to enroll?
Answer: Everyone who provides services for Medical Assistance Program members.
Rendering Versus Billing

Rendering Provider

- Individual that provides services to a Medicaid member

Billing Provider

- Entity being reimbursed for service
Verifying Eligibility

- Always print & save copy of eligibility verifications
- Keep eligibility information in member’s file for auditing purposes
- Ways to verify eligibility:

  - Web Portal
  - Fax Back 1-800-493-0920
  - CMERS/AVRS 1-800-237-0757
  - Medicaid ID Card with Switch Vendor
Eligibility Response Information

- Eligibility Dates
- Co-Pay Information
- Third Party Liability (TPL)
- Prepaid Health Plan
- Medicare
- Special Eligibility
- BHO
- Guarantee Number
Eligibility Request Response (271)

Information appears in sections:
- Requesting Provider, Member Details, Member Eligibility Details, etc.
- Use the scroll bar to the right to view more details

Successful inquiry notes a Guarantee Number:
- Print a copy of the response for the member’s file when necessary

Reminder:
- Information received is based on what is available through the Colorado Benefits Management System (CBMS)
- Updates may take up to 72 hours
Medicaid Identification Cards

- Both cards are valid
- Identification Card does not guarantee eligibility
Eligibility Types

• Most members = Regular Colorado Medicaid benefits
• Some clients = different eligibility type
  ➤ Modified Medical Programs
  ➤ Non-Citizens
  ➤ Presumptive Eligibility
• Some members = additional benefits
  ➤ Managed Care
  ➤ Medicare
  ➤ Third Party Insurance
Eligibility Types

Modified Medical Programs

- Members are not eligible for regular benefits due to income
- Some Colorado Medical Assistance Program payments are reduced
- Providers cannot bill the member for the amount not covered
- Maximum member co-pay for OAP-State is $300
- Does not cover:
  - Long term care services
  - Home and Community Based Services (HCBS)
  - Inpatient, psych or nursing facility services
Eligibility Types

Non-Citizens

• Only covered for admit types:
  ➢ Emergency = 1
  ➢ Trauma = 5
• Emergency services (must be certified in writing by provider)
  ➢ Member health in serious jeopardy
  ➢ Seriously impaired bodily function
  ➢ Labor / Delivery
• Member may not receive medical identification care before services are rendered
• Member must submit statement to county case worker
• County enrolls member for the time of the emergency service only
What Defines an “Emergency”?

- **Sudden, urgent, usually unexpected** occurrence or occasion requiring immediate action such that of:
  - Active labor & delivery
  - Acute symptoms of sufficient severity & severe pain-
    - Severe pain in which, the absence of immediate medical attention might result in:
      - Placing health in serious jeopardy
      - Serious impairment to bodily functions
      - Dysfunction of any bodily organ or part
Eligibility Types

Presumptive Eligibility

- Temporary coverage of Colorado Medicaid or CHP+ services until eligibility is determined
  - Member eligibility may take up to 72 hours before available
- Medicaid Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers DME and other outpatient services
  - Children ages 18 and under
    - Covers all Medicaid covered services
  - Labor / Delivery
- CHP+ Presumptive Eligibility
  - Covers all CHP+ covered services, except dental
Presumptive Eligibility

- Verify Medicaid Presumptive Eligibility through:
  - Web Portal
  - Faxback
  - CMERS
    - May take up to 72 hours before available
- Medicaid Presumptive Eligibility claims
  - Submit to the Fiscal Agent
    - Xerox Provider Services- 1-800-237-0757
- CHP+ Presumptive Eligibility and claims
  - Colorado Access- 1-888-214-1101
Managed Care Options

• Types of Managed Care options:
  ➤ Managed Care Organizations (MCOs)
  ➤ Behavioral Health Organization (BHO)
  ➤ Program of All-Inclusive Care for the Elderly (PACE)
  ➤ Accountable Care Collaborative (ACC)
Managed Care Options

Managed Care Organization (MCO)

• Eligible for Fee-for-Service if:
  ➤ MCO benefits exhausted
    ▪ Bill on paper with copy of MCO denial
  ➤ Service is not a benefit of the MCO
    ▪ Bill directly to the fiscal agent
  ➤ MCO not displayed on the eligibility verification
    ▪ Bill on paper with copy of the eligibility print-out
Managed Care Options

Behavioral Health Organization (BHO)

- Community Mental Health Services Program
  - State divided into 5 service areas
    - Each area managed by a specific BHO
  - Colorado Medical Assistance Program Providers
    - Contact BHO in your area to become a Mental Health Program Provider
Managed Care Options

Accountable Care Collaborative (ACC)

- Connects Medicaid members to:
  - Regional Care Collaborative Organization (RCCO)
  - Medicaid Providers
  - Connects Medicaid members to:
- Helps coordinate Member care
  - Helps with care transitions
Medicare members may have:
- Part A only- covers Institutional Services
  - Hospital Insurance
- Part B only- covers Professional Services
  - Medical Insurance
- Part A and B- covers both services
- Part D- covers Prescription Drugs
Qualified Medicare Beneficiary (QMB)

- Bill like any other TPL
- Members only pay Medicaid co-pay
- Covers any service covered by Medicare
  - QMB Medicaid- members **also** receive Medicaid benefits
  - QMB Only- members **do not** receive Medicaid benefits
    - Pays only coinsurance and deductibles of a Medicare paid claim
Medicare-Medicaid Enrollees

- Eligible for both Medicare & Medicaid
- Formerly known as “Dual Eligible”
- Medicaid is always payer of last resort
  - Bill Medicare first for Medicare-Medicaid Enrollee members
- Retain proof of:
  - Submission to Medicare prior to Colorado Medical Assistance Program
  - Medicare denials(s) for six years
Third Party Liability

• Colorado Medicaid pays Lower of Pricing (LOP)
  ➤ Example:
    ▪ Charge = $500
    ▪ Program allowable = $400
    ▪ TPL payment = $300
    ▪ Program allowable – TPL payment = LOP

          $400.00
          
          - $300.00
          
          = $100.00
Commercial Insurance

- Colorado Medicaid always payor of last resort
- Indicate insurance on claim
- Provider cannot:
  - Bill member difference or commercial co-payments
  - Place lien against members right to recover
  - Bill at-fault party’s insurance
Co-Payment Exempt Members

- Nursing Facility Residents
- Children
- Pregnant Women
Co-Payment Facts

• Auto-deducted during claims processing
  ➤ Do not deduct from charges billed on claim
• Collect from member at time of service
• Services that do not require co-pay:
  ➤ Dental
  ➤ Home Health
  ➤ HCBS
  ➤ Transportation
  ➤ Emergency Services
  ➤ Family Planning Services
Specialty Co-Payments

Optometrist

$2.00 per date of service
Billing Overview

- Record Retention
- Claim submission
- Prior Authorization Requests (PARs)
- Timely filing
- Extensions for timely filing
Record Retention

• Providers must:
  ➤ Maintain records for at least 6 years
  ➤ Longer if required by:
    ▪ Regulation
    ▪ Specific contract between provider & Colorado Medical Assistance Program
  ➤ Furnish information upon request about payments claimed for Colorado Medical Assistance Program services
Record Retention

• Medical records must:
  ➤ Substantiate submitted claim information
  ➤ Be signed & dated by person ordering & providing the service
    ▪ Computerized signatures & dates may be used if electronic record keeping system meets Colorado Medical Assistance Program security requirements
Submitting Claims

• Methods to submit:
  ➤ Electronically through **Web Portal**
  ➤ Electronically using **Batch Vendor, Clearinghouse**, or **Billing Agent**
  ➤ **Paper** only when
    ▪ Pre-approved (consistently submits less than 5 per month)
    ▪ Claims require attachments
ICD-10 Implementation Delay

• ICD-10 Implementation delayed until 10/1/2015
  ➢ ICD-9 codes: Claims with Dates of Service (DOS) on or before 9/30/15
  ➢ ICD-10 codes: Claims with DOS 10/1/2015 or after
  ➢ Claims submitted with both ICD-9 and ICD-10 codes will be rejected
Crossover Claims

• Automatic Medicare Crossover Process:

• Crossovers May Not Happen If:
  ➤ NPI not linked
  ➤ Member is a retired railroad employee
  ➤ Member has incorrect an Medicare number on file
Crossover Claims

• Provider Submitted Crossover Process:

  - Additional Information:
    - Submit claim yourself if Medicare crossover claim not on PCR within 30 days
    - Crossovers may be submitted on paper or electronically
    - Providers must submit copy of SPR with paper claims
    - Provider must retain SPR for audit purposes
Payment Processing Schedule

**Mon.**
Payment information is transmitted to the State’s financial system

**Tue.**
Accounting processes Electronic Funds Transfers (EFT) & checks

**Wed.**
EFT payments deposited to provider accounts

**Thur.**

**Fri.**
Weekly claim submission cutoff

**Sat.**
Fiscal Agent processes submitted claims & creates PCR

Paper remittance statements & checks dropped in outgoing mail
Electronic Funds Transfer (EFT)

- Several Advantages:
  - Free!
  - No postal service delays
  - Automatic deposits every Friday
  - Safest, fastest & easiest way to receive payments
  - Located in Provider Services Forms section on Department website
PARs Reviewed by ColoradoPAR

• With the exception of Waiver and Nursing Facilities:
  ➤ ColoradoPAR processes all PARs including revisions
  ➤ Visit coloradopar.com for more information

**Mail:**
Prior Authorization Request
55 N Robinson Ave., Suite 600
Oklahoma City, OK 73102

**Phone:**
1.888.454.7686

**FAX:**
1.866.492.3176

**Web:**
ColoradoPAR.com
Electronic PAR Information

• PARs/revisions processed by the ColoradoPAR Program must be submitted via CareWebQI (CWQI)

• The ColoradoPAR Program will process PARs submitted by phone for:
  ➢ emergent out-of-state
  ➢ out-of area inpatient stays
  ➢ e.g. where the patient is not in their home community and is seeking care with a specialist, and requires an authorization due to location constraints
PAR Letters/Inquiries

• Continue utilizing Web Portal for PAR letter retrieval/PAR status inquiries

• PAR number on PAR letter is only number accepted when submitting claims

• If a PAR Inquiry is performed and you cannot retrieve the information:
  ➤ contact the ColoradoPAR Program
  ➤ ensure you have the right PAR type
  ➤ e.g. Medical PAR may have been requested but processed as a Supply PAR
Vision PARs

• Not required for vision correction (eyeglasses, contact lenses) after surgery
  ➤ Must identify surgery related eyewear with modifier 55
• Prior Authorizations required for
  ➤ Contact Lenses
  ➤ Low Vision Aids
  ➤ Ocular Prosthetics (EPSDT members only)
  ➤ Tint, anti-reflective coating, U-V, oversize, occluder, and progressive lenses
What Requires a PAR

• To find most current list of procedures that require a PAR:
  ➤ Medicaid Fee Schedule
    ▪ Colorado.gov/Provider Services
    ▪ Look under Medicaid Fee Schedule for most current schedule
  ➤ (Colorado.gov/hcpf) ➔ For Our Providers ➔ Provider Services ➔ Billing Manuals ➔ Reference Appendix M
PAR Letters

• Xerox generates PAR Letters daily
  ➤ If a billing provider sends a request one a week/month, PAR letter will be generated once a week/month

• Who receives a PAR letter?
  ➤ Billing Providers retrieve directly from the FRS
  ➤ Requesting Provider and Member receives by mail

• Letters are available for 60 days
**Transaction Control Number**

- **Receipt Method**
  - 0 = Paper
  - 2 = Medicare Crossover
  - 3 = Electronic
  - 4 = System Generated

- **Batch Number**
- **Document Number**
- **Year of Receipt**
- **Julian Date of Receipt**
- **Adjustment Indicator**
  - 1 = Recovery
  - 2 = Repayment

0 14 129 00 150 0 00037
Timely Filing

• 120 days from Date of Service (DOS)
  ➤ Determined by date of receipt, not postmark
  ➤ PARs are not proof of timely filing
  ➤ Certified mail is not proof of timely filing
  ➤ Example – DOS January 1, 20XX:
    ▪ Julian Date: 1
    ▪ Add: 120
    ▪ Julian Date = 121
    ▪ Timely Filing = Day 121 (May 1st)
Timely Filing

From “through” DOS
- Nursing Facility
- Home Health
- Waiver
- In- & Outpatient
- UB-04 Services

From DOS
- Obstetrical Services
- Professional Fees
- Global Procedure Codes:
  - Service Date = Delivery Date

From delivery date
- FQHC Separately Billed and additional Services
Documentation for Timely Filing

• 60 days from date on:
  ➢ Provider Claim Report (PCR) Denial
  ➢ Rejected or Returned Claim
  ➢ Use delay reason codes on 837P transaction
  ➢ Keep supporting documentation

• Paper Claims
  ➢ CMS 1500- Note the Late Bill Override Date (LBOD) & the date of the last adverse action in Field 19 (Additional Claim Information)
Timely Filing – Medicare/Medicaid Enrollees

Medicare **pays** claim

• 120 days from Medicare payment date

Medicare **denies** claim

• 60 days from Medicare denial date
Timely Filing Extensions

• Extensions may be allowed when:
  ➤ Commercial insurance has yet to pay/deny
  ➤ Delayed member eligibility notification
    ▪ Delayed Eligibility Notification Form
  ➤ Backdated eligibility
    ▪ Load letter from county
Timely Filing Extensions

• Extensions may be allowed when:
  ➤ Commercial insurance has yet to pay/deny
  ➤ Delayed member eligibility notification
    ▪ Delayed Eligibility Notification Form
  ➤ Backdated eligibility
    ▪ Load letter from county
Extensions – Commercial Insurance

• 365 days from DOS
• 60 days from payment/denial date
• When nearing the 365 day cut-off:
  ➤ File claim with Colorado Medicaid
    ▪ Receive denial or rejection
  ➤ Continue re-filing every 60 days until insurance information is available
Extensions – Delayed Notification

• 60 days from eligibility notification date
  ➢ Certification & Request for Timely Filing Extension – Delayed Eligibility Notification Form
    ▪ Located in Forms section
    ▪ Complete & retain for record of LBOD

• Bill electronically
  ➢ If paper claim required, submit with copy of Delayed Eligibility Notification Form

• Steps you can take:
  ➢ Review past records
  ➢ Request billing information from member
Extensions – Backdated Eligibility

• 120 days from date county enters eligibility into system
• Report by obtaining State-authorized letter identifying:
  ➢ County technician
  ➢ Member name
  ➢ Delayed or backdated
  ➢ Date eligibility was updated
Vision Services

The following services may be included:

- Eyeglasses
- Repairs
- Contact lenses
- Ocular prosthetics
- Vision treatment

Inclusion of services is dependent on:

- Age
- Medical necessity
- Previous eye surgery
Vision Benefits - 20 and under:

**Examinations**
- No Limitations
- $2.00 co-pay for ages 19 & 20 not enrolled in an MCO

**Eyeglasses**
- One or two single or multi-focal clear plastic lenses & one standard frame
- $0 co-pay

**Contacts**
- Must be medically necessary & prior authorized unless provided for vision correction after surgery
- Contact lenses, supplies, & contact lens insurance not a benefit
Vision Benefits - 21 and over:

Examinations
- Must be medically necessary
- $2.00 co-pay

Eyeglasses
- A benefit only following eye surgery
  ➢ limited to single or multi-focal clear plastic lenses & one standard frame
- $0 co-pay

Contacts
- Must be medically necessary & prior authorized unless provided for vision correction after surgery
  ➢ Indicated by using modifier 55
- Contact lenses, supplies, & contact lens insurance not a benefit
Procedure Coding

• Lens Materials
  ➤ Glass, plastic or polycarbonate lenses may be used
    ▪ V2784 must be used for polycarbonate lenses
  ➤ Each lens is 1 unit
    ▪ Dispense 2 lenses of same strength
    ▪ bill 1 line with 2 units
    ▪ Dispense 2 lenses of different strengths
    ▪ bill 2 lines with 1 unit
• Lens Dispensing
  ➤ Dispensing fee is allowed for each lens
  ➤ Use CPT codes in range 92340-92355

• Partial visit
  ➤ Use code 92015 as partial vision screening for members
    ▪ 20 years of age and younger
Vision Billing

- To identify surgery-related eyewear
  - Modifier -55

- Deluxe frames
  - Member pays for non-covered costs
    - Non-covered = difference between provider’s retail charges for allowable frames and retail for upgraded frames requested
    - Provider must have written agreement from member authorizing the deluxe frames
# CMS 1500 Claim Form

**HEALTH INSURANCE CLAIM FORM**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>identifier</td>
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<td>2.</td>
<td>patient</td>
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<tr>
<td>3.</td>
<td>provider</td>
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<td>4.</td>
<td>payer</td>
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<td>5.</td>
<td>service</td>
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<td>6.</td>
<td>insurance</td>
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<td>7.</td>
<td>diagnosis</td>
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<td>8.</td>
<td>procedure</td>
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<td>9.</td>
<td>amount</td>
</tr>
<tr>
<td>10.</td>
<td>signature</td>
</tr>
</tbody>
</table>

**Instructions:**

- Complete all fields accurately.
- Use ink or dark pen for handwriting.
- Review and correct any errors.

**Important Notes:**

- Attach supporting documentation if required.
- Submit claims within the specified timeframe.
- Follow the Medicare guidelines for payments.
Common Denial Reasons

- **Timely Filing**: Claim was submitted more than 120 days without a LBOD
- **Duplicate Claim**: A subsequent claim was submitted after a claim for the same service has already been paid.
- **Bill Medicare or Other Insurance**: Medicaid is always the “Payor of Last Resort”. Provider should bill all other appropriate carriers first
- **PAR not on file**: No approved authorization on file for services that are being submitted
- **Total Charges invalid**: Line item charges do not match the claim total
**Claims Process - Common Terms**

- **Reject**: Claim has primary data edits – **not** accepted by claims processing system.
- **Denied**: Claim processed & denied by claims processing system.
- **Accept**: Claim accepted by claims processing system.
- **Paid**: Claim processed & paid by claims processing system.
Claims Process - Common Terms

**Adjustment**
- Correcting under/overpayments, claims paid at zero & claims history info
- Claim must be manually reviewed before adjudication

**Rebill**
- Re-bill previously denied claim

**Suspend**
- “Cancelling” a “paid” claim (wait 48 hours to rebill)

**Void**
Adjusting Claims

• What is an adjustment?
  ➤ Adjustments create a replacement claim
  ➤ Two step process: Credit & Repayment

Adjust a claim when:
• Provider billed incorrect services or charges
• Claim paid incorrectly

Do not adjust when:
• Claim was denied
• Claim is in process
• Claim is suspended
Adjustment Methods

Web Portal

• Preferred method
• Easier to submit & track

Paper

• Use Medicaid Resubmission Reason Code 7 to replace a prior claim or Reason Code 8 to void/cancel a claim. The TCN that needs to be replaced or voided is the original reference number. Providers will continue to see Reason Code 406 for replacement claims and Reason Code 412 for voided claims on the Provider Claim Reports.
Provider Claim Reports (PCRs)

• Contains the following claims information:
  ➢ Paid
  ➢ Denied
  ➢ Adjusted
  ➢ Voided
  ➢ In process

• Providers required to retrieve PCR through File & Report Service (FRS)
  ➢ Via Web Portal
Provider Claim Reports (PCRs)

• Available through FRS for 60 days
• Two options to obtain duplicate PCRs:
  ➢ Fiscal agent will send encrypted email with copy of PCR attached
    ▪ $2.00/ page
  ➢ Fiscal agent will mail copy of PCR via FedEx
    ▪ Flat rate- $2.61/ page for business address
    ▪ $2.86/ page for residential address
• Charge is assessed regardless of whether request made within 1 month of PCR issue date or not
## Provider Claim Reports (PCRs)

### Paid

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<tr>
<td>TOTALS - THIS PROVIDER / THIS CATEGORY OF SERVICE.... TOTAL CLAIMS PAID 1 TOTAL PAYMENTS 69.46</td>
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### Denied

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THE FOLLOWING IS A DESCRIPTION OF THE DENIAL REASON (EXC) CODES THAT APPEAR ABOVE:

1348 The billing provider specified is not a fully active provider because they are enrolled in an active/non-billable status of '62, '63', '64', or '65 for the FDOS on the claim. These active/non-billable providers can't receive payment directly. The provider must be in a fully active enrollment status of '60' or '61'.

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COUNT 0001
Provider Claim Reports (PCRs)

**Adjustments**

*ADJUSTMENTS PAID*

- **Voids**

**Repayment**

**Recovery**

**Net Impact**
Provider Services

Xerox
1-800-237-0757

- Claims/Billing/ Payment
- Forms/Website
- EDI
- Enrolling New Providers
- Updating existing provider profile

CGI
1-888-538-4275

- Email helpdesk.HCG.central.us@cgi.com
- CMAP Web Portal technical support
- CMAP Web Portal Password resets
- CMAP Web Portal End User training
Thank You!