

CLAIMS BILLING

CenCal Health generally follows the Medi-Cal guidelines and benefits outlined in the Manuals published by the State of California, with some exceptions. Please see also benefits and exclusions information for specific programs found in the Benefits Summary section of this Provider Manual. For specific claim questions, we recommend you contact your Claim Representative. The address and telephone numbers for the Claims Department are listed at the end of this section.

Below is a listing of bullet points outlining the general billing requirements. Bullets apply to all programs, except where specific programs are indicated:

- Claims may be submitted on a hard copy claim form, electronically (HIPAA compliant format), or via our Website at www.cencalhealth.org.
- “Clean” claims will be paid within 45 days of receipt. Clean claims are claims that include all of the necessary and accurate information for adjudication. This includes, but is not limited to, name, address, sex, date of birth, subscriber number of member; ICD-9 and CPT/HCPCS codes, modifiers, billed charges, applicable authorization numbers, place of service, quantity for services, Provider’s Identification Number, and an original signature (for hard copy claims).
- **For SBHI and SLOHI claims:** claims received within the 7th month from the date of service may be subject to a 25% reduction in payment. Claims received within the 10th month from the date of service may be subject to a 50% reduction in payment. If the member has other health coverage, claims must be received within 60 days from the date of the EOB from the other health coverage. Claims received within the 13th month from the date of service will be denied. There are exceptions to these filing limits – these are outlined in the Medi-Cal Billing Manual.
- **For HF, HK, PP2, and IHSS claims:** claims must be submitted within 180 days from the date of service or will be denied, unless Provider can prove extenuating circumstances. If the member has other health coverage, claims must be received within 180 days from the date of the EOB from the other health coverage. The Member cannot be billed for services that were denied due to Provider not meeting these requirements.
- **For HF, HK, PP2, and IHSS claims:** final claims payment will be subject to the Member’s deductible and/or co-payment. Providers may only bill the Member for the co-payment. Please refer to the benefits summaries in Section VI. of this manual for information about co-payments. The Member’s co-payment will also appear on the Explanation of Benefits.
- Unless listed on **“When RAFs Are Not Required”** list, specialty care, tests, medical equipment or any other service **must** be ordered by the Member’s PCP or payment will be denied. If Providers can obtain a retroactive authorization from the Member’s PCP, claims may be submitted for reconsideration.

- Any surgical or diagnostic procedure that requires a TAR/AR will be subject to prior authorization, utilizing a “**Treatment Authorization Request**” or “**Authorization Request**”. Samples of these forms can be found in the Authorization Request section of this Provider Manual.
- **DENIED CLAIMS:** Providers may submit corrections for denied services by submitting a [Claim Correction Form](#) (may be located and downloaded from this section of the Provider Manual), CIF (Claim Inquiry Form), a corrected claim with the denied claims CCN (Claim Control Number) written on the top of the corrected claim, or submitting corrections on the Explanation of Benefits on which the denial appears. CenCal Health must receive any corrections within 6 months from the date of the Explanation of Benefits in which the denial appeared. Any corrections received after the end of the sixth month will not be considered.
- **APPEALS:** If you do not agree with any decision made by CenCal Health with respect to payment or denial, you may appeal the decision. A letter explaining the reason for your appeal must be submitted to CenCal Health, along with a copy of the original claim and all supporting documentation. Your appeal will be reviewed by the appropriate staff members and you will be informed of the decision, in writing, within 60 days of receipt.

CONTACTS FOR CLAIMS:

Submit original claims to:

***CenCal Health
P.O. Box 1818
Bellflower, CA 90707-1818***

Send non-claim mail, claim inquiries, tracers, disputes, and RAFs to:

***CenCal Health
4050 Calle Real
Santa Barbara, CA 93110
ATTENTION: Adjudication Dept.***

Send claims appeals to:

***CenCal Health
4050 Calle Real
Santa Barbara, CA 93110
ATTENTION: Provider Services Dept.***

TELEPHONE NUMBERS:

For claims status or inquiries:

Main Line (Direct dial): 805.562.1083
(Toll free): 800.421.2560, extension 1083

Outpatient Facility and Allied Issues: Select 1
Inpatient Admission and LTC Issues Select 2
Physician and Vision Issues Select 3
DME Issues Select 4
General Inquiries or Claim Status Select 5

MedImpact (Pharmacy Benefit Manager) 800.788.2949
HealthHelp (Radiology Benefits Manager) 888.318.0276