EmblemHealth

Got Claims?

EmblemHealth is here to help you every step of the way.

The best way to check claims status is through the Provider Portal.

Remember, the Claims Corner section of our website is available 24/7 to provide guidance, resources and answers to most claims-related questions.

Timely filing requirements for claim submissions:

Participating Providers

- Claims must be received **within 120 days post-date-of-service** unless otherwise specified by the applicable participation agreement.
- Claims where EmblemHealth is the *secondary payer* must be received **within 120 days from the primary carrier's EOB voucher date** unless otherwise specified by the applicable participation agreement.
- **Corrected claims must also be submitted within 120 days post-date-of-service** unless otherwise specified by the applicable participation agreement.

Non-Participating Providers

- **Commercial products:** claims must be received within 18 months, post-date-of-service.
- **Medicaid, and Child Health Plus (CHPlus):** claims must be received within 15 months, post-date-of-service.
- **Medicare:** claims must be received within 365 days, post-date-of-service.

For more information, visit the Claims Corner section of our Provider website,
Claims Submission - Timely Filing | EmblemHealth

If you need to speak with someone, call Provider Services at **866-447-9717**.
Our hours are 8 am to 6 pm, Monday to Friday.

EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC and Health Insurance Plan of Greater New York (HIP) are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

EMB_PR_FLY_56858_CheckClaimsStatus 1/22

Common billing errors

Medical billing and coding errors are unfortunately common. Be mindful of these common billing pitfalls:

Correct CPT Code Use

- Check the coding crosswalk to confirm that the codes you are submitting are compatible with each other before billing.
- Confirm that the age of the member matches with the diagnosis code billed on the claim.
- When billing a bilateral CPT code, verify that the code is inherently bilateral, meaning providers need not add any additional modifier. For codes where the LT/RT modifier is required, make certain to add the modifier in two different lines as two separate units or, as per the CMS guidelines, bill the CPT with the 50 modifier.

Provide Complete Medical Records and Correct Claim Form Information

- For coding denials, send the appropriate medical records for the claim to be reviewed.
- When indicated/appropriate, provide complete medical records to ensure the claim is not denied for additional information needed.
- Verify that the correct service location address is displayed in box #32 on the claim form.