Doula Third Party Liability Training

Ohio Medicaid and Managed Care

Monday, July 27, 2026

Department of Medicaid

Access, Inclusion, and Reasonable Accommodation

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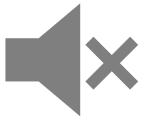
Housekeeping



All participants will be muted



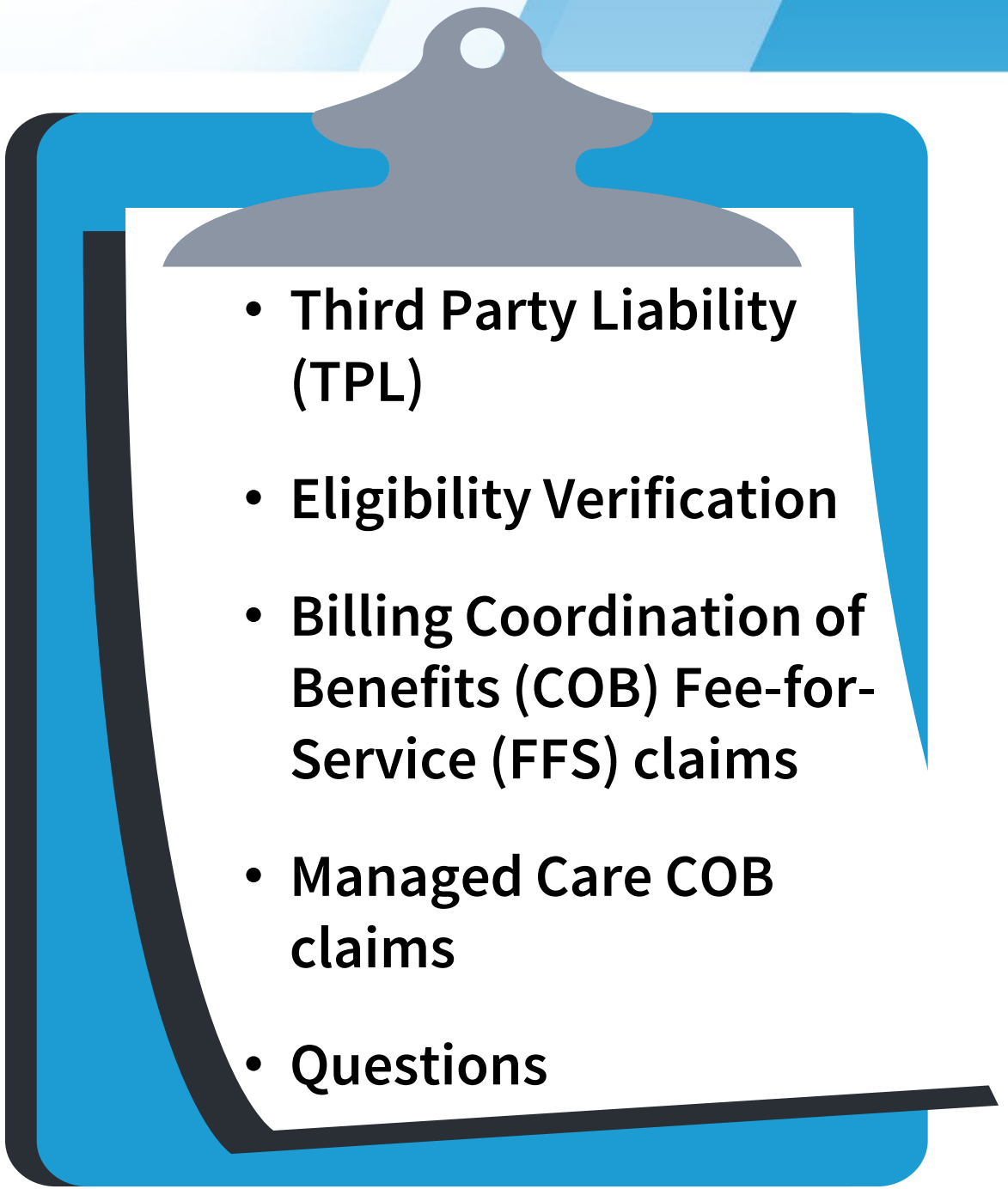
Today’s presentation is attached in the chat section, you can download it there



Submit your questions and comments via the Q&A box- responses will be provided verbally and/or as a direct response to you

Make sure to check the chat box for messages that may be sent to all attendees

Agenda



- Third Party Liability (TPL)
- Eligibility Verification
- Billing Coordination of Benefits (COB) Fee-for-Service (FFS) claims
- Managed Care COB claims
- Questions

Introduction

- **<u>Third Party Liability (TPL)</u>: when another insurance is responsible to pay before Medicaid.**
- TPL requirements apply when a Medicaid member has more than one source of health coverage, such as commercial insurance or Medicare, and ensures Medicaid is the payer of last resort
- TPL became a required part of the ODM Fee for Service (FFS) claims process for doula services beginning July 1, 2026, due to doula services beginning to be covered under some commercial health plans

ODM Coordination of Benefits Policy

- Rule 5160-1-08- Ohio Administrative Code | Ohio Laws

- Coordination of benefits (COB): when a Medicaid member has Medicaid and another insurance, it must be determined who pays first. **Medicaid is the payer of last resort and pays only after all other insurance options are used**

- Third Party: any insurance other than Medicaid. Examples of a third-party payers include:
  - **private/commercial health insurance**
  - accidental insurance
  - Medicare
  - CHAMPUS
  - Worker's compensation

- Third Party Benefit: when payment for the health service is the full or partial responsibility of the Third-Party Payer

General Reimbursement Principles:

OAC 5160-1-02

Medicaid Payment:

OAC 5160-1-60

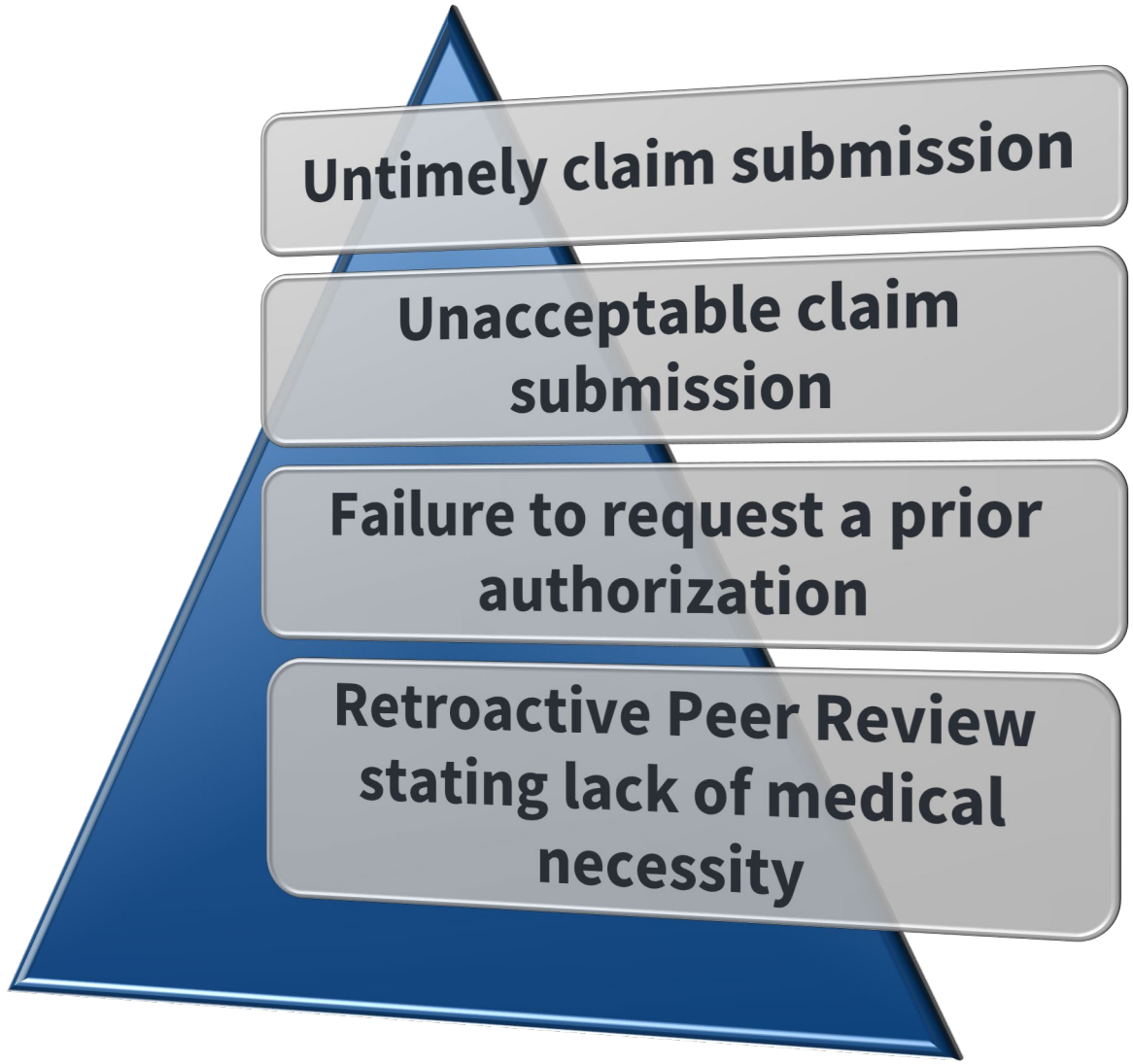
The department's payment constitutes payment-in-full for any of our covered services

Providers are expected to bill the department their Usual and Customary Charges (UCC)

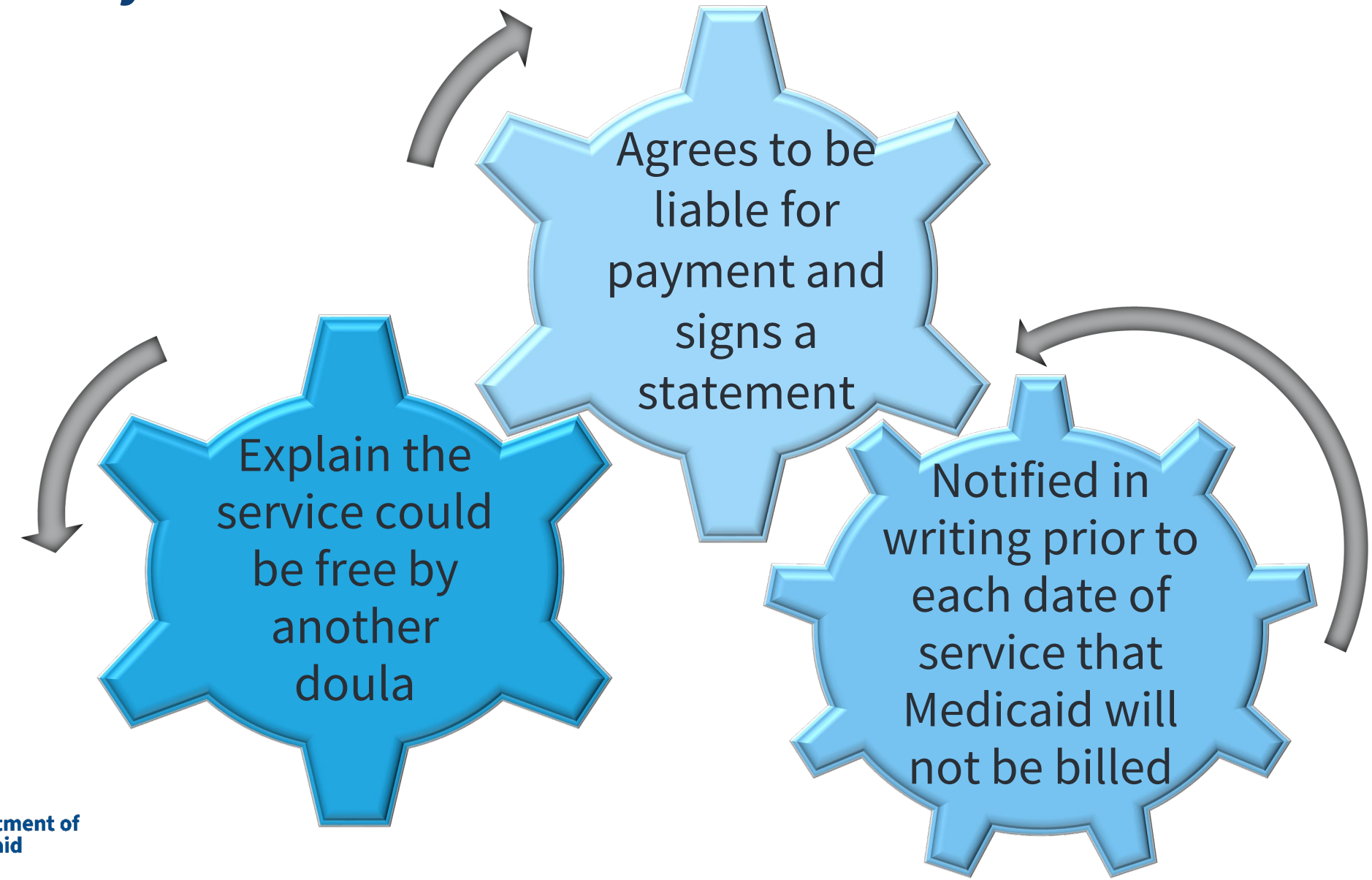
The department will reimburse the provider the lesser of the Medicaid maximum allowable rate (established fee schedule) or the UCC

Medicaid Consumer Liability 5160-1-13.1

A provider may **NOT** collect and/or bill for any difference between the Medicaid payment and the provider's charge, as well as for the following:



When Can you Bill an Individual on Medicaid?



Department of Medicaid

Medicaid Recovery Process

Medicaid may recover money from another insurer later. If a Medicaid member requests financial statements for a legal matter:

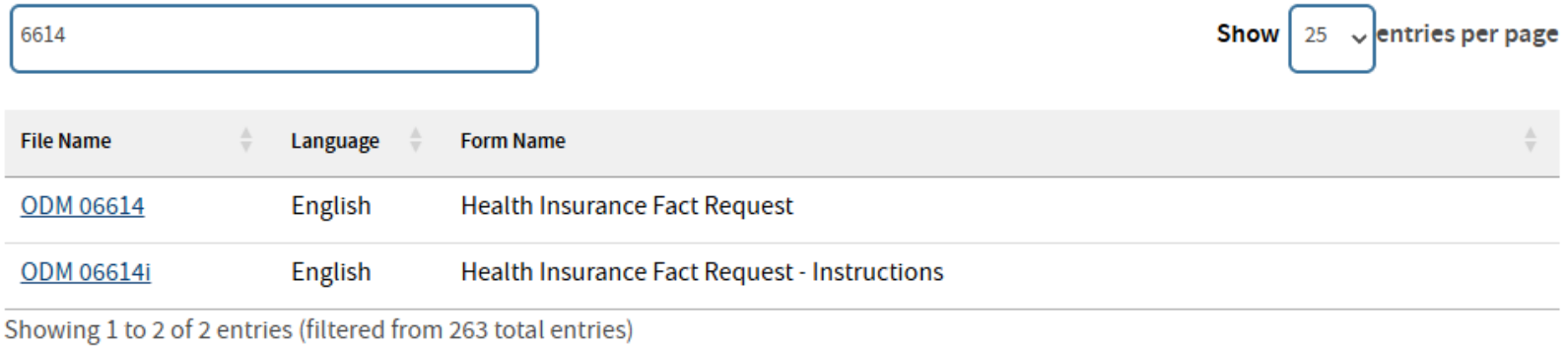
You must:

- Get the request in writing
- Notify Medicaid immediately
- Provide the statement within 30 days
- Stamp it with required Medicaid recovery language: "SUBJECT TO RIGHT OF RECOVERY PURSUANT TO SECTION 5160.37 OF THE OHIO REVISED CODE. FAILURE TO COMPLY MAY RESULT IN PERSONAL LIABILITY."

Eligibility Verification

Is There Other Health Coverage?

- Ask Medicaid members whether they have any insurance other than Medicaid
- Consider adding insurance questions to your intake form if not already included
  - » Consider getting copies of all their insurance cards for you records
- If a Medicaid member reports they have other coverage and it is not reflected in your eligibility lookup search, complete the ODM 06614 form- Health Insurance Fact Request to report the coverage and submit the form to ODM
  - » Advise the individual this must also be reported to their County Job & Family Service (CDJFS) office
  - » https://medicaid.ohio.gov/stakeholders-and-partners/legal-and-contracts/forms/forms
    - Type 6614 in the forms search field – follow the instructions to complete the form

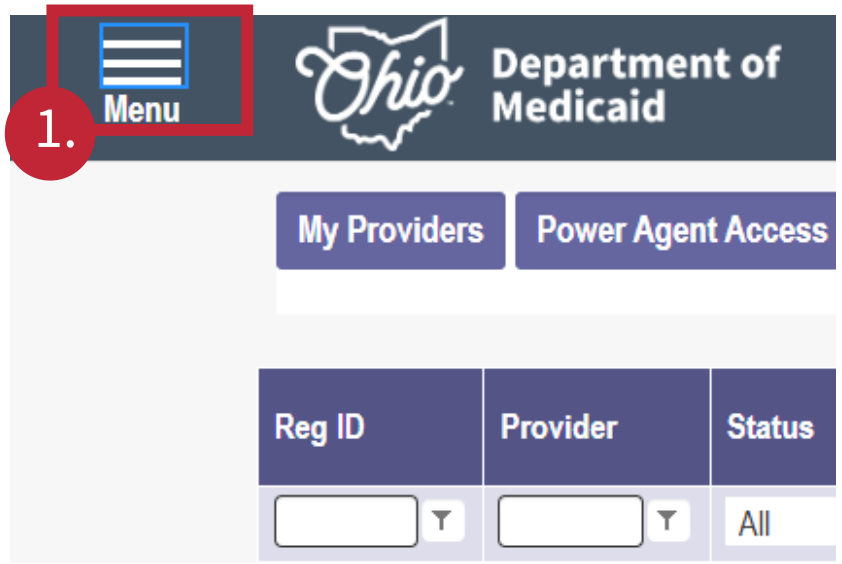


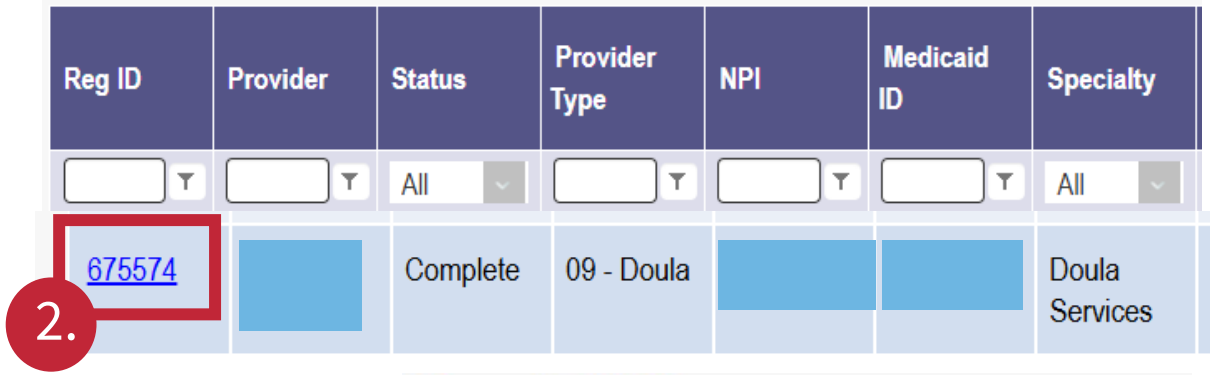
Step 1: Verify Eligibility and Coverage

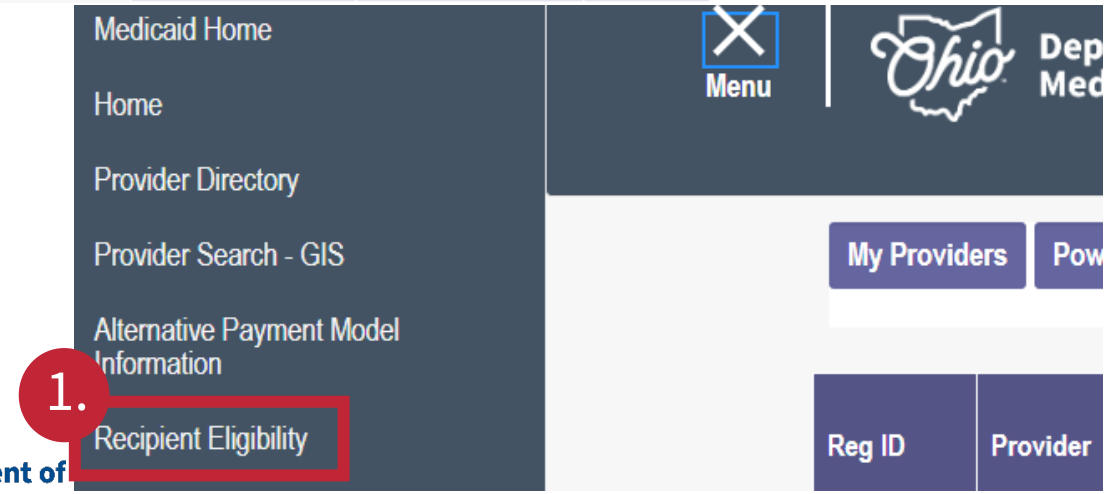
- Log into the Provider Network Management (PNM) module – provider portal
  - » https://ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx
- If you are a PNM Admin user or Power Agent User, you are able to do an eligibility search two ways:
  1. Click 'Recipient Eligibility' link in the left-hand Menu
  2. Click on a provider file on your dashboard
- If you are a PNM Agent user, you are able to do an eligibility search one way:
  2. Click on a provider file on your dashboard
- Best practice is to review eligibility all throughout your client's pregnancy
  - » Examples: MCO coverage could change to another MCO, change between fee-for-service vs MCO coverage, other health insurance coverage could begin or end, etc.

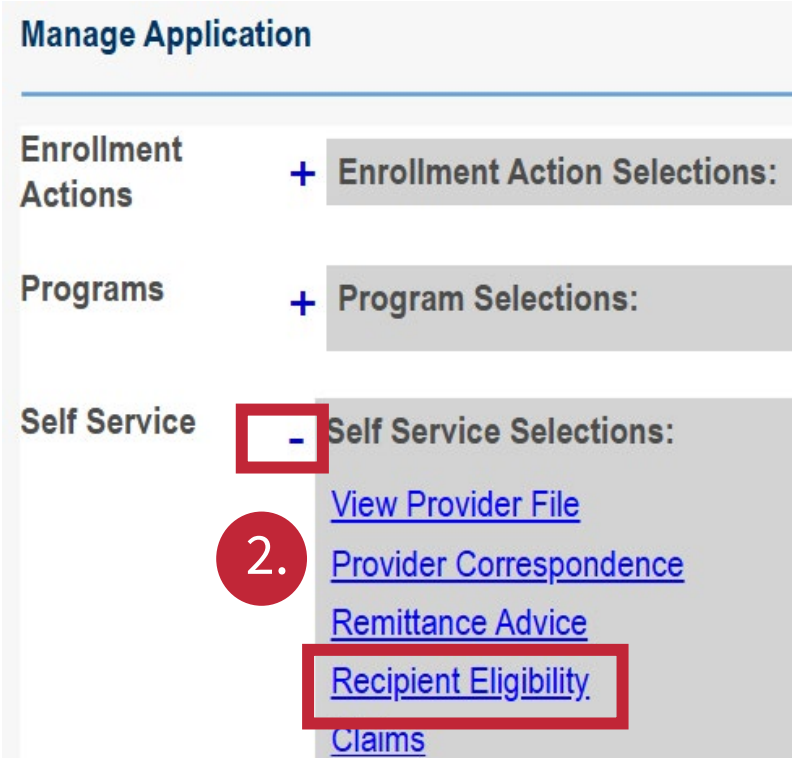
Two Ways to Verify Eligibility in PNM

- Screenshots for both PNM User paths



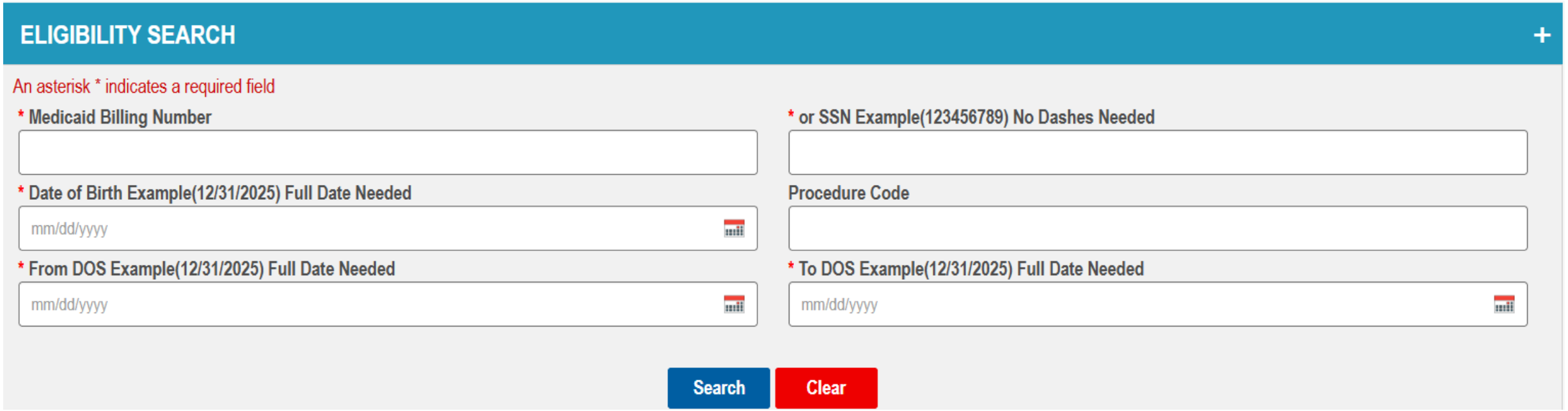






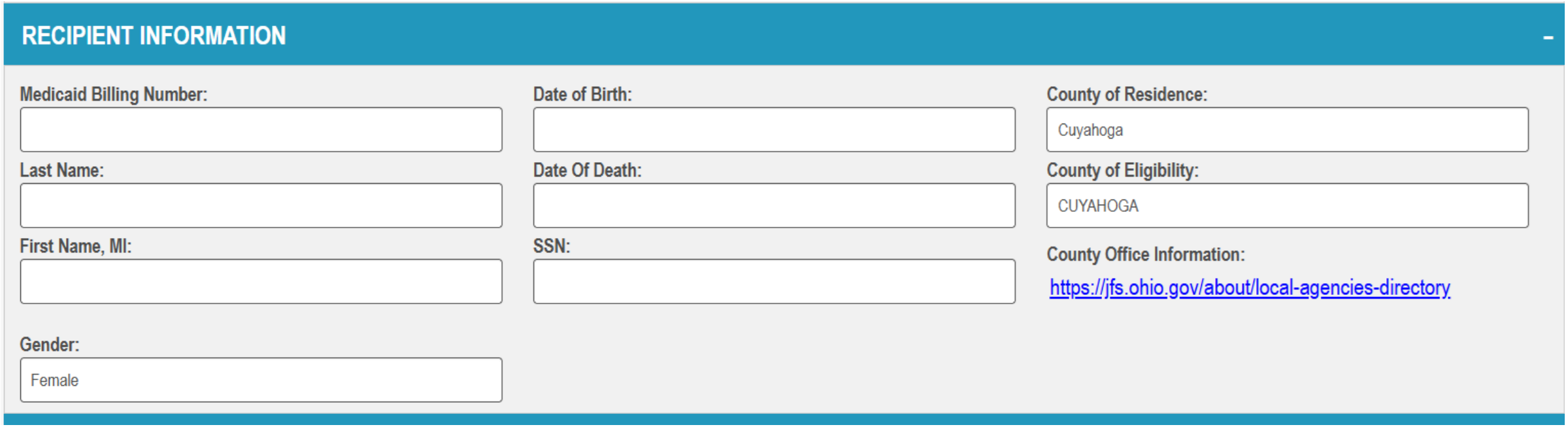
PNM Eligibility Search

- Enter in two key pieces of information – Medicaid billing number OR the SSN
- Enter date of birth (DOB)
- Enter a From and To date of service (DOS) – the To DOS cannot be a future date



PNM Eligibility Search Results

- The first three panels will populate with the Medicaid individual's information
  - » Recipient Information
  - » Benefit/Assignment Plan(s)
  - » Managed Care Plans



PNM Eligibility Search Results, cont.

- Whether the individual has full Medicaid coverage for the DOS and if applicable the managed care coverage will also display

BENEFIT/ASSIGNMENT PLAN(S)

Benefit/Assignment Plan	Effective Date	End Date
MAGI:Alternative Benefit Plan Medicaid Expansion	04/01/2026	07/31/2026
MAGI:Alcohol and Drug Addiction Services	04/01/2026	07/31/2026
MAGI:Medicaid	04/01/2026	07/31/2026
MAGI:HMO, CFC	04/01/2026	07/31/2026
MAGI:MRDD Targeted Case Mgmt	04/01/2026	07/31/2026
MAGI:Ohio Mental Health	04/01/2026	07/31/2026

MANAGED CARE PLANS

Plan Name	Payer ID	Plan Description	Effective Date	End Date	Managed Care Benefits
Anthem Medicaid MCE	0464229	Anthem Medicaid MCE	04/01/2026	07/31/2026	MEDICAID ONLY

PNM Eligibility Search Results, cont.

- Other panels, like the Third Party Liability panel will need opened – click the + to expand



PNM Eligibility Search Results, cont.

- When there is no TPL coverage, you will see only a – sign and the panel will not expand



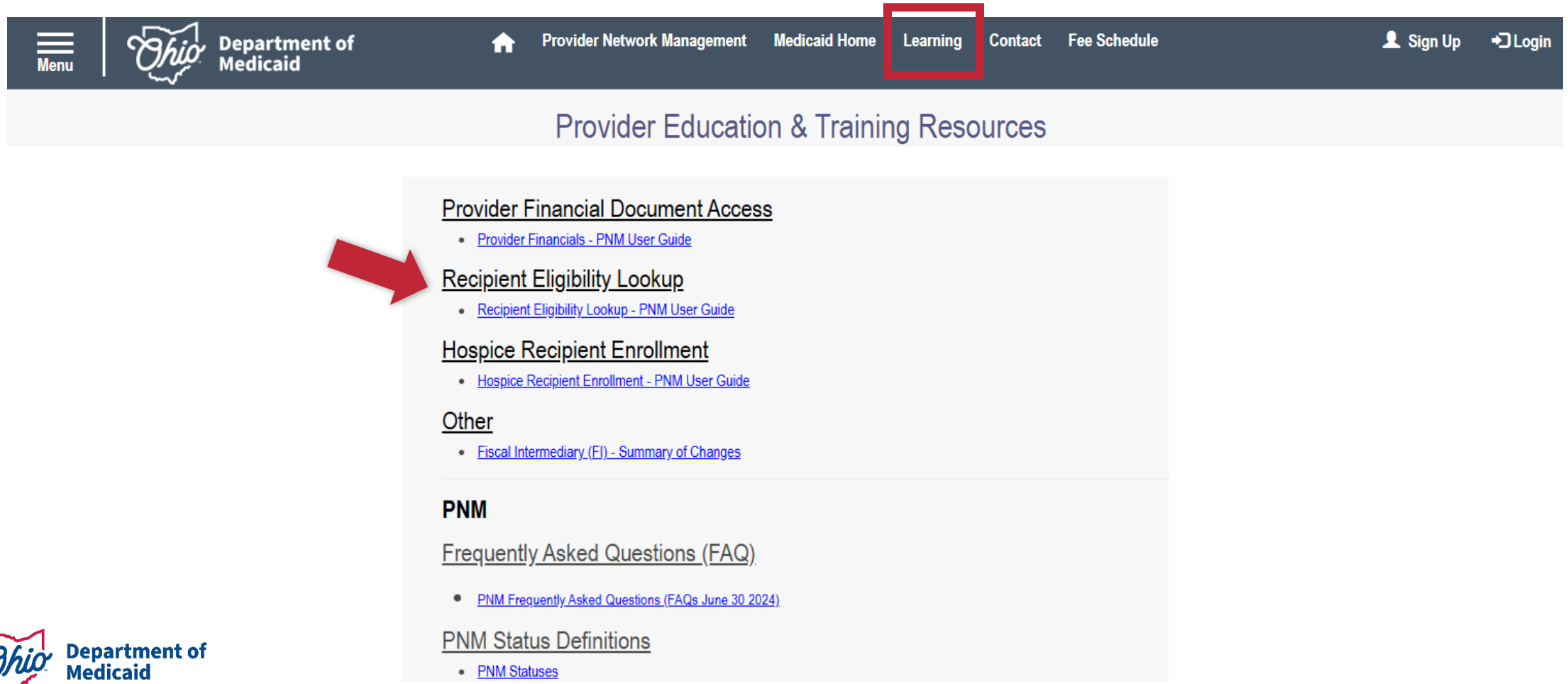
- When there is TPL coverage, the panel will expand and the information will be shown
  - » Pay close attention to the type of coverage to make sure the individual has full medical coverage
    - TPL coverage could be limited – dental, vision, behavioral health, pharmacy, etc.

THIRD PARTY LIABILITY -

Carrier Name	Carrier Number	NAIC	Policy Number	Policy Holder	Coverage Type	Coverage	Effective Date	End Date	Group Number
UNITED HEALTHCARE	15648		702419		Unknown	COB Comprehensive	03/04/2005	12/31/2078	
UNITED HEALTHCARE	15648		702419		Unknown	COB Hospital Only	10/02/2006	12/31/2078	

PNM Provider Resources

- PNM Learning Tab – many resources, including the Recipient Eligibility Lookup – PNM User Guide



Billing COB FFS Claims

If the Third-Party Insurer Pays the Member…

- Sometimes an insurance sends payment directly to the patient
  - » Ask your client to forward or sign over the payment to you
  - » If the client does not cooperate, report it to the CDJFS – reference this rule

- Conditions of Eligibility and Verification: OAC 5160:1-2-10(B)(6)
  - » They must cooperate with requests from third-party insurance companies to provide additional information needed in order to authorize coverage
  - » They must cooperate with requests from a Medicaid provider for additional information which is needed in order to bill a third party insurance appropriately
  - » They must forward or return to the third-party insurance, any payments received from that insurance company

Step 2: Bill Third- Party Insurance (when identified)

- When another third-party insurance has been identified, doulas should obtain the name and address of the insurance company, and any other necessary information needed to bill the insurance company
- Doulas may want to contract with private insurers to receive reimbursement
- **Doulas must bill the third-party insurance according to their stated billing process prior to billing Medicaid**

What is a CARC?

- **Reference X12-** https://x12.org/codes/claim-adjustment-reason-codes
  - » Claim Adjustment Reason Codes (CARCs) explain why a health insurance claim was paid differently than it was billed
    - Common Group Codes are:

About Claim Adjustment Group Codes

Did you receive a code from a health plan, such as: PR32 or CO286? The "PR" is a Claim Adjustment Group Code and the description for "32" is below. The Claim Adjustment Group Codes are internal to the X12 standard. These codes generally assign responsibility for the adjustment amounts. The format is always two alpha characters. For convenience, the values and definitions are below:

CO	Contractual Obligation
CR	Corrections and Reversal *Note: This value is not to be used with 005010 and up.*
OA	Other Adjustment
PI	Payer Initiated Reductions
PR	Patient Responsibility

What is a CARC?, cont.

- **Reference X12-** https://x12.org/codes/claim-adjustment-reason-codes
  - » Group Codes are always paired with Reason Codes
    - Common Reason Codes are:

1	**Deductible Amount** *Start: 01/01/1995*
2	**Coinsurance Amount** *Start: 01/01/1995*
3	**Co-payment Amount** *Start: 01/01/1995*
96	**Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*

What is an EOB?

- An Explanation of Benefits (EOB) is a statement from an insurance company detailing how a medical claim was processed

- Key details found on an EOB:
  - **Patient & Provider Information:** Identifies the person who received the care, policy details, doula or practice name, and the claim number
  - **Service Details:** Lists the date of service and procedure codes T1032 or T1033
  - **Total Billed Amount:** The initial fee the doula charges for the service
  - **Allowed Amount:** The pre-negotiated rate the insurance company has agreed to pay for the service
  - **Plan Paid:** The portion of the allowed amount that the insurance plan covered
  - **Patient Responsibility:** The amount that the patient may owe, which includes **copay, coinsurance**, or **amounts applied to the deductible** that Medicaid would share the costs

What is an EOB?, cont.

Example!

Horizon

PO BOX 820
NEWARK NJ 07101-0820

CUSTOMER SERVICE
1-800-355-2583
MO-TU-WE-FR 8AM-6PM
THUR 9AM-6PM
VISIT WWW.HORIZONBLUE.COM

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

SUBSCRIBER NAME: JANE DOE

SUBSCRIBER ID: 3HZN12345678

SUMMARY INFORMATION

CLAIM NUMBER	PATIENT NAME	RELATION	GROUP NUMBER	AMOUNT BILLED	YOUR PLAN PAID	WHAT YOU OWE
901234567890123 00	JANE DOE	SELF	000012345	4,000.00	2,160.00	1,840.00

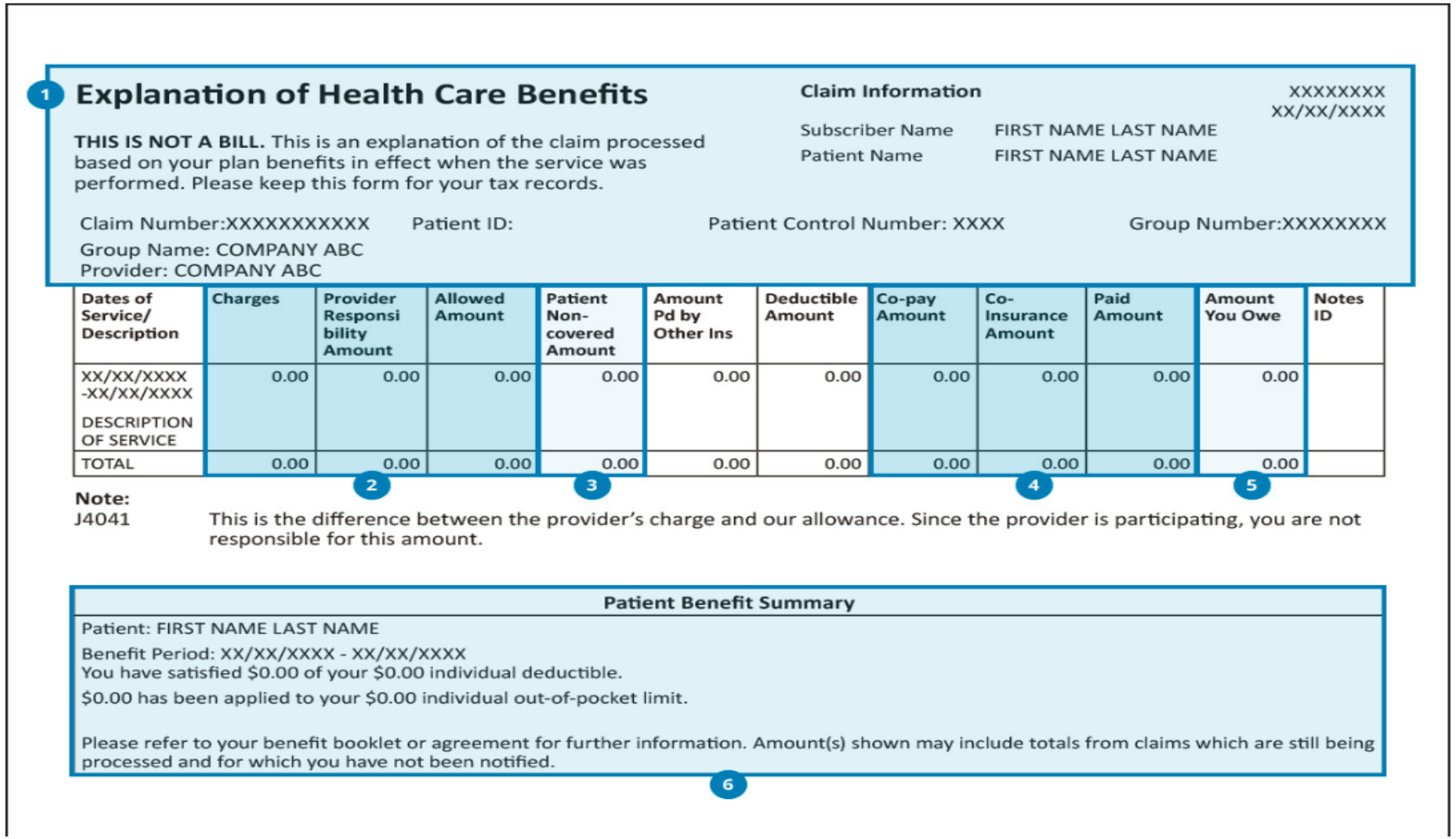
DETAIL INFORMATION

A DATE OF SERVICE	B PROVIDER TYPE OF SERVICE	C AMOUNT BILLED	D ALLOWED AMOUNT	E YOUR PLAN PAID	F YOUR OTHER INSURANCE PAID	G COPAY	H COINSURANCE	I DEDUCTIBLE	J AMOUNT NOT COVERED	K WHAT YOU OWE	L CLAIM DETAIL
03/08/2021	ANYTOWN MEDICAL CENTER SPECIALTY ROOM	2,000.00	2,000.00	360.00		100.00	40.00	1,500.00		1,640.00	Z189
03/08/2021	ANYTOWN MEDICAL CENTER LABORATORY	2,000.00	2,000.00	1,800.00			200.00			200.00	
	TOTAL	**4,000.00**	**4,000.00**	**2,160.00**		**100.00**	**240.00**	**1,500.00**		**1,840.00**	**Z084a Y596a Z036 Z028**

Ohio Department of Medicaid

What is an EOB?

Example!



1 Explanation of Health Care Benefits

THIS IS NOT A BILL. This is an explanation of the claim processed based on your plan benefits in effect when the service was performed. Please keep this form for your tax records.

Claim Information XXXXXXXX
XX/XX/XXXX

Subscriber Name FIRST NAME LAST NAME
Patient Name FIRST NAME LAST NAME

Claim Number:XXXXXXXXXXX Patient ID: Patient Control Number: XXXX Group Number:XXXXXXXX

Group Name: COMPANY ABC
Provider: COMPANY ABC

Dates of Service/ Description	Charges	Provider Responsibility Amount	Allowed Amount	Patient Non-covered Amount	Amount Pd by Other Ins	Deductible Amount	Co-pay Amount	Co-Insurance Amount	Paid Amount	Amount You Owe	Notes ID
XX/XX/XXXX -XX/XX/XXXX DESCRIPTION OF SERVICE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
TOTAL	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	

2 3 4 5

Note:
J4041 This is the difference between the provider's charge and our allowance. Since the provider is participating, you are not responsible for this amount.

Patient Benefit Summary

Patient: FIRST NAME LAST NAME

Benefit Period: XX/XX/XXXX - XX/XX/XXXX
You have satisfied $0.00 of your $0.00 individual deductible.

$0.00 has been applied to your $0.00 individual out-of-pocket limit.

Please refer to your benefit booklet or agreement for further information. Amount(s) shown may include totals from claims which are still being processed and for which you have not been notified.

6

What if Private Insurance Does Not Cover Doula Services?

- Efforts to expand doula coverage requirements in private insurance are gaining momentum but we know that not all commercial insurance will cover the service yet
  - » The EOB should report PR or CO 96 to indicate that the service is not covered
  - » See later claim examples on how this is entered on your Medicaid FFS claim

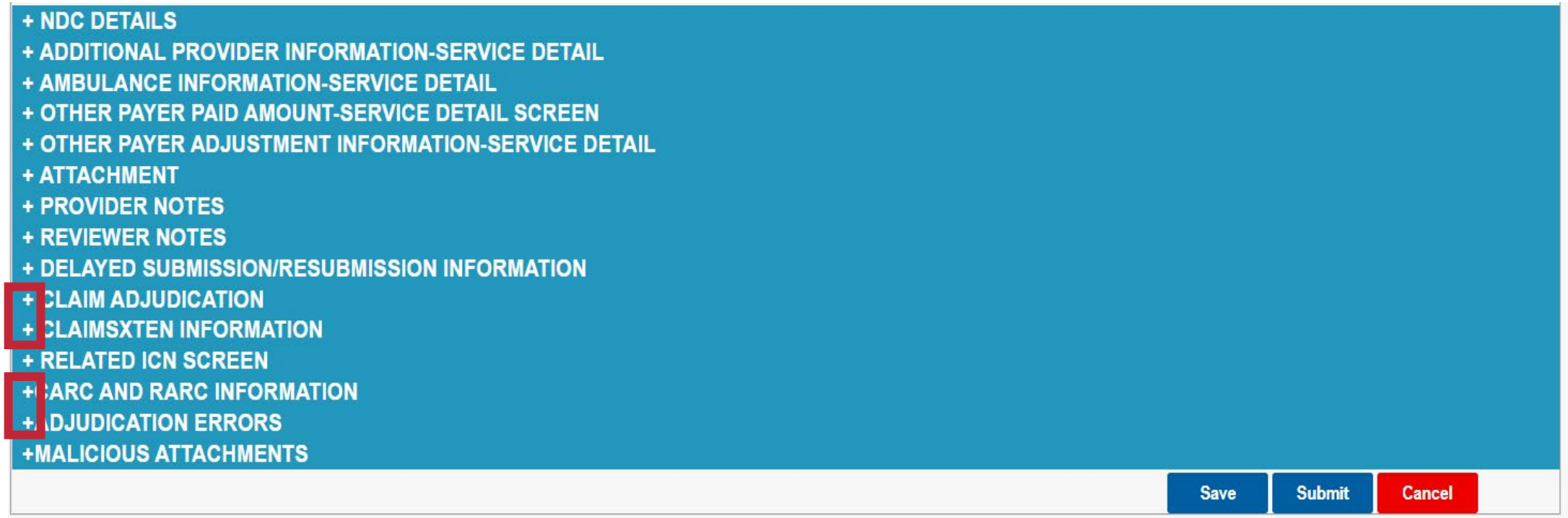
96	**Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*

Step 3: Billing Medicaid

- The other insurance has already paid, or the rate was applied in total across the individual's deductible, coinsurance, or co-payment for the third-party benefit
- The other insurance denied the claim for a valid reason (e.g. not covered, not eligible)
- Doula has taken “reasonable measures” to bill the other insurance but:
  - » They didn’t respond within 90 days after no less than 3 claims submissions within 90 days (90 days starts from the date of the last claim submission) or
  - » You have documentation showing the doula service is not covered
- In order to bill Medicaid, one of the following documents will be needed during the claims submission process:
  - » Explanation of Benefits (EOB)
  - » Having written documentation from 3rd party payer proving the doula service is not covered
  - » Documentation of submitting a claim 3 times in 90 days with no response after 90 days

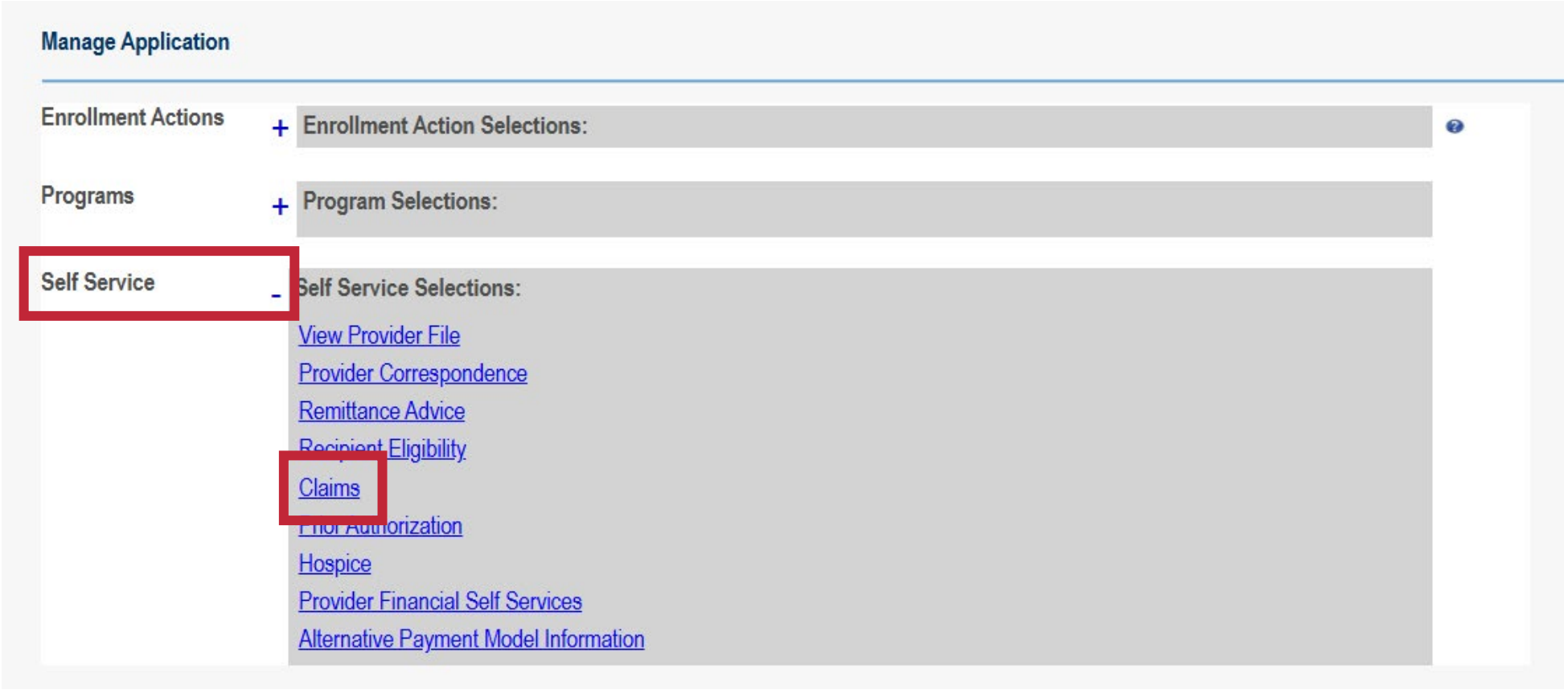
What Happens When TPL is Not Reported on the Claim and the Patient has Other Insurance?

- Claim will deny with edit 378 (No COB Amount on claim)
- Open the desired panels on your claim to see any denial edit reasons



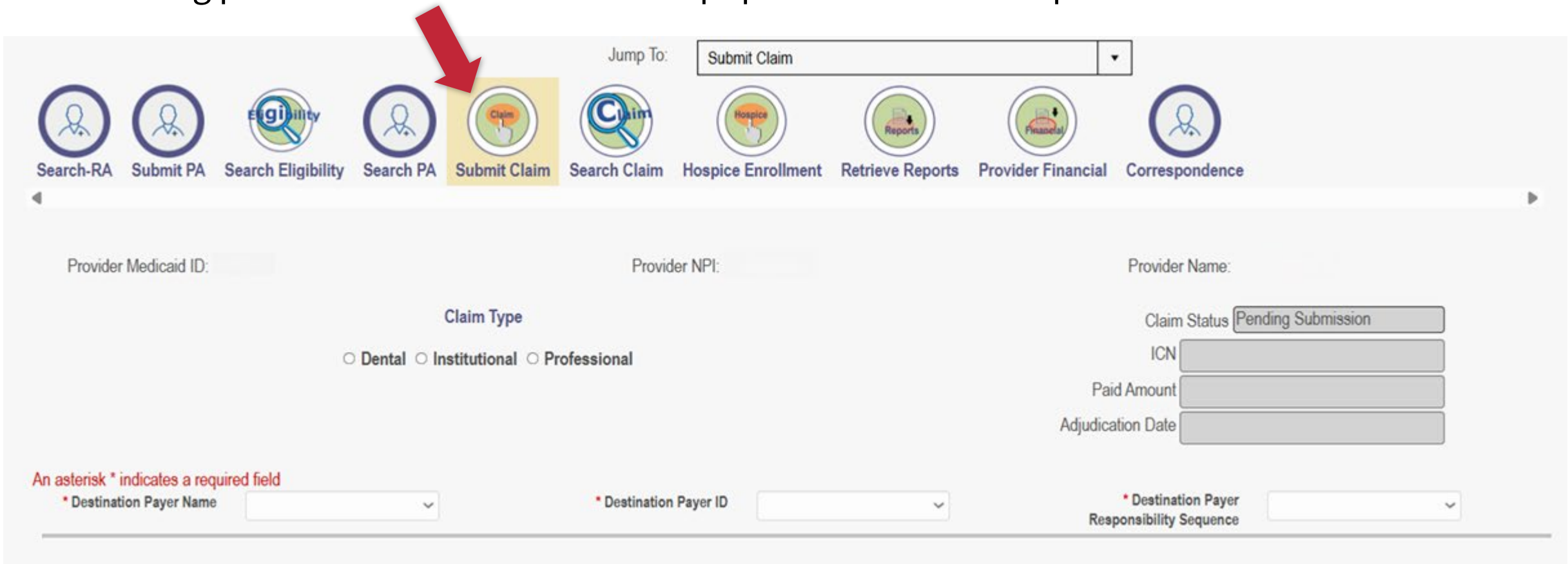
COB FFS Claim Submission

- Log into PNM and click on the provider file of the billing provider
- Click on the + to expand the Self Service section
- Click on Claims



COB FFS Claim Submission, cont.

- Click on Submit Claim and a new blank claim will open
  - » The billing provider information will auto populate across the top of the claim



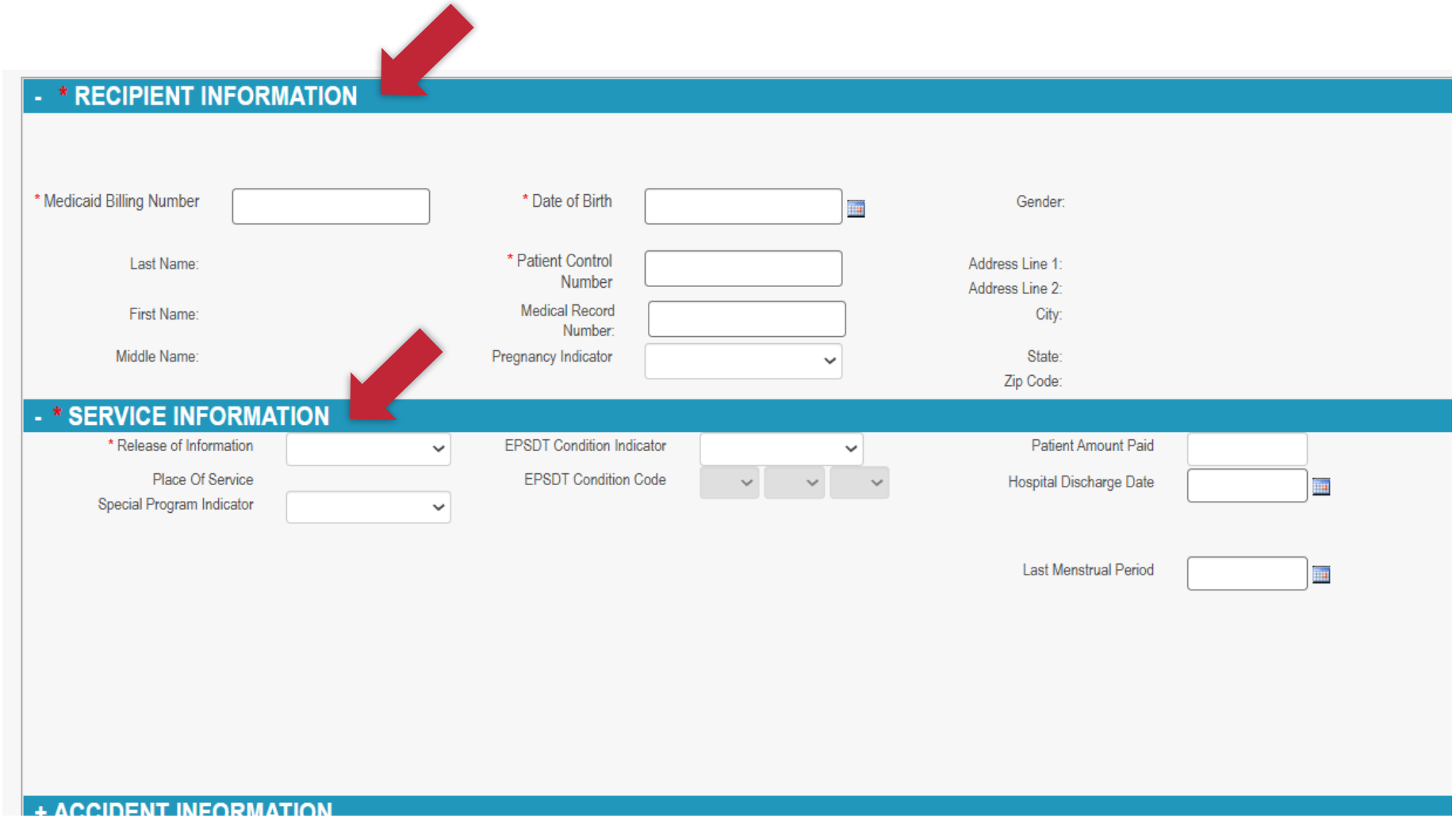
COB FFS Claim Submission, cont.

- Select Professional for your claim type
- Destination Payer Name – select ODM
  - » The Destination Payer ID will auto populate
- Destination Payer Responsibility Sequence – select Secondary if your client has only one other insurance other than Medicaid
  - » If your client has two other insurances, select Tertiary



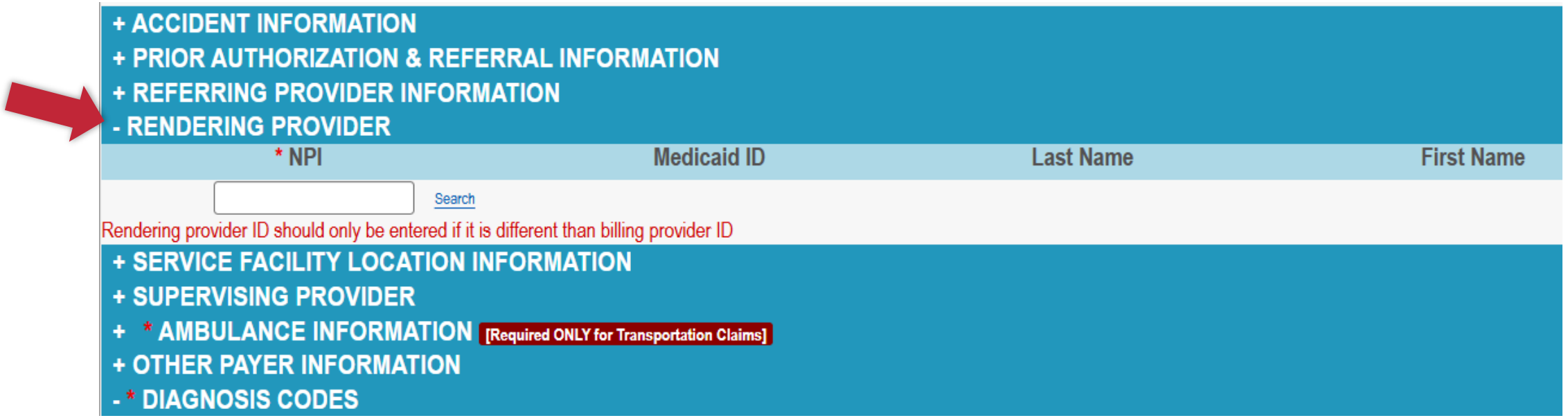
COB FFS Claim Submission, cont.

- Recipient Information Panel
  - » Enter in your client's Medicaid billing number and DOB
  - » Enter a Patient Control Number
- Service Information Panel
  - » Release of Information – select yes or no in the dropdown



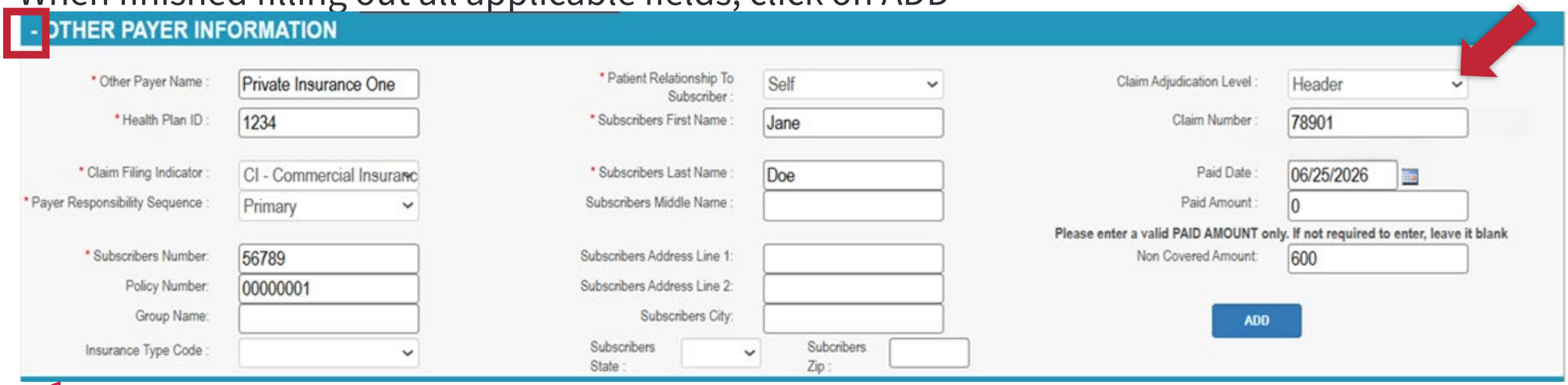
COB FFS Claim Submission, cont.

- If a group is the billing provider, the Rendering Provider panel will need expanded and the doula's NPI will need entered
  - » If the NPI is not known, click Search, and click on the appropriate NPI once found – it will populate into the field
- If an individual doula is billing the claim, this panel may be skipped



COB FFS Claim Submission, cont.

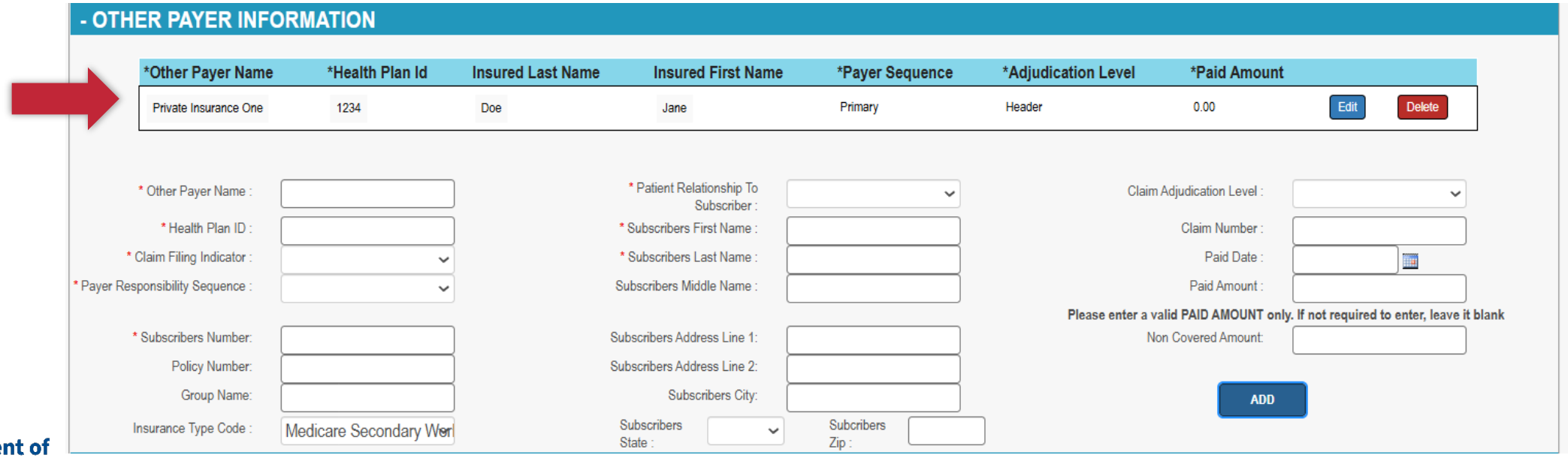
- Click the + to open the Other Payer Information panel – this is where you report the primary insurance and whether the insurance paid anything
  - » At a minimum, complete all the fields with a red *
  - » Selecting Self in the Patient Relationship to Subscriber dropdown will auto populate your client's name and address information
- When finished filling out all applicable fields, click on ADD



Claim Adjustment Level – Header or Detail?

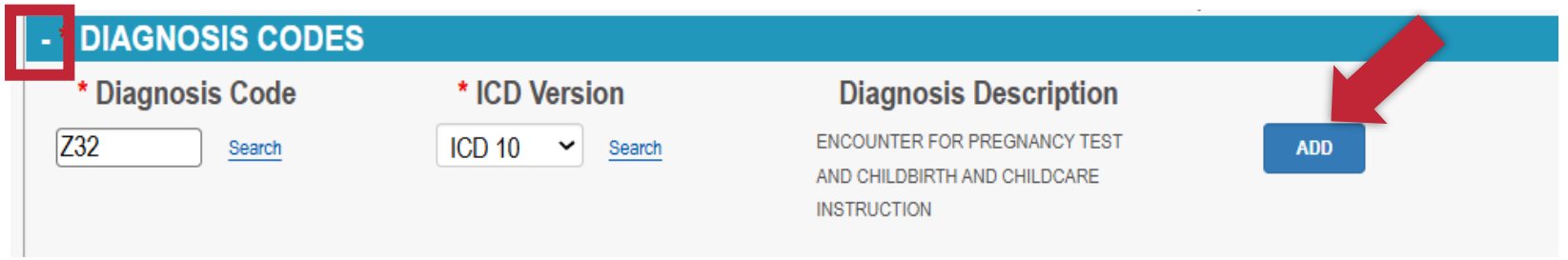
COB FFS Claim Submission, cont.

- After clicking ADD, if there are no errors, a new row will populate at the top of the panel saving the information you just entered
  - » Click edit to repopulate the information into the fields to make edits
  - » Click delete if you want to remove all the information in that row from the claim
- If your client has multiple other insurances other than Medicaid, you will need to repeat these steps to enter the next insurance

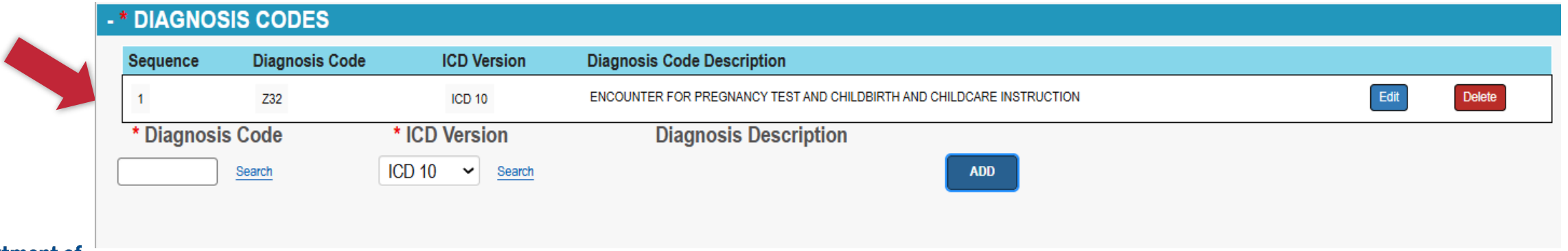


COB FFS Claim Submission, cont.

- Click on the + to expand the Diagnosis Codes panel
  - » If diagnosis is unknown, click Search and click on the appropriate code once found – it will auto populate into the field
  - » If known, enter it with no decimal
  - » Click ADD to populate the Diagnosis Description

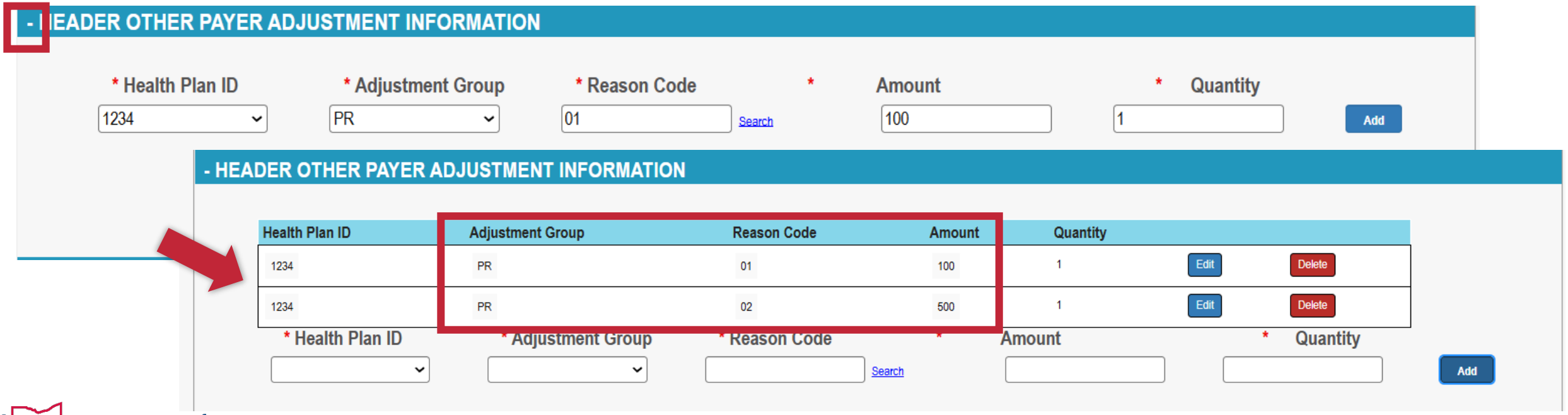


- Click ADD a **second time** to save the information and populate the row at the top



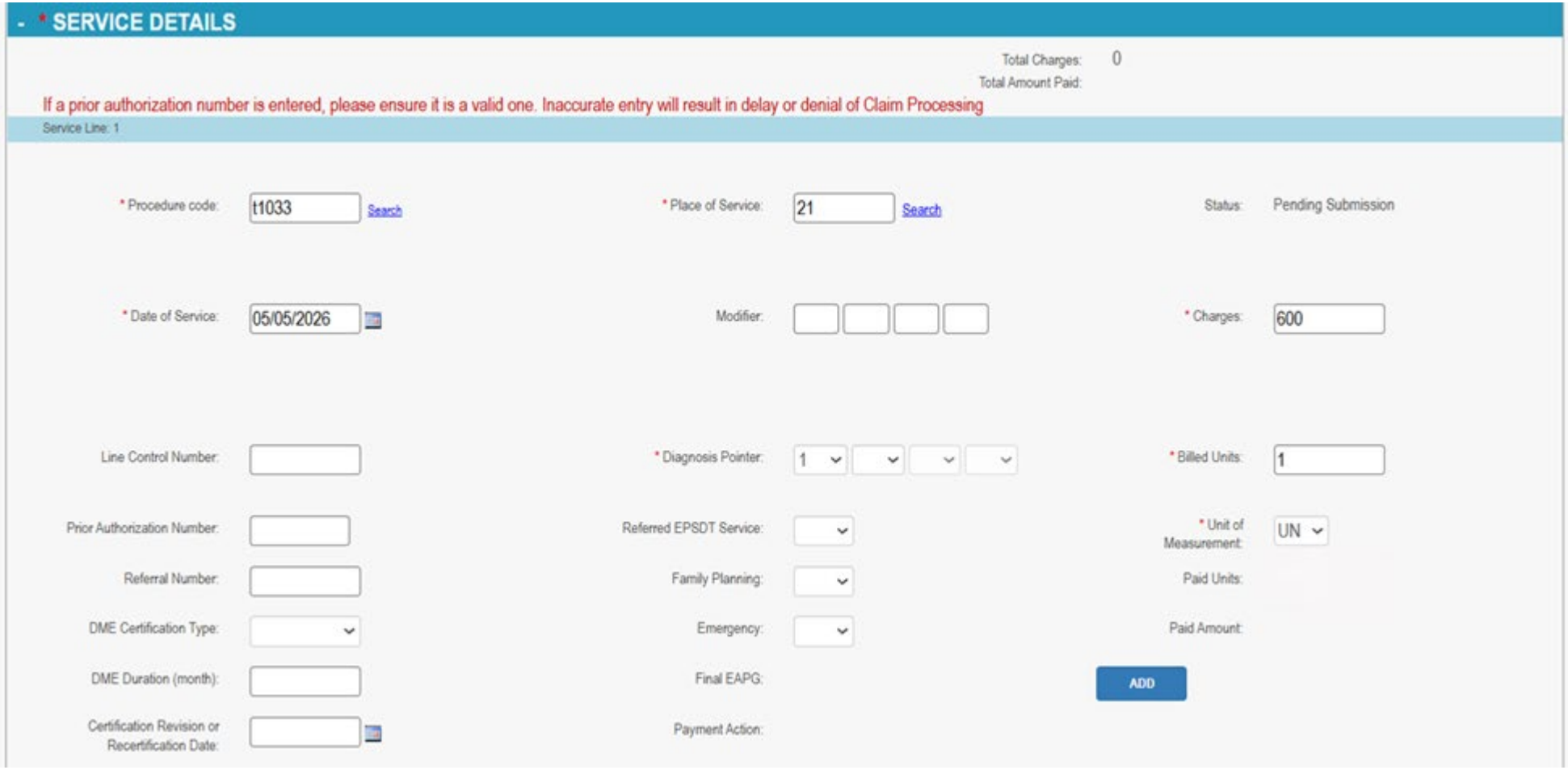
COB FFS Claim Submission, cont.

- Did the primary insurance process at the **header** or the **detail**?
  - » If at the **header**, you will need to complete the Header Other Payer Adjustment Information panel
  - » Click the **+** to expand this section and complete it
  - » Complete each field based on the EOB you received and click ADD to save the information
  - » If there are multiple CARCs are on your EOB, you will need to enter each one – equal total billed charges



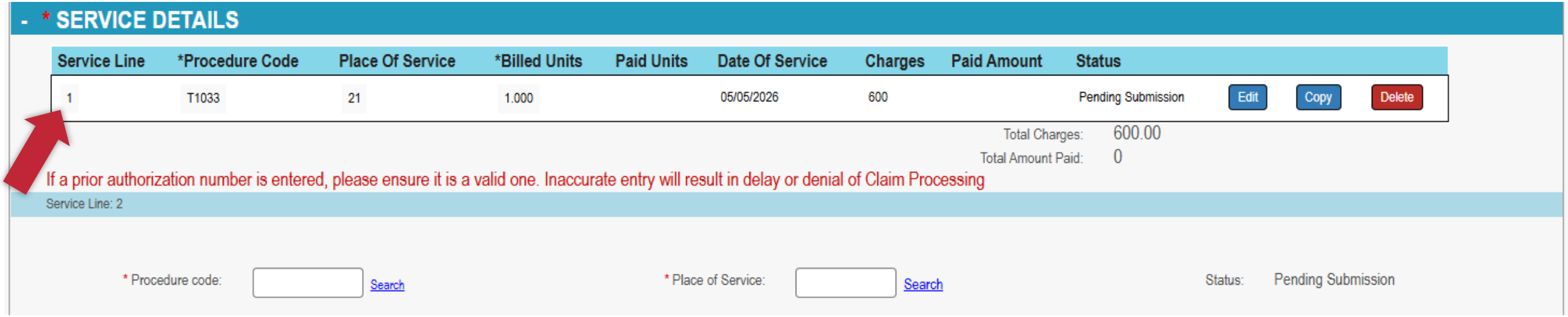
COB FFS Claim Submission, cont.

- Click on the + to expand the Service Details panel and complete it
  - » The DOS and doula service should match what was billed on the primary's claim



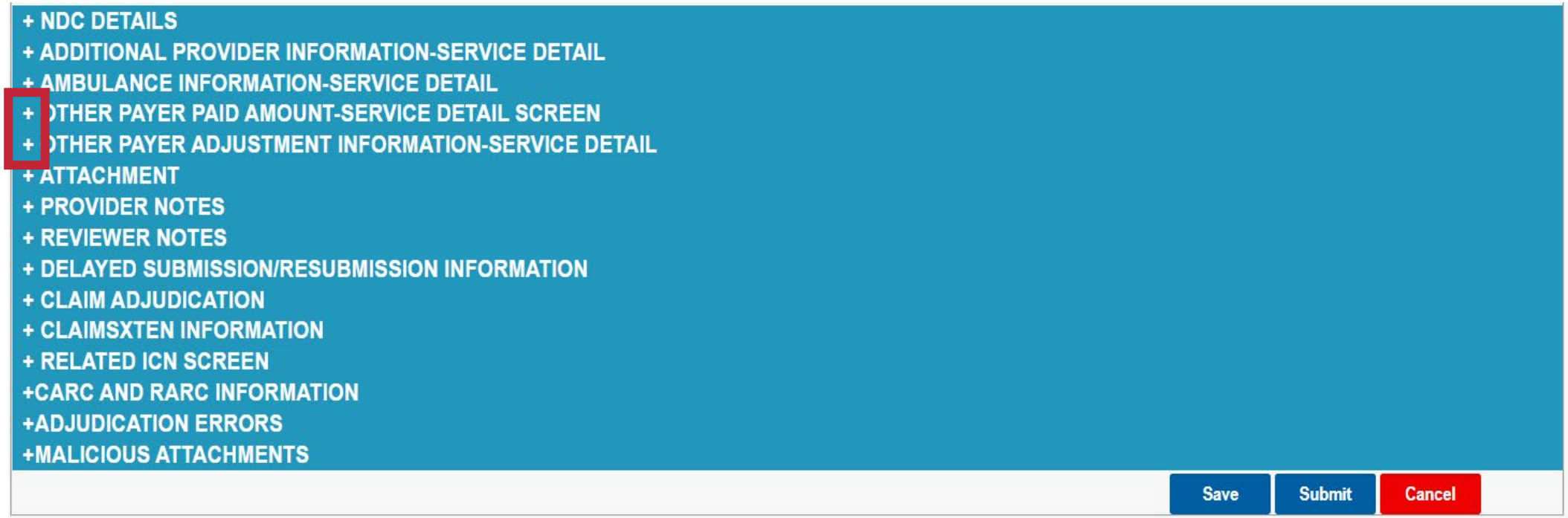
COB FFS Claim Submission, cont.

- Once finished filling out all applicable fields, click on ADD
  - » The saved row will show a status of Pending Submission and total amount paid as zero until the claim has been submitted and adjudicated
  - » If multiple services need to be billed, there will need to be a row for each doula service – each row will be numbered (Service Line 1, Service Line 2, etc.)



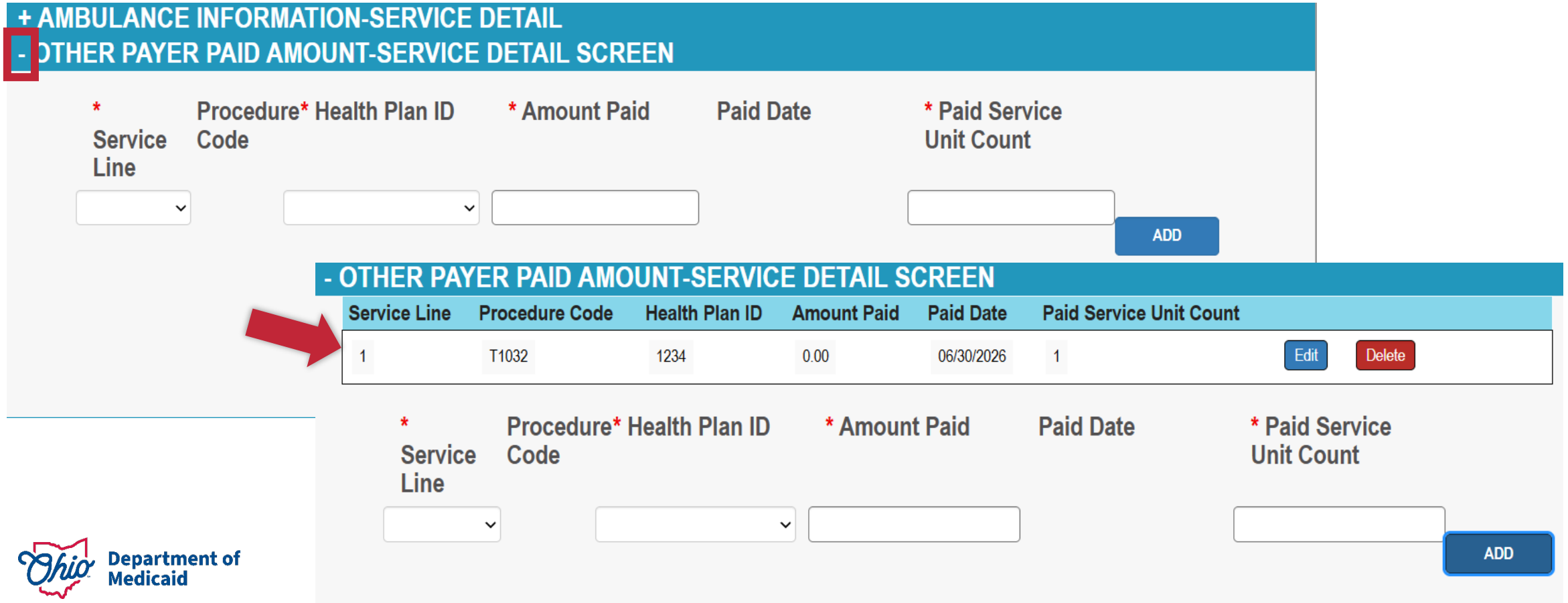
COB FFS Claim Submission, cont.

- Did the primary insurance process at the **header** or the **detail**?
  - » If at the **detail**, you will need to complete the Other Paid Amount-Service Details Screen and Other Payer Adjustment Information-Service Detail panels
  - » Click the + to expand each section and complete them



COB FFS Claim Submission, cont.

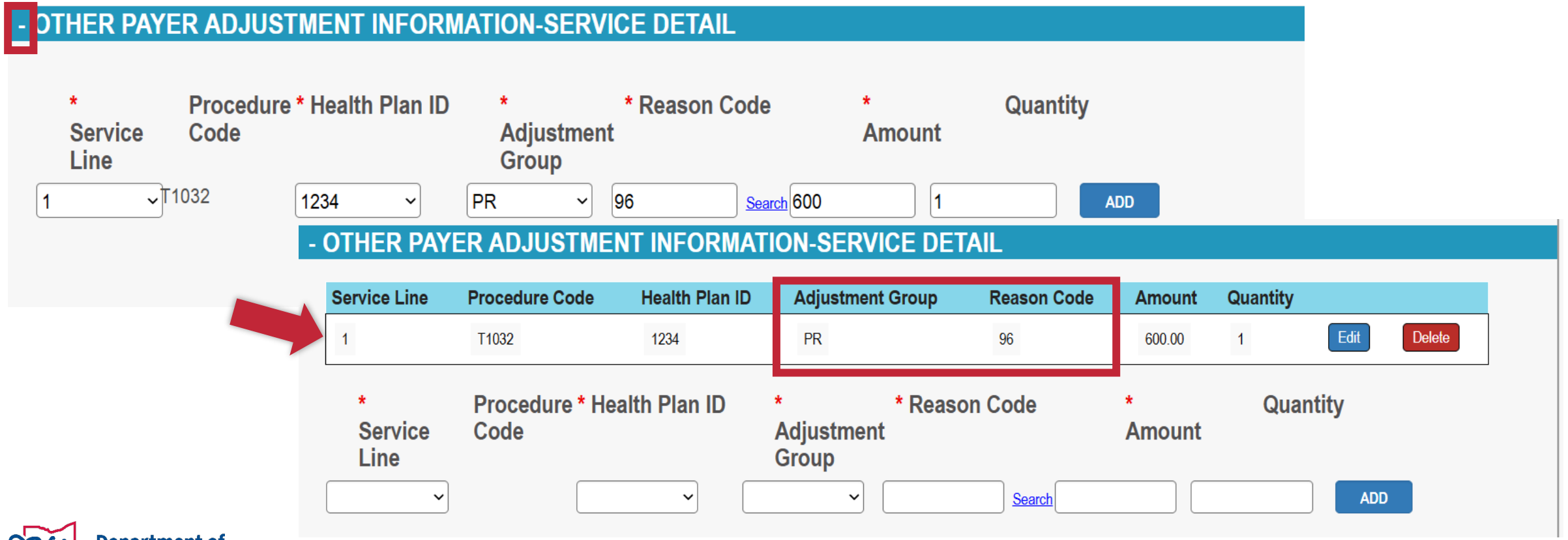
- Enter how much the primary payer paid, for each doula service, even if zero
  - » If multiple services were billed to primary, there will need to be a ‘row’ for what was paid on each service
  - » Complete each field based on the EOB you received and click ADD to save the information



Department of Medicaid

COB FFS Claim Submission, cont.

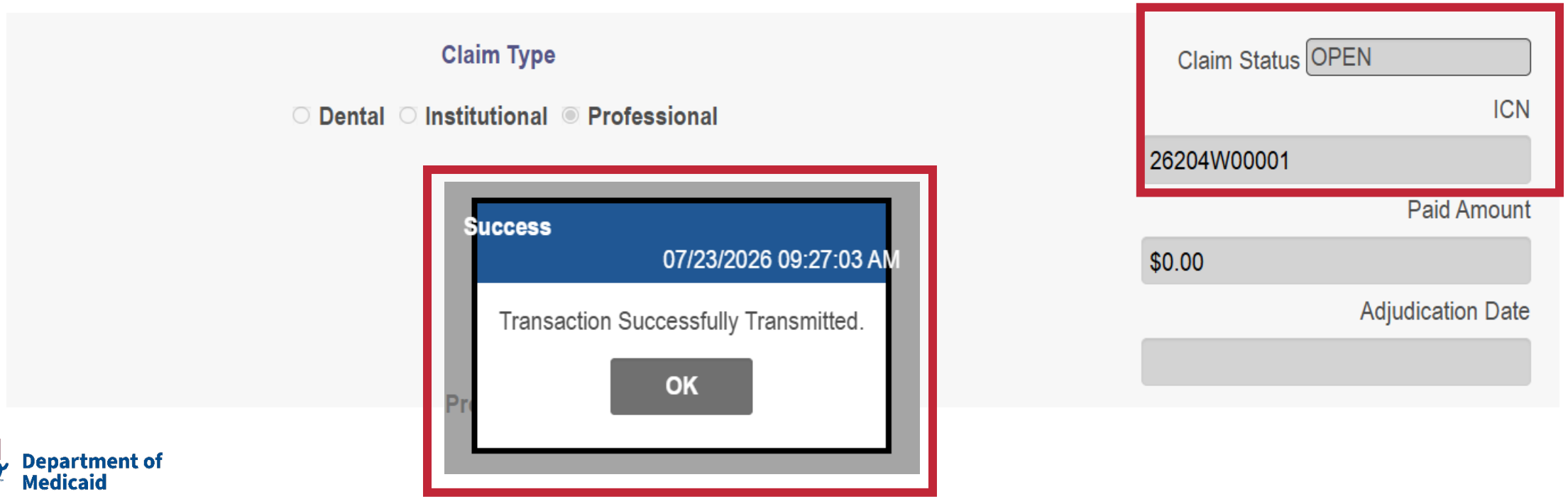
- In the next panel, enter the CARC and Reason Code details from your EOB and each dollar amount attached to them, click ADD to save that 'row' and repeat your steps as needed
  - » If there are multiple CARCs are on your EOB, you will need to enter each one – equal total billed charges



Department of Medicaid

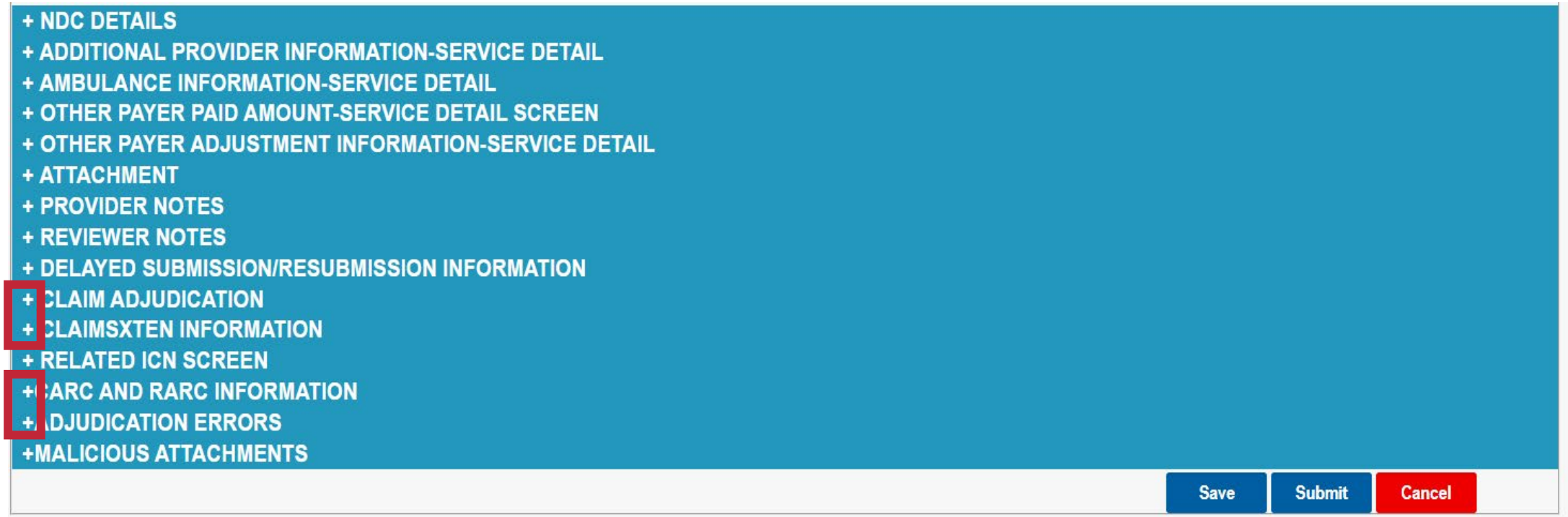
COB FFS Claim Submission, cont.

- Once all applicable information is entered on your claim, scroll to the bottom and click submit
- If your claim submission is successful, you will receive a Success notification pop-up box, the status of the claim will change to OPEN, and an ICN will populate
  - » If no pop-up is received, then scroll to the top of the claim to see what information is still needed



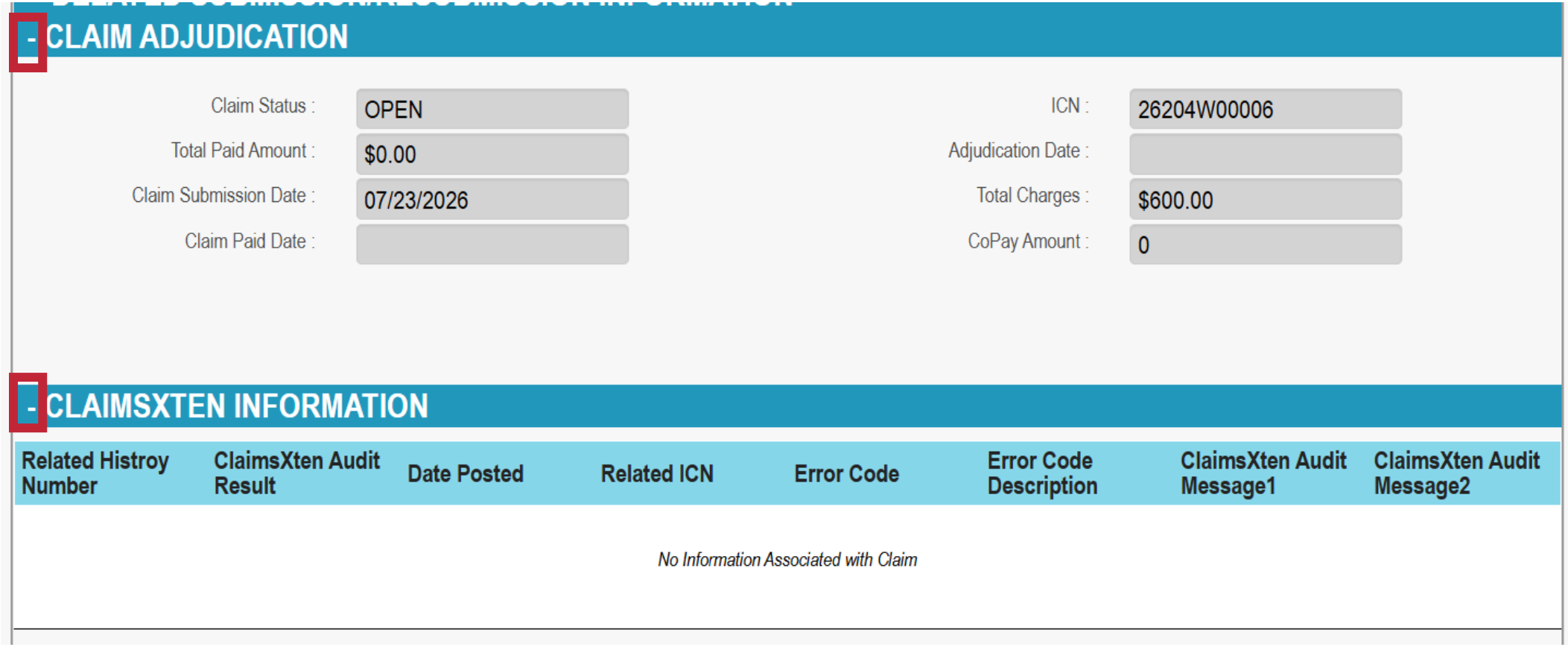
COB FFS Claim Submission, cont.

- The claim will process through certain initial claim adjudication checks, before moving to the next steps in the adjudication process
- It is best to scroll down to the bottom of your claim and expand all edit panels to ensure there were no immediate reasons for your claim to deny



COB FFS Claim Submission, cont.

- An example of a claim with no initial adjudication edits



- CLAIM ADJUDICATION

Claim Status :	OPEN	ICN :	26204W00006
Total Paid Amount :	$0.00	Adjudication Date :	
Claim Submission Date :	07/23/2026	Total Charges :	$600.00
Claim Paid Date :		CoPay Amount :	0

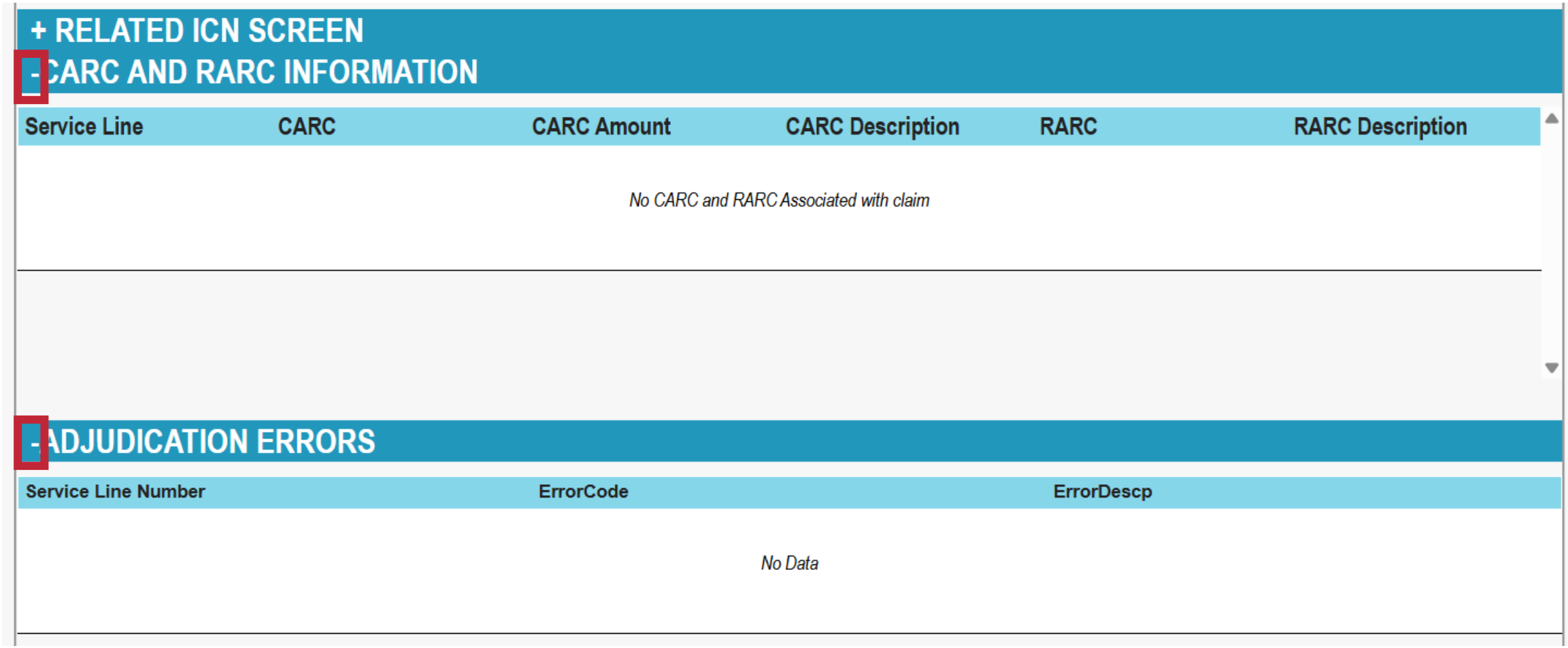
- CLAIMSXTEN INFORMATION

Related Histroy Number	ClaimsXten Audit Result	Date Posted	Related ICN	Error Code	Error Code Description	ClaimsXten Audit Message1	ClaimsXten Audit Message2

No Information Associated with Claim

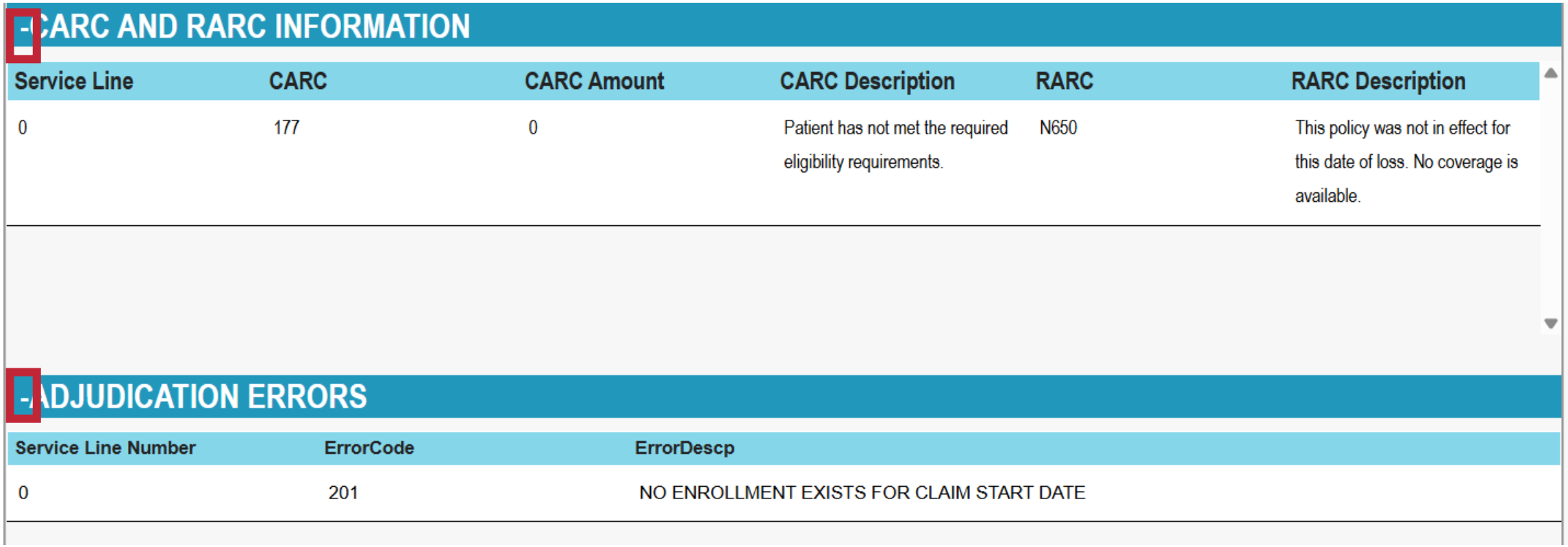
COB FFS Claim Submission, cont.

- Continuation of a claim example with no initial adjudication edits - nothing is populated



COB FFS Claim Submission, cont.

- A claim example with an initial adjudication edit - no Medicaid eligibility for the individual for the DOS that was entered on the claim
  - » Depending on the edit, claim resubmission may be appropriate



- CARC AND RARC INFORMATION

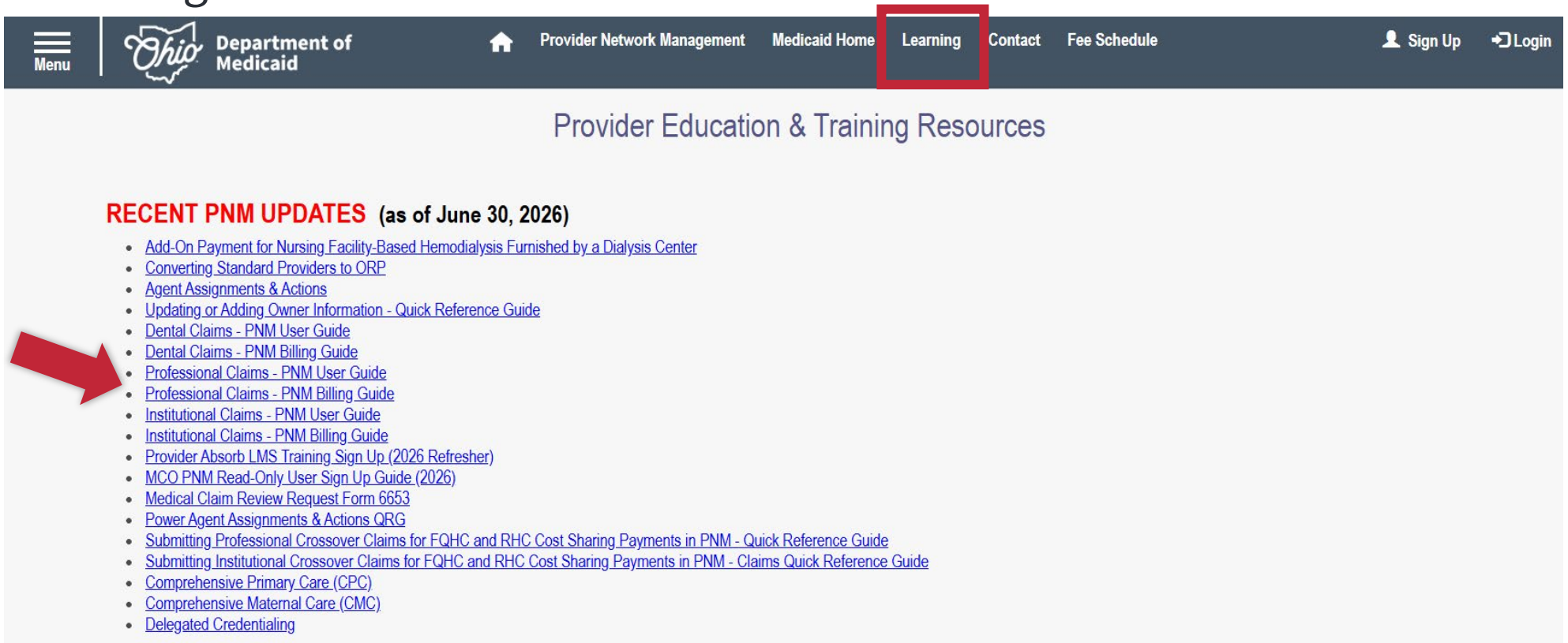
Service Line	CARC	CARC Amount	CARC Description	RARC	RARC Description
0	177	0	Patient has not met the required eligibility requirements.	N650	This policy was not in effect for this date of loss. No coverage is available.

- ADJUDICATION ERRORS

Service Line Number	ErrorCode	ErrorDescp
0	201	NO ENROLLMENT EXISTS FOR CLAIM START DATE

COB FFS Claim Submission Resources

- PNM Learning Tab – Professional Claims - User Guide resources are available among many other helpful resources
- For additional help contact the Integrated Helpdesk (IHD) at 1-800-686-1516 or IHD@medicaid.ohio.gov



Managed Care COB Claims

AmeriHealth Caritas Ohio TPL Claim Submission (Doula Services)

AmeriHealth Caritas Ohio

AmeriHealth Caritas Ohio
TPL Claim Submission

Overview

While TPL processes are largely aligned across MCOs, below are AmeriHealth-specific submission details and resources for reference.

Submission

- Bill the primary insurance first, when applicable
- After the primary payer processes the claim, submit the claim through the EDI vendor or PCH Global

Required Documentation

- Primary payer Explanation of Benefits (EOB), when applicable
- Accurate COB information
- Required provider and member information

Key Billing Requirements

- Submit each date of service separately (no date spans)
- Include all required claim fields, provider information, and NPI when applicable
- Ensure COB information is complete and accurate to avoid claim delays or denials.
- Doula Service CodesT1032 – Doula VisitsT1013 – Labor & Delivery SupportT1023 – Report of Pregnancy (ROP)

Resources

- Submission Process Links:
  - Link to Submission Process
  - Claims and Billing Manual

Support

- Provider Services: OhioProviderServices@AmeriHealthCaritasOH.com/**1-833-644-6001**
- AmeriHealth Provider Manual: Provider Manual
- AmeriHealth Provider Portal **Provider Portal**

AmeriHealth Caritas Ohio
Claim Submission PCH Global

PCH Global

Manual claims submission through PCH Global: To enroll for claims submission through PCH Global, please go to https://pchhealth.global [pchhealth.global] and click the **Sign-Up** link in the upper right-hand corner to register. Complete the registration process and log into your account. You will be asked how you heard about PCH Global; select **Payer**, then **AmeriHealth** and complete the account setup process. Access your profile by clicking on **Manage User** and then **My Profile**. You will need to complete all the profile information. When you go to the **Subscription Details** screen, select the **More** option on the right-hand side click on Promo Code enter the promo code **Exela-EDI** and then click on Apply and Continue.

When you are ready to submit claims, use the following information to search for our payer & Plan information:

Payer name: **AmeriHealth**

Plan Name: **AmeriHealth Caritas Ohio**

EDI Payer ID - **35374**

In the submission module use Direct Entry Submission Option and select Professional or Institutional Claim type based on what type of claim to be submitted.

AmeriHealth Caritas Ohio

AmeriHealth Caritas Ohio
To Verify Third Party Coverage

1) How to Verify Third Party Coverage : NaviNet- [NaviNet Registration]



2) How to Verify Third Party Coverage : Contact Customer Service

- **1-833-644-6001**

AmeriHealth Caritas Ohio

AmeriHealth Caritas Ohio
Provider Portal

AmeriHealth Caritas Ohio

LOGIN | REPORT FRAUD | LANGUAGE | SEARCH

Renew | Members | Providers | Community | Find a Provider | About us

Home › Providers

Providers

- Alerts and newsletters
- Claims and billing
- Find a provider
- Healthchek
- Join our network
- NaviNet
- OhioRISE
- Pharmacy services

ATTENTION PROVIDERS: FDA Class I Recall for TRUE METRIX Blood Glucose Monitoring Systems. Providers, please emphasize that if patients receive an E-5 Error Code when using these monitors, and are experiencing symptoms of high glucose, they should seek medical attention immediately. Class 1 Recall: TRUE METRIX Blood Glucose Monitoring Systems

AmeriHealth Caritas Ohio Providers

Your recommendation matters and is one of the stronger factors in a member's decision to get vaccinated. Please take a moment to discuss the benefits of flu and RSV vaccines during this flu season.

AmeriHealth Caritas Ohio

AmeriHealth Caritas Ohio
Recovery Process

Recovery Dispute Process

If AmeriHealth Caritas Ohio identifies a claim payment that may be subject to recovery, the provider will receive a recovery notification letter outlining:

- The impacted claim(s)
- The reason for the recovery
- The amount identified for recovery
- Instructions for disputing the recovery determination if the provider disagrees

Providers should carefully review the recovery notification and compare it to:

- Medical records (if applicable)
- Remittance advice details
- Explanation of Benefits (EOB) information
- Coordination of Benefits (COB)/Third Party Liability (TPL) information
- Any other supporting documentation related to the claim

If the provider believes the recovery was issued in error, they may submit a recovery dispute with supporting documentation. Supporting documentation may include:

- Primary payer EOBs
- Claim submission records
- Remittance advices
- Medical records, when applicable
- Other documentation supporting the provider's position

Recovery disputes should be submitted within **30 days from the date of the recovery notification**. Follow the steps in the recoupment letter and mail in their dispute, OR the best way to do it is via NaviNet (on next slide).

AmeriHealth Caritas Ohio will review the submitted documentation and evaluate whether:

- The recovery should be upheld,
- Modified, or
- Reversed based on the information provided.

Once the review is complete, the provider will be notified of the determination and any next steps regarding the recovery.

(The search results confirm providers receive notification and have dispute rights, but do not provide additional outcome details.)

AmeriHealth Caritas Ohio

AmeriHealth Caritas Ohio
Recovery Process in NaviNet

To dispute an overpayment recovery or recoupment,

- Log into NaviNet and select **Forms & Dashboards > Provider Disputes > Submit Provider Disputes**.
- Include the claim information, reason for the dispute, and any supporting documentation.
- Once submitted, you can monitor the status through the **Check Dispute Status** feature in NaviNet.
- NaviNet Registration

AmeriHealth Caritas Ohio

- Ohio | Anthem Blue Cross and Blue Shield Medicaid
- Ohio Medicaid Managed Care

Doula TPL Claim Submission

Third party liability (TPL)

- Submission process and required documentation:
  - When a member has doula coverage thru a commercial payer submit claim to the commercial payer first following the commercial payers claims submission process.
    - To review members eligibility:
      - Login into Availity Essentials - Sign In or
      - Login into the PNM
  - Once the commercial payer processes the claim and you receive a remittance advice (RA), also known as explanation of payment (EOP) submit the claim to Anthem.
    - Claims submission information and Provider manual

Third party liability (TPL), cont.

When a member has a commercial payer, you must submit one of the below for Anthem to process your claim.

- Commercial payer RA or
- Letter from the commercial payer explaining the denial of coverage or reimbursement
  - This can be uploaded on Availity Essentials - Sign In or mailed to:

    Anthem Blue Cross and Blue Shield Claims Correspondence
    P.O. Box 62500
    Virginia Beach, VA 23466-2509

- Timely filing is 365 days unless noted differently in your contract. Timely filing is counted from the date of the explanation of payment of the other carrier.

Claims overpayment recovery and refund procedure

- We seek recovery of all excess claim payments from the person or entity to whom the benefit check was made payable. We initiate the overpayment recovery process by sending a written notification when an overpayment is discovered.

- If you are notified by us of an overpayment or discover that you have been overpaid, mail the refund check, along with a copy of the notification or other supporting documentation, to:

  Anthem
  P.O. Box 933657
  Atlanta GA 31193

- Fax: 866-920-1874

- The Recoupment Notification Form and the Overpayment Refund Notification Form are on our provider site at providers.anthem.com/oh > Claims Forms.

Claims overpayment recovery and refund procedure (cont.)



- If a payment, a request for an extended payment arrangement, or a dispute request is not received within 30 calendar days of our notification to a care provider of an overpayment, we will process the recovery, and the overpaid funds will be applied to the care provider's account as a negative balance.

- If you believe the overpayment notification was created in error, contact Provider Services at 844-912-1226.

- For claims reevaluation, send your correspondence to the address indicated on the overpayment notice. If we do not hear from you or receive payment within 60 days, the overpayment amount will be deducted from your future claim payments.

Third party liability (TPL), cont.

Key Requirements:

- Verify third-party (TPL) prior to claims submission
- Ensure claim reflects accurate TPL information

Resources:

- Doula services and coordination of benefits (COB) - Provider News
- Third-Party Liability (TPL) and Coordination of benefits (COB)
- Rule 5160-1-08 - Ohio Administrative Code | Ohio Laws
- Anthem website
- Availity learning resources Provider Education and Training - Ohio Medicaid

Support:

- Email **Anthem Provider Inbox**
- Provider Services 844-912-1226

DOULA TPL CLAIM SUBMISSION

Denise Craven - Director, Claims

July 27, 2026

CareSource: Verify Third-Party Coverage

Use the Provider Portal before claim submission to confirm COB/TPL information on file.

Verification options

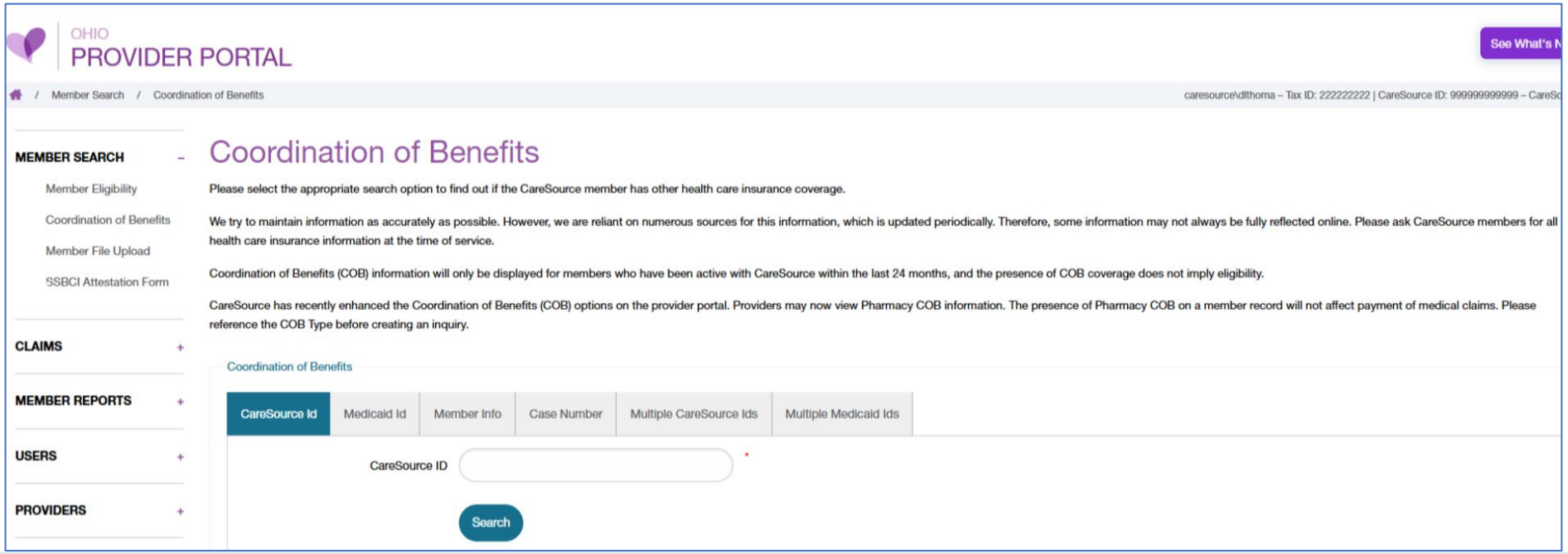
Provider Portal: https://providerportal.caresource.com/OH

View COB information CareSource has on file for the member.

Phone:

Call Provider Services at 1-800-488-0134 and follow the menu prompts.

Bill primary insurance first, when applicable.

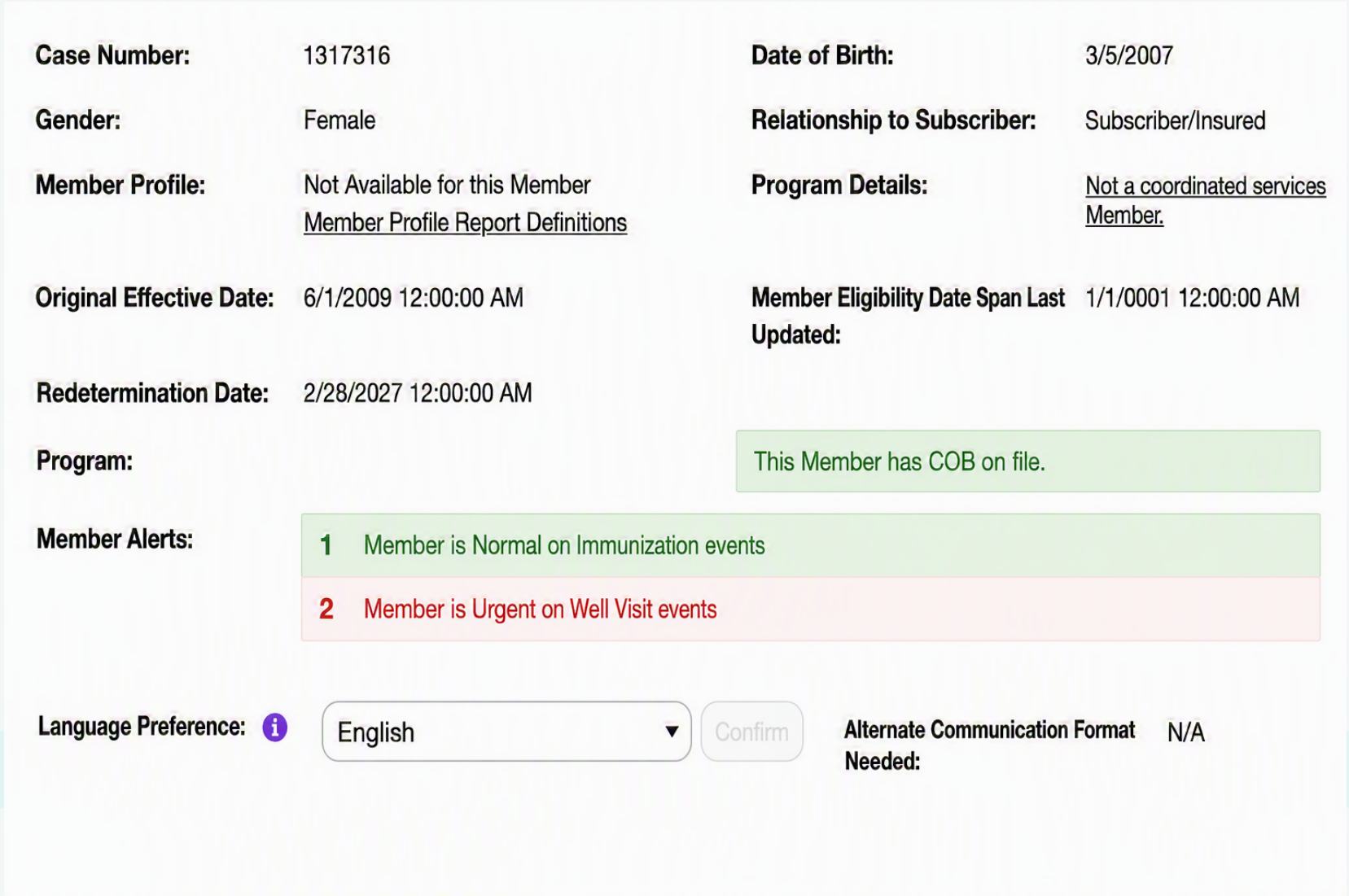


Retain portal verification, primary payer response/EOB, and claim submission confirmation.

Screenshots provided by CareSource

Portal Search / COB option

Use the Provider Portal before claim submission to confirm COB/TPL information on file.



Screenshots provided by CareSource

Portal Search / Member COB Details

2 Member is Urgent on Well Visit events

Language Preference: English Confirm

Alternate Communication Format Needed: N/A

Special Communication Needs:

Member Aid Category: N/A

COB Information

COB Info

Carrier: Anthem Blue Cross Blue Shield (BCBS) Ohio
PO BOX 105187
Atlanta, GA 303485187

Carrier Phone: (855) 690-7796

Insurance Type: Medical

Group Number: 280677M002

Policy Number: RBL2277469CT

Effective Date: 9/1/2022

CareSource: Timeframes & Claim Submission

Keep the primary payer EOB/adjudication information with the COB claim.

Timely filing

365 days from the service date; or
90 days from the primary carrier EOB date;
whichever is greater.

Paper claims

Mail with primary EOB attached.
CareSource P.O. Box 8730,
Dayton, OH 45401-8730.

EOB must include paid amounts, adjustment codes, amounts, and remark codes.

Electronic / EDI

Use clearinghouse, trading partner, or billing administrator.

Complete required COB loops/segments.
Referenced loops: 2320, 2330A, 2330B, 2330, 2430.

Use current CareSource resources, including the provider manual and Reimbursement Policy OH MCD-PY-1412.

Example CMS-1500 Professional Claim COB Entry

Use the CMS-1500 claim fields to identify other coverage, then support the claim with the primary payer EOB/ERA.

CMS-1500 PROFESSIONAL CLAIM — COB EXAMPLE

1. Insurance Type	2. Patient Name	3. DOB / Sex	4. Insured Name
Medicaid ☑	Jane Member	01/01/1975 F	Jane Member

1 Other Insured's Name	2 Other Insured Policy #	3 Insurance Plan Name
John Smith	ABC123456789	Anthem Blue Cross

10. Condition Related To	11. Insured Policy	11a. DOB	4 d. Another Health Plan?
No	—	—	YES ☑

24. Service Lines

DOS	CPT	DX	Charge	Primary Paid*	Balance	Rendering NPI
06/15/26	99213	A	$150.00	$90.00	$60.00	1234567890
06/15/26	36415	A	$25.00	$20.00	$5.00	1234567890

28. Total Charges	5 Amount Paid	30. Reserved
	$110.00	—

6 Attach / submit primary payer EOB or ERA

Needed to verify line-level paid amount, deductible, coinsurance, copay, and CARC/RARC details.

Provider billing checklist

When billing secondary, make these items clear on the claim:

1. **Box 9** — Other insured / subscriber name
2. **Box 9a** — Other insured policy or member ID
3. **Box 9d** — Primary payer plan name
4. **Box 11d** — Mark “Yes” when another health plan exists
5. **Box 29** — Total amount paid by the primary payer
6. **EOB/ERA** — Attach or transmit primary payer adjudication details

Box 29 captures total primary payment; EOB/ERA supports line-level COB.

CareSource FAQs: Denials & Missing Coverage Details

Use these steps when COB information needs to be corrected or completed.

COB denial but primary coverage is no longer effective

Notify CareSource through the Provider Portal, by email (COBOhio@caresource.com), or by calling Provider Services.

After CareSource confirms the member no longer has primary coverage, the member is updated in the system.

Keep documentation supporting the coverage status and denial outcome.

Portal missing group number or DOB

Check the primary carrier website or call the carrier directly.

Obtain missing information before submitting COB details.

Verify insurance coverage at the time of service.

Contact: Provider Portal | COBOhio@caresource.com | Provider Services 1-800-488-0134

CareSource FAQs: Takebacks & Recoupments

Use the letter source to determine where to send documentation.

If letter comes from HMS

Send documentation to HMS within 30 days.

Third Party Recovery Unit
Attn: CareSource COB Project HMS, Inc.
5615 High Point Drive
Suite 100
Irving, TX 75038
(877) 259-3308
Fax: (314) 905-2064

Documentation is typically an EOB showing coverage was not in effect, services were paid, or services were denied.

HMS phone: (877) 259-3308 | Fax: (314) 905-2064

If recoupment comes from CareSource

Automatic recoupment starts in 30 days from notification via a Recovery Notification Letter.

If disputing, send supporting documentation to CareSource within 60 days of the letter date.

Mail:
CareSource COB
P.O. Box 8730
Dayton, OH 45401-8730

Refund checks

Refund Checks can be mailed using this form, mailed to the address on the form.

If the overpayment is not refunded, recoupment will be made against future claim payments.

The recoupment will show on the Explanation of Benefit.

Doula TPL
Buckeye Health Plan

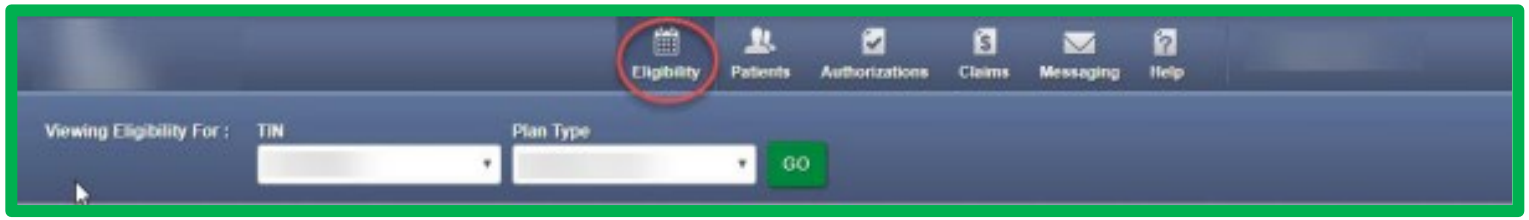
Mindy Ridgeway

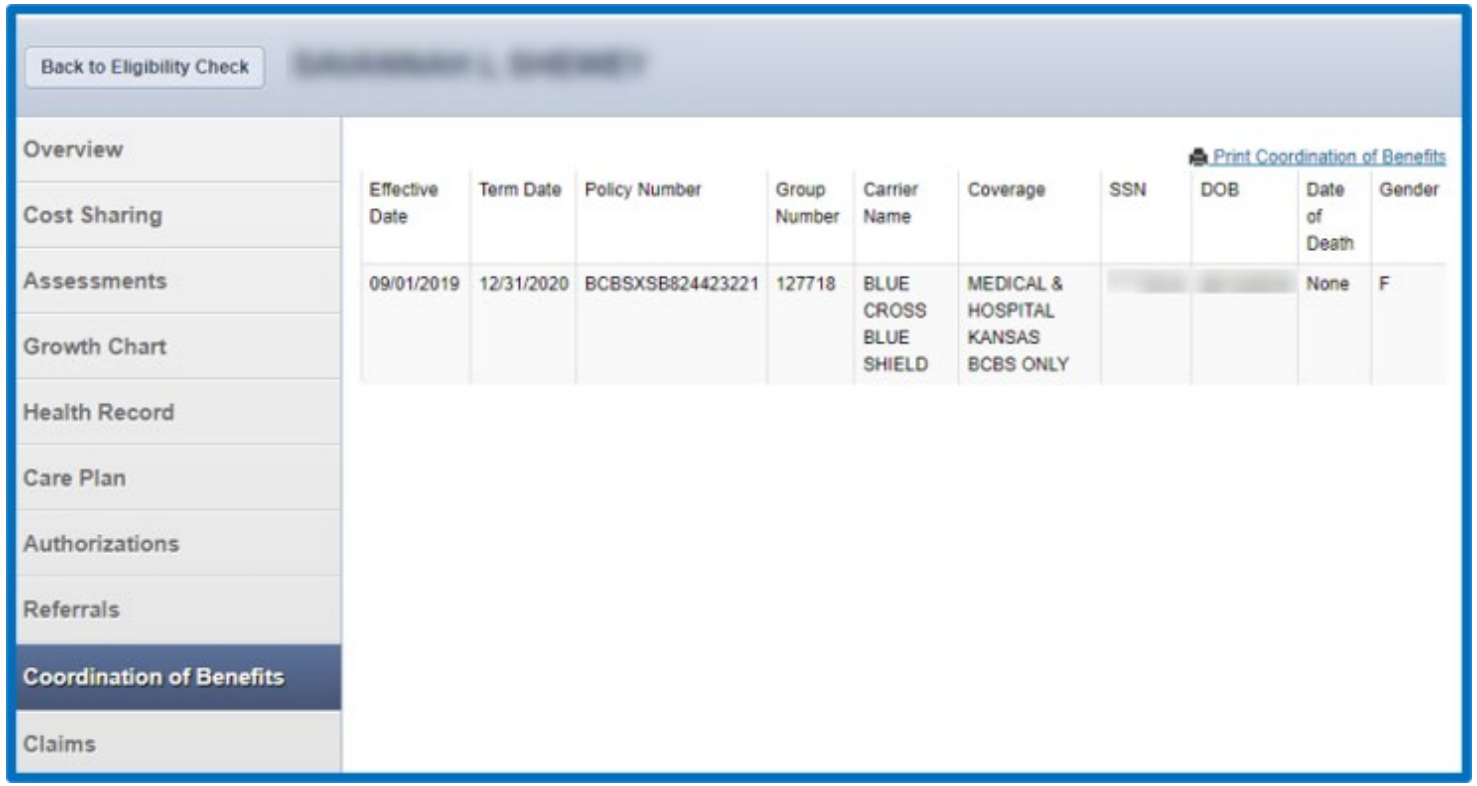
buckeye health plan

Key Requirements

Verify Eligibility – Commercial Insurance and Buckeye Coverage

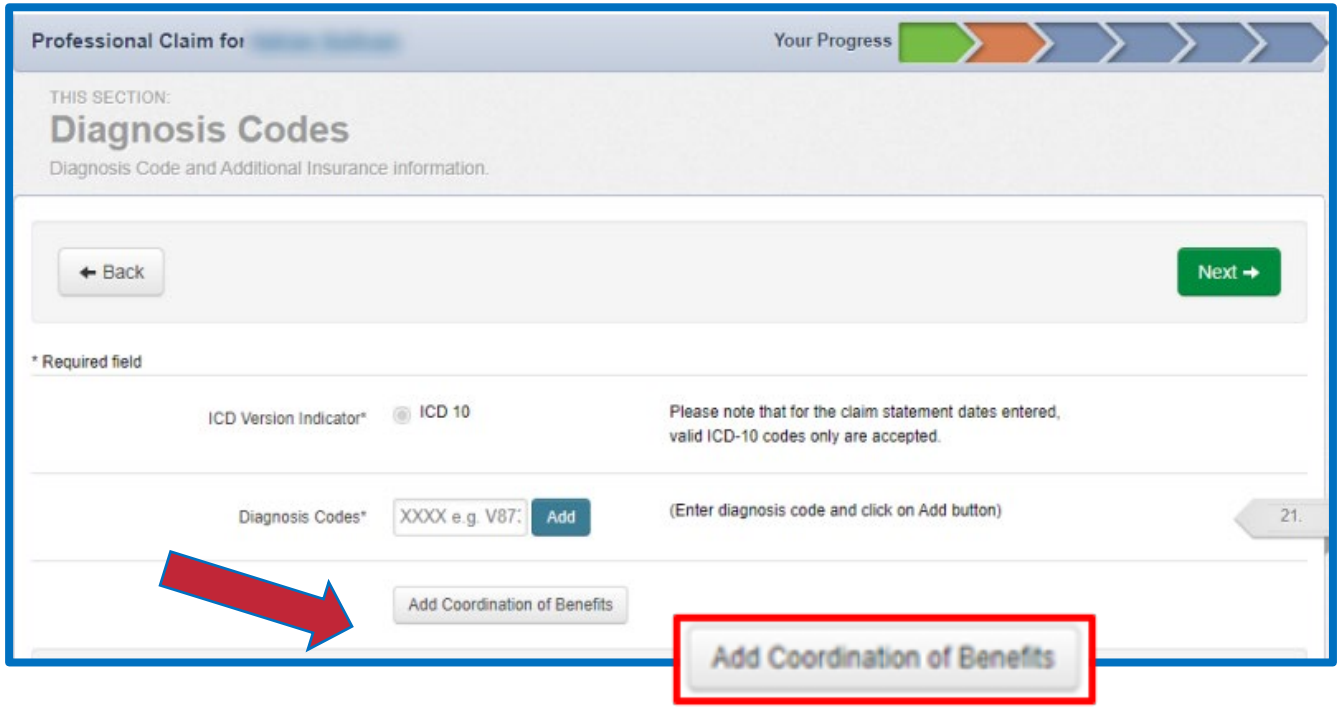
[Buckeye Provider Portal]





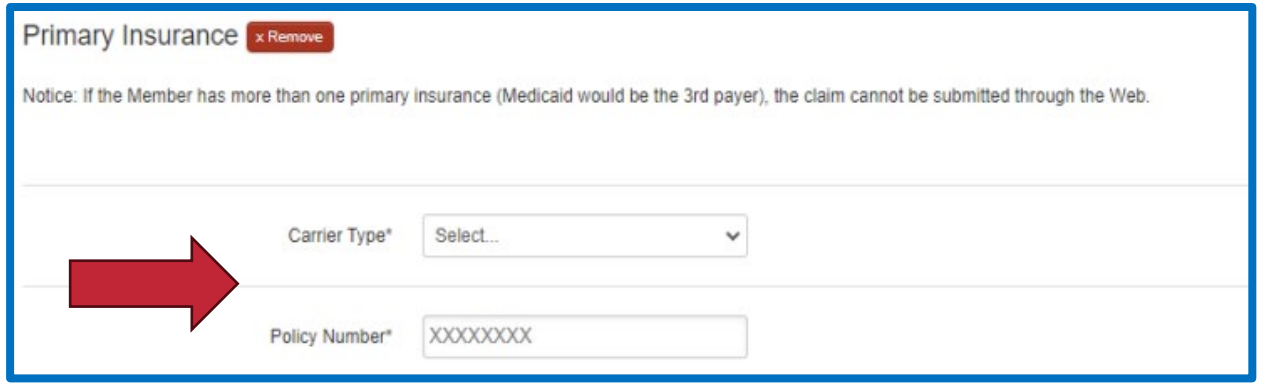
Submission Process

- Submit Claims to Primary Commercial Insurance
- Once Primary Insurance has responded, Create a New Claim on the Buckeye Provider Portal
- Select Professional Claim and enter Member Detail, Procedure Codes and Diagnosis

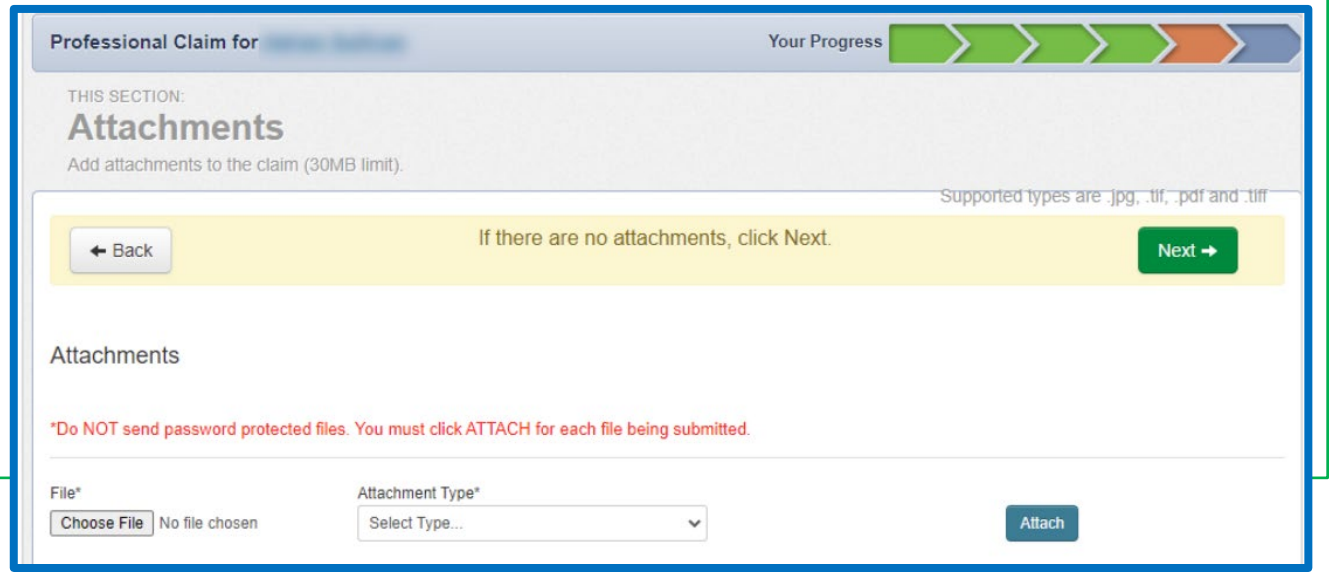


Submission Process

- Enter Primary Insurance Information



- Enter Claim Detail
  Add Primary Insurance
  Explanation of Payment as Attachment
  and Submit
  Format: jpg, tif, pdf and tiff



Recovery Process

Provider Receives Notification of Overpayment (USPS)

Recoupment / Recovery from Future Claims begins in 30 Days if no response is made

Option One

If a claim has not been filed to the Primary Insurance, submit a Primary Insurance claim.

Option Two

If a claim was filed but the Primary Insurance issued no payment or no response, request a review by filing a COB Dispute & Adjustment Request Form with Buckeye: **COB Dispute & Adjustment Form**

Note: *Requests for review must be submitted within 180 days of the original disposition of the claim.*

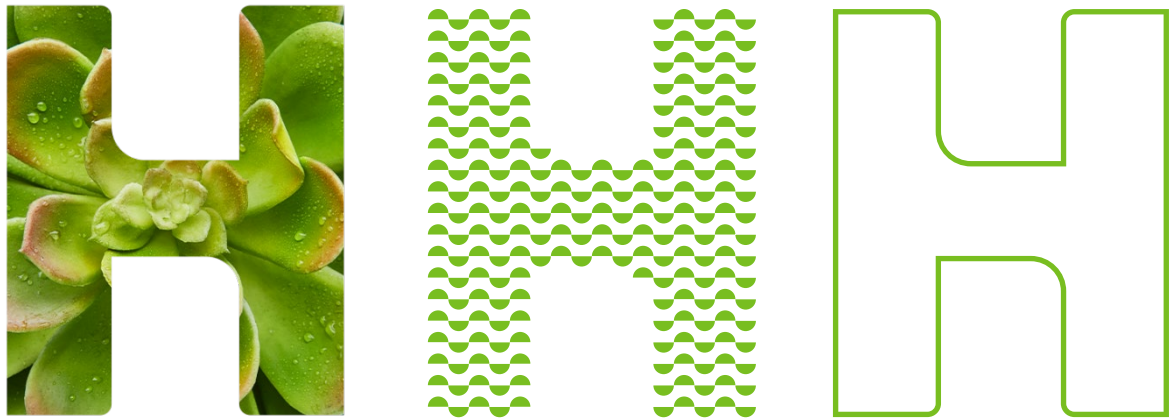
Resources

- Claims Submission Guide: Buckeye Provider Portal
- Provider Services: 866-296-8731
- Provider Manual: Medicaid Provider Manual Buckeye 2026
- Questions and Support : Mindy Ridgeway melinda.ridgeway@centene.com or 614-507-4003 (mobile)

Humana
Healthy Horizons®
in Ohio

Claim Submissions Process

Information for Ohio Medicaid healthcare providers and administrators



Humana Healthy Horizons in Ohio is a Medicaid Product of Humana Health Plan of Ohio, Inc.

OHHN4ZSEN

Availity Essentials

You can submit electronic claims via Availity Essentials. Availity Essentials provides access to:

- Check eligibility and benefits
- Submit claims and review claim status
- Submit PA and referral requests and review status
- Request electronic funds transfer (EFT) and electronic remittance advice (ERA) enrollment

Sign in to Availity Essentials (registration required).

From the Payer Spaces menu, select Humana.

From the Applications tab, select the ERA/EFT Enrollment app. (If you don't see the app, contact your Availity Essentials administrator.)



Learn about Availity

Claims submission process

The claims submission process is different for Humana Healthy Horizons than for other Humana business. For all payable claims:

- Electronic data interchange (EDI) must be submitted through the provider's EDI.
- Direct data entry (manual) claims and associated attachments must be submitted through Availity Essentials.
- Paper claim submissions are prohibited.
- All Humana Healthy Horizons claims must include Humana payer ID 61103.

Please note: Humana's traditional fee-for-services payer ID (61101) cannot be used to submit Humana Healthy Horizons claims. Humana rejects all claims for all Humana Healthy Horizons-covered patients submitted in this manner.

Submitting a secondary or tertiary claim

Before submitting a secondary claim, make sure you have the following information:

- The primary payer's remittance advice or Explanation of Benefits (EOB) for their portion of the claim
- The primary payer's Payer ID

Keep the following tips in mind before submitting a secondary or tertiary claim:

- If you're submitting a tertiary claim, make sure both the primary and secondary payer have paid their portions and you have the remittance advice from both.
- If your organization is enrolled to receive 835s through Availity or if it has access to stored ERA data in Remittance Viewer, select **Claims & Payments | Remittance Viewer** in the Availity Essentials navigation bar to find remittance and claim details. Otherwise, refer to ERAs or EOBs in accordance with your business processes.
- To find the primary payer's Payer ID (and the secondary payer's, if you're submitting a tertiary claim), you can select **More | Payer List** in the Availity Essentials navigation bar and type the payer's name in the search field.

Submitting a secondary or tertiary claim continued

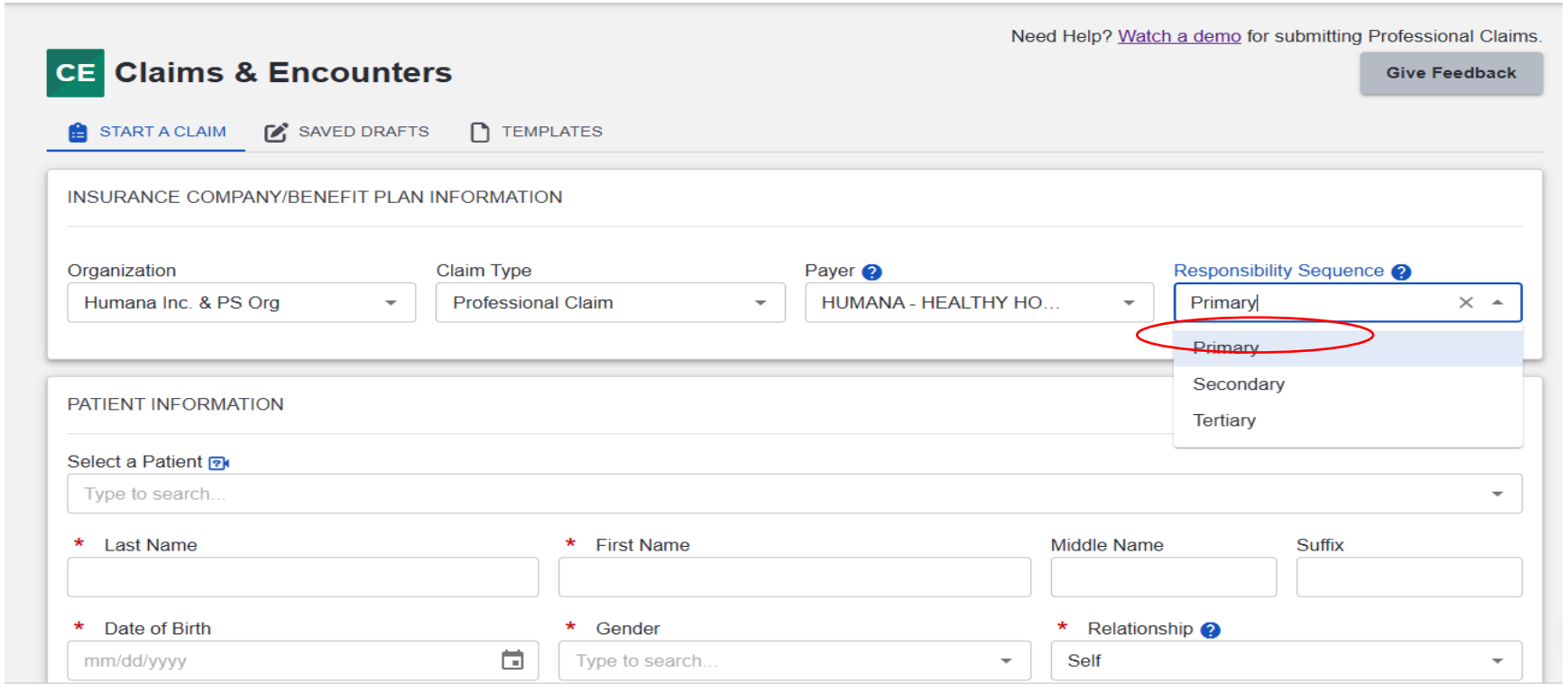
If a secondary payer is not on the Availity payer list, enter the payer ID listed on the back of the member's secondary insurance card or enter 99999 in the field. For a tertiary claim, you can enter 99999 for one of the two **Other Payer ID** fields and 9999 for the other, but cannot enter the same value in both fields.

1. On the Claims & Encounters main page, select your organization and claim type. In the **Responsibility Sequence** field, select **Secondary** or **Tertiary**. In the **Payer** field, select the patient's secondary payer if you are submitting a secondary claim and their tertiary payer if you are submitting a tertiary claim.
2. Complete all sections of the claim form starting from the top.

Please note: The claim form is dynamic, so the page might refresh with additional requirements based on selections you make. Therefore, you should always start at the top of the form and complete it in order.

Complete the Primary Insurance section

When you select Secondary in the Responsibility Sequence field of the Claims & Encounters page, a Primary Insurance section displays after the sections for patient and subscriber information. Based on what you select in the fields, additional fields and sections might display.



Complete the Primary Insurance section continued

Follow these tips for completing this section when submitting a secondary claim on Availity Essentials:

- In the Plan Information section, enter information about the other payer who adjudicated the claim and provided claim level information. Since this example is a secondary claim, enter payer details about the primary payer.
- In the Subscriber ID field, enter the payer-assigned number that displays on the patient's ID card for their primary insurance. In the Remaining Patient Liability Amount field, enter the remaining patient liability listed in the remittance information from the primary payer.
- No is the default option for this field. If the subscriber for the secondary claim is different from the primary plan subscriber, select Yes. You will be prompted to enter information about the subscriber for the secondary plan.

Complete the Primary Insurance section continued

Follow these tips for completing this section when submitting a secondary claim on Availity Essentials continued:

- The Adjustment Type field is used for coordination of benefits and submitting adjustments to previously submitted claim amounts. In this field, select:
  - No Payment Adjustment if you are not including adjustments.
  - Claim Level Payment Adjustment when you are including claim level payment amount adjustments.
  - Claim Line Payment Adjustment when you are including line level payment adjustments.
  - Both when you are including claim level and line level adjustments.

Tip: Refer to the Claim level and line level adjustments topic for more information about entering adjustments.

Complete the Primary Insurance section continued

Follow these tips for completing this section when submitting a secondary claim on Availity Essentials continued:

- Select the Outpatient Medicare Adjudication Information button to expand the section for adding remark code(s) to convey appeal information and other claim-specific information that does not involve a financial adjustment.

Remember: The process for submitting a tertiary claim is similar. In addition to completing the Primary Insurance section, you must also complete the Secondary Insurance section and enter adjustment information for both.

Claim level and line level adjustments

When submitting secondary and tertiary claims on Availity Essentials, you can enter two types of payment adjustments in the Adjustment Type field for the primary insurance plan (if submitting a secondary claim) and for the secondary insurance plan (if submitting a tertiary claim):

- Claim Level Payment Adjustment: An adjustment that applies to the entire claim as a whole.
- Claim Line Payment Adjustment (most common): An adjustment that applies to an individual service or procedure listed in the claim.

If you are entering both adjustment types, you can select Both. If you have no adjustments, select No Payment Adjustment.

Timely filing



You must submit initial claims within 365 calendar days of the date of service or discharge.



You must submit corrected claims within 365 calendar days of the date of service or discharge.



If a member has Medicare and Humana Healthy Horizons is secondary, you can submit claims for secondary payment within 180 calendar days of the Medicare adjudication date. If a member has other insurance and Humana Healthy Horizons is secondary, it is recommended that you submit for secondary payment within 180 calendar days of the other insurance payment date.

Overpayments

You should report all claim overpayments to Humana Healthy Horizons within 60 calendar days.

Humana Healthy Horizons provides written notice at least 30 calendar days before an adjustment for overpayment is made. If a dispute is not received from the provider, adjustments to the overpayment are made on a subsequent reimbursement.



Please mail refund checks for overpayments to:

Humana Healthcare Plans
P.O. Box 931655
Atlanta, GA 31193-1655

Provider dispute process

Provider claim disputes are any provider inquiries, complaints, appeals or requests for reconsideration, ranging from general questions about a claim to disagreement with a claim denial.

You have 12 months from the date of service or 60 calendar days after the payment, denial or partial denial of a timely claim submission, whichever is later.

You can expect to receive a written resolution to your reconsideration request no later than 15 business days from submission.



Submit disputes via:

Phone: 877-856-5707

Online: Availity Essentials

Mail:

Humana Healthy Horizons
Provider Disputes
P.O. Box 14601
Lexington, KY 40512-4601

Claims payment systemic error report

The claims payment systemic error (CPSE) report includes information about claims adjudication that is incorrectly paying, denying or suspending and is affecting or potentially may affect five or more billing providers.

For more information, please visit:

- CPSE report previous month- https://assets.humana.com/is/content/humana/CPSE_Report_PREVIOUS_Humanapdf

- CPSE report current month- https://assets.humana.com/is/content/humana/CPSE_Report_CURRENT_Humanapdf

Molina Healthcare of Ohio

Third Party Liability Claim Submissions

Doula Third Party Liability (TPL)

- A Medicaid beneficiary may have a third-party resource (health insurance, another person or entity) that is liable to pay for the beneficiary's health care. This can be validated on the Availity portal by checking the member's eligibility.
- Third Parties could include:
    - Health Insurers (include private or employer based coverage, Medicare and TRICARE)
    - Other government programs
    - Other liable people or entities
- Coordination of Benefits (COB) ensures that payment is not more than required and helps recover payments when a third party is responsible to pay for all or some of the health care received by a member.
    - When a person has Medicaid and there is another liable third party:
        - ❑ Validate the primary carrier information and submit the claim following their processes.
        - ❑ Once a payment determination has been made, submit a secondary claim, using the same coding and details to Molina within 90 days of the primary payer's remittance date. In the Coordination of Benefits section of the claim, complete the details on how the primary carrier paid or denied the claim.
        - ❑ Molina will process the claim using the information from the primary carrier to calculate if any additional payment is due. If the primary carrier denies the claim because their requirements for payment were not met, Molina will deny the claim as well.

Doula Third Party Liability (TPL)

- Consistent with the Deficit Reduction Act of 2005 and the Ohio Administrative Code, Molina has an established process to identify third party liability through review and coordination of benefits (COB).
- This process may identify and coordinate benefits pre-claim or post-claim payment. Pre-Claim: Provider receives Molina remittance advice denying the claim for other coverage/ primary Explanation of Benefits (EOB) as noted in the following grid.

Claim remit number	Claim remit message
377	EOB not received on Claim
216	No COB entered with a Secondary Enrollment

Post-claim more than 270 days for Medicaid:

If Molina identifies commercial third party liability more than 270 days from the provider's payment date from Molina for Medicaid line of business; Molina will submit the provider's claim to the third party payer following the Claim Recovery process.

The third-party reimburses Molina directly and no action is needed from the provider. The claim from the provider would remain paid by Molina.

Doula Third Party Liability (TPL) 2

- Additional Resources:
    - 2026 Next Generation Molina Medicaid Provider Manual
        - Page Citations: Page 126 – 131
    - Claims and Billing Orientation
    - Doula Training
    - Log in to Availity Essentials
    - Register for Availity Essentials
    - Molina Healthcare of Ohio Provider Quick Start Guide

Coordination of Benefits (COB) & Third-Party Liability (TPL)

UnitedHealthcare Doula Provider Training

- July 2026



What Is Coordination of Benefits (COB)?

Coordination of Benefits (COB) is the process used to decide the order in which health plans pay when a member is covered by more than one payer. **Third-Party Liability (TPL)** — such as commercial insurance— must pay before Medicaid, which is always the payer of last resort.

1 Payer order

One plan pays first (primary); the other pays the remaining balance (secondary).

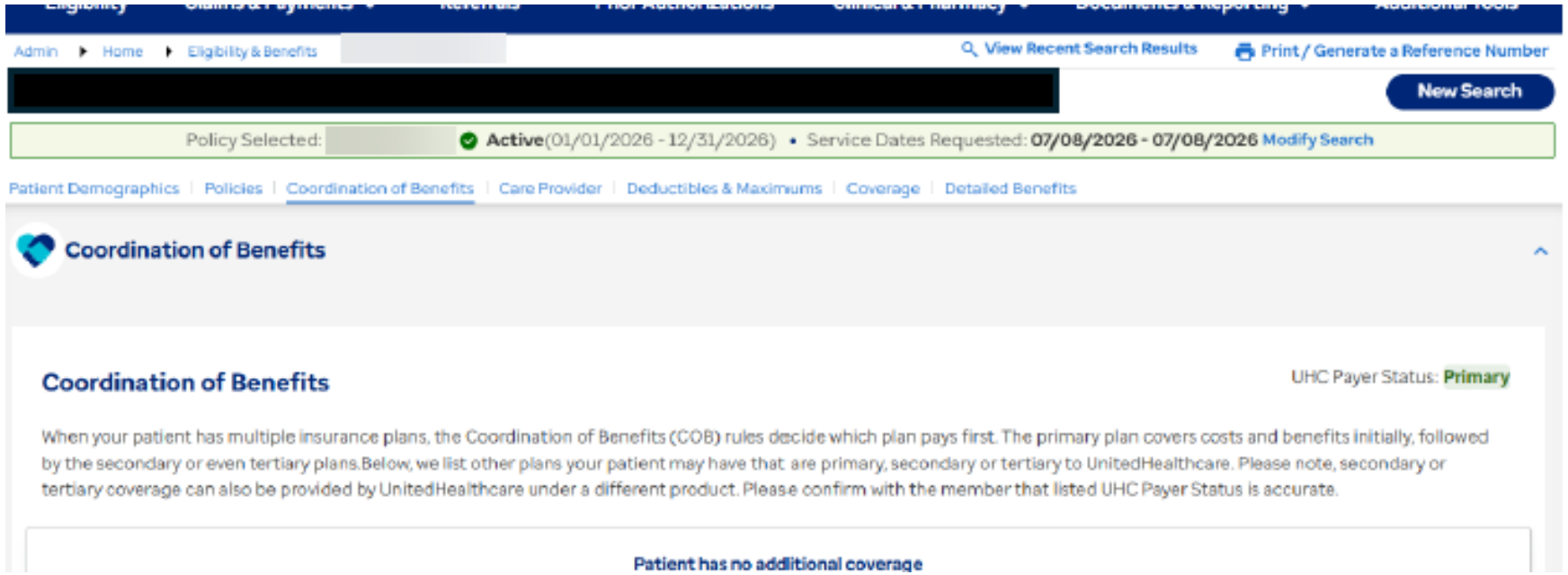
2 Medicaid pays last

Medicaid, including UnitedHealthcare Community Plan, is the payer of last resort.

3 Why it matters

Prevents duplicate payments, reduces denials, and keeps reimbursement accurate.

Example: Coordination of Benefits tab in the UnitedHealthcare Provider Portal



Coordination of Benefits (COB) & Third-Party Liability (TPL) Submission

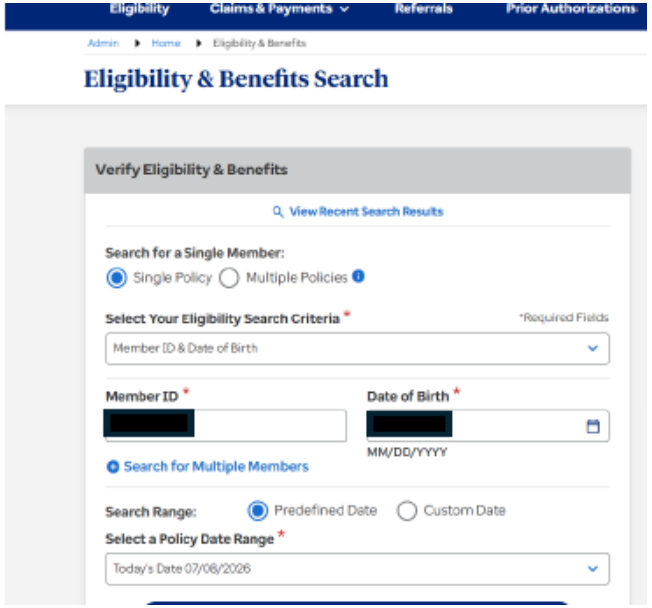
TPL and COB requirements are generally aligned across Ohio Medicaid MCOs, but providers should follow UnitedHealthcare-specific steps when a member has other insurance coverage.

Submitting the claim

1. First, check for CBO in the UHC provider portal (see screenshots below) **www.uhcprovider.com**
2. Bill the primary insurance first.
3. After the primary payer processes the claim, submit to UnitedHealthcare through the UHC Provider Portal: **www.uhcprovider.com**

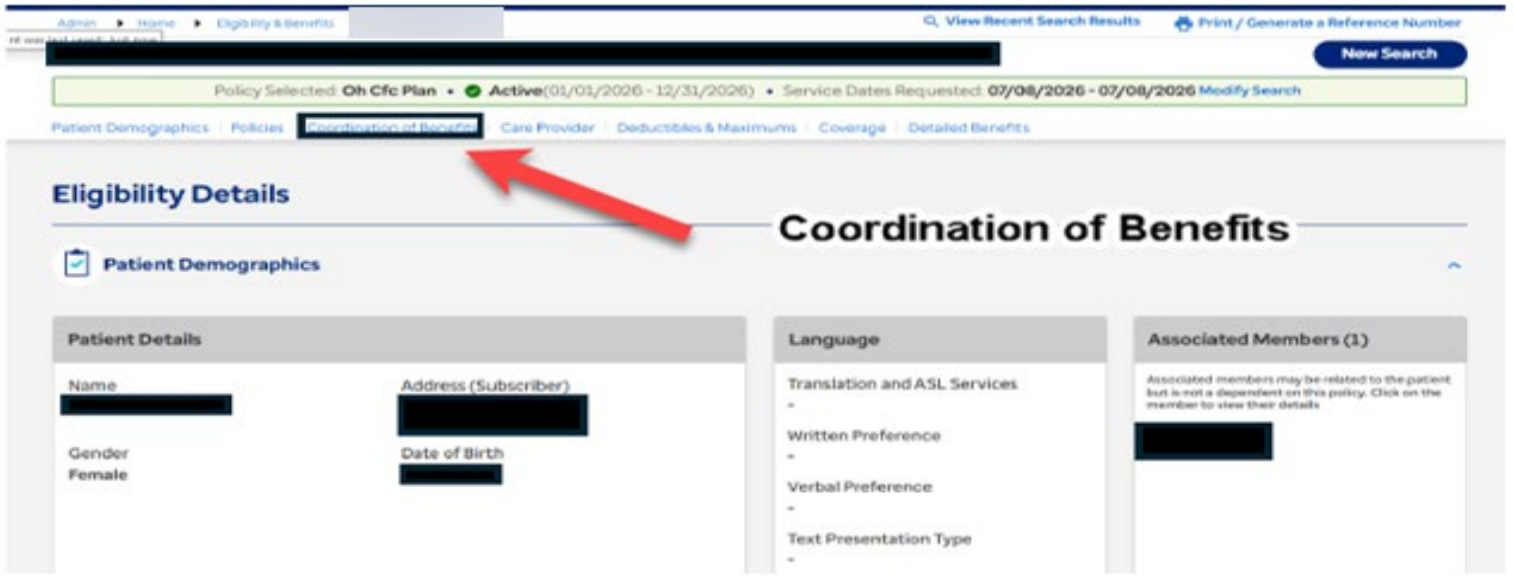
1 Search for the member

Enter the Member ID, date of birth, policy date range, then select Verify Eligibility.



2 Open the COB tab

In Eligibility Details, select the Coordination of Benefits tab.



3 Review COB status

Confirm the UHC Payer Status and any additional coverage listed.

Required Documentation

When a member has other coverage, include the following documentation so UnitedHealthcare can process the coordinated claim accurately and without delay.

Before you submit

If the member has primary insurance, attach the primary EOB when submitting the secondary claim to UnitedHealthcare to support timely processing and prevent denials.

1 Primary payer EOB

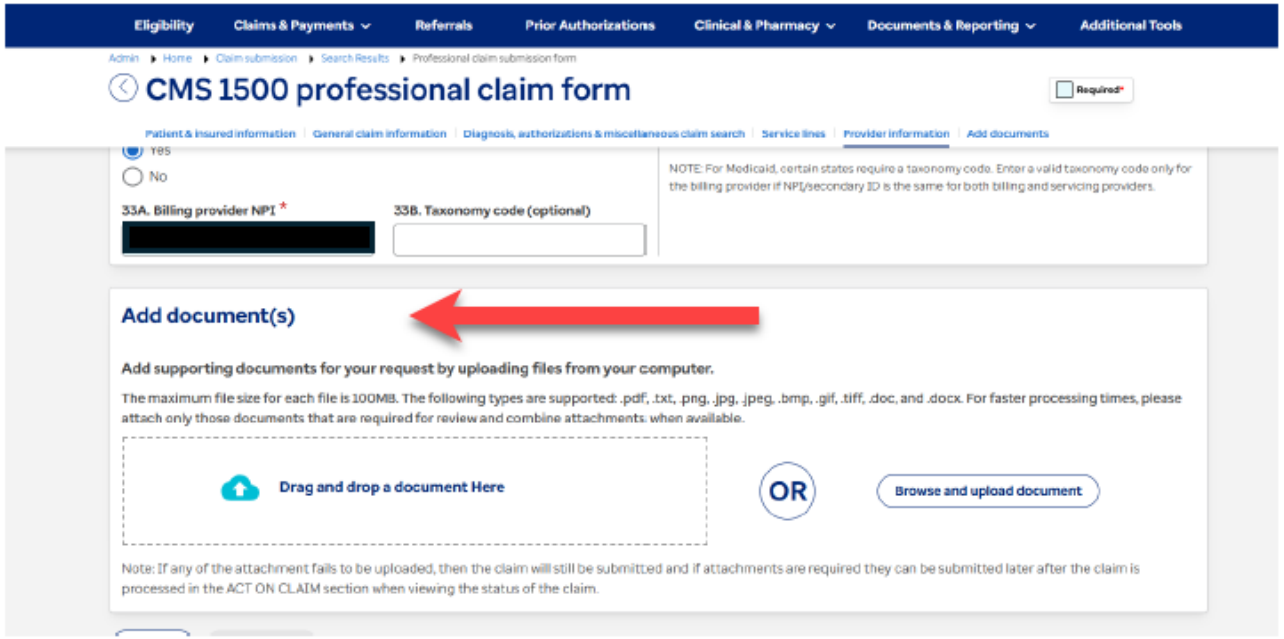
Submit the primary payer's Explanation of Benefits (EOB) when applicable.

2 Accurate COB information

Provide accurate Coordination of Benefits information for the member.

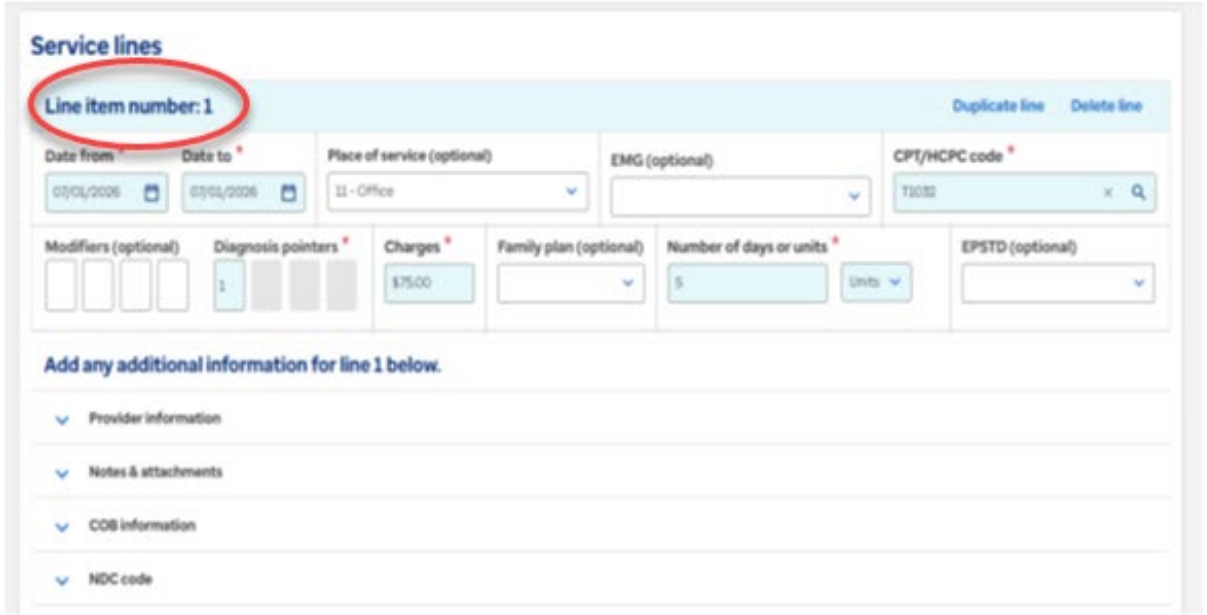
3 Provider & member information

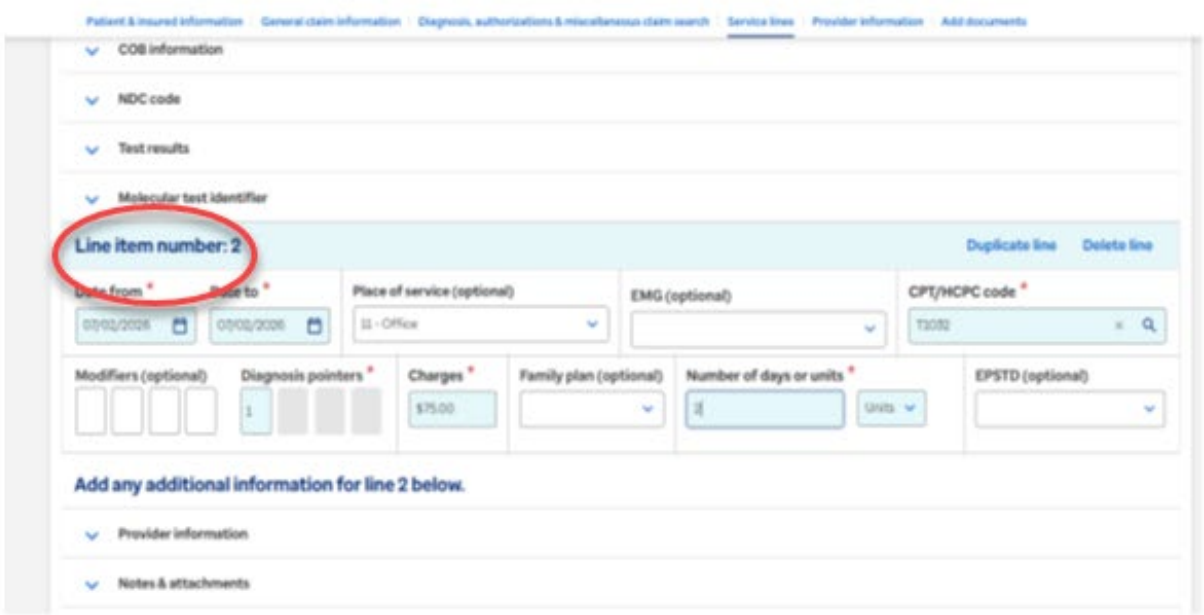
Include all required provider and member information on the claim.



Billing Multiple Dates of Service

The UHC portal requires each date of service to be billed on a separate line. Add a new line for every date of service until the full date span of the claim is reached.





Overpayments and Recoveries

An overpayment happens when a claim is paid for more than the allowed amount. Return or reconcile it within the time specified in your Provider Agreement.

Why overpayments happen

- A primary payer (TPL) or other insurance paid after the claim was already paid
- The same date of service was billed or paid more than once
- Member eligibility or coverage changed retroactively
- The claim was paid before other coverage was identified
- A billing or coding error led to payment above the allowed amount
- To have funds recouped from a future payment, call Provider Services at 1-800-600-9007.

Where to send refunds

Where to send:

Mail refunds with an overpayment return check or the Overpayment Refund/Notification form to:

UnitedHealthcare Community Plan
ATTN: Recovery Services
P.O. Box 740804
Atlanta, GA 30374-0800

Instructions and forms are on **UHCprovider.com/claims**.

If you do not agree with the overpayment findings, submit a dispute within the required time frame as listed in your contract.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal. See **Chapter 10, Resolving disputes** section.

We make claim adjustments without requesting additional information from you. You will see the adjustment on the EOB or provider remittance advice (PRA). When additional information is needed, we will ask you to provide it.

Sample Overpayment Report

The sample data below illustrates how overpayments are reported.

Sample overpayment report

*The information provided is sample data only for illustrative purposes.
Please populate and return with the data relevant to your claims that have been overpaid.

Member ID	Date of service	Original claim #	Date of payment	Paid amount	Amount of overpayment	Reason for overpayment
11111	01/01/24	14A000000001	01/31/24	$115.03	$115.03	Double payment of claim.
2222222	02/02/24	14A000000002	03/15/24	$77.29	$27.29	Contract states $50.00, claim paid $77.29.
3333333	03/03/24	14A000000003	04/01/24	$131.41	$98.56	You paid 4 units, we billed only 1.
44444444	04/04/24	14A000000004	05/02/24	$412.26	$412.26	Member has other insurance.
55555555	05/05/24	14A000000005	06/15/24	$332.63	$332.63	Member terminated.

UHC Resources

Use these links and contacts for portal access, training, and ongoing support.

Key links & contacts

- UHC Provider Portal
- Doula Orientation Training
- Network News | UHCprovider.com
- Contact: 888-835-2417 or ohmaternitysupport@uhc.com

Thank You

A collaboration across Ohio Medicaid Managed Care Organizations

For Third Party Liability and Coordination of Benefits questions, follow each plan's claim submission guidance using your member's specific MCO resources.

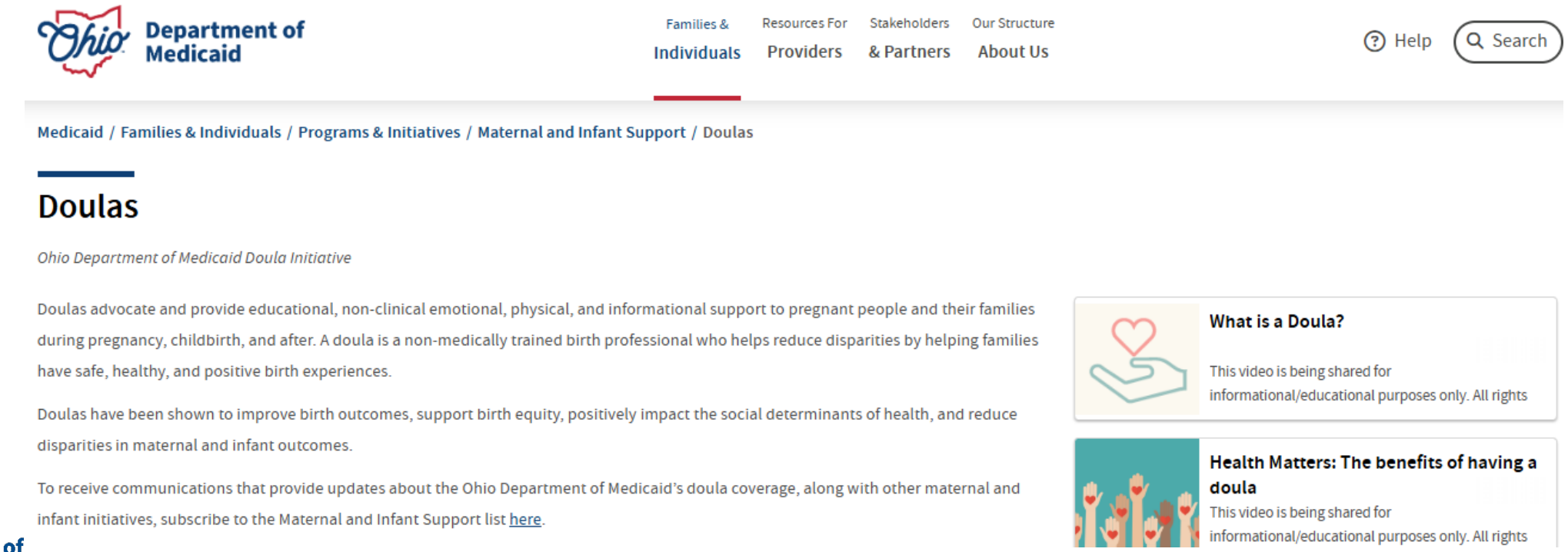
Participating Ohio Medicaid Managed Care Organizations

AmeriHealth Caritas · Anthem · buckeye health plan · CareSource · Humana · MOLINA HEALTHCARE · UnitedHealthcare

In Conclusion

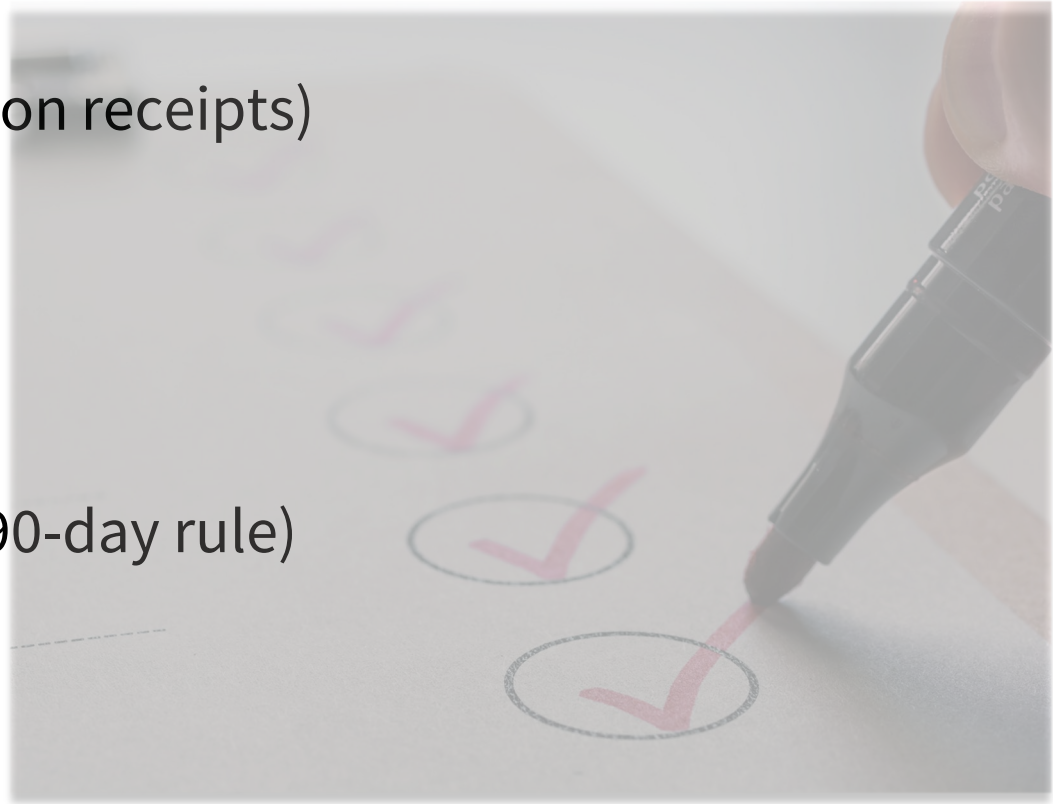
Doula Resources

- ODM Doula Webpage
  - » Previously recorded training sessions
  - » OAC 5160-8-43: Doula Services
  - » E-License Ohio – Find a Doula
  - » MCO doula claim videos
  - » All Managed Care Organization Doula Resource Guide
  - » And more!



Summary: What This Means for Your Doula Practice

- Always ask Medicaid members about other insurance
    - Verify their Medicaid coverage, prior to starting your doula services
- Keep documentation (EOBs, denials, and submission receipts)
- Bill private insurance first when applicable
- Only bill Medicaid after reasonable attempts
- Track dates of claims submissions (especially the 90-day rule)



Questions?



Ohio Department of Medicaid