Medical Foster Care Parent
Quick Reference Guide

Prestige Health Choice (PHC) prepared this Medical Foster Care (MFC) Parent Quick Reference Guide to outline how we will work together from the time a member is identified for MFC services to the successful payment of your claims.

Contracting

Once you have been identified as the MFC parent for a Prestige member, you will receive a contract to review, along with an Information Form to complete from our Provider Network team in a secured email. To become a participating MFC parent (provider) in our network, complete these following three (3) items:

- ✓ Signed Letter of Agreement (contract)
- ✓ Completed Information Form for Medical Foster Care parents
- ✓ W-9 form

Send all three (3) items back to our Provider Network team via fax or email.

- Fax # (561) 283-3400
- Scan and email back, using the secured email you received from Prestige with the blank documents for you to complete.

If you have any questions, email our Provider Network team at DL_PNM_MFC@prestigehealthchoice.com.

Care Coordination

We want to support your efforts to meet all the needs of the child. The Prestige Care Manager will be in contact with you regularly to review progress on the plan of care and assist in every way possible. The Care Management Department can be contacted via:

- Phone at 1-855-371-8076; Fax at 1-855-358-5851
- Email at DLPHCPHCMFCM@PrestigeHealthChoice.com.

Prior authorization for MFC services is **not** required for participating parents (providers).

Availity Provider Portal

You can register for the Availity portal at www.availity.com/providers/registration-details/ to access eligibility, benefits, and claim status information. If you need assistance, call 1-800-Availity.

How to File a Claim

All claims must be billed on a CMS 1500 claim form for submission to Prestige for payment.

For *line by line* instruction on how to complete a claim form (CMS 1500), go to AHCA's website at this link: http://ahca.myflorida.com/medicaid/review/Reimbursement/RH_08_080701_CMS-1500_ver1_4.pdf.

You can submit your claims 2 ways:

- Electronic Claim Submission: Prestige Health Choice **Payer ID # 77003**
- Paper Claims Submission: Prestige Health Choice
  P.O. Box 7367
  London, KY 40742

Timeframe to send claims: 180 days from the date of service (unless your contract specifies otherwise).
Timeframe for reimbursement:

- Electronic submission- within 15 days after receipt of a complete and correctly submitted claim
- Paper claim submission- within 20 days after receipt of a complete and correctly submitted claim

To submit claims electronically, you need to set up an account with Change HealthCare, or add Prestige to your existing account. We suggest you go to our portal at https://office.emdeon.com/vendorfiles/amerihealth.html and choose the option to "Enroll Now." If you need additional help, click on "Help" in the portal. You can also call Change HealthCare Customer Service directly at 877-469-3263, Option 2 for step-by-step assistance. Please be aware, for electronic submissions, the Operating System requirements are Windows Vista (minimum), or 7 or 8. The browser requirements are Internet Explorer v7.0, v8.0, v9.0, v10.0, or Firefox v3 or higher.

Note:* If you do **not have a National Provider Identifier (NPI) number, please submit the following in the "Loop 2310C" section: REF01=Qualifier G2, REF02=your Prestige Provider ID. For example, if your provider ID is 7599999, you would complete Loop 2310C with REF*G2*7599999~.

For additional information on submitting claims, corrections, and reimbursement, please go to our website at **www.prestigehealthchoice.com/provider/training-and-education/index.aspx** for online training materials.

Tips to Avoid Claim Denials:

- Bill with the child's ID, name, and DOB exactly as they appear on his/her ID card.
- Include the correct service code **modifier** (HA, TF, TG) on the claim; it's required to process the claim.

S5145 HA Level I Medical Foster Care Service
S5145 TF Level II Medical Foster Care Service
S5145 TG Level III Medical Foster Care Service

How to Submit a Complaint/Appeal Regarding a Claim

1. Download the Provider Appeal Form at www.prestigehealthchoice.com.
2. Submit the completed Provider Appeal Form via mail or fax:
   Mail: Prestige Provider Appeals Dept.
   PO Box 7366
   London, KY 40742
   Fax: 1-855-358-5853
3. Include all relevant items to support your appeal, such as the Remittance Advice, calculations, etc.
4. A Medical Foster Care parent has 180 days from the claims payment date to submit an appeal.
5. Prestige will send an acknowledgement letter within three (3) business days to confirm receipt.
6. Prestige will resolve all appeals within 60 days.