Sagamore Health Network, Inc
Provider Reference Manual

Physicians, Hospitals, Ancillaries, & Other Healthcare Professionals

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Introduction

- CIGNA Corporation acquired Sagamore Health Network in August 2007.
- Sagamore Health Network is not an insurance company, but rather a network of Providers accessed by Insurance Companies and other claims Payors. Since we are not an Insurance Company or Payor, there are some administrative differences we feel are very important that you and your office staff should understand.
- Sagamore Health Network, Inc. is committed to working collaboratively with our providers to deliver quality health care services. To assist you, we prepared this Provider Manual containing the Sagamore Health Network, Inc guidelines and procedures pertaining to our products. The Sagamore Provider Manual includes valuable information for contracted Hospitals, Ancillaries, Physicians and other Health Care Practitioners.
- Sagamore currently operates in Indiana, Illinois, Kentucky, Michigan, & Ohio.

Contact Information

Sagamore Health Network **Website**: **www.sagamorehn.com**

Sagamore Provider Service Department:	**Claim Submission Address:**
Telephone Number: (800) 320-0015 Fax: (317) 573-2787 Email: mps@sagamorehn.com Mailing Address Sagamore Health Network, Inc PO Box 6051 Indianapolis, IN 46206	Sagamore Plus & Sagamore Select PO BOX 6051 Indianapolis, IN 46206 Delegated Payor: Must check back of ID Card for claim submission address

Contact Payor to Obtain:	**Contact Sagamore to Obtain:**
• Member Eligibility • Patient Benefits • Claim adjudication status • Benefit Appeals • Pre-certification	• Claim re-priced status • Route Code information • Aged Claim Inquiry process • Provider Participation status • Credentialing information

Provider Demographic Information & Sagamore Provider Directories:

- Providers must notify Sagamore at least 30 days prior to any of the following changes: physical address, billing address, telephone number or tax identification number.
- Submit changes by using the Provider Action Request Form (PAR) located at www.sagamorehn.com under Provider Forms and fax to (317) 573-6638.

Please note: Sagamore is unable to make changes retroactively.

Sagamore Fee Requests- Providers may request a sampling of their current fee schedule:

- Contact Provider Services
  - mps@sagamorehn.com
  - 800-320-0015
  - Fax #: (317) 573-2787

Please include:

- Provider Tax Id Number
- List of top 50 CPT Codes
- Charge Amount for each CPT Code

Provider Relations Representatives are available to schedule time to educate your office staff on Sagamore tools. Please contact our member services to set up an appointment at (800) 320-0015.

Sagamore Logo Definitions

PLUS / SELECT

Sagamore offers two product options: **Plus** and **Select**. Member Identification Cards are distributed to all members who access the Sagamore Health Network. Each Identification Card will have a logo that you can use to identify the members product so you can determine if you are participating provider for that member.

DRG

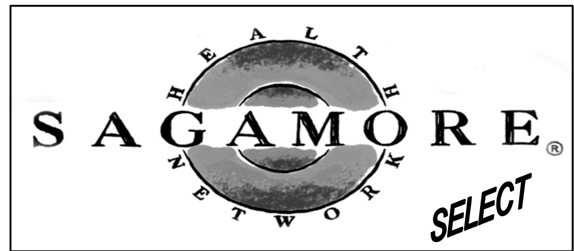
"DRG" is placed on identification cards for Payors or Employer Groups who elect DRG pricing arrangements.

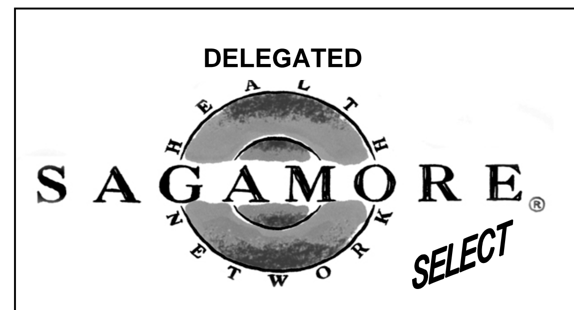
Delegated Re-pricing

Sagamore Health Network, Inc. routinely considers alternative options to our current processes to promote continuous quality improvement. One such item is delegate of repricing or delegation of claims receipt directly to the Payor(s). We have received many requests from both the Provider Community as well as the Payor Community for us to make this alternative a reality. We are pleased to announce we have entered into a delegated agreement with some Payors.

As a result of this agreement, we have required the delegated Payor to reissue all Member Identification Cards that will look slightly different from what you are accustomed. The new Identification Cards allow you to determine if the Member's Payor is a "Delegated Payor" so you can direct the claim accurately. If you see a delegated logo on an ID card, you will also see the address of the Payor instead of Sagamore. You can submit these claims directly to that Payor for prompt pricing and adjudication. We will forward any claims to the delegated Payor that are sent to our address in error. However, in the future these claims could be returned to your office requesting that you submit claims directly to the Payor at the address indicated on the Member's identification card.

Sample Sagamore Logo's Found on Identification Cards





SIMPLY THE BETTER CHOICE.

Route Codes

Route codes are unique identifiers that enable Sagamore to correctly identify the payor when claims are submitted. Utilizing the Route Code decreases the number of returned claims, improves auto adjudication and minimizes the overall number of days in your Accounts Receivables.

A Route Code is 7 digits and always begins with the letters 'SAG'. The Route Code will be located on the Members Identification Card.

When submitting your claims to Sagamore list the appropriate Route Code in Field 11C on the 1500 Form or in Field 50 of the UB. Updated format information can be found at www.sagamorehn.com under Physicians and Hospitals. Click on "Electronic Claims Filing", then: "Please click here to read "*Using the Sagamore Route Code with HIPAA*".

If you do not have a copy of the Member Identification Card you can search for a Route Code by accessing the Sagamore website at www.sagamorehn.com in the section titled Physicians and Hospitals and click on Route Code Lookup.

Route Code Lookup

Enter a valid **Group Number** in the field below and click the **Look Up** button. The Group Number and its corresponding **Route Code** will be displayed.

NOTE: Alphabetic characters must be entered as numbers that correspond to a telephone keypad. Use the guide below to help you. For example the Group Number **1SHN** would be entered as **1746**.

1	ABC 2	DEF 3
GHI 4	JKL 5	MNO 6
PQRS 7	TUV 8	WXYZ 9
*	0	#

Enter a Valid Group Number - See NOTE:

Look Up

NOTE:
Alphabetic characters must be entered as numbers that correspond to a telephone keypad. Use the guide at left to help you.
For example the Group Number **1SHN** would be entered as **1746**.

SIMPLY THE BETTER CHOICE.

Claim Submission Requirements

Sagamore Health Network, Inc. is not an insurance company. Claims are submitted to Sagamore for re-pricing and forwarded to the Payor for resolution. It is important to follow the required filing guidelines to insure proper handling of your claims. Please refer to the HIPPA compliance guidelines at www.sagamoreh.com. If you have questions contact our Provider Service Department at (800) 320-0015.

NOTE: Any missing or invalid information could result in your claim being returned without adjudication.

Electronic Claim Submission

We currently receive electronic claims from several EDI clearinghouses listed below. Please feel free to contact them or one of our Provider Representatives at (800) 320-0015.

Allscripts (PayorPath)	Payor ID 35164	(804) 560-2400	www.payerpath.com
Availity	Payor ID 35164	(972) 766-5480	www.availity.com
Capario (MedAvant)	Payor ID 35164	(800) 586-6870	www.capario.com
CPSI	Payor ID 35164	(251) 639-8100	www.cpsinet.com
Ehealthclaim.net	Payor ID 35164	(877) 881-7484	www.ehealthclaim.net
Emdeon / Webmd/ ENVOY / NEIC	Payor ID 35164	(800) 215-4730	www.emdeon.com
ENS an Ingenix Company	Payor ID 35164	(800) 341-6141	www.enshealth.com
Gateway EDI	Payor ID 35164	(800) 969-3666	www.gatewayedi.com
McKesson (RelayHealth)	Payor ID 4543 (Hospital) 6464 (Professional)	(800) 527-8133	www.mckesson.com
MedAssets / Xactimed		(888) 883-6332	www.medassets.com
NDCHealth / Per-Se (RelayHealth)		(800) 942-3022	www.relayhealth.com
RealMed	Payor ID 35164	(877) REALMED	www.realmed.com
The SSI Group, Inc.	Payor ID 35164	(800) 880-3032	www.thessigroup.com
TK Software Inc.	Payor ID 35164	(888) 372-2808	www.tksoftwareinc.com
Zirmed	Payor ID 35164	(877) 494-7633	www.zirmed.com

Sagamore only has a direct connection with these clearinghouses. Use of other clearinghouses will require the claims to go through multiple clearinghouses in order to get to Sagamore. Ultimately, one of the clearinghouses listed above must receive the claims in order for them to be loaded into the Sagamore system.

Sagamore will **not** electronically reject any claims. An intermediary clearinghouse - **not** Sagamore, generates any electronic rejects a provider may receive. If the Sagamore system is unable to process the claim, it is printed and mailed directly to the provider with a letter of explanation.

Aged Claims Inquiry Process

The purpose for the Aged Claim Inquiry Process is to provide a process for inquiry of aged claims 30 days and older. The procedure entails the use of correspondence to notify Payors of claims in excess of 30 days, aging from billing date (defined as SHN receipt date). Also, it gives notification of the provider's right to pursue accounts receivable from the member if the inquired claim is not resolved within 30 days from date of written notification.

The Provider must first contact the Payor to verify the claim was received and identify what action the Payor has taken on this claim. The Provider documents the date of this Payor contact, the name of the Payor representative and the claim status. If the Payor indicated the claim was not received, the provider can then contact Sagamore by either phone or correspondence. Any aged claim inquiries received without this documentation will be returned to the provider.

When a Sagamore contracted Provider initiates the Aged claim inquiry process, the Sagamore Provider Service Representative generates a notice to the Payor (Letter A), with a copy of the re-priced claim to the provider, advising the Payor this claim needs immediate attention. (Providers will receive a copy of the letter and should retain the copy as documentation of the Payor's 30 day notice).

If the 30 day period expires and the claim is still unresolved, the provider may pursue normal account receivable procedures.

There are three methods available for a Provider to use to initiate the Aged Claims Inquiry Process. Each process requires that you have the following data elements when checking claim status: provider's tax identification number, member's identification number numeric and/or alpha, date of service and the member's date of birth

1. **Claims Inquiry via the Internet**
    - Providers may perform claims inquiry by accessing the Sagamore website
    - Access to claims status information 24 hours a day, 7 days a week
    - Providers may inquire on a maximum of ten claims at a time
    - Providers are able to input Payor Contact Information and perform the Aged Claim Inquiry Process
2. **Claim Inquiry by Phone,** (800) 320-0015
3. **Written inquiry to Sagamore**, use Aged Claim Form that can be found at www.sagamorehn.com or at the end of this manual.

Aged Claim Internet Inquiry

The screen prints below are examples of the information you will see with completing an inquiring on the Sagamore website.

Claims Lookup - Search

Claim status lookup can be used to retrieve the status of Sagamore claims Only. All non-Sagamore claims, including delegated payor claims, are not Supported. Please contact the correct Payor for the claim's status.

Tax Identifier [ ] Help?

◉ Member ID or
○ Patient Account Number [ ] Help?

Service Date [ ]/[ ]/[ ] Help?

Look Up | Reset

File >>

Address

SAGAMORE

Claims Lookup - Search Results

Claim Status Lookup for Tax Id 999999999

Member ID : 123456789

Service Date 5/15/02

Status	Received/ Processed	Payor Name/ Phone Number	Patient Name/ Account Number	Patient Birth Date	Charges/ Allowed	Aged Claim Notification
Repriced Electronic Confirmed	5/15/02 5/16/02	Nyhart 800-428-7106	JOHN DOE JR. 1234567	9/2/1942	$2,338.00 $1,696.53	Create Letter
Repriced Confirmed	2/26/02 2/28/02	Principal 800-247-4695	JOHN DOE JR. 548759896	9/2/1942	$507.00 $405.60	Create Letter

Return to Provider (RTP) Guidelines

Sagamore Health Network, Inc. makes every attempt to re-price a claim. If there are missing items on the claim form it will result in a Return to Provider (RTP). The following items are critical to the proper identification and re-pricing of a claim, if any of these items are missing the claim may be returned for additional information:

- Route Code
- Group information including group number, group name or payor name
- Diagnosis Codes
- Procedure Codes
- Name of provider (not included in box 31 of 1500 form)
- Tax Identification Number (invalid or omitted)
- Dates of Service
- Billing Address
- Correct Number of Units
- Date of Service
- Place of Service
- Patient Control Number (omitted from UB)
- Type of Bill (omitted from UB)

If a claim is returned to the provider a RTP Cover Letter is included indicating the missing information.

Credentialing for Physicians and Health Care Providers

Providers are credentialed before joining the Sagamore network and periodically thereafter to help ensure they continue to meet our qualifications for participation. Criteria for participation are determined by business needs and by our credentialing/recredentialing policies and procedures, reviewed annually to reflect National Committee for Quality Assurance (NCQA), local and state standards. Sagamore has delegated credentialing to CIGNA Healthcare. You will begin your enrollment with Sagamore, but CIGNA will assist with the completion of the credentialing and recredentialing.

Sagamore credentials the following provider types/specialties:

- APN, APRN, ARNP- Advanced Practice Nurse
- CNM- Certified Nurse Midwife
- CNS, RN, CNS- Clinical Nurse Specialist
- CRNA-Certified Registered Nurse Anesthetist
- DC- Chiropractor
- DDS, DMD- Oral Surgeon only
- DO-Doctor of Osteopathy
- DPM-Podiatrist
- LCSW-Licensed Clinical Social Worker
- LMFT-Licensed Marriage & Family Therapist
- LMHC-Licensed Mental Health Counselor
- MD-Medical Doctor
- NP, ACNP, RN, RNP- Nurse Practitioner
- OD-Optometrist
- PA-Physician Assistant
- PhD, PsyD, EdD-HSPP certified-Psychologist

Follow these steps to complete the credentialing process:

1. Complete CAQH Application
2. Complete Sagamore Provider Data Sheet
3. Forms can be accessed on our website – www.sagamorehn.com **(**under Physicians & Hospitals)

Council for Affordable Quality Healthcare (CAQH) Credentialing Database System

Sagamore is part of the Council for Affordable Quality Healthcare (CAQH), a not-for-profit alliance of greater than 350 managed care plans, physician/hospital organizations and trade organizations. CAQH recognizes the need to simplify administrative requirements and allow you to focus on caring for patients. Improving processes for obtaining and managing data is a key factor to saving time. Working with health care delivery systems and various technical and software specialists, CAQH sponsors the Universal Provider DataSource initiative. This sophisticated online database system was developed by managed care organizations with help from physicians, professional associations and accreditation organizations. It allows health care professionals to complete one credentialing application and enter confidential information into one, secure database. With your approval, this information is shared with participating health plans and other participant organizations. The basic information is provided only once, and updates are made online or by fax. There is no charge to submit information to the CAQH credentialing database and providers are contacted regularly to ensure the information is complete and current. Provider use of the CAQH application is mandated in some states. Sagamore strongly encourages the use of the CAQH Universal Provider DataSource when submitting your application in all states. For more information about the Universal Provider DataSource or to apply online, visit www.CAQH.org. For questions about completing the application, call the CAQH Help Desk at 1.888.599.1771 or e-mail CAQH at caqh.updhelp@acsgs.com.

Submitting Paper Forms

If you do not have Internet access, call CAQH at 1.888.599.1771 to request a paper application. In addition, you need to call Sagamore at 1.800.320.0015 to initiate the credentialing and contracting process. The credentialing process includes a review of the standard application and independent verification of certain documentation submitted. Information submitted must be accurate, current and complete. Sagamore requirements for physician participation include, but are not limited to, the following:

- A completed signed and dated application (dated within 250 days). Correction liquid must not be used in the signature area. Applications with altered signatures will not be processed
- A completed, signed and dated authorization and release form, if not included in the application form

Credentialing/ Recredentialing (Cont'd)

■ A completed, signed and dated provider agreement (2 originals), copy of a completed Provider Data Sheet, copy of a completed W-9, and copy of a CMS-1500 claim form with Box #33 completed, if not provided on Provider Data Sheet
■ A current unrestricted license to practice medicine in the state where practicing
■ A current unrestricted DEA certificate (if applicable)
■ A current unrestricted CDS certificate (if applicable)
■ Board Certification in a recognized specialty by the American Board of Medical Specialties (ABMS), American Osteopathic Association, American Board of Podiatric Surgery or American Board of Podiatric Orthopedics and Primary Podiatric Medicine
■ Unrestricted admitting privileges to at least one Sagamore participating hospital, depending on the network in which you are requesting to participate. Exceptions may be granted in instances where an applicant's specialty does not typically require admitting privileges (e.g. allergy, radiology) or where satisfactory alternative mechanism has been established, e.g. hospitalist, and documentation included. Temporary or pending privileges are not acceptable
■ Professional liability insurance with minimum coverage of $1,000,000 per incident and $3,000,000 aggregate for physicians and other health care providers
■ Acceptable history of professional liability claim experience as determined by Sagamore
■ Completed professional liability form (with explanation of each case). (Not required if provided via CAQH application.)
■ Acceptable history of Medicare/Medicaid sanctions as determined by Sagamore.
■ Acceptable responses to all questions on the credentialing application form as determined by Sagamore.
■ A query and results from the National Practitioner Data Bank.

You have certain rights during the credentialing process, including the right to:
■ Review information submitted to support your application, including information from outside sources
■ Correct erroneous information if credentialing information obtained from other sources varies substantially from what you provided
■ Be informed of the status of your credentialing or recredentialing application.
The decision to accept or deny participation will be communicated in writing.

Notice of Material Changes
As a participating provider, you are responsible for notifying Sagamore immediately of any material changes to the information presented as part of the credentialing or recredentialing process. Failure to notify Sagamore of changes or to satisfy requirements may result in your removal from the Sagamore network.

Termination Appeal Process

You may appeal a decision by Sagamore to terminate your participation in the Sagamore networks. Submit appeals in writing within 30 days of notification of termination from the network. Refer to your provider agreement and the dispute resolution sections of this reference guide for further details.

Re-credentialing Process

Sagamore recredentials its participating physicians once every three years or more often if required by state law. If you have not applied through the CAQH Universal Provider DataSource, you will be mailed a recredentialing letter approximately six months before your recredentialing date. The letter will direct you to complete the CAQH Universal Provider DataSource credentialing form. If you already completed and updated the CAQH application and attestation and authorized Sagamore to receive current credentialing information, Sagamore will automatically have access to your application during the recredentialing process, and Sagamore will only contact you if needed. If you use a state-mandated form outside of CAQH, you must update any information that has changed, sign the attestation and submit the application along with current supporting documents. During the recredentialing process, completed applications are reviewed and certain new information is independently verified.

The criteria reviewed include but are not limited to:

■ Original signature and date of signature (can be done through the CAQH Universal Provider Data Source application);
■ Completed, signed and dated authorization and release form if not included in the application form;
■ Current, unrestricted license to practice medicine in the state where practicing;
■ Current DEA certificate number (if applicable);
■ Current CDS certificate number (if applicable);
■ Status of current board certification;
■ Record of adequate education and board certification for any new specialty in which you request to be credentialed
■ Verification of unrestricted admitting privileges to at least one Sagamore participating hospital dependent upon the network participation being requested.

Exceptions may be granted in instances where a provider's specialty does not typically require admitting privileges, e.g. allergy, radiology, or where a satisfactory alternative mechanism has been established, e.g. hospitalist, and documentation included;
■ Professional liability face sheet to ensure professional liability coverage meets Sagamore requirements;

Credentialing/ Recredentialing (Cont'd)

■ Acceptable history of professional liability claim experience as determined by Sagamore;
■ Completed professional liability form with explanation of each case; (not required if provided via CAQH application):
■ Written explanation relevant to professional liability and practice review questions;
■ Acceptable history of Medicare/Medicaid sanctions as determined by Sagamore;
■ A query and results from the National Practitioner Data Bank
■ Acceptable responses to all questions on the credentialing application form as determined by Sagamore

Credentialing

You must not make any material misrepresentations in the information provided during your contractual relationship with Sagamore, including medical record information. In addition, you must continue to satisfy the criteria referenced above that were applied at your initial credentialing. The following documents must be current in the CAQH Universal Provider DataSource system or be submitted in a recredentialing packet. If any of the following documents are missing, your file cannot be processed, and participation in the Sagamore network may be terminated.

■ Signed, dated and completed professional liability form (Form A) (not required if submitted through CAQH)
■ Copy of current DEA and CDS (if applicable) certificates
■ Copy of current professional liability face sheet if liability coverage is not listed in the CAQH application.

Non-Physician Practitioners

Sagamore credentials and recredentials non-physician practitioners in the following categories when Sagamore holds a direct provider agreement with the practitioner:
■ Certified Midwives and Certified Nurse Midwives
■ Certified Registered Nurse Anesthetists
■ Nurse Practitioners
■ Physician Assistants

This list is subject to change and is subject to state law mandates. Credentialing and recredentialing requirements are similar to physician requirements.

Credentialing for Hospitals & Ancillary Facilities

This information pertains to Hospital & Ancillary Facilities only.

To help ensure Sagamore network providers meet CIGNA quality standards for participation and to comply with accreditation requirements, hospitals and ancillary facilities are credentialed before participating in the Sagamore provider network. Participating hospitals and ancillary facilities must maintain an ongoing quality improvement program that monitors and evaluates the quality and appropriateness of patient care, pursues improvement opportunities and resolves problems. Accrediting organizations, such as the Joint Commission (JC), validate a quality improvement program. When accreditation, state Department of Health or Medicare certification evidence is not available, CIGNA performs a site visit and review of the hospital or ancillary facility quality improvement program. In accordance with the Sagamore credentialing requirements, hospitals and ancillary facilities must apply for participation by completing a standard application form and satisfactorily meeting the established criteria. The CIGNA Credentialing/Recredentialing Policies and procedures are reviewed at least annually and revised as necessary, including revisions to reflect state and local quality assurance standards. The information required to complete the credentialing process includes but is not limited to the following:

- Copy of unrestricted state license or state operating certificate, as applicable
- Copy of current accreditation letter or certificate
- Proof of current professional and general liability insurance coverage that meets Sagamore minimum guidelines
- National Provider Identifier
- Any explanation requested on application, including a list of malpractice settlements and judgments
- If not accredited, a copy of the most recent Centers for Medicare and Medicaid Services (CMS) evaluation
- An onsite assessment, if not accredited or Medicare/Medicaid-certified
- A copy of the Quality Management Plan, if not accredited or Medicare/Medicaid certified
- List of available services that can be rendered by facility
- Absence of current sanctions from Medicaid or Medicare

If an ancillary facility is not subject to State licensure requirements, the Sagamore credentialing committee will determine if the facility meets remaining credentialing standards for participation in the Sagamore network.

Recredentialing Requirements for Facilities

Participating hospital and ancillary facilities are recredentialed every three years or more frequently if required by applicable law. Sagamore credentialing staff will confirm that the hospital/facility continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body. Participating providers are responsible for notifying Sagamore immediately of any material changes to the information presented at the time of the provider's prior credentialing/recredentialing cycle. Failure to notify Sagamore of changes or to satisfy requirements may result in termination from the Sagamore network. Recredentialing and continued participation in the provider network is dependent upon the hospital or ancillary facility continuing to meet the Sagamore credentialing/recredentialing standards.

Types of Hospitals and Ancillary Facilities to be Credentialed

Sagamore credentials and recredentials, but may not be limited to, the following types of hospitals and facilities:

- Hospitals (i.e. acute, subacute, transitional, or rehabilitation)
- Home health agencies (nursing and home infusion)
- Long term care facilities (skilled nursing facilities or nursing homes)
- Hospices
- Free standing ambulatory surgical centers (such as cardiac catheterization labs and endoscopy centers)

* States may require credentialing of additional facility types and Sagamore will adhere to state guidelines where required.

Aged Claim Follow-Up Form

Sagamore® Health Network, Inc.
Aged Claim Follow-Up - Form

Sagamore Health Network
Aged Claim Inquiry - Payor Contact Information

Patient Name: ______________________________________

Identification Number: ______________________________________

Service Date: ______________________________________

Total Charge: ______________________________________

Name of Payor: ______________________________________

Date of Payor Contact: ______________________________________

Payor Representative Name: _________________________________

Payor's Status of Claim: ______________________________________

Please return the above form with attached claim to:

Sagamore Health Network, Inc.
ATTN: Provider Services Department
P.O. Box 6051
Indianapolis, Indiana 46206
(800) 320-0015

Return to Provider (RTP) Sample Letter

Jane Smith, MD
1234 Any Street, Suite 245
Indianapolis, IN 46032

January 1, 2015

Dear Dr. Smith:

Every attempt has been made to prevent the return of this claim; however, we are unable to reprice and/or forward the claim to the appropriate payor (insurance company or third party administrator) due to the following:

____1. The claim(s) was returned by the payor as unidentified or no longer effective with them.

____2. The claim(s) was incurred when not effective with Sagamore Health Network.

____3. The claim(s) cannot be identified as belonging to Sagamore Health Network.

____4. The claim(s) had incomplete or invalid information. Please resubmit with the following:

- _____ a. ICD-9-CM diagnosis code
- _____ b. CPT-4 procedure code
- _____ c. Itemized charges
- _____ d. Tax identification number
- _____ e. Date(s) of service
- _____ f. Billing address
- _____ g. Number of units
- _____ h. Complete name of provider of service
- _____ i. Present On Admission (POA) indicators
- _____ j. Other ____

If you feel this claim was returned in error, please resubmit it with a copy of the patient's current identification card showing that Sagamore Health Network was effective on the date of service.

Thank you for your assistance,

Claims Department/Sagamore Health Network

Please return this form and the attached claim with the requested information to:

11595 North Meridian Street, Suite 600 • Carmel, Indiana 46032
TEL (317) 573-2900 • FAX (317) 573-2747

Example of Letter A

Dear:

Attn: Customer Service

Patient:
Patient ID Number:
Date of Service:
Total Charged: $

RE: A *Aged Claim Inquiry*
Claim Previously by SHN

Dear
Sagamore Health Network, Inc. has received an inquiry regarding the above noted claim.

Our records indicate this claim was sent to you on for consideration. A copy of the repriced claim has been printed and attached for your convenience. The Provider has not received an Explanation of Benefit (EOB) that would indicate the claim has been processed.

Please provide the status of the claim to the provider's office as soon as possible.

Hopefully, by bringing this claim to your attention, the claim will be processes within the next 30 days. If the claim has been processed previously, please provide a copy of the EOB or other notification of payment/denial to the below listed provider address.

If the claim remains unprocessed and /or provider has not received notification of payment /denial from you within 30 days of receipt of this letter, the Provider will pursue normal account receivable processes.

Thank you for your prompt attention to this matter.

Sincerely,

Member and Provider Services

Attachment: Copy of Repriced Claim

cc: Provider

Example of Adjustment Letter

Date:

Attn: Customer Service

Patient:
Patient ID Number:
Date of Service:
Total Charged: $

RE: F ***Adjustment***

Dear Customer Service:

Please do not deny the enclosed claim as a duplicate. This claim is an adjustment of a previously filed claim. The reason for the adjustments is one of the following:

- ☐ Corrected Number of Units
- ☐ Corrected Repricing
- ☐ Corrected Provider Information
- ☐ Corrected Patient Information

Please review the claim for further consideration and respond to the provider of service regarding your findings. Thank you for your prompt attention to this matter.

Sincerely,

Member and Provider Services

Attachment: Copy of Repriced Claim

cc: