Preferred IPA
Provider Notice

Claim Submission Instructions

A. Sending Claims to Preferred IPA. Claims for services provided to members assigned to Preferred IPA must be sent to the following:

Via Electronic Submission:	Office Ally (866)575-4120 or (360)975-7000
Via Mail:	Preferred IPA Attn: Claims Department P.O. Box 4449 Chatsworth, CA 91313
Via Physical Delivery:	9131 Oakdale Avenue, Suite 150 Chatsworth, CA 91311
Via Fax:	(818) 407-1699

B. Calling Preferred IPA Regarding Claims. For claim filing requirements or status inquiries, you may contact Preferred IPA by calling: (800) 874-2091. The claims inquiry telephone line is open Monday through Friday from 9 a.m. – 4 p.m. The claims inquiry telephone line will be closed on Federal Holidays.

C. Claim Submission Requirements. The following is a list of claim submission requirements for Preferred IPA:

Timely submission of claims: Claims must be received at the claims address above within 180 days from the date of service. Claims received which exceed the timely filing limit must be accompanied by documentation supporting the reason for the late submission. Claims not received within the timely filing limit may be denied.

Complete Claim submission: Each submitted claim must be complete claim as that term is defined in, Title 28 California Code of Regulations (CCR) §1300.71(a)(2):

"Complete claim" means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides "reasonably relevant information" as defined in section (a)(10), "information necessary to determine payer liability" as defined in section (a)(11) and:

- For emergency services and care provider claims as defined by section 1371.35(j):
  - The information specified in section 1371.35(c) of the Health and Safety Code; and
  - Any state-designated data requirements included in statutes or regulations.
- For institutional providers:
  - The completed UB92 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC;
  - Entries stated as mandatory by NUBC and required by federal statute and regulations; and
  - Any state-designated data requirements included in statutes or regulations.
- For dentists and other professionals providing dental services:
  - The form and data set approved by the American Dental Association;
  - Current Dental Terminology (CDT) codes and modifiers; and
  - Any state-designated data requirements included in statutes or regulations.
- For physicians and other professional providers:
  - The Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format;
  - Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD-9CM) codes;
  - Entries stated as mandatory by NUCC and required by federal statute and regulations; and
  - Any state-designated data requirements included in statutes or regulations.
- For pharmacists:
  - A universal claim for and data set approved by the National Council on Prescription Drug Programs; and
  - Any state-designated data requirements included in statues or regulations;
- For providers not otherwise specified in these regulations:
  - A properly completed paper or electronic billing instrument submitted in accordance with the plan's or the plan's capitated provider's reasonable specifications; and
  - Any state-designated data requirements included in statutes or regulations.

In addition, each claim shall include the following information:

Supplemental Claims Information and documentation: In addition to the information described above, supplemental claims information, including medical records and invoices for drugs or durable medical equipment, that is necessary to identify the patient and/or the nature and cost of the services rendered

may be required to process claims. In the event that any supplemental claims information necessary for claims processing is not included with the claims submission, a written request for the supplemental information will be mailed to the provider.

D. Claim Receipt Verification. For verification of claim receipt by Preferred IPA, please do the following (allow 15 working days after the claims submission for paper submissions and 2 working days after the claims submission for electronic submissions prior to requesting receipt verification):

Via Telephone: For claim receipt verification inquiries, you may contact Preferred IPA by calling: (800) 874-2091. The claims inquiry telephone line is open Monday through Friday from 9 a.m. – 4 p.m. The claims inquiry telephone line will be closed on Federal Holidays.

Via Mail: Should you wish to obtain claims receipt verification via mail, please submit a written request to:

Preferred IPA
Attn: Claims Department
P.O. Box 4449
Chatsworth, CA 91313