

## Provider Information Guide

Use this guide as a quick reference for the administration of plans using the ChoiceCare® Network. For further information, call Provider Relations at 1-800-626-2741, Monday - Friday (8 a.m. - 6 p.m.).

### ChoiceCare Network Identification Cards

All patients should have an ID card. Key information is identified on the sample identification card below.

**Payor/self-funded group identification**

**Payor Name**

INSURED NUMBER: 999999999

INSURED NAME: Employee Last Name, Member's First Name

MEDICAL COVERAGE: Coverage Type

**ChoiceCare Network logo**

**PPO**

GROUP NUMBER: 7777777

EFFECTIVE DATE: MM/DD/YY

PPO NETWORK OFFICE COPAYMENT: \$xx.xx

EMERGENCY ROOM COPAYMENT: \$xx.xx

**Product/plan identification (i.e., PPO/EPO/POS)**

**Member coverage description**

**Claims submission address**

Present this card to your provider at the time services are rendered.

- Precertification is required, please call 1-xxx-xxx-xxxx. For more information, refer to your Certificate of Coverage.
- Benefit and Claims Information: 1-xxx-xxx-xxxx
- Enrollment Changes: Contact your local HR representative.
- Provider Verification: To verify if your doctor, hospital or facility is in the ChoiceCare Network: Call 1-xxx-xxx-xxxx.

**This Plan provides automatic assignment of benefits to the provider. Mail itemized bills including diagnosis to the Plan Supervisor at:**

Attn: Claims Department  
 Payor's Name  
 Payor's Claims Department Address  
 Payor's Claims Department City, State and Zip

### Preadmission Review/Authorization

Preadmission review and authorization may be required by the payor. Please follow the directions and call the appropriate phone number listed on the identification card. Please have the following information ready:

- Subscriber's name
- Patient's name
- Patient's date of birth
- Patient's relationship to insured
- Group number
- Date and time of planned admission
- Patient's address
- Admitting hospital name
- Admitting physician's name
- Proposed plan of care (including relevant prior therapies)

### Claims

All claims must be submitted on a HCFA 1500 form for Provider or a UB-92 form for Hospitals and Surgery Centers. In order for claims to be processed quickly, please include the information listed below:

- Member's name and SSN
- Member's group number
- Patient's name
- Patient's date of birth
- Current procedure coding (CPT)
- Current diagnosis coding (ICD9)
- Current revenue codes
- Provider's tax ID number
- Charges for each procedure
- Authorized signature

### Who do I call?

- **Claims and Benefits, Eligibility and Preadmission Review:** Please refer to the member's ID card and call the appropriate number listed on the back of the card.
- **Provider Relations:** Please call provider relations to update provider information, such as address and Tax ID changes or additions and deletions of participating providers. (Monday - Friday, 8 a.m. - 6 p.m.)

**Phone: 1-800-626-2741**  
**Fax: 1-800-626-1686**