**Contracted Provider Process for Submitting Other Health Coverage Explanation of Benefits to the**

**Department of Behavioral Health**

1. After claims have been sent and as responses [Explanation of Benefits (EOB) or Remittance Advice (RA)] are received, send EOB/RA denials with proper denial reason to the assigned Contract Analyst and DBH Accounts Receivable inbox as follows:

1. Contracted Providers will submit a copy of any full/partial payment, original 1500 claim form, and response from OHC [Explanation of Benefits (EOB)/Remittance Advice (RA)] and any other applicable documentation to the assigned Contract Analyst and DBH Accounts Receivable inbox at DBHAccountsReceivable@fresnocountyca.gov.
2. Each person served packet should be scanned separately
	1. The pdf file may contain one or more of the following documents for the same person served: EOB/Master Client Report/Plan Information/Eligibility Responses, etc.
	2. If there is more than one EOB for the same person served for multiple Dates of Service, scan all of the documents in the same file.
3. Include the following file name format for each file: Date of Service YY MM DD – whether a Denial or Payment - Client Initials
	1. **Example**: 2018 06 07 Denial YT
	2. If there is more than one Date of Service, list the oldest date
4. Email Subject line format: EOB – Provider Name – Date of Service YY MM DD
	1. **Example**: EOB Exodus 2018 06 07
	2. If there is more than one Date of Service, list the oldest date
5. Contracted Providers are to submit the information outlined above to the Department of Behavioral Health (DBH) as the information is received and on a continual basis. Contracted Providers should not delay submission to DBH; timely submission is crucial for timely processing.

**Important**: A proper denial reason is one that essentially could not have been corrected by the provider. If a denial is received with a denial reason due to a provider error, correct the error and rebill for the service(s). Please prioritize charges that are nearing the 9-month mark to allow DBH billing staff sufficient time to process charges.

**Example**: OHC responses (EOB/RA) for services that were rendered in January 2019 must be submitted to DBH no later than October 2019.

1. It is the Contracted Providers responsibility to track the timeframe of claims to ensure timely claim submission.
2. Contracted Providers are responsible for verifying each person served’s coverage and obtaining the following information:
	1. Assignment of Benefits (required annually and to be kept on provider records)
	2. Front and back copy of insurance card
	3. Medi-Cal Eligibility Verification
3. Contracted Providers should contact the other health coverage to inquire about submission process and if prior authorization is needed for services.

**Note**: If a response has not been received within 45 days of submitting a claim to OHC, it is the Contracted Providers responsibility to follow-up with the OHC. When person served has Medi-Cal as a secondary coverage, under Medi-Cal rules, if after 90 days from prior submission and no response has been received from the OHC, Contracted Providers must submit proof of prior submission via email to assigned Contract Analyst and DBH Accounts Receivable inbox for processing.