ApexHealth Claims Manual

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Claims Manual

The ApexHealth Claims Manual describes the billing and claims processing policies, procedures, and protocols of ApexHealth, herein referred to as Apex or the Plan. All claims that are submitted for medical services provided for beneficiaries enrolled with ApexHealth Medicare Advantage Plan are processed in accordance with Medicare Guidelines and follow all Centers for Medicare and Medicaid Services (CMS) claims policies. For a copy of the Medicare Claims Processing Manual, please visit www.cms.gov.

Definitions

Clean Claim: The term clean claim means a claim that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

All claims, both electronic and paper, must conform to CMS clean claims requirements and claims billing and submission guidelines, including those set forth in the Medicare Claims Processing Manual and in accordance with prevailing Correct Coding Initiative (CCI) edits.

CMS: Centers for Medicare and Medicaid Services

Coordination of Benefits Agreement (COBA): Agreement which standardizes the way that eligibility and Medicare claims payment information within a claims crossover context is exchanged. COBAs permit other insurers and benefit programs (also known as trading partners) to send eligibility information to CMS and receive Medicare claims data for processing supplemental insurance benefits from CMS' national crossover contractor, the Benefits Coordination & Recovery Center (BCRC). The BCRC houses COBA trading partner's eligibility information for crossover purposes only in those instances where the information successfully matches with the in-file CMS entitlement information. COBA trading partners are apprised of situations where their eligibility information matches CMS eligibility data as well as when their submitted information does not result in a match.

Coordination of Benefits (COB): Coordination of benefits (COB) establishes the order in which benefits are paid and the amount by which the secondary plan may reduce its benefits. COB ensures that the combined payments of all plans do not add up to more than the covered health care expenses.

Non-Contract Provider: A provider or supplier that does not contract with ApexHealth to provide services covered by the Plan

Participating Provider: A Participating Provider is a health care provider, supplier, or practitioner who is contracted with ApexHealth to provide services to our members

Primary Payers: Those payers that have the primary responsibility for paying a claim. Medicare remains the primary payer for beneficiaries who are not covered by other types of health insurance or coverage. Medicare is also the primary payer in certain instances, provided several conditions are met.

Waiver of Liability: A form holding the enrollee harmless regardless of the outcome of the appeal

Claims Submission

Apex accepts medical claims sent electronically via Electronic Data Interchange (EDI) and paper claims submitted by mail. Apex strongly encourages Participating Providers to submit claims electronically. Claims from Participating Providers will be processed in accordance with their agreement with the plan. Claims from Non-Contracted Providers, or by members or their representatives for out-of-network services, will be processed in accordance with the Non-Contracted Provider CMS Guidelines.

Apex requires that providers use HCPCS, CPT, ICD-10, and revenue codes when billing the Plan.

Providers must use the current revision of the International Classification of Diseases, Clinical Modification (ICD-10-CM) codes and adhere to all conventions and guidelines specified in the ICD-10-CM Official Guidelines for Coding and Reporting. Complete, accurate use of both the CMS Healthcare Common Procedure Coding System (HCPCS Level II) and the required procedural codes of the American Medical Association’s (AMA’s) Current Procedural Terminology (CPT), current edition.

- The ICD-10 CM codes must be to the highest level of specificity: A code is invalid if it does not contain the full number of required characters detailed in the tabular list. Valid codes may contain three to seven characters.
- Report all secondary diagnoses that impact clinical evaluation, management and/or treatment.
- Report all status codes pertinent to the care provided. An unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

Failure to use current coding guidelines may result in a delay in payment and/or rejection of a claim.

Electronic Claims

Providers can submit claims electronically through their EDI partner using the following Electronic Payer ID: 83112.

Claims must be submitted via an ASC X12 837 professional claim or ASC X12 837 institutional claim file meeting the 2010 HIPAA EDI standards.

Paper Claims

Providers can submit paper claims by mail to Apex for processing:

ApexHealth
P.O. Box 981802
El Paso, TX 79998-1802

Paper claims must be submitted on current CMS standard forms:

- Hospital, skilled nursing facility (SNF), home health, inpatient mental health, inpatient psych and ESRD dialysis claims must be billed on UB-04
- Physician and all other claims (DME, lab/X-ray, transportation, and ancillary services,) except pharmacy, must be billed on CMS-1500

For additional information published by CMS, see the CMS UB-04 Fact Sheet:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837I-FormCMS-1450-ICN006926.pdf

CMS-1500 Fact Sheet
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837P-CMS-1500.pdf

Clean Claim Elements

At ApexHealth, our goal is to process all claims at the initial submission. Before we can process a claim, it must be a “clean” or complete submission. Clean claims must be filed in the timely filing period and include all information necessary to adjudicate the claim, as well as supporting documentation as applicable.

The Centers for Medicare and Medicaid Services (CMS) developed claim forms that record the information needed to process and generate provider reimbursement. The required elements of a clean claim must be complete, legible and accurate. A clean claim includes at least all of the following:

- Patient name and ApexHealth Member ID number
- ApexHealth provider ID number
- Provider information, including federal tax ID number (FTIN)
- Date of service (DOS)
- Place of service
- Diagnosis code(s)
- Procedure code(s) billed
- Individual charge for each service

- Required modifiers (if applicable)
- Required time duration (if applicable)

Clean claims are processed according to the benefits of the member at the time of service.

Prior Authorization Number

If prior authorization was obtained from ApexHealth prior to rendering services, the provider must include the prior authorization number in the appropriate data field on the claim.

National Drug Codes

ApexHealth follows CMS guidelines regarding National Drug Codes (NDC). Providers must submit NDC(s) as required by CMS.

Incomplete Claims

Claims submitted without all required information may be returned (paper claims) or rejected (electronic claims). If additional information is needed to process the claim, the Plan will issue a request for information and the claim will be pended. Participating providers are expected to promptly respond to requests for additional information and/or records to facilitate prompt payment and resolution of claims. Failure to submit the requested information within 60 days may result in rejected claims.

Submission Time Frames

Participating Providers are encouraged to submit all claims as soon as possible to facilitate prompt payment. All claims must be submitted within 365 days from the last date of service being billed. Failure to submit claims within the defined time frame may result in denied claims.

Timely filing requirements may be waived if "Good Cause" for late filing is submitted. Good Cause may be found when a physician or supplier claim filing delay was due to:

- Administrative error, for example, incorrect or incomplete information was furnished by official Medicare sources, e.g., carrier, intermediary, CMS, to the physician or supplier
- Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the physician/supplier to secure such documentation or evidence;
  - Unusual, unavoidable, or other circumstances beyond the service provider's control which demonstrate that the physician or supplier could not reasonably be expected to have been aware of the need to file timely; or

  - Destruction or other damage of the physician's or supplier's records unless such destruction or other damage was caused by the physician's or supplier's willful act or negligence.
- Apex can extend the timely filing for good cause when the provider is able to document a reason for delay.

Rejected Versus Denied Claims

Providers must ensure that all claims submitted to Apex are clean and accurate. The Plan may reject claims that are not processable due to invalid or missing required information. Rejected claims do not have appeal rights. Providers must correct and resubmit claims within timely filing limits based on the date of service for processing or adjudication.

Corrected Claims

Providers resubmitting claims for corrections must clearly mark them as "Corrected Claim/s." Failure to mark the claim appropriately may result in denial of the claim as a duplicate. Corrected claims must be received within the applicable, timely filing requirements of the original claim.

Balance Billing Prohibited for Medicare Eligibles

Providers may not balance bill for services and supplies furnished to ApexHealth members. Members are only responsible for their cost-share when receiving plan covered services. Any difference between what you bill and what the Plan pays cannot be billed to the member.

Additionally, you may not bill for services and supplies furnished to Qualified Medicare Beneficiaries (QMBs); for these beneficiaries, Medicaid is responsible for premiums, deductibles, coinsurance and copayment amounts for Medicare Part A and Part B covered services. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B deductibles, coinsurance, or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program, a dual eligible program which exempts individuals from Medicare cost-sharing liability. Billing prohibitions may also apply to other dual eligible beneficiaries in Medicare Advantage plans if the State Medicaid Program holds these individuals harmless for Medicare Part A and Part B cost-sharing.

Member expenses are limited by a maximum-out-of-pocket (MOOP) amount. If a member has reached the maximum out-of-pocket amount for that particular member's Benefit Plan, a provider should not collect any additional out-of-pocket amounts from the member for Medicare-covered services and should not apply or deduct any member expenses from that provider's reimbursement. Providers may determine a member's

accumulated out-of-pocket amount via the Apex provider portal or by contacting Concierge Services toll free at 1-888-279-0508.

In the event a provider collects an out-of-pocket amount that causes a member to exceed his or her annual maximum out-of-pocket, Apex will notify the provider that the amount collected from the member was in excess of the maximum out-of-pocket, and the provider shall promptly reimburse the member for that amount. If Apex determines that the provider did not reimburse the amount in excess of the maximum out-of-pocket amount to the member, Apex may pay the overage amount to the member directly and recoup the amount directly from the provider. Apex may audit the provider's compliance with this section and may require the provider to submit documentation to Apex demonstrating that the provider reimbursed members for amounts in excess of the maximum out-of-pocket amounts in the event this occurs.

Note: The prohibition on collecting Medicare cost-sharing is limited to services covered under Medicare Part A and Part B. Low-Income Subsidy copayments still apply for Part D benefits.

Note: QMBs are sometimes called "dual eligible." They are entitled to Medicare Part A, eligible for Medicare Part B, have income below 100% of the Federal Poverty Level, and have been determined to be eligible for QMB status by the State Medicaid Office.

Coordination of Benefits

Coordination of benefits (COB) establishes the order in which benefits are paid and the amount by which the secondary plan may reduce its benefits. COB ensures that the combined payments of all plans do not add up to more than the covered health care expenses.

If Apex is the secondary insurer, Providers must bill the primary insurer(s) for items and services they provide before they submit claims for the same items or services to Apex. Any balance due after receipt of payment from the primary payer should be submitted to Apex for consideration and the claim must include information verifying the payment amount received by the primary payer. Apex may recoup payments for items or services provided to a member where other insurers are determined to be responsible for such items and services, to the extent permitted by applicable laws.

If a member is covered under any of the insurance plans listed in Payer Types below, the Plan will be considered a secondary payer. The Plan will require an Explanation of Benefits or Explanation of Payment from the primary payer before making payment.

COBA Process

- Ensures claims are paid correctly by identifying the health benefits available to a Medicare beneficiary, coordinating the payment process, and ensuring that the primary payer, whether Medicare or other insurance, pays first.

- Shares Medicare eligibility data with other payers and transmits Medicare-paid claims to supplemental insurers for secondary payment. Note: An agreement must be in place between the Benefits Coordination & Recovery Center (BCRC) and private insurance companies for the BCRC to automatically cross over claims. In the absence of an agreement, the person with Medicare is required to coordinate secondary or supplemental payment of benefits with any other insurers he or she may have in addition to Medicare.
- Ensures that the amount paid by plans in dual coverage situations does not exceed one hundred (100) percent of the total claim, to avoid duplicate payments.
- Accommodates all the coordination needs of the Part D benefit. The COB process provides the True Out of Pocket (TrOOP) Facilitation Contractor and Part D Plans with the secondary, non- Medicare prescription drug coverage that it must have to facilitate payer determinations and the accurate calculation of the TrOOP expenses of beneficiaries; and allowing employers to easily participate in the Retire Drug Subsidy (RDS) program.

Medicare Contractors

Medicare contractors; i.e., MACs, Intermediaries, and Carriers, are responsible for processing claims submitted for primary or secondary payment. These entities help ensure that claims are paid correctly when Medicare is the secondary payer. They use information on the claim form and in the CMS data systems to avoid making primary payments in error. Where CMS systems indicate that other insurance is primary to Medicare, Medicare will not pay the claim as a primary payer and will return it to the provider of service with instructions to bill the proper party.

Medicare Secondary Payer (MSP)

The term generally used when the Medicare program does not have primary payment responsibility - that is, when another entity has the responsibility for paying before Medicare. Common Situations of Primary vs. Secondary Payer Responsibility are:

- Employer or spouse’s Group Health Plan (GHP)
- Disability and Employer GHP
- End-Stage Renal Disease (ESRD)
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- Retiree Health Plans
- No-fault Insurance and Liability Insurance
- Workers’ Compensation Insurance

Other Data Exchanges

CMS has developed data exchanges for entities that have not coordinated benefits with Medicare before, including Pharmaceutical Benefit Managers (PBMs), State Pharmaceutical Assistance Programs (SPAPs), and other prescription drug payers.

CMS has worked with these new partners to educate them about coordination needs, to inform CMS about how the prescription drug benefit world works today, and to develop data exchanges that allow all parties to efficiently serve our mutual customer, the beneficiary.

Payer Types

Group Health Insurance (Commercial) - Employer has at least twenty (20) employees. Member has direct coverage as the employee or through a spouse who is covered by this insurance.

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- Workers Compensation - If the claim arises out of a Workers' Compensation claim. The Workers' Compensation insurer is the primary payer.
- Black Lung Disease Program - If the primary diagnosis on the claim is black lung, the Medicare plan is the secondary payer and the Federal Black Lung program is the primary payer on the claim.
- Veteran's Administration (VA) - The VA is the primary and only payer on the claim. Medicare does not coordinate benefits with the VA.
- End Stage Renal Disease - In the first thirty (30) months after diagnosis, if the member has coverage through an employer, regardless of the size of the group, the employer's coverage is primary, and Medicare is secondary. After thirty (30) months of ESRD, Medicare becomes the primary payer.
- Liability or No-Fault Insurance - If the claim arises from an accident that is covered by a private insurer (for example, automobile or home insurance) the private insurer is the primary payer.

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) This law added mandatory reporting requirements for Group Health Plan (GHP) arrangements and for liability insurance, including self-insurance, no-fault insurance, and workers' compensation. Insurers are legally required to provide information.

- CMS will send the Plan a file toward the end of the first full week of each month. The file will contain data on other group health and non-group health insurance that covers the Plan's members. All periods of primary insurance coverage will be shown on the CMS report.
    - If the Plan learns that the member should be deleted, updated, added, or terminated from this file due to discrepancy in the file information to the health plans more current information, the Plan will use the Electronic Correspondence Referral System (ECRS) to notify the COB Contractor of the required action. This process is described in the IOM, Chapter 5.1 of Publication 100-05 Medicare Secondary Payer Manual. The Plan will send

the CMS supplied MA Questionnaire to the member to gather information about other payers prior to the submission of updates through ECRS.

- Each of the records in the CMS file shows at least one valid Medicare Secondary Payer Period, however there may be more than one period for a member. For a valid period of other payer coverage, the file will show a code of “A” for working aged, “B” for ESRD, or “G” for disabled to ensure the Plan has accurate information regarding members other insurers.
- If a member receives covered services that are also covered under other primary insurance, the Plan will authorize a provider to bill the member’s primary insurance.
- If the Plan is the secondary payer to a GHP and, for a given service, the cost sharing required by the GHP is greater than the cost-sharing required by the Plan then:
  - The member must pay the Plan’s cost-sharing; and
  - The Plan pays the GHP the difference between that higher cost-sharing and the Plan’s cost-sharing (see 42 CFR § 422.504(g), which obligates the Plan, even if it is a secondary payer, to protect the member from paying more than plan cost-sharing.
- If a claim is received for a member and the Plan has not received verification that other insurance is valid or primary, the Plan will pay the claim as the primary insurer and issue correspondence to the member to deny or validate other insurance coverage.
- The Plan will not withhold payment for submitted claims unless it has been confirmed that another health insurer will pay primary to Medicare. Auto-insurance is not assumed in cases of automotive accident injury and the Plan will not withhold payment in these instances.
- Claims received for members with validated primary insurance coverage will pend and a request will be sent to the provider for a copy of the primary insurance payment documentation. Once the COB information is received, the claim will process for secondary payment to the provider.
- The Plan will retain all documentation regarding member’s other insurance information and payment as secondary insurer.

Claims Payment

Claims will be adjudicated within 60 days from receipt. 95% of all clean claims will be processed within 30 days from receipt.

Provider Payment

Apex partners with Change Healthcare and ECHO Health, Inc. to offer multiple payment options for our providers. Your office may receive payment via a virtual credit card (VCC), an Automated Clearing House (ACH)/Electronic Funds Transfer (EFT), or check

payment. To manage your payment options, please visit us at https://echovcards.com/letter. To access this site, you will need your Tax ID and your verification access code.

Providers may log into www.providerpayments.com to access a detailed explanation of payment for each transaction.

If you have any difficulty with the website or have additional questions, please call us at 800-937-4102.

Virtual Card Services

Providers that are not currently registered to receive payments electronically will receive Virtual Credit Card payments with their Explanation of Payment (EOP). For providers that have a HIPAA certified fax number on file, your office will receive fax notifications; if not, your virtual card will be mailed. When a fax number is available, payments are received 3-7 days earlier than paper checks sent by U.S. Postal Service®. At this time, virtual credit cards cannot be emailed for security purposes.

Each notification will contain a virtual credit card with a number unique to that payment transaction including an instruction page for processing. The steps for processing this payment is like how you manually key-in patient payments today. Be sure to enter the payment information for the full amount of the card's value and do so prior to the expiration date on the card. If the virtual credit card is not processed within 60 days, the transaction will be voided, and a new payment will be issued to your office in another payment method such as ACH or check. Normal transaction fees apply based on your merchant acquirer relationship.

To opt out of the virtual credit card, providers can visit echovcards.com to manage their payment online. You can also contact ECHO directly at 800-937-4102.

If you are not currently able to accept credit card payments, please contact the support team at 800-937-4102 for other VCC processing options.

New to EFT Payments

Providers interested in receiving payment via electronic funds transfer (EFT), setting up EFT is a fast and reliable method. In addition to your banking account information, you will need to provide a Change Healthcare payment draft number and payment amount as part of the enrollment authentication.

Providers have two enrollment options to sign up for EFT:

- Option 1 - Enrollment with only **ApexHealth, (no feeds apply)** visit, https://enrollments.echohealthinc.com/efteradirect/ApexHealth

- Option 2 – Enrollment to receive EFT from **All Payers** processing payments on the Settlement Advocated platform (A fee for this service will apply), visit, https://enrollments.echohealthinc.com

Please note: Payment will appear on your bank statement from Huntington National Bank and ECHO as “HNB – ECHO”.

To check the status of an EFT enrollment, providers can contact customer support at ECHO (888) 834-3511.

Medical Payment Exchange (MPX)

Providers that are not enrolled with us to receive payments via electronic funds transfer (EFT) and opt-out of virtual card, and have enrolled for MPX with another payer, you will continue to receive your payments in your MPX portal account via EFT, Virtual card or paper check via print and mail. Otherwise, you will receive a paper check via print and mail.

Paper Check

To receive paper checks and paper explanation of payments (EOP), you must opt out of the Virtual Card Services by visiting us at https://echovcards.com/letter. To access this site, use your Tax ID and your verification access code. You can also contact ECHO directly at 800-937-4102.

835 Electronic Remittance Advice (ERA)

Providers who enroll for EFT payments will continue to receive the associated ERAs from ECHO with the Change Healthcare Payer ID. If you have not already, please make sure that your Practice Management System is updated to accept the Change Healthcare Payer ID: 83112. All generated ERAs will be accessible to download from the ECHO provider portal. (www.providerpayments.com).

Changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO Health Enrollment team at 440-834-3511

Payment to Non-Contracted Providers

In accordance with CMS requirements, Apex will make timely and reasonable payment for certain services that are rendered by an out-of-network provider at a minimum rate that complies with the Original Medicare rates if the service is covered by the plan and performed on the member’s behalf.

Examples of reimbursable services obtained by an out-of-network provider are determined in accordance with 442.100(b), and include:

- Ambulance services dispatched through 911 or its local equivalent
- Emergency and urgently needed services

- Maintenance and post-stabilization care services
- Renal dialysis services provided while the member was temporarily outside the plan's service area
- Services for which coverage has been denied by the Plan and found, upon appeal, to be services the member was entitled to have furnished, or paid for, by Apex

Claim Notices

The Plan will send a Remittance Advice or Explanation of Payment to the provider or provider group for each claim processed.

When Apex denies a request for payment from a Non-Contracted Provider the Plan will notify the provider of the reason for the denial and provide instructions on how they can appeal the decision.

Notification to Members

Apex will provide all members with an Explanation of Benefits (EOB) per the CMS regulatory requirements.

- Apex is required to send the Explanation of Benefits either monthly or on a per claim basis with quarterly summary statements. Explanation of Benefits must be sent by the end of the month for claims incurred the previous month. Apex will include the following information on the EOB: The members cost-sharing amounts applied to the plan deductible for the plan year.
- The member's year-to-date progress towards the Maximum Out of Pocket (MOOP) for the benefit year.
- All Part C claim amounts billed and paid during the reporting period, including all claims for Part A and Part B covered services, mandatory supplemental benefits, and optional supplemental benefits.
- The year-to-date total of all claim amounts billed and paid for the member.

Any Part D prescription drug claims will be reflected in a separate Part D EOB.

Any EOB that includes a denied claim(s) for non-contract providers will include within the EOB information regarding the denial reason and the member's appeal rights. The denied service will be identified by the following:

- Date of Service
- Billing procedure codes and associated description of service
- Rendering provider
- Member's appeal rights

Claim Appeals

Apex offers a post-service claims appeal process for disputes related to denial of payment for services rendered to ApexHealth members. This process is available to all providers, regardless of whether they are in or out-of-network.

The appeals process is in place for two main types of issues:

- The provider disagrees with a determination made by the Plan, such as combining two stays as a 15-day readmission. In this case, the provider should send additional information, such as medical records, that support the provider's position.
- The provider is requesting an exception to an ApexHealth policy, such as prior authorization requirements. In this case, the provider must explain the circumstances and why the provider feels an exception is warranted in that specific case.

A provider's lack of knowledge of a member's eligibility or insurance coverage is not a valid basis for an appeal. Providers cannot appeal denials due to member ineligibility on the date of service or non-covered benefits.

Submitting Claim Appeals

Providers can submit a claim appeal by sending a letter to Apex explaining the nature of the appeal and any special circumstances they would like the Plan to consider. A copy of the claim and supporting documentation, such as medical records, should be attached to the appeal request. Claim appeals can be sent to:

Attn: Claims Appeals
96 Kercheval Avenue Ste 200
Grosse Pointe Farms, MI 48236

There is only one level of claims appeals available. All appeal determinations are final.

If you have any questions about the post-service claim appeal process, please call Concierge Services.

Appeal Timeframes

Apex requires Participating Providers to submit claim appeals within 120 days from the last date of the claim denial, provided that the claim was submitted within one (1) year of the date of service. Non-contracted providers must submit claim appeals within 60 days from receipt of the remittance notice. Appeals submitted after the timeframe has expired will not be reviewed by Apex.

Claim appeals will be reviewed within 60 days from the date of receipt. Providers will receive a remittance with the decision and denial reason if the appeal is denied.

Non-Contract Provider Appeals

Non-Contracted Providers have the right to request a reconsideration of the plan's denial of payment. A non-contract provider may request reconsideration for a denied claim only if the non-contract provider completes a Waiver of Liability (WOL) statement, of which provides that the non-contract provider will not bill the enroll regardless of the outcome of the appeal.

The Waiver of Liability statement can be found on our website here: Waiver of Liability

Overpayment Recovery

Apex will timely process adjustments to finalized claims requiring modification to correct inaccurate information or payment amounts. Adjustments resulting in a provider overpayment will trigger an overpayment recovery request notification. This notification will include the following:

- Overpayment reason
- Immediate recoupment request options
- Extended Repayment Schedule (ERS) request options
- Rebuttal rights
- Appeal rights

The provider will have the option to:

- Make an immediate payment
- Request immediate recoupment
- Submit a rebuttal
- Appeal the overpayment by requesting a redetermination

Providers have 97 days from the overpayment request notification to send the plan a refund. Refunds can be sent to the following address:

ApexHealth, Inc.
P.O. Box 772724
Detroit, MI 48277-2724

If Apex does not receive a refund within 97 days, the Plan will proceed with the recoupment against future claims.

Claim Status

Providers can check claim status by using our online Provider Portal or by calling Concierge Services at **(844) 279-0508**. (TTY users should call 711). Hours are 8 a.m. to 8 pm. local time, seven days a week from October 1 to March 31 and 8 a.m. to 8 p.m. Monday-Friday from April 1 to September 30.

96 Kercheval Avenue, Suite 200
Grosse Pointe Farms, MI 48236

1-844-279-0508 (TTY: 711)
www.apexhealth.com

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