Parkland
Community Health Plan

Provider Resubmission Process and Form

PLEASE READ CAREFULLY AND FOLLOW THE INSTRUCTIONS INDICATED

A **resubmission request** is defined as an item that prevents Parkland Community Health Plan (PCHP) from processing a claim due to any of the following reason(s)**:**

1. Originally denied because of incorrect coding (would be a considered a "Corrected Claim"); or
2. Missing information (would be considered a "Resubmission").

Examples of a Corrected Claim
• Newly added modifier
• Code changes
• Any change to the original claim

Corrected Claim Instructions

A corrected claim can be submitted through the Provider Portal /**Electronic (EDI) Claims Submission**

- using **EDI X12 837 5010** transactions.
- Payer ID for electronic claims is **Payer ID # 66917**.

TriZetto Provider Solutions: Our Preferred Electronic Data Interchange (EDI) Source

TriZetto EDI Login

Parkland and Cognizant Healthcare Services, LLC (a subsidiary of Cognizant Technology Solutions) are partners. Part of that business venture includes encouraging our providers to submit electronic claims through Cognizant's TriZetto Provider Solutions (TPS).

TPS is more than just a clearinghouse. It provides exceptional service by combining enhanced provider solutions with superior client support. TPS is Parkland's preferred EDI connection.

If you would like to connect directly to TPS at no cost, please **complete this form**.
If you already use a clearinghouse, such as Availity, Office Ally, Emdeon, Claim Logic, etc., your claims will be sent to Parkland. There will be no changes, and you do not need to complete the form.

For more information, please email TTPSSupport@cognizant.com

Resubmission Instructions

1. Submit **a written request** and mark on top of it, "RESUBMISSION" and/or include a completed *Provider Resubmission Request Form*, provided on page 4.
2. Submit medical records and/or additional information required to reconsider the claim. Information should be submitted single sided.

Examples of Resubmissions
Invoice Needed: • All claims associated with an Invoice being needed must be broken out per revenue codes to verify charges billed on a UB or HCFA claim form match the charges billed on the Invoice. (Please attach Invoice that is broken out by rev code with sub-totals.)
Claim denied as a duplicate: • Provide documentation as to why the denied claim or service is not a duplicate, such as medical records showing two services were performed
New Texas Provider Identifier (TPI) Issues or Re-attestation: • Claims with a denial reason for timely filing or provider is not approved by Medicaid o Provide a copy of the attestation notification indicating the date of the attestation along with copy of any denied EOBs
Coordination of Benefits (COB): • Claims denied for Primary Coverage information or a copy of the Primary EOB o Attach an EOB or if no longer effective documentation from the primary carrier of coverage termination.

ALL CLAIM Resubmissions

Must Be Submitted To (Claims Mailbox):

Parkland Community Health Plan
PO Box 560327
Dallas, TX 75356

Parkland
Community Health Plan

Provider Resubmission Request Form

Please complete the information below in its entirety and mail with supporting documentation to the claims address:

Parkland Community Health Plan
PO Box 560327
Dallas, TX 75356

Questions regarding a submission should be directed to the Provider Services call center at:

Health*first* (STAR):	**Kids*first* (CHIP):**	**CHIP Perinate:**
1-888-672-2277	1-888-814-2352	1-888-814-2352

Please indicate the reason for your request and any pertinent details below: Please attach any additional information you would like to have considered.

Plan Type: ☐ HEALTH*first* ☐ KIDS*first* ☐ CHIP Perinate

Provider Name:	
Provider NPI#:	
Submitter's name:	
Provider Phone Number:	
Date(s) of Service:	
Remittance Advice Date:	
Amount Billed:	
Claim Number(s):	
Member Name:	
Member ID #:	

_____ _____

Signature of Sender Date

DISCLAIMER: Providers should always refer to the PCHP Provider Manual and their contract for further details. For general claims inquiry, please contact the toll-free number located on the member's ID card, 8:00 am – 5:00 pm (CST) Monday to Friday. You may also contact this number for more information on the Claims Inquiry process. Be prepared to provide the Provider Relations Representative with the Provider Name and Provider ID, Member Name and ID, Date(s) of Service, and Claim Number from the Remit Notice.