



Absolute Total Care & Wellcare Claims 411 – Training Tool Kit

Meeting Overview

01— Eligibility (additional resources in the Appendix)

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- **Wellcare Medicare Advantage Provider Portal**
- **Availity Essentials: New Multi-Payer Portal**

02— Prior Authorizations

- **Vendors, News and Updates**
- **Pre-Auth Tool**

03— Clinical and Payment Policies

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05— Claim Submission Time Frames

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- **Top Denial and Explanations**

08— Preventing Common Denials

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- **Avoiding Timely Filing Denials**
- **Avoiding “COB” Denials**
- **Avoiding Prior Auth Denials**

09— APPENDIX

Eligibility

Eligibility

Member eligibility should be checked **each month** and **each time prior to rendering services** for all lines of business.

Eligibility can be verified through Absolute Total Care Provider Portal, Wellcare Provider Portal, Availity Essentials or the Interactive Voice Response (IVR)

IVR is available **24 hours** a day, **seven days** a week



**absolute
total care**
Healthy Connections

Absolute Total Care
(Medicaid)
1-866-433-6041




ambetter FROM **absolute
total care**

Ambetter from
Absolute Total Care
(Marketplace)
1-833-270-5443

ambetter
HEALTH

**Ambetter Health
Solutions
(ICHRA Off-
Exchange)**
1-833-543-3145



wellcare
PRIME

Healthy Connections
PRIME

Wellcare Prime
(Medicare-Medicaid
Plan)
1-855-735-4398
(Ended 12/31/2025)

wellcareTM

Wellcare Medicare
Advantage
1-866-270-5223



wellcare By **absolute
total care**

**Wellcare By Absolute
Total Care Dual Align
(HMO D-SNP)**
1-833-998-5401
(Effective 1/1/2026)

Prior Authorizations

Prior Authorizations, Vendors, News and Updates

❖ Prior Authorizations

Prior authorization requires the provider to make a formal medical necessity determination request to the plan before the service may be rendered. The preferred and easiest method for submitting authorization requests is through Availity Essentials or the Secure Provider Portal.

❖ Pre-Auth Tool

Providers should refer to the Pre-Auth Check Tool to look up a service code to determine if prior authorization is needed.

❖ Vendors and Partners

Absolute Total Care and Wellcare partner with various vendors to provide prior authorization for certain services. You will find the most current and up to date list of these vendors, as well as their individual link to request a prior authorization on the Absolute Total Care and Wellcare Prior Authorization Tool Look Up.

❖ Provider News and Bulletins

To stay informed, providers are encouraged to check the Provider News section of our website, where we post all updates and changes to authorizations, policies, and billing.

ATC: <https://www.absolutetotalcare.com/providers/provider-news.html>

Wellcare: <https://www.wellcare.com/south-carolina/providers/bulletins>

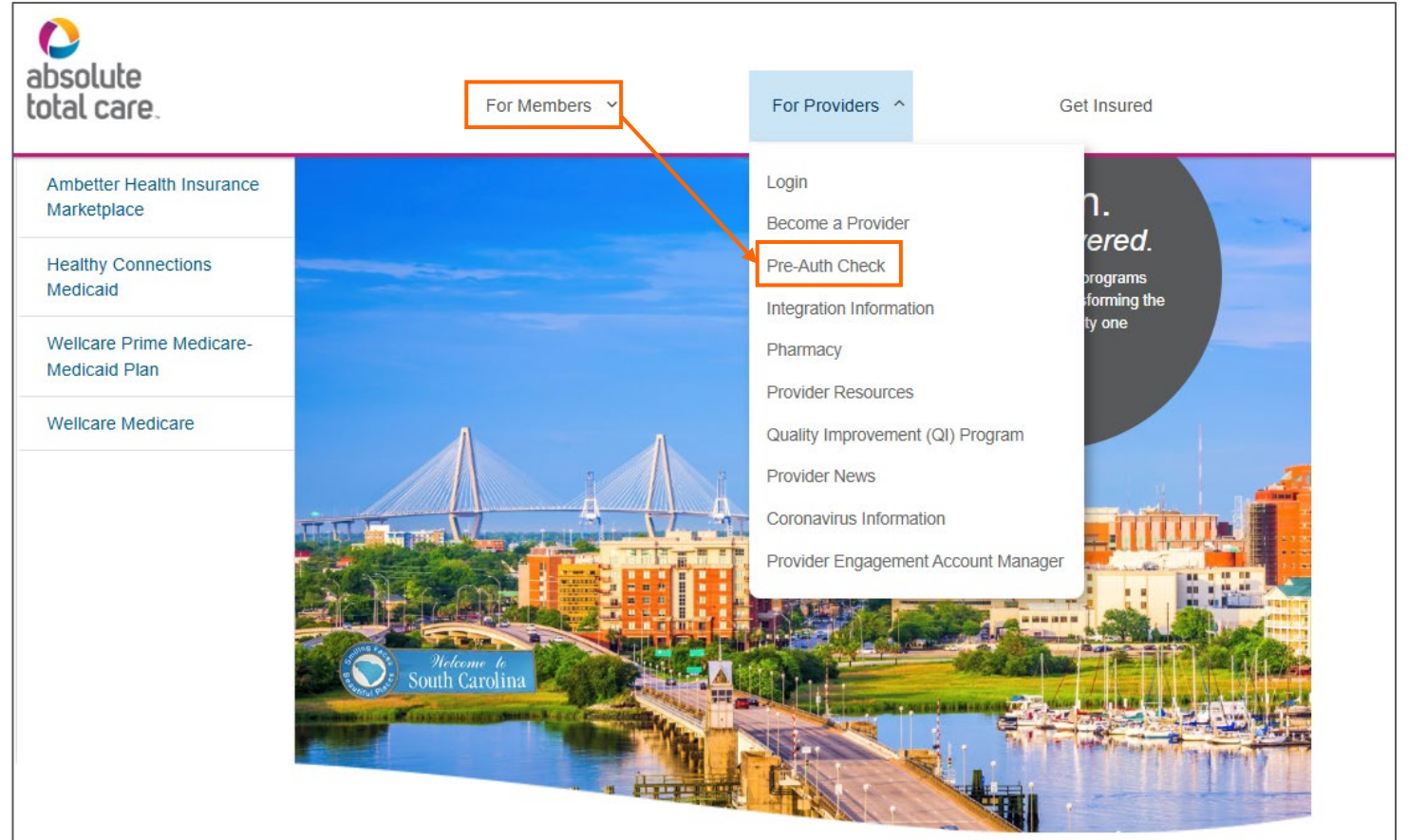
Absolute Total Care: Pre-Auth Lookup Tool



Use our tool to see if a pre-authorization is needed, it's quick and easy!

If an authorization is needed, you can submit via the provider portal or complete the appropriate fax form on the provider manuals and forms page.

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Check Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices.



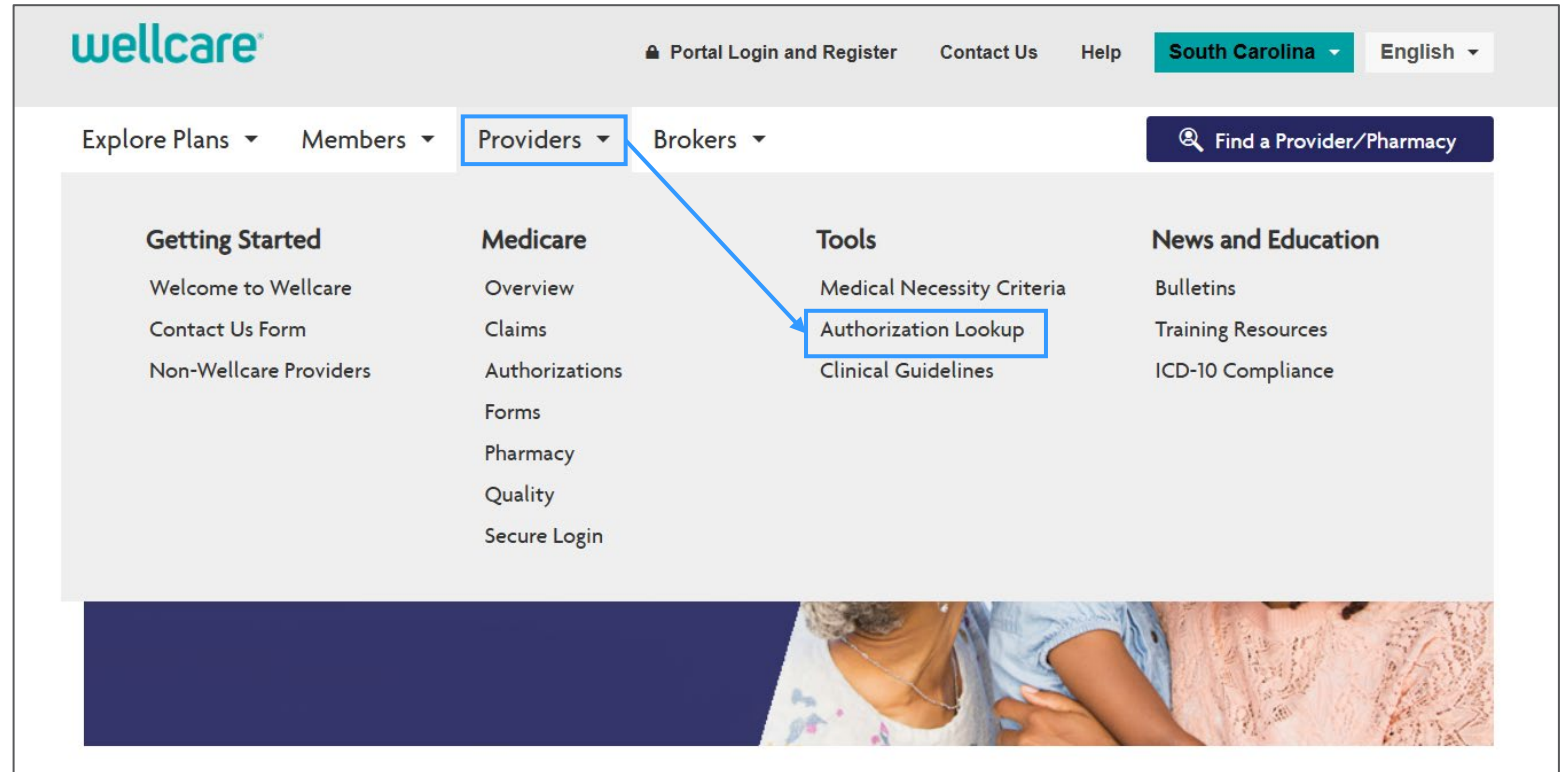
<https://www.absolutetotalcare.com/providers/preauth-check.html>

Wellcare Pre-Auth Lookup Tool

 Use our tool to see if a pre-authorization is needed, it's quick and easy!

If an authorization is needed, you can submit via the provider portal or complete the appropriate fax form on the provider manuals and forms page.

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Check Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices.



<https://www.wellcare.com/south-carolina/providers/authorization-lookup>

Clinical and Payment Policies

Clinical and Payment Policies

Clinical policies are one set of guidelines used to assist in administering health plan benefits, either by prior authorization or payment rules. They include but are not limited to policies relating to evolving medical technologies and procedures, as well as pharmacy policies.

Medical Clinical Policy links:

<https://www.absolutetotalcare.com/providers/resources/clinical-payment-policies.html>

<https://www.absolutetotalcare.com/providers/resources/behavioral-health-clinical-policies.html>

<https://www.wellcare.com/south-carolina/providers/clinical-guidelines>

Payment Policies (Healthcare claims payment policies) are guidelines designed to support the administration of payment rules based on generally accepted principles of correct coding. These policies help determine whether healthcare services are appropriately coded for reimbursement.

Payment Policy links:

<https://www.absolutetotalcare.com/providers/resources/payment-policies.html>

<https://www.wellcare.com/south-carolina/providers/medicare/claims/payment-policy>

Claim Adjustments, Reconsiderations, and Disputes

Claims Adjustments, Reconsiderations and Disputes

Claims Adjustments

- ❑ Requests to change the initial claim.

Reconsideration

- ❑ Submitted when a provider disagrees with how a clean or adjusted claim was processed.

Disputes

- ❑ Submitted when a provider has received an unsatisfactory response to a previous reconsideration request.

Claim Submission Time Frames

Claim Submission Time Frames

MEDICAID		
Submission Timeframes	Par	Non-Par
Claim Initial/Resubmission	365 days	365 days
Claim Adjustment	365	365
Claim Dispute	60*	60*
Decision Timeframes	Par	Non-Par
Dispute Decision	30	30
Mailing Address		
Absolute Total Care ATTN: Claims Department P.O. Box 3050 Farmington, MO 63640-3821 Behavioral Health Claims Absolute Total Care ATTN: Claims Department P.O. Box 7001 Farmington, MO 63640-3818		

MARKETPLACE / ICHRA		
Submission Timeframes	Par	Non-Par
Claim Initial/Resubmission	180 days	180 days
Claim Adjustment	60*	60*
Claim Reconsideration	60*	60*
Claim Dispute	60*	60*
Decision Timeframes	Par	Non-Par
Appeal Decision	30	30
Dispute Decision	30	30
Mailing Address		
Ambetter ATTN: Claims P.O. Box 5010 Farmington, MO 63640-5010		



Claim adjustments or disputes submitted to the **SC or MO offices** will not be accepted.

Wellcare By Absolute Total Care		
Submission Timeframes	Par	Non-Par
Claim Initial	365 days	365 days
Claim Resubmission	180 days	365 days
Claim Adjustment	60*	365*
Claim Appeal***	120*	60*
Decision Timeframes	Par	Non-Par
Appeal Decision	60	60
Dispute Decision	30	30
Mailing Address		
Wellcare By Absolute Total Care ATTN: Claims Department P.O. Box 9700 Farmington, MO 63640-0700		

- * From date of EOP
- ** Waiver of Liability required
- *** Additional required information found in Provider Manual



Wellcare Medicare Advantage

Provider Timeframes, Claim Adjustments and Disputes

Type	Par	Non-Par
Initial Claim/Resubmission	180*	180*
Claim Payment Dispute	90*	90*
Claim Payment Policy Dispute	30***	30***
Appeal (Medical)	90	60**

*From date of service

**Waiver of Liability required

***From date of last processed claim

Mailing Address
Wellcare ATTN: Claims Department P.O. Box 31372 Tampa, FL 33631-3372

Claims Submission Guidelines

Claims Submission Guidelines

Form Field	Requirements	CMS-1500 (Professional)	UB-04 (Institutional)
Billing provider name, address and NPI	Enter the name, address, and 10-character NPI ID and taxonomy of the billing entity	Box 33	Box 1
Subscriber (name, address, DOB, sex, and member ID required)	Enter the subscriber's Health Plan ID exactly as it appears on the member's current ID card.	Subscriber box 1a, 4, 7, 11	Box 58 and 60
Patient (name, address, DOB, sex, relationship to subscriber, status, and member ID)	Enter the member's Health Plan ID exactly as it appears on the member's current ID card.	Patient box 2, 3, 5, 6, 8	Box 8, 9, 10, 11

Form Field	Requirements	CMS-1500 (Professional)	UB-04 (Institutional)
Attending provider with NPI	Enter the 10-character NPI ID and taxonomy for the attending practitioner.	N/A	Box 76
Rendering provider	Enter the 10-character NPI ID and taxonomy for the individual practitioner who rendered the service (this can be blank if a sole proprietor and that NPI is entered as the Billing Provider).	NPI in Box 24J	Box 56
Service facility information	Enter the name, address, and 10-character NPI ID and taxonomy where the patient service was delivered (this can be blank only if provider is a sole proprietor).	Box 32	Box 1

Taxonomy Guide

IMPORTANT

- ❑ Taxonomy codes are 10-digit federally established numbers which health care providers use to identify their unique specialty areas.
- ❑ Taxonomy Code Example: 282N00000X

CMS 1500 PAPER SUBMISSION:

Rendering – Box 24i should contain the qualifier “ZZ.” Box 24j (shaded area) should contain the taxonomy code.

24. A.	DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.	G.	H.	I.	J.	
	From	To					PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)				DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY				CPT/HCPCS	MODIFIER									
																		ZZ	208U00000X
																			NPI REQUIRED

Billing – Box 33b should contain the qualifier “ZZ” along with the taxonomy code.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ()
SIGNED _____ DATE _____	a. NPI _____ b. _____	a. REQUIRED _____ b. ZZ208U00000X

Referring – If a referring provider is indicated in Box 17 on the claim, Box 17a should contain the qualifier of “ZZ” along with the taxonomy code in the next column.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	17b.
	ZZ 208U00000X	NPI REQUIRED

PROVIDERS ARE REQUIRED TO SUBMIT CLAIMS WITH THE CORRECT TAXONOMY CODE AND QUALIFIER CONSISTENT WITH THE PROVIDER'S SPECIALTY TO ENSURE APPROPRIATE CLAIM ADJUDICATION. THE CLAIM WILL BE REJECTED IF THE TAXONOMY CODE IS INCORRECT OR OMITTED FROM THE CLAIM.

Taxonomy Guide

CMS 1500 Electronic Submission:

Rendering – Loop 2310B PRV01 “PE” = Referring PRV02 = “ZZ” qualifier PRV03 = 10 character taxonomy code

Billing – Loop 2000A-PRV01 “BI” PRV02 = “ZZ” qualifier PRV03 = 10 character taxonomy

Referring –If a referring provider is indicated in Box 17 on the claim, Box 17a should contain the qualifier of “ZZ” along with the taxonomy code.

PROVIDERS ARE REQUIRED TO SUBMIT CLAIMS WITH THE CORRECT TAXONOMY CODE AND QUALIFIER CONSISTENT WITH THE PROVIDER’S SPECIALTY TO ENSURE APPROPRIATE CLAIM ADJUDICATION. THE CLAIM WILL BE REJECTED IF THE TAXONOMY CODE IS INCORRECT OR OMITTED FROM THE CLAIM.

Taxonomy Guide

IMPORTANT

- ❑ UB-04 Submissions
- ❑ Taxonomy Code Example: 282N00000X

UB-04	PAPER SUBMISSION: Billing – Box 81CCa should contain the qualifier of “B3” in the left column and the taxonomy code in the middle column. <table border="1"><tr><td>81CCa</td><td>B3</td><td>282N00000X</td></tr><tr><td>b</td><td></td><td></td></tr><tr><td>c</td><td></td><td></td></tr><tr><td>d</td><td></td><td></td></tr></table>	81CCa	B3	282N00000X	b			c			d		
	81CCa	B3	282N00000X										
b													
c													
d													
	ELECTRONIC SUBMISSION: Billing - Loop 2000A - PRV01 “BI” = “Billing”; PRV02 – “PXC” qualifier; PRV03 = 10 character taxonomy code												

PROVIDERS ARE REQUIRED TO SUBMIT CLAIMS WITH THE CORRECT TAXONOMY CODE AND QUALIFIER CONSISTENT WITH THE PROVIDER’S SPECIALTY TO ENSURE APPROPRIATE CLAIM ADJUDICATION. THE CLAIM WILL BE REJECTED IF THE TAXONOMY CODE IS INCORRECT OR OMITTED FROM THE CLAIM.

Common Rejections and Denials

Common Claim Rejections and Denials

Common Claim Rejections

- Incorrect Member details
- Member Inactive
- Incorrect Claim Form
- Taxonomy Missing

A rejection occurs BEFORE the claim has cleared entry into the system for processing

Claim denials happen AFTER the claim has been processed and is denied

Common Claim Denials

- Timely Filing
- Duplicate Claim
- Coordination of Benefits (COB)
- No Authorization on File that Matches Service(s) Billed

For rejection inquiries, reach out to the EDI team at EDIBA@centene.com

Top Rejections and Causes

IMPORTANT

Claim REJECTIONS occur BEFORE claims are entered into the system and processed. This is usually due to a technical issue or inaccurate formatting. For rejection inquiries, reach out to the EDI team at EDIBA@centene.com for assistance.

Incorrect Member Details

- Misspelled Names
- Inaccurate DOB
- Incorrect Member ID
- Incorrect Line of Business

Member Inactive at Time of Service

- Eligibility should be verified often and prior to rendering services.

Incorrect Claim Form

- File claims based on CMS guidelines or Contractual agreement

Missing Taxonomy

- Providers are required to submit claims with the correct Taxonomy code and qualifier consistent with provider's specialty

Best Practices for Correcting and Avoiding Rejections

IMPORTANT

Claim **REJECTIONS** occur **BEFORE** claims are entered into the system and processed. This is usually due to a technical issue or inaccurate formatting. For rejection inquiries, reach out to the EDI team at EDIBA@centene.com for assistance.

Verify Member Eligibility and Benefits

- Validate coverage for service date
- Review payer ID or plan information

Review Claims Processing Data

- Rendering provider NPI and Taxonomy codes
- Billing provider TIN and Group NPI
- Review DOS is populated

ACT IMMEDIATELY

- Review all errors and resubmit within 24-72 hours
- ALWAYS submit the claim as a “NEW” claim. Due to initial submission being rejected, there is not a claim on file to correct

Monitor, Analyze and Audit

- Monitor to confirm successful claim submission
- Establish an audit process for claim submission to capture rejections timely

Top Denials and Explanations

IMPORTANT

A Claim DENIAL happens AFTER the claim has been processed and is denied due to but not limited to issues such as lack of medical necessity, coverage limitations, incorrect billing codes or timeliness of filing.

Duplicate Claim Service

- ❑ A duplicate claim is a claim submitted more than once for the same service, DOS, Provider and member – without any changes or corrections

Timely Filing

- ❑ Timely Filing is the maximum amount of time allowed between the DOS and the date a claim was submitted

Coordination of Benefits (COB)

- ❑ COB is the process used to determine the order in which multiple insurance plans pay for the services

No Authorization on file that Matches Service(s) Billed

- ❑ Due to either the prior authorization was not obtained or approved authorization does not match the billed services to include CPT/HCPCS, Provider, location or date

Preventing Common Denials

Preventing “Duplicate Claim” Denials

IMPORTANT

A Claim DENIAL happens AFTER the claim has been processed and is denied due to but not limited to issues such as lack of medical necessity, coverage limitations, incorrect billing codes or timeliness of filing.

How it happens...

- System Errors
- Miscommunication
- Resubmitted before initial claim is processed

Why it matters...

- Unnecessary denials
- Reimbursement delays
- Increased administrative work
- Audit trigger/Compliance risk
- Resolving duplicates time is better spent improving patient care and operations

Best Practices

- Verify claim status before resubmitting
- Modify/correct claim as needed
- Refer to the reconsideration and dispute process
- Keep staff trained and up to date on procedures and guidelines

Preventing “Timely Filing” Denials

IMPORTANT

A Claim DENIAL happens AFTER the claim has been processed and is denied due to but not limited to issues such as lack of medical necessity, coverage limitations, incorrect billing codes or timeliness of filing.

How it happens...

- ❑ Filing claim past the Timely Filing guidelines outlined per the line of business or individual provider agreement

Why it matters...

- ❑ Faster claim processing
- ❑ Reduces lost revenue
- ❑ Increased administrative work
- ❑ Billing efficiency

Best Practices

- ❑ Submit claims immediately after rendering services
- ❑ Implement software alerts and tracking to monitor deadlines
- ❑ Keep detailed records of submission attempts and confirmations
- ❑ Conduct regular billing audits and train staff on guidelines

Preventing “Coordination of Benefits” (COB) Denials

IMPORTANT

A Claim DENIAL happens AFTER the claim has been processed and is denied due to but not limited to issues such as lack of medical necessity, coverage limitations, incorrect billing codes or timeliness of filing.

How it happens...

- Missing COB information or updates
- Incorrect Primary/Secondary insurance designation
- Claim submitted to secondary payer without primary EOB
- Member did not notify payer of coverage changes
- Duplicate or overlapping coverage records

Why it matters...

- Faster claim processing
- Reduces lost revenue
- Increased administrative work

Best Practices

- Verify eligibility and coverage each visit
- Ask member about other insurance
- Update COB details with payers regularly
- Submit claims in correct order: Primary first, then secondary
- Include primary EOB when billing secondary payer
- Train staff on COB workflows and guidelines

Preventing “No Authorization on File” Denials

IMPORTANT

A Claim DENIAL happens AFTER the claim has been processed and is denied due to but not limited to issues such as lack of medical necessity, coverage limitations, incorrect billing codes or timeliness of filing.

How it happens...

- Approved Prior Authorization does not match the billed service to include CPT/HCPC Codes, Provider, location or requested date(s)
- Provider failed to obtain Prior Authorization

Why it matters...

- Faster claim processing
- Reduces lost revenue
- Increased administrative work

Best Practices

- Regularly review Prior Auth requirements
- Verify Authorization details prior to rendering services
- Confirm approved authorization details prior to submitting claim
- Update authorization request *immediately*, if needed, prior to filing claim
- Authorization number must be included on the submitted claim (CMS 1500 BOX 23, UB-04 BOX 63)

Appendix

Absolute Total Care Provider Portal

The screenshot displays the Absolute Total Care Provider Portal interface. At the top is a navigation bar with the Absolute Total Care logo and 'Healthy Connections' text, followed by icons and labels for 'Manage Practice', 'Eligibility', 'Patients', 'Authorizations', 'Claims', and 'Messaging'. Below this is a section for 'Viewing Eligibility For : TIN' with a dropdown menu and a 'Plan Type' dropdown menu. The 'Plan Type' dropdown is open, showing options: 'Absolute Total Care', 'SC - Medicare / MMP', 'Behavioral Health from Absolute Total Care', 'Wellcare Absolute Total Care', 'Ambetter', and 'Absolute Total Care' (highlighted). A green 'GO' button is to the right. Below this is an 'Eligibility Check' form with fields for 'Date of Service', 'Member ID or Last Name', and 'Date Of Birth', along with 'Check Eligibility' and 'Print' buttons. At the bottom, a table header is visible with columns: 'ELIGIBLE', 'DATE OF SERVICE', 'PATIENT NAME', 'DATE CHECKED', 'CARE GAPS', and 'LOG ER VISIT'.

Wellcare Provider Portal



wellcare™ Provider Portal Return To Dashboard > Messages ad\ismacon

Home | My Patients | Care Management | Claims | My Practice | Resources

My Patients

[< Back To Home](#)

Check Member Eligibility

This section allows you to search for members and check eligibility.

If you need additional assistance, please select the Help button. There, you can access FAQs or select your state and plan to chat with a Customer Service agent.

Select search criteria to find a member

Member ID

Member ID

Medicaid ID Medicare ID

[+ Enter multiple member IDs to display](#)

Check patient eligibility on this date

Search

Result(s) [Filter Results](#) [Download Report](#)

Member Name	Member ID	Eligible	Effective Date	Term Date	Plan Name	Care Gaps	Important Info	PCP
No items to display								

0 10

Availity Essentials: New Multi-Payer Portal

✓ Comprehensive Administrative Tools
Availity Essentials offers tools to validate eligibility, submit claims and check claim status efficiently.

✓ Integration with Health Plans
The platform supports multiple health plans like Absolute Total Care and Wellcare for streamlined processes.

✓ Reduced Administrative Burden
Centralized functionalities minimize errors and improve workflow, enhancing provider satisfaction.

✓ Enhanced Patient Care Support
Accurate and efficient administrative processes contribute to better patient care outcomes.



New Accounts:

The Availity Administrator registers and manages user accounts and must have the legal authority to sign agreements. Visit [Register and Get Started with Availity Essentials](#) for training.



Existing Accounts:

Log in to enjoy full functionality. Add apps to My Favorites and save provider information for faster transactions.



Contact Info:

Availity Client Services: 1-800-AVAILITY (282-4548), Mon–Fri, 8 AM–8 PM EST. For general questions: Contact Provider Services or Provider Engagement Administrator

Claims Submission



- Claims submitted to the **SC or MO offices** will not be accepted.
- Follow the applicable procedure based on your line of business.

Line of Business	Electronic Claim Submission	Paper Claim Submission
Medicaid	Secure Provider Portal: www.AbsoluteTotalCare.com/login Or EDI Payer Numbers- (Medical): 68069-Emdeon/WebMD/Envoy/PayerPath 42772-Relay Health/McKesson 68055 – Allscripts/Payerpath/Practice Insights EDI Payer Numbers- (Behavioral Health): 68068 – Emdeon/WebMD/Envoy/Availity 68068 – Relay Health/McKesson 68059 – Allscripts/Payerpath/Practice Insights	Absolute Total Care (Medical and Behavioral Health) P.O. Box 3050 Farmington, MO 63640-3821 Behavioral Health (before 10/1/2025) P.O. Box 7001 Farmington, MO 63640-3811
Marketplace	Secure Provider Portal: www.AbsoluteTotalCare.com/login Or EDI Payer Numbers- (Medical): 68069-Emdeon/WebMD/Envoy/PayerPath	Ambetter from Absolute Total Care P.O. Box 5010 Farmington, MO 63640-5010
Wellcare Absolute Total Care Dual Align (HMO D-SNP)	Secure Provider Portal: www.AbsoluteTotalCare.com/login Or EDI Payer Numbers- (Medical): 68069-Emdeon/WebMD/Envoy/PayerPath	Wellcare by Absolute Total Care Attn: Claims P.O. Box 9700 Farmington, MO 63640-0700

Wellcare Medicare Advantage

Claims Submission

IMPORTANT

- ❑ Claims submitted at the **SC or MO** offices will not be accepted.
- ❑ Follow the appropriate procedure for your line of business to submit your claim.

CLAIM SUBMISSION INFORMATION

SUBMISSION INQUIRIES

EDI team: EDIBA@centene.com

PREFERRED EDI CLEARINGHOUSE

Availity: **1-800-282-4548**.

Web portal for direct data entry (DDE) claims:

availity.com/Essentials-Portal-Registration.

PAYER IDs: 14163 (CH - Chargeable)
59354 (RF - Reporting only)

Visit our [Claims](#) page to locate detailed claims information, addresses, claim forms and guidelines.

Timely Filing guidelines: 180 days from date of service.

EFT

Register: payspanhealth.com or call **1-877-331-7154**.

Email: providersupport@payspanhealth.com.



MAIL PAPER CLAIMS TO:

Wellcare

Attn: Claims Department

P.O. Box 31372

Tampa, FL 33631-3372

Member Billing AKA Balance Billing

- ❖ Pursuant to Law, Members who are dually eligible for **Medicare** and **Medicaid** shall not be held liable for Medicare Part A and B cost sharing when the State or another payor is responsible for paying such amounts.
- ❖ The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization. Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Wellcare By Absolute Total Care to the Provider.
- ❖ Providers may not bill Wellcare By Absolute Total Care DSNP Members for covered services, also known as “balance billing”, regardless of whether they believe the amount they were paid or will be paid by Wellcare By Absolute Total Care is appropriate or sufficient. Balance billing a Member for Covered Services is prohibited, *except* for the Member’s applicable Patient Liability towards covered Medicaid services such as Nursing Facility.

Thank you



wellcare™