AmeriHealth Caritas Next | FirstChoice Next (A Product of Select Health of South Carolina, Inc.)

# Provider Alerts

Important information for our providers

**May 8, 2026**

## *Tips to Avoid Timely Filing and Other Common Claim Denials*

**Claim Filing Deadlines**

- All original paper and electronic claims must be submitted to the Plan within 180 calendar days from the date services were rendered (or the date of discharge for inpatient admissions). This applies to both capitated and fee-for-service claims.
- Please allow for normal processing time before re-submitting a claim either through the EDI or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim.
- Claims must be received by the EDI vendor by 9:00 p.m. in order to be transmitted to the Plan the next business day.
- Unless otherwise agreed to by the Plan and the Provider, failure to submit a claim within the 180-day timely filing deadline does not invalidate or reduce any claim if it was not reasonably possible for the Provider to file the claim within the 180-day period, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the Provider, later than one (1) year from the time submittal of the claim is otherwise required.

**Rejected Claims**

Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or Member data. Rejected claims are those returned to a Provider or EDI source without being processed or adjudicated due to a billing issue. Rejected claims are missing or have invalid data elements, such as the Provider tax identification number or Member ID number. Rejected claims are not registered in the claim processing system and can be re-submitted as a new claim. Claims originally rejected for missing or invalid data elements must be re-submitted with all necessary and valid data within 180 calendar days from the date services were rendered (or the date of discharge for inpatient admissions).

- Rejected paper claims will be returned to the provider with a letter attached with a document control number (DCN). The DCN is not the same as the claim number, but it is a marker that helps AmeriHealth Caritas Next to track claims internally.
- Rebilling of a rejected claim should be done as an original claim. Since rejected claims are considered original claims, the 180-day timely filing limits must be met.

**Denied Claims**

Denied claims are those that were processed in the claims system. They may have a partial payment attached or may have been denied in their entirety. A corrected claim (see below) may be submitted to have the claim reprocessed.

**Corrected claims**

A corrected claim is defined as a claim submitted by a Provider that corrects information on the original claim. A corrected claim must be submitted within 365 days of the original date of service. The original claim number must be submitted as indicated below as well as the correct frequency code.

- You can find the original claim number from the 835 ERA, the paper Remittance Advice or from the claim status search in NaviNet®.
- If you do not have the claim number, then you may need to wait for the original claim to be processed or conduct further research on NaviNet® to get the claim number. Corrected/replacement and voided claims may be sent electronically or on paper.
- If sent electronically, the claim frequency code (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values '7' for the Replacement (correction) of a prior claim or '8' for the void of a prior claim. The Value '6' should not be used.
- In addition, the submitter must also provide the original claim number in Payer Claim Control Number (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files).

**Common Causes of Claim Processing Delays, Rejections or Denials**

- Authorization Invalid or Missing. A valid authorization number must be included on the claim form for all services requiring prior authorization:
- Inaccurate/Incomplete Claim Forms: All required information must be included on the claim forms in order to ensure prompt and accurate processing. Make sure all information is correct, including Member information, service codes, and medical records. Claims without the provider signature or without a tax identification number will be rejected.
- Diagnosis, Procedure or Modifier Codes Invalid or Missing. Coding from the most current coding manuals (ICD-10-CM, CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure and modifier fields must be completed. Please remember to review denied claims to identify patterns and to make sure billing is up to date on the latest rules and codes.

**Questions:**

Thank you for your participation in our network and your continued commitment to the care of our members. If you have questions about this communication, please contact your Provider Network Account Executive.