HPSM Claims and Encounter Data Submission

All providers rendering services to Health Plan of San Mateo (HPSM) members must submit claims/encounter data electronically, or use one of the following forms:

- CMS-1500
- UB-04

Paper Claims Submission

Paper claims should be mailed to HPSM at 801 Gateway Boulevard, Suite 100, South San Francisco, CA, 94080. PCPs must document and submit both fee-for-service claims and capitated service encounters.

Electronic Claims Submission

- HPSM offers many services electronically to providers. These include:
- Batch Claim Submission
- WebClaims Billing, Status Inquiry, and Eligibility Information
- Electronic Remittance Advice
- Electronic Funds Transfer

For more information on electronic services, please contact HPSM's MIS Department at (650) 616-2026.

HPSM supports the following batch claim file formats:

- HIPAA 837 (Professional and Institutional)
- HPSM also has a web portal for direct claim entry of CMS1500 over the web.

Delivery Method	Directions
FTP (File Transfer Protocol)	FTP to hpsm.org. Dial-in number is (650) 616-8062. Plaintext only, migrating to 128-bit SSL encryption. Please contact the HPSM MIS Department at (650) 616-2026 to set up your User ID and Password and receive more detailed instructions.
E-mail	E-mail to ec@hpsm.org PGP encryption preferred.
Modem	Dial-in number is (650) 616-8057. Please contact the HPSM MIS Department at (650) 616-2026 to set up your User ID and Password and receive more detailed instructions.

WebClaims	CMS-1500 professional claims can be completed and submitted via HPSM's website at www.hpsm.org. Please contact the HPSM Provider Department to set up your User ID and Password and receive more detailed instructions.

Claims Receipt Confirmation

Electronic claims are acknowledged via e-mail within 2 working days. Paper claims are acknowledged on the EOPs within 15 working days of receipt.

The status of claims, regardless of submission method, can be checked via HPSM's website once a User ID and Password have been established. Please contact the HPSM MIS Department at (650) 616-2026 for assistance.

Timelines for Claims Submission

Claims Submission from date of service	Reimbursement Policy
0-6 months	100% of approved payment
7-9 months	75% of approved payment
10-12 months	50% of approved payment
> 1 year	0% of approved payment (without written justification)

Member Eligibility

To check a member's PCP assignment, and verify eligibility, providers should call HPSM's 24 hour Automated Eligibility Verification System (AEVS) at 1-800-696-4776 and follow the automated instructions.

When the member is not assigned a PCP, the eligibility recording will state "Special Member". (Please note: member status may change from month to month, so it is important to verify status for the month that the service was performed).

Member eligibility can also be checked via HPSM's website once a User ID and Password have been established. Please contact the HPSM MIS Department at (650) 616-2026 for assistance.

Claims for services provided to members who are later determined to be retroactively eligible with HPSM must be submitted within 60 days of determination of eligibility by the Department of Health Services.

Note: In order to avoid a denied claim for late submission, please note in the remarks section the date that Proof of Eligibility (POE) was received by the Provider.

If You Need Assistance

If you have a question or a problem, you can call HPSM at (650) 616-0050 and ask for a Claims Provider Services Representative or a Provider Services Representative for assistance. However, for specific problems, please remember that you can:

1. **File a CIF (Claims Inquiry Form**) if you want to request an adjustment to an underpaid or overpaid claim, re-submit a denied claim, or trace the status of a claim not recorded on an EOP (Explanation of Payment).

   CIFs must be submitted to the Claims Department within 6 months following the date of a payment or denial on an EOP. However, if it is within 6 months of the date of service, you can just re-bill HPSM .
   You can find more information on CIFs for HPSM here: www.hpsm.org

2. **File a Provider Claims Appeal** if you are dissatisfied with the processing, of a CIF. Provider Claims Appeals must be submitted to the Provider Services Department within 90 days of the CIF determination.

   Provider Claims Appeals may also be submitted if a provider misses the 6-month time-frame for submitting a CIF. The Provider Claims Appeal must be submitted within 365 calendar days of the original claim payment or denial. In this case, providers are only entitled to one level of review at the Provider Claims Appeals level.

3. **File a Reconsideration Request** if you are dissatisfied with an Utilization Review decision about RAFs or TARs (Referral Authorization Forms or Treatment Authorization Requests). Reconsiderations must be submitted to the Health Services Department within 60 days of the date of the original adverse determination notice.

If you have multiple claims and disputes

If you would like to file substantially similar multiple claims disputes and other billing or contractual disputes in a batch as a single provider dispute, HPSM can accommodate this request. Please provide an Excel spreadsheet of the multiple issues, including at least the following data:

- Member Name
- Member ID #
- Date(s) of Service
- Procedure(s)
- Amount(s) Originally Billed
- HPSM Claim Number
- Dispute Explanation

Provider Grievance: If you are dissatisfied, with other aspects of HPSM's operations (with the exception of an Organization Determination) or with another provider's or member's activities or behaviors, you may submit a Provider Grievance by calling HPSM and asking to speak to the Grievance and Appeals Coordinator.

You can call HPSM at (650) 616-0050 or write us at;

801 Gateway Boulevard, Suite 100,
South San Francisco, CA, 94080

HPSM Contact Information:

Health Plan of San Mateo
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080
(650) 616-0050 (all departments)

MIS Department
(Electronic Services)
(650) 616-2026
(650) 616-8235 (fax)

Grievance and Appeals Coordinator
(Provider Grievances)
(650) 616-0060 (fax)

Provider Services Department
(Questions, Problems, Provider Claims Appeals)
(650) 616-2106
(650) 616-8046 (fax)

Claims Department
(Claims, CIFs)
(650) 616-2056
(650) 616-8047 (fax)

Health Services
(TARs, RAFs, Reconsiderations)
(650) 829-2079 (fax)