Provider Manual

An Administrative Guide for Participating Providers

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Dear Provider:

Welcome to the HFN, Inc. Network! We are pleased you have elected to be a Participating Provider in our effort to provide quality health care services to employees and dependents who access our network.

This provider information booklet was developed to help you and your office staff relate to HFN and our clients. We are confident you will find this guide useful. Please review it with your staff at their convenience.

We are keenly aware that HFN's strength in the marketplace relies greatly on the services you provide. Therefore, we depend upon you and encourage you to share your thoughts on how we can enhance our service through you. Please call me or our Provider Relations Team at anytime relative to how we can enhance your participation in HFN's Network.

Please know that your participation as a Participating Provider is greatly appreciated by our membership and HFN.

Thank you.

Sincerely,

Liz Kerr

Elizabeth Kerr
VP Strategic Provider Relationships
HFN, Inc. A Stratose Company

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History of HFN

HFN is a managed care organization incorporated on March 1, 1985 and has become known for providing access to quality healthcare services. HFN is focused on direct contracting with employers, third party administrators (TPA), insurance carriers, Taft-Hartley plans, and others. The company offers employers and Payors an integrated product mix encompassing group health, Workers' Compensation, auto, and disability products.

HFN's mission is to market an accessible and high value array of quality health care services that are tailored to the health care needs of the individual and business community to fulfill the expectations of the Shareholders.

In 1995, HFN repositioned itself as pre-eminent provider network in Illinois by creating an EPO Network consisting of 99 DRG reimbursement based hospitals and physicians who are reimbursed on an RBRVS fee schedule. Further, HFN has expanded its Workers' Compensation Network statewide and services over a million employees.

In October 2013, HFN became part of the Stratose family of companies.

HFN Ideology

We demand integrity of ourselves and from the people with whom we work. We strive to satisfy the needs of our customers while providing superior customer service. We meet our employee needs and aspirations in order to exceed our customer expectations. We compete with ourselves and are our own worst critic.

Vision Statement

HFN will be recognized and respected by employers and providers as a comprehensive healthcare network preferred by employees. We will cultivate relationships by listening and will deliver what our customers want and need by being flexible, innovative, and technically competent.

Core Competency

Our Core Competency is packaging and deploying comprehensive quality health care services that meet the wants and expectations of our clients.

The purpose of this Provider Manual is to inform Participating Providers about HFN's guidelines, policies and procedures as it relates to them. **The Provider Manual is intended as an administrative guide. The terms and conditions expressed in your provider agreement with HFN take precedence over information that is included in the Provider Manual.** The manual covers topics such as the product offerings, claims processing and payment, repricing, and credentialing.

HFN SERVICE AREA

HFN's Network service area includes Illinois, Northwest Indiana, Quad Cities, St Louis, and Southeast/Southwest Wisconsin, from Madison to Green Bay and Milwaukee.

Network Affiliations contract to utilize the HFN Network in our Service Area. Outside of the HFN Service Area, the Network Affiliate uses its network. Refer to the Client Description for a list of insurance carriers, Network Affiliations, third party administrators, and Workers' Compensation clients.

HFN Product Offerings

HFN is one of the largest PPOs in the State of Illinois with well over a million employees enrolled in our Group Health and Workers' Compensation programs. All of these products are included in our provider agreements; however, a separate agreement for hospitals is required for Platinum participation.

HFN's group health products include the following:

HFN 10

HFN 10 is a traditional PPO structure encompassing hospital, physician, and ancillary services with regional or national coverage. Savings range from ten percent (10%) to thirty-five percent (35%).

Beneficiaries enrolled in the HFN 10 must have at least a ten percent (10%) incentive between in and out of network benefits with access to all PPO network hospitals.

HFN 20

HFN 20 consists of a full range of physicians, hospitals, and ancillary services. With a network of hospitals and physicians using DRG based rates and Medicare RBRVS fee schedules, respectively, this product generates greater savings between thirty-five percent (35%) to fifty percent (50%) on their health care cost.

Beneficiaries enrolled in the HFN 20 must have at least a twenty percent (20%) incentive between in and out of network benefits with access to all PPO hospitals, but receive the deepest discount when they utilize a subset of the HFN 20 hospitals, the 99 DRG reimbursed HFN 20 hospitals.

For Taft-Hartley Funds/labor unions, enrolled in the HFN 20 program, financial incentives that are reasonable under the particular circumstances will be required, but the levels of such incentives may be less than other Payors.

HFN Platinum

Platinum is a very limited network of physicians, hospitals, and ancillary services. This health plan saves clients forty percent (40%) to fifty-five percent (55%) on their healthcare charges.

For Beneficiaries enrolled in the Platinum Health Plan, their plan requires at least a twenty percent (20%) incentive between in and out of network benefits. Platinum Beneficiaries must utilize Platinum hospitals, facilities and practitioners for in-network benefits, and Participating Providers must refer them to contracted Platinum providers.

HFN Participating Providers may qualify for Platinum Group Health Insurance Plans for their employees, and of course, themselves. The Platinum Health Plan is also marketed to fully-insured employer-sponsored health plans, health and welfare plans, insurance carriers, and third party administrators.

Community Health Connect (CHC)

CHC is a community based network created for select geographical areas in Illinois. HFN has negotiated deeper discounts with those hospitals and providers in those select geographical areas, while still giving employers and employees comprehensive access to providers around those areas at a lower negotiated discount. The HFN CHC network will enable employers to experience significantly deeper discounts when utilizing their community based providers and local expertise with the benefit of full state coverage. To qualify for access a plan must have at least a 20% differential between in and out of network benefits.

CHC Elite and CHC Premiere

These networks are based in the Peoria, IL area. HFN created this "choice option" in Peoria to accommodate the market need to have access to the 2 key hospitals systems in the Peoria market, Methodist Medical Center and OSF St. Francis Medical Center. This network development enables the member to select, at the time of enrollment, to participate in EITHER CHC Elite or CHC Premiere. The member will have access to the anchor hospitals of their choice in the Peoria area and all other CHC hospitals outside their geographic area. To access the HFN CHC Elite and CHC Premiere network discounts, there must be a minimum of a 20% plan design differential between in-network and out-of-network benefits. This network structure may be expanded to other market areas as the market need develops.

Custom Networks

These Networks are narrow custom networks of physicians, hospitals and ancillary services created for specific client needs. This health plan saves clients forty-five percent (45%) to fifty-five percent (55%) on their healthcare charges. HFN Beneficiaries must utilize their designated hospital, facilities and practitioners for in network benefits and Participating Providers must refer them to contracted providers. The Health Plan requires at least a twenty percent (20%) incentive between in and out of network benefits. These clients use the HFN FLEX logo as part of the customized ID cards.

ID

ID is a Group Health product for Beneficiaries with a plan differential of less than ten percent (10%). HFN ID is identified on the EOB but not necessarily incentivized.

Auto/Disability Program

HFN Auto/Disability Program consists of providers electing to be a Participating Provider who sees Beneficiaries that are channeled into the network. An information packet contains our toll-free phone number and a list of physicians and hospital providers who participate in this product.

The HFN Auto/Disability Program is identified but not necessarily incentivized. Beneficiaries enrolled in this program have less than a ten percent (10%) incentive between in and out of network benefits.

HFN's Workers' Compensation products include the following:

Workers' Compensation

Since September 1987, HFN has been offering a Workers' Compensation Network to support a Workers' Compensation Program between providers and employers in the community. Through our Coordinated Occupational Health Provider (COP®) Network, HFN offers injury care, physical examinations, OSHA screening, drug and alcohol testing, health risk assessments, and other preventive screenings that allow employers to identify any at-risk employees.

HFN has contracts with several types of Workers' Compensation clients, including insurance companies, TPA's, bill review companies, and employers that are self-funded for their Workers' Compensation business.

HFN is an approved Workers' Compensation Preferred Provider Program (WC PPP). As such, HFN works with clients to establish the policies and procedures that allow for the direction of care to in-network providers.

Coordinated Occupational Health Provider Program (COP®)

COP® is a coordinated/comprehensive program focusing on the delivery of primary care and occupational health services with a “return to work” philosophy. There is a defined panel of referral specialists and case managers and a registration/notification process for “fast tracking” employees.

A certified COP® site must first be contracted as an HFN provider for Workers' Compensation. Each site completes and submits an HFN COP® Performance and Certification Criteria Form to HFN. HFN certified COP® sites must meet HFN qualifications and adhere to the HFN COP® philosophy of “return to work”. Finally to complete the certification process, HFN conducts a tour and interview of the site to verify adherence to performance standards and certification criteria. The site is then issued approval, probationary or deferred status.

Network Management is evaluating expansion throughout our service area. You may call our Network Management Department for information regarding participation in COP®.

BENEFICIARY IDENTIFICATION (ID)

HFN group health clients issue Beneficiaries ID cards with the HFN name or logo on the ID card. The HFN name or logo may be included on the card via stamp, print, or sticker. We recommend that you obtain a copy of the Beneficiary's ID card for your records, at least annually, and request to see the Beneficiary's ID card at each visit. Refer to Exhibit A to view our logos and Exhibit B to view sample ID cards. Workers' Compensation does not have an ID card.

Please refer to the Beneficiary's ID card to determine his/her ID number. Either the insured's ID number or social security number is required for repricing claims.

Refer to the phone number listed on the group health ID card to verify benefits and eligibility before rendering services. Call HFN's Customer Service Department at (800) 295-5444 for assistance if the ID card is not available. Notify the Beneficiary of any non-covered services, exclusions, or limitations before rendering such services. The address for claims submission is also included on the card. **However, the claims address may vary by Payor. In order to facilitate prompt and accurate payment, please submit claims to the appropriate address, indicated on the card.**

Contact the phone number listed on the Beneficiary's group health ID card for utilization management protocols regarding pre-certification or authorization requirements for elective inpatient admissions; outpatient services; emergency inpatient admissions; emergency outpatient services; and maternity care, etc. Call Customer Service at (800) 295-5444 for assistance if the ID card is not available.

Check the Beneficiary's group health ID card for any applicable co-payments due at the time of service. Participating Providers cannot bill Beneficiaries for any fees or charges whatsoever, except co-pays, deductibles or co-insurance as defined by the benefit plan or seek or accept any other payments from Beneficiaries. After the Participating Provider has received an Explanation of Benefits, the Participating Provider is permitted to collect for services provided to persons determined to be ineligible for Covered Services, or (c) for services denied as not being Covered Services or Medically Necessary only if the provider has obtained the specific written consent of the Beneficiary to pay for such services in advance of their provision. Usually, this provision [the aforementioned part (c)] is met when new patients fill out the forms at their initial visit to the provider. Participating Providers must immediately refund a Beneficiary's monies upon notice by HFN or a Payor, any amounts erroneously collected from the Beneficiary.

Explanation of Benefits/Explanation

All Payors are required to supply providers with an Explanation of Benefits (EOB) for group health and an Explanation of Review (EOR) for Workers' Compensation. HFN requires that our name appear in a remark code on the EOB/EOR. The EOB message may be tied to the product the Payor client is accessing (i.e. HFN 10 or HFN 20). If not, we request that a general message be used. We recommend that Payor clients use the suggested wording or language otherwise approved by HFN:

Discount taken per the HFN 20 contracted rate;

Discount taken per the HFN 10 contracted rate;

Discount taken per the HFN ID contracted rate;

Discount taken per the HFN CHC contracted rate;

Discount taken per the HFN CHC Elite / Premiere contracted rate

Discount taken per the HFN Platinum contracted rate; or

Discount taken per the HFN Network Participating Contracted Rate.

As a Participating Provider in the HFN Network, you are the core of our business and a very important client.

The Network Management Department is charged with the development and retention of the HFN Network. To develop the network, Network Management has contracted with a variety of medical providers to participate in our programs throughout our service area. We target, recruit and enter into agreements with practitioners such as medical doctors, doctors of osteopathy, podiatrists, and other medical professionals/practitioners i.e. certified registered nurse anesthetists, chiropractors, mental health providers, physician assistants, and therapists. Ancillary providers, hospitals and clinics and other facilities are also an integral part of our network. HFN packages these providers' services and offers them to our business partners, employers, insurers and third party administrators.

Provider Relations is a function of the Network Management Department. Provider Relations is designed to enhance our partnering relationships with our providers. Provider Relations conducts provider orientation sessions at the HFN corporate office on a Wednesday of each odd month to educate participating providers about the HFN Network. Provider Relations is also available weekdays to assist providers in resolving issues that have been escalated by our provider-friendly Claims/Customer Service Department.

Network Management also offers an array of on-line value-added services. Visit our website at www.hfninc.com and click on 'Provider Links'. This section includes non-secured and secured information for providers.

Non-secured information includes information regarding:

Electronic Claims Submission

HFN can receive claims from numerous clearinghouses: Availity (THIN), CareVu, Emdeon (WebMD Envoy), JDA eHealth, McKesson, MedAvant (ProxyMed), Payerpath, RealMed, and The SSI Group. This link provides information about submitting claims electronically to HFN via one of these clearinghouses.

Provider Newsletters

Keeping you informed about HFN's current products and services as well as our ongoing marketing efforts on your behalf is one of our strategies to enhance our partnering relationships. To that end in October 2002, HFN introduced the inaugural issue of its provider e-newsletter, *ProviderPartner*, to communicate with you about the strides we are making to enhance our partnering relationships. For back issues of *ProviderPartner*, you may contact Network Management at (630) 954-1232.

In order to improve our communications process, provide us with your e-mail address, if available, so that you may be included in our distribution list to receive valuable information. Ensure that your e-mail system is set-up to accept e-mails with links and/or URLs from providerpartner@hfninc.com. Pursuant to our agreement, you are required to provide us with such demographic information. Likewise, HFN is obligated to make available to you information regarding our programs, changes in policies and procedures, and value-added services, etc; the e-newsletter is our vehicle to communicate such information. Your e-mail address will not be shared with any third parties. It will strictly be used by HFN to make network communications to you.

You may submit your practice's/organization's e-mail addresses by visiting our website at www.hfninc.com. Click on 'Provider Links', then on 'Provider Update Requests'. Check 'other', then provide the appropriate e-mail address (es) and contact information in the text box.

ProviderPartner provider newsletters are distributed electronically bi-monthly. *ProviderPartner* has addressed hot topics in the provider community, such as the rise of malpractice insurance costs and the nursing shortage at hospitals. *ProviderPartner* introduced value-added services such as the on-line Claims Repricing Status Inquiry functionality, the ability to submit electronic Network Provider Update Requests, and the capability of viewing the on-line HFN Client Repricing List to assist you with increased operational efficiencies and greater benefits via electronic claims submission to HFN.

National Provider Identifier Information and Submission Form

National Provider Identifier (NPI) is the standard ten digit unique health identifier for health care providers that has been adopted as a result of HIPAA to replace the various legacy numbers, UPINs, Medicaid numbers and other proprietary numbers that health care entities or health plans have assigned to health care providers. For Medicare and Medicaid programs, NPI will hopefully be the tool that standardizes the national health care provider

identification system which will also be accepted by health plans, clearinghouses, etc.

Facts you should know…

- You may apply on-line at https://nppes.cms.hhs.gov/NPPES/Welcome.do; it is free and will be operational about 120 days after you receive it. You may call the NPI Enumerator Call Center at (800) 465-3203 if you have questions.

- HFN is prepared to record your NPI in our system to assist our clients with the HIPAA mandate. Providers must still include their tax identification number on claims for 1099 purposes. Participating Providers may register their NPI on-line with HFN

- Please note that if not using an NPI number, your clearinghouse or the Payor may reject a claim until submitted with your NPI number.

- Contractually, HFN Participating Providers are required to maintain current demographics and any other pertinent information (including but not limited to your NPI number) required by us to operationalize, manage, and adjudicate any services rendered.

- NPI and any other identifying information shared with us will be held in the strictest of confidence and is allowed to be shared as it pertains to billing, adjudication and payment activity for claims.

Orientation Schedule

This link gives providers the opportunity to register to attend one of the Provider Orientation Sessions that are offered throughout the year. Providers may also use this section to request a provider orientation at their office/site.

Provider Application

For your convenience, we have posted a link on our website to the Illinois State mandated credentialing application, the Health Care Professional Credentialing and Business Data Gathering Form. The Health Care Credentials and Data Collection Act requires the use of this form to collect credentialing information commonly requested by health care entities and health care plans for credentialing and recredentialing. This application is available in Microsoft Word 97 and Adobe Acrobat versions.

Provider Update Requests

Participating Providers may use this vehicle to ensure that HFN has the most current information about their practice i.e. relocation of practice/site, name change, board certification achievement, TIN change, new billing address/ company or other important demographic information. Keeping us well-informed assists us in marketing your current practice demographics in our provider directory to our clients and helps our Payor clients with recognizing your Federal Tax Identification Number and billing address for remittance. Individual practitioners may also mail or fax updates to us. Clinics, groups, IPAs, PHOs, and facilities may also use the appropriate Exhibit B or Exhibit D of their provider agreement to update contact and demographic information; then mail or fax to us.

Secured information may only be accessed by Participating Providers who have obtained a login and password. A request for login may be submitted on-line at www.hfninc.com under 'Provider Links'.

Secured information includes the following:

Claims Repricing Status

Participating Providers may use this feature to make claims repricing status inquiries. The result of the inquiry yields the a) HFN claim number, b) date claim was repriced, c) repriced amount, d) name of third party administrator (TPA) or Payor that is responsible for provider payment, and e) phone number of the TPA or Payor should there be any further questions. Additionally, there is a hyperlink to click and view the actual repriced claim. The repriced claim will appear on the appropriate claim form (UB-04 or CMS-1500). The repriced claim will show the repriced amount line by line, if appropriate, and/or the total repriced amount.

HFN Payor Listing

For access at anytime, we provide on-line secured access to our Payor listing to participating hospitals, PHOs, large groups, and facilities. For confidentiality purposes, the HFN Payor Listing is only supplied to eligible Participating Providers. Additionally, for new hospitals we e-mail a comprehensive Payor profile. Thereafter, updates are e-mailed on a monthly basis.

The Payor listing includes employer names and their corresponding a) Payor, b) product, c) benefit differential, d) claims address, e) the company and number to call for eligibility and benefits f) the pre-certification company and number to call

for pre-certification, g) the utilization review firm and number to call for utilization review, and h) effective date. The on-line Payor listing is updated dynamically each time an update is entered into our database.

HFN Client Repricing List

In an effort to assist Participating Providers with electronic claims submission, HFN has made its Client Repricing List available on-line. For claims submission, we recommend that you tie the HFN Payer ID number (36335 or 2717 for McKesson) to these clients in your practice management system or key entry to reap the benefits of EDI.

Fee Lookup

This functionality is available for Participating Providers to view their contracted rates on-line. Participating Providers may search a particular procedure code, a range of procedure codes, or the comprehensive fee schedule.

CLAIMS/CUSTOMER SERVICE

HFN has a provider-friendly Claims/Customer Service Department that services Beneficiaries and providers with the highest level of customer care. Claims/Customer Service is available weekdays between 8:30 AM and 4:30 PM at (630) 573-6224 or toll-free at (800) 295-5444. Providers may call for concerns or questions such as network referrals, claims issues/investigations, and fee look-up. **Since HFN does not offer a gatekeeper product, written referrals are not required.**

For issues and/or claims investigations and disputes that require follow-up, you may speak with any of our Customer Service Representatives. The representative will document the case in our tracking system and provide you with a case number. The case is routed internally through the proper channels to resolve the case. In the event you need to follow-up with the case, you may call Claims/Customer Service and provide the available representative with your case number. With your case number, the representative can look up your case and tell you the status or resolution.

Providers may contact HFN's Claims/Customer Service Department to obtain the number to call to verify benefits and eligibility or pre-certification/ authorization. This information should be on the Beneficiary's ID card, but you may contact the HFN Claims/Customer Service Department in the event the Beneficiary's card is not available. Please be prepared with the insured's name, unique ID number and employer. Then, Claims/Customer Service can provide you with the appropriate telephone number.

Beneficiaries may also contact our Claims/Customer Service Department regarding referrals to Participating Providers, quality of care concerns, access issues, and other compliments or complaints. These cases are logged in our tracking system, as well. For cases regarding provider complaints, a member of Provider Relations will contact the provider to resolve the matter.

The Claims/Customer Service Department also offers on-line services:

Provider Search

Our provider agreement requires Participating Providers to refer Beneficiaries to other Participating Providers, except in cases that in the referring Participating Provider's judgment, we do not have a Participating Provider able to provide the Covered Service the Beneficiary needs. To refer Beneficiaries to Participating Providers, you may use the Provider Search function of our website to search by physician and other professionals, product; hospital/facility; specialty/ category; address/city/state/zip code; and radius/distance.

This on-line directory contains all Participating Providers in the HFN Provider Network. The HFN Network is continually changing and all information is subject to change. Please verify a provider's participation in the network prior to recommending that a Beneficiary seek treatment from a particular provider.

There are no required fields to complete a search, however the only required field will be in the 'Search by Distance' section, if you decide to use this feature, as the search engine will be required to determine a valid reference point to perform the search. Results are limited to 400 providers per search.

Customer Satisfaction Survey

As part of our commitment to superior customer service, we have initiated a customer satisfaction survey. This on-line survey requests responses regarding general performance of customer service, claims, provider relations, and comments or suggestions about our website.

Customer Communications Form

HFN values your opinion. There is also a web page designed for you to e-mail your comments and suggestions to us.

Participating Providers have one-hundred-twenty (120) days after the provision of the Covered Service to submit Clean Claims to a Payor or its designee. Clean Claims submitted to Payors for Covered Services will be paid in accordance with the contracted rates, Exhibit A of the agreement.

Submit Clean Claims using current UB-04 or CMS-1500 or successor or electronic equivalent forms. For claims submission use current, applicable coding including, but not limited to ICD-9, CPT Revenue and HCPCS coding; and current billing and reimbursement guidelines as established by the Centers for Medicare and Medicaid Services ("CMS"), formerly known as HCFA and modified from time to time.

Ensure that you submit claims to the claims address indicated on the Beneficiary's ID card or the HFN Payor Listing. In some cases, the payer ID number for submitting claims electronically will be included on the Beneficiary's ID card.

The following data elements for CMS-1500 and UB-04 forms are the minimum requirements for HFN to reprice claims.

Clean Claims include the following data elements:

For CMS-1500 (See Exhibit C)

- Insured's Unique ID Number
- Patient's Name
- Patient's Birth Date
- Insured's Name
- Patient's Street Address
- Patient's City
- Patient's State
- Patient's Zip Code
- Insured's Street Address
- Insured's City

Clean Claim data elements for CMS-1500 (cont'd)

- Insured's State
- Insured's Zip Code
- Insured's Policy Group or FECA Number
- Insured's Date of Birth
- Employer's Name or School Name
- Diagnosis or Nature of Illinois or Injury
- Dates of Service
- Place of Service
- Procedures, Services, or Supplies with applicable CPT/HCPCS and/or Modifier
- Diagnosis Code
- Charges
- Days or Units
- Federal Tax Identification Number
- Total Charge
- Signature of the Physician or Supplier including Degrees or Credentials
- Name and Address of Facility Where Services were Rendered
- Physician's, Supplier's Billing Name, Address, Zip Code and Phone Number
- National Provider Identifier (as of May 23, 2007)

HFN claim repricers review box 25 (tax identification number), box 31 (Signature of the Physician or Supplier including Degrees or Credentials), box 32 (Name and Address of Facility Where Services were Rendered), and box 33 (Physician's, Supplier's Billing Name, Address, Zip Code and Phone Number) to ensure that the data on the CMS-1500 matches the data in our database. It is imperative that physicians and practitioners include their name on their credentialing application in the manner in which they submit their names on the CMS-1500 claim form. Additionally, if box 32 reads "same", HFN claim repricers will populate that box with information in box 33 as long as box 33 lists a physical street address. Otherwise, the claim is not clean and considered incomplete. It is also important to notify us within thirty (30) days of changing your tax identification number and/or demographics. You may mail, fax, or use the Provider Update Requests functionality on-line to notify us of such changes.

For UB-04 (See Exhibit C)

These data elements are required for HFN to reprice claims.

- Facilities Name and Address
- Federal Tax Identification Number
- Statement Coverage Period
- Patient Control Number
- Type of Bill
- Patient's Name
- Patient's Address
- Birth Date
- Sex
- Admission Date
- Revenue Codes
- HCPCS/Rates
- Service Dates

Clean Claim data elements for UB-04 (cont'd)

- Service Units
- Total Charges
- Insured's Name
- Insured's Unique ID Number
- Principal Diagnosis Code
- Other Codes
- Adm Diagnostic Code
- E Code (if applicable)
- DRG (required for Workers' Compensation claims and for Group Health if provider has a DRG contract)
- Principal Procedure - Code and Date
- National Provider Identifier (as of May 23, 2007)

HFN claim repricers review box 1 of the UB-04 to ensure that the data on the claim matches the facility name and physical location or billing location in our database. Additionally, the Federal Tax Identification Number in box 5 should be the Federal Tax Identification Number reported to HFN. It is imperative that facilities notify HFN within thirty (30) days of a Federal Tax Identification change (including supporting W-9 form), name, change, relocation, additional campus, lock box/post office box change, or demographic changes.

Paper Claims

For practices and facilities that are not set up to submit claims electronically, HFN accepts claims submitted in hard copy on the current applicable CMS-1500 or UB-04 claim form with scannable red dropout ink. Submitting claims on black lined claim forms may slow down the claims repricing process because they are not as easily scanned as red lined forms. Superbills are not acceptable.

Clean paper claims submitted to HFN in the red dropout ink are circulated through HFN's Repricing Off-Line Engine (ROLE®), an EDI batch claims repricing system. ROLE® accepts claim files in ANSI 837-5010 standard claim format.

HFN ROLE® Benefits:

- Scanning/OCR capabilities to convert paper claims to EDI files
- Secure access to scanned images for scanned paper claims
- Fast, batch processing
- Results in faster turnaround for payment
- Eliminates duplicate data entry

HFN Claim Address

HFN, Inc.		HFN, Inc.
PO Box 3428	Or	1315 W. 22nd Street
Oak Brook, IL 60522		Suite 300
		Oak Brook, IL 60523

The claims address may vary by Payor. In order to facilitate prompt and accurate payment, please submit Clean Claims to the appropriate address.

Electronic Claims Submission

As part of HFN's aggressive EDI strategy, HFN accepts electronic submission of medical claims from the following clearinghouses: Emdeon (institutional/ professional), McKesson (professional), Payerpath (professional), Capario (professional), RealMed (professional), The SSI Group (institutional/professional), and SmartData (institutional/professional).

HFN would like to facilitate providers' submission of claims electronically to accelerate payment and enhance cash flow to your organization.

HFN reprices claims for approximately seventy-five percent (75%) of its clients, but our provider research indicates that many of our network providers are submitting paper claims, or only sending claims electronically for a few HFN clients. Providers who share in electronic transactions have decreased accounts receivable days and faster claim payments. We appreciate and applaud your efforts; however, we would like you to experience more operational efficiencies and greater benefits by sending claims electronically for all of the clients for whom HFN handles repricing.

Benefits of EDI include:

- cleaner claims;
- cost effectiveness;
- faster turnaround times;
- increased productivity;
- minimized storage needs;
- paper reduction; and
- reduced cycle time.

For those providers who would like to start sending electronic claims to HFN, here are the tools needed to accomplish this mission:

- HFN Payer ID — 36335 (except for McKesson: 2717);
- Clearinghouse information — visit our website at www.hfninc.com, click on 'Provider Links' then select electronic claims submission.

HFN's Repricing On-line Claims System (ROCS®) is an Internet-based claims repricing system providing HFN's clients a secure and easy-to-use solution for repricing claims. HFN claims repricers and clients who have elected to use this service to reprice Clean Claims using ROCS®.

HFN ROCS® Benefits:

- Easy access
- Simple to use
- Secure user logon and data transmission
- Real-time repricing

Common Claim Data Errors

To avoid delays in being reimbursed by a Payor, submit Clean Claims in a timely manner. Once an improper claim has been corrected and resubmitted because it is complete, properly coded; and/or on the required form or in the required format, as the case may be; the Payor will adjudicate the claim accordingly.

Considering the complex evolution of the professional and institutional claim forms, HFN has compiled a list of common claim form data errors that delay HFN claim repricing and the subsequent turnaround time for Payor reimbursement. As some providers struggle to get their practice management software or key entry system updated to maintain HIPAA compliance while transitioning to the new CMS-1500 or UB-04 claim forms, the following list will hopefully be a reference tool relative to submitting Clean Claims to HFN for repricing. However, please be advised that this list of *common claim data errors* is a subset of the *required data elements* for HFN to deem a claim as clean as referenced on pages twenty-two through twenty-five of this manual.

Common Claim Data Errors Include:

- ☒ Missing or incomplete Name and Address of Facility where Services were Rendered (CMS-1500 & UB-04);
- ☒ Missing or invalid Admission date (UB-04);
- ☒ Missing Name of Individual Provider Rendering Services (CMS-1500);
- ☒ Missing DRG code for Inpatient Claims (UB-04);
- ☒ Missing or incorrect Patient Relationship code (CMS-1500 & UB-04);

- ☒ Missing Insured's Name (CMS-1500 & UB-04);
- ☒ Missing Unique ID Number of Insured (CMS-1500 & UB-04);
- ☒ Missing Patient's Name (CMS-1500 & UB-04);
- ☒ Missing CPT code (CMS 1500);
- ☒ Missing Line Charge Dollar Amount (CMS-1500 & UB-04);
- ☒ Missing Federal Tax Identification Number (CMS-1500 & UB-04).

HFN is a repricer. We reprice claims submitted by Participating Providers in accordance with the contracted rate; then, we provide the repricing statement to our Payors to adjudicate accordingly. For medical doctors and other professionals, contracted rates are generally based upon an RBRVS fee schedule.

Payors are generally required to pay claims within forty-five (45) days of receipt of Clean Claims, or as specified in your agreement. Group health insurance company Payors must abide by the Illinois Prompt Pay Law by paying claims within thirty (30) days. Taft-Hartley funds/labor unions, and self-insured employers are covered under ERISA; therefore, the Illinois Prompt Pay Law does not apply to them. The same exemption applies to Workers' Compensation programs.

PRICING POLICY

Fee Schedule Methodology

In 1995, HFN converted to a Resource Based Relative Value System (RBRVS) methodology for practitioner reimbursement. This methodology has allowed HFN considerable greater flexibility and control over its reimbursement strategy. Together with a move into claims management, utilizing this methodology has enabled HFN to respond with greater sensitivity and agility to the complementary concerns of both Participating Providers and Payors.

HFN is using a modified RBRVS reimbursement methodology by type of service: primary care service or specialty care service. The type of service is not dependent on primary care physician versus specialists, but how Medicare had categorized the procedure codes, hence primary care service or specialty care service.

The HFN Fee schedule and Reimbursement Protocols are based upon the Optum Publication, The Essential RBRVS, which includes procedure codes valued by CMS, including RBRVS and HCPCS, as well as the codes that are not valued by Medicare. Procedure codes not valued by Medicare are supplied by Optum and referred to as Gap Filled Codes. The same methodology utilized to develop the Medicare RBRVS has been applied to the Gap Filled Codes, and supplied through Optum. HFN uses Gap Filled Codes because our membership is a commercial population.

Fee schedules are updated usually on February first of each year, or as designated by HFN, to reflect Medicare changes and updates. As policy revisions occur, they will be conveyed to Participating Providers. Normally,

policy revisions will coincide with annual updates to the fee schedules.

Anesthesia Services

The formula for determining the fee for anesthesia services using the ASA approach is as follows:

1. Basic Unit Value: Each procedure has been assigned a basic unit value, which measures the complexity, gravity, risk and resources for the procedure relative to other procedures.
2. Time Unit Value: The length of time that the anesthesiologist is providing his services allowing 1.0 unit for each fifteen (15) minutes of anesthesia time. Five (5) minutes or greater is considered a significant portion of a time unit.
3. Patient Status Units: The severity of the condition of the patient is recognized in the fee through the use of patient status units.

P1	Healthy patient	0 Units
P2	Mild systemic disease	0 Units
P3	Severe systemic disease	1 Unit
P4	Life threatening severe disease	2 Units
P5	Cannot survive without operation	3 Units
P6	Brain-dead donor	0 Units

4. Qualifying Circumstance Units: For certain qualifying circumstances, additional unit values are also added. The following CPT codes and situations qualify for these additional units:

99100	Patient under age 1 or over age 70	1 Unit
99116	Utilization of total body hypothermia	5 Units
99135	Utilization of controlled hypotension	5 Units
99140	Specific emergency conditions	2 Units

5. Conversion Factor: This factor is determined by the fee schedule the physician is using.

The formula for calculating the anesthesia fee once the above values have been determined from the bill:

[Basic Unit Value + Time Unit Value + Patient Status Units + Qualifying Circumstance Units] X Conversion factor

Modifiers

Modifier NU (New durable medical equipment)

Modifier RR (Rental durable medical equipment)

Modifier TC (Technical Component)

Modifier UE (Used durable medical equipment)

Modifier 26 (Professional Component)

Modifier 50 (Bilateral Procedure)

Modifier 51 (Multiple Procedures)

Modifier 53 (Discontinued Procedure)

Modifier 54 (Surgical Care Only)

Modifier 55 (Postoperative Management Only)

Modifier 56 (Preoperative Management Only)

Modifier 78 (Return to the Operating Room for a Related Procedure during the Postoperative Period)

Modifier 80 (Assistant Surgeon)

Modifier 81 (Minimum Assistant Surgeon)

Modifier 82 (Assistant Surgeon –when qualified resident surgeon not available)

Modifiers TC, 26, 53, NU, UE, RR and their reprice amounts are still attached to the HFN Fee Schedule.

Modifier 50: 150% of allowable charges

Modifier 50 only applies to surgery codes, 10000-69999.

Modifier 51: 50% of allowable charges

Beginning with the 2003 Fee Schedule, HFN recognizes modifier 51 exempt codes. All modifier 51 exempt codes are marked in the Fee Schedule table. If a code is marked as modifier 51 exempt, the 51 modifier should not be applied to that line of the claim. The CPT code would reprice according to its individual fee schedule without modifier 51.

Modifier 54: 70% of allowable charges

Modifier 55: 30% of allowable charges

Modifier 56: 10% of allowable charges

Modifier 78: 70% of allowable charges

Modifier 80: 20% of allowable charges

Modifier 81: 10% of allowable charges

Modifier 82: 20% of allowable charges

Modifier AS: 10% of allowable charges

In order to apply these modifiers, use the HFN fee schedule to determine the reprice amount for that particular CPT code. This is the allowable charge. Then take the applicable percent of allowable charges for the modifiers listed above.

With the exception of anesthesia services, HFN only uses the modifiers listed above to reprice claims. Any modifier not listed above does not impact repricing and is ignored when calculating the HFN reprice amount.

Immunization Administration for Vaccines/Toxoids

Procedure codes 90471 – 90749 are exempt from RBRVS fee schedule application. Refer to your agreement for reimbursement.

ASC General Overview

This section pertains to outpatient surgical hospital claims. In order to be an ASC claim, there must be at least one (1) ASC CPT Code on the claim billed with rev codes 36x or 49x. In addition, surgeries in the emergency room do not fall under the ASC methodology. If any line on the claim has revenue codes 450-459, this is not an ASC claim.

Hospitals with an ASC contract will have an ASC schedule in the *ASC Schedule* field.

In the event that a CPT code is between 70000 and 89999 or a Revenue code is listed in the Rev Code Exception file, the reimbursement reverts to the standard outpatient discount on that line of the claim.

In cases where there is more than one surgical procedure, the procedure with the highest ASC schedule amount is repriced to the amount in the ASC schedule. Subsequent codes are paid at 50%.

Finally, the overall claim is paid according to the lessor of the total ASC reprice amount or the hospital's outpatient discount. Please refer to the outline below for the complete list of rules for ASC repricing.

I. Hospitals with an ASC schedule in the *ASC Schedule* field follow the rules below.

ASC Repricing

A. Line by line on the claim, look up every CPT code in the ASC Schedules document to verify if it is an ASC CPT Code. The ASC Schedules document lists all ASC CPT Codes, the ASC schedules listed in *ASC Schedule*, and the reprice amounts for the ASC CPT codes.

1. If only one CPT code is listed in the ASC Schedules document, find the ASC reprice amount for that CPT code according the ASC schedule that the hospital has in *ASC Schedule*.
2. I If there are multiple ASC CPT Codes, the ASC CPT code with the highest ASC schedule amount on the claim is repriced to the amount in the ASC schedule. All other ASC CPT codes are paid at 50% of their ASC Schedule reprice amount.
3. If there is any non-ASC CPT codes on the claim:
   a. If the non-ASC CPT code is between 70000-89999, reprice that line at the *outpatient* discount.

b. If the non-ASC CPT code is not between 70000-89999, see below.

B. For every line on the claim that has not been repriced, look at the line's revenue code to see if any fall under the ASC Rev Code Exception Document.

1. If a revenue code is on the ASC Exception document's list, reprice that line at the hospital's *outpatient* discount.
2. If a revenue code is not on the ASC Exception document's list, continue to Step C.

C. If there are any lines that do not have an ASC CPT code, a revenue code exception, or a CPT code between 70000 and 89999, reprice those lines at a 100% discount, i.e. the reprice amount is $0.

D. Compare the claim's total discount to the hospital's outpatient discount.

1. If the claim's total ASC discount is greater than the outpatient discount off total billed charges, **this is the final reprice amount.**
2. If the claim's total ASC discount is less than the outpatient discount off total billed charges, apply the *outpatient* discount to the claim's total billed charges. **This is the final reprice amount.**

Hospital DRG Calculation

DRG Reimbursement

HFN has been utilizing the standard Medicare DRGs for hospital inpatient reimbursement for many years. This form of fixed rate pricing provides assurance to our clients that they will not experience fee schedule creep during the term of the agreement. At the same time DRGs provide much of the same assurances to our hospital providers, as opposed to the more prevalently utilized per diem reimbursement. Since the DRG is based upon average rates and a predetermined negotiated base rate, the hospital has an opportunity to determine with HFN a more reasonable and more equitable reimbursement versus the more aggressive and sometimes inappropriate per diem. HFN only uses the most current DRG weights consistent with CMS. Our annual update is usually in October after the new CMS weights have been tested and downloaded into our system. The typical DRG payment calculation is as follows.

Hospital-specific DRG rate x Medicare DRG weight factor = reimbursement rate.

In all cases, HFN must negotiate a lessor of clause; such that we will always pay the lessor of the DRG calculated payment or a minimum of ninety percent (90%) of billed charges. A limited and reasonable number of DRGs may be carved out of this formula and calculation, which should provide some protection to the hospital, for those limited number of DRG carve outs, in return for a more aggressive base rate. HFN also has the ability to negotiate stop loss triggers, but cannot accept inpatient revenue code carve outs, since CMS has included all services in the reimbursement methodology. Please see your specific hospital agreement for more detailed information. For questions contact Network Management at (630) 954-1232.

HFN employs DRGs for reimbursement for our Group Health products and on a limited basis for Workers' Compensation reimbursement. DRGs are never used for either the HFN ID product or the auto/disability programs.

Outpatient Services:

The appropriate discount from a contracted hospital's published charges are applied to the following outpatient services including, but not be limited to, hospital-based rehabilitation centers, hospital outpatient departments, hospital ambulatory care centers and hospital medical centers that are included under hospital's federal tax identification number.

HFN has established an objective set of criteria to reflect the commitment of this organization to develop a practitioner panel of well trained, highly qualified practitioners who understand the principles of cost effective and quality healthcare.

PROCEDURE:

The following criteria will be used as a basis for practitioner credentialing. Meeting criteria does not guarantee participation. The credentialing committee reviews each practitioner on individual merit.

A completed application for membership by the applicant which includes a questionnaire regarding:

A. Ability to perform the essential functions of the position with or without accommodation.

B. Lack of impairment due to chemical dependency/substance abuse.

C. History of loss of license and/or felony convictions.

D. History of loss or limitations of privileges or disciplinary activities.

1. An attestation to the correctness/completeness of the application
2. A signed and dated general provision/release form
3. A current valid license to practice
4. Clinical privileges in good standing at the hospital designated as the primary admitting facility
5. A valid DEA and CDS certificate as applicable
6. Complete residency program in the field designated as the primary specialty in the directory board certification, within three years of eligibility
7. No significant gaps in work history (greater than 3 months)
8. Current malpractice liability insurance (limits to be determined by geographic location) An acceptable claims history
9. Provider has experienced no state disciplinary actions and reductions, supervision or termination of hospital privileges or Medicare/Medicaid sanctions

Failure to meet any of the above criteria will result in formal review by Credentialing Peer review committee.

Initial Credentialing

HFN, Inc. shall administer a process through which each new Participating Provider (including licensed hospitals, medical centers, physicians, physician groups, providers of ancillary services and other provider organizations that have entered into a Provider Service Agreement with HFN, Inc., each " **Participating Provider**") is to be evaluated for eligibility for participation in the HFN network. The initial credentialing process will be undertaken by the HFN credentialing staff. It is the task of the HFN Physician Credentialing Committee to review each new Provider application and accompanying materials in an effort to accept or deny a Participating Provider for inclusion into the HFN network. The initial credentialing by the HFN Physician Credentialing Committee of each new Participating Provider to the HFN network will be based upon data collected for review by the HFN credentialing staff.

The Initial Credentialing of Participating Providers will entail Primary and or Secondary Source evaluation of the following data:

(a) Completed and executed State of Illinois Healthcare Professional Credentialing and Business Data Gathering form

(b) Signed and Dated General Provisions \ Release Form

(c) Confirmation of valid licensure in the practicing state as verified through the Illinois Department of Professional Regulation and all other listed state boards

(d) Medicare / Medicaid Provider Status and Sanction History

(e) NPDB Query status and Sanction History

(f) Confirmation of Board Certification

(g) Current Malpractice Liability Insurance Verification

(h) DEA License and State Controlled Substance Certificate

The Credentialing of hospitals will entail Primary and or Secondary Source evaluation of the following data:

(a) HFN will review and identify that the hospital maintains accreditation by the Joint Commission on Accreditation of Healthcare Organizations ("**JCAHO**") or alternatively, the Hospital shall provide adequate proof of quality acceptable to HFN in lieu of JCAHO accreditation

(b) HFN will confirm valid licensure in the practicing state as verified through Illinois Department of Professional Regulation and all other listed state boards

(c) Medicare / Medicaid Provider Status and Sanction History

The Credentialing of Ancillary Participation Providers will entail Primary and or Secondary Source evaluation of the following data:

(a) HFN will confirm valid licensure in the practicing state as verified through Illinois Department of Professional Regulation and all other listed state boards

(b) Current Malpractice Liability Insurance Verification

Recredentialing

Each Provider will be recredentialed no less than every three years from the Initial Credentialing or the last instance of Recredentialing. The Recredentialing process will occur for each any Participating Provider on the State of Illinois Single Cycle Recredentialing. Recredentialing of each Participating Provider may, in the sole discretion of HFN, occur more often than every three years only: (a) when a Provider is initially credentialed; (b) when a Provider's credentialing data changes substantively; or (c) when a Provider's patient or quality assurance issues indicate.

The Recredentialing for Participating Providers will entail Primary and or Secondary Source evaluation of the following data:

(a) Confirmation of valid licensure in the practicing state as verified through the Illinois Department of Professional Regulation and all other listed state boards;

(b) Medicare / Medicaid Provider Status and Sanction History

(c) NPDB Query status and Sanction History

(d) DEA License and State Controlled Substance Certificate

The Recredentialing of participating Hospitals shall be done every 3 years will entail Primary and or Secondary Source evaluation of the following data:

(a) HFN will review and identify that the hospital maintains accreditation by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") or alternatively, the Hospital shall provide adequate proof of quality acceptable

To HFN in lieu of JCAHO accreditation

(b) HFN will confirm valid licensure in the practicing state as verified through the Illinois Department of Professional Regulation and all other listed state boards

(c) Medicare / Medicaid Provider Status and Sanction History

The Recredentialing of Ancillary Participation Providers shall be done every 3 years will entail Primary and or Secondary Source evaluation of the following data:

(a) HFN will confirm valid licensure in the practicing state as verified through the Illinois Department of Professional Regulation and all other listed state boards.

If at any point a Participating Provider leaves a delegated affiliation where this was their sole HFN affiliation the Participating Provider will then be subject the full initial credentialing process.

At the time of recredentialing when any newly discovered adverse information is found the Participating Provider will be contacted for documentation to explain the discrepancies found. This information will be reviewed at the next scheduled Physician Credentialing Committee for consideration and determination if participation in the HFN network should continue.

Delegated Credentialing

The Credentialing/Recredentialing process may be delegated by contract to an IPA, PHO, Physician Groups, or other Provider organizations that have entered into a Provider Service Agreement with HFN, Inc. The Credentials Manager will review the entity's Credentialing/Recredentialing Policies and Procedures to ensure compliance with HFN Credentialing/Recredentialing policy. The entity must agree to permit HFN, Inc access to credentialing/ recredentialing files and Credentials Committee meeting minutes to complete a delegated oversight audit. The HFN Credentials Manager will complete an oversight audit every 3 years. Audit will include a review of the entities policies and procedures, and a minimum of 25 credentialing and 25 recredentialing files. The file audit will include the proof of:

(a) Completed State of Illinois Healthcare Professional Credentialing and Business Data Gathering Form

(c) Confirmation of valid licensure in the practicing state as verified through the Illinois Department of Professional Regulation and all other listed state boards

(d) Medicare / Medicaid Provider Status and Sanction History

(e) NPDB Query status and Sanction History

(f) Confirmation of Board Certification

(g) Malpractice Liability Insurance Verification

(h) DEA License and State Controlled Substance Certificate

(i) Documentation of Recredentialing conducted at lease every 3 years

(j) Evidence of Peer Review and fair process for review of decision

If audit findings indicate discrepancies of credentialing/recredentialing processes, the HFN Physician Credentialing Committee may not grant and/or may rescind the delegation and conduct internal credentialing/recredentialing for the entity.

HFN, Inc. Client Description

Insurance Carriers

Group Health

Allied National
Assurant/John Alden/Fortis
CenBen USA, Inc.
Concert Health Plan
Federated Insurance
Health Alliance
Midwest Security
Nippon Life
Pekin
US Health & Life

Other

Health & Welfare Funds

HFN has significant business relationships with Labor Unions.

Network Affiliations

AHA
America's PPO / ARAZ
Coalition America / NPPN
Devon
Encore
GlobalCare
HealthSmart
HSI
Intergroup Services Corp.
NHBC
NovaNet

Stop Loss Carriers

AIG
Berkley Risk
Best Life
Commercial Group Underwriters
Companion
E.C.U. (East Coast Underwriters)
Employers RE
Fairmont
Houston Casualty (HCC)
Majestic Underwriters
MRM
Perico
Symetra
Spectrum Underwriting
TPAC
Zurich
XS Risk

TPAs

Acordia National
Aegis
Allied Benefits
Alternative Risk Management (ARM)
American Administrative Group
Assure Care
Auxiant / MBA / EGS
Bartlett Agency
Benefit Administrative Systems (BAS)
Benefit Systems
Benesight
Butler Benefit Services
Commerce Group
Cornerstone Benefits
CoreSource
Corporate Benefit Services
DLC Administrative Services
EBC
First Choice
Group Administrators, Inc.
Group Insurance Administration
Harrington Benefit Services
HCH Administration
HealthScope Benefits
HRH of Illinois
Insurance & Risk Management
JF Malloy (Principal)
J.N. Morcos
Meritain
MGIS
Mid-America Admin. Service
Morris Associates
Mutual Medical
NGS
People 1st Health Strategies
Professional Benefit Admin. (PBA)
Preferred One
Primary Physician Care
Professional Claims Management
Progressive Benefits
Seabury / Marsh
Self Funded Plans
SISCO
Superior Health
Total Broker Benefits
TPA, Inc.
URM
Westlake Financial
Westport Benefits / Century Planner

Workers' Comp

ABF Freight
Accident Fund
AIG
AMCC
Alpha Review
American Country Insurance
American Family Insurance
ASU Recovery
Avizent
Badger Mutual
Brentwood Services
Broadspire
CCMSI
Chartis
Cintas Uniforms
Claims One
Crawford & Company
Diamond Insurance
Federal Express
Federated Insurance
Frank Gates
GAB Robbins
Gates McDonald
Genex Services
Great American Insurance
Illinois Municipal League
Illinois Public Risk Fund
IHP
Illinois Tollway Authority
Indiana Insurance
Ingenix
Liberty Mutual
Martin Boyer / Cambridge
MCMC
Mitchell International
Nationwide Auto
NHRMA
PDRMA
Rising Medical Solutions
Sedgwick CMS
Spraying Systems
StarTech/Manageability
State Farm Insurance
State Farm Auto
StrataCare
Tokio Fire & Marine
Tyson Foods
United Fire & Casualty
United Heartland Insurance
WAL-MART
Wausau Insurance
West Bend Mutual Insurance
Xchanging

Contact HFN for the full list of clients and partners

The following procedures shall apply to disputes between a Participating Provider and a Payor, Facilitator or other similar party under contract with HFN with respect to the administration of a Provider Agreement:

1) In the event of such a dispute, the complaining party shall provide written notice of the dispute to HFN, and HFN shall notify the other party. The notice shall set forth a brief summary of the dispute, including dates and names of individuals who may have relevant information. The parties shall attempt in good faith to resolve the dispute, including participating in meetings and sharing documents and information relevant to the dispute.

2) If, after a period of thirty (30) days from the receipt of the notice described in Section 1, the dispute is not resolved, it shall be submitted to mediation and the mediator shall be a member of HFN Senior Management. The parties shall participate in good faith in such mediation.

3) If the dispute is not resolved by mediation under Section 2, within thirty (30) days, it shall be submitted to mediation and the mediator by a disinterested third party qualified and experienced in managed care matters, who shall be selected by HFN. The parties shall participate in good faith in such mediation.

4) If the dispute is not resolved by mediation under Section 3, it shall be settled by binding arbitration before one (1) arbitrator selected by HFN from the duly qualified and experienced panel of arbitrators of the American Arbitration Association the (AAA), in accordance with the commercial arbitration rules of the AAA. Arbitration shall be conducted in the jurisdiction of Participating Provider's domicile.

5) Each party shall bear its own costs in resolving disputes, except that the costs of arbitration proceedings shall be borne equally by the parties.

6) This dispute resolution policy shall not apply to disputes regarding utilization review or coverage decisions, including medical necessity determination, which shall be governed by the policies and procedures of the applicable Payor or its designee. Similarly, these policies do not apply to grievances or other disputes raised by Beneficiaries which also shall be governed by the policies and procedures of the Payor or its designee.

Beneficiary. An individual who is eligible under the terms of a Plan or applicable state Workers' Compensation laws to receive Covered Services through a Payor.

Clean Claim. A claim submitted by a Participating Provider on a UB-04, CMS-1500 Form or its successor or via equivalent electronic forms which is complete, has no defect, impropriety and may be adjudicated. A non-clean claim is one that is incomplete and for which inquiries must be made to render the bill complete and processable.

Covered Services. Those health care services which are provided or arranged by Group to or for Beneficiaries and which are reimbursable under a Plan or under applicable state Workers' Compensation laws.

Emergency/Emergency Services. "Emergency" means the sudden medical condition or injury manifesting itself by acute symptoms of sufficient severity that a prudent layperson could reasonably expect the absence of immediate medical attention to result in (a) the person's health being placed in jeopardy; (b) serious impairment of bodily functions; (c) serious dysfunction of any bodily organ or part; or (d) other serious medical consequences.

"Emergency Services" means any medical services, including medical screening, examination and evaluation by a physician or to the extent permitted by appropriate laws, by appropriate personnel under the supervision of a physician to determine whether an Emergency exists, and if it does, the care, treatment, or surgery which is necessary to evaluate, stabilize, and/or treat a person who is the subject of such Emergency.

Medically Necessary. Medical or surgical treatment which is determined in accordance with the applicable Utilization Management program to be:

(a) Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition of a Beneficiary;

(b) Provided for the diagnosis, direct care and treatment of the medical condition of a Beneficiary;

(c) Within standards of good medical practice within the community;

(d) Not primarily for the convenience of the Beneficiary, a physician or other health care provider; and

(e) The most appropriate supply or level of service which can safely be provided.

Participating Providers. Those hospitals/medical centers, physicians, physician groups, physician organizations and ancillary services providers who (as described in Exhibit B) have agreed to provide Covered Services to Beneficiaries pursuant to agreements with HFN.

Payor. An insurance company, health maintenance organization, self-funded employer, employer group or other organization that offers or sponsors a Plan, and claims administrators and others who are involved in the administration, operation or control Plans.

Plan. The contract, certificate, policy or plan document issued by a Payor under which Beneficiaries are entitled to coverage for health care services furnished by Participating Providers.

Represented Physician. A physician who (a) is employed by, associated with or otherwise represented by Group, (b) is authorized by Group to provide Covered Services pursuant to this Agreement and the Contracts, (c) has been accepted for participation in this Agreement by HFN, and (d) has agreed with Group to comply with and be subject to the terms of this Agreement and the Contracts.

Utilization Management. The review and determination by, Payors or their designees on a prospective, concurrent or retrospective basis of the Medical Necessity of services provided to Beneficiaries.

EXHIBIT A - HFN LOGOS

Exhibit B - Sample ID Cards

Front Side

123 Company Name: Joseph Doe ID#: 123 45 6789 Effective: 07/01/2004 To Verify Coverage Call: (123) 456-7890	
This card does not guarantee coverage or benefits. PRE-CERTIFICATION REQUIRED CALL (8XX) 456-7890	
Medical Office Visit Co-pay: $XX.	

Back Side

Send all Medical Claims to:
HFN, Inc. **P.O. BOX 3428** **OAK BROOK, IL 60522** **(800) 295-5444** **HFN Payer EDI# 36335**
Failure to contact *UR Firm* (8XX) 123-4567 will result in a reduction in benefits.
Employee Signature: _____

Front Side

123 Company	
Employee Name: Jack Sample Subscriber I.D.#: 12345	
Coverage: Family Effective Date: 01/01/2004 Medical Office Visit Co-pay: $XX.	

Back Side

For Pre-certification of Inpatient and any Surgical procedure contact UR Firm at 800-XXX-XXXX.

For Participating Providers visit www.hfninc.com

Or call HFN Inc. at 800-295-5444.

Send all Medical Claims to:	**Benefit and Eligibility Questions**
HFN, Inc.	**TPA Name**
P.O. BOX 3428	**Phone (8XX) 123-4567**
OAK BROOK, IL 60522-3428	
HFN Payer EDI# 36335	

Employee

Signature: _____

EXHIBIT B - SAMPLE ID CARDS

Front Side

123 Company	
Employee Name: Jane Sampleton Member I.D.#: 123-45-6789 Group #: 11111	
Coverage: Employee Effective Date: 01/01/2004 Medical Office Visit Co-pay: $XX.	

Back Side

For Precertification of Inpatient and any Surgical procedure contact UR Firm at 800-XXX-XXXX.

For Participating Providers visit www.hfninc.com

Or call HFN Inc. at 800-295-5444.

Send all Medical Claims to:	**Benefit and Eligibility Questions**
HFN, Inc.	**TPA Name**
P.O. BOX 3428	**Phone (8XX) 123-4567**
OAK BROOK, IL 60522-3428	
HFN Payer EDI# 36335	

Employee

Signature: _____

Front Side

123 Company	
Employee Name: Susan Q. Public Employee I.D.#: 987-65-4321	
Coverage: Family Effective Date: 01/01/2004 Medical Office Visit Co-Pay: $XX.	

Back Side

Send all Medical Claims to:

HFN, Inc.

P.O. BOX 3428

OAK BROOK, IL 60522-3428

(800) 295-5444

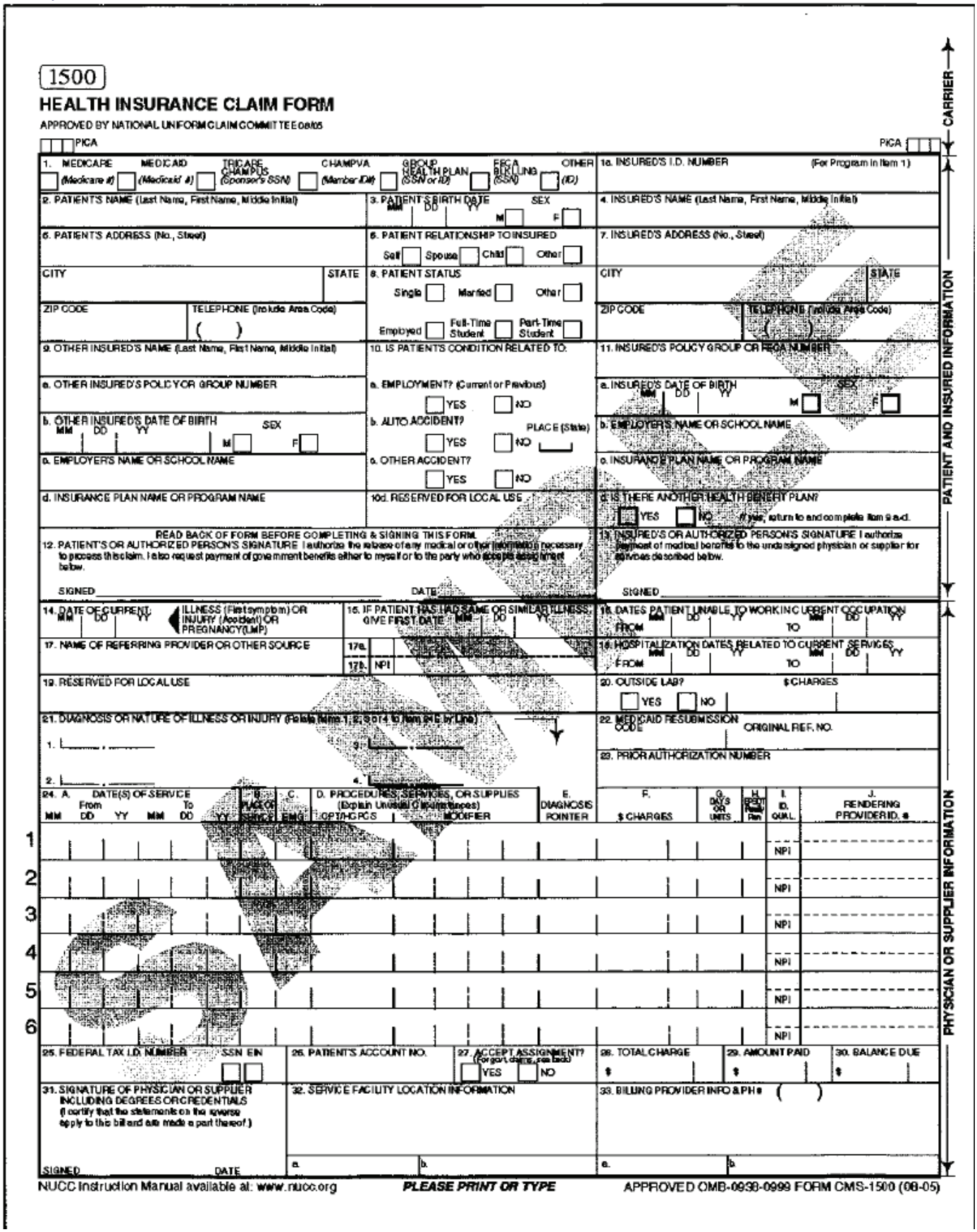
HFN Payer EDI# 36335

Call UR Firm at (8XX) 123-4567 prior to all Inpatient Admissions within 48 hours/next business day for emergencies. Failure to contact UR Firm will result in a reduction in benefits.

Employee

Signature: _____

For Network provider listing, visit www.hfninc.com



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

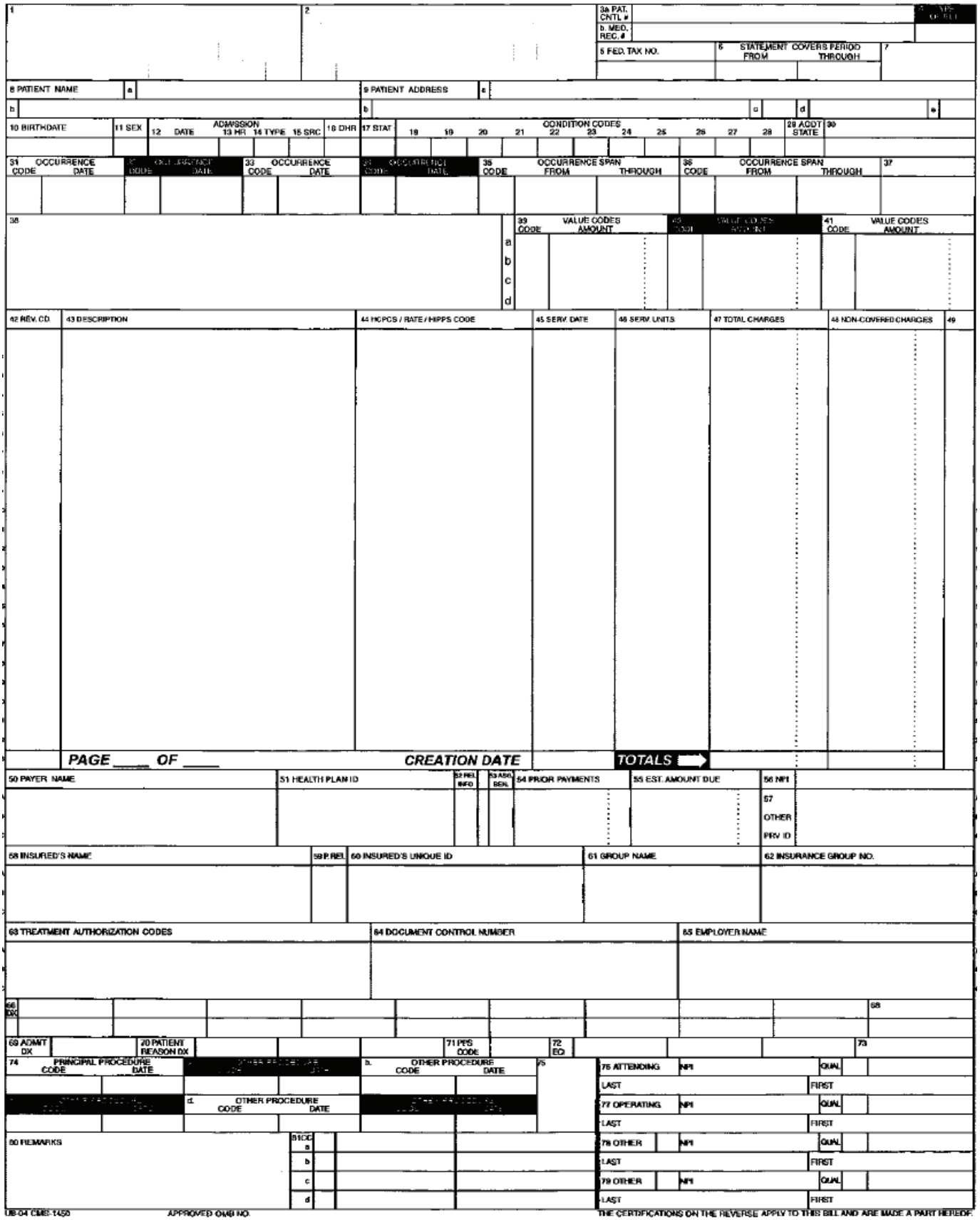
PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION


1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 DATE
ADMISSION 13 HR 14 TYPE 15 SRC
16 DHR
17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
a b c d
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE ____ OF ____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE
OTHER PROCEDURE
b. OTHER PROCEDURE CODE DATE
75
OTHER PROCEDURE
d. OTHER PROCEDURE CODE DATE
OTHER PROCEDURE
76 ATTENDING NPI QUAL
LAST FIRST
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST
80 REMARKS
81CC
a b c d
UB-04 CMS-1450
APPROVED OMB NO.
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.
NUBC
UC0213257