Help Us Pay You Quickly and Accurately

Be Sure Your Claim Has the Correct NPI and Tax ID Number

PHP and PHC California want to process and pay your claims promptly and accurately. To do so, we must have your correct National Provider Identifier (NPI) and Federal tax identification number (tax ID).

Contradicting NPIs and tax IDs is one of the most common reasons network provider claims are suspended or denied. NPI and tax ID mismatch is most common for claim submissions from group practices, individual providers who have incorporated their practices, and hospitals.

HIPAA requires all providers to have a unique ten-digit NPI, which identifies you in all standard transactions. There are two types of NPIs described below.

Your clean claim submissions must include the correct type NPI and correctly related tax ID.

Type 1 NPI Providers:

Individual providers who are physicians, dentists, specialists and sole proprietors.

An individual is eligible for only one NPI. Bill using the individual provider's personal NPI and tax ID.

Type 2 NPI Providers:

Providers that physician groups, hospitals, residential treatment centers, laboratories and group practices formed as a result of a legal entity incorporation.

Bill using the organization's corporate NPI and tax ID.

When submitting a claim for services rendered to a PHP or PHC California member, keep in mind:

- **All participating providers requesting reimbursement must have an NPI number,**
- **We require a valid billing NPI, group NPI, rendering/attending provider NPI and relevant taxonomy code on both paper and electronic claims,**
- **We require a valid tax ID, which aligns with your NPI, and**
- **We must have a completed W-9 form on file for you.**

If you have any questions, please contact the Provider Relation Department for further assistance at **(888) 726-5411**. Hours are 8:30 am to 5:30 pm, Monday through Friday. You may also email us at **capr@aidshealth.org**.

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General Billing Guidelines

Claims payment is contingent on provider compliance with claims submission requirements, enrollee eligibility on date(s) of service, medical necessity, plan rules, benefit limitations and exclusions.

Providers must submit claims on the appropriate billing form (CMS1500 or UB04) within ninety (90) calendar days, or as stated in the written service agreement with the plan. Provider are responsible to submit all claims to the plan within the specified timely filing limit. We may deny any claim billed by the provider that is not received within the specified timely filing limit.

Complete Claims

For proper payment and application of applicable enrollee cost sharing (copays), providers must accurately code all diagnoses and services in accordance with national coding guidelines. You must submit a claim for your services, regardless of whether you have collected cost sharing (if applicable) from our enrollee at the time of service.

A "complete claim" is a claim that has all the required fields filled out correctly and is legible. We will return unprocessed claims to the submitting provider that are not filled out completely or are illegible. We will not consider incomplete or illegible claims received by the plan.

We will process and deny claims that have inaccurate or inappropriate information in the required fields. Providers may then resubmit a corrected claim for processing.

Claims Submission

You submit claims electronically though **Change Healthcare** (clearinghouse). Our payer IDs are:

- **95411 - PHP Claims**
- **95422 - PHC California Claims**
- **95433 - Ryan White Grant Claims**

We encourage our contracted providers to submit non-inpatient claims through our provider portal, eHEALTHsuite. The portal accepts CMS1500 claim submissions only. At this time, UB04 claims cannot be submitted through the portal; however, you may submit them electronically through our clearinghouse or send paper claims. You may access our provider portal at **phpphcportal.org**.

If you need assistance navigating our provider portal, please visit our website at **www.php-ca.org/for-providers/portal**.

Please do not send any claims to the plan's corporate office. Claims sent to the corporate office will be returned to sender and may be denied for untimely filing.