Community Health Choice
Transparency in Coverage

Enrollee claims submission

Members may submit a claim in lieu of provider submission.

Submission of Claims
Claims should be submitted on a standard HCFA 1500 form. All claims must be submitted 95 days from the date of service, claims not filed within 180 days from the date of service may not be considered for reimbursement.

All claims submissions should include the following:

- Patient Name*
- Patient Date of Birth*
- Provider Identification Number*
- Current CPT codes that are appropriate for the services provided
- Current ICD-9 codes or legibly written diagnoses
- Usual and customary fee, even for multiple surgical procedures
- Date of services
- Physician's signature
- Physician's name
- Physician's address where services were provided
- Physician's Provider ID Number
- Physician's Medicaid Number
- Physician Tax I.D. Number
- Referral Authorization Number (outpatient services and in-office visits)
- Inpatient Authorization Number

A separate claim must be completed for each Member and each Provider.

Send claims to:
Community Health Choice, Inc.
Attn: Claims Department
PO Box 301424
Houston, Texas 77230-1424

Claim forms may be obtained from the provider office where services are rendered.