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Quick Billing and Eligibility Facts

Identifying an Eligible Group/Member:

Physicians Health Collaborative requires that the network logo is prominently displayed on the front of all member ID cards. However, possession of an ID card does not guarantee that the member is an active eligible member of the group health plan or that the group plan is an active client of the network.

To verify group status online, network providers can log-in at the PROVIDERS page to search for groups who are eligible to access the network. The providers' Network ID number and individual NPI number is required to log-in. The search function will display information including the groups' network eligibility period, basic benefit of group health plan, phone numbers to pre-certify services or verify eligibility and the claim submission address. Information is also available by calling Physicians Health Collaborative during normal business hours.

Eligibility and Benefit Information:

Physicians Health Collaborative does not maintain or verify member eligibility. As well, the network does not determine benefits or services covered by the group health plan. Contact the insurance company or plan administrator shown on the members ID card to verify benefits and eligibility.

Pre-Certification Requirements:

Pre-certification requirements are set by the insurance company or the employer group. Refer to the member ID card for the appropriate telephone number to pre-certify services or inquire about pre-certification requirements.

Claim Submission / Billing Process

Claims can be submitted by paper or electronically using the electronic payer ID number or mailing address shown of the member ID card. Claims should be submitted using the standard UB92, CMS1500, or electronic 837 formats.

The Network will price clean claims using Medicare processing guidelines through an outside vendor, Innovative Resources for Payers (IRP), who uses proprietary editing software. Priced claims are forwarded to the payer who is responsible to process claim for payment. The payer will issue claim payment along with an Explanation of Benefits (EOB) that identifies the network discount (or adjustment) as well as any amount due from the covered member.

Please note: The member should not be balance billed for the contracted network discount amount shown on the Explanation of Benefits.