

Claims Transition Information



MA-Multi-P-5583954a



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Claims | Billing Overview

Commonwealth Care Alliance® (CCA) accepts both electronic data interchange (EDI) and paper claim submissions.

- Electronic billing is preferred. Use Payer ID **A2793**.
- Mail paper claims to: **Commonwealth Care Alliance**
Attn: Claims Department
P.O. Box 1127
Dayton, OH 45401-1127
- Contracted providers must file claims no later than 90 days from date of service or discharge date unless the filing limit is otherwise stipulated in their contract.

Provider shall not seek or accept payment from a CCA member for any covered service if the member is wholly enrolled and eligible for both Medicare and MassHealth.

Please refer to CCA's *Claims and Billing Procedures* (Section 7 of the [Provider Manual](#)) for more detail.



Claims | Submissions

ELECTRONIC CLAIM SUBMISSIONS

- It is encouraged to use electronic claim submission as the primary submission method.

PORTAL SUBMISSION

- Providers can submit claims through our **NEW** secure, online Provider Portal at [CCA Provider Homepage](#) > [Provider Portal](#). Providers can submit claims along with any documentation, track payments and more.
- Within the Provider Portal: FirstSource Claims User Guide and Video

CLEARINGHOUSE

- For EDI transactions, CareSource accepts electronic claims through our clearinghouse, Availity. Providers can also use their existing clearinghouse if they are configured to accept the CCA Payer ID (**A2793**).

Please refer to CCA's *Claims and Billing Procedures* (Section 7 of the [Provider Manual](#)) for more detail.



Claims | Electronic Funds Transfer (EFT)

ECHO Health offers three payment options:

1. EFT – preferred
2. [Default] Virtual Card Payment (QuicRemit) – Standard bank and card issuer fees apply*
3. Paper Checks

We partner with ECHO Health for EFT. You must enroll with ECHO Health to participate.

Sign up for ECHO Health online at enrollments.echohealthinc.com/EFTERADirect/CareSource to complete your enrollment in EFT with your Tax ID, bank information, ECHO payment draft number and payment amount. For questions, call ECHO Support at 1-888-485-6233.

*Payment processing fees are what you pay your bank and credit card processor for use of a payment terminal to process payments via credit card.

Providers who elect to receive EFT payment can also choose to receive an EDI 835 (Electronic Remittance Advice) through a designated clearinghouse. Providers can download the PDF version of the Explanation of Provider Payment (EPP) from the [Provider Portal](#).

**Notice: Email notifications are not sent when a deposit/payment is made.
Deposits/payments are made twice weekly.**

EPP | ECHO



1. Click the **Search Type** drop-down list and choose appropriate search criteria.
 - The below search options may provide the best results:
 - **ECHO Draft Number**: this is the payment check number on the Remittance tab on the claim.
 - **Provider ID**: the provider's tax ID number.
 - **Claim Number**: claim number.
2. Input the appropriate information in the **Search Criteria** field.
3. Click **Search**.
4. Locate the appropriate payment.
5. Click **EPP**.

Advanced Search

Search Type

1 Claim Number

Search Criteria

2 2525405TLL00

3 SEARCH

Please enter your search criteria

Produced

Filtered Search:

Claim Number	Insured	Patient	Certificate No	Group ID	Provider Name	Payee Name	Amt Paid	Check No	ECHO Draft	EOB Prepared	EOB	EOD	EPP	Draft	OD	835	Payment Details
				MS-CSMS	EyeMed	EyeMed (Routine Vision)	\$103.34						5 EPP	Draft	OD	835	Details

Payment Details

ECHO Draft #	Type	Payment Date	Payee	Address	Status	Status Date	Remarks	Activity By	Draft
	ACH/EFT Notification Date: 09/23/2025		EyeMed (Routine Vision)	PO Box 74008410 Chicago IL 60674	Clear	09/23/2025			Draft

Rows per page: 100

« First « Prev 1 Next » Last »

Claims | Explanation of Payment (EOP)

Past CCA EOP

Claim Identifier: MA Claim#: 260170206700 DRG:							Provider Name: LG NEWCORP INC Provider ID: 1033936810					
Patient Name: Patient Account #:							Insured Name: Insured ID: 000000000					
Service Date From - To	Procedure Code	Service Code	Modifier(s)	Total Charge	Excluded Amount	Reason Codes	Allowed Amount	Other Carrier Amount	Deductible Amount	Copay Amount	Coinsurance Amount	Payment Amount
11/19/25 - 11/25/25	0124			\$8,088.00	\$0.00	94, 253	\$12,724.29	\$0.00	\$0.00	\$0.00	\$0.00	\$12,724.29
11/19/25 - 11/25/25	0259			\$1,620.46	\$1,620.46	M15, N1, M15, N1, 97	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
11/19/25 - 11/25/25	0301			\$357.00	\$357.00							
11/19/25 - 11/25/25	0307			\$28.00	\$28.00							
11/19/25 - 11/25/25	0450			\$2,154.00	\$2,154.00							
Patient Responsibility												
Totals				\$12,247.46								
Claim Interest				\$0.00								

Patient:
Patient Acct #:
Rendering Provider:

Insured:
Product Name: CareSource
D-SNP)

Line of Business	Line Number	Service Date	Procedures (Modifiers)	Units	Total Charge	Allowed Amount	Provider (Disal
MCR	1	1/3/2026 - 1/3/2026	71045(26)	1	\$79.00	\$0.00	
MED	1	1/3/2026 - 1/3/2026	71045(26)	1	\$79.00	\$0.00	
Total:					\$158.00	\$0.00	

Patient:
Patient Acct #:
Rendering Provider:

Insured:
Product Name: CareSource
D-SNP)

Service Date From - To	Procedure Code	Service Code	Modifier(s)	Total Charge	E #
10/31/25 - 11/13/25	0124			\$18,226.00	\$5.
10/31/25 - 11/13/25	0259			\$2,803.58	\$2.
10/31/25 - 11/13/25	0301			\$1,843.00	\$1.

The new CCA EOP will display Medicare and Medicaid adjudication results separately, giving you clearer visibility into coordination of benefits. You will also see Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) codes broken out for each payer.

New CCA EOP

Patient: [REDACTED]				Insured: [REDACTED]				Payor Claim #: 2605702YGN00					
Patient Acct #: [REDACTED]				Product Name: CareSource MyCare Ohio (HMO									
Rendering Provider: 1 [REDACTED]				D-SNP)									
Line of Business	Line Number	Service Date	Procedures (Modifiers)	Units	Total Charge	Allowed Amount	Provider Discount (Disallowed)	Other Plan Payment (COB)	Other Adjustment	Patient Obligation	Net Payment Amount	Adjustment Reason	Remark
MCR	1	1/3/2026 - 1/3/2026	71045(26)	1	\$79.00	\$0.00	\$79.00	\$0.00	\$0.00	\$0.00	\$0.00	CO39	
MED	1	1/3/2026 - 1/3/2026	71045(26)	1	\$79.00	\$0.00	\$79.00	\$0.00	\$0.00	\$0.00	\$0.00	CO45	N219
Total:					\$158.00	\$0.00	\$158.00	\$0.00	\$0.00	\$0.00	\$0.00		

Patient: [REDACTED]				Insured: [REDACTED]				Payor Claim #: 260570332H00					
Patient Acct #: [REDACTED]				Product Name: CareSource MyCare Ohio (HMO									
Rendering Provider [REDACTED]				D-SNP)									
Line of Business	Line Number	Service Date	Procedures (Modifiers)	Units	Total Charge	Allowed Amount	Provider Discount (Disallowed)	Other Plan Payment (COB)	Other Adjustment	Patient Obligation	Net Payment Amount	Adjustment Reason	Remark
MCR	1	1/10/2026 - 1/10/2026	71260(26)	1	\$510.00	\$0.00	\$510.00	\$0.00	\$0.00	\$0.00	\$0.00	CO198	N640
MED	1	1/10/2026 - 1/10/2026	71260(26)	1	\$510.00	\$0.00	\$510.00	\$0.00	\$0.00	\$0.00	\$0.00	CO109	N36
Total:					\$1,020.00	\$0.00	\$1,020.00	\$0.00	\$0.00	\$0.00	\$0.00		

Patient: [REDACTED]				Insured: [REDACTED]				Payor Claim #: 26057033HJ00					
Patient Acct [REDACTED]				Product Name: CareSource MyCare Ohio (HMO									
Rendering Provider: 1 [REDACTED]				D-SNP)									
Line of	Line	Service	Procedures	Units	Total	Allowed	Provider Discount	Other Plan	Other	Patient	Net Payment	Adjustment	Remark



Two 2100 Loops Showing Medicare and Medicaid Adjudication

- 1 Processed as Primary
- 2 Processed as Secondary

- MB indicates Medicare Part B
- MC indicates Medicaid

- Single claim ID used in both segments indicating dual adjudication



Claims | Corrected Claims

To modify a paid or denied claim, providers must submit a corrected claim electronically or on paper.

- If the correction requires changes to the original data, the new claim can be sent via the EDI/clearinghouse.
- If the correction requires additional information (e.g., invoice, prescription, Medicaid Records, or Primary Carrier Explanation of Benefit) the corrected claim can be submitted on paper or in the **Provider Portal**.

Corrected submissions should include:

- Original claim number for the claim you are correcting (most recent claim iteration available)
- Any necessary modifications from the original claim
- Any required supporting documentation

Mailing address for corrected and rejected paper claims: **Commonwealth Care Alliance**
P.O. Box 1127
Dayton, OH 45401-1127

Please refer to *CCA's Claims and Billing Procedures* (Section 7 of the [Provider Manual](#)) for more detail.

Claims | Common Claim Rejections



Claim Status Code	Rejection Descriptions
538	Corrected claim with no original claim ID
33	Member not found for submitted member ID
544	Lab claim missing Clinical Laboratory Improvement Amendments (CLIA) number
632	Sanctioned due to Centers for Medicare and Medicaid (CMS) preclusion
453	Invalid procedure code
187	Date of service after received date
488	Invalid diagnosis code

Claim Rejections

EDI claim rejections will be returned to providers using X12 standard acknowledgement formats

- 999 - Implementation Acknowledgement
- 277CA - Health Care Claim Acknowledgement

Paper claim and portal rejections will be returned via United States Postal Service mail to the billing address received on the claim.

Claims | Claim Appeals and Disputes

ALL CLAIM APPEALS MUST BE:

- Must be submitted within **60 calendar days** of the original adjudication date
 - Coordination of Benefits (COB) denials must be submitted within 60 days of the COB denial date (retro-authorization policy still applies)
- Non-contracted providers must include a signed Waiver of Liability form holding the member harmless regarding the outcome of the appeal.
- Submitted via one of these methods:
 - Provider Portal (preferred method)
 - Mail: Commonwealth Care Alliance
P.O. Box 1947
Dayton, Ohio 45401-1947
 - Fax: 857-453-4517

CLAIM DISPUTES

- Used for payment-related issues (e.g., incorrect adjustments, timely filing denials, overpayment recovery)
- Must be submitted in writing within 90 days of the payment or denial date (per EOP)
- Must include supporting documentation and Request for Claim Review form
- Submit via portal, fax, or the address above

NOTE: If you are responding to a denied authorization that required medical necessity review, please submit an appeal.

- The Provider Portal is the most efficient method of submission to ensure timely receipt and resolution of the appeal.
- As a CCA provider, you may submit a dispute or appeal for a member.
- Providers must obtain a member's written consent to appeal an adverse benefit determination on their behalf.
- We may contact you to obtain documentation when a member has filed a request for one of these. CCA does not retaliate or discriminate against any member or provider for utilizing the grievance and appeals process.



Claims | Payment Disputes

Contracted providers may file a payment dispute for CCA's reconsideration if they disagree with CCA's decision of denial or reimbursement of a claim.

- Disputes must be submitted via fax, portal, or mail. Disputes should be sent to:
 - Mail:
Commonwealth Care Alliance
Attn: Appeals Department
P.O. Box 1947
Dayton, OH 45401-1947
 - Fax: 1-937-531-2398

Payment dispute requests will be considered when received within 90 days from the original payment or denial date, as indicated on the EPP, with supporting documentation and the *Request for Claim Review* form.

Contracted providers may file a dispute for CCA's reconsideration if they believe CCA is paying an amount different than contractually agreed upon.

For additional questions on provider Payment Disputes or Appeals, please contact CCA Provider Services at 1-866-420-9332 from 8 a.m. to 5 p.m. Eastern Time (ET) Monday, Tuesday, Wednesday, and Friday, and from 8:30 a.m. to 5 p.m. ET Thursday.

Please refer to CCA's *Claims and Billing Procedures* (Section 7 of the [Provider Manual](#)) for detail.

Claims | Recovery Letters



May 15, 2026

RE: Outstanding Claim Recovery

Dear [Redacted]

Commonwealth Care Alliance, Inc. (CCA) has completed a review on the services rendered in the attached enclosure and determined that an overpayment occurred. For your reference, the attached spreadsheet provides a description of the improper payment and the claim(s) identified. Pursuant to 130 CMR 450.235, we are notifying you of our intent to recover the overpaid amount; the net recovery amount is \$32.23.

CCA will initiate an automatic recoupment after 30 calendar days. The funds will be recovered through offsets to future claim payments until paid in full. However, if future claim volume to CCA is not anticipated and sufficient enough to offset future claim payments, you must submit a check for the amount owed in accordance with 42 CFR 401.305 (b)(1), along with a copy of the overpaid claims to:

Commonwealth Care Alliance, Inc.
Attention: Refund Check Department
P.O. Box 632710
Cincinnati, OH 45263-2710

If you disagree with our findings, you have the right to dispute this overpayment recovery by submitting supporting information within 30 calendar days of this notification. Disputes may be submitted through the provider portal at <https://providerportal.caresource.com/GL/User/Login.aspx>.



Provider Name: A			Provider Tax ID: 0			National Provider Identifier (NPI): 1		
Claim ID	Patient Account Number	Begin Date of Service (DOS)	End DOS	Claim Paid Date	Line	Recovery Amount	Recoupment Reason	
Member Name: ujPeAbTestTDM TestmemMxINHPTDM					Medicaid ID: 1		Member ID: 1	
			03/18/2026	04/14/2026	1		Duplicate Claim	

Providers may receive this updated format on any recovery letters that are mailed. The claim detail page includes more information about the claim, including claim line level information and claim line recoupment reasons.



Provider Portal | Training Resources

The **new** Provider Portal is a robust, secure, and encrypted online tool available for all providers who serve our members.

- Available Documents
 - Provider Portal Solutions
 - Clinical Practice Registry Flier
 - Provider Portal User Guide
 - Provider Portal Quick Start Guide
 - Provider Portal Registration Guide
- Available Training Videos
 - Portal Overview
 - Provider Portal: Service Plan Reviews Prior Authorizations
 - Provider Portal: Managing User Access
 - Provider Education Series: Provider Portal Service Plan Review

Visit the [Transition Information page](#) at CCA's website to access these resources.

The screenshot shows the CCA website's 'Transition Information' page. The header includes the CCA logo, location (Massachusetts), and language (English) dropdowns. Navigation links for Home, Contact Us, and Menu are present. The main content area is titled 'Transition Information' and includes a brief description of the page's purpose. Below this, there is a list of expandable sections: 'What You Need to Know First', 'Provider Transition Communications', 'Transition Orientation', 'New & Improved Provider Portal - Education & Resources' (highlighted with a red box), and 'Important Reminders'. Each section has a red plus icon to its right. The footer contains social media icons for Facebook, Twitter, LinkedIn, YouTube, and Instagram, along with the CCA logo and a copyright notice.

cca commonwealth care alliance®

Massachusetts English

Home Contact Us Menu

Home > For Providers > Transition Information

Transition Information

This page contains important information you need to know for CCA Senior Care Options (HMO D-SNP) and CCA One Care (HMO D-SNP) business starting June 26, 2026.

What You Need to Know First +

Provider Transition Communications +

Transition Orientation +

New & Improved Provider Portal - Education & Resources +

Important Reminders +

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Provider Portal | Training



 MASSACHUSETTS
PROVIDER PORTAL

 / Users / Prov

USERS

Link Account

Manage Users

Update My Account

Impersonate User

Provider Training

PROVIDERS

Using the Provider Portal

[Provider Portal User Guide](#)

[Claims Transition Overview](#)

Additional Guides

[FirstSource Claims User Guide](#)

[FirstSource Claims Instructional Video](#)

[Medicaid Deeming FAQs](#)

[CCA Senior Care Options and CCA One Care Benefit FAQ](#)

[2026 CCA Products and Benefits Overview](#)

[2026 CCA Medicaid Deeming Overview](#)

Provider Portal Resource Library

CCA wants you to have the tools you need to manage your CCA members efficiently. The Provider Portal makes it easy for you to work with us 24/7 and has critical information and tools to save time.

Access the links below to learn about resources on the portal, how to use them and which ones will work best for your practice!

If you are having trouble viewing the training materials and are using Chrome, please try to use Firefox or Microsoft Edge.

Using the Provider Portal

Provider Portal User Guide

Claims Transition Overview

Additional Guides

FirstSource Claims User Guide

FirstSource Claims Instructional Video

Member Incentives and Rewards Programs

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Provider Portal | Claim Submission Information



The screenshot displays the Provider Portal interface. On the left is a navigation menu with sections: MEMBER SEARCH, CLAIMS, MEMBER REPORTS, USERS, PROVIDERS, ASSESSMENTS, and PROGRESS NOTES. The CLAIMS section is expanded, showing options like Online Claim Submission, Claim Information and Attachments, Rejected Claims, Real Time Claims, Payment History, Recovery Request, Disputes, Pharmacy Appeals, and Post Service Appeals. A red arrow points from 'Online Claim Submission' to the CLAIMS header. Another red arrow points from 'Claim Information and Attachments' to the corresponding section on the right. The CLAIMS header includes buttons for '+ New HCFA Claim', '+ New UB Claim', '+ New Dental Claim', 'Upload Claim', and '+ Reports'. The 'Claim Information and Attachments' section contains instructions on how to search for claims and a search form with a dropdown for 'Search by' (set to Member ID), a text input for 'Member ID', and a 'Search' button. Below this is another search form with a dropdown for 'Search by' (set to CareSource ID) and a 'Search' button. A 'Reset' button is also present.

Please refer to *FirstSource Claims User Guide* and *Instructional video* under *Additional Guides on the Provider Portal* for detail.

Provider Portal | Claims Submission Screen



CLAIMS [+ New HCFA Claim](#) [+ New UB Claim](#) [+ Upload Claim](#) [+ Reports](#)

HCFA Claims
(10)

UB Claims
(4)

SEARCH CLAIMS

[Select filters](#) [Clear text](#)

SUBMISSION DATE: Start Date (MMDDYYYY) End Date (MMDDYYYY)

CLAIM ID: Type Claim ID

INSURED ID: Type Insured id

STATUS: Select status

DCN: Type DCN

[Search](#)

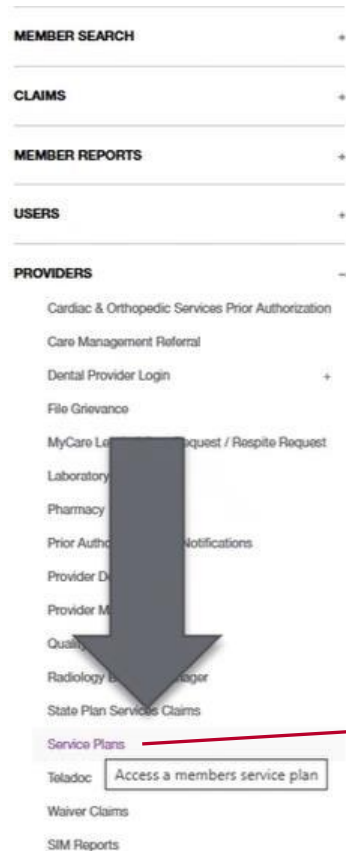
10 LATEST CLAIMS (HCFA)

CLAIM INFO	PATIENT INFO	INSURED INFO	
837_SUBMISSION_IN_PROGRESS			
Claim ID: 86cf2d88-99d6-49fa-ba43-4e697ee51ac2			
☒ May 7th 2026, 19:38:12 by test_user_ma			
☐ May 7th 2026, 19:38:50			
\$ 500 \$	TEST TEST	Insured ID: 1091116364	Edit View Copy
DCN: 26127261270H230002		TEST TEST	
☒ COPY_PORTAL		01012000	
IN_PROGRESS			
Claim ID: d5cf4cb2-8808-4f63-9337-78994464f765			
☒ May 7th 2026, 19:14:12 by test_user_ma			
☐ May 7th 2026, 19:14:44			
\$ 500 \$	TEST TEST	Insured ID: 1091116364	Edit View Copy
test_user_ma		TEST TEST	
☒ COPY_PORTAL		01012000	

Please refer to *FirstSource Claims User Guide* and *Instructional video under Additional Guides on the [Provider Portal](#)* for detail.



Provider Portal | Service Plan Claim Submission Information



Long-Term Services and Supports (LTSS) and Home- and Community-Based Services (HCBS) providers without an NPI or MassHealth ID will be able to submit claims using service plans in the Provider Portal.

Service Plan Summary

Summary of Selected Plan

Status Legend

- New Item
- Updated Item
- Acknowledged Item
- Verified Item
- Deleted Item
- Completed Item

Status	Details	Provider Name	Service Type	Procedure	Diagnosis	Service Description	Begin Date	End Date	Prior Authorization	Submit
	View Details	Cozy Home Health Care LLC	CPT	T1019UA	I63.9	MyCare Personal care Aide T1019UA	6/1/2021	7/1/2021	0607MCEL3	Submit Claim

Export Service Plan Summary: PDF

Acknowledge My Service Plan Items

Please refer to the [Provider Education Series: Provider Portal Service Plan Review](#) video on the transition information page for step-by-step guidance.

Provider Portal | Rejected Claims



MEMBER SEARCH

+

CLAIMS

-

Online Claim Submission

Claim Information and Attachments

Rejected Claims

Real Time Claims

Payment History

Recovery Request

Disputes

Pharmacy Appeals

Post Service Appeals

MEMBER REPORTS

+

USERS

+

PROVIDERS

+

ASSESSMENTS

+

PROGRESS NOTES

+

CareSource Policies

Rejected Claims

Rejected claims are defined as claims that are not properly billed according to the National Billing standards, State requirements, or CareSource requirements, such as invalid or missing data elements that are returned to the submitter or EDI source without registration in the claims processing system. Since rejected claims are not registered in the claims processing system, the claim must be re-submitted with all appropriate changes made within timely filing guidelines.

The claims that initially display on this page are the rejected claims from the previous two years (24 months) that are directly associated with your Provider ID, Tax ID, or NPI. To locate rejected claims that do not appear in the initial result set, use the other search criteria available on this page to find them. If you only search by DOS, you will also only find results that are directly associated with your Provider ID, Tax ID, or NPI.

Rejected Claims

Rejected Claims Search

Member First Name

Member Last Name

Patient Number

Clearinghouse Claim #

NPI

Charge Amount

Date of Service (Minimum)

Date of Service (Maximum)

Search

Export Rejected Claims: [CSV](#)

Please refer to *FirstSource Claims User Guide* and *Instructional video* under *Additional Guides on the Provider Portal* for detail.

Provider Portal | Payment History



MEMBER SEARCH +

CLAIMS -

- Online Claim Submission
- Claim Information and Attachments
- Rejected Claims
- Real Time Claims
- Payment History
- Recovery Request
- Disputes
- Pharmacy Appeals
- Post Service Appeals

MEMBER REPORTS +

USERS +

PROVIDERS +

ASSESSMENTS +

PROGRESS NOTES +

CareSource Policies

Payment History

Payment History

Search Payments Capitation Payments

Search for payments using one or more of the following criteria.

Start Date: 5/1/2025

End Date: 5/1/2026

Check Number:

Claim Number:

Search

Please refer to *FirstSource Claims User Guide* and *Instructional video under Additional Guides on the [Provider Portal](#)* for detail.

Claims | Transition Impact



Transition Impacts

- EPP format
- Accessing EOPs/835/EPP
- Portal Submission Options
- Recovery Letter Format
- Claims/Payment Policy Updates
- Application of CMS Claim Standards
 - *Be sure to follow CMS submission guidelines to ensure no interruption in claim processing*
- Mailing Addresses

Not Impacted

- Member IDs
- Deeming
- Benefits
- Opt-Out/Medicaid Run Out
- Payor ID
- Wholesale Policy
- Accessing Payment Policies Online

Find more Claims Transition Information training at
commonwealthcarealliance.org/ma/providers/transition-information/.

Thank you!

