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## **Buckeye Health Plan Patient Liability Discrepancy Process**

- Provider may contact Buckeye Provider Services at 866-296-8731 to submit inquiry for discrepancies. The Representative will complete a request and submit the request to the Buckeye MyCare Ohio claims team.
- Provider may complete the attached Patient Liability Reconciliation Spreadsheet and email it securely to [MyCareOHClaims@CENTENE.com](mailto:MyCareOHClaims@CENTENE.com) Please indicate Patient Liability in the email subject line and include the supporting documentation.
- Buckeye will notify the provider of the resolution via email.
- If the variance can be resolved with the information provided, Buckeye will advise that the claim has been sent for adjustment and provide a project tracking number. Most adjustments are completed within 30 days of submission.
- If Buckeye cannot resolve the variance using the documentation provided, Buckeye will determine that ODM and MITS reflects a different patient liability, Buckeye Health Plan will contact ODM to resolve discrepancy. Resolution received from ODM will be communicated to the Provider.



<b>Column Header</b>	<b>Instructions for Completing Column Header</b>
<p><b>Description of Issue</b></p> <p><b>Member's Name</b></p> <p><b>Member's Medicaid ID</b></p> <p><b>PL Amount on 834/PL in Plan's system</b></p> <p><b>PL Amount provided by Provider</b></p> <p><b>Date of PL Verification from the Provider</b></p> <p><b>Dates of Service for Discrepancy</b></p> <p><b>Provider Contact Name</b></p> <p><b>Provider Email Address</b></p>	<p>Provide a detailed description of the patient liability discrepancy.</p> <p>List the member's name with the patient liability discrepancy.</p> <p>List the Medicaid ID for the member.</p> <p>Please list the patient liability amount the plan shows for the member for the dates of service in question.</p> <p>Please list the patient liability the provider has for the member for the dates of service in question.</p> <p>Include the date the provider verified the patient liability. This could include a screen shot from MITS with the date MITS was checked or a Notice of Action (NOA) letter. Please also include a copy of the documentation the provider submitted to verify the patient liability.</p> <p>Please list all dates of service where there is a patient liability discrepancy for this member.</p> <p>List the contact name for the provider who reported the patient liability discrepancy.</p> <p>List the email address for the provider contact. If an email address is not available please provide a phone number.</p>