Provider Bulletin

Central Health Medicare Plan

September 19, 2025

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Claims Data Submission Requirements

This is an advisory notification to Central Health Medicare Plan (CHP) network providers applicable to CHP Medicare business.

What you need to know:

CHP is responsible for delivering monthly claims details to members through a Centers for Medicare & Medicaid Services (CMS) approved Explanation of Benefits (EOB). To comply with CMS requirements, the EOB must include enrollee claims activity for the reporting period, covering services provided by both delegated and capitated providers.

Independent Physician Associations (IPAs) are required to:

- Collect member cost shares (copayments, coinsurance, and deductibles) in accordance with plan benefits.
- Report these payments to CHP using the Standard 837 format.
- Follow CHP's specified submission format and timeline to ensure proper reconciliation.

Please see Page 2 for the Standard 837 format mapping, including example submissions.

Provider Action

Please ensure your organization submits all required claims and member cost share data in the Standard 837 format by the deadlines outlined in CHP's reporting schedule.

What if you need assistance?

If you have any questions regarding the notification, please contact your CHP Provider Relations Representative at PRCalifornia@molinahealthcare.com.

Central Health Plan: 200 Oceangate, Suite 100 Long Beach, CA 90802

CENTRAL HEALTH MEDICARE PLAN

Data Requirements Overview

The required claim data mapping in the Standard 837 format, including example submissions for each loop and segment, follows:

1. **Provider Name**
   a. Already a required field in Enc file.
   b. Loop 2010AA – Billing Provider Name NM103
      i. Example: NM1*85*2*ABC Group Practice*
2. **Claim Number**
   a. Already a required field in Enc file.
   b. Loop 2300 – Claim Information CLM01
      i. Example: CLM*A37YH556*
3. **Out of Network Provider Status**
   a. There is no specific 'out of network' indicator field. However, the Par/Non-Par Provider status field in 837 encounters shows whether a Provider had a participation agreement with the submitting IPA at the time of claim filing.
   b. Loop 2300 – Claim Information CLM07
4. **Date of Service**
   a. Already a required field in Enc file.
   b. Loop 2400 – Service Line Number DTP03
      i. Example: DTP*472*RD8*20250314-20250325
5. **Amount Billed to Plan**
   a. Already a required field in Enc file.
   b. Loop 2300 – Claim Information CLM02
      i. Example: CLM*A37YH556*500
6. **Total Cost (Allowed Amount)**
   a. There is no direct field for this amount value; however, it can be calculated by Molina.
7. **Plan's Share (IPA Paid Amount)**
   a. Molina requires the IPA Paid amount.
   b. Loop 2320 – Other Subscriber Information AMT02 (Header Paid Amount)
      i. Example: AMT*D*411
   c. Loop 2430 – Line Adjudication Information SVD02 (Line Paid Amount)
      i. Example: SVD*MHC*55
8. **Member's Share (Patient Paid Amount)**
   a. Required for balancing the claim billed amount; not required for certain adjustment reason codes.
   b. Loop 2430 – Line Adjudication Information CAS Adjustment Group = PR (Line Patient Paid Amount)
      i. Example: CAS*PR*1*7.93
   c. Loop 2430 – Line Adjudication Information CAS Adjustment Reason = 1, 2, or 3 (Line Patient Paid Amount)
      i. Example: CAS*CO*1*7.93