



INDEPENDENT CARE HEALTH PLAN

iCare is a wholly-owned subsidiary of Humana

iCare Guide for Ambulance Claims Processing Overview

Disclaimer:

- This information is provided as a courtesy from *iCare* to assist you with claims submission and billing. This does not replace Forward Health and CMS Guidelines. *iCare* relies upon Forward Health and CMS for payment rules and regulations for claim submission.

Ambulance Services – Modifiers

Origin/Destination	Description
D	Diagnostic or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than 1819 facility)
G	Hospital based ESRD facility
H	Hospital
I	Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport
J	Freestanding ESRD facility
N	Skilled nursing facility
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office on way to hospital (This is a destination code only)

Ambulance Services - Modifiers

Multiple Carry Modifier	Description
GM	Multiple patients on one ambulance trip

Pronouncement of Death Modifier	Description
QL	Patient pronounced dead after ambulance called

Trip Modifiers	Description
U1	First or only trip
U2	Second trip
U3	Third trip
U4	Fourth trip
U5	Fifth trip
U6	Sixth trip

Clean Claim Guidelines – HCFA

iCare Requirements for Clean Claim (CMS 1500)		
Box	Description	Comments
1a	Insured's ID Number	
2	Patient Name	
3	Birth Date and Sex	Date of birth must be valid date and not future date
5	Patient Address	
12	Patient's or Authorized Person's Signature and Date Signed	Acceptable alternatives: Unable to sign, signature on file, SOF, Computer generated, signature marked with "X", Authorization of File, Medicare/Medicaid Reclamation Claims, Transportation, Lodging
21	Diagnosis or Nature of Illness	
24a	Dates of Service	Claim must include one detail line, must be a valid date, From date cannot include a future date, cannot have a date span into the future, cannot span a calendar year
24b	Place of Service	Must be 2 characters
24d	Procedures, Services or Supplies	Must be at least 5 characters
24f	Charges	A negative amount will be neglected
24g	Days or Units	
24i/j	Taxonomy code and prefix	Must be present here or in Box 33b. Not required for SMV, personal care attendant, Blood bank or Community Care Organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted.
24J (b)	NPI	Must be 10 numerical characters. Not required for SMV claims billed with POS 41,42,99
25	Federal Tax ID Number	Must be 9 numerical characters
28	Total Charge	Total charges must equal the sum of the line charges
31	Signature of Physician or Supplier Physician	Not required for SMV claims billed with POS 41,42,99
33	Physician/Provider's Name, Billing Address, Zip Code	
33a	Billing Physician/Provider NPI	Must be 10 numerical characters. Not required for SMV claims billed with POS 41, 42,99. The Medicaid provider must be certified as a billing provider.
33b	Taxonomy code and prefix	Must be present here or in Box 24i/24j. Not required for SMV, personal care attendant, Blood bank or Community Care Organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted. For electronic submission: Loop Number

Clean Claim Guidelines – UB04

 iCare Requirements for Clean Claim (UB-04)		
Box	Description	Comments
1	Provider Name and Address	
4	Bill Type	
5	Federal Tax ID	
6	Statement Covers Period	From and Through Dates of Claim
8b	Patient Name	
9a-e	Patient Address	
10	Date of Birth	
11	Patient Sex	
12	Admission Date	Required Inpatient, Home Health and SNF
14	Admission Type	Inpatient claims only
15	Admission Source	
17	Discharge Status	Not required for rural health or federally qualified clinics.
18-28	Condition Codes	
29	Accident State	
42	Revenue Codes	If Revenue code of 0022, 0023, 0024 is listed in box 42 and there is no entry box on 44, reject claim for RUGS code missing
44	HCPCS/Rate	Required based on Type of Bill
45	Service Date	
46	Service Units	
47	Total/Line Item Charges	Negative Amount: Claim will reject for "No Dollar Amount". Total Charges must equal the sum of the line item charges or claim will reject "Total charge does not match line charge totals". Total charges with claim with Revenue Codes 0022, 0023, 0024 may be zero.
49	Unlabeled	
56	NPI	Atypical providers excluded i.e., Personal Care Agency, Adult Day Care, Chore Srvc.
57a-57c	Other Provider ID	
58a	Insured's Name	
59a	Relationship to Uninsured	
60a	Insured Identification Number	
67	Primary Diagnosis Code	Box 67A-67Q other diagnosis code - Inpatient Required. The hospital enters the full ICD codes for up to eight additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67 as an additional or secondary diagnosis. Outpatient Required. The hospital enters the full ICD codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.
69	Admitting Diagnosis Code	Inpatient claims only
81a-d	Taxonomy Code	For Electronic Submissions: Loop Number 2000A_BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL, Segment PRV, element PRV02 =PXC, PRV03=value populated

Updated 7/1/2026

Claim Filing Limits

- Timely filing limits for all providers is 120 days from the date of service, unless otherwise agreed upon and included in the Provider's service agreement with *iCare*.
- Providers are to submit all claims for services rendered where *iCare* Medicare is primary or *iCare* Medicaid is primary according to the terms of the contract. Timely filing limits apply to initial claim submissions, resubmissions and corrected claims.

Claims Submission

- Medicare/Medicaid Covered Services
Independent Care Health Plan
P.O. Box 280
Glen Burnie, MD 21060-0280
- Long-Term Care Services
Independent Care Health Plan
P.O. Box 670
Glen Burnie, MD 21060-0670
- *iCare* is partner with the claims clearinghouse, SSI Claimsnet, to allow electronic claims submission.
- To register with SSI Claimsnet for electronic claims submission via the Internet, click [here](#). Select *iCare* in the payer drop down box on the registration form to avoid paying any set-up or submission fees for your *iCare* claims through SSI Claimsnet

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

Electronic Funds Transfer (EFT) Enrollment*i*Care has joined the InstaMed Network to deliver your payments as free electronic remittance advice (ERA) and electronic funds transfer (EFT).

[Sign up now](#) to receive *i*Care payments as direct deposits!

ERA/EFT is a convenient, paperless and secure way to receive claims payments. Funds are deposited directly into your designated bank account and include the TRN Reassociation Trace Number in accordance with CAQH CORE Phase III Operating Rules for HIPAA standard transactions. Additional benefits include:

- Accelerated access to funds with direct deposit into your existing bank account
- Reduced administrative costs by eliminating paper checks and remittances
- No disruption to your current workflow — ERAs can also be routed to your existing clearinghouse

You have two simple options to register for free ERA/EFT from InstaMed:

- Online: visit www.instamed.com/eraeft
- Phone: call us at [\(866\) 945-7990](tel:(866)945-7990) to speak with a live agent

iCare Provider Portal Access

- Your time is valuable. iCare's Provider Portal allows you to view prior authorizations, service requests, verify eligibility and view claim information for the iCare members you serve.
- **Getting Started**
- Registration can be completed with information already at your disposal using your TIN (Tax ID Number), NPI and most recent check number. Use the Facility/Group name as listed on your Explanation of Payment. iCare can also generate a one-time PIN, you can request a one-time PIN via the request button below. **If you have checks with more than 20 claims processed your will need to request a PIN to register.**
- If you do not receive your PIN, please contact iCare at ProviderRelationsSpecialist@iCareHealthPlan.org for additional assistance.
- If an organization chooses to assign roles for the employees, the Office Manager will need to create a user account for the users within your organization. Office Managers can set up additional users individually and invite them to register or you can create user accounts in bulk via spreadsheet upload.
- The **[iCare Portal User Guide](#)** provides step by step instructions for registration and outlines functionalities. If you have any questions, please contact ProviderOutreach@iCareHealthPlan.org
- Use care when entering your password in the Provider Portal. If the incorrect password is attempted 3 times, your account will be locked. If you are not able to reset your own password or retrieve your forgotten password, email ProviderOutreach@iCareHealthPlan.org . Include your Username and your password will be reset within 24 hours.

Frequently Asked Questions

- Will *iCare* cover Hospital to Hospital transport.
 - Yes
- Multiple ambulance providers respond to a 911 call, will *iCare* pay the ambulance provider if there was not provide the transport.
 - No, payment is made only if you actually transport the member to the nearest hospital
- Will *iCare* pay the ambulance provider if Member is pronounced dead on arrival.
 - Yes, payment your BLS base rate; No mileage or rural adjustment; and Use QL modifier, "Patient pronounced dead after ambulance called," on claim .

GENERAL CONTACT/INDIVIDUAL DEPARTMENT PHONE AND FAX NUMBERS

MAIN NUMBER

414-223-4847 or 800-777-4376

Claims/Appeals/Reconsiderations

Local: 414-231-1029

Fax: 414-231-1094

Out of Area: 877-333-6820

Email: department-providerservices@icarehealthplan.org

Eligibility and Provider Services

Local: 414-231-1029

Fax: 414-231-1094

Out of Area: 877-333-6820

Prior Authorization

Local: 414-299-5539

Out of Area: 855-839-1032

Fax: 414-231-1026

Provider Contracting

414-225-4741

Fax: 414-272-5618