Submit claims

Change Healthcare Outage Update

On February 21, 2024, Change Healthcare experienced a disruption to their systems due to a cybersecurity threat. There is no current threat to WellSense systems, and we continue to accept and process both claims and prior authorization requests without interruption. Please continue to submit notifications and requests for authorization for any services that require notification or authorization.

If you use Change Healthcare to submit claims, referrals or prior authorization requests for medical services or to check member eligibility, please refer to your WellSense provider manual for alternative methods. Many of these requests can be completed electronically using our provider portal.

For questions, please contact WellSense Provider Services at 888-566-0008.

Claims should be submitted within 90 days for Qualified Health Plans including ConnectorCare, and within 150 days for MassHealth and Senior Care Options.

party. You can register with Trizetto Payer Solutions or, use the following clearinghouses:

- Gateway EDI
- NEHEN (New England Healthcare EDI Network)

Paper claims may be submitted via U.S. mail by filling out the Professional Paper Claim Form (CMS-1500) or Institutional Paper Claim Form (UB-04/CMS-1450) and sending it to the address below for covered services rendered to WellSense members. Sending claims via certified mail does not expedite claim processing and may cause additional delays.

MassHealth & QHP:
WellSense Health Plan
P.O. Box 55282
Boston, MA 02205-5282

SCO only:
WellSense Health Plan
P.O. Box 55991
Boston, MA 02205-5049

Non-Participating Providers: Please refer to the tab labeled "Non-Participating Providers".

**If you require training or assistance with our online portal, please contact your dedicated provider Relations Consultant.*

Log in to the provider portal to check the status of a claim or to request a remittance report.

More Claims Information

Submitting Electronic Claims

WellSense HEALTH PLAN

Request for Claim Review

Submit a Provider Administrative Claims Appeal

Providers may request that we review a claim that was denied for an administrative reason. We offer one level of internal administrative review to providers. The administrative appeal process is only applicable to claims that have already been processed and denied. An administrative appeal cannot be requested for services rendered to a member who was not eligible on the date(s) of service, or for benefits that are not administered or covered by WellSense. Submit the administrative appeal request within the time frames specified in the Provider Manual.

The following types of provider administrative claim appeals are IN SCOPE for this process:

- Level of Compensation/Reimbursement
- Timely Filing of Claims
- Retroactive Eligibility
- Lack of Prior Authorization/Inpatient Notification Denials
- Non-Covered and/or Unlisted Code Denials
- Other Party Liability (OPL)/Third Party Liability (TPL)/Coordination of Benefits (COB)
- Provider Audit and Special Investigation Unit (SIU) Appeals
- Duplicate Claim Appeals

All documentation a provider wishes to have considered for a provider administrative appeal must be submitted at the time the

- The preferred method is to submit the Administrative Claim Appeal request through our online portal. See instructions in the Request for Claim Review Section.
- Download and complete the Request for Claim Review Form and submit with all required documents via Mail. Sending requests via certified mail does not expedite processing and may cause additional delay.
  WellSense
  Attn: Provider Administrative Claims Appeals
  P.O. Box 55282
  Boston, MA 02205

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Documents & Forms

Access documents and forms for submitting claims and appeals.

Access training guides for the provider portal.

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