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PAN Provider billing guide

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About PAN billing

This guide supports provider office personnel with PAN billing. The PAN Foundation contracts with Trustmark Health Benefits to process medical claims.

PAN gives grants to reimburse your practice for deductible, co-payment, and coinsurance costs related to eligible medications or supplies. **PAN is the payer of last resort**, so all patients must be insured, and the patient's insurance must cover their medication.

When you can submit claims

If the grant is active, you may submit claims throughout the eligibility period. The eligibility period for PAN grants is 12 months with a look back period of 90 days for any initial grant.

Note: you can find the eligibility period in the provider portal. Just click on the patient's name, then go to "Grants" tab.

At the end of the grant eligibility period, you have 60 days to submit any outstanding claims with dates of services within the eligibility period.

Grant use policy

PAN's grant use policy requires patients, or their representative, to request and receive payment for a claim from PAN every 120 days to keep the grant active. If a claim is not submitted and paid during that timeframe, the grant will be canceled. You can read more about the grant use policy on page 7.

How to contact PAN

You can submit an inquiry or request on our website anytime at panfoundation.org/contact.

If you have questions about your application that are not answered on our website (panfoundation.org), call us at **1-866-316-7263** from Monday through Friday, 9 a.m. to 5:30 p.m. ET.

Before giving us a call, we encourage you to reference the information in this guide and below.

- FAQs: panfoundation.org/provider-faqs
- Webinar library: panfoundation.org/webinar
- How to send a secure message: panfoundation.org/provider-guides

Services considered for reimbursement

PAN covers products that are FDA-approved or listed in official compendia or evidence-based guidelines for the specific disease fund. PAN reimburses:

- All prescription medications in the disease fund formulary, including:
    - Brand medications
    - Generic medications
    - Bioequivalent or biosimilar drugs
    - Specialty drugs
    - Radiopharmaceuticals
- Certain disease funds cover medical supplies for administering treatments, preventative vaccines, food items, travel, and premium assistance.

For medical claims, PAN requires that the diagnosis code submitted is covered under the respective disease fund. To verify diagnosis code coverage and review the list of disease funds and covered medications, visit at panfoundation.org/find-disease-fund and select the relevant disease fund for more information.

Services not considered for reimbursement

PAN **won't** reimburse:

- Eligible medications or over-the-counter products not covered by the patient's insurance.
- Eligible medications paid by the insurance payer at 100%.
- Eligible medications billed only to drug discount cards and not insurance.
- Medical services, such as lab work, diagnostic testing, genetic testing, ER visits, and office visits.
- Medications not covered under PAN's formulary for the relevant disease fund.

Request new medication coverage

If a patient's medication is not covered by their grant, you can submit an online request at panfoundation.org/contact or call PAN. Note that we **cannot** guarantee new medication coverage.

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How to submit claims

Check your patient's grant balance

Before submitting claims, verify the patient's grant balance using your portal account at providerportal.panfoundation.org. You can also call us and verify their grant balance using our IVR system.

Submit an electronic claim

Electronic claim submissions are the preferred and fastest way to submit a claim. You can submit electronic claims directly via your billing software. Claims are processed within five business days.

Please use:

Payer ID: 38225 (Payer ID is tied to Trustmark Health Benefits)

Billing ID: 10-digit numeric ID unique to each patient

Submit a manual claim

You can access the forms hyperlinked below at panfoundation.org/how-to-file-a-claim.

To submit a manual claim, you must:

1. Collect your:
   - W-9 form (required annually for each practice and the first time they submit a claim to PAN).
   - Completed CMS-1500, UB-92, or UB-04 form.
   - Corresponding itemized Explanation of Benefits (EOB) or Medicare Remittance Advice (RA) showing payment by the insurance.

2. Make sure the claim form and the EOB/RA are legible. All illegible claims will be returned and require resubmission, which can cause delays.
   - For DRG claims, the billing code/type on the claim form and the itemized or non-itemized EOB **must** indicate DRG.
   - For APC claims, make sure the EOB is itemized. If an itemized EOB is not available, contact PAN after submitting the claim.

3. Fax, mail, or upload claim(s) to:

   Online: PAN provider portal (providerportal.panfoundation.org)
   Fax: 1-844-726-4728
   Mail: PAN Foundation
   PO Box 2310
   Mt. Clemens, MI 48046

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Manual claims are processed on a first-come, first-served basis. Please wait five business days before following up on claims.

Mailing or faxing multiple claims together

Each date of service needs its own claim form and EOB/RA. Separate each date of service submission with a blank page, or a fax cover sheet. You may also use the PAN medical claim fax cover sheet between every individual medical claim, available at panfoundation.org/how-to-file-a-claim/.

Please do not fax any additional documentation such as welcome letters, clinical notes, fax confirmations or income verification documents with a claim.

After submitting a claim

Checking status of submitted claims

You can verify receipt of claims, status, and payment details through the Trustmark portal at mytrustmarkbenefits.com, or by calling PAN.

To review processed claims and payment details, you may use the PAN provider portal at providerportal.panfoundation.org. Note that to review a claim in your portal account, the tax ID and NPI on the claim **must** match the tax ID and NPI used to create the portal account.

Note: The patient must be linked to your PAN portal account before you can submit claims, review claim submission status, and view payment details. For details on how to link your patients to your portal account, visit panfoundation.org/linking.

Returned claims

A claim may be returned if:

- The submitted claim is illegible or
- The claim is missing required documentation for processing

For reconsideration, update the claim with the correct information and resubmit a legible claim for reprocessing. Make sure you write "corrected claim" on the claim resubmission.

Processed and denied claims

If the claim was processed and denied, check the Explanation of Provider Payment (EPP) for the claim denial reason. If additional information is required or you want the claim to be reconsidered, please update, and resubmit the claim with the original documents along with the required information and write "corrected claim" for reprocessing.

You can read more about following up on denied claims on page 9.

Appeals

We also have an appeal process for extenuating circumstances. Contact us via secure message on the PAN provider portal or call us to learn more.

Getting provider payments

Provider payments are sent by ECHO Health, PAN's third-party healthcare payment vendor.

Payment methods

You have three payment options:

- QuicRemit virtual credit cards (the default method)
  - No action needed
- ACH transfers
  - You must email edi@echohealthinc.com to obtain the enrollment form.
- Paper checks
  - You must contact ECHO Health at 1-440-835-3511.

Explanation of provider payments (EPP)

EPP statements can be accessed electronically at trustmarkbenefits.com or on the ECHO portal at providerpayments.com.

If the claims were processed electronically, you can access these statements through your clearinghouse via the 835 file.

Refunds

We accept refunds when the insurance company made an adjustment resulting in PAN overpayment of claims. If the patient's grant is still active, we will adjust the grant accordingly. If the patient's grant is no longer active, we will make the funding available for other recipients.

Send your refund check and the EPP to:
PAN Foundation
PO Box 2310
Mt. Clemens, MI 48046

Note: For adjustments, send the check if applicable, and the corrected EOB showing the adjustment.

Grant use policy

PAN's grant use policy requires patients, or their representative, to request and receive payment for a claim from PAN every 120 days to keep the grant active. If a claim is not submitted and paid during that timeframe, the grant will be canceled.

Grant at risk of cancelation

If the grant is at risk of getting canceled, contact us for an extension if extenuating circumstances will prevent you from submitting the claim before the grant is disenrolled.

Tip: you'll get a letter in your portal account after 90 days letting you know that the grant expires on day 120. This is a good time to let PAN know if you don't plan on submitting a claim in this time period, but still need the grant.

Submitting claims after grant use policy disenrollment

You may submit any patient claims incurred before the patient was disenrolled. You have 20 days after the grant cancelation date to submit the claim.

Disenrollment reversal

If the grant is disenrolled due to the grant use policy, contact us if extenuating circumstances prevented the timely filing of the claim for a review and potential reinstatement of the grant. Note, this is dependent upon funding availability.

Initial grant

An initial grant is the patient's first enrollment in a new disease fund at PAN. The initial eligibility period is for 12 months plus an additional 90-day look-back period to allow any claims incurred 90 days before obtaining the grant to be submitted for payment.

You can start filing claims with dates of service within the initial grant eligibility period on the eligibility start date.

Renewal grant

A renewal grant is a grant awarded after the previous eligibility period has ended, starting a new grant eligibility period for 12 months.

You may begin applying for a renewal grant up to 30 days before the current grant period ends, even if there is still a grant balance remaining. You may file claims with dates of service within the renewal grant eligibility period, starting on the eligibility start date.

Second grant

If the full value of the patient's grant is used and there is still time left in the patient's eligibility period, you may apply for a second grant. To qualify, the current grant balance must be $0, and the disease fund must be open.

Note: only one second grant can be awarded per eligibility period.

To prepare for a second grant:

1) Make sure the disease fund is open.
    a) You can check the provider portal at providerportal.panfoundation.org or the Find a Disease Fund page at panfoundation.org/find-disease-fund.
2) Check the patient's grant balance in the portal.
    a) If the grant balance is not $0, file a claim amount that is equal to or more than the current balance.
    b) Then call us or use the portal to apply for a second grant once the grant balance is zero.
    c) If the submitted claim was partially paid, PAN will automatically reprocess the claim for full payment after a second grant is issued.

For step-by-step instructions on how to apply for a second grant, refer to our how-to guides at panfoundation.org/provider-guides.

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Following up on denied claims

For claims denied in error or for other reasons not listed below, please call PAN for help.

The following table contains follow up steps for common claim denial message and reasons:

Denial message	Reason for denial	Steps
Non-covered service or diagnosis (or similar denials) *The patient is responsible for the billed charges.*	The diagnosis code and/or service code submitted on the claim form for the date(s) of service is not covered under the patient's disease fund.	1. Refer to page 3 for services that PAN does not cover. 2. Verify if the diagnosis code and/or medication are covered on the PAN website at panfoundation.org/find-disease-fund. 3. If the diagnosis code and/or medication are covered under the disease fund, update the claim form and resubmit with EOB. Write “Corrected Claim” on the claim form. 4. If a denial was issued for a medication that is listed on the PAN website for the disease fund, contact PAN to request a review.
Secondary payment cannot be issued. *A copy of the primary plan's EOB must be submitted to consider these charges.*	The insurance plan's EOB was not submitted with the claim form. The EOB must be submitted to be considered for reprocessing.	1. Resubmit the claim form with a copy of the EOB from the insurance plan.
An itemized primary EOB must be submitted to consider these charges.	The EOB from the insurance plan is not itemized; an itemized EOB must be submitted to determine payment for the covered charges.	1. Contact patient’s insurance plan to obtain an itemized EOB. Write “Corrected Claim” on the claim form when resubmitting. 2. If an itemized EOB is not available, contact PAN to advise.
Please resubmit the claim with a copy of the primary and secondary plan's EOB.	Patient has primary and secondary plan coverage; both the primary and secondary plans EOBs must be submitted for claim reimbursement to be considered for processing.	1. Submit the claim form with the EOBs for both the primary and secondary insurances. Write “Corrected Claim” on the claim form when resubmitting. 2. If there is no longer a secondary plan or the secondary plan does not cover the medication, contact PAN.

Denial message	Reason for denial	Steps
Duplicate charge previously processed.	The services submitted were previously processed and paid.	1. If resubmitting a claim with updated information, please write "Corrected Claim" on top of the second claim submission. 2. If the claim was denied in error, contact PAN, and request a re-review.
Ineligible patient. Patient responsible for billed charges.	The grant was not effective on the date of service billed.	1. If DOS falls after the eligibility period, check the disease fund status to renew the grant. 2. Contact PAN for possible coverage.
Fund limit exhausted. No payment issued. *Partial reimbursement issued.* Fund limit exhausted	The claim was denied or partially paid because the grant does not have any more funds available to process the claim.	1. If the balance is exhausted and the eligibility period has not ended, refer to page 8 to learn how you can apply for a second grant.
Timely filing period exceeded.	Claim submitted outside the timely filing period of 60 days after the end of the grant eligibility period.	1. Refer to page 2 to learn more about PAN billing.