



EDI Claims Submission Guide

The Health Insurance Portability and Accountability Act (HIPAA) requires Mail Handlers Benefit Plan and all other covered entities comply with Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. In support of HIPAA and its goal of administrative simplification, we encourage physicians and medical providers to submit claims electronically. Electronic claims submission can have significant, positive impact on the productivity and cash flow for your practice.

- **Reduces Paperwork and Costs** associated with printing and mailing paper claims.
- **Reduces Time** for Mail Handlers to receive a claim by eliminating mailing time.
- **Reduces Delays** due to incorrect claim information by returning errors directly to you through the same electronic channel. These claims can be corrected and re-submitted electronically.
- **Improves Accuracy** by decreasing the chance for transcriptions errors and missing/incorrect data.
- **Tracks and Monitors Claims** through claim status reports received electronically.

Electronic claim submission to the Mail Handlers Benefit Plan is easy to establish. **Contact your practice management system vendor or clearinghouse to initiate the process.** Electronic claim submissions will be routed through Emdeon Business Services who will review and validate the claims for HIPAA compliance and forward them directly to Coventry.

Providers can also submit directly to Emdeon Business Services. Emdeon will provide the electronic requirements and set-up instructions. Providers should call **(800) 215-4730** for information on direct submission to Emdeon Business Services.

EDI claim submitters should review the [EDI Exclusion List and Electronic Claim Submission Requirements](#). Mail Handlers Benefit Plan uses the **ANSI X12N 837 v4010** and **v4010A1** implementation guides that have been established as the standard claim transactions for HIPAA. The official implementation guides for claim transactions are available electronically from the Washington Publishing Company website at www.wpc-edi.com.

Mail Handlers encourages and recommends regular review of all EDI Acknowledgement and Reject reports returned to you. We have staff available to assist you with EDI claim filing. For more details on each of these topics please select from the topics below.

This document was last revised on May 16, 2008.






Frequently Asked Questions









1. EDI Specifications








Plan: **Mail Handlers Benefit Plan**

Emdeon Payer ID: **62413**

Refer to 2008 Claim Submission Guide for Coventry health plans below for details:

Member ID Card Logo	Plan Name	Payor ID	Claims Address	Plan Contact
 COVENTRY HEALTH CARE NATIONAL NETWORK	Multiple corporate and national clients	87043	Coventry Health Care P.O. Box 8400 London, KY 40742	800-937-6824
 COVENTRY HEALTH CARE NATIONAL NETWORK	Strategic Outsourcing Inc.*	87043	P.O. Box 241508 Charlotte, NC 28224	888-836-7764
 COVENTRY HEALTH CARE NATIONAL NETWORK	American Postal Workers Union (APWU) Health Plan*	44444	PPO Hospital: Coventry Health Care APWU HP PO Box 10398 Scottsdale, AZ 85271-0398 All other: APWU Health Plan PO Box 1358 Glen Burnie, MD 21060	800-222-APWU
  COVENTRY HEALTH CARE NATIONAL NETWORK	The Mail Handlers Benefit Plan	62413	MHBP P.O. Box 8402 London, KY 40742	800-410-7778

Member ID Card Logo	Plan Name	Payor ID	Claims Address	Plan Contact
 COVENTRY HEALTH CARE NATIONAL NETWORK	First Health Life & Health Ins. Co.	59140	HealthPlan Services P. O. Box 44199 Las Vegas, NV 89116	800-681-0056
 COVENTRY Health Care of Delaware, Inc.	Coventry Health Care of Delaware	25130	PO Box 7713 London, KY 40742	800-833-7423
 COVENTRY Health Care of Georgia, Inc.	Coventry Health Care of Georgia	25127	PO Box 7711 London, KY 40742	800-395-2545
 COVENTRY Health Care of Iowa, Inc.	Coventry Health Care of Iowa	25132	P O Box 7709 London, KY 40742	800-257-4692
 COVENTRY Health Care of Kansas, Inc.	Coventry Health Care of Kansas	25133	P O Box 7109 London, KY 40742	800-969-3343
 COVENTRY Health Care of Louisiana, Inc.	Coventry Health Care of Louisiana	25135	PO Box 7707 London, KY 40742	800-341-6613
 COVENTRY Health Care of Nebraska, Inc.	Coventry Health Care of Nebraska	23136	P O Box 7705 London, KY 40742	800-288-3343
 COVENTRY HEALTH CARE NATIONAL NETWORK	Coventry Life and Health of Oklahoma	25133	P.O. Box 7153 London, KY 40742	866-219-7695

Member ID Card Logo	Plan Name	Payor ID	Claims Address	Plan Contact
 Logo changes for an ASO template	Altius (a Coventry company)	25149	P O Box 7147 London, KY 40742	800-377-4161
	CareLink (a Coventry company)	25139	P O Box 7373 London, KY 40742-7373	800-348-2922
	Group Health Plan (a Coventry company)	25141	P O Box 7374 London, KY 40742-7374 ASO plans use P.O. Box 7121	800-755-3901
 HMO products use the HealthAmerica logo	HealthAssurance (a Coventry company)	25126	P O Box 7088 London, KY 40742	Varies by region 800-691-9984 West PA 800-788-8445 East PA
 Logo changes for an ASO template	PersonalCare (a Coventry company)	25146	PO Box 7141 London, KY 40742-7141	800-431-1211 fully insured 866-557-5781 ASO
 Torch is a watermark and is part of the background	Southern Health Services (a Coventry company)	25128	P O Box 7704 London, KY 40742	800-627-4872
	Wellpath (a Coventry company)	25129	P O Box 7102 London, KY 40742	800-735-7284

2. Professional (HCFA) Claim Submission Information

The 837P claim transaction is utilized for electronic professional claims and encounters. Mail Handlers Benefit Plan uses the ASC X12N 837 Professional Health Care Claim (004010X098A1). This document contains clarifications and payer specific requirements related to data usage and content with submitting an 837 professional claim to Mail Handlers. Please note that this document is intended to list only those elements where payer specific requirements or clarifications apply.

The loop, segment and data element references below in *italics* relate to the 004010X098A1 format. If you submit your electronic claims using a different format, you should check with your software vendor or clearinghouse to ensure that your data is mapped to the proper data elements.

REQUIRED INFORMATION

Provider

- **Federal Tax ID (TIN) of Billing Provider** (9 digit number).
- **National Provider ID (NPI)** for Billing and Rendering Provider is recommended, but not required until the official implementation date.
- **Billing Provider's Last Name (NM103)** and **Provider's First Name (NM104)** are both required if the provider entity type qualifier indicates "person". Provider first name should be submitted completely and not just a first initial.
- **Rendering Provider Name and ID Number (Loop 2310B)** is required when different than the billing provider (2010AA). Provider first name should be submitted completely and not just a first initial.
 - If the rendering provider is a person, both the first name (NM104) and the last name (NM103) are required.

- For the rendering provider's ID number, the NPI is preferred in *NM109*, otherwise, the employer identification number (also known as the Federal Tax ID) is required.
- If you submit rendering provider information at the claim header level (*Loop 2310B*), do **not** also submit service line level (*Loop 2420A*) rendering provider information. Coventry will read the provider at the claim header level only. If you do not have a rendering provider at the claim header, Coventry will read the billing provider data.
- **Referring Provider Name and ID Number** (*Loop 2310A*)
 - If the referring provider is a person, both the first name (*NM104*) and last name (*NM103*) are required.
 - Do **not** submit referring provider information at the service line level (*Loop 2420F*) if it is the same as the claim header level (*Loop 2310A*).
 - When there is only one referral on the claim, use code *DN* in *NM101*. When two referrals are reported, use code *DN* in *NM101* of the first iteration of the loop and code *P3* in *NM101* in the second iteration of the loop. Coventry will only read the first referral submitted.
- **Service Facility Location** (*Loop 2310D or 2420C*) is required when the service location is different than the location in the billing provider (*2010AA*).
 - Service facility location name (*NM1*) is required except when the place of service is the patient's home.
 - Do not submit service facility location information at the service line level (*Loop 2420C*) if it is the same as the claim header level (*Loop 2310D*).
 - For the Service Facility ID number, the NPI is preferred in *NM109*.
- **Admission Date** (*Ref02 where REF0=435*) is required for inpatient medical visits and ambulance claims when the patient was admitted to the hospital.
- **Compliant Medical Code Sets** such as HCPCS, ICD-9, and CPT-4 are required on both electronic and paper claims.
- **ICD-9-CM** codes should be submitted with the highest level of specificity (the correct number of digits) for proper adjudication. These codes should be submitted without the decimal point on electronic claims.

Patient

- **Member ID Number** (7-11 digit number) as shown on the patient's ID card.
- **Member Date of Birth & Gender Code**
- **Subscriber's Date of Birth** (*DMG02 where DMG01=D8*) and **Gender Code** (*DMG03*) are required if either:
 - The subscriber is the same person as the patient.
 - For secondary COB claims when using *Loops 2320 and 2330*.
- **Insurance Type Code** is required on secondary COB claims (*Loop 2320 SBR05*).

RECOMMENDED INFORMATION

- **Anesthesia EDI Claims.** Mail Handlers requires the submission of time-based CPT codes (formally called ASA codes) for all anesthesia services. Anesthesia claims submitted with surgical CPT codes will be denied during processing.
 - Total Anesthesia Minutes are required on all time-based CPT codes, with the exception of 01995 and 01996. Total Minutes should be entered in the SV104. The qualifier MJ should be entered in the SV103.
 - All non time-based services and 01996 require units of service. Units should be entered in the SV104, with a Qualifier of UN in the SV103.
- **Claims with Attachments.** Mail Handlers is able to receive and use in processing the

EDI Claim Supplemental Information paperwork segment as defined in the Health Care Claim 837 Implementation Guide.

4010 Specifications for 2300 Loop - PWK Segment

- PWK01 - Report Type Code (see applicable codes below)
- PWK02 - Report Transmission Code *must be* 'AA' for available on request at provider site.
- PWK06 - Attachment Control number (not used now, but will be implemented in the future).
- PWK07 - Description (optional)(UB claims only).

Mail Handlers' business practices support the following paperwork codes (PWK01), which will be considered during adjudication:

- (AS) Admission Summary
- (DG) Diagnostic Report
- (DS) Discharge Summary
- (NN) Nurse Notes
- (PN) Physical Therapy Notes
- (B3) Physician Order
- (OB) Operative Notes
- (EB) Explanation of Benefits
- (RT) Report of Tests and Analysis Report
- (RR) Radiology Reports

Please note for claims with attachments:

- The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established policies.
- The specific paperwork codes in the PWK segment will trigger processors to consider the contents of the supplemental information obtained via fax. Therefore, use of these codes incorrectly may delay the processing of the claim as compared to a like claim without a PWK.
- If the documentation is needed for adjudication, Mail Handlers will contact you and request a faxed copy. This copy must be received within 72 hours of the request or the claim will be denied.
- Mail Handlers will continue to accept paper claims with attachments.
- **Secondary COB Claims** - secondary claims may be submitted electronically.
 - Send the secondary claim electronically using the 837 4010A1 using *Loops 2320 and 2330* for claim header data and *Loops 2420G and 2430* for claim service line data.
 - All COB secondary claims must contain information regarding the other payer approved and allowed amounts. Additionally, we need to receive the applicable claim adjustment reason codes at the header or line level for other payer amounts.
 - MailHandlers does not require secondary COB claims to be submitted electronically. Providers may continue to submit COB claims on paper and attach a copy of the paper EOB.
- **Resubmitted Claims** - Corrected or replacement claims may be submitted electronically. Use the *Claim Frequency Type Code (CLM05-3)* value equal to "7" to indicate a replacement claim. The *Claim Type Frequency Code (code set 235)* may be used for other resubmitted claim types as well.
- **Pharmaceutical Claims** - May be submitted electronically. These drug claims should not be for retail pharmacy claims nor can they be in an NCPDP format. If you are submitting a claim for pharmaceutical services, the HCPCS J codes are required to identify the drug.

However, if the appropriate J-code is J3490 or a J9999, we also require the NDC code using *Loop 2410*. Use a F2 qualifier on the service line level to indicate DOSAGE for this NDC code.

DATA NOT USED

Although Mail Handlers accepts the following data, it is not used in claim adjudication.

- **Pay-To Provider that is *different* than the Billing Provider.** Mail Handlers' business policy does not recognize or enumerate a "Pay-To" provider separate from a "Billing" provider. Therefore, payments will be made to the billing provider, even if a pay-to provider is submitted in the claim transaction.
- **Providers loops and segments at the claim line level.**
- **Supervising or Purchasing provider information.**
- **Currency.** Information in the *CUR* segment will not be considered in processing. All electronic transactions will be with trading partners in the United States.
- **Select Patient Information Segment** including **date of death** (*PAT06*), **Weight** (*PAT08*), and **Pregnancy Indicator** (*PAT09*).
- **Responsible Party Information** (*Loop 2010 BC*) information submitted on appropriate legal documentation and maintained in internal files will be used.
- **Participation Indicator** (*Loop 2300 CLM16*) we will use the participation indicator in our internal provider files.
- **Contract Information** in *Loop 2400 CNJ* segment. Data in internal files will be used.
- **Service Authorization Exception Code** in *Loop 2300 REF*.
- **Ambulatory Patient Group** in *Loop 2300 REF*. We are in the process of developing APGs.
- **Demonstration Project Identifier** in *Loop 2300 REF*.
- **File Information** (*Loop 2300 K3 segment*). No usage for the segment has currently been defined.
- **Claim Pricing/Repricing Information** (*Loop 2300 HCP segment*).
- **Durable Medical Equipment Service** (*Loop 2400 SV5 segment*). DME should be billed in the *Loop 2400 SV1 segment*.
- **Mandatory Medicare Crossover Indicator** (*Loop 2300 REF*).
- **Mammography Certification Number** (*Loops 2300 and 2400 REF*).
- **DMERC CMN Indicator** (*Loop 2400 PWK*).
- **Hospice Employee Indicator** (*Loop 2400 CRC*).
- **Credit/Debit Card Account Holder Name** (*Loop 2010BD*) and **Credit/Debit Card Maximum Amount** (*Loop 2300 AMT segment*)

3. Institutional (UB) Claim Submission Information

The 837I transaction is used for institutional claims and encounters. Mail Handlers uses the ASC X12N 837 Institutional Health Care Claim (004010X096A1) implementation guide. This document contains clarifications and payer-specific requirements related to data usage and content when submitting an 837 institutional claim to Mail Handlers. Please note that this document is intended to list only those segments where payer specific requirements or clarifications apply.

The loop, segment and data element references below in *italics* relate to the 004010X096A1 format. If you submit your electronic claims using a different format, you should check with your software vendor or clearinghouse to ensure that your data is mapped to the proper data elements.

REQUIRED INFORMATION

Provider

- **Federal Tax ID (TIN) of Provider** (9 digit number).
- **National Provider ID (NPI)** for Billing Provider is recommended, but not required until the official implementation date.
- **Billing Provider's Last Name (NM103)** and **Provider's First Name (NM104)** are both required if the provider entity type qualifier indicates "person". Provider first name should be submitted completely and not just a first initial.
- **Attending Provider Name and ID Number (Loop 2310A)** is recommended on all institutional claims.
 - If the attending provider is a person, both the first name and the last name are required.
- **Service Facility Name and Address (Loop 2310E)** is required when the service facility is different than the billing provider (2010AA).
 - For the Service Facility ID number, the National Provider ID is preferred in NM109.
- **Admission Date and Time** are required for all inpatient claims. *DTP03* should be in this format: *CCYYMMDDHHMM* where *DTP01=435* and *DTP02=DT*.
- **Service Line Date** is required on outpatient claims. *DTP03* where *DTP01=472* in Loop 2400.
- **Unit or Basis for Measurement Code SV204** in Loop 2400 (days, units, international unit or dosage) is required at the service line level.
- **Quantity Segment (QTY** in Loop 2300) should only be used for information related to DAYS, such as the number of covered, co-insured, life-time reserve or non-covered days. Do not use this segment on outpatient claims.
- **Compliant Medical Code Sets** such as HCPCS, ICD-9, and CPT-4 are required on both electronic and paper claims.
- **ICD-9-CM** codes should be submitted with the highest level of specificity (the correct number of digits) for proper adjudication. These codes should be submitted without the decimal point on electronic claims.

Patient

- **Member ID Number** (7-11 digit number) as shown on the patient's ID card.
- **Member's Date of Birth and Gender Code**
- **Subscriber's Date of Birth (DMG02** where *DMG01=D8*) and **Gender Code (DMG03)** are required if either:
 - The subscriber is the same person as the patient.
 - For secondary COB claims when using *Loops 2320 and 2330*.
- **Patient Status Code CL103** in Loop 2300 (2-digit code from box 22 of the UB-92) is required on all inpatient claims.

RECOMMENDED INFORMATION

- **Claims with Attachments.** Mail Handlers is able to receive and use in processing the EDI Claim Supplemental Information paperwork segment as defined in the Health Care Claim 837 Implementation Guide.
4010 Specifications for 2300 Loop - PWK Segment
 - PWK01 - Report Type Code (see applicable codes below)
 - PWK02 - Report Transmission Code *must be 'AA'* for available on request at provider site.
 - PWK06 - Attachment Control number (not used now, but will be implemented in the future).

- PWK07 - Description (optional)(UB claims only).

Mail Handlers' business practices support the following paperwork codes (PWK01), which will be considered during adjudication:

- (AS) Admission Summary
- (DG) Diagnostic Report
- (DS) Discharge Summary
- (NN) Nurse Notes
- (PN) Physical Therapy Notes
- (B3) Physician Order
- (OB) Operative Notes
- (EB) Explanation of Benefits
- (RT) Report of Tests and Analysis Report
- (RR) Radiology Reports

Please note for claims with attachments:

- The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established policies.
- The specific paperwork codes in the PWK segment will trigger processors to consider the contents of the supplemental information obtained via fax. Therefore, use of these codes incorrectly may delay the processing of the claim as compared to a like claim without a PWK.
- If the documentation is needed for adjudication, Mail Handlers will contact you and request a faxed copy. This copy must be received within 72 hours of the request or the claim will be denied.
- Mail Handlers will continue to accept paper claims with attachments.
- **Secondary COB Claims** - secondary claims may be submitted electronically:
 - Send the secondary claim electronically using the 837 4010A1 using *Loops 2320 and 2330* for claim header data and *Loop 2430* for claim service line data.
 - All COB secondary claims must contain information regarding the other payer approved and allowed amounts. Additionally, we need to receive the applicable claim adjustment reason codes at the header or line level for other payer amounts.
 - Mail Handlers does not require secondary COB claims to be submitted electronically. Providers may continue to submit COB claims on paper and attach a copy of the paper EOB.
- **Pharmaceutical Claims** - may be submitted electronically using an 837. These drug claims should not be for retail pharmacy claims nor can they be in an NCPDP format. If you are submitting a claim for pharmaceutical services, the HCPCS J codes are required to identify the drug. However, if the appropriate J-code is J3490 or a J9999, we also require the NDC code using *Loop 2410*. Use a F2 qualifier on the service line level to indicate DOSAGE for this NDC code.

DATA NOT USED

Although Mail Handlers accepts the following data, it is not used in claim adjudication.

- **Payer Secondary Information.** (*Loop 2010BB REF*)
- **Currency.** Information in the *CUR* segment will not be considered in processing. All electronic transactions will be with trading partners in the United States.

- **Responsible Party Information** (*Loop 2310BC*) will not be considered in processing. The information submitted on appropriate legal documentation and maintained in internal files will be used.
- **Contract Information** in *Loop 2400 CN1* segment. Data in internal files will be used.
- **Demonstration Project Identifier** in *Loop 2300 REF*.
- **File Information** in *Loop 2300 K3* segment. This is not needed as no usage for this segment has been defined.
- **Claim Pricing/Repricing Information** (*HCP segment*).
- **Peer Review Organization Approval Number** (*Loop 2300 REF segment*). Information on internal files will be used.
- **Medicare PPS Assessment Date** (*Loop 2400 DTP*).
- **Explanation of Benefits Indicator** (*CLM18*). Information from our internal files will be used.
- **Treatment Code Information** (*in Loop 2300 HI segment*). Home Health Agency treatment plan information is not needed for processing at this time.
- **Credit/Debit Card Account Holder Name** (*Loop 2010BB*) and **Credit/Debit Card Maximum Amount** (*Loop 2300 AMT segment*)
- **Property and Casualty Claim Number** (*REF segments in Loops 2010BA and 2010CA*)

4. EDI Acknowledgement and Reject Reports

For every claim filed electronically, the provider should monitor whether or not that claim has been rejected by reviewing EDI Acknowledgement and Reject reports on a regular basis. The following reports should be monitored regularly.

- **Initial Reject Report (Emdeon report R022 or equivalent vendor report)** - This is a report that shows claims rejected by Emdeon that were not forwarded to Mail Handlers Benefit Plan. These claims should be corrected and re-submitted electronically.
- **Initial Accept Report (Emdeon Envoy Report R026 or equivalent vendor report)** - This is a report that shows Emdeon accepted the EDI claim and forwarded it to Mail Handlers Benefit Plan for processing.
- **Payer Reject Report (Emdeon Report R059 or equivalent vendor report)** - This report states why the health plan rejected the claim. These claims should be corrected and re-submitted electronically when possible.

Monitoring Your EDI Reports

Please note that claims appearing on the **Initial Reject Report** have not met the initial clearinghouse criteria approved by Mail Handlers and have not been sent to Mail Handlers for adjudication. Any claims appearing on this report must be corrected and should be re-submitted electronically as soon as possible to avoid timely filing issues.

Claims displayed on the **Initial Accept Report** have passed the clearinghouse edits and have been forwarded to Mail Handlers for additional payer editing.

It is also important to note that a claim can pass the clearinghouse edits and be displayed on the Initial Accept Report, but still be rejected by Mail Handlers. Claims rejected by Mail Handlers will appear on the **Payer Reject Report**. Any claims appearing on this report should be corrected and re-submitted electronically as soon as possible to avoid timely filing issues.

Timely Filing

Mail Handlers must accept a claim within its timely filing limit or it will be denied for untimely filing. If you are not receiving the described clearinghouse and payer reports on a regular basis, please contact your clearinghouse or Emdeon Business Services. A provider can avoid timely filing issues through understanding and regular monitoring of EDI Reports. This process will help to

ensure all rejected claims are re-filed timely and electronically.

5. Common Rejection Reasons

Review the following tips for assistance with resolving the most common rejections received by providers.

Member Identification Number

Submit the 7 or 11 digit number as displayed on the patient's ID card.

NOTE: Mail Handlers Benefit Plan recently issued new Member ID cards to all of its members, with a new 11 digit number, replacing the current 7 digit member ID number. Please use this new 11 digit number as the recognized Member ID for all Mail Handlers Benefit Plan subscribers moving forward.

Previously Mail Handlers Benefit Plan utilized the Social Security Number of its members as their Member ID #. Providers can still use that 9 digit number in the member field for EDI claim submissions.

The most common claim reject reason for Mail Handlers is "member not found." This reject could be due to the fact that claim was submitted to the incorrect Payer ID. For a complete list of Coventry's payer id, click on the link below:

http://transact.emdeon.com/edi_fact_sheet_CoventryPlans.php

Use Mail Handlers Benefit Plan/Coventry's secure provider portal, *directprovider.com*, to verify/validate member's eligibility and health plan prior to submitting claims.

Patient Date of Birth

Submit a valid date of birth for the patient.

- Do not send "00" for the month or date.
- Do not send dummy dates such as "17760704".
- Do not send a date of birth greater than the date of service.

A claim will be rejected if a valid date of birth does not match the date of birth on file in the Coventry system. If this is the case, please verify the patient date of birth with the patient or policyholder.

Date Format

Submit all dates in the following format CCYYMMDD unless otherwise specified.

- Submit valid dates of service.
- Do not submit future dates of service.

Monetary Amount Format

Include the decimal point in all monetary amounts unless otherwise specified.

- Do not submit negative dollar amounts.

Coding Detail

Consider the following when verifying service codes and/or modifiers that have been rejected.

- Submit service codes and modifiers appropriate to the age and gender of the patient.
- Submit service codes and modifiers appropriate to the date of service.

6. EDI Assistance

Your Clearinghouse - typically, your first point of contact for resolving an EDI issue is your practice's specific clearinghouse.

Emdeon Business Services - The Emdeon Business Services customer service center can track all EDI submissions received by them. Emdeon also maintains the status message returned on an EDI claim from the health plan. This information is readily available for 45 days after the submission. Information on older submissions is also available, but will have to be forwarded to their research division for follow-up. Emdeon Customer Support can be reached at **(877) 469-3263**.

Mail Handlers staff are available to assist you with electronic filing concerns as they relate to our submission requirements or status messages. Please contact (302) 283-6570 or via email at EDIClaims@cvtv.com.