Keystone First
Keystone First Community HealthChoices
200 Stevens Drive
Philadelphia, PA 19113

Keystone First | Keystone First Community HealthChoices

To: **Keystone First/Keystone First Community HealthChoices (CHC) Providers**

Date: **June 29, 2026**

Re: **Important information regarding claims submission requirements**

Keystone First/ Keystone First CHC would like to remind providers of claim submission and enrollment requirements to help reduce claim denials and/or inaccurate payments.

Global, Technical and Professional Billing Radiology/Lab Services
Providers must submit claims:

- Without a modifier if billing for the **global component** of radiology and/or lab services
- With the TC modifier if only billing for the **technical component**
- With a 26 modifier if only billing for the **professional component** of a study
- With modifiers 50 and TC if billing for the technical component of a bilateral radiology procedure and modifier 50 in isolation if billing for a bilateral global radiology procedure

The same provider should not be submitting a claim line with a TC modifier and another claim line with the 26 modifier. The global procedure code, without a modifier, should be billed.

Facility Place of Service (POS) Billing
Professional claims (CMS1500 or 837P) submitted with a facility POS code (19, 21, 22, 23, 24, 25, 31, 32 and 33) must include the National Provider Identifier (NPI) of the **servicing location** in Box 32. Group NPIs are not permitted. Claims submitted with group level NPIs in Box 32 for services delivered in facility settings may be denied.

All Services – One Claim
Providers must bill **all services** provided to each Member/Participant on the same claim. Split-billing of claim lines is not permitted. Split-billed claims will be denied.

Corrected Claims
Providers must bill frequency 7 for all corrected claims. New claims should not be submitted when there is a claim on file. Claims that do not include frequency 7 (corrected claim) when there is a claim on file may be denied.

Voided Claims
Providers must bill frequency 8 to void a claim submitted to the Plan where the services billed never occurred, where the TAX ID is incorrect, or where the Member/Participant ID is incorrect. All other claims should be corrected and submitted with a frequency 7.

Service Location Enrollment/Claim Billing
Every provider/facility must enroll in Pennsylvania Medical Assistance (PAMA) at every service location in which services are provided to Medicaid Members/Participants. Providers/facilities not enrolled may receive claim denials. Taxonomy codes, which identify the provider's specialty, should also match PAMA enrollments.

Over Enrollment
Providers should not enroll service locations where he/she does not have regularly scheduled office hours. Providers covering for other providers are not expected to enroll in covering locations as long as the coverage is not regularly scheduled – if the coverage is routine, the provider covering must enroll at the said location.

If you have questions regarding this notice, please contact your Provider Account Executive or Provider Services at **1-800-521-6007**

Coverage by Vista Health Plan, an independent licensee of the Blue Cross and Blue Shield Association.