PAN Foundation
Provider Billing Guide

The Patient Access Network (PAN) Foundation is an independent, national 501 (c)(3) organization dedicated to helping federally and commercially insured people living with life-threatening, chronic and rare diseases with the out-of-pocket costs for their prescribed medications.

This billing guide is intended to support provider office personnel with PAN billing. The PAN Foundation contracts with Trustmark Health Benefits, formerly known as CoreSource, to process medical claims.

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Need more information? Contact PAN at 1-866-316-7263, option 2.

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Services considered for reimbursement

PAN provides reimbursement in the form of grants for deductible, co-payment and coinsurance amounts related to eligible medications or supplies. PAN is the payer of last resort, so all patients must be insured, and insurance must cover the medication or supply for which the patient seeks assistance.

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

The following items are reimbursable by PAN:

- All prescription medications in the disease fund formulary.
  - Brand medications
  - Generic medications
  - Bioequivalent or biosimilar drugs
  - Specialty drugs
  - Radiopharmaceuticals
- Certain disease funds cover medical supplies for administering treatments.

For medical claims, PAN requires that the diagnosis code submitted is covered under the respective disease fund. To verify diagnosis code coverage, visit our assistance programs page at https://bit.ly/2bxcCcq and select the appropriate disease fund for additional information.

Services not considered for reimbursement

PAN is the payer of last resort, so all patients must be insured, and insurance must cover the medication or supply for which the patient seeks assistance.

The following items are not reimbursable by PAN:

- 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, preventative vaccinations, diagnostic testing, genetic testing, ER visits and office visits.
- Medications not covered under PAN's formulary for the corresponding disease fund.

Medication not covered? Call PAN at 1-866-316-7263 or submit a request at https://bit.ly/2mcFEsd.

How to submit claims

To verify the grant balance remaining in the patient's account before submitting claims, check the portal or contact PAN.

Electronic claim submissions

Electronic claims are the preferred method of claim submission and can be submitted through your billing system. Electronic claims are processed within 5 business days. To submit an electronic claim, use the following billing information:

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

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

Manual claim submissions

The standard processing time for manual claims is 10 business days. Claims are processed on a first-come, first-served basis. Please allow 5 business days upon PAN's receipt before following up on submitted claims.

1. To submit a claim manually, gather the following items:
   - W-9 form (required annually for each practice).
   - 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. Ensure the claim form and the EOB/RA is legible prior to submitting. All illegible claims will be returned to the provider for resubmission and can cause a delay in processing.

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

   Fax: 1-844-726-4728
   Mail: PAN Foundation
   PO Box 2310
   Mt. Clemens, MI 48046
   Portal: https://bit.ly/2kHBJmD

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Mailing or faxing multiple claims together
Each date of service must have its own claim form and respective EOB/RA. Separate each date of service submission with a blank page or a fax cover sheet.

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

Receiving provider payments

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

Payment methods

There are three payment options for providers:

- QuicRemit virtual credit cards
- ACH transfers
- Paper checks

QuicRemit virtual credit cards are the default payment method.

If you would like to continue receiving QuicRemit virtual credit cards, no further action is needed.

If you would like to receive payments with ACH transfers, email edi@echohealthinc.com to obtain the enrollment form.

If you would like to receive payments with paper checks, contact ECHO Health at 1-440-835-3511.

Explanation of provider payments (EPP)

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

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

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Timely filing

At the end of the patient's grant period, PAN allows 60 days to submit any outstanding claims with dates of services that are within the eligibility period.

PAN also has a Grant Use Policy that requires grant recipients to use their grants as intended to help cover the out-of-pocket costs for their medications. Ensure claims are submitted and paid every 120 days to keep the patient's grant active; otherwise the grant will be at risk of being canceled. Contact PAN if there are any extenuating circumstances that prevent a claim from being filed every 120 days.

Additional assistance

If the patient's grant is exhausted during the eligibility period, you may apply for additional assistance, called second grants. To qualify, the current grant balance must be $0, and the disease fund must be open.

Visit the PAN provider portal at https://bit.ly/36J0OB8 or call PAN at 1-866-316-7263 to see if the patient qualifies.

Please note:
- To achieve a $0 balance, you must submit the claim and a partial payment will be issued to zero out the account. You may apply for a second grant once the balance is $0.
- The claim will not need to be resubmitted once the second grant is issued; PAN will reprocess the claim.
- Only one second grant can be awarded per eligibility period.

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Following up on denied claims

For claims denied in error or for other reasons not listed below, please call PAN at 1-866-316-7263 for further assistance.

The following table contains common claim denial 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. See "Services not considered for reimbursement" for services that PAN does not cover. 2. Verify if the diagnosis code and/or medication are covered on the PAN website. 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 insurance EOB must be submitted in order 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 insurance plan's EOB was not itemized; an itemized insurance EOB needs to 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.
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 patient's primary and secondary insurances. Write "Corrected Claim" on the claim form when resubmitting. 2. If the patient no longer has a secondary plan or the secondary plan does not cover the medication, contact PAN.
Duplicate charge previously processed.	The services submitted were previously processed and paid.	1. If information was updated and "Corrected Claim" was written on the second claim submission or the claim has been denied in error, contact PAN.

Denial Message	Reason for Denial	Steps
Ineligible patient. Patient responsible for billed charges.	Patient's grant was not effective for the date of service billed.	1. If DOS falls after the eligibility period, check the disease fund status to renew grant. 2. If DOS falls before the eligibility start date, contact PAN for an exception review.
Fund limit exhausted. No payment issued. *Partial reimbursement issued.* Fund limit exhausted	The claim submitted was denied or partially paid as the patient does not have any funds available to process the claim.	1. If the balance is exhausted and the eligibility period has not ended, see "Additional Assistance"
Timely filing period exceeded.	Claim was submitted outside the timely filing period of 60 days from the end of the patient's grant period.	1. Refer to "Timely Filing"