

# Secure Provider Portal Quick Start Guide

USING THE SECURE PROVIDER PORTAL

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## About the Secure Provider Portal

The Provider Portal is a secure web-based platform. Use this tool to support eligibility inquiry, authorization submission, claim submission, claim status inquiry, and a number of clinical applications.

### System Requirements

Access the secure provider website using Internet Explorer 10.0 or higher, Firefox and/or Google Chrome. Each browser should be updated to the most recent version available optimal performance.

## Purpose of this Guide

This guide provides an overview of the key features and functionality offered by the Secure Provider Portal. The guide also explains many ways to use the site to get the most out of the resource. If you need additional support, contact Provider Services.

## Audience

Registered users of the secure Provider Portal.

## Introduction

This guide contains updated instructions to reflect recent changes to the Secure Provider Portal.

### **Some administrative tasks that registered users can do include:**

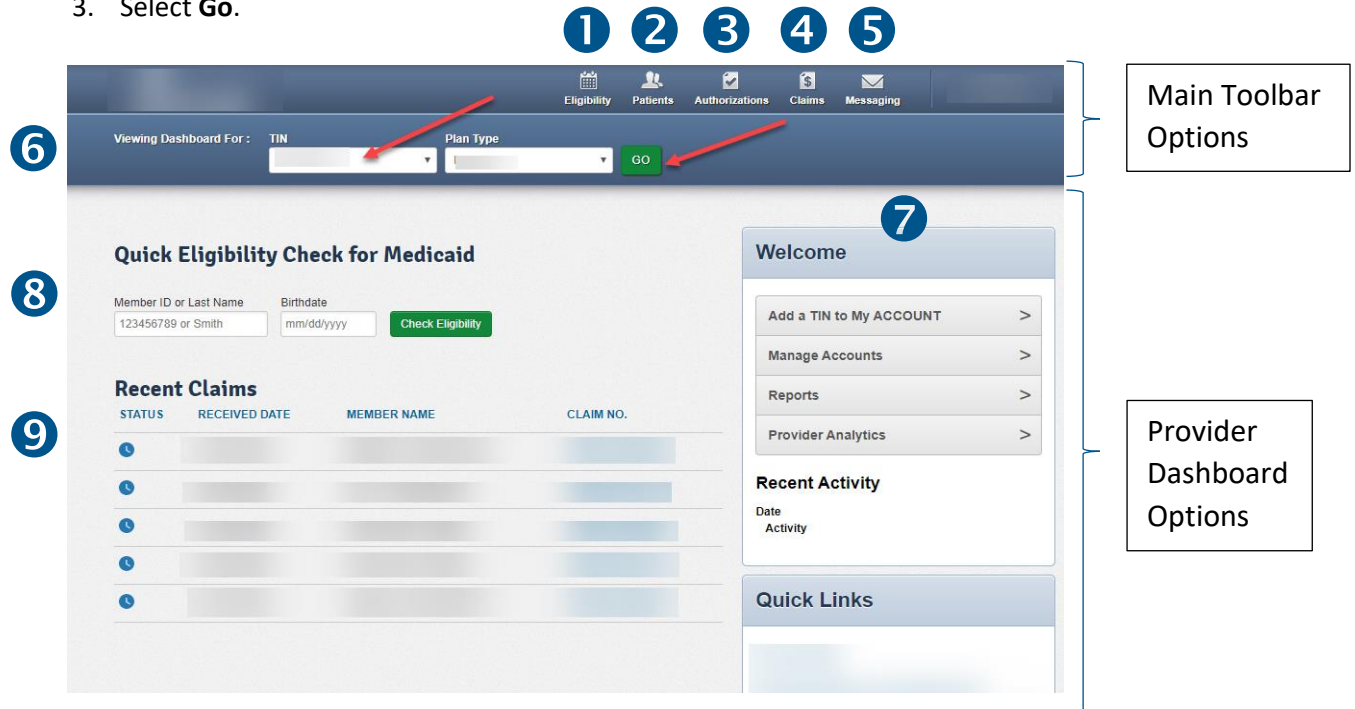
- Check eligibility
- View the specific benefits for a member
- View benefit details including member cost share amounts for medical, Pharmacy, dental, and vision services
- View demographic information for the providers associated with the registered TIN such as office location, office hours and associated practitioners
- Update demographic information, such as address, office hours, etc.
- View and print patient lists (primary care providers). This patient list will indicate:
  - Member's name,
  - Member ID number,
  - Date of birth, and
  - The product in which they are enrolled
- Submit authorizations and view the status of authorizations that have been submitted for members
- View claims and the claim status
- Submit individual claims, batch claims or batch claims via an 837 file View and download Explanations of Payment (EOP)
- View a member's health record including visits (physician, outpatient hospital, therapy, etc.); medications, and immunizations
- View gaps in care specific to a Member including preventive care or services needed for chronic conditions
- Send secure messages

## Using the Provider Landing Page

Once logged in, the Dashboard displays with access to recent claims, functions and controls.

To get started

1. Choose the Tax ID from the **TIN** drop-down list.
2. Choose the appropriate Product under **Plan Type**.
3. Select **Go**.



## Provider Landing Page Overview

You can perform the following tasks from the Dashboard. **Note:** Features vary by Health Plan product.

### Main Toolbar Options:

1. **Eligibility:** Verify patient eligibility
2. **Patients:** View and print your patient list (PCP/PMP)
3. **Authorizations (Auths):** Submit and view authorizations
4. **Claims:** Submit, view, correct, copy, void/recoup claims
5. **Messaging:** Send and receive secure messaging
6. **TIN and Health Plan Selector:** Switch between Multiple Provider Tax ID's and the corresponding products (i.e. Medicaid, Ambetter, Advantage Plans, Behavioral Health or MMP)

### Provider Dashboard Options:

#### Menu Options:

7. Access additional functionality, such as manage accounts and view provider related reports

#### Eligibility Quick Check:

8. Check the eligibility of a member

#### Recent Claims:

9. View the last five claims submitted on the portal within the last 24 months

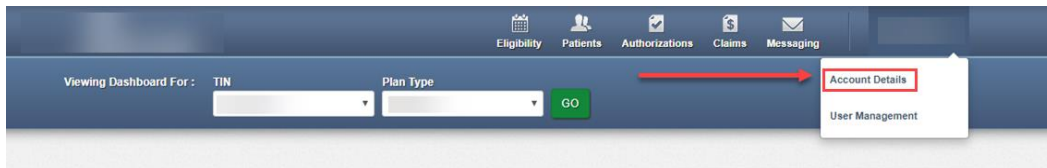
## Managing Account Details

From the Account Details screen, you can:

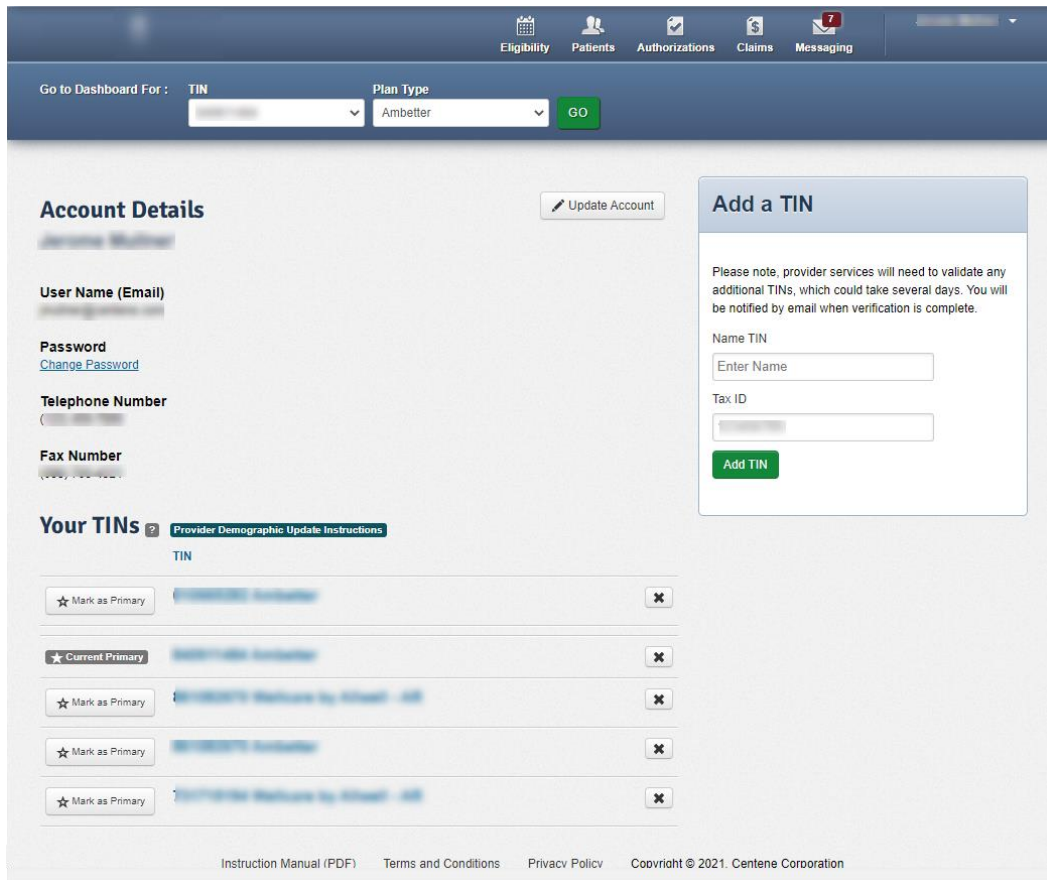
- View and manage information related to your account profile.
- Add and manage Tax Identification Numbers (TINs) on the account.

### To Access the Account Details Screen

1. From the main dashboard, select the **drop-down arrow** next to your name in the upper-right corner on the screen.
2. Choose **Account Details**.



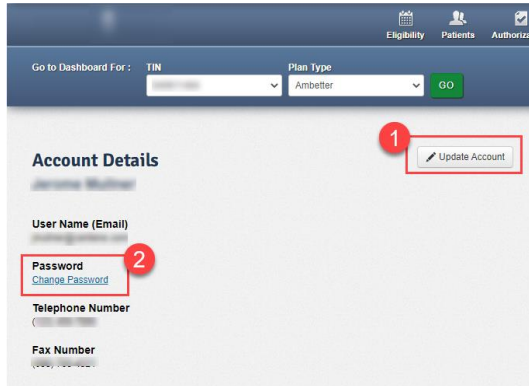
The Account Details screen appears.





## Account Details: Manage Your User Profile and Account Details

Any updates that you make to your available account details will display on the screen. Use the Update Account and Change Password features to make any changes.



### 1 To Update Account Information

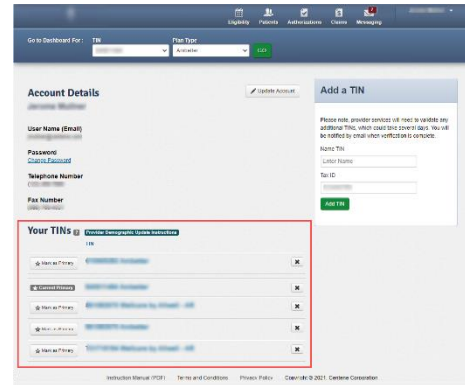
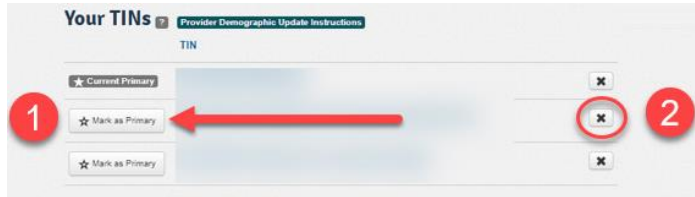
1. Click the **Update Account** button. The Update Your Information screen appears.
2. Make any needed updates to your account Information.

### 2 To Change Your Password

1. Click the **Change Password** link under Account Details.
2. Follow the instructions on the EntryKeyID Change Password screen.

## Account Details: Manage Your TINs

TINs added to your account display in a list under the **Your TINs** section. You can mark one primary TIN to appear by default when you access the dashboard. You can also remove TINs from your account.



1. To change your default TIN, select **Mark as Primary** next to a different TIN.
2. To remove a TIN from the account, select the **x** next to one you no longer want.

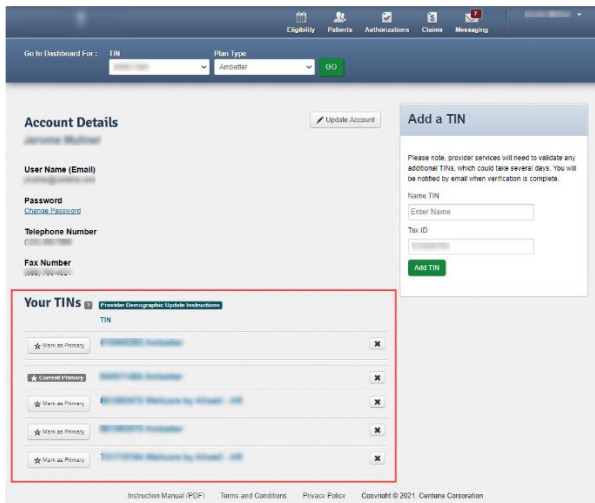
### Additional Instructions:



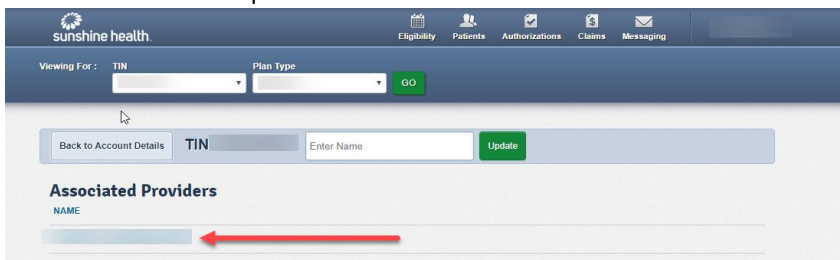
The primary TIN on the account appears by default in the TIN drop-down list at the top of the dashboard. The associated plan also displays. You can select any TIN that you have added to your account.

## Account Details: Modify Demographic Information about a Specific TIN

1. Click on the individual TIN.



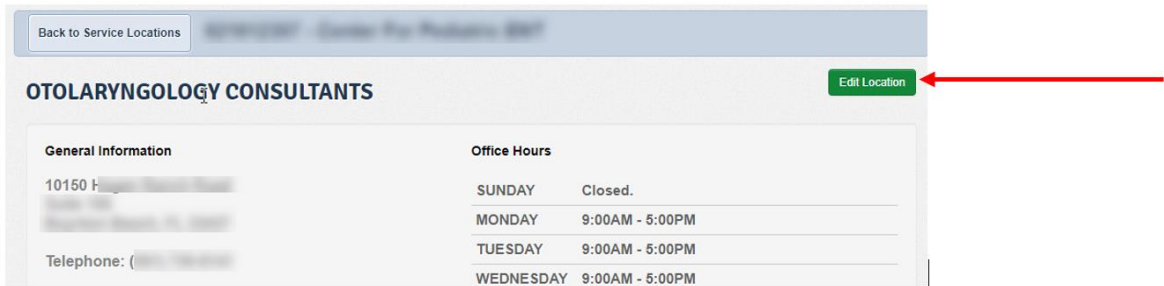
2. Click on the Name to update information about one of the Associated Providers.



- A list of possible Service Locations appears. Click on the name associated with the address.



- Make updates on the screen that appears.



- Click **Edit Location** to update the provider information

**Note:** This information will update the Find A Provider website.

The following Transaction attributes will be available for edits.

**Note:** Only one update within a transaction set is allowed per day.

**Transaction Set #1 - Provider Location Address**

- Address1
- Address2
- City

**Transaction Set #2 - Provider Location Phone**

- Phone
- Fax

**Transaction Set #3 - Provider Location Accessibility**

- Accessibility (Yes or No)

**Transaction Set #4 - Provider Office Hours**

- Monday- Sunday (7 Data Attributes for each day)

**Transaction Set #5 - Practitioner Gender**

- Gender

**Transaction Set #6 - Practitioner Office Hours**

- Monday- Sunday (7 Data Attributes for each day).

- Save changes by clicking on the **Save Location** button at the bottom of the screen.



**Note:** If any additional updates are necessary, please contact your Provider Relations Representative.

## Account Details: Add a TIN to an Account

1. Enter the name for the TIN and the Tax ID number.
2. Click **Add TIN**.

[Update Account](#)

### Add a TIN

Please note, provider services will need to validate any additional TINs, which could take several days. You will be notified by email when verification is complete.

Name TIN

Tax ID

[Add TIN](#)

### Add a TIN

We could not find your Tax ID in our system. If you have not already, please visit our public site to join the network.

**⚠ Note:** If the TIN entered is not found the above message appears. Each new TIN added will require verification from the health plan and can take up to 48 hours to complete.

## Managing Users

The **User Management** feature helps Account Managers manage their office staff or users associated with their practice. You can disable or enable users, and manage permissions for your account.

### To Access the User Management Screen

1. Select the **drop-down** arrow next to your name in the upper-right corner.
2. Select **User Management**.
3. Click **Update User** to the right of the user name. The Support User screen appears with the user and profile information for the selected person.

## User Management: Modify User Permissions

1. Select or clear each **Can Access** checkbox. Selections determine what the user can access.
2. Click **Update User** when finished. All changes take effect immediately.

You will return to the Support Users screen where you can manage additional users.

### Account Permissions Definitions

Selecting the following settings gives the user:

Term	Definition
<b>Assessments:</b>	Ability to complete and submit HRA and/or NOP forms
<b>Authorizations:</b>	Ability to view or submit authorizations
<b>Claims:</b>	Ability to view or submit claims
<b>Eligibility:</b>	Access to check eligibility
<b>Health Record:</b>	Access to health history including visits and medications
<b>Manage Account:</b>	Access to all functions within the secure Portal, and Access rights as the Administrator for that TIN

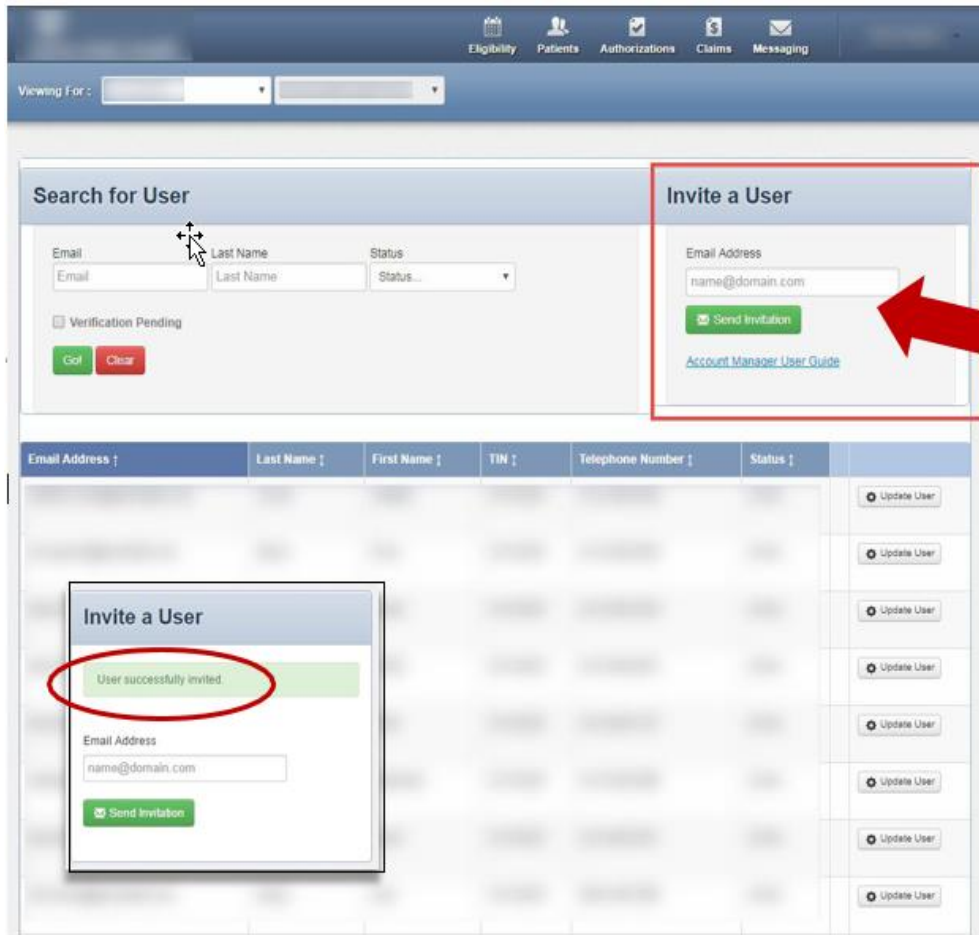
**⚠ Note:** If you clear the **Manage Account** checkbox, the user will not be able to manage other accounts.

## User Management: Invite Others to Join Your Account

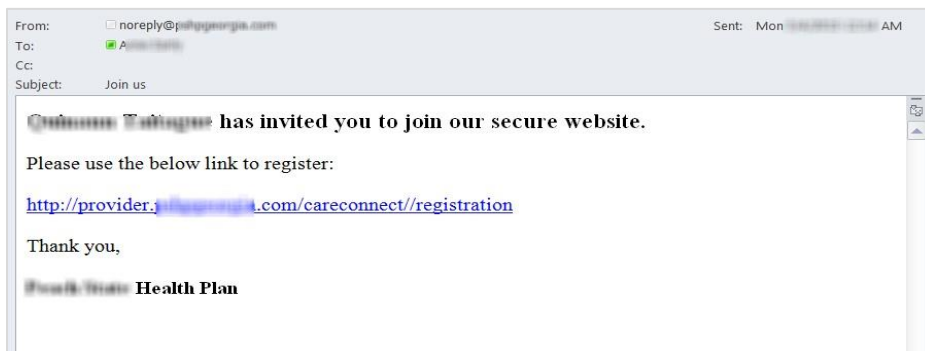
You can invite someone else to join your account. The email is sent from the Support Users screen. Each new invitee must register to use the secure Provider Portal.

### To Invite a User

1. Enter the person's email address under Invite a User.
2. Click **Send Invitation**. Each user should successfully receive an invite notification.



### Sample Provider invitation email:



## Verifying Patient Eligibility

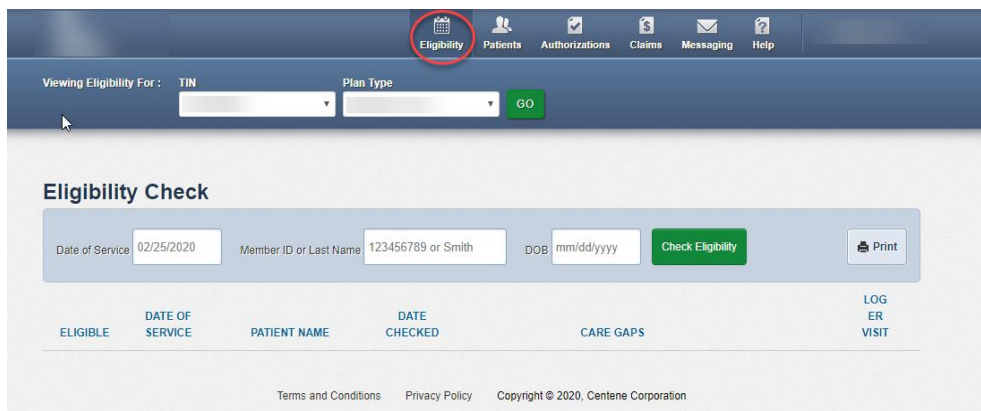
This check verifies if a patient is eligible for care.

### To Access the Eligibility Check Screen

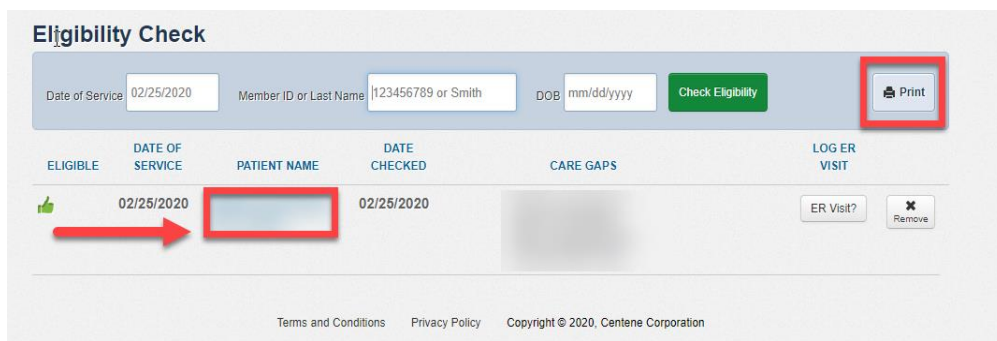
Select **Eligibility** from the top of any screen.

### To Look Up Eligibility Information for a Patient

1. Enter the following information:
  - **Date of Service** (If it is not today's date)
  - **Member ID or Last Name**
  - **Date of Birth** of the patient



2. Click **Check Eligibility**. The green thumbs-up icon verifies that the member is eligible for care. A red thumbs-down icon verifies that the member is not eligible for care.



**This view also contains:**

- Eligibility status
- Date of service
- Patient name
- Date checked
- Care gaps
- ER Visit



Additional Instructions:



- Add an Emergency Room (ER) visit for a patient. This log can alert their Case Managers of recent activity.
- Print the patient’s eligibility details.
- Repeat Steps 1 and 2 above to check the eligibility of another patient.

To Print the Patient’s Eligibility Details

From the Eligibility Check screen, click **Print**. The print window opens.

**Eligibility Check**

Date of Service:  Member ID or Last Name:  DOB:

Example of Eligibility Check printout:

9/27/21, 4:40 PM Medicaid / CHIP Provider Tools

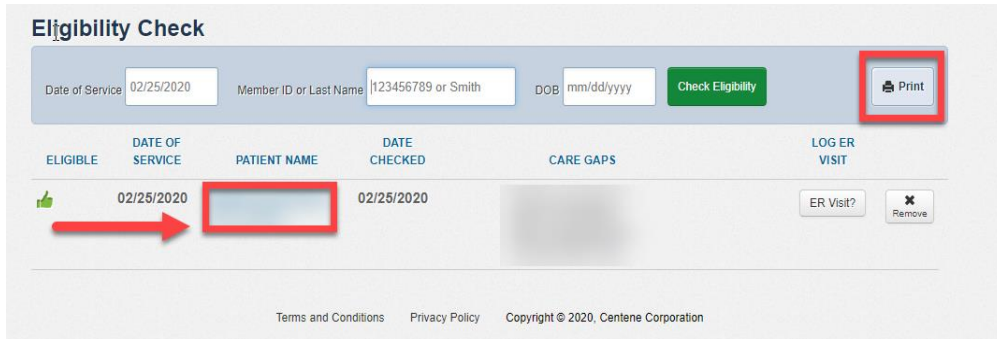
### Eligibility Check

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	RECENT ADT	CARE GAPS	LOG ER VISIT
	09/27/2021	[REDACTED]	09/27/2021	NO	Risk Category Alerts: COPD/Asthma Immunizations not current for age	<input style="border: 1px solid gray;" type="button" value="ER Visit?"/>

<https://support.superiorhealthplan.com/careconnect/eligibility/bulkChecker> 1/1

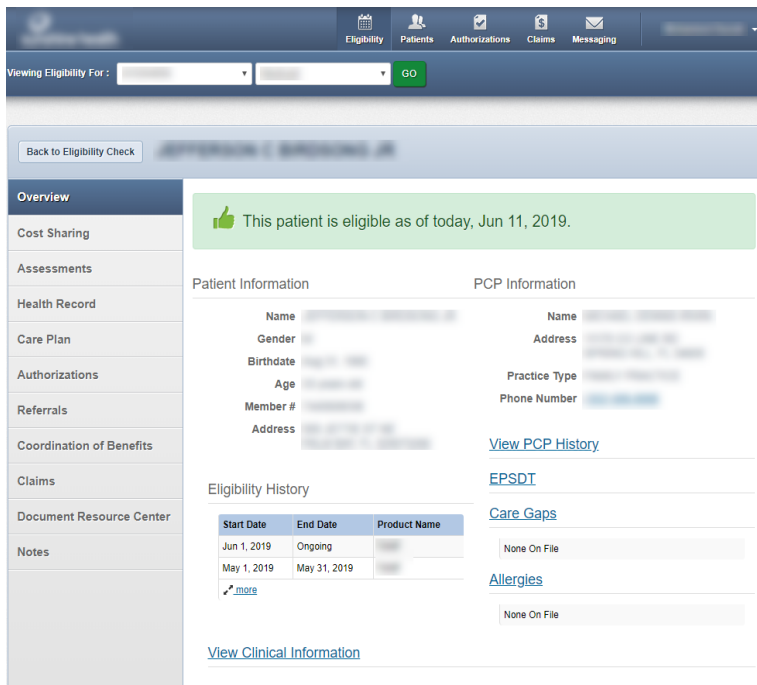
## Managing the Member Record

From the **Eligibility Check** screen, click the name of the member linked under **Patient Name**.



The **Overview** tab displays key information from the member record. You can view the following:

- Member Information
- PCP Information
- Eligibility History
- View PCP History
- EPSDT
- Care Gaps
- Allergies



**Note:** The displayed details are based on patient eligibility.

## Member Record Overview Tab – View Clinical Information

Click **View Clinical Information** at the bottom of the Overview tab. The following details are available:

- Three Most Recent ER Visits
- 5 Top Most Occurring Diagnosis
- Three Most Recent Inpatient Admissions
- Recent Pharmacy Activity
- Three Most Recent Office Visits

[View Clinical Information](#)

**Three Most Recent ER Visits**  
None On File

**Three Most Recent Inpatient Admissions**  
None On File

**Three Most Recent Office Visits**

Primary Diagnosis	Date	Facility/Provider
<a href="#">REGULAR ASTIGMATISM</a>	07/01/2018	Classic Optical Laboratories Inc
<a href="#">REGULAR ASTIGMATISM</a>	07/01/2018	Classic Optical Laboratories Inc
<a href="#">PRESBYOPIA</a>	04/01/2018	Lake Worth Vision Center

**Top 5 Most Occurring Diagnosis**

- UNS HOUSING/ECONOMIC CIRCUMSTANCE
- COUGH
- REGULAR ASTIGMATISM
- MYOPIA
- LACK OF COORDINATION

**Recent Pharmacy Activity**  
None On File

## Member Record Components

Term	Definition
<b>Overview:</b>	The Overview Screen
<b>Cost Sharing:</b>	The patient's portion of health care costs not covered by the plan
<b>Assessments:</b>	Any available assessments for this member will appear as well as Notice of Pregnancy NOP (if gender and age appropriate)
<b>Health Record:</b>	The Health Record tab allows you to view a record of visits or medications for the patient
<b>Care Plan:</b>	Care plans are created by the health plan's case manager to help manage the health of the patient
<b>Authorizations:</b>	The Authorizations tab of the member record allows you to view current authorizations, and create new authorizations for the member
<b>Referrals:</b>	The Referrals tab allows you to send a member to specialized services
<b>Coordination of Benefits:</b>	The Coordination of Benefits (COB) tab displays the other insurance information for the patient
<b>Claims:</b>	The Claims tab of the member record allows you to view any recent claims for the member and also create a new claim

**Note:** Not all plans have all the listed components

## Member Record: Cost Sharing Tab

Select the **Cost Sharing** tab to access cost sharing information from inside the member record.

This sample screens shows a member with cost sharing:

Back to Eligibility Check [Print Cost Sharing](#)

Cost Sharing Summary					
Nursing Facility Information Levels Of Service					
#	EFFECTIVE DATE	END DATE	TYPE	LEVEL	
	09/07/2018	01/07/2019			
	01/08/2019	02/14/2019			
	02/15/2019	04/24/2019			
	04/25/2019	04/30/2019			
	05/01/2019	08/25/2019			
	08/26/2019	12/09/2019			
	12/10/2019	04/10/2020			

Income/Co-Payment (Applied Income)					
#	EFFECTIVE DATE	END DATE	AMOUNT	PERCENT	TYPE
	09/01/2018	05/31/2019			
	06/01/2019	06/30/2019			
	07/01/2019	07/31/2019			
	08/01/2019	08/31/2019			
	09/01/2019	12/31/2019			
	01/01/2020	12/31/9999			

This sample screen shows a Member without cost sharing:

Eligibility Patients Authorizations Claims Messaging

Viewing Eligibility For: [dropdown] [dropdown] GO

Back to Eligibility Check [Link to Member](#)

Cost Sharing Summary	
	This member has no co-pay

## Member Record: Assessments Tab

Select the Assessments tab to access an assessment from inside the member record.


### To Add an Assessment to a Patient's Record

1. Click **Fill Out Now** to the right of the assessment.
2. Enter your responses. Be sure to complete all required fields.
3. Submit the assessment.

This sample screen shows examples of some available Assessments:

The screenshot shows a web interface for a patient's member record. At the top left is a button labeled 'Back to Eligibility Check'. Below it is a navigation menu with the following items: Overview, Cost Sharing, Assessments (highlighted in blue), Health Record, Care Plan, Authorizations, Referrals, Coordination of Benefits, Claims, Document Resource Center, and Notes. The main content area is titled 'Please tell us about your patient's health' and contains a list of assessments. Each assessment has a 'Fill Out Now' button to its right. The assessments listed are: AUDIT C (Optional Screening Tool), DAST (Optional Screening Tool), GAD-7 (Optional Screening Tool), 4-Month HAP (Required Screening Tool), 8-Month HAP (Required Screening Tool), Initial HAP (Required Screening Tool), Health Risk Screening (Required Screening Tool), KATZADL (Required Screening Tool), and PHQ-9 (Required Screening Tool). To the right of this list is a section titled 'Previous Assessments' which contains a yellow message box stating: 'You have not told us about anything yet. Please fill out a form.'

	Please tell us about your patient's health	Previous Assessments
Overview		
Cost Sharing	AUDIT C For Health Home Members- Optional Screening Tool	You have not told us about anything yet. Please fill out a form.
Assessments	DAST For Health Home Members- Optional Screening Tool	
Health Record	GAD-7 For Health Home Members- Optional Screening Tool	
Care Plan	4-Month HAP For Health Home Members - Required Screening Tool	
Authorizations	8-Month HAP For Health Home Members - Required Screening Tool	
Referrals	Initial HAP For Health Home Members - Required Screening Tool	
Coordination of Benefits	Health Risk Screening A Health Risk Assessment helps determine ways to help your patient stay healthy and prevent diseases	
Claims		
Document Resource Center	KATZADL For Health Home Members - Required Screening Tool	
Notes	PHQ-9 For Health Home Members - Required Screening Tool	

 **Note:** Assessments can differ by Health Plan.

To View Previously Submitted Assessment Responses

Submitted assessments appear in a column on the right under **Previous Assessments**. Response information is available to view for any linked assessment.

1. Click the link for the name of the assessment you want to view. The responses display.
2. Click the **Back** button to return to the previous screen.

Back to Eligibility Check

Overview	Please tell us about your patient's health	Previous Assessments
Cost Sharing	AUDIT C For Health Home Members- Optional Screening Tool	<a href="#">Fill Out Now!</a>
<b>Assessments</b>	DAST For Health Home Members- Optional Screening Tool	<a href="#">Fill Out Now!</a>
Health Record	GAD-7 For Health Home Members- Optional Screening Tool	<a href="#">Fill Out Now!</a>
Care Plan	4-Month HAP For Health Home Members - Required Screening Tool	<a href="#">Fill Out Now!</a>
Authorizations	8-Month HAP For Health Home Members - Required Screening Tool	<a href="#">Fill Out Now!</a>
Referrals	Initial HAP For Health Home Members - Required Screening Tool	<a href="#">Fill Out Now!</a>
Coordination of Benefits	Health Risk Screening A health risk assessment helps determine ways to help your patient stay healthy and prevent diseases	<a href="#">Fill Out Now!</a>
Claims	KATZADL For Health Home Members - Required Screening Tool	<a href="#">Fill Out Now!</a>
Document Resource Center	PHQ-9 For Health Home Members- Required Screening Tool	<a href="#">Fill Out Now!</a>
Notes		

Assessment Name	Submit Date
<a href="#">HAP-8 Month V3</a>	12/18/2014
Katz Index of Independence in Activities of Daily	06/10/2014
<a href="#">HAP-4 Month V2</a>	06/10/2014
<a href="#">WA HRS</a>	04/15/2014
HAP-Initial V2	02/27/2014
<a href="#">WA HRS</a>	02/21/2014
<a href="#">Health Risk Assessment_2012</a>	02/18/2014
Katz Index of Independence in Activities of Daily	02/18/2014
<a href="#">Health Risk Assessment_2012</a>	02/18/2014
PL Health Questionnaire-9 (PHQ-9)	02/18/2014
<a href="#">WA HRS</a>	07/25/2012
<a href="#">WA HRS</a>	06/26/2012

Back to Eligibility Check

**WA HRS - 04/15/2014**

Member First Name: *no answer*

Member Last Name: *no answer*

Member ID: *no answer*

Member Date of Birth (mmddyyyy): *no answer*

Name of Person Answering Questions: *no answer*

Relationship to Member: *no answer*

**How are you submitting this form:**

Mail

If we would need to return a call to you, what is the best time and telephone number to reach you?

Morning

Telephone number: *no answer*

Member's Height (Feet/Inches)

5 3

Member's Weight (LB)

*no answer*

Primary language used if other than English

*no answer*

Do you know who your Primary Care Provider (PCP) is?

Yes

PCP's Name:

KAREN JA

PCP's Phone Number:

*no answer*

When did you last see your PCP?

Less than three months ago.

Do you have an appointment scheduled with your PCP?

*no answer*

[Back](#)

**Note:** Text that appears in a gray font indicates the question was not completed.

## Member Record: Health Record Tab

Information displayed in the Health Record is based on the last 24 months of claims data. Allergies records are the exception. Information is self-reported by the member.

### To Access the Member’s Health Record

Click the **Health Record** tab. The following records are available:

- Visits,
- Medications,
- Immunizations,
- Labs, and
- Allergies

### To View Visit Details

The Visits screen is the default record on the Health Record tab. Some examples of patient visits include an office or Emergency Room visit.

1. Click the **Primary Diagnosis** link. More details about that diagnosis code displays.

The screenshot shows the 'Health Record' tab selected in the navigation menu. A table lists several visits with columns for Primary Diagnosis, Date, Visit Type, Claim Type, and Facility/Provider. The first row has a link for 'Ac Supprtv Om W/O Rupt Ear Drum Rt'.

Primary Diagnosis	Date	Visit Type	Claim Type	Facility/Provider
<a href="#">Ac Supprtv Om W/O Rupt Ear Drum Rt</a>	06/02/2019 - 06/03/2019	Emergency Room - Hospital	Medical	
<a href="#">Myopia Bilateral</a>	09/21/2018 - 09/21/2018	Providers Office	Vision	
<a href="#">Enc Rtn Child Hlth Ex W/O Abnm Find</a>	06/21/2018 - 06/21/2018	Providers Office	Medical	
<a href="#">Streptococcal Pharyngitis</a>	12/23/2017 - 12/23/2017	Emergency Room - Hospital	Medical	
<a href="#">Streptococcal Pharyngitis</a>	12/23/2017 - 12/23/2017	Emergency Room - Hospital	Medical	
<a href="#">Acute Pharyngitis Unspecified</a>	12/23/2017 - 12/23/2017	Emergency Room - Hospital	Medical	

2. Click **Back to Visits** to return to the previous page.

The screenshot shows the 'Back to Visits' screen. A table displays visit details with columns for Date, Description, and Code. The first row shows a visit from 06/02/2019 - 06/02/2019 with the description 'Emerg Room /Enterotomy' and code 450.

Date	Description	Code
06/02/2019 - 06/02/2019	Emerg Room /Enterotomy	450
06/03/2019 - 06/03/2019	Urin Pg Test By Visual Color Compar Methd	81025

To View Medications Details

Select the **Medications** tab to view medications prescribed for the member.

Back to Eligibility Check

Overview	<a href="#">Visits</a> <a href="#">Medications</a> <a href="#">Immunizations</a> <a href="#">Labs</a> <a href="#">Allergies</a>															
Cost Sharing																
Assessments																
<b>Health Record</b>	<table border="1"> <thead> <tr> <th>Fill Date</th> <th>Drug Name</th> <th>Dose</th> <th>Quantity</th> <th>Dispensing Pharmacy</th> </tr> </thead> <tbody> <tr> <td>06/03/2019</td> <td>AMOXICILLIN SUS 400/5ML</td> <td>400 MG/5ML</td> <td>150</td> <td>CVS PHARMACY</td> </tr> <tr> <td>12/24/2017</td> <td>AMOXICILLIN SUS 125/5ML</td> <td>125 MG/5ML</td> <td>300</td> <td>CVS PHARMACY</td> </tr> </tbody> </table>	Fill Date	Drug Name	Dose	Quantity	Dispensing Pharmacy	06/03/2019	AMOXICILLIN SUS 400/5ML	400 MG/5ML	150	CVS PHARMACY	12/24/2017	AMOXICILLIN SUS 125/5ML	125 MG/5ML	300	CVS PHARMACY
Fill Date	Drug Name	Dose	Quantity	Dispensing Pharmacy												
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12/24/2017	AMOXICILLIN SUS 125/5ML	125 MG/5ML	300	CVS PHARMACY												
Care Plan																
Authorizations																
Referrals																
Coordination of Benefits																
Claims																
Document Resource Center																
Notes																

To View Immunizations Details

Select **Immunizations** to view any vaccinations received (i.e. Hepatitis, Influenza, etc.).

Back to Eligibility Check

Overview	<a href="#">Visits</a> <a href="#">Medications</a> <a href="#">Immunizations</a> <a href="#">Labs</a> <a href="#">Allergies</a>												
Cost Sharing													
Assessments													
<b>Health Record</b>	<table border="1"> <thead> <tr> <th>Code</th> <th>Description</th> <th>Facility/Provider</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>90471</td> <td>Immuniz Admin; 1/Combo Vaccine/Toxoid</td> <td>Colquitt County Board Of Health</td> <td>09/20/2017 - 09/20/2017</td> </tr> <tr> <td>90686</td> <td>liv4 Vacc No Prsv 0.5 Ml Im</td> <td>Colquitt County Board Of Health</td> <td>09/20/2017 - 09/20/2017</td> </tr> </tbody> </table>	Code	Description	Facility/Provider	Date	90471	Immuniz Admin; 1/Combo Vaccine/Toxoid	Colquitt County Board Of Health	09/20/2017 - 09/20/2017	90686	liv4 Vacc No Prsv 0.5 Ml Im	Colquitt County Board Of Health	09/20/2017 - 09/20/2017
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Care Plan													
Authorizations													
Referrals													
Coordination of Benefits													
Claims													
Document Resource Center													
Notes													



To View Lab Details

1. Select Labs to view testing results (i.e. Comprehensive Metabolic Panel, CBC, etc.).
2. Click the **Procedure** link. More detailed information displays.

Back to Eligibility Check **FRANK S. JONES**

Overview	Visits Medications Immunizations <b>Labs</b> Allergies
Cost Sharing	
Assessments	
<b>Health Record</b>	
Care Plan	
Authorizations	
Referrals	
Coordination of Benefits	
Claims	
Document Resource Center	
Notes	

Date Of Service	Procedure	Ordering Provider
Dec 26, 2013	<a href="#">CULTURE_THROAT</a>	
Apr 29, 2013	<a href="#">CHOLESTEROL_TOTAL</a>	
Apr 29, 2013	<a href="#">HDL_CHOLESTEROL</a>	
Apr 29, 2013	<a href="#">TRIGLYCERIDES</a>	
Apr 29, 2013	<a href="#">LDL-CHOLESTEROL</a>	
Apr 29, 2013	<a href="#">COMPREHENSIVE METABOLIC PANEL</a>	
Apr 29, 2013	<a href="#">HEMOGLOBIN A1c</a>	


To View Allergies Details

Select Allergies to view allergy information.

Back to Eligibility Check **FRANK S. JONES**

Overview	Visits Medications Immunizations Labs <b>Allergies</b>
Cost Sharing	
Assessments	
<b>Health Record</b>	
Care Plan	
Authorizations	
Referrals	
Coordination of Benefits	
Claims	
Document Resource Center	
Notes	

Substance	Reaction	Severity	Source	Allergy Details	Active	Date Identified
Other (zofran)	Hives	Moderate	Member/Self-Reported	None Reported	Yes	Jul 2, 2014
Radiologic Dye	Hives	Moderate	Member/Self-Reported	None Reported	Yes	Jul 2, 2014

 **Note:** Allergies are self-reported and will only display if provided by the member. Examples of allergies include Sulfa, Codeine, etc.

## Member Record: Care Plans Tab

Three types of care plans can display:

- Medical Care Plans (Most common, includes medical terminology)
- Member Centric Care Plans (Self-Management in the title, also displayed in the Member Portal)
- Free Test Care Plans (Created by Cases Manager without a template)

This sample screens shows a member with a Care Plan.

The screenshot displays the 'Care Plan' tab in a member record. On the left is a navigation menu with options: Overview, Cost Sharing, Assessments, Health Record, Care Plan (highlighted), Authorizations, Coordination of Benefits, and Claims. A 'Back to' button is at the top left. The main content area shows 'This member's care plan to treat: Diabetes Self-Management Care Plan' with a 'Case Worker' label and '- OPEN' status. Below this is a section titled 'Follow a healthy diet' with a goal: 'Establish a healthy eating routine by 2013-07-31'. Under 'What we're doing:', there are tasks: 'Meet with dietician to discuss Healthy Diet hints' and 'Log daily food intake'.

This sample screens shows a member without a Care Plan.

The screenshot displays the 'Care Plan' tab for a member with no active care plans. The navigation menu on the left is identical to the previous screenshot, with 'Care Plan' highlighted. A 'Back to Eligibility Check' button is at the top left. The main content area displays the message: 'No Care Plans available for member.'

## Member Record: Authorizations Tab

Create a new Authorization or view previously submitted authorizations from within the member record.

Available Authorization Information:

- Status
- Authorization Number
- Service date
- Diagnosis
- Authorization Type
- Service Provided

### To View Authorization Details

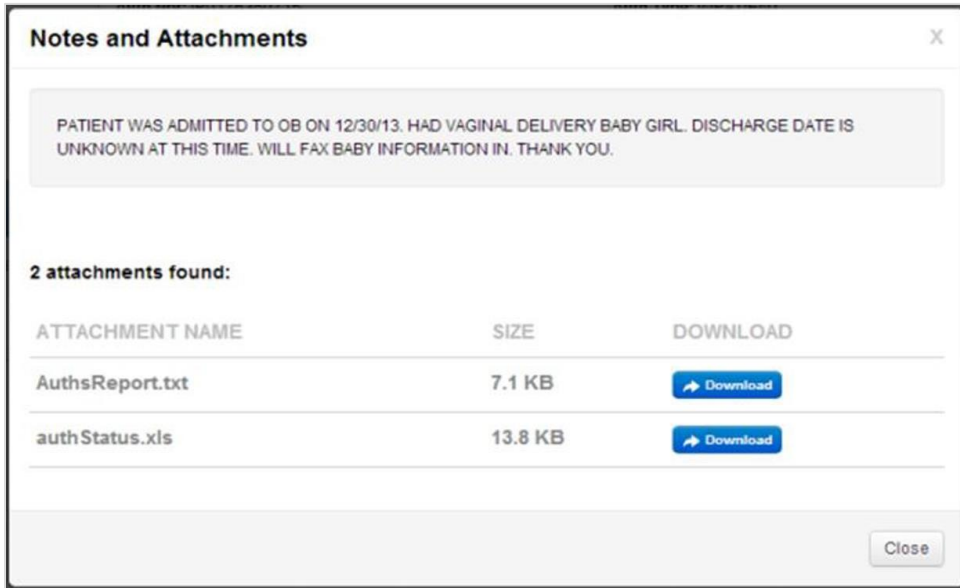
1. Click an authorization number. The details display.

2. Click **View**. The Notes and Attachments screen displays.

Line Item	Service type	Start Date	End Date	Units Req.	Units Apprd	Modality	Location	Status	Medical Necessity	Decision Date
1		12/27/2013	01/27/2014	1	1			APPROVE	Met as requested	01/10/2014
1		12/27/2013	01/27/2014	1	1			PEND	Not Met	12/31/2013
1		12/27/2013	01/27/2014	1	0			VOID		01/16/2014

To Download Notes and Attachments

3. Select **Download** for each file.



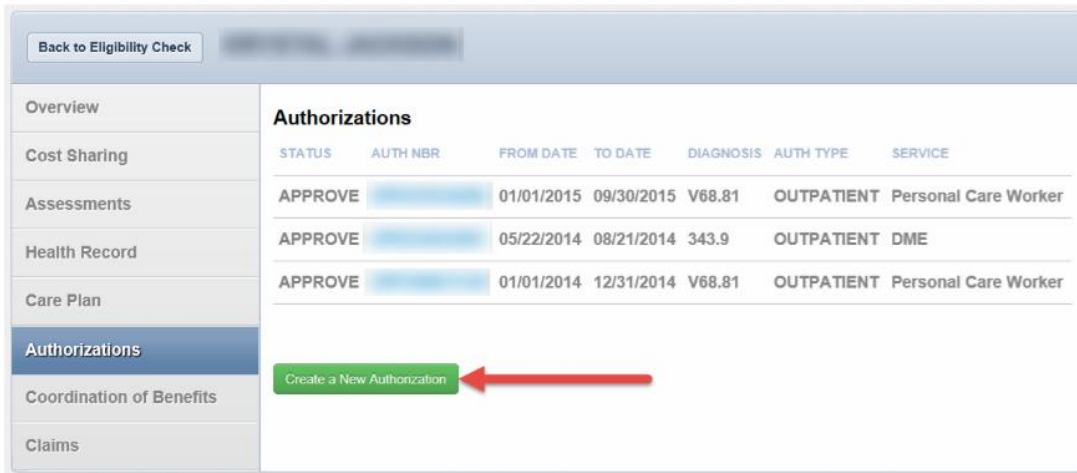
4. Click **Close** when you are done. You are returned to the Authorization Number details screen.
5. Click **Back to Authorization List** when done.

**⚠ Note:** All processed prior authorization requests submitted within the last 90 days will display the status, Authorization ID, member name, date range for services, authorization type and service.

## Member Record: Authorizations Tab – Create a New Authorization

To Create a New Authorization for a Member

Click **Create a New Authorization**. The Authorization For screen opens.

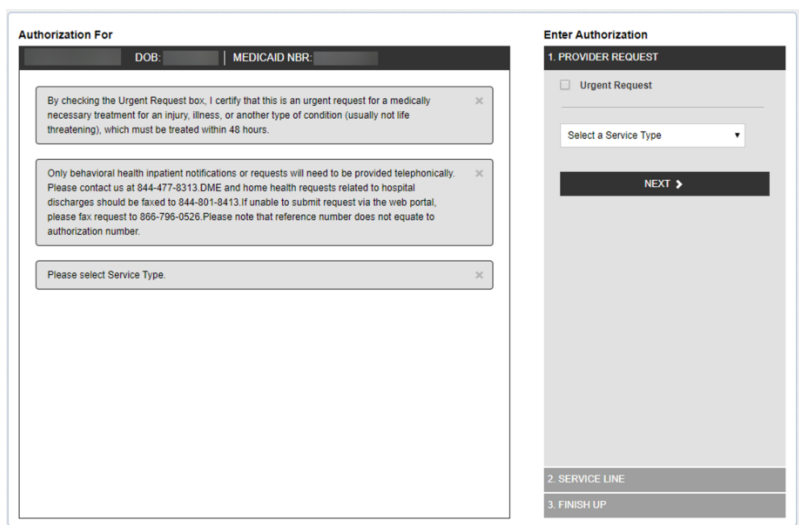


**Note:** You are already viewing a member’s information on this screen. When you click **Create a New Authorization** from here, the Authorization screen appears and the member data is pre-populated.

### About the Authorization Form

The Authorization For form has two sections:

- The left panel:** Displays who the authorization is for and instructional and definition messages.
- The right panel:** is where you enter data for **Provider Request**, **Service Line**, and **Finish Up**.



See also:

- [To Complete the Authorization Form](#)
- [Managing Authorizations](#)

Complete the Authorization Form

Enter details for each step in the right panel.

Step 1: Provider Request.

1. Select the Service Type. The Requesting Provider search box appears.
2. Enter the provider's last name or NPI number. A list of provider names and locations appear.

3. Choose the name of the provider at the location that matches your search.

Select a Provider							
PROVIDER NAME	PHONE NUMBER	TAX ID	PROVIDER LOCATION ADDRESS	NPI	SPECIALTY DESC	IN NETWORK	SELECT
[Blurred]	[Blurred]	*****5895	7809 Massachusetts Avenue , New Port Richey, Florida, 34653	[Blurred]	Community/Behavioral Health	✓	Select
[Blurred]	[Blurred]	*****5895	747 Jenks Avenue Suite D, Panama City, Florida, 32401	[Blurred]	Community/Behavioral Health	✓	Select
[Blurred]	[Blurred]	*****5895	1701 NE 42nd Avenue Suite 301, Ocala, Florida, 34470	[Blurred]	Community/Behavioral Health	✓	Select
[Blurred]	[Blurred]	*****5895	3020 S Florida Avenue Suite 207, Lakeland, Florida, 33803	[Blurred]	Community/Behavioral Health	✓	Select

4. Enter the Primary Diagnosis Code.

To add Additional Diagnosis

5. Click the **+** sign. The diagnosis field appears.
6. Enter the **ICD code** and click **Next**.

*Step 2: Service Line*

7. Scroll down on the right panel. The second service line displays the provider information, service dates, days/visits/units, procedure code, and place of service.



**Note:** To add Additional Service Lines, click on the **+** sign. The Service line field appears. Click **Next**.

Step 3: Finish Up

8. Finish Up auto populates the user’s name, phone, fax and email address.
9. The questionnaire that displays will vary based on the service type selected. Enter N/A if additional information is not applicable.

**Enter Authorization**

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE [EDIT](#)

3. FINISH UP

(813) 290-8560

Fax

(813) 435-2258

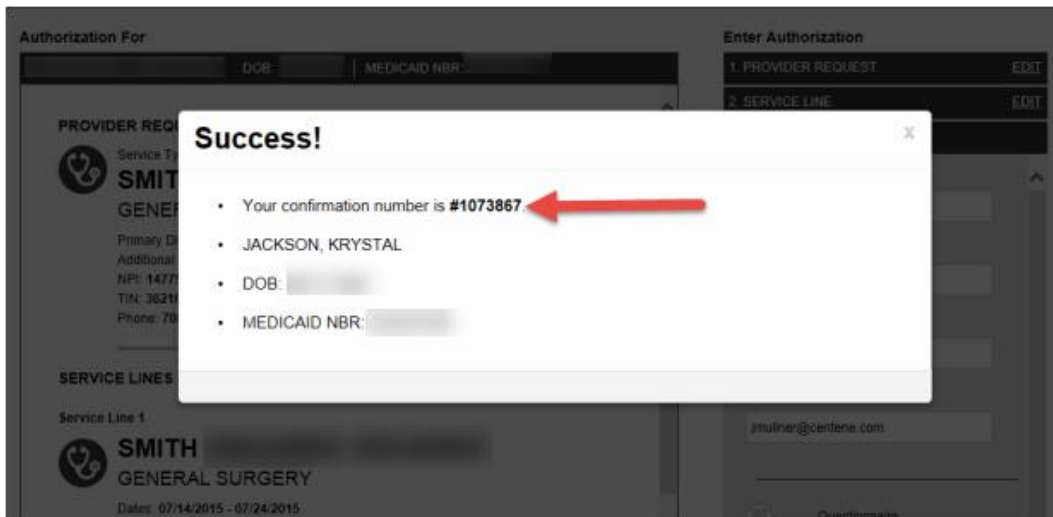
Behavioral Service

Questionnaire

**Attachment:**  
Upload any relevant attachments. (5Mb limit)  
Attachment name cannot contain any spaces or special characters.

No file chosen

10. Click **Submit**. A success message appears. Click the **X** to close the window.



See also:

- [Managing Authorizations](#)



## Member Record: Document Resource Center

Providers can review and upload documents for quality management or medical necessity for a member's record.

### To Access the Document Resource Center

Click the Document Resource Center tab.

### To Upload Documents

1. Select a **Document Category**, and then **Document Type**.
2. Click **Choose File**.

The File Name will be the document name. The file will appear in the browse window.

3. Click **Submit**. The File Accepted success message appears.

To Review Documents

- 1. Click **Document Review**.
- 2. Select the **Document Category**.
- 3. Choose a **Date Range**.
- 4. Click **Search Documents**.

Back to Eligibility Check    Address & Settings

Overview

Cost Sharing

Assessments

Health Record

ADT

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

**Document Resource Center**

Notes

Document Upload    **Document Review**

1. Document Category:

2. Date Range: Start Date:  End Date:   
Date span limited to a 3-month period.

3.

## Member Records: Notes

The Notes section varies by health plan and allows providers to:

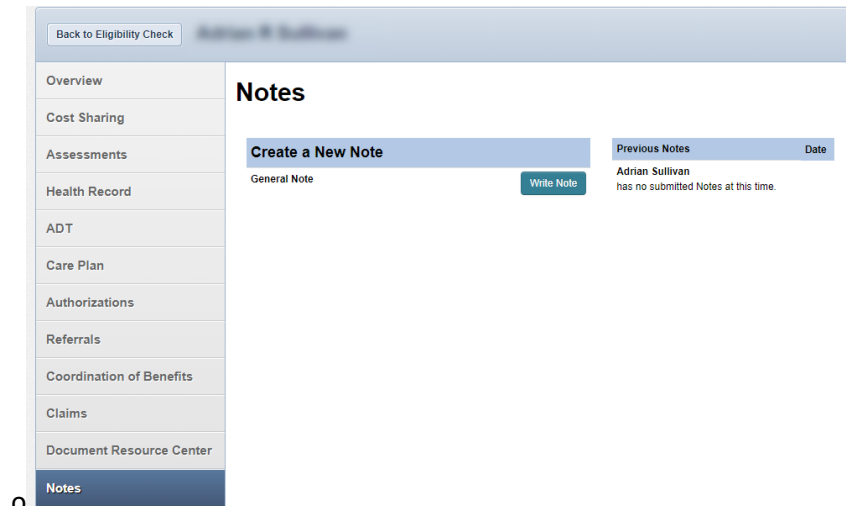
- Upload notes of any kind to a member’s chart.
- Review previously submitted notes already uploaded.

### To Access Notes

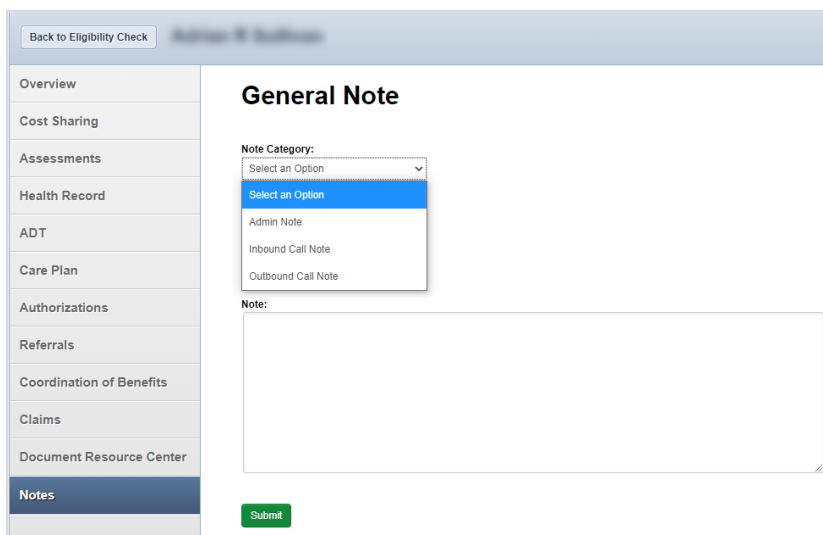
Click the Notes tab. Any previous notes display.

### To Add a New Note

1. Click **Write Note**. The General Note screen appears.



2. Select the **Note Category**.
3. Type your message in the **Note** box.
4. Click **Submit**. Your note appears under Previous Notes.



**Note:** The user will be able to create a generic note for the Health Plan. The Health Plan will be able to follow up on the request and store the note within the health record of the member.

## Member Record: ADT Notifications (For Allwell Health Plans Only)

The Admission Discharge, Transfer (ADT) notifications display for the last 12 months.

To Access Notes Admission Discharge, Transfer (ADT) Notifications  
Click the **ADT** tab.

Back to Eligibility Check
Address # 00000000

<ul style="list-style-type: none"> <li style="background-color: #f0f0f0; padding: 5px;">Overview</li> <li style="background-color: #f0f0f0; padding: 5px;">Cost Sharing</li> <li style="background-color: #f0f0f0; padding: 5px;">Assessments</li> <li style="background-color: #f0f0f0; padding: 5px;">Health Record</li> <li style="background-color: #2c5e8c; color: white; padding: 5px;"><b>ADT</b></li> <li style="background-color: #f0f0f0; padding: 5px;">Care Plan</li> <li style="background-color: #f0f0f0; padding: 5px;">Authorizations</li> <li style="background-color: #f0f0f0; padding: 5px;">Referrals</li> <li style="background-color: #f0f0f0; padding: 5px;">Coordination of Benefits</li> <li style="background-color: #f0f0f0; padding: 5px;">Claims</li> <li style="background-color: #f0f0f0; padding: 5px;">Document Resource Center</li> <li style="background-color: #f0f0f0; padding: 5px;">Notes</li> </ul>	<h3 style="margin: 0;">ADT Notifications</h3> <p style="font-size: small; margin: 5px 0;">Admission Discharge &amp; Transfer Notifications display for the last 12 months</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d9e1f2;"> <th style="text-align: left; font-size: x-small;">DATE &amp; TIME</th> <th style="text-align: left; font-size: x-small;">TYPE</th> <th style="text-align: left; font-size: x-small;">FACILITY NAME</th> <th style="text-align: left; font-size: x-small;">DISCHARGE DISPOSITION</th> </tr> </thead> <tbody> <tr> <td style="font-size: x-small;">2021-04-23T18:59:00.000Z</td> <td style="font-size: x-small;">Emergency Room Visit</td> <td style="font-size: x-small;">PALM BAY HOSPITAL</td> <td></td> </tr> <tr> <td style="font-size: x-small;">2021-04-23T18:59:00.000Z</td> <td style="font-size: x-small;">Emergency Room Visit</td> <td style="font-size: x-small;">PALM BAY HOSPITAL</td> <td></td> </tr> <tr> <td style="font-size: x-small;">2021-04-23T22:24:00.000Z</td> <td style="font-size: x-small;">Emergency Room Discharge</td> <td style="font-size: x-small;">PALM BAY HOSPITAL</td> <td></td> </tr> <tr> <td style="font-size: x-small;">2021-08-03T19:03:00.000Z</td> <td style="font-size: x-small;">Emergency Room Visit</td> <td style="font-size: x-small;">PALM BAY HOSPITAL</td> <td></td> </tr> <tr> <td style="font-size: x-small;">2021-08-03T19:03:00.000Z</td> <td style="font-size: x-small;">Emergency Room Visit</td> <td style="font-size: x-small;">PALM BAY HOSPITAL</td> <td></td> </tr> <tr> <td style="font-size: x-small;">2021-08-03T23:04:00.000Z</td> <td style="font-size: x-small;">Emergency Room Discharge</td> <td style="font-size: x-small;">PALM BAY HOSPITAL</td> <td></td> </tr> <tr> <td style="font-size: x-small;">2021-08-03T19:03:00.000Z</td> <td style="font-size: x-small;">Emergency Room Visit</td> <td style="font-size: x-small;">PALM BAY HOSPITAL</td> <td></td> </tr> </tbody> </table>	DATE & TIME	TYPE	FACILITY NAME	DISCHARGE DISPOSITION	2021-04-23T18:59:00.000Z	Emergency Room Visit	PALM BAY HOSPITAL		2021-04-23T18:59:00.000Z	Emergency Room Visit	PALM BAY HOSPITAL		2021-04-23T22:24:00.000Z	Emergency Room Discharge	PALM BAY HOSPITAL		2021-08-03T19:03:00.000Z	Emergency Room Visit	PALM BAY HOSPITAL		2021-08-03T19:03:00.000Z	Emergency Room Visit	PALM BAY HOSPITAL		2021-08-03T23:04:00.000Z	Emergency Room Discharge	PALM BAY HOSPITAL		2021-08-03T19:03:00.000Z	Emergency Room Visit	PALM BAY HOSPITAL	
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2021-04-23T22:24:00.000Z	Emergency Room Discharge	PALM BAY HOSPITAL																															
2021-08-03T19:03:00.000Z	Emergency Room Visit	PALM BAY HOSPITAL																															
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2021-08-03T19:03:00.000Z	Emergency Room Visit	PALM BAY HOSPITAL																															

## Member Record Tab: Managing Referrals

### To Access Referrals

Click the Referrals tab.

Back to Eligibility Check **Adrian R Sullivan**

**Overview**

Cost Sharing

Assessments

Care Plan

Authorizations

**Referrals**

Coordination of Benefits

Claims

👍 This patient is eligible as of today, Sep 9, 2021

[Print Eligibility Overview](#)

Patient Information

PCP Information

Name: [REDACTED] UNASSIGNED PCP

Gender: M

Birthdate: [REDACTED] [View PCP History](#)

Age: 4 years old

Member #: [REDACTED]

Address: [REDACTED] [EPSDT](#)

Eligibility History

Start Date	End Date	Product Name
Jan 1, 2021	Ongoing	Foster Care

### To Submit a Referral for a Member

1. Select an available specialized service option from the **Source** drop-down menu. The Referral form auto-populates the date, time and users name.

Back to Eligibility Check **Adrian R Sullivan**

**Overview**

Cost Sharing

Assessments

Care Plan

Authorizations

**Referrals**

Coordination of Benefits

Claims

\*Source: Please select Source

\*Date: Behavioral Health Referral to Health Plan

Last Name, First Name: [REDACTED]

Phone Number, Extension: ( ) - - - -

Additional Comments: [REDACTED]

**Submit**

2. Complete the phone number. Provide an extension if needed.
3. Additional comments are optional.
4. Click **Submit**. You will receive a message that your referral was submitted successfully.

Back to Eligibility Check **Adrian R Sullivan**

**Overview**

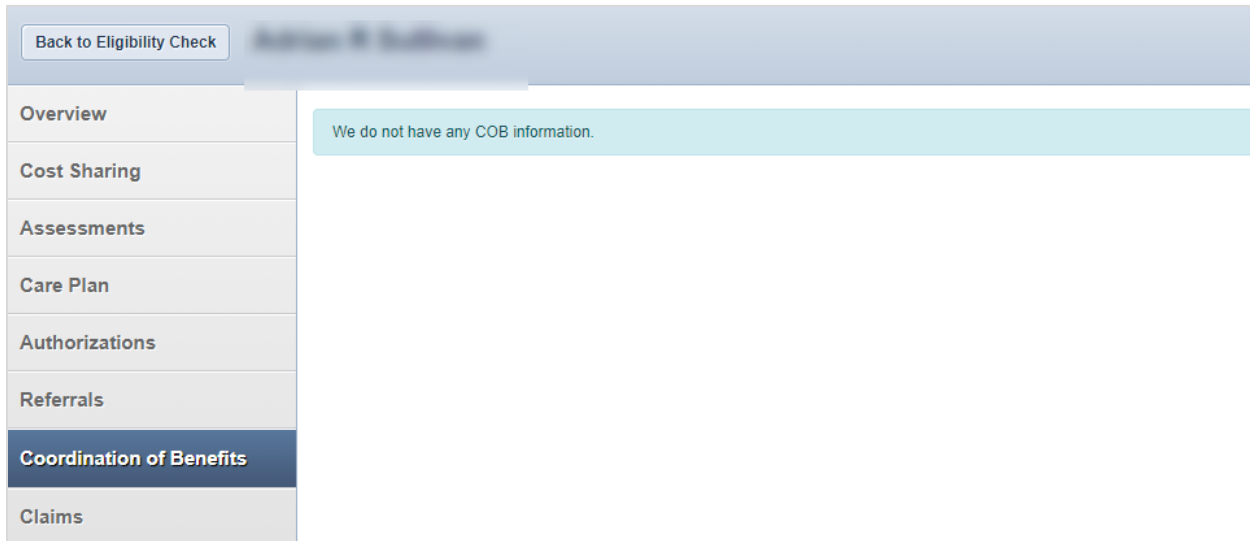
Cost Sharing

**Your request is submitted Successfully**

## Member Record Tab: Viewing Coordination of Benefits (COB)

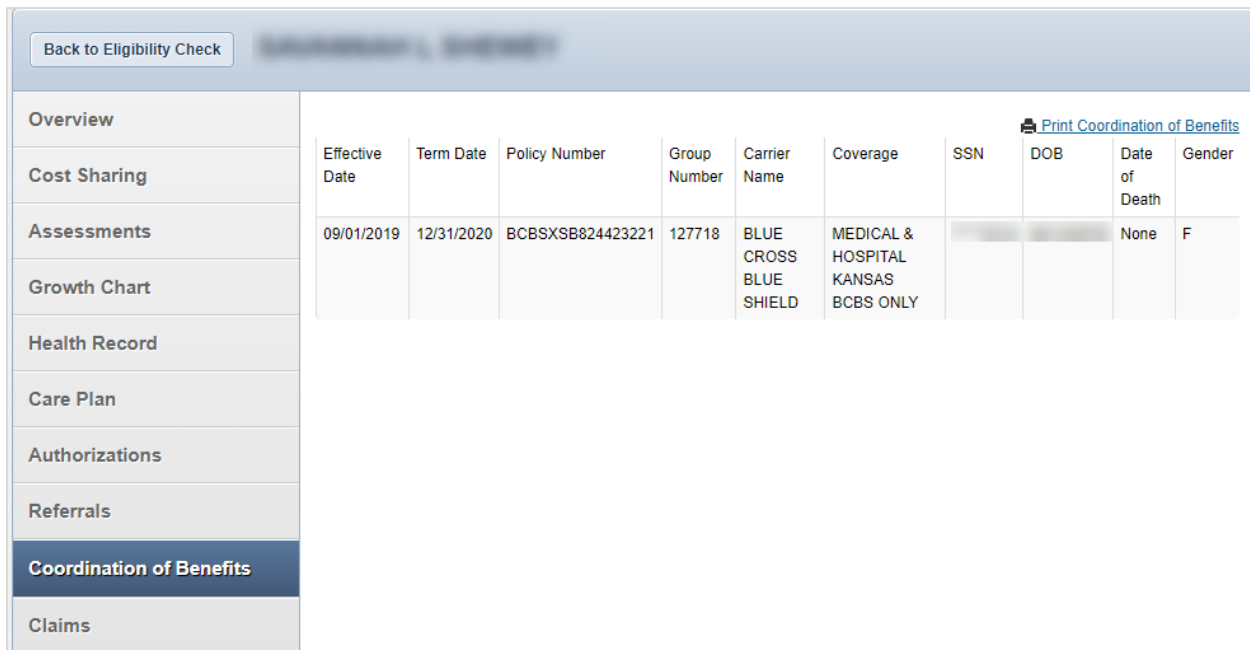
### To Access the Members Coordination of Benefits Information

1. From inside the patient record, select **Coordination of Benefits**.
2. The following screen appears. This view shows no COB information is available for this member.



The screenshot shows a navigation menu on the left with the following items: Overview, Cost Sharing, Assessments, Care Plan, Authorizations, Referrals, **Coordination of Benefits** (highlighted), and Claims. The main content area displays a light blue message box stating: "We do not have any COB information."

The COB will display termed and active insurances as seen below.



The screenshot shows the same navigation menu as above. The main content area displays a table of insurance information. A "Print Coordination of Benefits" link is visible in the top right of the table area.

Effective Date	Term Date	Policy Number	Group Number	Carrier Name	Coverage	SSN	DOB	Date of Death	Gender
09/01/2019	12/31/2020	BCBSXSB824423221	127718	BLUE CROSS BLUE SHIELD	MEDICAL & HOSPITAL KANSAS BCBS ONLY			None	F

## Member Record Tab: Managing Claims

The Claims tab of the patient record allows you to view any recent claims for the patient. You can also manually create a new claim. If the patient has any recent claims, they display on this tab.

### To Access Claim Information

From inside the patient record, select the **Claims** tab.

### To Create a New Centers for Medicare and Medicaid Services (CMS) Claim

1. Click **Create a New Claim** on the right.

Back to Eligibility Check    Address & Address

Overview

Cost Sharing

Assessments

Care Plan

Authorizations

Referrals

Coordination of Benefits

**Claims**

**Claims: Recent** Create a New Claim

The last one month of claims for this member are displayed below. To view more claims for this member, [visit the Claims page](#).

Show claims for: 2021    September    GO View most recent month

CLAIM NO. ↑	REF/ACCT NO. ↑	DOS RANGE ↑	PAYMENT DATE ↑	RECEIVED DATE ↑	BILLED/PAID ↑	STATUS ↑
<a href="#">U243FHE00826</a>	1215124-38156	08/15/2021 - 08/15/2021		08/31/2021	\$969.60 / \$969.60	PAID

One item found. Page 1/1 1

2. Select the type of claim you want to create.

- [CMS 1500 \(Professional Claim\)](#)
- [CMS UB-04 \(Institutional Claim\)](#)

Eligibility    Patients    Authorizations    Claims    Messaging

Viewing Claims For: TIN    Plan Type    GO    Upload EDI    Create Claim

Choose Claim for

Choose a Claim Type

**CMS 1500**  
Professional Claim →

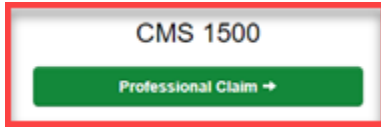
**CMS UB-04**  
Institutional Claim →

UPDATE: In order to be compliant with ICD-10 regulations, Cenpatco will require claims with discharge dates or service dates on or after October 1, 2015, be coded with ICD-10 codes. This change applies to the date of service on the claim, not the submission date. For more information, please refer to the applicable State provider page on cenpatco.com and click on the ICD-10 countdown box.

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## Member Record Tab: Managing Claims (Professional Claims)

1. Select Professional Claim by clicking CMS 1500.



2. In the General info section, enter the Patient's Account Number, and the other information related to the patient's condition.

The screenshot shows the "General Info" section of a "Professional Claim for Adrian Sullivan". It includes a progress bar and a "Next" button. Below the "Next" button is a "Required field" section with the following fields: "Patient's Account Number" (text input with "XXXXXXXXXX"), "Statement Dates" (From MM/DD/YYYY To MM/DD/YYYY), "Date of current illness, Injury, Pregnancy (LMP)" (Select Type... dropdown and MM/DD/YYYY input), and "Other Date" (Select Type... dropdown and MM/DD/YYYY input).

### Claim Field Tabs

The displayed line items on this electronic form reflect those on a CMS 1500 paper form.

Hovering over the Claim Field Tabs to the right of the screen will help determine what field on the CMS 1500 paper claim form from which to obtain the information.

## Member Record Tab: Claims – Adding Diagnosis Codes

3. On row 21, enter the Diagnosis Codes for the patient.
4. Click the **Add** button to save the code.

The screenshot shows the "Diagnosis Codes" section of a "Professional Claim for Adrian Sullivan". It includes a progress bar and "Back" and "Next" buttons. Below the buttons is a "Required field" section with the following elements: "ICD Version Indicator\*" with a radio button selected for "ICD 10", a note "Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.", "Diagnosis Codes\*" with a text input containing "XXXX e.g. V873" and an "Add" button, and a note "(Enter diagnosis code and click on Add button)". A "21." tab is visible on the right side of the form.

**Note:** Click the Coordination of Benefits Button (If applicable) or the **Next** button.



Member Record Tab: Claims – Adding Coordination of Benefits

5. Click **Add Coordination of Benefits** to include any payments made by another insurance carrier (If applicable).



The following screen will appear:

Professional Claim for [Member Name] Your Progress

THIS SECTION:  
**Diagnosis Codes**  
 Diagnosis Code and Additional Insurance information.

← Back Next →

\* Required field

ICD Version Indicator\*  ICD 10 Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.

Diagnosis Codes\*   (Enter diagnosis code and click on Add button) 21.

**Primary Insurance**

Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.

Carrier Type\*  9d

Policy Number\*  9a

← Back Next →

6. Enter the **Carrier Type** and **Policy Number**.
7. Click **Next**.

*Adding Service Lines to the Claim*

- In the Service Lines screen, add your service line information.
  - ⚠ When entering charges for the service billed, include the decimal point to ensure the data displays accurately. For example, 99.0 converts to \$99.00.

To add additional service lines

- Click the **Save/Update** button on the right
- Click the **New Service Line** button on the left. You can enter up to 99 service lines.
- Click **Next**.

Professional Claim for XXXXXX
Your Progress

THIS SECTION:

## Service Lines

Enter maximum of 50 service lines.

← Back
Provider Details →

Total: \$0.00

+ New Service Line

Your added service lines will appear here.

\* Required field Save / Update

### Add New Service Line

Dates of Service\* From  To  24.a

---

Place of Service\* Select... 24.b

---

Emergency  Yes  No 24.c EMG

---

Procedure Code\*  24.d

---

Modifiers  Add Please enter the modifier and click the Add button.

Adding Provider Information to the Claim

12. Enter referring and billing provider information.
13. Add rendering only if different from the billing.
14. Enter Service Facility location.
15. Click **Next**. The Attachments screen appears.

Professional Claim for: XXXXXX
Your Progress

THIS SECTION:  
**Providers**  
 Providers on this claim.

← Back
Next →

\* Required field

**Referring Provider**

NPI 17.

Find Provider

Last Name or Organizational Name

Find Provider

Qualifier

Select...

First Name

First Name

**Rendering Provider** Only enter rendering provider information if not the same as Billing Provider information.

NPI

Find Provider

Taxonomy #

XXXXXXXXXX

Tax ID 24.j

Find Provider

Last Name or Organizational Name

Find Provider

First Name

Clear X

**Billing Provider**

Tax ID 33.

593655895

Name\*

NPI

Taxonomy \*

Address\*

City\*

State\*

Select...

Zip\*

**Service Facility Location** Same As Billing Provider

Name

Address

XXXXXXXXXX

NPI 32.

XXXXXXXXXX

City

XXXXXXXXXX

State

Select...

Zip

XXXXX

← Back
Next →

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### Adding attachments to claim

You can attach any documents to the claim as desired. Skip this section and click **Next** if you do not have any attachments.

#### To Attach a File

16. Click **Choose File** in the Attachments section.
17. From the **Attachment Type** drop-down list, select the type of file you want to attach.
18. Click **Attach**. **Note:** You must click Attach for each file you submit.
19. Click **Next**. The Review screen appears.

**For best results, use the following guidelines:**

- ⚠ You can attach the following files types: .jpg, .Tif, .Tiff, and .pdf.
- ⚠ The file attachment size cannot be larger than 30MB.
- ⚠ The file cannot be password protected.

Professional Claim for [blurred] Your Progress

THIS SECTION:  
**Attachments**  
Add attachments to the claim (30MB limit). Supported types are .jpg, .tif, .pdf and .tiff

← Back If there are no attachments, click Next. Next →

**Attachments**

*\*Do NOT send password protected files. You must click ATTACH for each file being submitted.*

File\* Attachment Type\*

No file chosen

There are no attached files.

← Back If there are no attachments, click Next. Next →

## Review Claim

All the information that you entered is summarized on the Review screen.

1. Make any needed edits.
2. Click **Submit** when you are done.

Professional Claim for [Redacted]
Your Progress

THIS SECTION:  
**Review**  
Please review your claim and submit.

← Back
Submit →

### Almost done!

You can go back to review your claim or submit now.

Claim Id: [Redacted]  
 Member Record Number: [Redacted]  
 Member Claim Amount Pa: [Redacted]  
 Patient's Account Number: [Redacted]

**General Info** [Edit](#)  
 Statement From Date: 09/01/2021  
 Statement To Date: 09/01/2021  
 Date of current illness, injury, pregnancy (LMP):  
 Other Date:  
 Hospitalized From:  
 Hospitalized To:  
 Additional Claim Information:  
 Outside Lab?: No  
 Outside Lab Amount:  
 Prior Authorization Number:  
 CLIA Number:

**Diagnosis Codes and Primary Insurance** [Edit](#)

Diagnosis Codes  
 V873 -- PERSON INJURED IN COLLISION BETWEEN CAR AND BUS (TRAFFIC)

**Service Lines** [Edit](#)

Line	From	To	Place	EMG	Proc	Diagnosis	Amount	Units/Days	Family Plan	EPSDT	NDC	Supplemental Info
1	09/01/2021	09/01/2021	11	No	H0031	V873	\$100.00	1.0	No			

**Providers** [Edit](#)

Provider Type	Name	Tax ID	NPI	Taxonomy	Address
Referring Provider	Families First of Florida,				
Rendering Provider					
Billing Provider	Families First of Florida,				

Service Facility Location

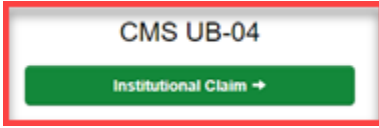
**Attachments**

← Back
Submit →

See also: [CMS UB-04 \(Institutional Claim\)](#)

Member Record Tab: Managing Claims (CMS UB-04 Institutional Claim)

1. Select Institutional Claim by clicking the CMS UB-04.



2. In the **General** section, enter the admission, discharge and other information related to the patient's condition.

The screenshot shows the 'General' section of the 'Institutional Claim for [Patient Name]' form. The form includes fields for Patient Control #, Medical Record #, Type Of Bill, Statement Dates, Prior Payments, and Prior Authorization Number. Below these are sections for Admission (Time, Type, Source) and Discharge (Status, Hour). A 'Next →' button is visible at the bottom right of the form. On the right side, a vertical sidebar contains 'Claim Field Tabs' numbered 3.a through 16. A dashed blue box highlights the tabs from 3.a to 16.

**Claim Field Tabs**

The displayed line items on this electronic form reflect those on a UB-04 paper form.

Hovering over the Claim Field Tabs to the right of the screen will help determine what field on the UB-04 paper claim form from which to obtain the information.

Add a New Service Line

- In the Service Lines screen, add your service line information.
  - ⚠ When entering charges for the service billed, include the decimal point to ensure the data displays accurately. For example, 99.0 converts to \$99.00.

To add additional service lines

- Click the **Save/Update** button on the right
- Click the **New Service Line** button on the left. You can enter up to 99 service lines.
- Click **Next**. The Provider Details screen displays.

**Institutional Claim fo** Your Progress

THIS SECTION: **Service Lines** Enter maximum of 97 service lines.

← Back Next →

**Total: \$0.00**  
Non-Covered : \$0.00

**+ New Service Line**

Your added service lines will appear here.

**\* Required field** Save / Update

**Add New Service Line**

Revenue Code\* 0XXX e.g. 867 42.

HCPCS / Rate / HIPPS Code  44.

NDC  Guide

Modifiers XX  Please enter the modifier and click the Add button.

Service Date\* MM/DD/YYYY 45.

Service Units\* XXXX 46.

Charge Amount\* XXXXX.XX 47.

Non-Charge Amount XXXXX.XX 48.

- In the **Provider Details** screen, enter billing and other information in the appropriate sections.
- Click **Next** when done. The Additional Insurance screen appears.

THIS SECTION: **Provider Details** Basic information about the patient's status and condition.

← Back Next →

Please note: a taxonomy code is required for all claim submissions

Per TMHP billing guidelines, the billing provider and rendering or attending provider cannot be the same. Claims filed with the same billing and rendering or attending provider may be subject to denial.

\* Required field

**Billing Provider**

NPI\*  56.

Taxonomy\*  57.

**Pay-to Provider**  2.

NPI\*  Taxonomy\*  IRS/Tax ID Number\*  Pay-To Name\*

Address\*  City\*  State\*  Zip\*

**Attending Provider** 76.

NPI\*  Taxonomy\*  First Name\*  Last Name\*

IRS/Tax ID Number\*

**Rendering Provider** 81.

Please enter rendering provider information (if not the same as Attending Provider information).

NPI

First Name  Last Name  Organization Name

**Operating Provider** 77.

NPI  Taxonomy  First Name  Last Name

IRS/Tax ID Number

**Other Operating (Physician) Provider** 78.

NPI  Taxonomy  First Name  Last Name

IRS/Tax ID Number  Qualifier

**Other Provider** 79.

NPI  Taxonomy  First Name  Last Name

IRS/Tax ID Number

← Back Next →



- 9. In the **Additional Insurance** screen, enter primary insurance details as needed. If there is no additional insurance, you may skip this section.
- 10. Click **Next**. The Attachments screen appears.

Institutional Claim for [Member Name] Your Progress [Progress Bar]

THIS SECTION:  
**Additional Insurance** Enter additional insurance details.

**You may skip this section if there is no additional insurance.** [Next →](#)

**Primary Insurance**  
Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.

Carrier Type	Select...	50
Policy Number	XXXXXXXX	60
Amount Allowed	XXXX.XX	
Deductible	XXXX.XX	
Copay	XXXX.XX	
Co-Insurance	XXXX.XX	
Amount Paid	XXXX.XX	
Denial Reasons	Select... Amount XXXX.XX	<a href="#">Add Denied Reason</a>

[← Back](#) [Next →](#)

### Adding attachments to claim

You can attach any documents to the claim as desired. Skip this section and click **Next** if you do not have any attachments.

#### To Attach a File

11. Click **Choose File** in the Attachments section.
12. From the **Attachment Type** drop-down list, select the type of file you want to attach.
13. Click **Attach**. **Note:** You must click Attach for each file you submit.
14. Click **Next**. The Review and Submit screen appears.

#### For best results, use the following guidelines:

- ⚠ You can attach the following files types: .jpg, .Tif, .Tiff, and .pdf.
- ⚠ The file attachment size cannot be larger than 30MB.
- ⚠ The file cannot be password protected.

The screenshot displays the 'Attachments' section of an Institutional Claim form. At the top, there is a progress bar labeled 'Your Progress' with several green arrows and one red arrow. Below this, the section is titled 'Attachments' with the instruction 'Add attachments to the claim (30MB limit)'. A note states 'Supported types are .jpg, .tif, .pdf and .tiff'. The main area contains a yellow bar with 'Back' and 'Next' buttons and the text 'If there are no attachments, click Next.' Below this is the 'Attachments' section with a red warning: '\*Do NOT send password protected files. You must click ATTACH for each file being submitted.' The form includes a 'File\*' field with a 'Choose File' button and 'No file chosen' text, and an 'Attachment Type\*' dropdown menu with 'Select Type...' and a downward arrow. An 'Attach' button is positioned to the right. A light blue bar below the form states 'There are no attached files.' At the bottom, another yellow bar with 'Back' and 'Next' buttons and the text 'If there are no attachments, click Next.' is visible.

## Review Claim

All the information that you entered is summarized on the Review screen.

1. Make any needed edits.
2. Click **Submit** when you are done.

Institutional Claim for [blurred]
Your Progress

THIS SECTION:  
**Review and Submit** Please review your claim before submitting.

### Almost done!

Submit →

You can go back to review your claim or submit now.

Claim ID: [blurred]

**General Info** [Edit](#)

Patient Control #: 657964  
 Medical Record #:  
 Type Of Bill: 111  
 Statement From Date: 09/01/2021  
 Statement To Date: 09/01/2021  
 Prior Payments:  
 Prior Authorization Number:  
 Admission Date: 09/01/2021  
 Admission Hour: 09  
 Admission Type: 1  
 Admission Source: 7  
 Discharge Status: 01  
 Discharge Hour: 01

**Provider Details** [Edit](#)

Provider Type	NPI	Taxonomy	Name	Tax ID	Address (1)	Address (2)	City	State	Zip
Billing Provider	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]
PayTo Provider	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]

Provider Type	NPI	Taxonomy	First Name	Last Name	IRS/Tax ID Num	Organization
Attending Provider	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]
Rendering Provider	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]
Operating Provider	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]
Other Operating Provider	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]
Other Provider	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]

**Service Lines** [Edit](#)

Line	Revenue Code	HCPCS/Rate/HIPPS	Modifiers	NDC	Date	Units	Charge amount	Non-Charge Amount
1	867				09/01/2021	1.0	\$280.00	

**Primary Insurance** [Edit](#)

- COB Carrier Type:
- COB Policy Number:
- COB Amount Allowed:
- COB Deductible:
- COB Co-Pay:
- COB Co-Insurance:
- COB Amount Paid:

**Diagnosis Codes** [Edit](#)

Admitting Diagnosis Code : V837  
 Principal Diagnosis Code : V837  
 Principal POA Indicator :  
 External Cause of Injury Code (ECI) :  
 Prospective Payment Code :

**Attachments** [Edit](#)

← Back
Submit →

See also: [CMS 1500 \(Professional Claim\)](#)

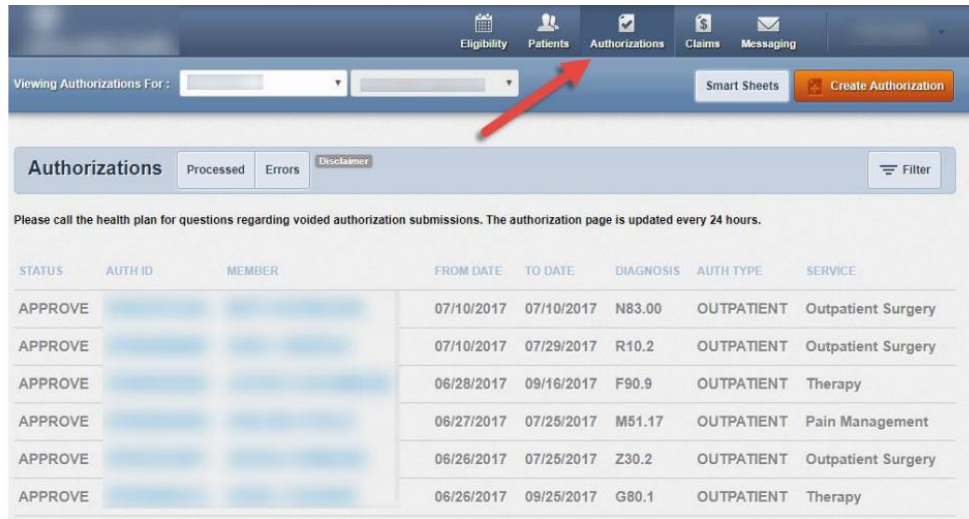
Page 50 of 79

## Managing Authorizations

Submitted authorizations display for 90 days. Prior Authorization requests may take 24-48 hours to display on the Authorization list.

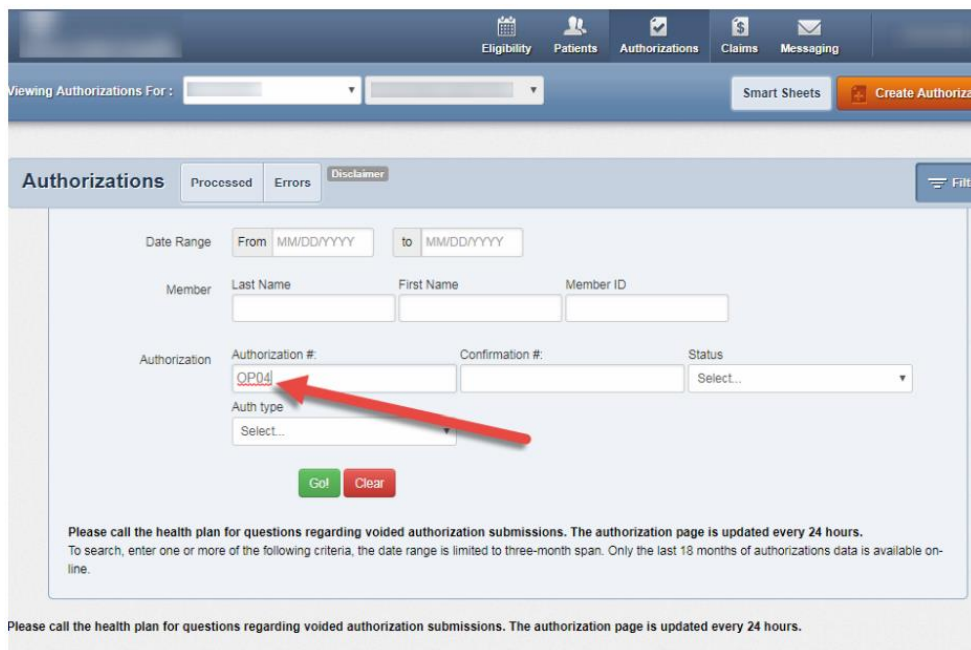
### To Access Authorizations

Select **Authorization** from the Main Toolbar. Authorizations appear based on TIN and Product selected.



### To Search for an Authorization

1. Click **Filter** at the upper-right of the Authorizations screen.
2. Enter the authorization number in the **Authorization #** box.
3. Click **Go**.



### Authorizations: View a Prior Authorization Request

1. Enter the *Authorization Number* or the *Confirmation Number*.
2. Click **Go**.

The screenshot shows a search form for authorizations. It includes fields for Date Range, Member information (Last Name, First Name, Member ID), and Authorization details (Authorization #, Confirmation #, Status, Auth type). The 'Authorization #' field is populated with 'OPO94'. A red box highlights the 'Authorization #' and 'Confirmation #' fields, and a red arrow points to the 'Go' button.

The screenshot shows the 'Authorizations' table with a single row of data. The status is 'APPROVE'.

STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE			06/27/2017	08/26/2017	I15.9	OUTPATIENT	DME

### Authorizations: View a Prior Authorization Request (Processed)

All processed prior authorization requests submitted within the last 90 days will display the following information:

- Status
- From and To Date
- Service
- Authorization ID
- Diagnosis
- Member Name
- Authorization Type

The screenshot shows the 'Authorizations' table with five rows of data. The status is 'APPROVE' for all rows.

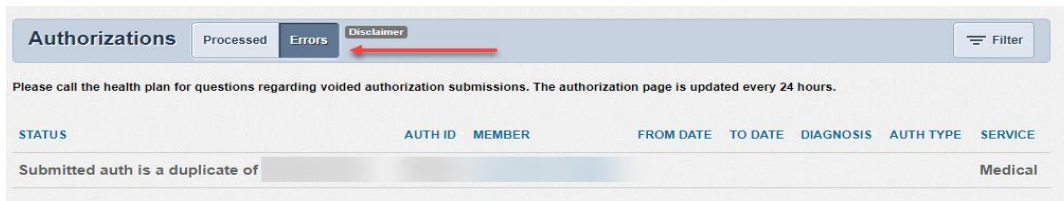
STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE			04/02/2020	12/31/9999	M17.12	INPATIENT	Surgical
APPROVE			03/25/2020	04/25/2020	Z83.2	OUTPATIENT	Genetic Testing & Counseling
APPROVE			03/17/2020	04/16/2020	H72.01	OUTPATIENT	Outpatient Surgery
APPROVE			03/10/2020	12/31/9999	T22.391A	INPATIENT	Surgical
PEND			03/09/2020	06/07/2020	Z83.2	OUTPATIENT	Genetic Testing & Counseling

## Authorizations: View a Prior Authorization Request (Errors)

Prior authorization requests that are submitted with errors are not processed. Links to the requests display on the Authorizations Error screen. Providers can fix the errors and resubmit the request.

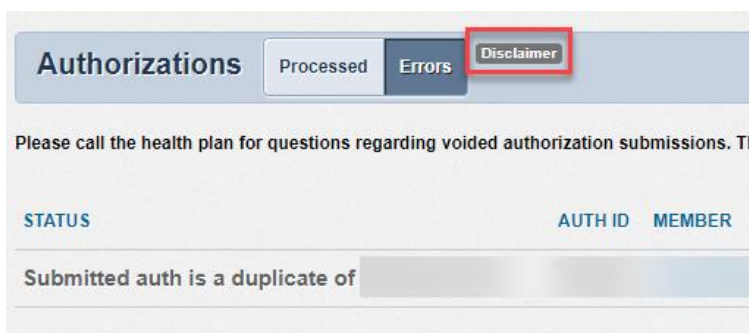
The following details about the request display:

- Status
- From and To Date
- Service
- Authorization ID
- Diagnosis
- Member Name
- Authorization Type

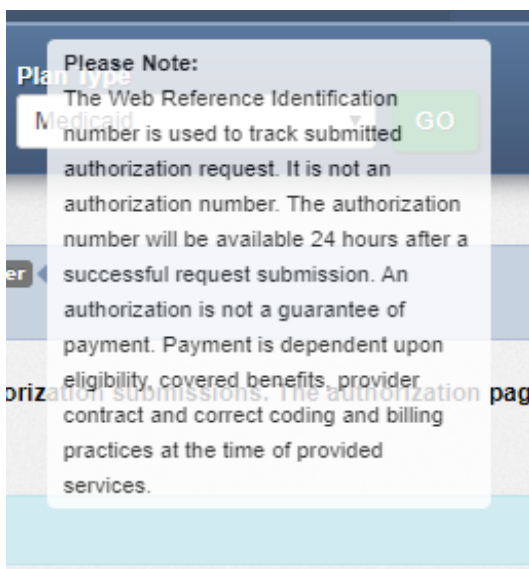


### To View the Disclaimer

Place the mouse cursor over **Disclaimer**.



The disclaimer text displays.

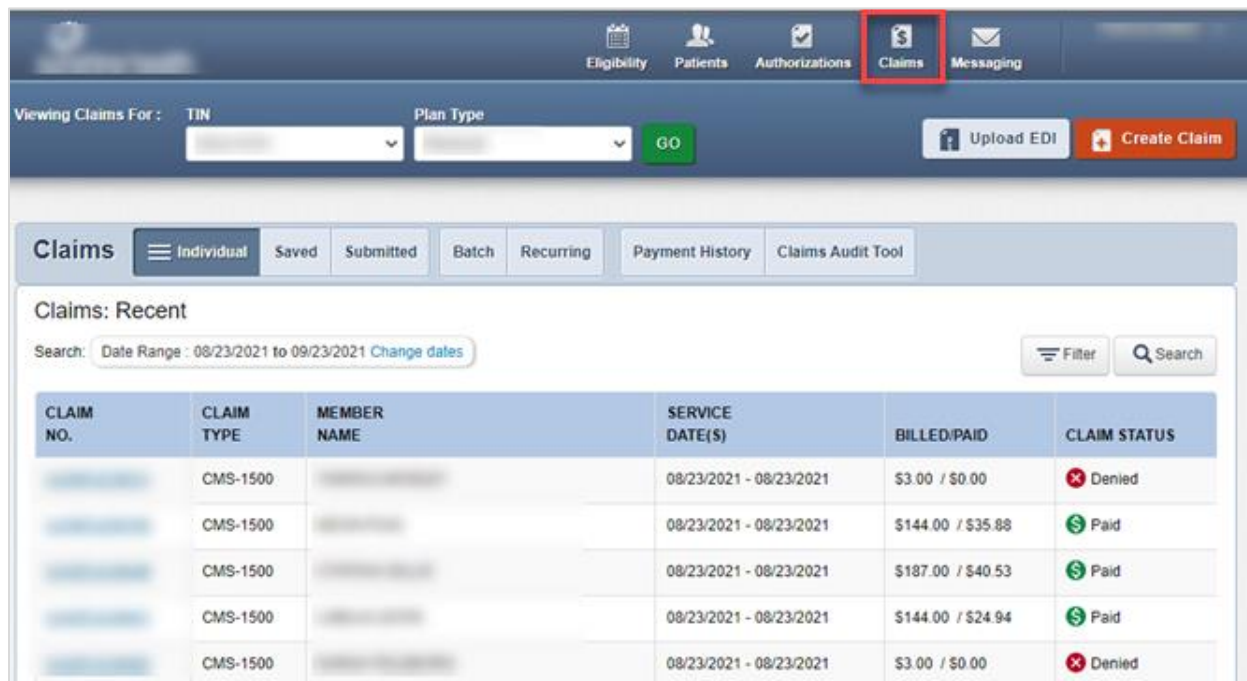


## Managing Claims

The Claims tool allows you to create new claims. You can also view details and manage all aspects of your saved and submitted claims.

### To Access Claim

Select **Claims** from the top of any screen.



### Claims Overview

Term	Definition
<b>Individual Claims:</b>	List of manual claims submitted using the Provider Portal, Clearing House, or paper
<b>Saved Claims:</b>	Saved drafts of manual claims that have errors or missing information that have not been completed
<b>Submitted Claims:</b>	List of manual claims submitted using the Provider Portal only
<b>Batch ClaimsL</b>	List of 837 electronic claim files uploaded from the Provider Portal to EDI. Only the last 24 months of batch files are available online.
<b>Upload EDI Claims:</b>	Tool to upload 837 electronic claim files from your shared drive or other location.
<b>Recurring Claims:</b>	Bulk uploaded claims template for long-term care. Complete only a few key fields. All other required service line details are auto-completed for you.
<b>Payment History Claims:</b>	Provides Explanation Of Payments (EOP) documents for claims. Payment history is available up to 24 months.
<b>Claims Audit Tool:</b>	Clear Claim Connection is the claims audit tool used to look up Procedure Code, Quantity, Modifiers, Date and Place of Service, and Diagnosis for a claim proactively before you submit or retroactively after you submit a claim to get coverage details.

## Managing Individual Claims

### To Access Individual Claims

Select **Individual**. A list of individual claims appears.

The screenshot shows the 'Claims' section of the provider portal. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims (highlighted with a red box), and Messaging. Below the navigation, there are filters for 'Viewing Claims For' (TIN and Plan Type) and buttons for 'Upload EDI' and 'Create Claim'. The main content area is titled 'Claims: Recent' and includes a search bar with a date range of 08/23/2021 to 09/23/2021. Below the search bar is a table of recent claims.

CLAIM NO.	CLAIM TYPE	MEMBER NAME	SERVICE DATE(S)	BILLED/PAID	CLAIM STATUS
[Redacted]	CMS-1500	[Redacted]	08/23/2021 - 08/23/2021	\$3.00 / \$0.00	Denied
[Redacted]	CMS-1500	[Redacted]	08/23/2021 - 08/23/2021	\$144.00 / \$35.88	Paid
[Redacted]	CMS-1500	[Redacted]	08/23/2021 - 08/23/2021	\$187.00 / \$40.53	Paid
[Redacted]	CMS-1500	[Redacted]	08/23/2021 - 08/23/2021	\$144.00 / \$24.94	Paid
[Redacted]	CMS-1500	[Redacted]	08/23/2021 - 08/23/2021	\$3.00 / \$0.00	Denied

The following claim details display:

- Claim Number
- Member Name
- Claim Status
- Service Dates
- Billed/Paid

### Managing Individual Claims Details

#### To View Details of the Individual Claim

From the **Individual** tab, click the blue claim number to open that claim.

The following screen appears. You can see which services were covered or denied, view the payment amount, date and check number.

The screenshot shows the 'Claim Details' page for a denied claim. At the top, there is a 'Back to Claims' button and the title 'Claim Details'. Below this, the claim status is shown as 'Denied' with a red 'X' icon. There are four action buttons: '+ Copy Claim', 'Correct Claim', 'Void/Recoup Claim', and 'Reconsider Claim'. A progress bar shows the claim status: 'Claim Accepted' (green checkmark), 'In Process' (green checkmark), and 'Denied' (red 'X'). Below the progress bar, there are four sections: 'Member', 'Provider', 'Claim', and 'Most Recent Payment'. The 'Member' section includes Member Name, Member ID, and Member DOB. The 'Provider' section includes Ref/Acct No., Servicing Provider, and Servicing NPI. The 'Claim' section includes DOS Range (08/23/2021 - 08/23/2021), Received Date (08/26/2021), and Billed Amount (\$3.00). The 'Most Recent Payment' section includes Payment Date, Paid Claim Amount (\$0.00), Check/EFT Number, Total Check Amount (\$0.00), and Check Dated. At the bottom, there is a 'Service Lines' section with a table of service details.

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Paid Amount	Payment Date	Check/EFT Number	Status	Payment Codes
1	08/23/2021	36415	Z13228		50	\$3.00	\$0.00	09/02/2021		⊗ DENY	IE



*To Copy an Existing Claim*

Copying a claim copies the information in the existing claim into a new claim.

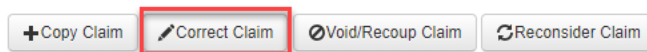
1. Click **Copy Claim**. The copied claim information appears.



2. Proceed through the claims screens updating any information that may differ.
3. Click **Next** to move through the screens.
4. Review your claim and click **Submit**.

*To Correct a Claim*

5. Click the **Correct Claim** button.



6. Proceed through the claims screens correcting the information that you may have omitted when the claim was originally submitted.
7. Continue clicking **Next** to move through the screens required to resubmit.
8. Review the claim information and click **Submit**.

**⚠ Note:** Claim Corrections are not available if the provider data on the first submission is different from the corrected claim submission.

*To Void/Recoup a Claim (If applicable)*

Use Void/Recoup claims when you want to void an original claim that has already been processed, and request a full recoupment of payment.

1. Click **Void/Recoup Claim**.



2. Under the claim review the appropriate information that should be voided and click submit

**⚠ Note:** Use the Void/Recoup function to void an original claim and fill recoup of payment. The Correct Claim function should be used to correct how an original claim was submitted.

*To Reconsider Claim*

Use reconsider claim to provide documentation in support of a paid or denied claim. Providers are not to use this tool for Appeals.

1. Click **Reconsider Claim**. The Reconsider Claim pop-up window displays.

**Note:** The Reconsider Claim button will be visible unless a web-initiated reconsideration is already in progress.

**Claim Details**

Claim # [REDACTED] : Denied

Buttons: +Copy Claim, Correct Claim, Void/Recoup Claim, **Reconsider Claim**

Progress: Claim Accepted (✓) → In Process (✓) → Denied (✗)

Member	Provider	Claim	Most Recent Payment	
Member Name:	Ref/Acct No.:	DOS Range: 08/23/2021 - 08/23/2021	Payment Date:	Paid Claim Amount: \$0.00
Member ID:	Servicing Provider:	Received Date: 08/26/2021	Check/EFT Number:	Total Check Amount: \$0.00
Member DOB:	Servicing NPI:	Billed Amount: \$3.00	Check Dated:	

**Service Lines**

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Paid Amount	Payment Date	Check/EFT Number	Status	Payment Codes
1	08/23/2021	36415	Z13228		50	\$3.00	\$0.00	09/02/2021		✗ DENY	IE

2. From the **Reconsider Claim Type** drop-down menu, select the type of reconsideration you want to submit. **Note:** Options vary by plan type.

**Reconsider Claim**

Claim No: [REDACTED]

A submission on this form will be processed as a Reconsideration. To submit a claim Appeal, please refer to your Provider Manual. For example, if an authorization was not obtained and/or you need a review of medical necessity, an Appeal must be submitted. [Hide example](#)

Reconsideration Type: Select Reconsideration Type...

Buttons: Cancel, Submit Reconsideration

**Reconsider Claim**

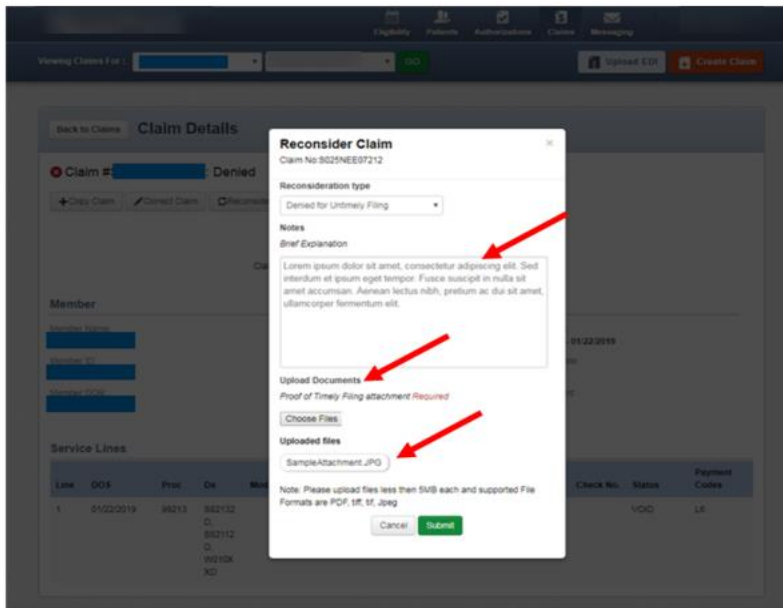
Claim No: [REDACTED]

Reconsideration type: [REDACTED]

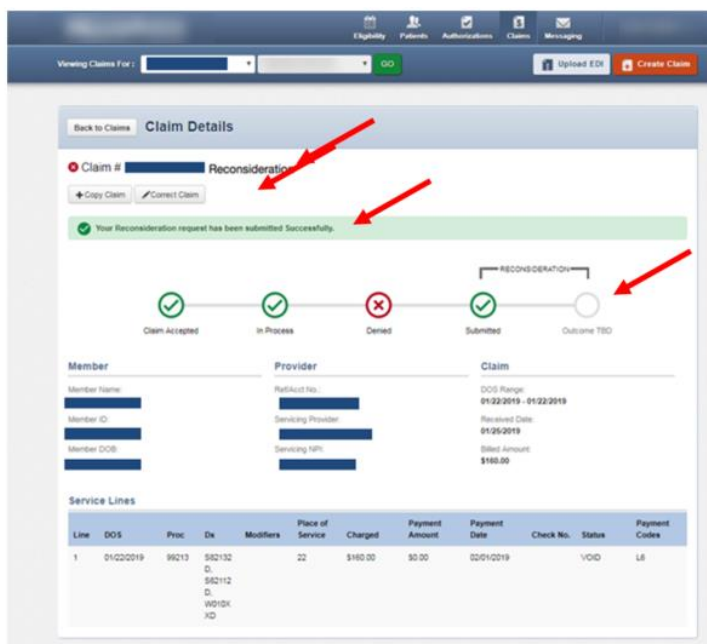
- Select Reconsideration Type
- Select Reconsideration Type
- Denied for a Global/Unbundled Procedure
- Denied for Untimely Filing
- Denial Related to an Authorization
- Claim Paid at the Incorrect Amount
- Coordination of Benefits (COB)
- Co-insurance/Co-pay/Deductible Applied Incorrectly
- Emergency Department Services
- Consent Form
- Denial Related to Itemized Billing
- Other

3. Add notes or upload documents as required.

**Note:** The Reconsider Claims form is dynamic; depending on the type of reconsideration selected, notes and/or documents may be required.



4. Click **Submit** to close the Reconsideration Claim form screen.
5. Click **Submit Reconsideration**. Upon submission, a success banner displays.
6. The Claims Tracker screen updates to reflect that a reconsideration is in progress. **Note:** The Reconsider Claim button is no longer available. Once processing begins, the reconsidered claim details appear on the tracker.



*Managing Claims Reconsideration Details*

Once processing begins on a reconsidered claim, the Reconsideration Details table appears on the Claims Tracker.

Accessing Reconsideration Claims Details

From the **Individual** tab, click the blue claim number to open that claim.

Viewing Claims For: [ ] [GO] [Upload EDI] [Create Claim]

Back to Claims **Claim Details**

Claim #: [ ]: Reconsideration

+ Copy Claim / Correct Claim / Void/Recoup Claim

RECONSIDERATION

Claim Accepted (✓) In Process (✓) Denied (✗) Submitted (✓) Outcome TBD (○)

**Reconsideration Details**

Created Date	Type	Current Status	Reference #
01/01/2019	General Correspondence	New	[ ]
02/02/2019	COB Correspondence	Resolved	[ ]

**Member**  
 Member Name: [ ]  
 Member ID: [ ]  
 Member DOB: [ ]

**Provider**  
 Ref/Acct No.: [ ]  
 Servicing Provider: [ ]  
 Servicing NPI: [ ]

**Claim**  
 DOS Range: 10/10/2018 - 10/10/2018  
 Received Date: 10/10/2018  
 Billed Amount: \$300.24

Check the status of a Reconsidered Claim


View available onscreen details and attachments.

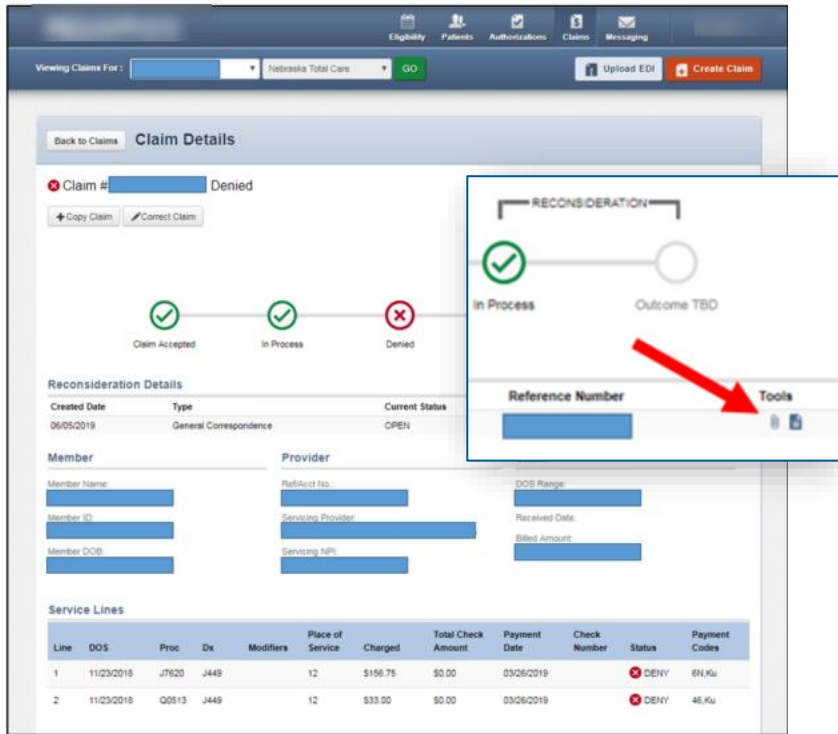
The Reconsideration Details table has one entry per reconsideration and includes:

- Created Date
- Type
- Current Status
- Reference#

To View and Upload Additional Attachments

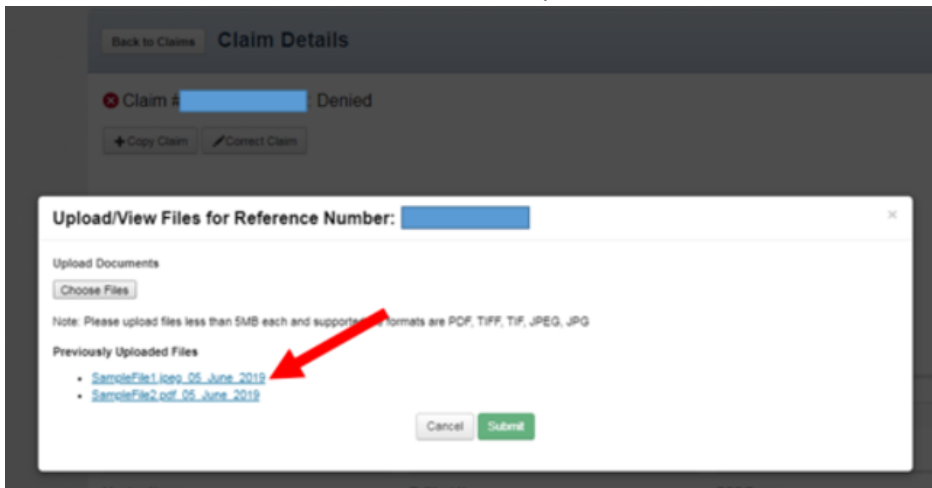
From the Reconsiderations Details table you can view and attach additional references to on-going reconsideration cases.

1. Select the Paperclip  icon. The Upload/View Files window appears.



To View Previously Uploaded Files

2. Click the document name to download and open the file.

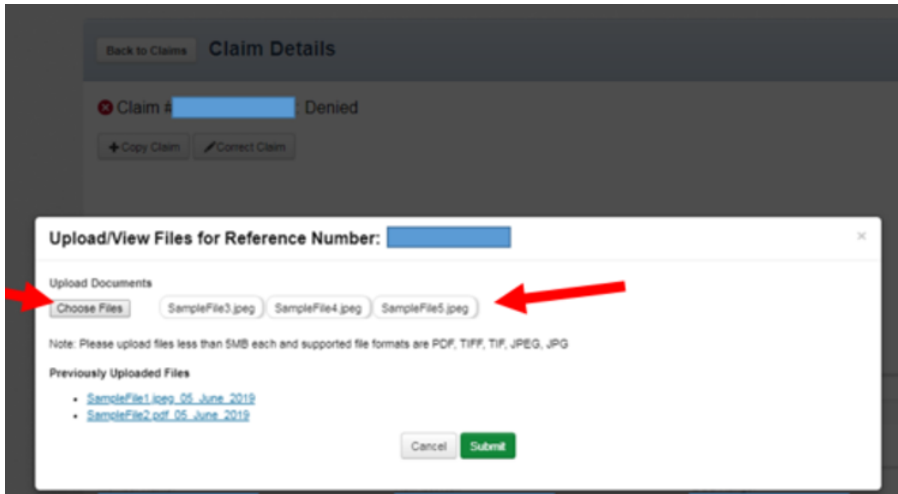


- ⚠ Files will appear with the original file name and appended date. Special characters are removed.

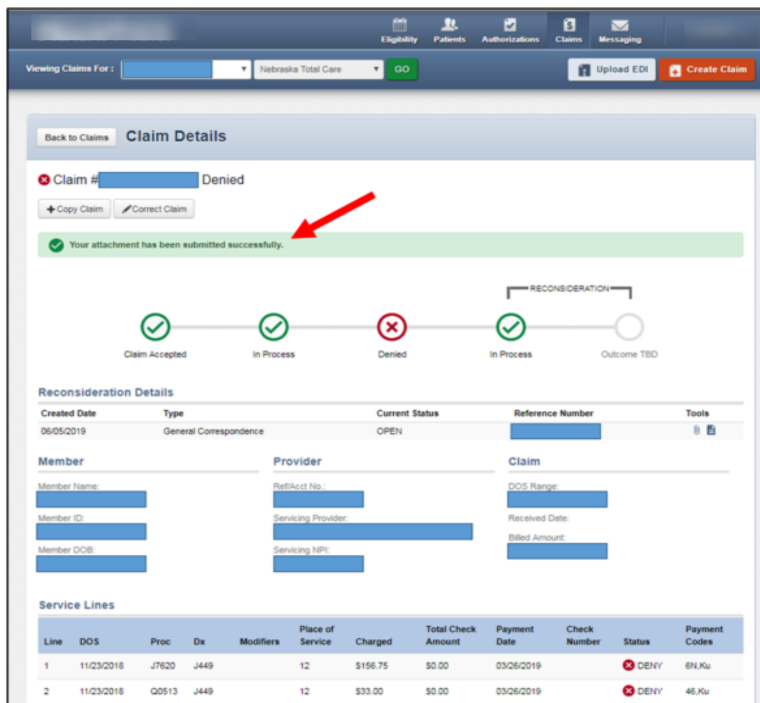
*To Upload Additional Files*

3. Click to the **Choose Files** button and select the documents you want to upload. Selected files appear next to the Choose Files button.

**Note:** Each submission is limited to 5 files. There is no limit on the number of successive submissions



4. Click **Submit**. Upon successful upload of files, a success banner displays.



To view or upload additional attachments, repeat Steps 1 through 4.

*To View the Reconsideration Letter*

Select the Reconsideration Letter icon to view Acknowledge and Outcome Letters associated to a reconsideration case.

- Click on the document icon to open the letter. Frequency of letters is dependent on CenPas operations.

The screenshot displays the 'Claim Details' page for a denied claim. The status is 'Denied' with a red 'X' icon. A 'Reconsideration' process is shown with a flow: Claim Accepted (green check), In Process (green check), Denied (red X), In Process (green check), and Outcome TBD (grey circle). A 'Tools' dropdown menu is open, showing a document icon highlighted with a red arrow.

**Reconsideration Details**

Created Date	Type	Current Status
06/05/2019	General Correspondence	OPEN

**Member**

Member Name: [Redacted]  
 Member ID: [Redacted]  
 Member DOB: [Redacted]

**Provider**

Referral No: [Redacted]  
 Servicing Provider: [Redacted]  
 Servicing NPI: [Redacted]

**Reference Number**: [Redacted]

**Tools**: [Document Icon]

**Service Lines**

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Total Check Amount	Payment Date	Check Number	Status	Payment Codes
1	11/23/2018	J7620	J449		12	\$156.75	\$0.00	03/06/2019		DENY	6N,KU
2	11/23/2018	Q0513	J449		12	\$33.00	\$0.00	03/06/2019		DENY	46,KU

## View and Edit Saved Claims

You can view and edit drafts of Professional or Institutional claims.

To view saved claims

Select **Saved**. The following screen appears.

Claims listed below have missing information or contain errors. Click 'Edit' to view a claim, then fix any errors or complete it before submitting.

DATE CREATED ↑	CLAIM TYPE ↑	CLAIM ID ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑		
08/29/2021	CMS-1500					\$178.01	<a href="#">Edit</a>	<a href="#">Delete</a>
08/29/2021	CMS-1500					\$178.00	<a href="#">Edit</a>	<a href="#">Delete</a>
08/29/2021	CMS-1500					\$178.00	<a href="#">Edit</a>	<a href="#">Delete</a>
08/29/2021	CMS-1500					\$178.00	<a href="#">Edit</a>	<a href="#">Delete</a>
08/29/2021	CMS-1500					\$178.00	<a href="#">Edit</a>	<a href="#">Delete</a>
08/29/2021	CMS-1500					\$178.00	<a href="#">Edit</a>	<a href="#">Delete</a>
08/29/2021	CMS-1500					\$178.00	<a href="#">Edit</a>	<a href="#">Delete</a>
08/29/2021	CMS-1500					\$178.00	<a href="#">Edit</a>	<a href="#">Delete</a>
08/29/2021	CMS-1500					\$178.00	<a href="#">Edit</a>	<a href="#">Delete</a>
08/29/2021	CMS-1500					\$178.00	<a href="#">Edit</a>	<a href="#">Delete</a>

### Types of Saved Claims

**Draft Claims**            Claims that have missing information or contain errors and have not been completed

**Professional Ready to be Submitted Claims**            Claims that have been completed but not submitted

**Institutional Ready to be Submitted Claims**            Claims that have been completed but not submitted

### To Edit a Saved Claim

1. Click **Edit** to the right of the claim you want to view.
2. Fix any errors or complete the claim.
3. Click **Submit**.

### To Delete a Saved Claim

1. Click **Delete** to the right of the claim that is no longer needed.
2. Click **OK** to confirm the deletion.

**Note:** Once a claim is deleted, it cannot be recovered.



### Viewing Submitted Claims

Submitted claims are manual claims created and submitted using the Provider Portal only. Information is view only.

Select **Submitted**. The following screen appears. Information is view only

Claims									
Individual		Saved		Submitted		Batch		Recurring	
Payment History			Claims Audit Tool			Filter			
SUBMITTED STATUS ↑	DATE SUBMITTED ↑	WEB #/ REF # ↑	CLAIM NUMBER ↑	CLAIM TYPE ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑	
(L)	09/06/2021			CMS-1500				\$338.00	
(L)	08/29/2021			CMS-1500				\$178.01	
(L)	08/29/2021			CMS-1500				\$178.00	
(L)	08/26/2021			CMS-1500				\$61.02	
(L)	08/26/2021			CMS-1500				\$208.00	
(L)	08/26/2021			CMS-1500				\$144.00	
(L)	08/26/2021			CMS-1500				\$144.00	
(L)	08/26/2021			CMS-1500				\$144.00	
(L)	08/26/2021			CMS-1500				\$144.00	
(L)	08/26/2021			CMS-1500				\$144.00	

## Viewing Submitted Batch Claims

Use the Batch tab to view batch claims that were supported using the Provider Portal. Previously uploaded batch files appear at the bottom of the Batch Claims screen. If no batch files are uploaded, the **No Data Found** banner appears.

- ⚠ The last 24 months of batch claims submission data is available online. Passing the format verification process is not a guarantee of claim(s) payment. Claim(s) payment is contingent upon accuracy of data submitted. You will receive an explanation of payment (EOP) or 835 for your claims submission depending on your contract arrangement.

### To Access Batch Claims

Select **Batch**. The following screen appears.

### To Search for a Batch Claim

You can search by one or more criteria – date, confirmation number and batch claim status.

1. Select the **Start Date** and **End Date**. **Note:** You can only search in monthly increments.
2. Click **Search**. The Batch Claims list updates to display your search results.

## Uploading Batch Files to EDI

Use the Upload EDI tool to upload 837 electronic claim files from your shared drive or other location.

### To Access Upload EDI

Click **Upload EDI** from the top of any **Claims** screen.



### To Upload a Batch of Claims Using Upload EDI

1. Click the **Upload EDI** button.
2. On the **Batch Claims Upload** screen, select the **File Type** of either **837I** or **837P**.

- ⚠ For an Institutional Claims batch upload select 837I
- ⚠ For a Professional Claims batch upload select 837P

To Attach Your Batch Claims

3. Click **Choose File**. Browse and select the batch claims file (837 files) you want to upload.  
**Note:** Be sure to check that you are submitting the correct codes.
  4. Click **Open** to attach the file. The name of the file you selected appears next to the Choose File button. The file name must be 50 characters or less and not include any special characters.
  5. Click **Submit**. When a file is successfully uploaded, the Web Reference ID # is generated for your record
- 
1. **Note:** On the Batch Claims Upload screen, companion guides and a list of FAQs are provided as resources. An EDI Support telephone line and an email address are also included as additional support with uploading EDI files.

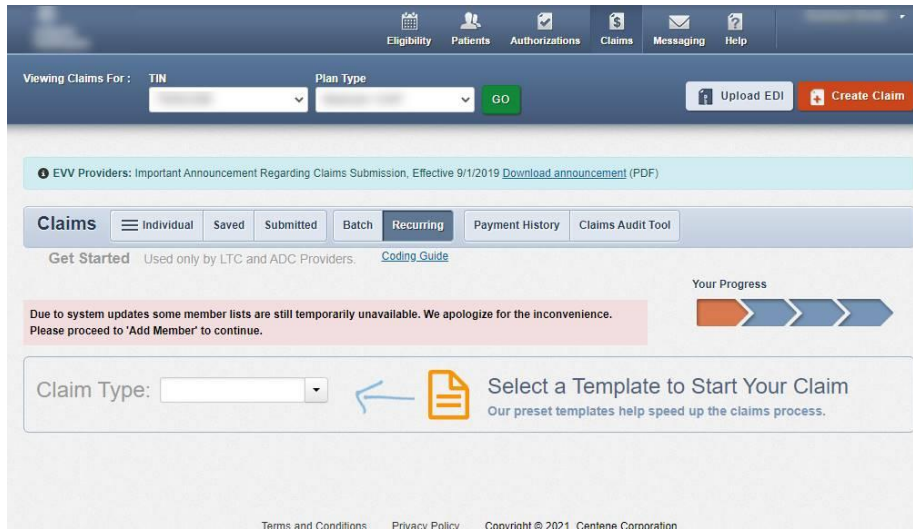
See also: [Viewing Submitted Batch Claims](#)

## Creating Recurring Claims

Recurring Claims provides a bulk upload claims template for long-term care. Complete only a few key fields. All other required service line details are auto-completed for you.

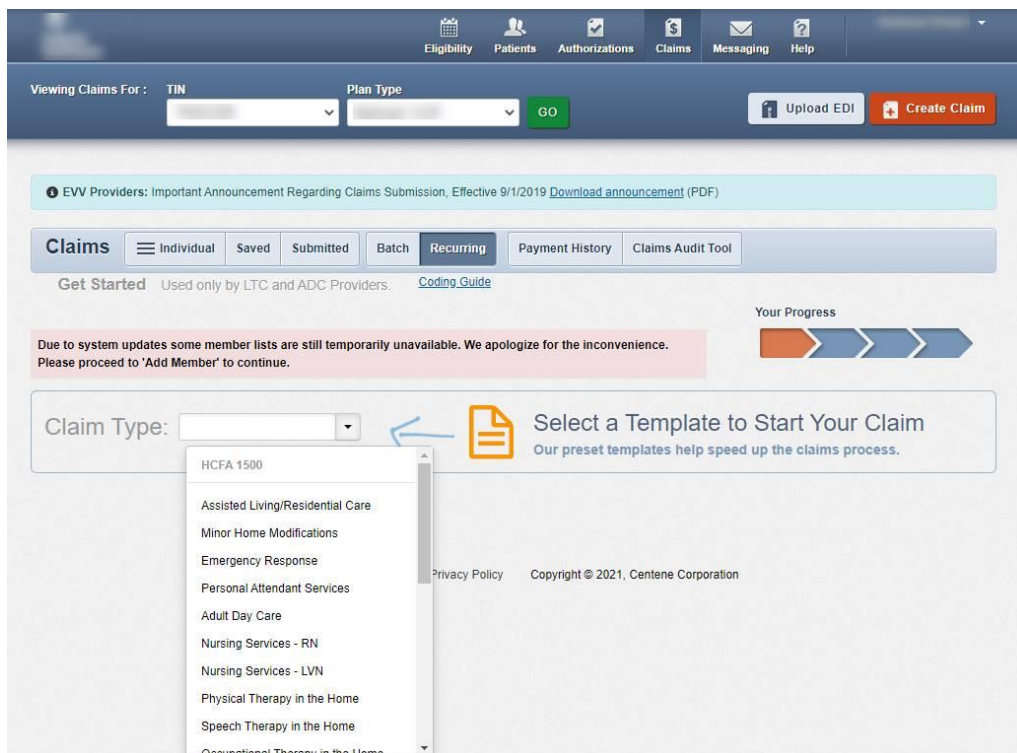
### To Access Recurring Claims

Click the **Recurring** tab on the Claims screen.

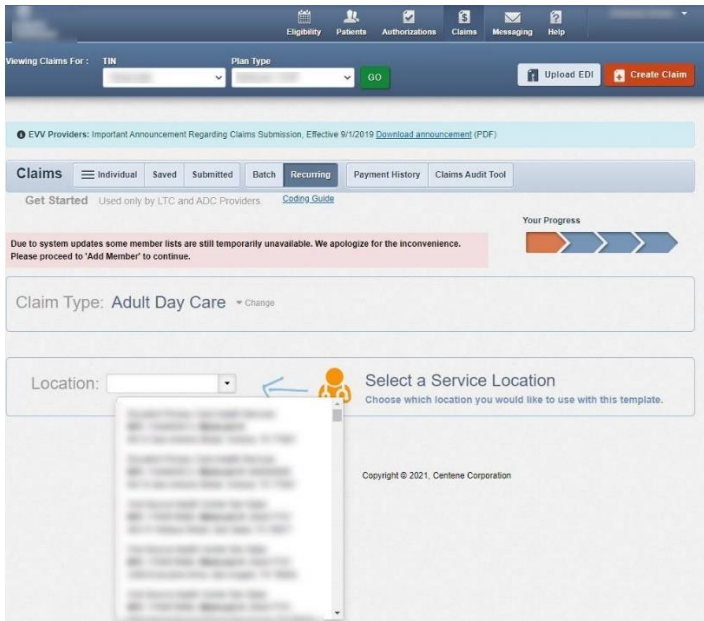


### To Create a Recurring Claim

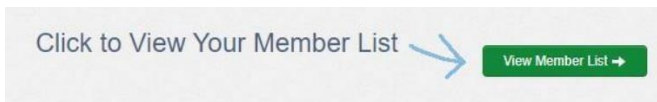
1. From the **Claim Type** drop-down menu, select the type of recurring claim you want to submit. **Note:** Options vary by plan type.



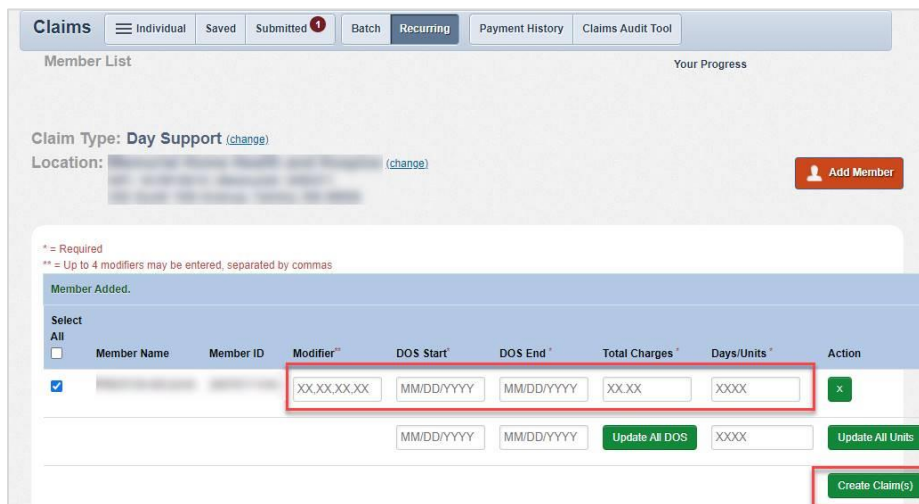
- From the **Location** drop-down menu, select the address for the place of service.



- Click **View Member List**.



- Select the **checkbox** to the left of the member(s) you are creating the recurring claim for, and complete the required fields (Modifier, Date of Service Start date, Date of Service End date, Total Charges, and Days/Limits).

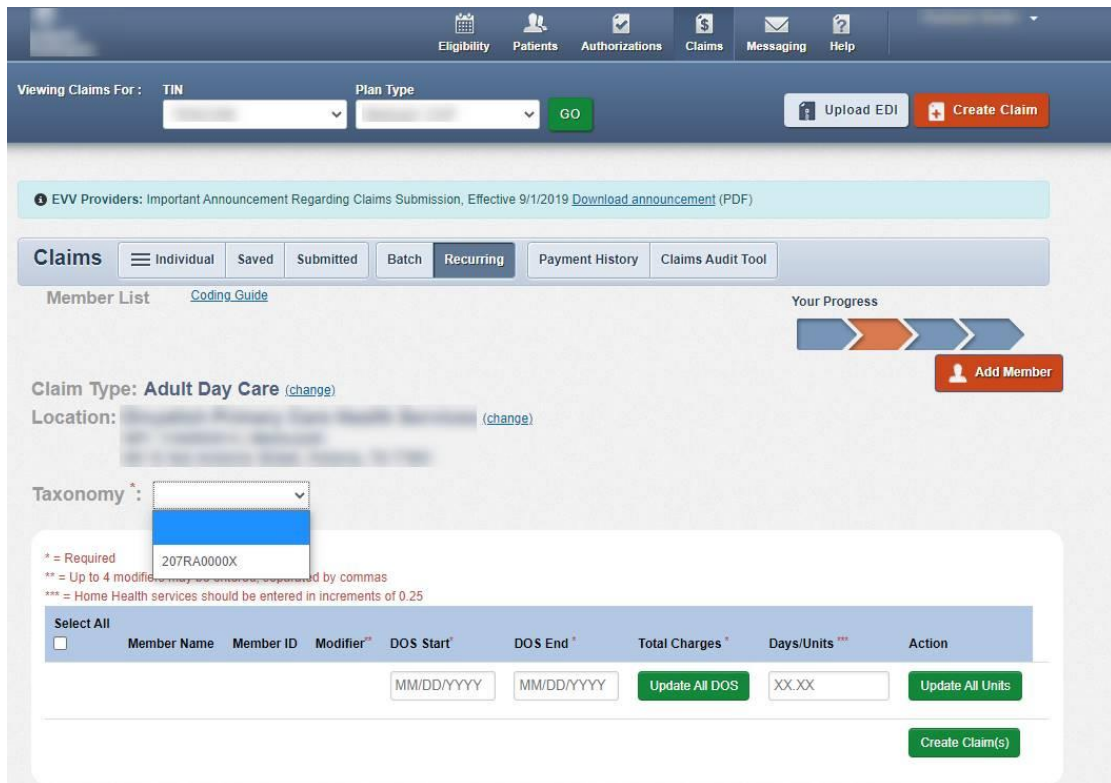


- Click **Create Claim** at the top of the Claims screen.

**Note:** If you do not have any members on your list, you can add and then select them.

To Add a Member

1. Click the **Add Member** button.
2. Enter the Member ID or last name and Date of Birth, and click **Add**. The member appears on your list.
3. Select the **checkbox** to the left of the member(s) you are creating the recurring claim for, and complete the required fields (Modifier, Date of Service Start date, Date of Service End date, Total Charges, and Days/Limits).
4. Click **Create Claim** at the top of the Claims screen.

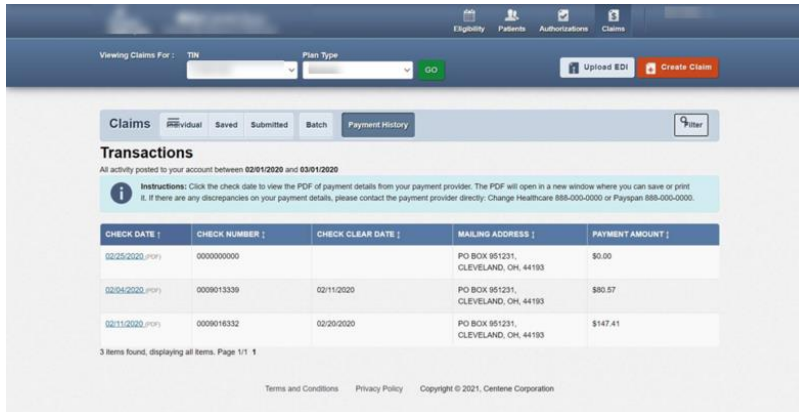


## Payment History

Provides Explanation Of Payments (EOP) documents for claims. Payment history is available up to 24 months.

### To Access Payment History

Click **Payment History** from the Claims screen. The following screen will appear.

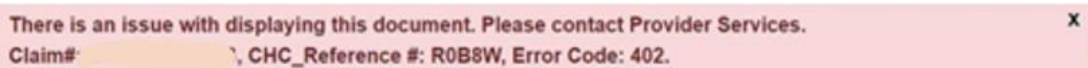


### To View Payment History

1. Click the **Check Date** for the claim that you want to view payment history.
2. The EOP PDF document downloads and appears at the bottom of the browser window.



3. If an error occurs instead of the PDF, a message should display with a prompt to call Provider Services.



### Example of Payment History (PDF document):



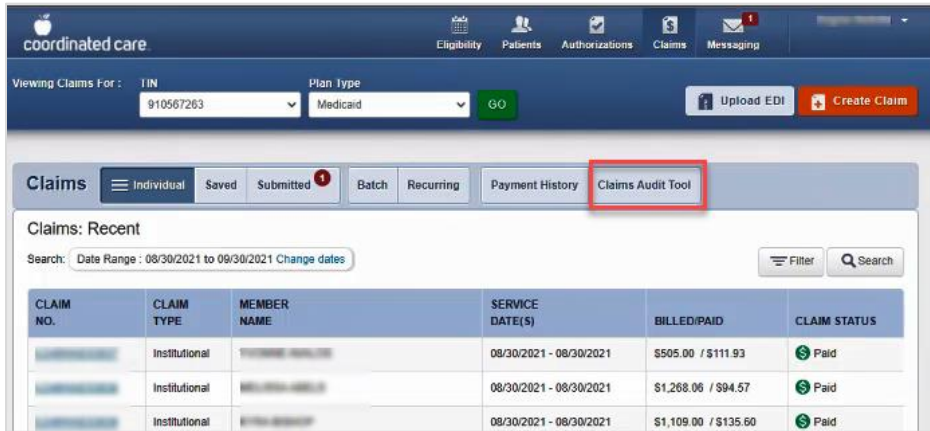


## Using the Clear Claim Connection Audit Tool

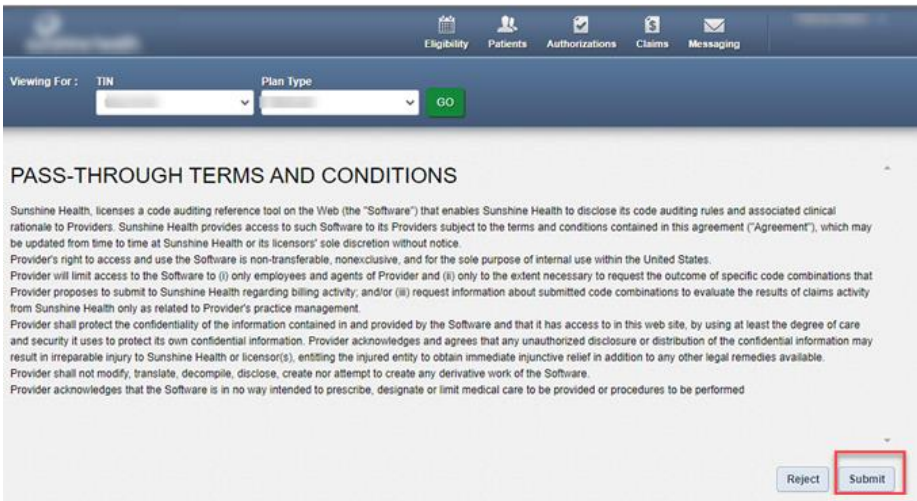
Clear Claim Connection is the claims audit tool used to look up Procedure Code, Quantity, Modifiers, Date and Place of Service, and Diagnosis for a claim proactively before you submit or retroactively after you submit a claim to get coverage details. The tool is also referred to as the code editing assistant screen.

### To Access the Claims Audit Tool

1. Select **Claims Audit Tool** from the Claims screen.



2. **Reject** or **Submit** to terms and conditions.



When you click **Submit**, the Clear Claim Connection code editing assistant screen appears.

To Use the Claim Audit Tool

3. Complete member information:
  - Select the gender.
  - Enter the date of birth.
4. Complete service-related information. All fields are required for each line item.
  - Procedure Code
  - Date of Service
  - Quantity
  - Place of Service
  - Modifiers
  - and Diagnosis Code

**⚠ Note:** Click **Add More Procedures** to look up as many procedures as needed. Or, click **Clear** to reset the form.

**Clear Claim Connection™**  
McKesson Edit Development Glossary About Help Logoff

**Claim Entry**

Gender:  Male  Female  
Date of Birth:  (mm/dd/yyyy)

Click grid to enter information.  
\* For quick entry, use your Down Arrow key after you enter a Procedure Code. Date of Service will default to today's date, and Place of Service will default to 11 (Office). Tabbing through Date of Service and Place of Service will give you the same defaults.

Line	Procedure	Quantity	Mod 1	Mod 2	Date of Service	Place of Service	Diagnosis
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	--select--	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	--select--	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	--select--	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	--select--	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	--select--	<input type="text"/>

Add More Procedures >>

5. Click the **Review Claim Audit Results** button. The results of the claim audit display the Recommendation Status of Allow, Disallow, or Review.

**Clear Claim Connection™**  
McKesson Edit Development Glossary About Help Logoff

**Claim Audit Results**

Gender:   
Date of Birth:

Click on recommendation of "Disallow" or "Review" to obtain clinical edit clarification.

Line	Procedure	Description	Quantity	Mod 1	Mod 2	Date of Service	Place of Service	Diagnosis	Recommend
1	80053	COMPREHEN METABOLIC PANEL	1			7/21/2012	23 (ER - Hospital)	311	Allow
2	85025	COMPLETE CBC W/AUTO DIFF WBC	1			7/21/2012	23 (ER - Hospital)	311	Allow
3	81001	URINALYSIS AUTO W/SCOPE	1			7/21/2012	23 (ER - Hospital)	311	Allow

*The results displayed do not guarantee how the claim will be processed.*

- ⚠ The results displayed do not guarantee how the claim will be processed. The information only assists in claims submittal.
- ⚠ If the Recommendation Status states Disallow or Review, click the status for more clinical edit information

## Viewing and Downloading the Patient List

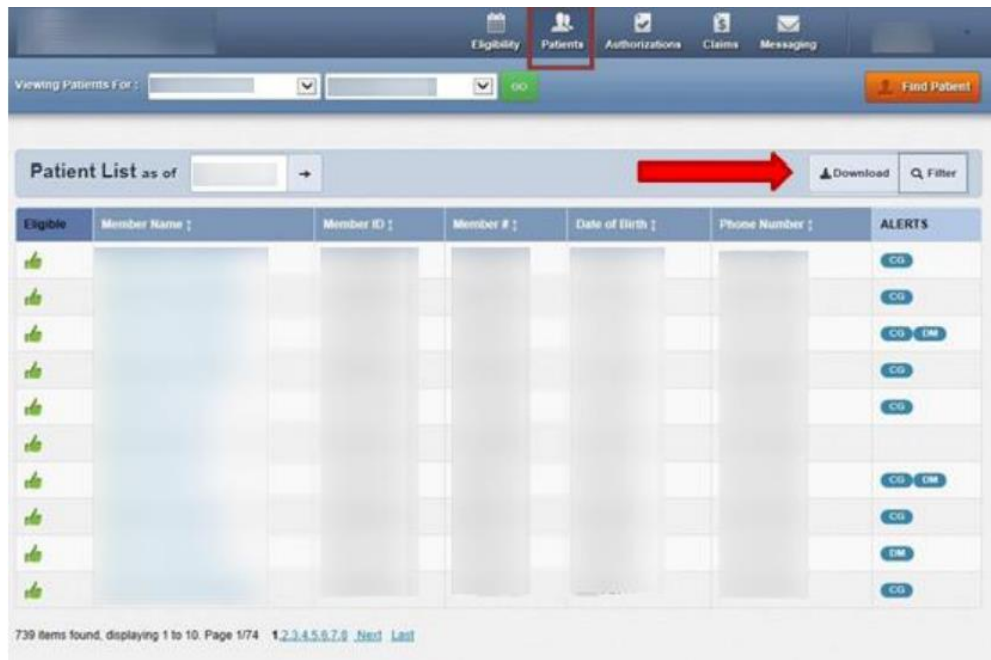
You can view and download a patient list from the Dashboard (only available for PCP's/PMP'S). Only the following patient information appears on the screen:

- Member Name
- Member ID
- Member Number
- Date of Birth
- Phone Number

Download the patients list to get more details.

### To View the Patients List

1. Click **Patients** on the Main Toolbar. The **Patient List** screen appears if available.



### To Download the Patients List

2. Click **Download**.
3. Select an option: **Open**, **Save** or **Save As**. The patient list file will either display or download.

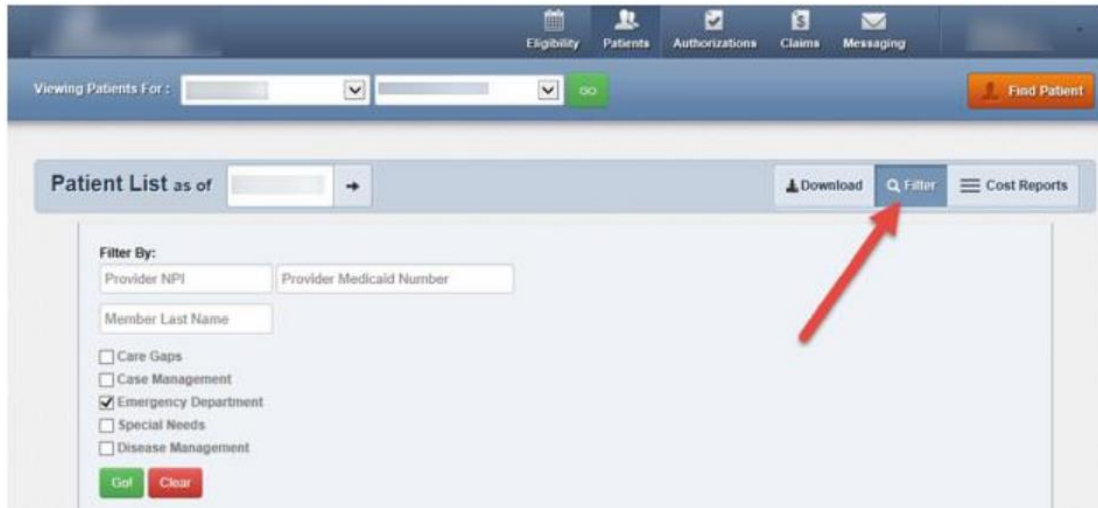


⚠ You can download a copy of the patient list in an Excel format only.

## To Filter the Patients List

You can choose the data you want to include in your patients list. You can apply multiple filters based on the Provider’s NPI, Medicaid Number, Specific Member Last Name, or Specific Alert. **Note:** Your filtered preferences are preserved in the downloaded list.

1. From the Patients List, click **Filter**.
2. Select the checkbox next to the information you want included in the list. **Note:** If you do not make a selection, all the patient information will be included in the list.
3. Click **Go** at the bottom of the screen.



Sample of a downloaded patients list Excel document:

The screenshot shows an Excel spreadsheet with the following columns: Member Last Name, Member First Name, Preferred Language, Lock In, Member ID, Member #, Effective Date, Term Date, Program (Category), Product Name, Gender, Date of Birth, Phone Number, Address 1, and Address 2. The data is partially obscured by a red box and is mostly blurred. A red box highlights the header row and the first few rows of data. The spreadsheet also shows a date of 9/29/2021 and a time of 8:26:40 PM.

## Managing Secure Messaging

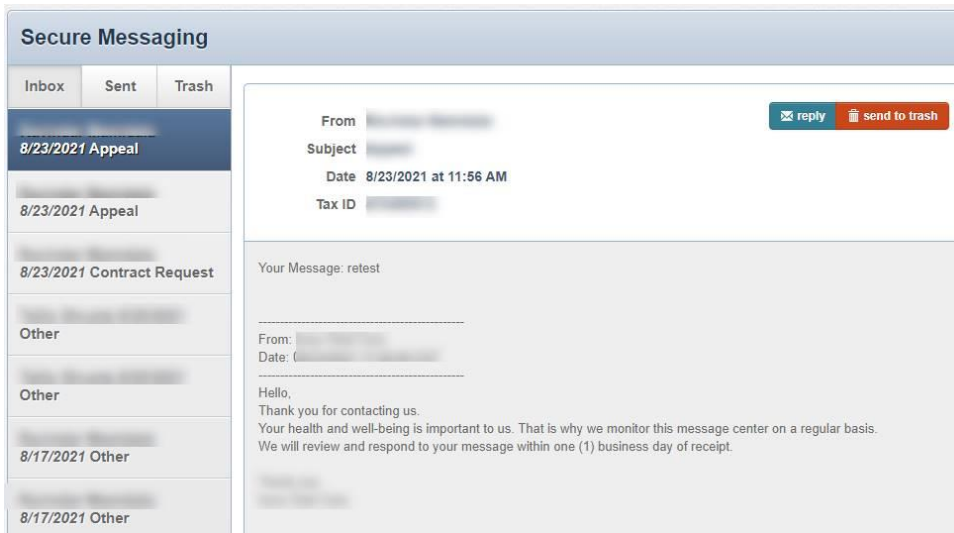
### To Access Secure Messaging

Click **Messaging** from the Main Toolbar on the Dashboard. The Secure Messaging screen displays the **Inbox**.

### To View and Respond to Received Secure Messages

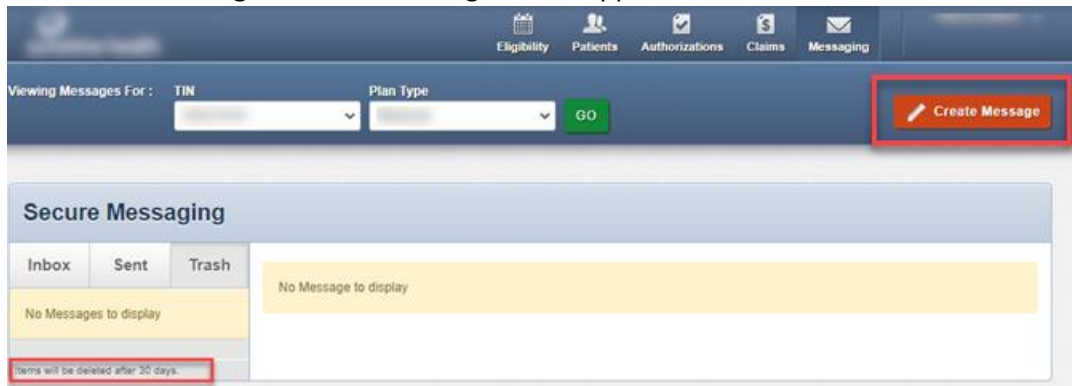
From the **Inbox**, click on the message you want to view.

- Click **Reply** to respond to a message.
- Click **Send To Trash**. The message is moved from your Inbox to the Trash.



### To Create a Secure Message

1. Click **Create Message**. The New Message screen appears.



- On the New Message screen, select a **Subject** from the drop-down menu.

*Additional Instructions:*



- The **To** box displays the same Plan Type you selected at the top of the Dashboard.
- If you select a different Plan Type from the drop-down list at the top of the Dashboard, the **To** box automatically updates to match the selected health plan.

**Draft a Message**

- Type a message to the Health Plan staff in **Your Message**.

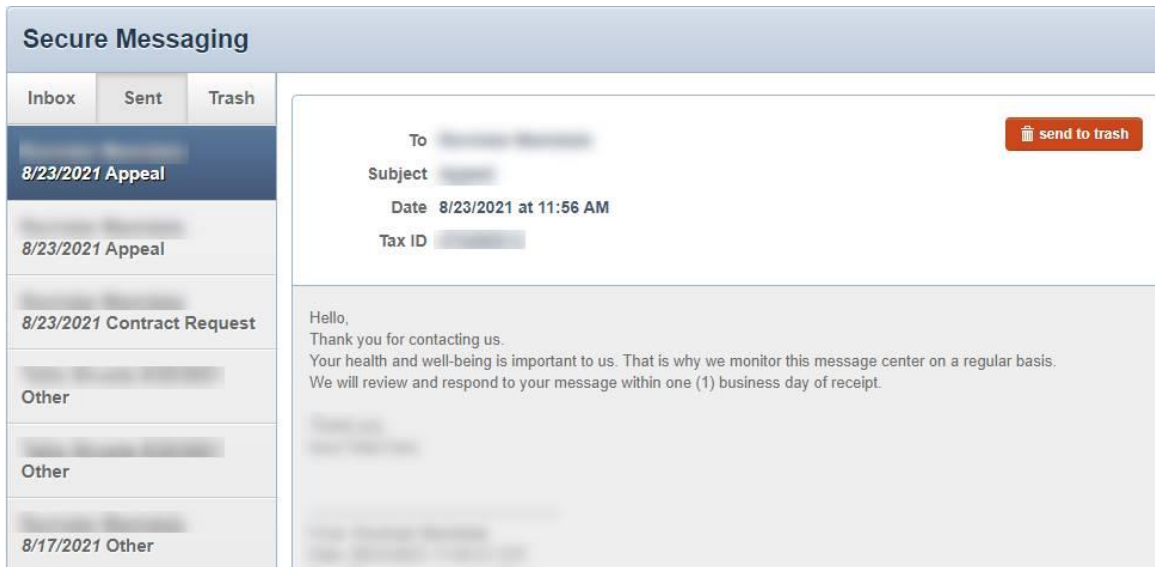
- Click **Send** when you are done. A confirmation that your message was sent successfully appears.

## Manage Sent Secure Messages

1. Click **Sent**. Any messages you've sent display on the left.
2. Click on a sent message to view it on the right.

### To Send to Trash

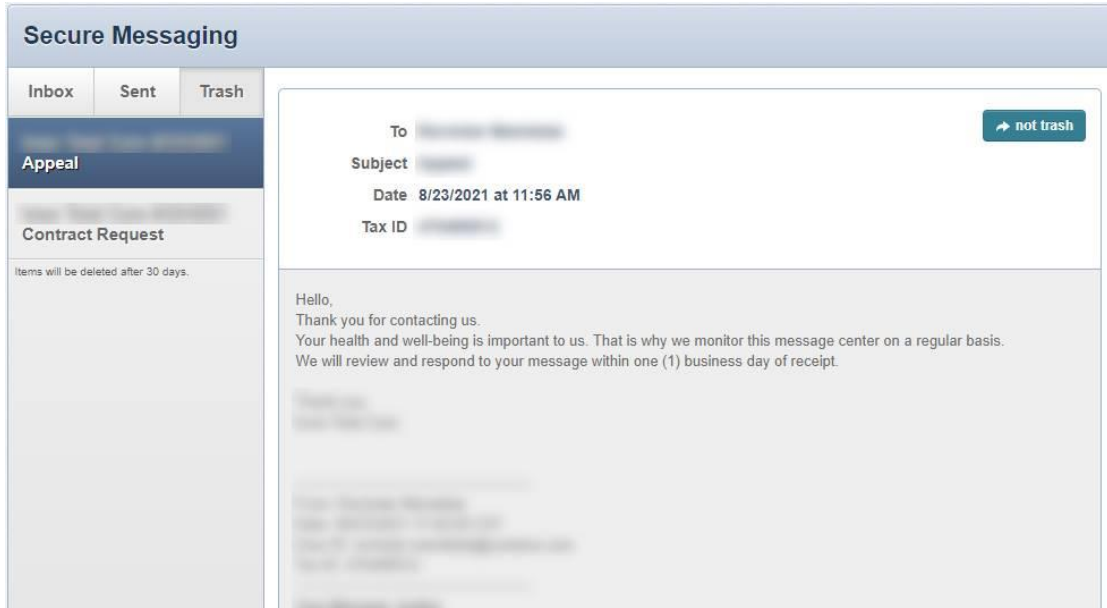
3. Click the **Send to trash** button.




**⚠ Note:** Messages sent to Trash will be deleted after 30 days. If a message is not trash, but is found under the Trash tab, you can reverse it by clicking the Not trash button.

## Manage Messages Sent To Trash

1. Click **Trash**. Any messages sent to trash appear on the left.



-  **Note:** The messages sent to Trash will be deleted after 30 days. If a message is not trash, you can reverse it by clicking the **Not trash** button.