2021

Secure Provider Portal Quick Start Guide

USING THE SECURE PROVIDER PORTAL

Last Updated: September 30, 2021

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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:

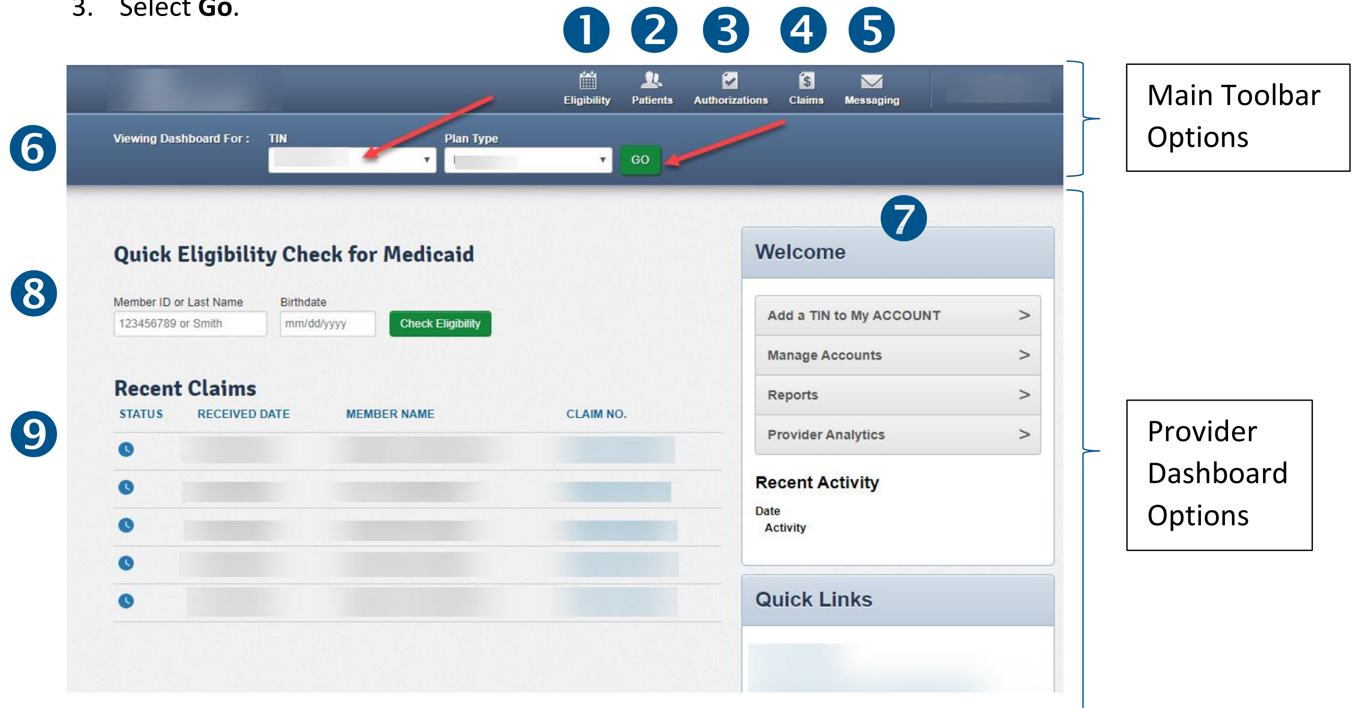
- Check eligibility
- View the specific benefits for a member
- View benefit details including member cost share amounts for medical, Pharmacy, dental, and vision services
- View demographic information for the providers associated with the registered TIN such as office location, office hours and associated 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

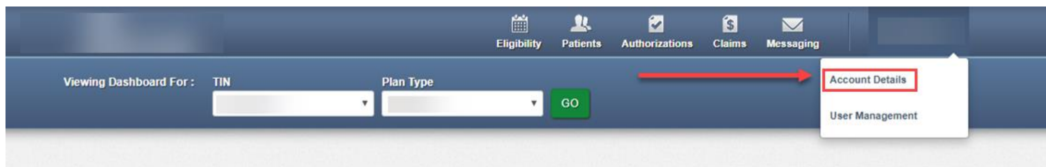
Managing Account Details

From the Account Details screen, you can:

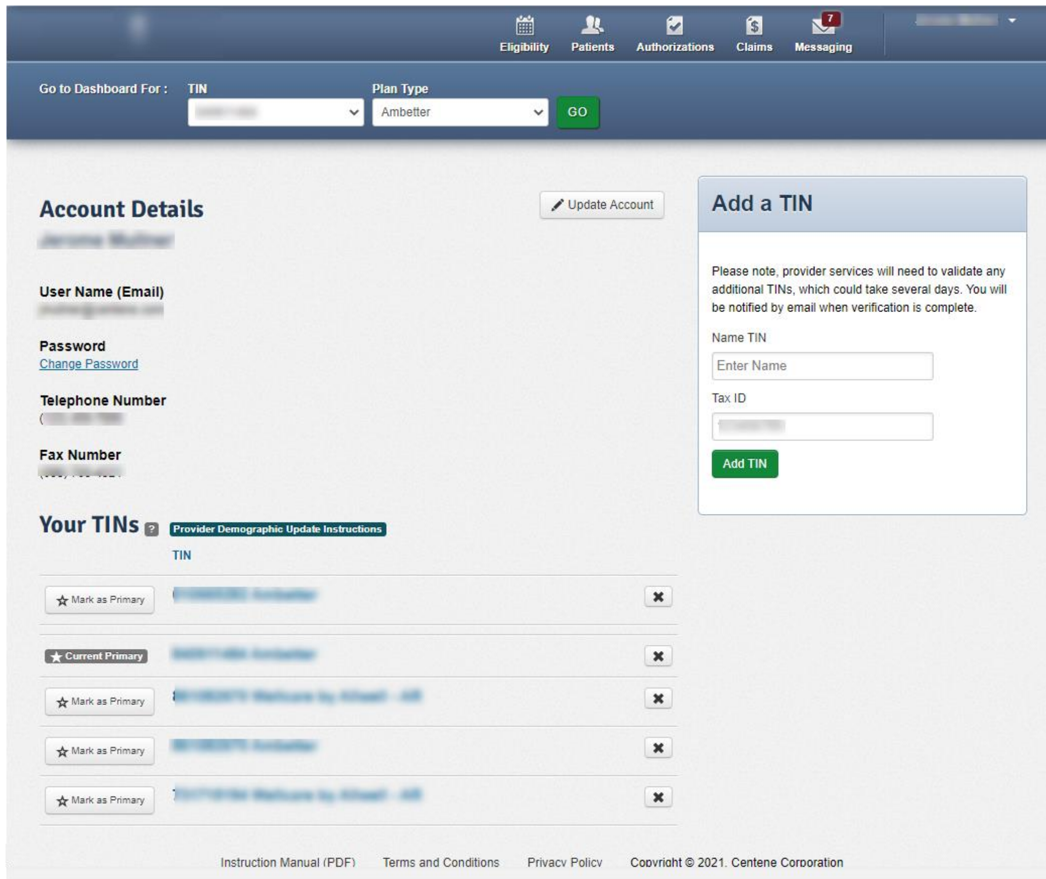
- View and manage information related to your account profile.
- Add and manage Tax Identification Numbers (TINs) on the account.

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**.

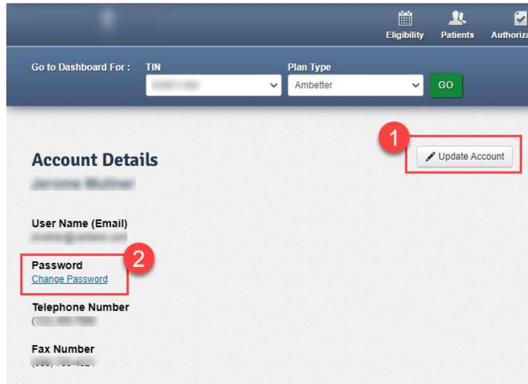


The Account Details screen appears.



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.



❶ 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.

Update Your Information

Your Information

Email

Telephone Number

Fax Number

First Name

Last Name

❷ To Change Your Password

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

English

Change Password

Enter your current password. Enter a new password and confirm it.

Email Address

Current Password

New Password

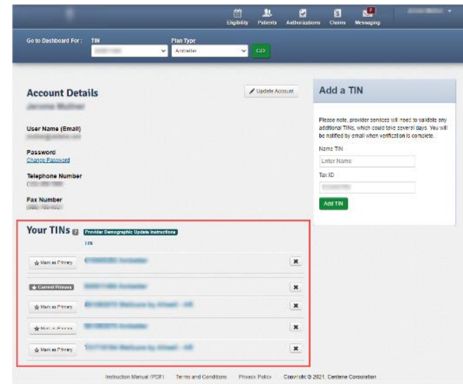
Confirm New Password

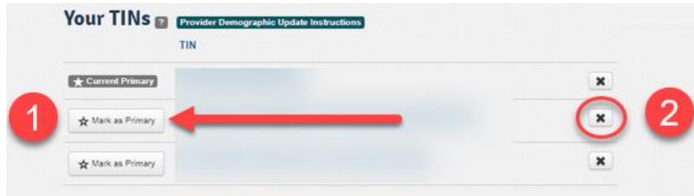
SUBMIT

CANCEL

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.





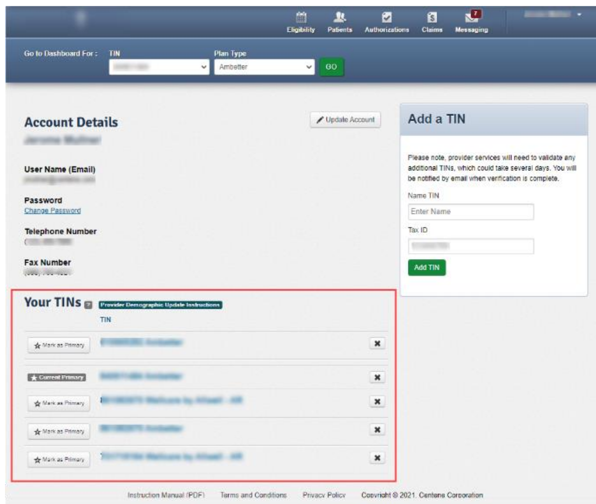
1. To change your default TIN, select **Mark as Primary** next to a different TIN.
2. To remove a TIN from the account, select the **x** next to one you no longer want.

Additional Instructions:

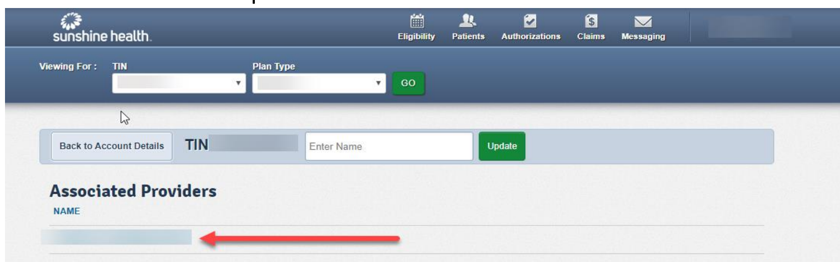
The primary TIN on the account appears by default in the TIN drop-down list at the top of the dashboard. The associated plan also displays. You can select any TIN that you have added to your account.

Account Details: Modify Demographic Information about a Specific TIN

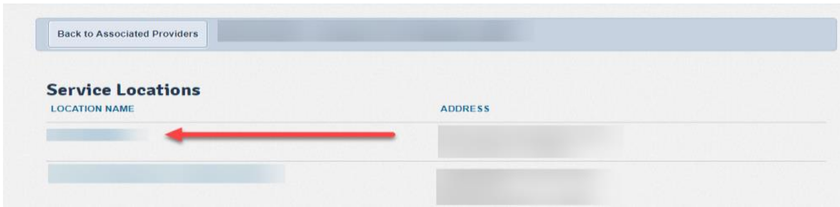
1. Click on the individual TIN.



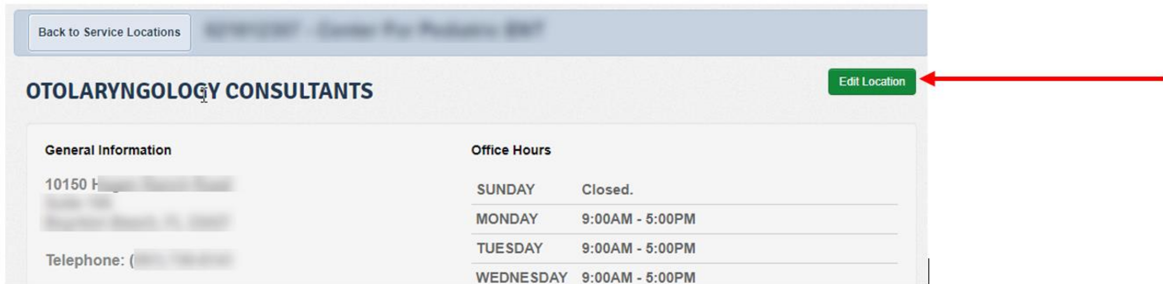
2. Click on the Name to update information about one of the Associated Providers.



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



4. Make updates on the screen that appears.



5. 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).

6. 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**.

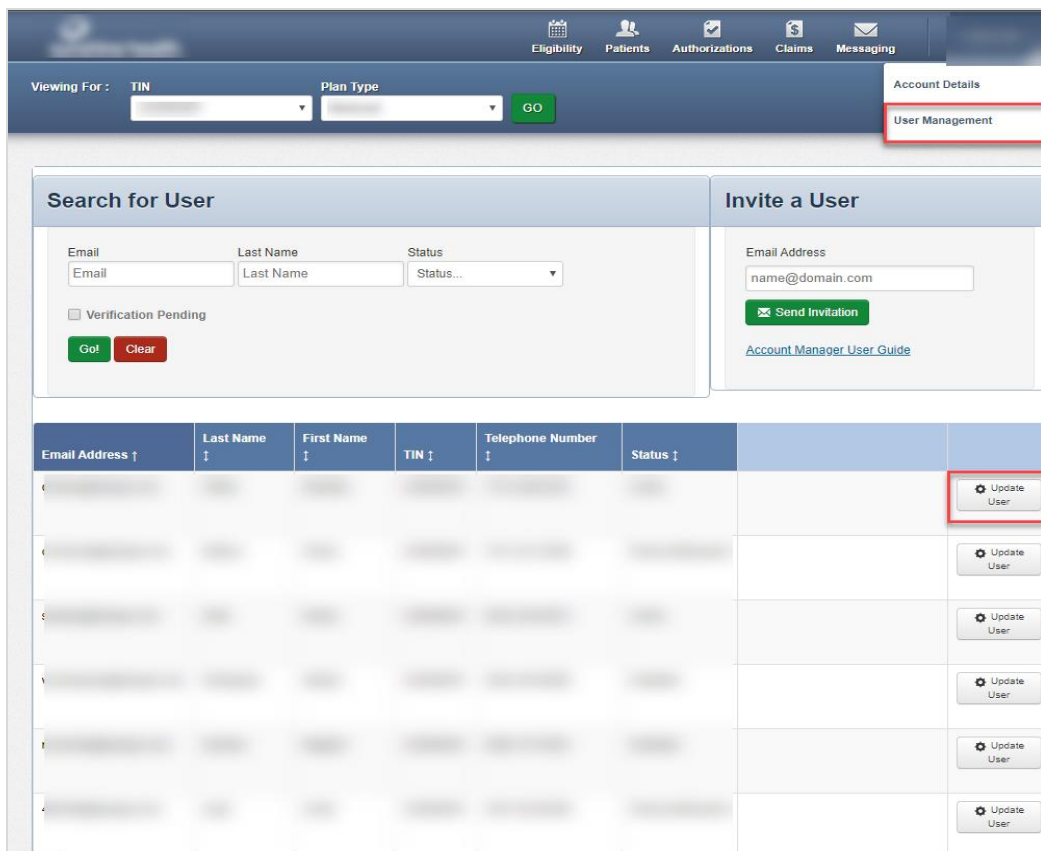
⚠ **Note:** If the TIN entered is not found the above message appears. Each new TIN added will require verification from the health plan and can take up to 48 hours to complete.

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

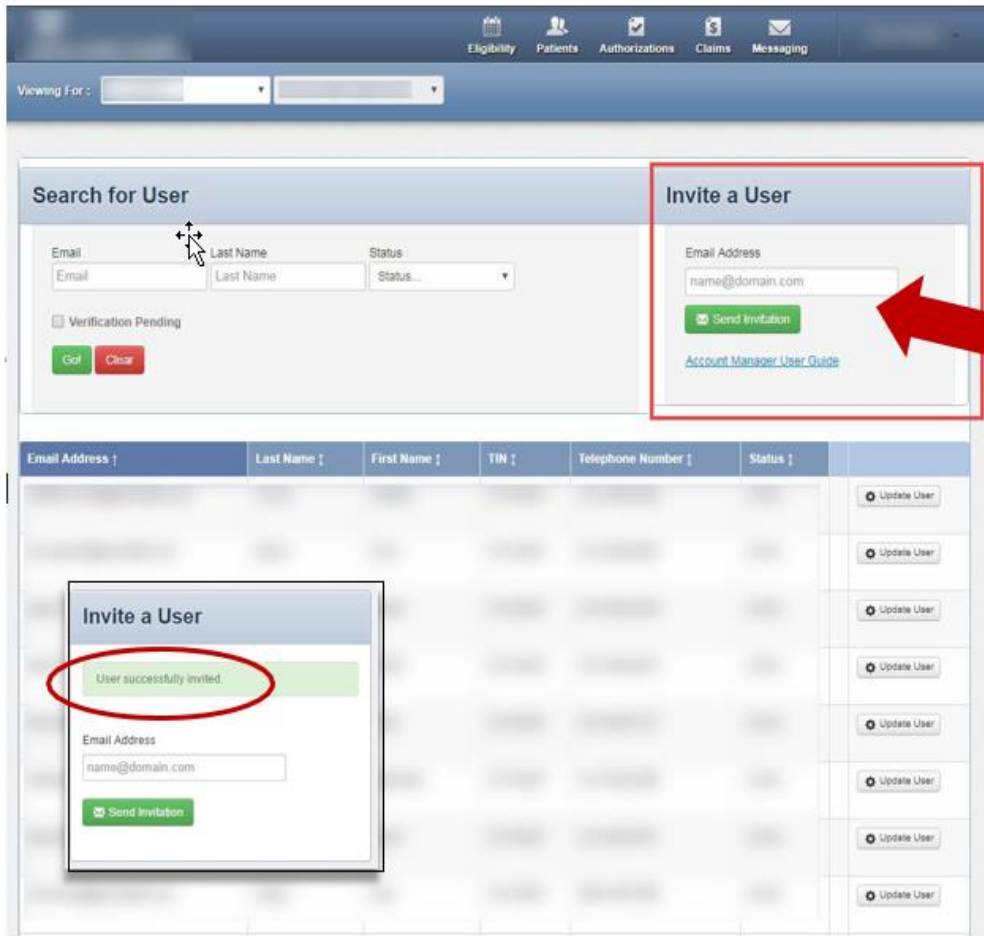
⚠ **Note:** If you clear the **Manage Account** checkbox, the user will not be able to manage other accounts.

User Management: Invite Others to Join Your Account

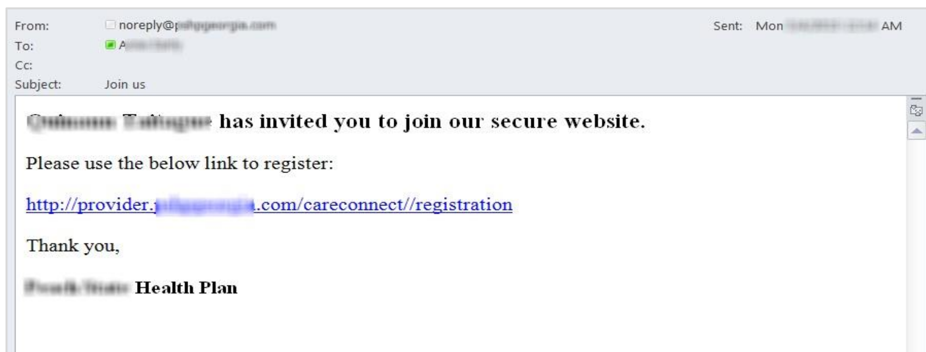
You can invite someone else to join your account. The email is sent from the Support Users screen. Each new invitee must register to use the secure Provider Portal.

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:



From: noreply@

To:

Cc:

Subject: Join us

Sent: Mon AM

has invited you to join our secure website.

Please use the below link to register:

http://provider. .com/careconnect//registration

Thank you,

Health Plan

Verifying Patient Eligibility

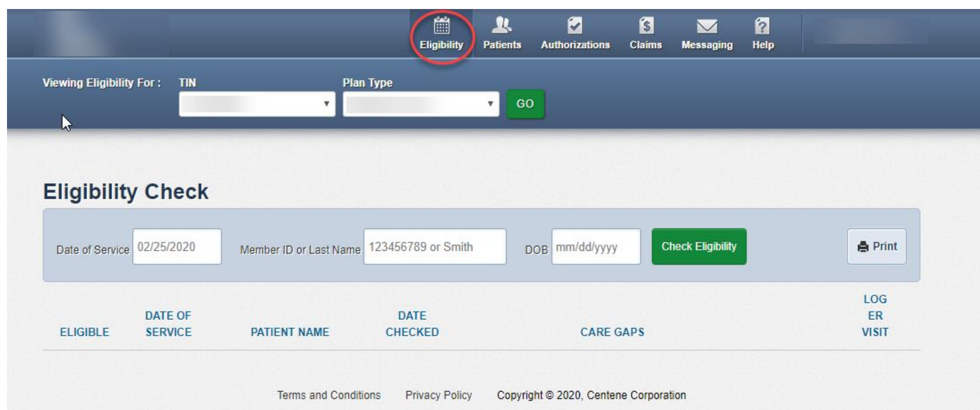
This check verifies if a patient is eligible for care.

To Access the Eligibility Check Screen

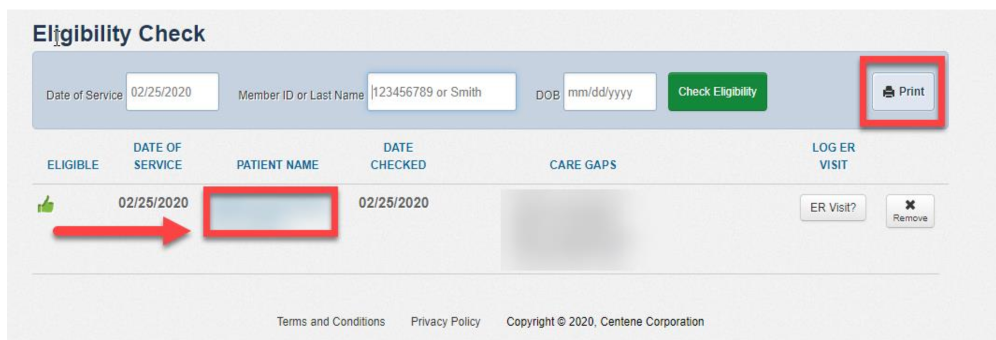
Select **Eligibility** from the top of any screen.

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 checked
- Date of service
- Care gaps
- Patient name
- 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 02/25/2020 Member ID or Last Name 123456789 or Smith DOB mm/dd/yyyy Check Eligibility Print

Example of Eligibility Check printout:

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

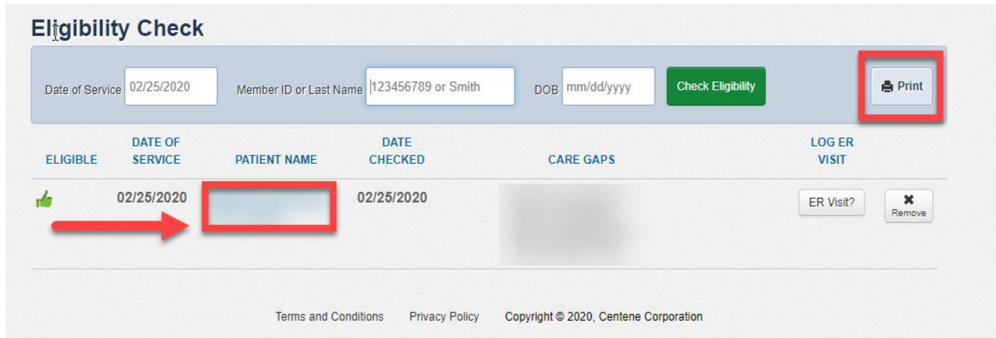
Eligibility Check

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	RECENT ADT	CARE GAPS	LOG ER VISIT
	09/27/202		09/27/2021	NO	Risk Category Alerts: COPD/Asthma Immunizations not current for age	ER Visit?

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

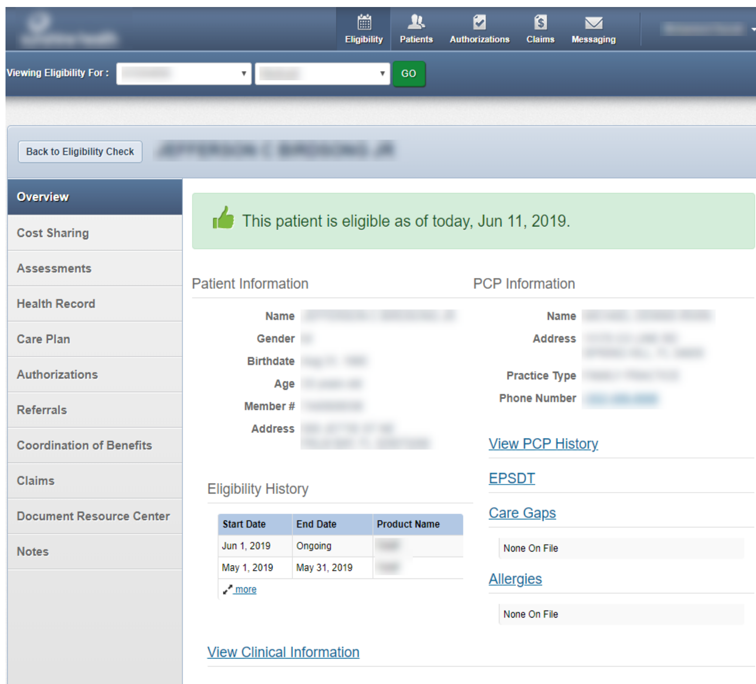
Managing the Member Record

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
REGULAR ASTIGMATISM	07/0	Classic Optical Laboratories Inc
REGULAR ASTIGMATISM	07/0	Classic Optical Laboratories Inc
PRESBYOPIA	04/2	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
Overview:	The Overview Screen
Cost Sharing:	The patent's portion of health care costs not covered by the plan
Assessments:	Any available assessments for this member will appear as well as Notice of Pregnancy NOP (if gender and age appropriate)
Health Record:	The Health Record tab allows you to view a record of visits or medications for the patient
Care Plan:	Care plans are created by the health plan's case manager to help manage the health of the patient
Authorizations:	The Authorizations tab of the member record allows you to view current authorizations, and create new authorizations for the member
Referrals:	The Referrals tab allows you to send a member to specialized services
Coordination of Benefits:	The Coordination of Benefits (COB) tab displays the other insurance information for the patient
Claims:	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

- Overview
- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations
- Referrals
- Coordination of Benefits
- Claims

Print Cost Shari

Cost Sharing Summary
Nursing Facility Information
Levels Of Service

#	EFFECTIVE DATE	END DATE	TYPE	LEVEL
	09/07/2018	01/07/2019	[illegible]	[illegible]
	01/08/2019	02/14/2019	[illegible]	[illegible]
	02/15/2019	04/24/2019	[illegible]	[illegible]
	04/25/2019	04/30/2019	[illegible]	[illegible]
	05/01/2019	08/25/2019	[illegible]	[illegible]
	08/26/2019	12/09/2019	[illegible]	[illegible]
	12/10/2019	04/10/2020	[illegible]	[illegible]

Income/Co-Payment (Applied Income)

#	EFFECTIVE DATE	END DATE	AMOUNT	PERCENT	TYPE
	09/01/2018	05/31/2019	[illegible]	[illegible]	[illegible]
	06/01/2019	06/30/2019	[illegible]	[illegible]	[illegible]
	07/01/2019	07/31/2019	[illegible]	[illegible]	[illegible]
	08/01/2019	08/31/2019	[illegible]	[illegible]	[illegible]
	09/01/2019	12/31/2019	[illegible]	[illegible]	[illegible]
	01/01/2020	12/31/9999	[illegible]	[illegible]	[illegible]

This sample screen shows a Member without cost sharing:

Eligibility | Patients | Authorizations | Claims | Messaging

Viewing Eligibility For : GO

Back to Eligibility Check

- Overview
- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations
- Referrals
- Coordination of Benefits
- Claims
- Document Resource Center
- Notes

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:

⚠ **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.

⚠ **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.

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

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

Service Layer For **Ac Supprtv Om W/O Rupt Ear Drum Rt** - H66001

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 | Cost Sharing | Assessments | Health Record | Care Plan | Authorizations | Referrals | Coordination of Benefits | Claims | Document Resource Center | Notes

Visits | Medications | Immunizations | Labs | Allergies

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

To View Immunizations Details

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

Back to Eligibility Check

Overview | Cost Sharing | Assessments | Health Record | Care Plan | Authorizations | Referrals | Coordination of Benefits | Claims | Document Resource Center | Notes

Visits | Medications | Immunizations | Labs | Allergies

Code	Description	Facility/Provider	Date
90471	Immuniz Admin; 1/Combo Vaccine/Toxoid	Colquitt County Board Of Health	09/20/2017 - 09/20/2017
90686	Iiv4 Vacc No Prsv 0.5 Ml Im	Colquitt County Board Of Health	09/20/2017 - 09/20/2017

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.

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- Assessments
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- Care Plan
- Authorizations
- Referrals
- Coordination of Benefits
- Claims
- Document Resource Center
- Notes

Visits | Medications | Immunizations | **Labs** | Allergies

Date Of Service	Procedure	Ordering Provider
Dec 26, 2013	CULTURE, THROAT	
Apr 29, 2013	CHOLESTEROL, TOTAL	
Apr 29, 2013	HDL CHOLESTEROL	
Apr 29, 2013	TRIGLYCERIDES	
Apr 29, 2013	LDL-CHOLESTEROL	
Apr 29, 2013	COMPREHENSIVE METABOLIC PANEL	
Apr 29, 2013	HEMOGLOBIN A1c	

To View Allergies Details

Select Allergies to view allergy information.

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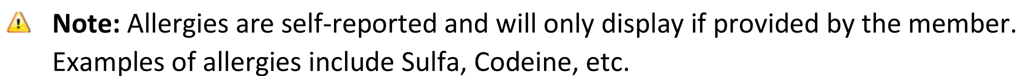
- Care Plan
- Authorizations
- Referrals
- Coordination of Benefits
- Claims
- Document Resource Center
- Notes

Visits | Medications | Immunizations | Labs | **Allergies**

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.

Back to

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Health Record
Care Plan
Authorizations
Coordination of Benefits
Claims

This member's care plan to treat — Case Worker

Diabetes Self-Management Care Plan
- OPEN

Follow a healthy diet

Goal: Establish a healthy eating routine by 2013-07-31

What we're doing:
Meet with dietician to discuss Healthy Diet hints
Log daily food intake

This sample screens shows a member without a Care Plan.

Back to Eligibility Check

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Claims

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

To View Authorization Details

1. Click an authorization number. The details display.

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Authorizations

STATUS	AUTH NBR	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE		01/01/2015	09/30/2015	V68.81	OUTPATIENT	Personal Care Worker
APPROVE		05/22/2014	08/21/2014	343.9	OUTPATIENT	DME
APPROVE		01/01/2014	12/31/2014	V68.81	OUTPATIENT	Personal Care Worker

Create a New Authorization

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

Auth Status: APPROVE
Auth Nbr:
Service:
Provider of Service(s):

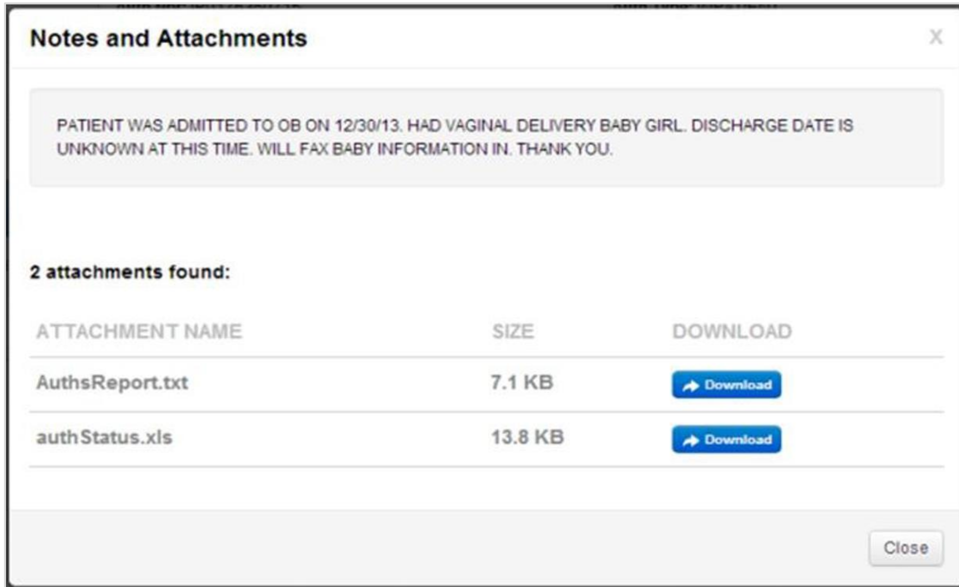
Explanation: Pay
Auth Type:
From Date: 12/27/2013
To Date: 01/27/2014
Notes & Attachments: View

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

Back to Authorization List

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.

Authorization For

DOB: | MEDICAID NBR:

By checking the Urgent Request box, I certify that this is an urgent request for a medically necessary treatment for an injury, illness, or another type of condition (usually not life threatening), which must be treated within 48 hours.

Only behavioral health inpatient notifications or requests will need to be provided telephonically. Please contact us at 844-477-8313.DME and home health requests related to hospital discharges should be faxed to 844-801-8413.If unable to submit request via the web portal, please fax request to 866-796-0526.Please note that reference number does not equate to authorization number.

Please select Service Type.

Enter Authorization

1. PROVIDER REQUEST

Urgent Request

Outpatient Services

Requesting Provider

Smith

Primary Diagnosis

Diagnosis Code

CODE LOOKUP: ICD-10

Add Additional Diagnosis

NEXT

2. SERVICE LINE

3. FINISH UP

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
[illegible]	[illegible]	*****5895	7809 Massachusetts Avenue , New Port Richey, Florida, 34653	[illegible]	Community/Behavioral Health		Select
[illegible]	[illegible]	*****5895	747 Jenks Avenue Suite D, Panama City, Florida, 32401	[illegible]	Community/Behavioral Health		Select
[illegible]	[illegible]	*****5895	1701 NE 42nd Avenue Suite 301, Ocala, Florida, 34470	[illegible]	Community/Behavioral Health		Select
[illegible]	[illegible]	*****5895	3020 S Florida Avenue Suite 207, Lakeland, Florida, 33803	[illegible]	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.

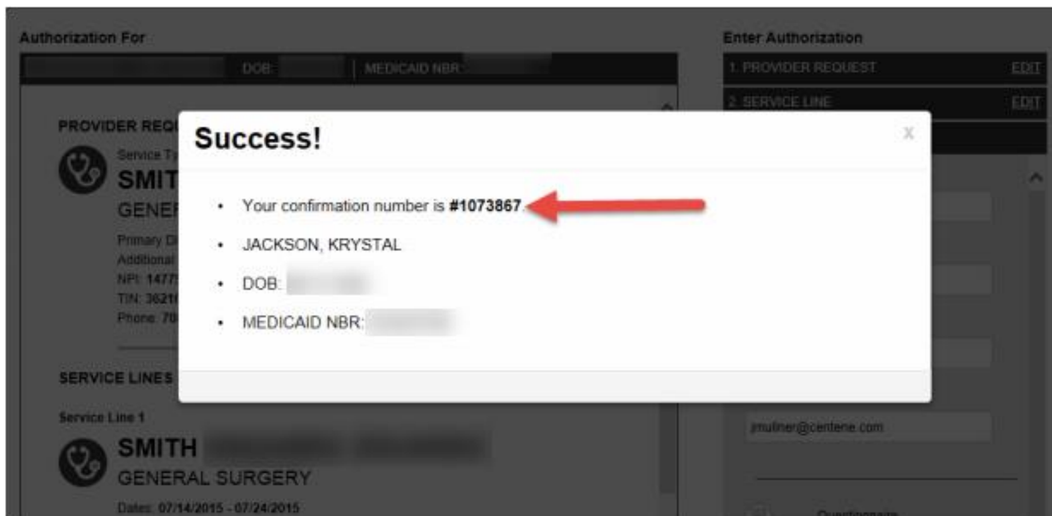
Note: To add Additional Service Lines, click on the **+ sign**. The Service line field appears. Click **Next**.

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.
Choose File No file chosen
Attach
SUBMIT

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**.

Member Records: Notes

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

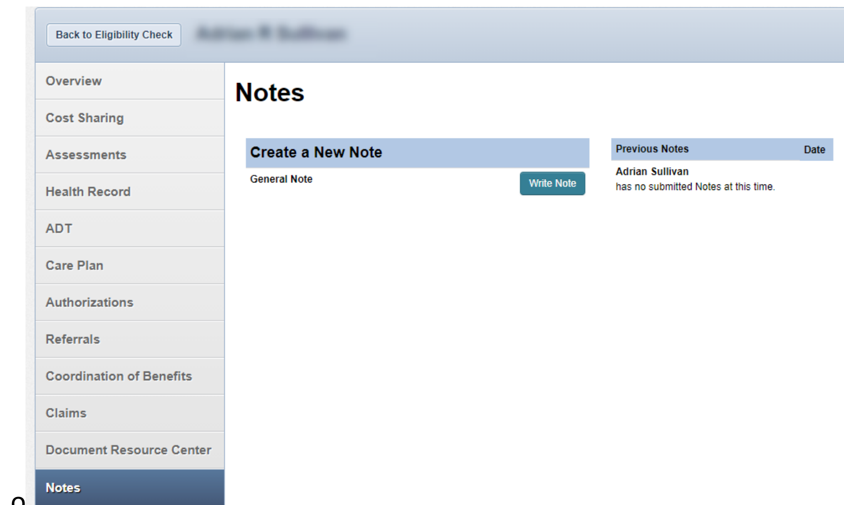
- Upload notes of any kind to a member's chart.
- Review previously submitted notes already uploaded.

To Access Notes

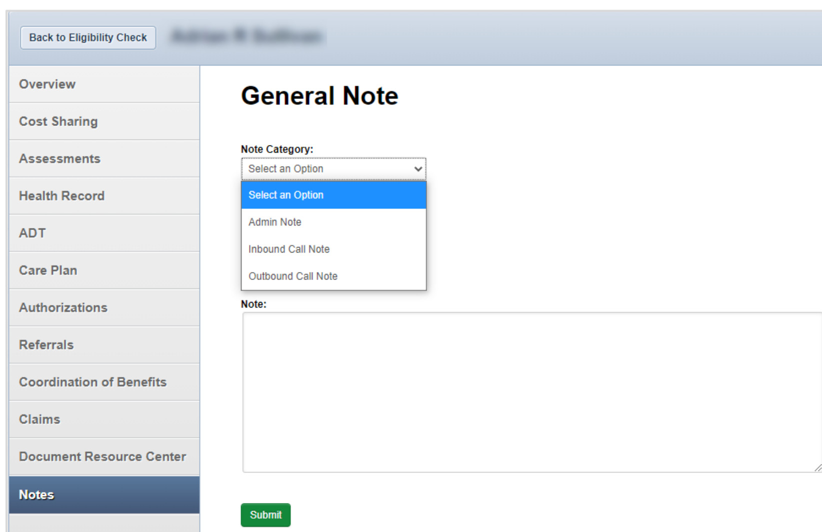
Click the Notes tab. Any previous notes display.

To Add a New Note

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

o 

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

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ADT Notifications

Admission Discharge & Transfer Notifications display for the last 12 months

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	

Member Record Tab: Managing Referrals

To Access Referrals

Click the Referrals tab.

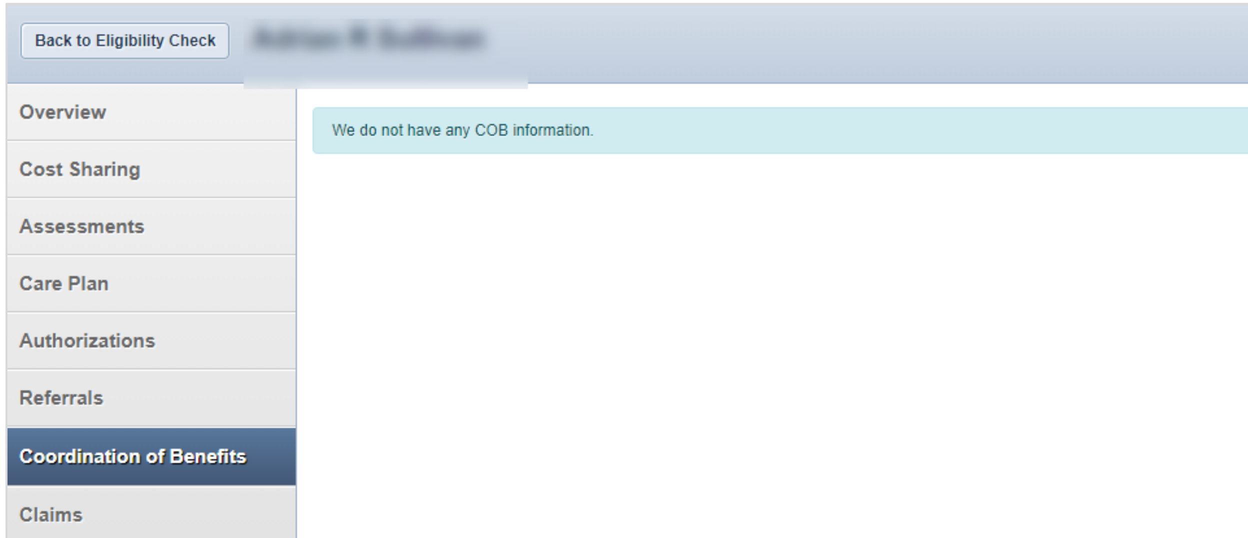
To Submit a Referral for a Member

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

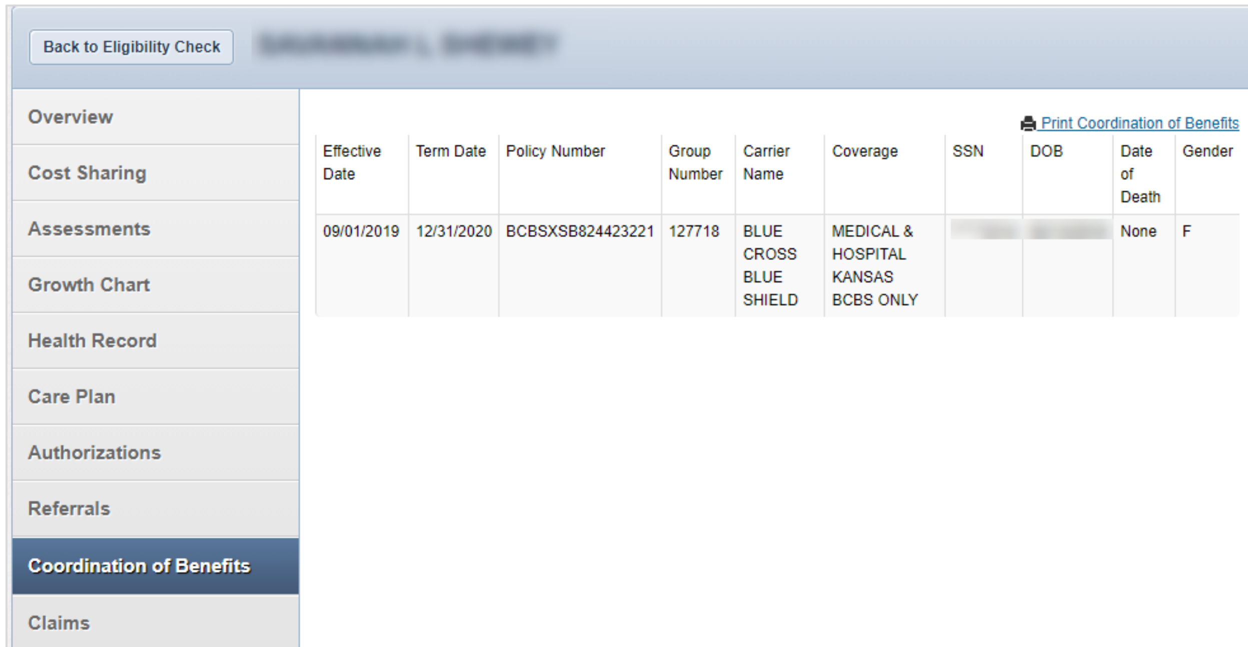
Member Record Tab: Viewing Coordination of Benefits (COB)

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 COB will display termed and active insurances as seen below.



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.

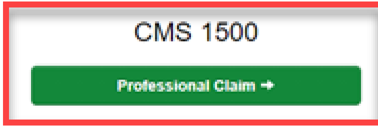
To Create a New Centers for Medicare and Medicaid Services (CMS) Claim

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

2. Select the type of claim you want to create.
   - CMS 1500 (Professional Claim)
   - CMS UB-04 (Institutional Claim)

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.

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.

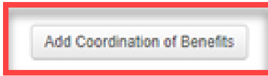
Member Record Tab: Claims – Adding Diagnosis Codes

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

⚠ **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
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* XXXX e.g. V87: Add
(Enter diagnosis code and click on Add button)
21.

Primary Insurance x Remove

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...
9d

Policy Number* XXXXXXXX
9a

Back
Next

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

Adding Service Lines to the Claim

8. 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

9. Click the **Save/Update** button on the right

10. Click the **New Service Line** button on the left. You can enter up to 99 service lines.

11. Click **Next**.

Professional Claim for
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 MM/DD/YYYY To MM/DD/YYYY 24.a
Place of Service* Select... 24.b
Emergency Yes No 24.c EMG
Procedure Code* XXXXX e.g 24.d
Modifiers XX 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.

Adding attachments to claim

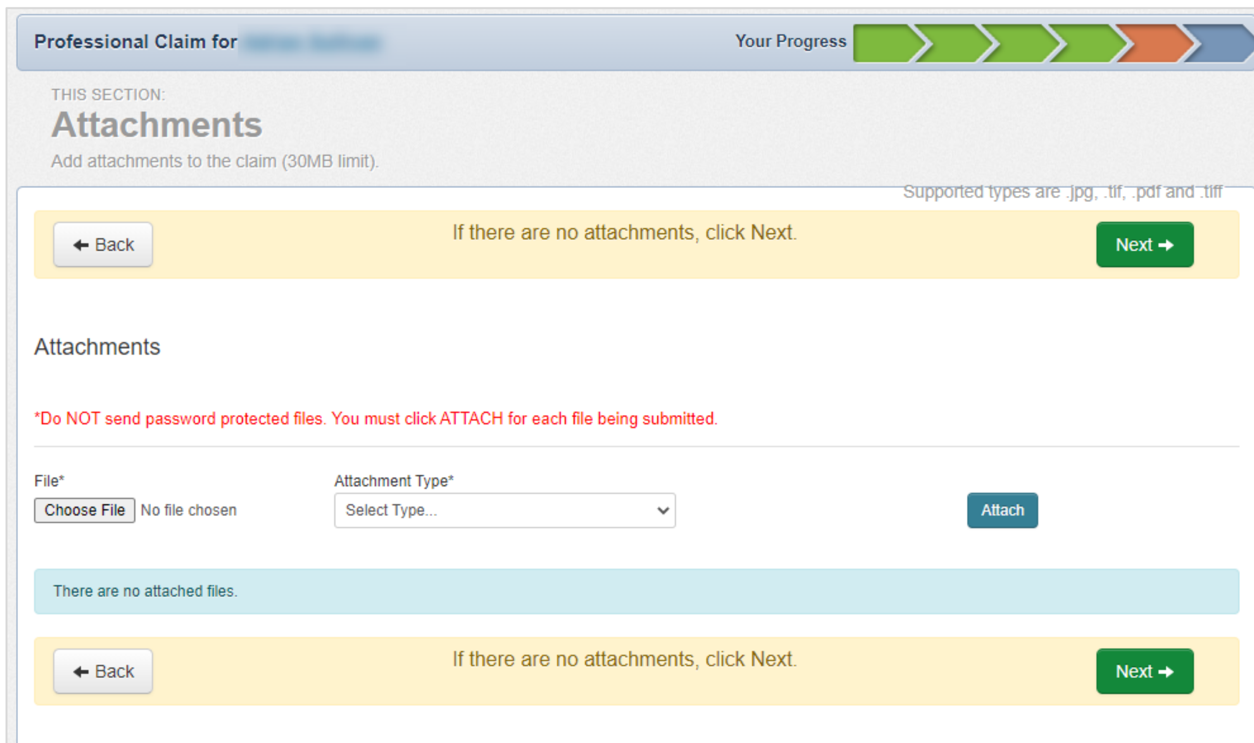
You can attach any documents to the claim as desired. Skip this section and click **Next** if you do not have any attachments.

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.



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

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:

Member Record Number:
Member Claim Amount Pa
Patient's Account Number

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 ,				
RenderingProvider					
BillingProvider	Families First of Florida,				
Service Facility Location					

Attachments

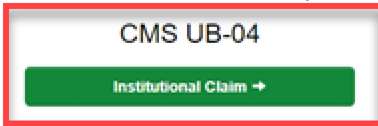
Back

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.

Institutional Claim for
Your Progress
THIS SECTION:
General Enter Information for the Admission and Condition Codes
* Required field
Next
Patient Control #* XXXXXXXXXX 3.a
Medical Record # XXXXXXXXXX 3.b
Type Of Bill* Select... 4.
Statement Dates* From MM/DD/YYYY To MM/DD/YYYY 6.
Prior Payments 54.
Prior Authorization Number 63.
Admission
Time Date MM/DD/YYYY Hour Select... 12-13.
Type* Select... 14.
Source* Select... 15.
Discharge
Status* Select... 17.
Hour* Select... 16.
Next
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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

3. 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

4. Click the **Save/Update** button on the right

5. Click the **New Service Line** button on the left. You can enter up to 99 service lines.

6. 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 Lookup 42.
HCPCS / Rate / HIPPS Code 44.
NDC Guide
Modifiers XX Add 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.

7. In the **Provider Details** screen, enter billing and other information in the appropriate sections.
8. 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* XXXXXXXXXXXX Search 56.

Taxonomy* XXXXXXXXXX 57.

Pay-to Provider Same As Billing Provider

NPI* XXXXXXXXXXXX Taxonomy* XXXXXXXXXX IRS/Tax ID Number* XXXXXXXXXX Pay-To Name* XXXXXXXXXX 2.

Address* XXXXXXXXXX City* XXXXXXXXXX State* Select... Zip* XXXXX

Attending Provider

NPI* XXXXXXXXXXXX Taxonomy* XXXXXXXXXX First Name* XXXXXXXXXX Last Name* XXXXXXXXXX 76.

IRS/Tax ID Number* XXXXXXXXXX

Rendering Provider

Please enter rendering provider information (if not the same as Attending Provider information). 81.

NPI XXXXXXXXXXX Find Provider

First Name XXXXXXXXXX Last Name XXXXXXXXXX Organization Name XXXXXXXXXX Clear ✕

Operating Provider

NPI XXXXXXXXXXXX Taxonomy XXXXXXXXXX First Name XXXXXXXXXX Last Name XXXXXXXXXX 77.

IRS/Tax ID Number XXXXXXXXXX

Other Operating (Physician) Provider

NPI XXXXXXXXXXXX Taxonomy XXXXXXXXXX First Name XXXXXXXXXX Last Name XXXXXXXXXX 78.

IRS/Tax ID Number XXXXXXXXXX Qualifier Select...

Other Provider

NPI XXXXXXXXXXXX Taxonomy XXXXXXXXXX First Name XXXXXXXXXX Last Name XXXXXXXXXX 79.

IRS/Tax ID Number XXXXXXXXXX

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
Your Progress
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 Add Denied Reason
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.

Institutional Claim for
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*
Choose File No file chosen
Attachment Type*
Select Type...
Attach
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.

Institutional Claim fo

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:

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									
PayTo Provider									

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

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 Deductable:
- 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

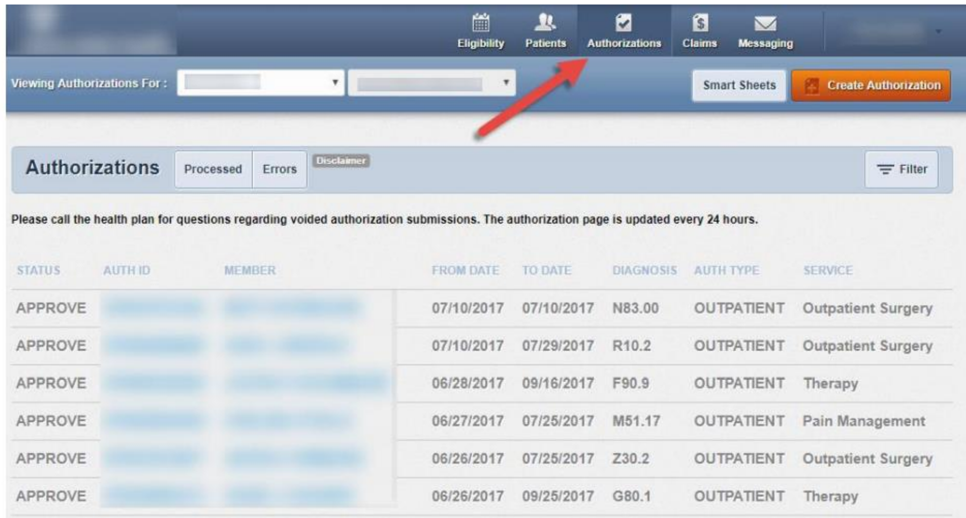
See also: CMS 1500 (Professional Claim)

Managing Authorizations

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

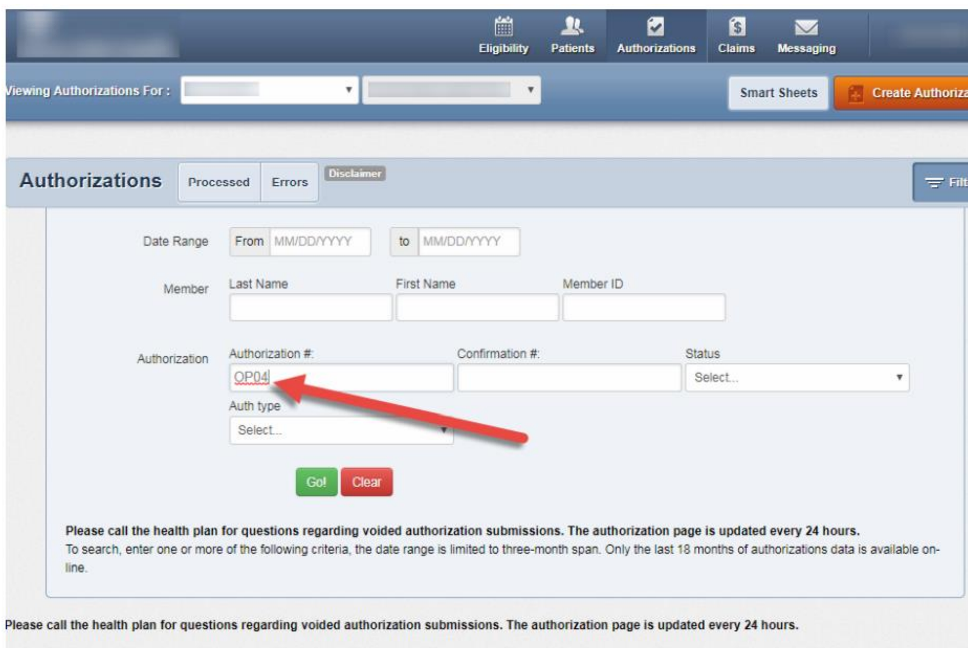
To Access Authorizations

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**.

Authorizations | Processed | Errors | Disclaimer | Filter

Date Range: From MM/DD/YYYY to MM/DD/YYYY

Member: Last Name, First Name, Member ID

Authorization: Authorization #, Confirmation #, Status (Select...)

Auth type (Select...)

Go! | Clear

Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.
To search, enter one or more of the following criteria, the date range is limited to three-month span. Only the last 18 months of authorizations data is available on-line.

Authorizations | Processed | Errors | Disclaimer | Filter

Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.

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

Authorizations | Processed | Errors | Disclaimer | Filter

Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.

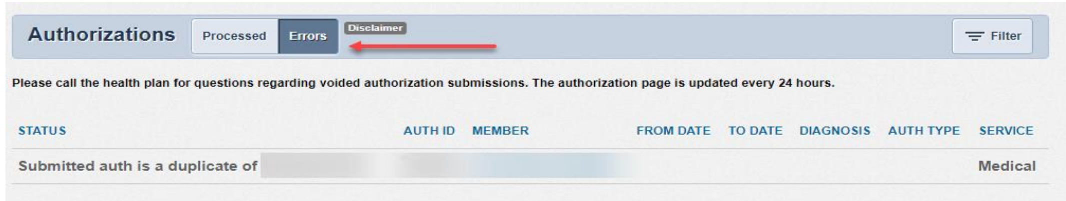
STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE			04/02/2020	12/31/9999	M17.12	INPATIENT	Surgical
APPROVE			03/25/2020	04/25/2020	Z83.2	OUTPATIENT	Genetic Testing & Counseling
APPROVE			03/17/2020	04/16/2020	H72.01	OUTPATIENT	Outpatient Surgery
APPROVE			03/10/2020	12/31/9999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

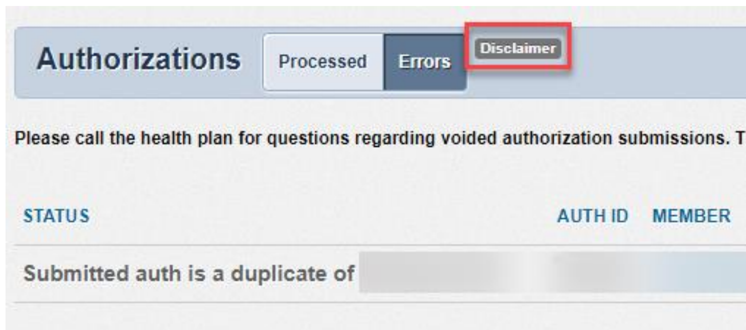
The following details about the request display:

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

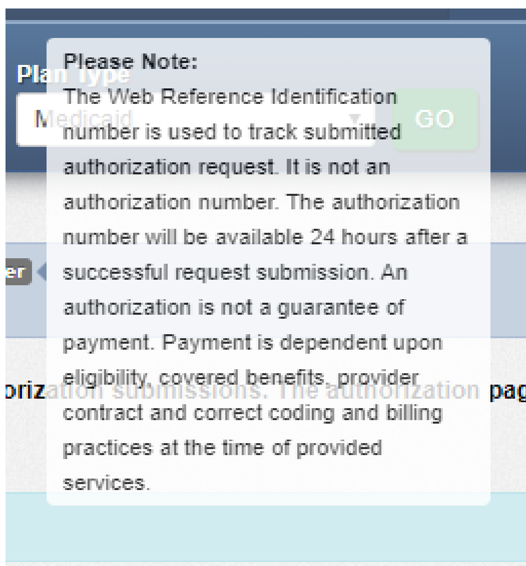


To View the Disclaimer

Place the mouse cursor over **Disclaimer**.



The disclaimer text displays.

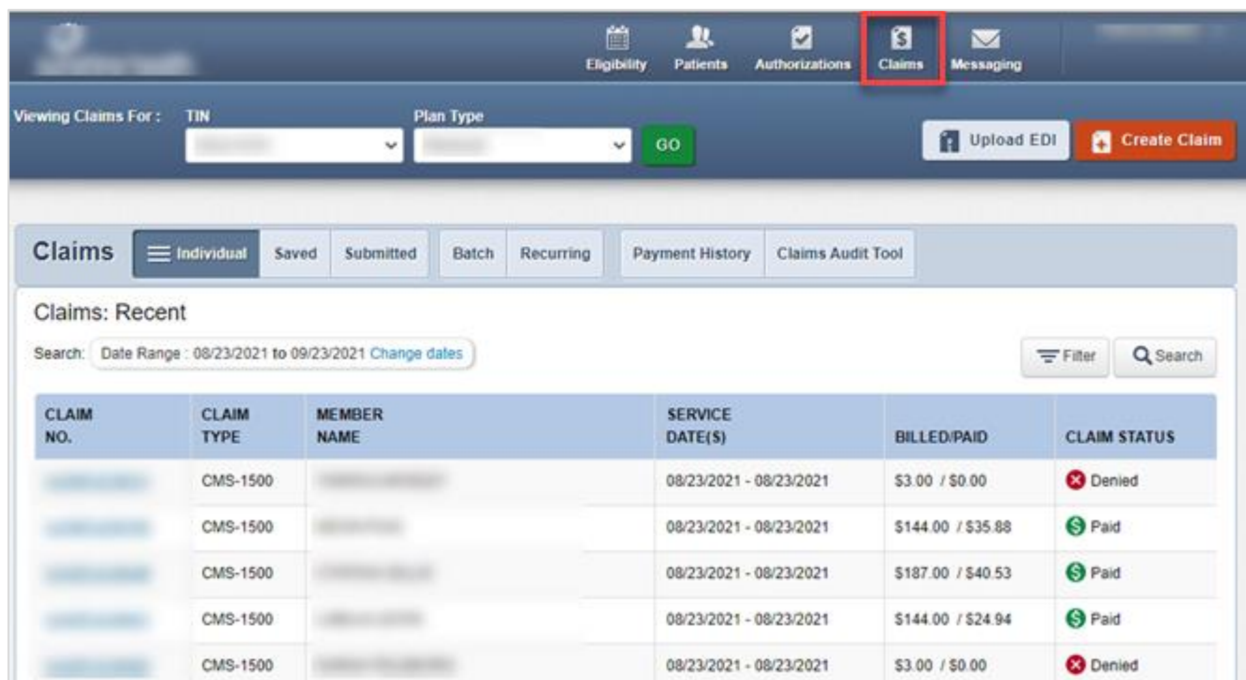


Managing Claims

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
Individual Claims:	List of manual claims submitted using the Provider Portal, Clearing House, or paper
Saved Claims:	Saved drafts of manual claims that have errors or missing information that have not been completed
Submitted Claims:	List of manual claims submitted using the Provider Portal only
Batch ClaimsL	List of 837 electronic claim files uploaded from the Provider Portal to EDI. Only the last 24 months of batch files are available online.
Upload EDI Claims:	Tool to upload 837 electronic claim files from your shared drive or other location.
Recurring Claims:	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.
Payment History Claims:	Provides Explanation Of Payments (EOP) documents for claims. Payment history is available up to 24 months.
Claims 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.

Managing Individual Claims

To Access Individual Claims

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

The following claim details display:

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

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.

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

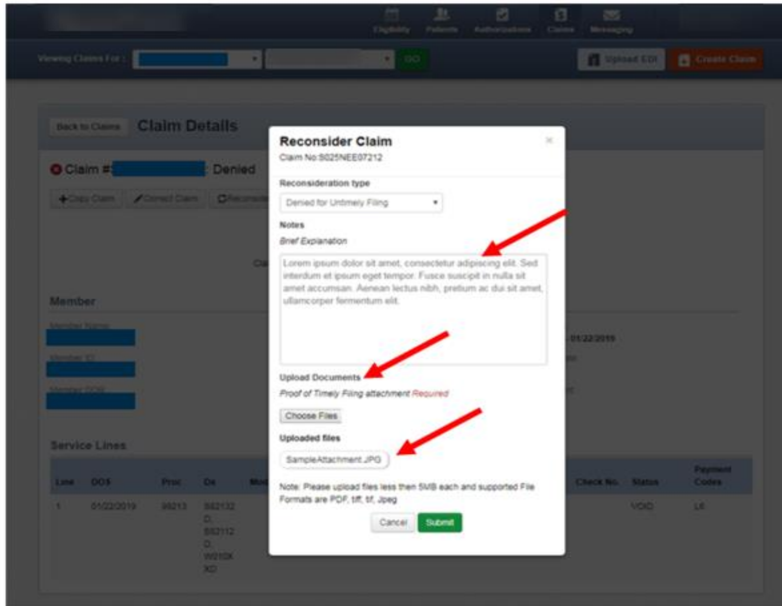
Use reconsider claim to provide documentation in support of a paid or denied claim. Providers are not to use this tool for Appeals.

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.

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

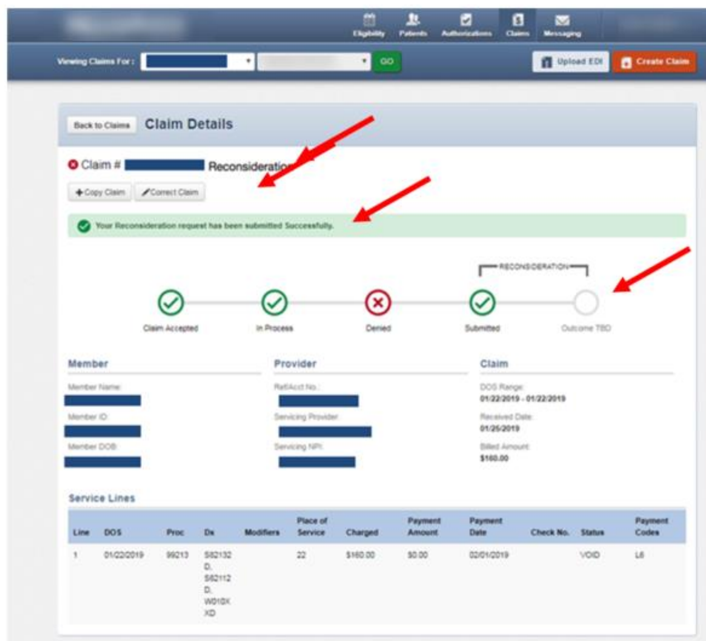
3. Add notes or upload documents as required.
   Note: The Reconsider Claims form is dynamic; depending on the type of reconsideration selected, notes and/or documents may be required.



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.

Check the status of a Reconsidered Claim

View available onscreen details and attachments.

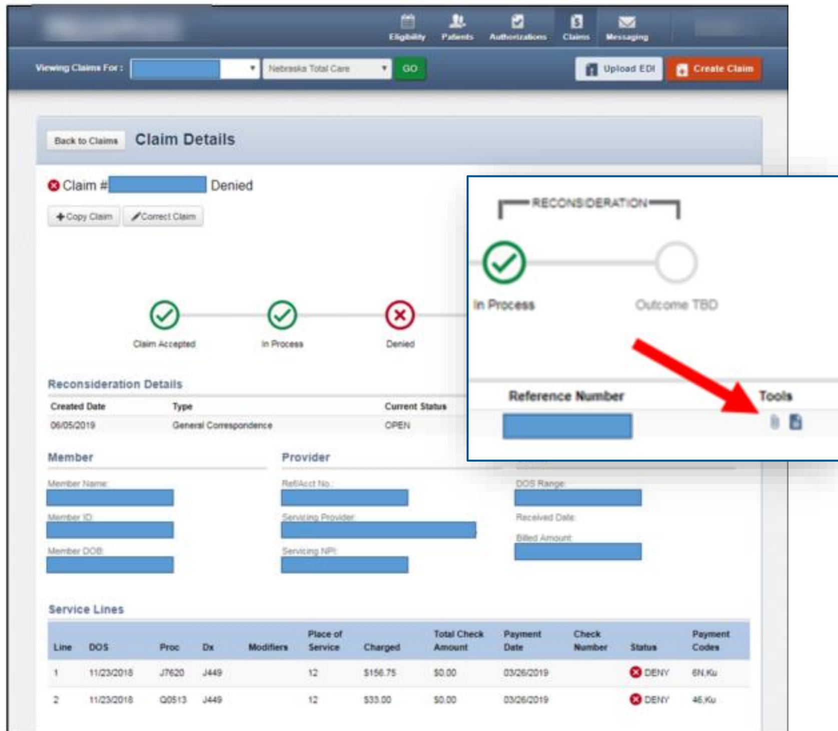
The Reconsideration Details table has one entry per reconsideration and includes:

- Created Date
- Type
- Current Status
- Reference#

To View and Upload Additional Attachments

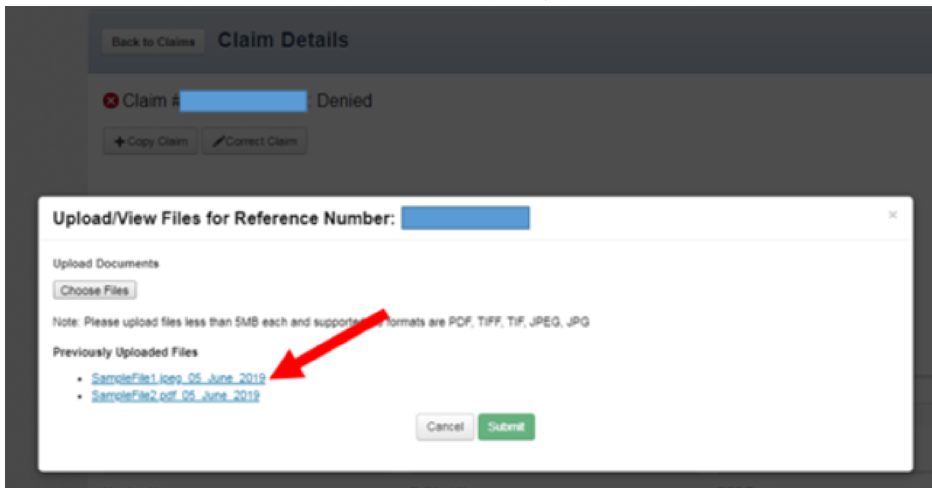
From the Reconsiderations Details table you can view and attach additional references to on-going reconsideration cases.

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.

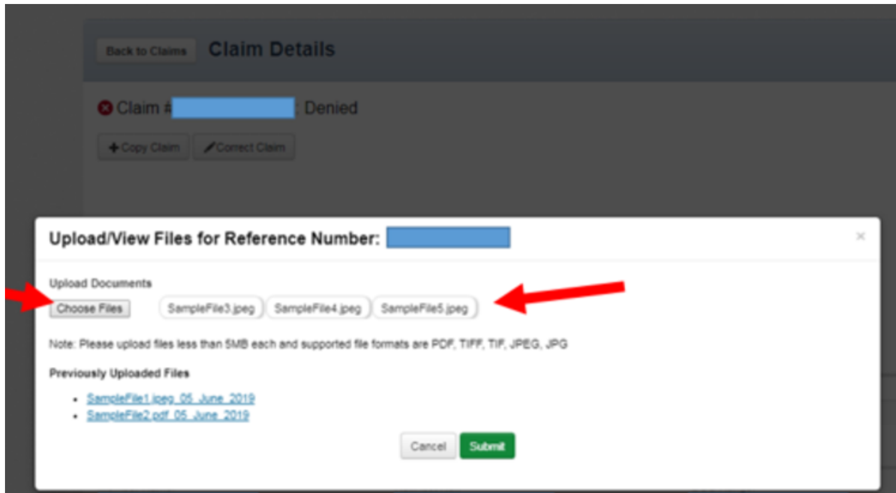


⚠ Files will appear with the original file name and appended date. Special characters are removed.

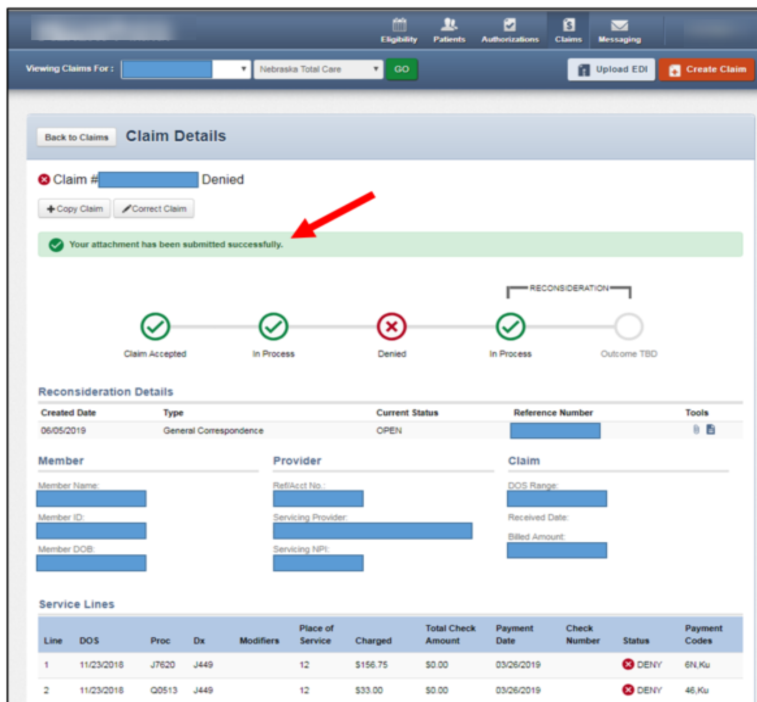
To Upload Additional Files

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.

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

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 | Individual | Saved | Submitted | Batch | Recurring | Payment History | Claims Audit Tool

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

Drafts | Professional Ready to be Submitted | Institutional Ready to be Submitted

DATE CREATED ↕	CLAIM TYPE ↕	CLAIM ID ↕	MEMBER NAME ↕	MEMBER ID ↕	ORIGINAL CLAIM # ↕	TOTAL CHARGES ↕		
08/29/2021	CMS-1500	[illegible]	[illegible]	[illegible]		$178.01	Edit	Delete
08/29/2021	CMS-1500	[illegible]	[illegible]	[illegible]		$178.00	Edit	Delete
08/29/2021	CMS-1500	[illegible]	[illegible]	[illegible]		$178.00	Edit	Delete
08/29/2021	CMS-1500	[illegible]	[illegible]	[illegible]		$178.00	Edit	Delete
08/29/2021	CMS-1500	[illegible]	[illegible]	[illegible]		$178.00	Edit	Delete
08/29/2021	CMS-1500	[illegible]	[illegible]	[illegible]		$178.00	Edit	Delete
08/29/2021	CMS-1500	[illegible]	[illegible]	[illegible]		$178.00	Edit	Delete
08/29/2021	CMS-1500	[illegible]	[illegible]	[illegible]		$178.00	Edit	Delete
08/29/2021	CMS-1500	[illegible]	[illegible]	[illegible]		$178.00	Edit	Delete
08/29/2021	CMS-1500	[illegible]	[illegible]	[illegible]		$178.00	Edit	Delete

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 ↕
	09/06/2021	[illegible]	[illegible]	CMS-1500	[illegible]	[illegible]	[illegible]	$338.00
	08/29/2021	[illegible]	[illegible]	CMS-1500	[illegible]	[illegible]		$178.01
	08/29/2021	[illegible]	[illegible]	CMS-1500	[illegible]	[illegible]		$178.00
	08/26/2021	[illegible]	[illegible]	CMS-1500	[illegible]	[illegible]		$61.02
	08/26/2021	[illegible]	[illegible]	CMS-1500	[illegible]	[illegible]		$208.00
	08/26/2021	[illegible]	[illegible]	CMS-1500	[illegible]	[illegible]		$144.00
	08/26/2021	[illegible]	[illegible]	CMS-1500	[illegible]	[illegible]		$144.00
	08/26/2021	[illegible]	[illegible]	CMS-1500	[illegible]	[illegible]		$144.00
	08/26/2021	[illegible]	[illegible]	CMS-1500	[illegible]	[illegible]		$144.00
	08/26/2021	[illegible]	[illegible]	CMS-1500	[illegible]	[illegible]		$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.

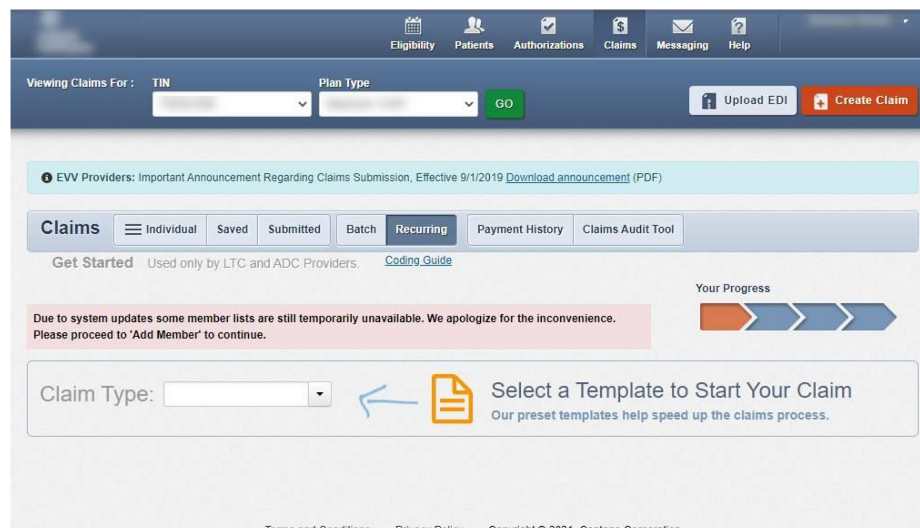
See also: Viewing Submitted Batch Claims

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.

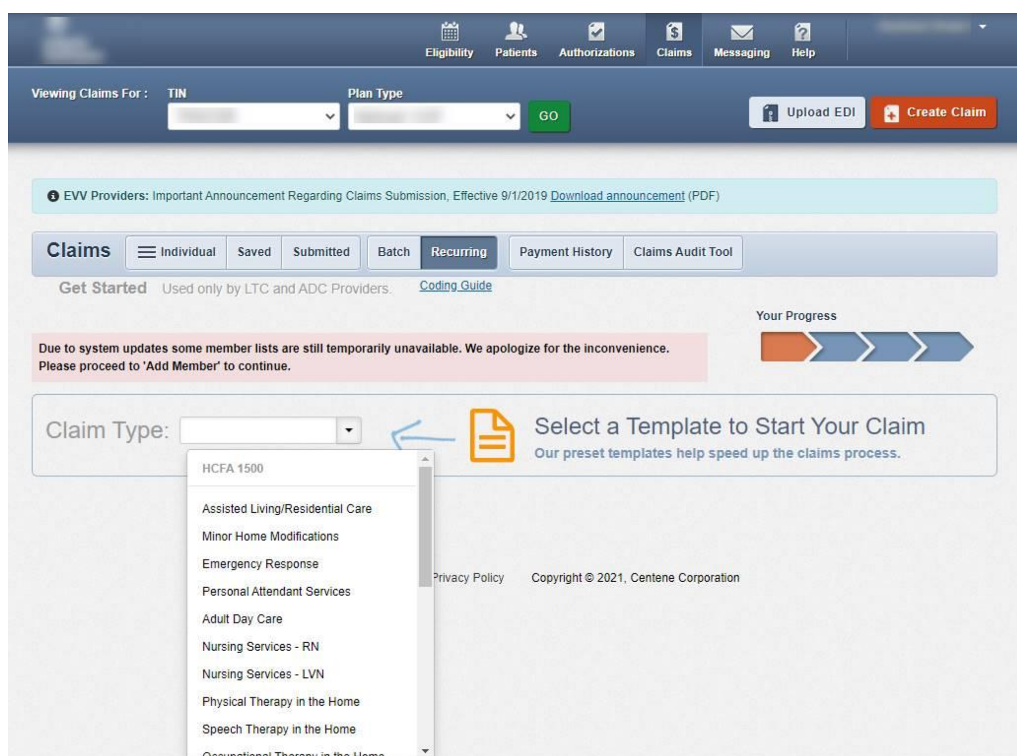
To Access Recurring Claims

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

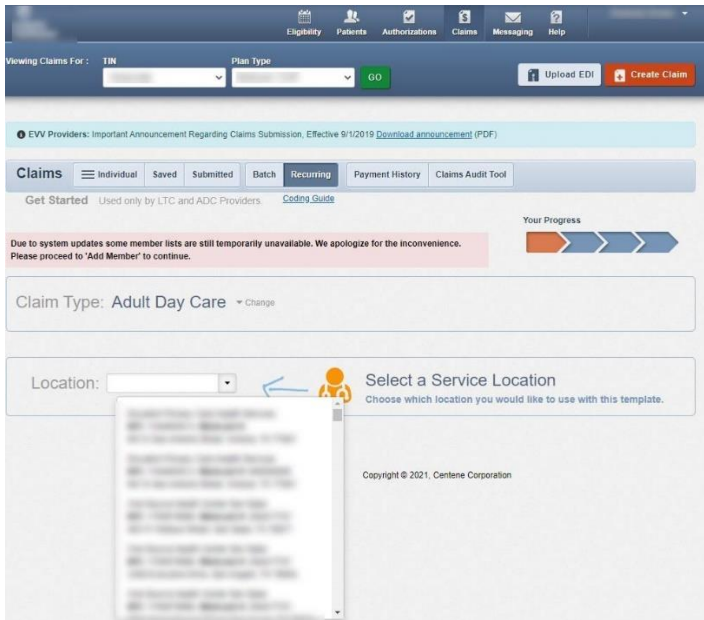


To Create a Recurring Claim

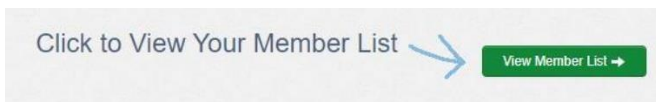
1. From the **Claim Type** drop-down menu, select the type of recurring claim you want to submit. **Note:** Options vary by plan type.



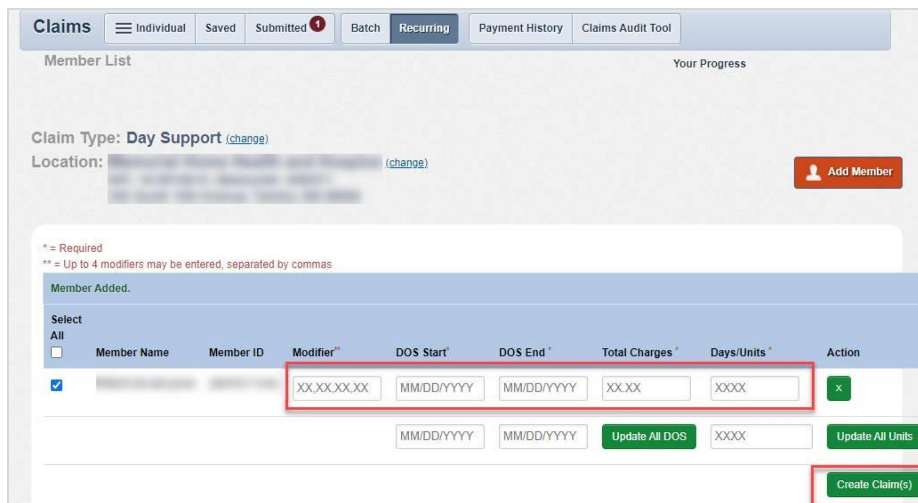
2. From the **Location** drop-down menu, select the address for the place of service.



3. Click **View Member List**.



4. 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).



5. 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

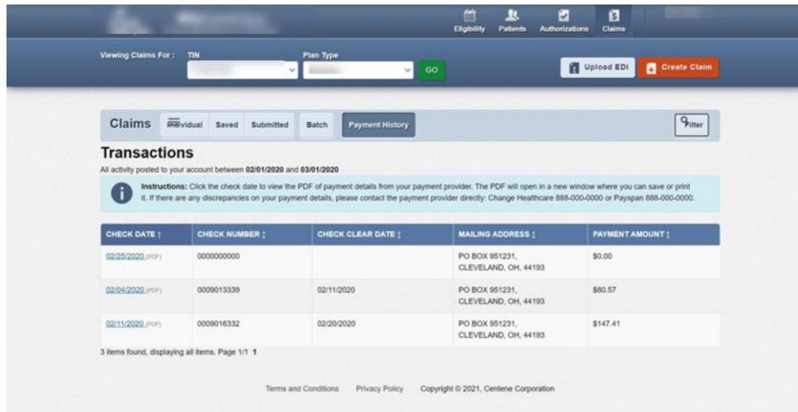
1. Click the **Add Member** button.
2. Enter the Member ID or last name and Date of Birth, and click **Add**. The member appears on your list.
3. Select the **checkbox** to the left of the member(s) you are creating the recurring claim for, and complete the required fields (Modifier, Date of Service 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

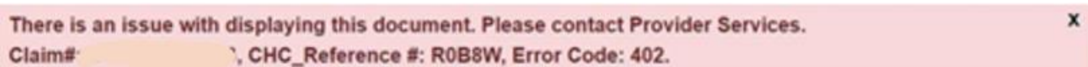
Click **Payment History** from the Claims screen. The following screen will appear.



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.



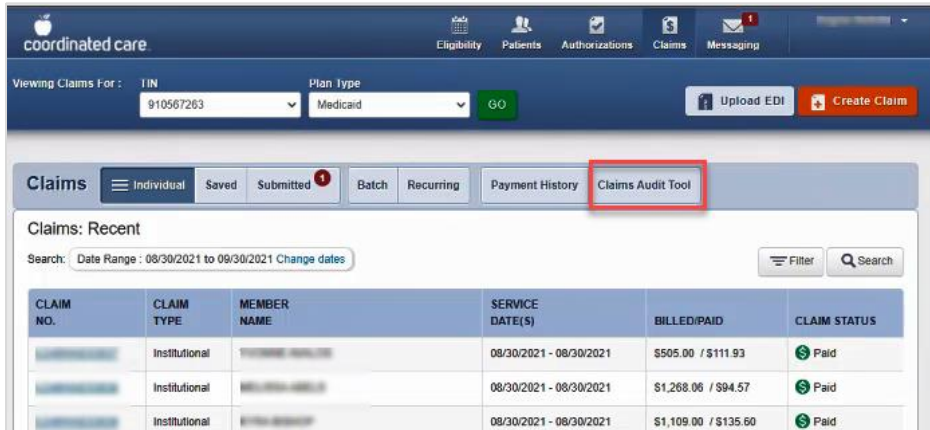
Example of Payment History (PDF dodument):

Using the Clear Claim Connection Audit Tool

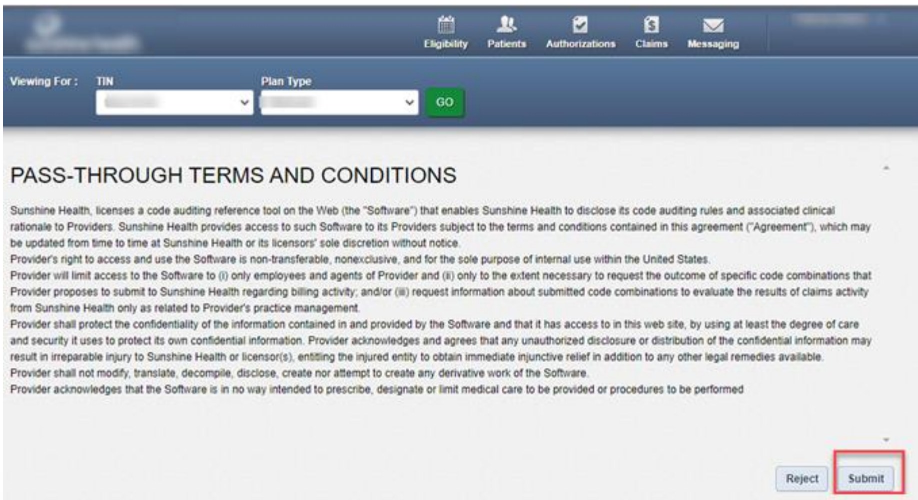
Clear Claim Connection is the claims audit tool used to look up Procedure Code, Quantity, Modifiers, Date and Place of Service, and Diagnosis for a claim proactively before you submit or retroactively after you submit a claim to get coverage details. The tool is also referred to as the code editing assistant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

Add More Procedures >>

Review Claim Audit Results | Clear

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

New Claim | Current Claim

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

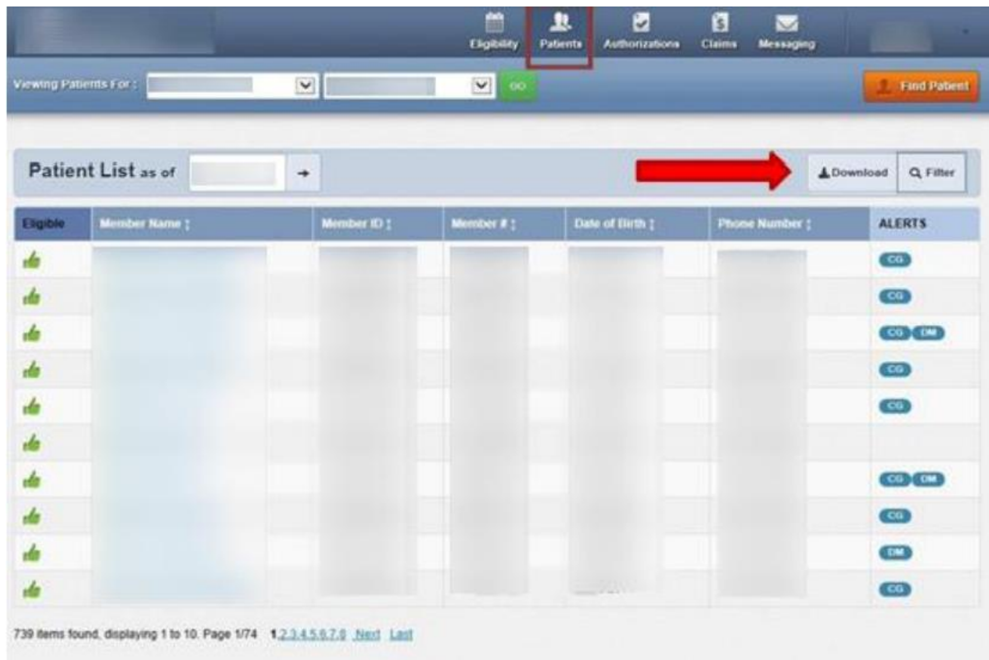
You can view and download a patient list from the Dashboard (only available for PCP's/PMP'S). Only the following patient information appears on the screen:

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

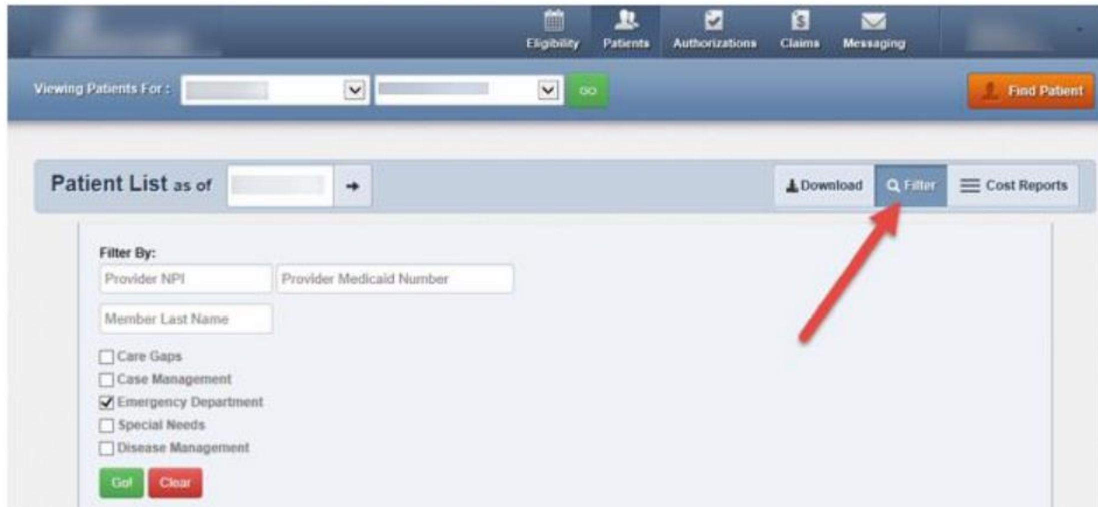
2. Click **Download.**
3. Select an option: **Open**, **Save** or **Save As**. The patient list file will either display or download.

⚠ 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:

9/29/2021 8:26:40 PM

9/29/2021

This is only a list of your patients, please check eligibility to confirm the effective date and benefits for this member.

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	Address 2

Managing Secure Messaging

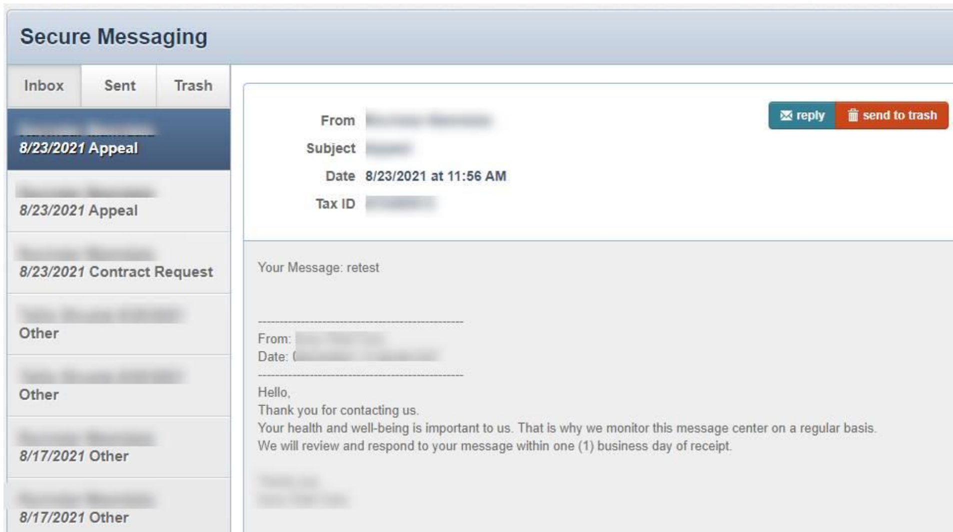
To Access Secure Messaging

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

To View and Respond to Received Secure Messages

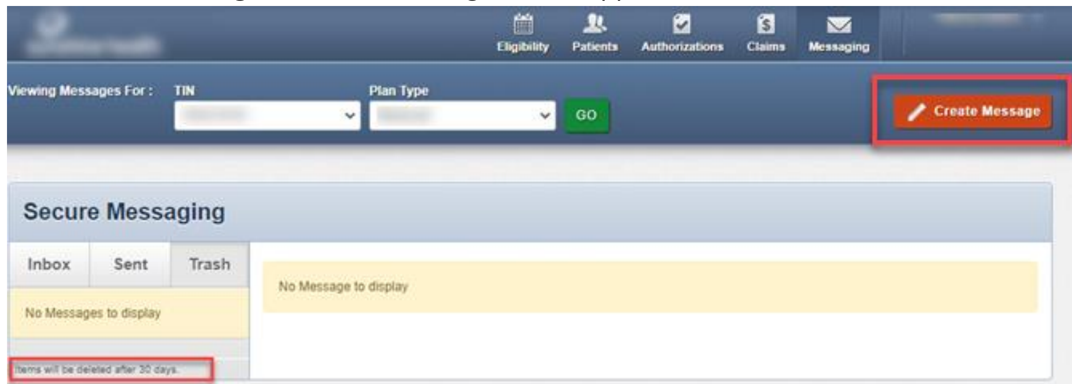
From the **Inbox**, click on the message you want to view.

- 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.



2. 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

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

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

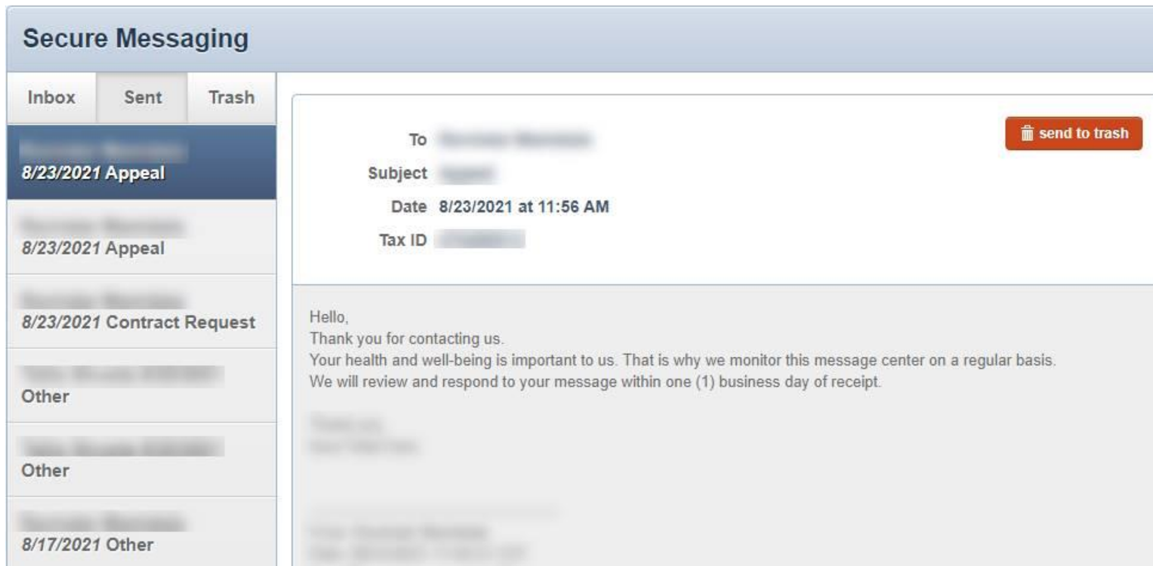
Manage Sent Secure Messages

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

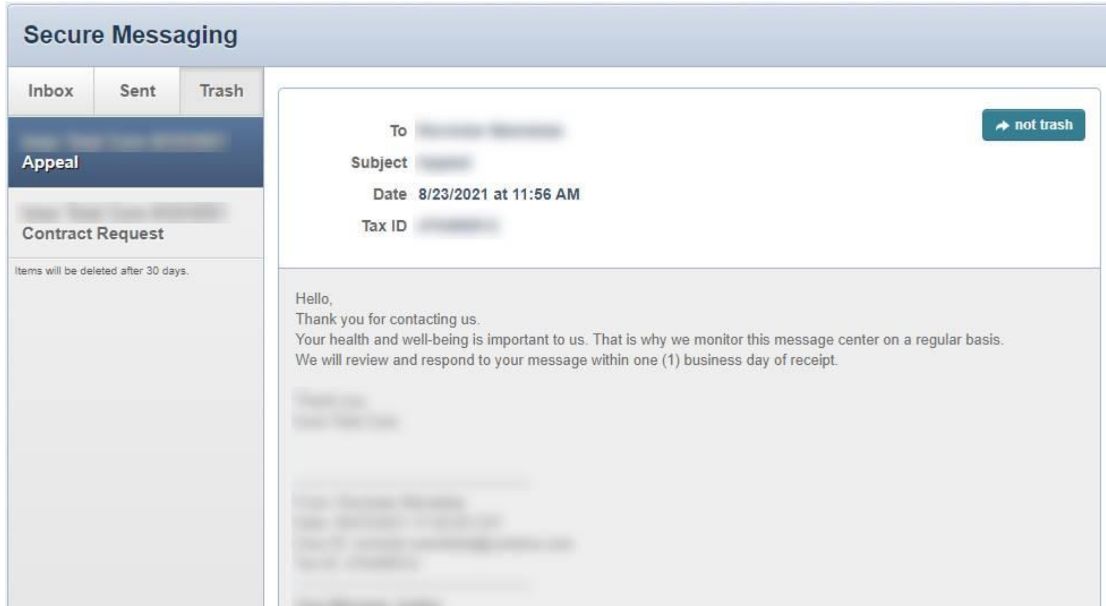
3. Click the **Send to trash** button.



⚠ **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.