

Secure Provider Website

Instructional Guide



Introduction

The Secure Provider Web is a secure website developed to allow Providers across Centene health plans to perform a variety of functions from their office. By registering and creating an account, a Provider can easily check patient eligibility, and view their patient list. Providers can view and submit both authorizations and claims through the website. A secure messaging feature allows a Provider to communicate with the health plan without having to pick up the telephone.

How to Use the Manual

This manual is intended to be a quick reference for using a tool or function offered on the website when a Provider or staff member needs assistance. The manual also explains many ways to use the site in order to get the most out of the resource.

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.

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Registration

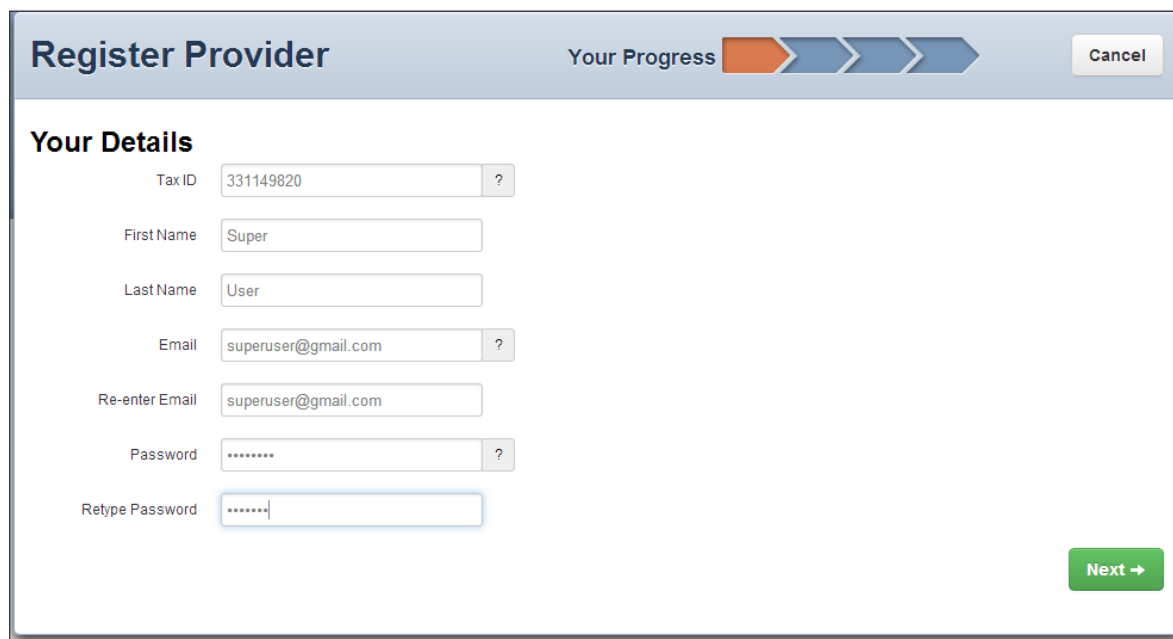
Create an account:

1. Click on 'Create An Account'.

The screenshot shows a website interface for registration. At the top right, there is a navigation bar with links for 'Features', 'Join Our Network', and a blue 'CREATE ACCOUNT' button. The main content area has a header 'The Tools You Need Now!' with the text 'Our site has been designed to help you get your job done. Manage all products with ease in one location'. Below this, there are three service cards: 'Check Eligibility' (thumbs up icon), 'Authorize Services' (checkmark icon), and 'Manage Claims' (dollar sign icon). A red arrow points from the 'Manage Claims' card to an orange 'Create An Account' button. To the right of the main content, there is a 'Login' overlay with fields for 'User Name (Email)' (containing 'name@domain.com') and 'Password', a green 'Login' button, and a link for 'Forgot Password / Unlock Account'. Below the 'Create An Account' button, there is a section titled 'Need To Create An Account?' with the text 'Registration is fast and simple, give it a try.' and a 'How to Register' section with the text 'Our registration process is quick and simple. Please click the button to learn how to register.' and two blue buttons: 'Provider Registration Video' and 'Provider Registration PDF'.

Note: A video is available which will walk new users through the registration process. Or, for step by step printed instructions, click on the provider registration pdf.

The screen below appears:



The image shows a web form titled "Register Provider". At the top right, there is a "Your Progress" indicator with four arrows, the first of which is orange and filled, followed by three blue arrows. A "Cancel" button is located to the right of the progress indicator. The main section is titled "Your Details" and contains several input fields: "Tax ID" (with the value "331149820" and a help icon), "First Name" (with the value "Super"), "Last Name" (with the value "User"), "Email" (with the value "superuser@gmail.com" and a help icon), "Re-enter Email" (with the value "superuser@gmail.com"), "Password" (with masked characters "*****" and a help icon), and "Retype Password" (with masked characters "*****"). A green "Next →" button is located at the bottom right of the form.

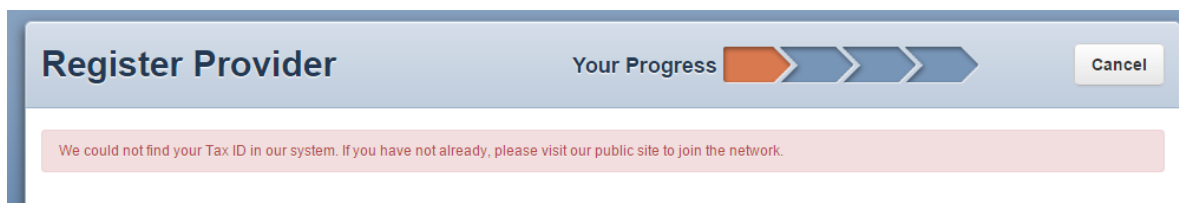
Enter the following information:

1. Enter Tax ID
2. Name
3. E-mail address
4. Create a password.

Note: Passwords must be at least 6 characters in length, with at least one uppercase and lowercase letter, and at least 1 number or symbol (A@#\$\$%&*8a).



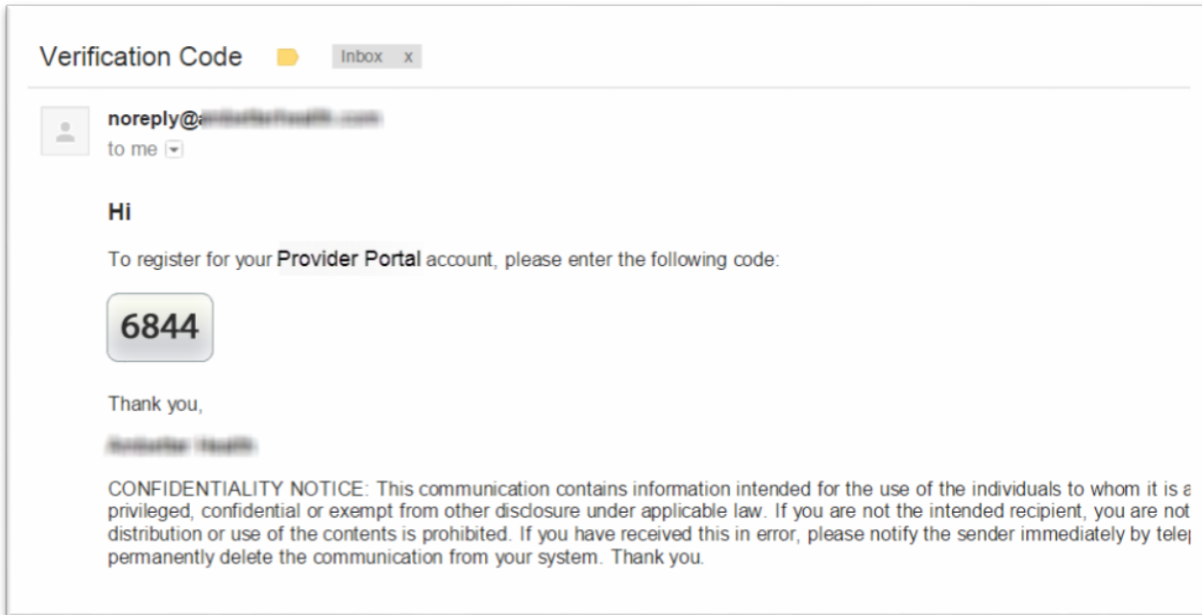
If you receive error message: "We could not find your Tax ID in our system. If you have not already, please join our network." Please return to our public site to join the network. Once your data is in our systems you'll be able to create your account.



The image shows the "Register Provider" form with an error message displayed in a red box at the bottom. The error message reads: "We could not find your Tax ID in our system. If you have not already, please visit our public site to join the network." The form fields and progress indicator are the same as in the previous image.

Note: Non-network providers can also use the secure provider portal once their TIN, NPI and billing information has been added to our claims system. Once an initial claim has been processed, the user should be able to create a secure account.

5. Confirmation Email will be sent to the email address provided during registration.



6. Enter the verification code

Register Provider Your Progress Cancel

Registering Provider 331149820 at superuser@gmail.com

Confirm Email

We've sent you an email with a 4-digit code to validate your email address.
If you didn't receive it, please check your Spam or Junk folder.

6844 Confirm

[Still didn't receive an email from us?](#)



If you do not see the verification email in your inbox: Please check your junk or spam email folder

7. Begin by completing the secret questions for your account

The screenshot shows a web form titled "Register Provider" with a progress bar indicating the current step. The form is for "Registering Provider 532129065 at anearly@centene.com". The "Account Setup" section includes instructions to enter secret questions and contact information, with a warning not to close the window. The "Secret Questions" section contains three questions, each with a dropdown menu and an answer field. The "Contact Information" section includes fields for Telephone Number and Fax Number, both with a question mark icon. A green "Submit" button is at the bottom right.

Register Provider Your Progress Cancel

Registering Provider 532129065 at anearly@centene.com

Account Setup
Enter your secret questions and contact information below, and then click "Submit" to complete your registration.
Please do not close this window or your changes will be lost.

Secret Questions

Question 1 What city were you born in?

Answer Clayton

Question 2 What is your favorite pet's name?

Answer Clayton

Question 3 What is your mother's maiden name?

Answer Clayton

Contact Information

Telephone Number 3144450016 ?

Fax Number 3144450016 X ?

Submit →

8. Hit Submit

The following screen appears:

The screenshot shows a confirmation screen titled "Registration Complete!". It includes a progress bar and a message thanking the user for completing registration. The message states that a Health Plan provider services specialist will be sending an email when the profile has been activated, within 2 business days. It also provides instructions for what to do if the email is not received within 2 business days. A green "Login" button is at the bottom left.

Registration Complete! Your Progress

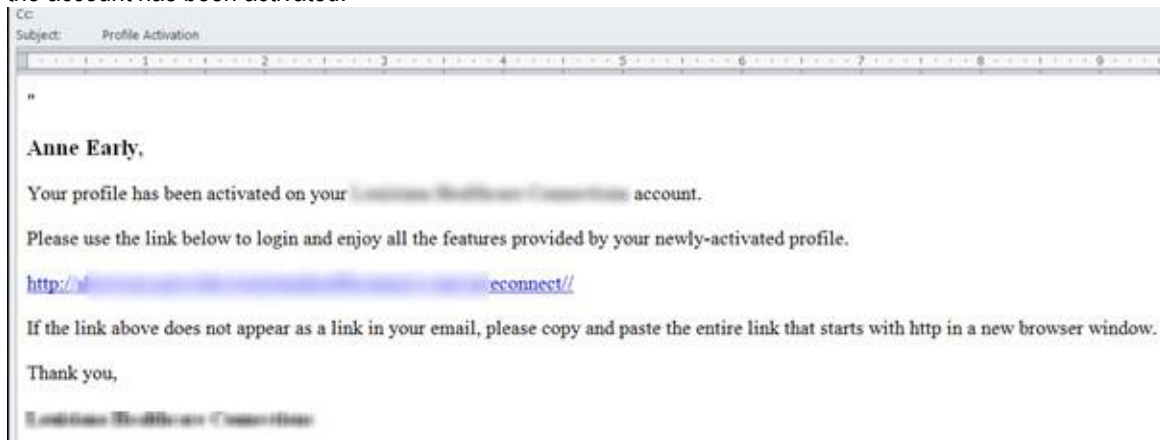
Thank you for completing your registration! A Health Plan provider services specialist will be sending you an email when your profile has been activated. Please allow up to 2 business days for processing.

If you do not receive an email within 2 business days, please log in and contact us using secure messaging or call (866) for additional assistance.

Login

Note: Until the plan verifies your user name, the only available options in the secure portal will be sending and receiving secure messages.

Note: the Health Plan will first verify your account (which can take up to 48 hours) and you will receive an email when the account has been activated.



Login

Below is the screen that allows you to Login to the secure provider portal.

A screenshot of a web application's login page. The header has a dark blue bar with the "econnect" logo and navigation links for "Features", "Join Our Network", and a "CREATE ACCOUNT" button. The main content area has a light blue background. On the left, there's a section titled "The Tools You Need Now!" with the text "Our site has been designed to help you get your job done. Manage all products with ease in one location". Below this are three icons with corresponding text: a thumbs up icon for "Check Eligibility" (Find out if a member is eligible for service.), a checkmark icon for "Authorize Services" (See if the service you provide is reimbursable.), and a dollar sign icon for "Manage Claims" (Submit or track your claims and get paid fast.). On the right, there's a white "Login" box with input fields for "User Name (Email)" (containing "name@domain.com") and "Password", a green "Login" button, and a link "Forgot Password / Unlock Account". Below the login box, there's a section "Need To Create An Account?" with the text "Registration is fast and simple, give it a try." and an orange "Create An Account" button. At the bottom right, there's a "How to Register" section with the text "Our registration process is quick and simple. Please click the button to learn how to register." and two blue buttons: "Provider Registration Video" and "Provider Registration PDF".

1. Enter user name
2. Enter Password
3. Click Login

The Dashboard

The Dashboard will appear after a user logs in.

1. Pick the Tax ID
2. Choose the appropriate Product
3. Select Go

Viewing Dashboard For: 123456789

Quick Eligibility Check

Member ID or Last Name: 123456789 or Smith Birthdate: mm/dd/yyyy

Check Eligibility

Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.

Welcome

Add a TIN to My ACCOUNT >

Reports >

Recent Activity

Date	Activity
------	----------

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Features accessible from the Dashboard are:

- Verify patient eligibility
- View and print your patient list (PCP/PMP) (Some plans also have Health Home providers)
- Submit and view authorizations
- Submit, view, correct, copy, void/recoup claims
- View provider related reports
- Send and receive secure messaging

Note: these features can vary by Health Plan and product

From the Dashboard you can also:

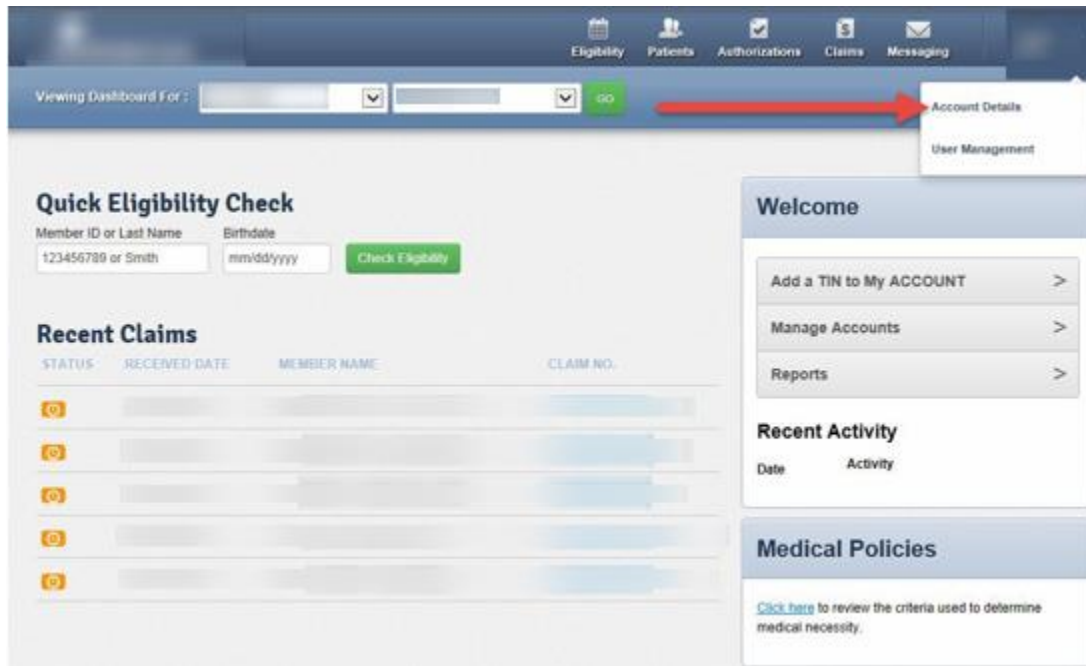
- Switch between Multiple Provider Tax ID's
- Switch between multiple products, i.e. Medicaid, Ambetter, Advantage Plans or MMP by using the drop down feature

Note: Users only need one account to manage all of their health plan products. Once a user creates a secure account, all products will be added for them. A TIN must be affiliated to the product in the claims system for the product to appear. If a product is missing – contact your provider relations representative for assistance. It can take up to 24 hours for the new product to show up in the portal once it is updated.

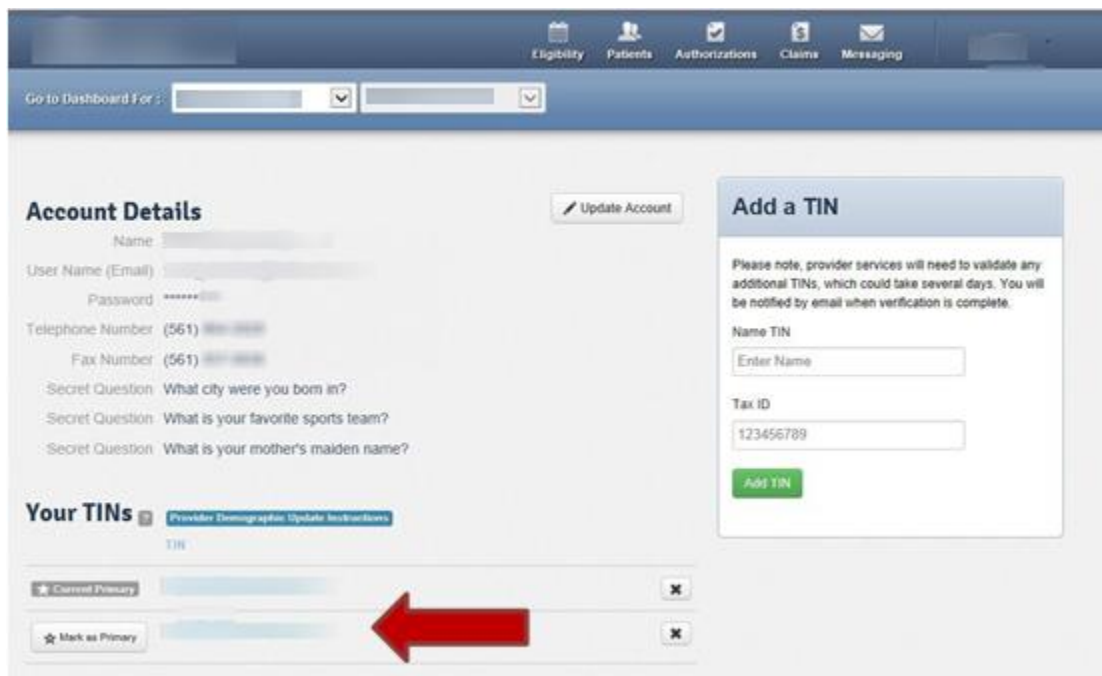
Your Account

To view your account:

1. Select the **drop-down arrow** next to your name in the upper right corner on the dashboard
2. Click **Account Details**



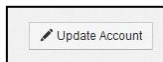
The following screen appears:



Note: Under Your TINs you see the Current Primary Default TIN for the account, and can select another TIN to **Mark As Default** or **Remove** a TIN.

Update an account

1. Click the **Update Account** button.

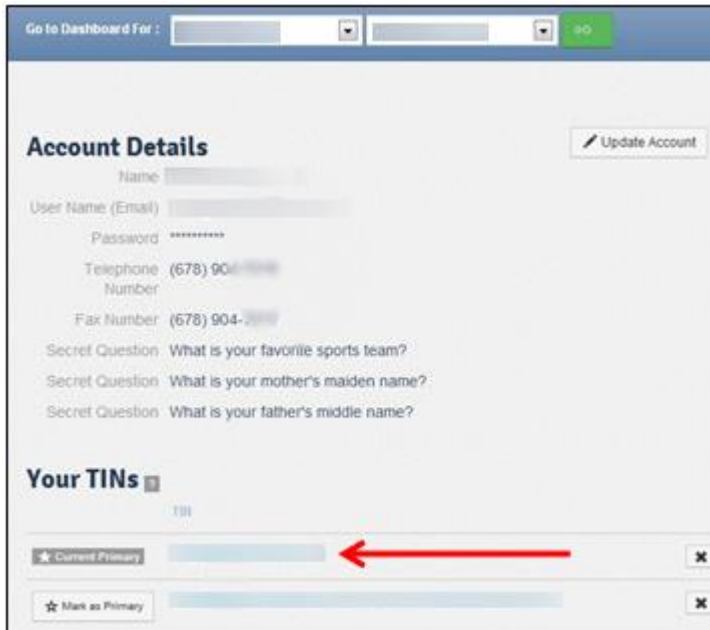


You are able to update the details of your account, and your security information.

- Change/Update Name
- Change/Update Email
- Change Password
- Update Phone/Fax Numbers

To modify demographic information about the Specific TIN

1. Click on the individual TIN to update.

A screenshot of a web application interface. At the top, there's a "Go to Dashboard For:" section with two dropdown menus and a green "GO" button. Below this is the "Account Details" section, which includes fields for Name, User Name (Email), Password, Telephone Number, Fax Number, and three Secret Questions. To the right of this section is an "Update Account" button. Below the account details is the "Your TINs" section, which lists TINs with a "Current Primary" status and a "Mark as Primary" button. A red arrow points to the "Current Primary" button.

The following screen appears

2. To update information about one of the Associated Providers, click on the name.

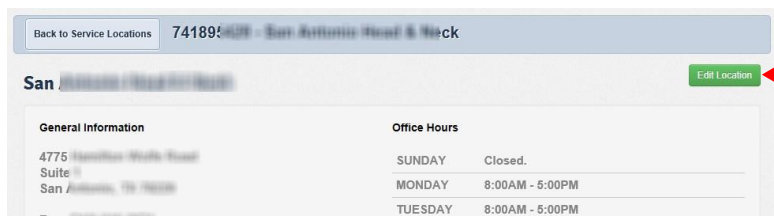
A screenshot of a web application interface. At the top, there's a "Back to Account Details" button, a "TIN:" label, an "Enter Name" input field, and an "Update" button. Below this is the "Associated Providers" section, which lists providers with a "NAME" column. A red arrow points to the "NAME" column.

3. A list of possible Service Locations will appear

A screenshot of a web application interface. At the top, there's a "Back to Associated Providers" button. Below this is the "Service Locations" section, which lists locations with a "LOCATION NAME" column and an "ADDRESS" column. A red arrow points to the "LOCATION NAME" column.

4. Click on the name associated to the address to update

The following screen appears.



4. Click Edit Location to update the provider information – This information will update the Find A Provider website
5. The following Transaction attributes will be available for edits - **only one update within a transaction set is allowed per day.**

(If any additional updates are necessary – please contact your provider relations representative)

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)

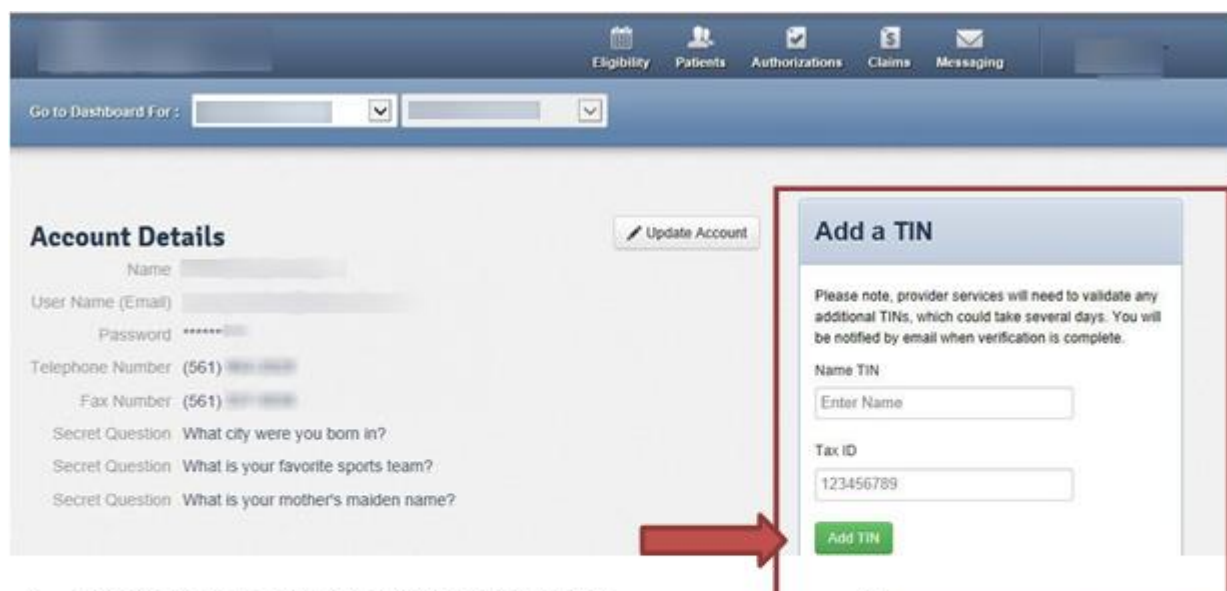
Transaction Set #5 - Practitioner Gender

- Gender

Transaction Set #6 - Practitioner Office Hours

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

Adding 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 following message appears. Each new TIN added will require verification from the health plan and can take up to 48 hours to complete



The following screen appears:

Viewing For : [dropdown]

Update User status and permissions for [redacted]

User Information

Email: [text box] Status: [text box]
Name: [text box] Last Login Time: [text box]
Telephone Number: [text box]

Profile Information

TIN: [text box] Verified: [text box]

Can Access

☒ Claims ☒ Assessments ☐ Health Passport ☒ Health Record ☐ Manage Account ☒ Eligibility ☒ Authorizations

Update Status: ☐ Disable user

Comments: [text box] 200 characters left

Comments History: [text box]

Cancel Update User

1. Check/Uncheck the boxes according to what permissions each user should have.
2. Click **Update User**.

Account Permission Definitions:

Health Record	Health history including visits and medications
Claims	Ability to view or submit claims
Manage Account	Provides access to all functions within the secure portal and is the Administrator for that TIN
Eligibility	Access to check eligibility
Health Passport	Only necessary for plans using Health Passport
Assessments	Ability to complete and submit HRA and/or NOP forms
Authorizations	Ability to view or submit authorizations



If you uncheck the **Manage Account** box, the identified user will not be able to manage other accounts. Once you click save you will return to the Support Users screen to manage additional users. All changes take effect immediately

Invite a others to join your account

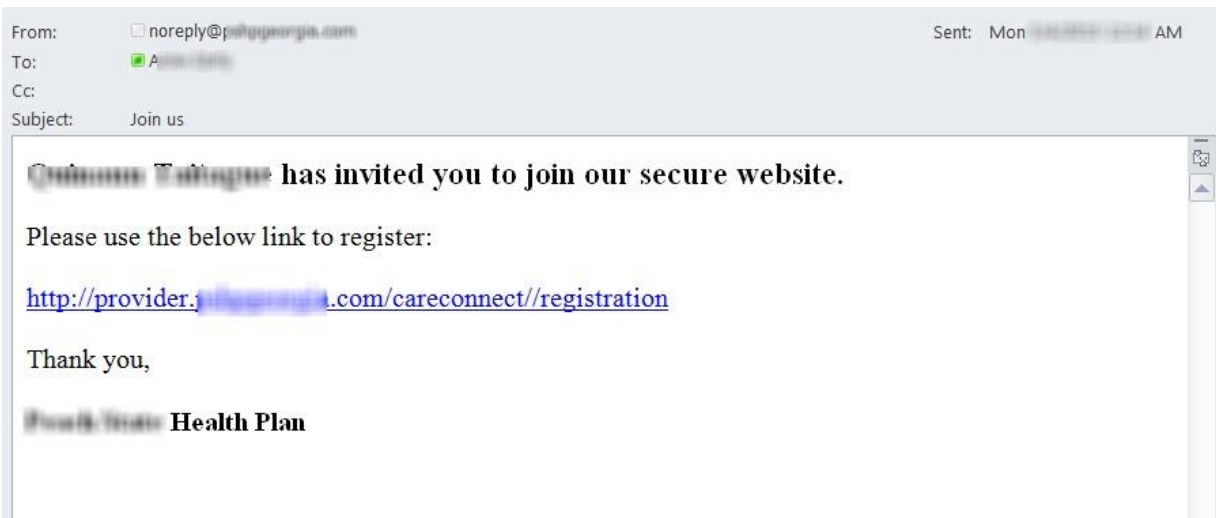
From the **Support Users** screen enter a user's email address to invite them to join your account.

1. Enter their Email Address in the email address field and click **Send Invitation**.

The screenshot shows the 'Support Users' interface. At the top, there's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this is a 'Viewing For' dropdown. The main content area is divided into two panels. The left panel, 'Search for User', has input fields for Email, Last Name, and Status, along with a 'Verification Pending' checkbox and 'Go'/'Clear' buttons. The right panel, 'Invite a User', is highlighted with a red box and contains an 'Email Address' input field with 'name@domain.com', a 'Send Invitation' button, and a link to the 'Account Manager User Guide'. A large red arrow points to the 'Send Invitation' button. Below these panels is a table with columns: Email Address, Last Name, First Name, TIN, Telephone Number, Status, and an 'Update User' button for each row. A modal window titled 'Invite a User' is overlaid on the table, showing a green message box that says 'User successfully invited.' circled in red, and the same 'Email Address' and 'Send Invitation' fields as the main form.

Note: A successful invitation email was sent when you see the following message

An example of the invitation email is shown below



Note: Each new invitee will follow the registration process defined [here](#).

Verifying Patient Eligibility

To verify patient eligibility:

1. Select **Eligibility** at the top of your screen.

The screenshot shows the 'Eligibility' tab selected in the top navigation bar. Below the navigation bar, there are dropdown menus for 'Viewing Eligibility For:'. The main section is titled 'Eligibility Check' and contains a form with the following fields:

- Date of Service: 05/19/2015
- Member ID or Last Name: 123456789 or Smith
- DOB: mm/dd/yyyy
- Check Eligibility (green button)
- Print (button with printer icon)

Below the form is a table with the following headers:

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	PRODUCT	CARE GAPS
----------	-----------------	--------------	--------------	---------	-----------

- Enter the **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 following screen appears:

Viewing Eligibility For :

Eligibility Check

Date of Service: 06/30/2017 Member ID or Last Name: 123456789 or Smith DOB: mm/dd/yyyy

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	CARE GAPS
	06/30/2017	<input type="text"/>	06/30/2017	<input type="button" value="+ Emergency Room Visit?"/> <input type="button" value="x Remove"/>

This view contains:

- Eligibility status
- Date of service
- Patient name
- Date checked
- Care gaps
- You can also add an Emergency Room visit for a patient from this screen to alert their case managers of their recent activity

1. To check additional patients, repeat the steps above.
2. To print the eligibility information click **Print**.
3. To open the Patient Record, click on the blue **Patient Name**.

Overview Tab on Patient Record

The Patient Record opens to the Overview tab and displays:

- Patient Information
- PCP Information
- PCP History
- Eligibility History
- Care Gaps
- Allergies

The screenshot shows the 'Overview' tab of a patient record. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this is a search bar labeled 'Viewing Patients For:' with two dropdown menus and a 'Find Patient' button. On the left, a sidebar contains a list of tabs: Overview (selected), Cost Sharing, Assessments, Health Record, Care Plan, Authorizations, Referrals, Coordination of Benefits, and Claims. The main content area displays a green message: 'This patient is eligible as of today, Jun 15, 2015.' Below this, there are two columns of information: 'Patient Information' and 'PCP Information'. The 'Patient Information' column lists fields: Name, Gender, Birthdate, Age, Member #, and Address. The 'PCP Information' column lists fields: Name, Address, Practice Type, and Phone Number. Below the 'Patient Information' column is an 'Eligibility History' table with columns for Start Date, End Date, and Product Name. The table contains two rows of data. Below the table is a link to 'View Clinical Information'. To the right of the 'Eligibility History' table are links for 'View PCP History', 'Care Gaps', and 'Allergies'. The 'Care Gaps' and 'Allergies' sections each show a text input field with the value 'None On File'.

Back to Patient List

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

This patient is eligible as of today, Jun 15, 2015.

Patient Information

PCP Information

Name

Gender

Birthdate

Age

Member #

Address

Name

Address

Practice Type

Phone Number

[View PCP History](#)

[Care Gaps](#)

[Allergies](#)

Eligibility History

Start Date	End Date	Product Name
Feb 5, 2015	Ongoing	
Dec 22, 2014	Feb 4, 2015	

[View Clinical Information](#)

None On File

None On File

View Clinical Information displays

Three Most Recent ER Visits
Recent Pharmacy Activity

5 Top Most Occurring Diagnosis
Three Most Recent Office Visits

Three Most Recent Inpatient Admissions

[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	07/01/2018	Classic Optical Laboratories Inc
REGULAR ASTIGMATISM	07/01/2018	Classic Optical Laboratories Inc
PRESBYOPIA	04/20/2018	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

Patient (Member) Record Components

Overview	Click Here to view the Overview Screen
Cost Sharing	The patient'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 patient record allows you to view current authorizations, and create new authorizations for the patient
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 patient record allows you to view any recent claims for the patient, and also create a new claim



Note: Not all plans have all the listed components.

Cost Sharing

To access the cost sharing information from inside the member record:

1. Select Cost Sharing

This sample screens show a member with cost sharing:

The screenshot shows a web application interface for viewing patient information. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this is a search bar labeled "Viewing Patients For:" with two dropdown menus and a "GO" button. A "Find Patient" button is also present. The main content area has a sidebar on the left with a "Back to Patient List" button and a list of menu items: Overview, Cost Sharing (highlighted), Assessments, Health Record, Care Plan, Authorizations, Coordination of Benefits, and Claims. The main panel displays the "HIP BASIC MEMBER COST SHARING GRID".

Type of Service	Co-Pay Amount
Preventive Care	No co-pay
Family Planning Services	No co-pay
Outpatient Services	\$4.00
Inpatient Services	\$75.00
Preferred Drugs	\$4.00
Non-Preferred Drugs	\$8.00

*MHS will not collect POWER Account contributions or impose any other cost-sharing, including co-pays for non-urgent care use of hospital emergency departments, on members who are pregnant or Native American Indian.

# of Non-Emergency Emergency Room Visits	Co-Pay Amount
1st Visit	\$8.00
Each Visit After 1st Visit	\$25.00

*Co-pays for non-emergency use of an emergency room will be collected by all eligible HIP member EXCEPT for those exempt from cost-sharing (pregnancy or Native American Indian).

This sample screens show a member without any cost sharing:

The screenshot shows the same web application interface as the previous one, but for a different member. The patient's name is "VALENTINA MAR V AGUIRRE GONZALEZ". The sidebar menu is the same, with "Cost Sharing" highlighted. The main panel displays the "Cost Sharing Summary" section, which states: "This member has no co-pay".

Assessments

To access an assessment from inside the member record:

1. Select **Assessments** on the left.

The following screen displays the Notification of Pregnancy:

This screenshot shows a web interface for a patient's record. On the left is a vertical navigation menu with the following items: Overview, Cost Sharing, Assessments (highlighted in blue), Health Record, Care Plan, Authorizations, Coordination of Benefits, and Claims. The main content area has a header with a 'Back to' button. Below the header, the page is divided into two columns. The left column is titled 'Ways you can let us know about your health.' and contains a section for 'Notification of Pregnancy' with the text 'Please let us know if you are pregnant so we can help keep you and your baby healthy.' and a blue 'Fill Out Now!' button. The right column is titled 'Previous Assessments' and contains a yellow message box that reads: 'You have not told us about anything yet. Please fill out a form.'

The following sample screen appears showing other assessments available for the provider to complete:

This screenshot shows a web interface for a patient's record, specifically for 'BRAND L. JACOBLEY'. The left navigation menu is identical to the previous screenshot, with 'Assessments' highlighted. The main content area has a header with a 'Back to Patient List' button and the patient's name. Below the header, the page is divided into two columns. The left column is titled 'Please tell us about your patient's health' and lists several assessment tools, each with a description and a blue 'Fill Out Now!' button: 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 (A health risk assessment helps determine ways to help your patient stay healthy and prevent diseases), KATZADL (Required Screening Tool), and PHQ-9 (Required Screening Tool). The right column is titled 'Previous Assessments' and contains the same yellow message box as the previous screenshot: 'You have not told us about anything yet. Please fill out a form.'

2. Select the **Fill out now** button
3. The questionnaire opens for data entry
4. Complete questionnaire
5. Select **Submit** button

Viewing Submitted Assessment Responses

To access an assessment from inside the member record:

1. Select **Assessments** on the left.

Assessment Name	Submit Date
HAP-8 Month V3	12/18/2014
Katz Index of Independence in Activities of Daily	06/10/2014
HAP-4 Month V2	06/10/2014
WA HRS	04/15/2014
HAP-Initial V2	02/27/2014
WA HRS	02/21/2014
Health Risk Assessment 2012	02/18/2014
Katz Index of Independence in Activities of Daily	02/18/2014
Health Risk Assessment 2012	02/18/2014
Pt. Health Questionnaire-9 (PHQ-9)	02/18/2014
WA HRS	07/25/2012
WA HRS	06/26/2012

2. Completed assessments will appear in a column on the right side of the health record.
3. Click on the assessment hyperlink.

WA HRS - 04/15/2014

Member First Name: [redacted]

Member Last Name: no answer

Member ID: [redacted]

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?

[Back](#)

4. All of the completed responses appear in black font. Gray text means the question was not completed.
5. Click **Back** to return to the member's health record.

Health Record

To access the Members Health Record from inside the patient record

1. Select **Health Record**.
The Health Record tab allows you to view a record of visits or medications for the patient.
2. Click on **Visits** to view any visit information (i.e. Office Visits, ER visits, etc.) for the patient.

The screenshot shows the 'Health Record' section of a patient's record. On the left is a sidebar with navigation links: Overview, Cost Sharing, Assessments, **Health Record** (selected), Care Plan, Authorizations, Coordination of Benefits, and Claims. The main content area has tabs for Visits, Medications, Immunizations, Labs, and Allergies. The 'Visits' tab is active, displaying a table of visit information.

Primary Diagnosis	Date	Visit Type	Claim Type	Facility/Provider
Essential Hypertension, Benign	04/01/2015 - 04/01/2015	Independent Laboratory	Medical	Vpa Pc Lab
Depressive Disorder Neg	11/10/2014 - 11/10/2014	Emergency Room - Hospital	Medical	Kopczynski, Bogumila
Lumbago	11/10/2014 - 11/10/2014	Emergency Room - Hospital	Medical	Harris, Daniel
Unspecified Chest Pain	11/03/2014 - 11/03/2014	Emergency Room - Hospital	Medical	Reyes, Benedicto
Oth Chron Nonalcoholic Liver Disease	11/03/2014 - 11/03/2014	Emergency Room - Hospital	Medical	Reyes, Benedicto

- a. To view details for the visit, click on the **Diagnosis Hyperlink**.

The screenshot shows the details for a specific visit. The sidebar is identical to the previous screen. The main content area has tabs for Back to Visits, Medications, Immunizations, and Labs. The 'Back to Visits' tab is active. Below the tabs, it says 'Service Layer For Hypermetropia - 3670'. A table displays visit details.

Date	Description	Code
08/14/2012 - 08/14/2012	Ophth Serv: Med Exam; Comp New Pt 1/more Visits	92004
08/14/2012 - 08/14/2012	Determ Refractive State	92015

- Click on **Medications** to view any medication information (i.e. Medications prescribed to a Member) for the patient.

Back to Patient List

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Coordination of Benefits

Claims

Visits

Medications

Immunizations

Labs

Allergies

Fill Date	Drug Name	Dose	Quantity	Dispensing Pharmacy
05/20/2015	HYDROCO/APAP TAB 7.5-325	N/A	90	KROGER PHARMACY DBA PAYLESS
05/15/2015	AMOX/K CLAV TAB 875MG	N/A	20	CVS PHARMACY
04/22/2015	POLYMYXIN B/ SOL TRIMETHP	N/A	10	CVS PHARMACY
04/22/2015	POLYMYXIN B/ SOL TRIMETHP	N/A	10	CVS PHARMACY
04/20/2015	HYDROCO/APAP TAB 7.5-325	N/A	90	KROGER PHARMACY DBA PAYLESS
03/20/2015	HYDROCO/APAP TAB 7.5-325	N/A	90	KROGER PHARMACY DBA PAYLESS
02/19/2015	HYDROCO/APAP TAB 7.5-325	N/A	0	KROGER LIMITED PARTNERSHIP I
02/19/2015	HYDROCO/APAP TAB 7.5-325	N/A	90	KROGER PHARMACY DBA PAYLESS

- Click on **Immunizations** to view any vaccination received (i.e. Hepatitis, Influenza, etc.).

Back to			
Overview	Visits Medications Immunizations Labs		
Cost Sharing			
Assessments			
Health Record			
Care Plan			
Authorizations			
Coordination of Benefits			
Claims			
	Code	Description	Facility/Provider
	90633	Hepatitis A Vaccine Ped/adoles Dose-2 Dose-im	Harshman, Kathryn
	90713	Poliovirus Vaccine, Inactivated (Ipv), For Subcutaneous Use	Harshman, Kathryn
	90715	(Tdapp), For Use On Age 7 Or Older, For Intramuscular Use	Harshman, Kathryn
	90744	Hepatitis B Vac Ped/adoles Dose-im Use	Harshman, Kathryn
			07/16/2012 - 07/16/2012
			07/16/2012 - 07/16/2012
			07/16/2012 - 07/16/2012
			07/16/2012 - 07/16/2012

- Click on **Labs** (i.e. Comprehensive metabolic panel, CBC) to view lab information for the member.

Back to Eligibility Check

Overview

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Visits

Medications

Immunizations

Labs

Allergies

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

Note: For additional details about these lab values, click on the blue hyperlink of the test name.

6. Click on the **Allergies** (i.e. Sulfa, Codeine) tab to view the allergies for this member.

[Back to Eligibility Check](#)

Overview

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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: Components appearing in the Patient Record are based on the last 18 months of claims data.

Care Plans

Providers can view three types of care plans;

1. Medical Care Plans are the most common and include medical terminology
2. Member Centric Care Plans include "Self-Management" in the title and can be viewed by the member
3. Free Text Care Plans are created by the case manager without a template

To access a care plan from inside the member record

1. Select **Care Plan**

Back to	
Overview	This member's care plan to treat: Case Worker
Cost Sharing	Diabetes Self-Management Care Plan
Assessments	- OPEN
Health Record	
Care Plan	
Authorizations	
Coordination of Benefits	
Claims	

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

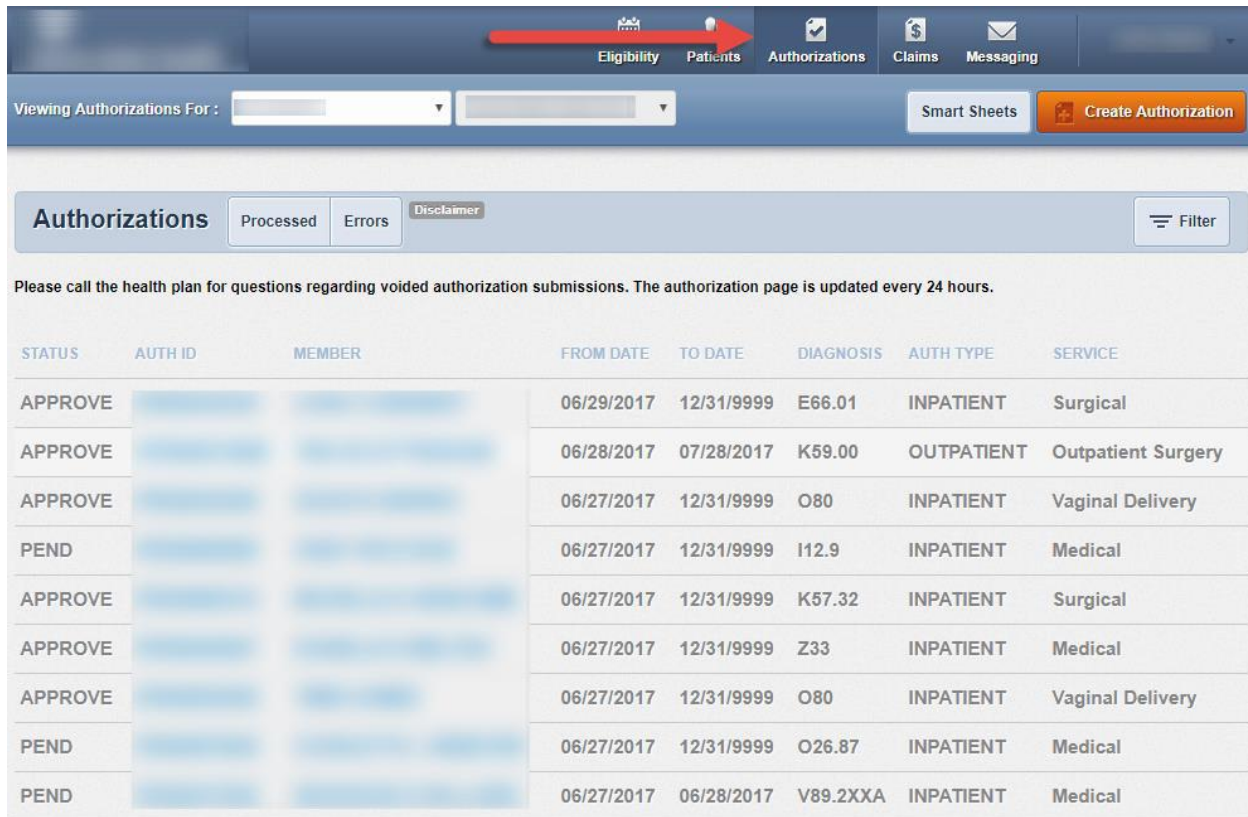
Log daily food intake

If the member does not have a plan, the following message appears:

Back to Patient List	
Overview	No Care Plans available for member.
Cost Sharing	
Assessments	
Health Record	
Care Plan	
Authorizations	
Coordination of Benefits	
Claims	

Authorizations

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



Viewing Authorizations For :

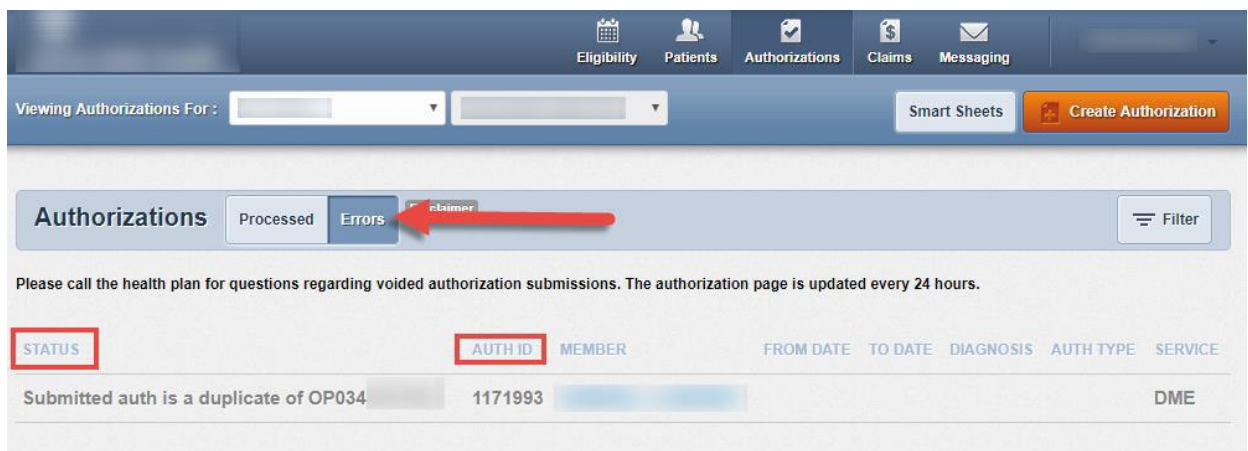
Smart Sheets [Create Authorization](#)

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			06/29/2017	12/31/9999	E66.01	INPATIENT	Surgical
APPROVE			06/28/2017	07/28/2017	K59.00	OUTPATIENT	Outpatient Surgery
APPROVE			06/27/2017	12/31/9999	O80	INPATIENT	Vaginal Delivery
PEND			06/27/2017	12/31/9999	I12.9	INPATIENT	Medical
APPROVE			06/27/2017	12/31/9999	K57.32	INPATIENT	Surgical
APPROVE			06/27/2017	12/31/9999	Z33	INPATIENT	Medical
APPROVE			06/27/2017	12/31/9999	O80	INPATIENT	Vaginal Delivery
PEND			06/27/2017	12/31/9999	O26.87	INPATIENT	Medical
PEND			06/27/2017	06/28/2017	V89.2XXA	INPATIENT	Medical

- Click the **Error** button to view prior authorization requests. The status displays the **Authorization Number** and the **Auth ID** is the confirmation number received when submitting a request on the secure provider website.



Viewing Authorizations For :

Smart Sheets [Create Authorization](#)

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
Submitted auth is a duplicate of OP034	1171993						DME

1. To view a prior authorization request, enter the **Authorization or Confirmation Number** in the field, and click **Search**.

Authorizations Processed Errors Disclaimer Filter

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

Member Last Name First Name Member ID

Authorization Authorization #: OP094 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.

2. The prior authorization request will display the status, authorization number, member name, service date ranges, diagnosis, authorization type and 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			06/27/2017	08/26/2017	I15.9	OUTPATIENT	DME

3. To view details of a prior authorization request, click the authorization number. Provider can view attached documents submitted with the request by clicking **view**.

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

4. Notes and attachments will appear. Select download to view the document.

Auth Mbr ID: 01755574EAuth Type: INDICAT

Notes and Attachments

X

PATIENT WAS ADMITTED TO OB ON 12/30/13. HAD VAGINAL DELIVERY BABY GIRL. DISCHARGE DATE IS UNKNOWN AT THIS TIME. WILL FAX BABY INFORMATION IN. THANK YOU.

2 attachments found:

ATTACHMENT NAME	SIZE	DOWNLOAD
AuthsReport.txt	7.1 KB	Download
authStatus.xls	13.8 KB	Download

Close

Create an Authorization:

To create an authorization for a patient

1. Enter the patient's last name or member ID and DOB. Check eligibility. Click on member's name to open the overview.

Eligibility Check

Date of Service07/14/2015

Member ID or Last Name

DOBmm/dd/yyyy

Check Eligibility

Print

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	CARE GAPS
	07/14/2015		07/14/2015	Due for annual physical. <div><div>Emergency Room Visit?</div><div>Remove</div></div>

2. Select the authorization tab.

Back to Eligibility Check

Overview

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Claims

This patient is eligible as of today, Jul 14, 2015.

Patient Information

Name

Gender **F**

Birthdate

Age

Member #

Address

Phone Number

PCP Information

Name

Address

Practice Type

Phone Number

[View PCP History](#)

[Care Gaps](#)

3. Authorizations displays requests previously submitted or create a new prior authorization request.

Back to Eligibility Check

Overview

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Claims

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

4. The authorization form opens and displays two sections. The left side will display definition of **Urgent Request, Disclaimer** and the completed fields for prior authorization as it is being created. The right side is where data is entered for **Provider Request, Service Line**, and **Finish Up**.

The screenshot shows a two-column form. The left column, titled 'Authorization For', contains a header with 'DOB:' and 'MEDICAID NBR:' fields. Below this are three informational boxes: the first explains the 'Urgent Request' box, the second provides after-hours contact information, and the third is a prompt to 'Please select Service Type.' The right column, titled 'Enter Authorization', has a sub-header '1. PROVIDER REQUEST' and contains an unchecked 'Urgent Request' checkbox, a 'Select a Service Type' dropdown menu, and a 'NEXT >' button. At the bottom of the right column are sections for '2. SERVICE LINE' and '3. FINISH UP'.

5. Select a **Service Type** from the drop-down list.

This screenshot is similar to the previous one, but the 'Select a Service Type' dropdown menu is open, displaying a list of service types. A red arrow points from the 'Please select Service Type.' prompt in the left column to the dropdown menu. The dropdown list is categorized into 'Medical Outpatient' and 'Medical Inpatient'. The 'Medical Outpatient' list includes: Biopharmacy, Cardiac / Pulmonary Rehabilitation, Cochlear Implants & Surgery, DME, Genetic Testing & Counseling, Home Health, Hospice, Neuropsych Testing, OB Ultrasound, Office Visit, Orthotics, Outpatient Services, Outpatient Surgery, Pain Management, Prosthetics, Therapy, Transport, and Vaginal Delivery. The 'Medical Inpatient' list includes: C-Section Delivery, Medical, Premature/False Labor, Rehab Inpatient, Skilled Nursing, Sub Acute, Surgical, Transplant, and Vaginal Delivery.

6. Once the service type is selected, the **Requesting Provider** information will display. The provider's last name or NPI number can be entered to search.

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.

After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 866-329-4701 for after-hours urgent admission, inpatient notifications or requests.

Please select Service Type.

Enter Authorization

1. PROVIDER REQUEST

☐ Urgent Request

Outpatient Services

Requesting Provider

Smith

Primary Diagnosis

Diagnosis Code

CODE LOOKUP ICD-9 ICD-10

+ Add Additional Diagnosis

NEXT

2. SERVICE LINE

3. FINISH UP

7. The list of providers and their specialty will display. Click select for the appropriate provider.

Select a Provider

PROVIDER NAME	PHONE NUMBER	TAX ID	NPI	SPECIALTY DESC	SELECT
SMITH AND NEPH					Select
SMITH				SKILLED NURSING FACILITY	Select
SMITH				GENERAL SURGERY	Select
SMITH,				EMERGENCY MEDICINE	Select
SMITH.				GENERAL SURGERY	Select
SMITH.				HEMATOLOGY ONCOLOGY	Select

8. The requesting provider NPI will appear in the search field. Below will display the NPI, TIN and name.

Authorization For

DOB: [REDACTED] | MEDICAID NBR: [REDACTED]

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. ✕

After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 866-329-4701 for after-hours urgent admission, inpatient notifications or requests. ✕

Please select Service Type. ✕

Enter Authorization

1. PROVIDER REQUEST

☐ Urgent Request

Outpatient Services ▾

Requesting Provider

147

NPI: 147
TIN: [REDACTED]
Name: SMITH

Primary Diagnosis

Diagnosis Code

CODE LOOKUP: [ICD-9](#) [ICD-10](#)

+ Add Additional Diagnosis

NEXT >

2. SERVICE LINE

3. FINISH UP

9. The **Primary Diagnosis** can be entered for known or hyperlinks to ICD-9 and ICD-10 are available.

Authorization For

DOB: [REDACTED] | MEDICAID NBR: [REDACTED]

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. ✕

After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 866-329-4701 for after-hours urgent admission, inpatient notifications or requests. ✕

Please select Service Type. ✕

Enter Authorization

1. PROVIDER REQUEST

☐ Urgent Request

Outpatient Services ▾

Requesting Provider

147

NPI: 147
TIN: [REDACTED]
Name: SMITH

Primary Diagnosis

543.0 ✕

CODE LOOKUP: [ICD-9](#) [ICD-10](#)

+ Add Additional Diagnosis

NEXT >

2. SERVICE LINE

3. FINISH UP

10. The corresponding clinical name will display under the CPT code entered.

Authorization For

DOB: [REDACTED] | MEDICAID NBR: [REDACTED]

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. ✕

After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 866-329-4701 for after-hours urgent admission, inpatient notifications or requests. ✕

Please select Service Type. ✕

Enter Authorization

1. PROVIDER REQUEST

☐ Urgent Request

Outpatient Services ▾

Requesting Provider

147 [REDACTED]

NPI: 147 [REDACTED]
TIN: [REDACTED]
Name: SMITH

Primary Diagnosis

543.0 ✕

CODE LOOKUP: ICD-9 ICD-10

+ Add Additional Diagnosis

NEXT >

2. SERVICE LINE

3. FINISH UP

11. To add **Additional Diagnosis**, click on the + sign and the diagnosis field will appear. Enter the ICD code. Providers **cannot** combine ICD-9 and ICD-10 codes on the same request.

Authorization For

DOB: [REDACTED] | MEDICAID NBR: [REDACTED]

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. ✕

After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 866-329-4701 for after-hours urgent admission, inpatient notifications or requests. ✕

Please select Service Type. ✕

Enter Authorization

1. PROVIDER REQUEST

☐ Urgent Request

Outpatient Services ▾

Requesting Provider

147 [REDACTED]

NPI: 147 [REDACTED]
TIN: [REDACTED]
Name: SMITH

Primary Diagnosis

543.0

HYPERPLASIA OF APPENDIX

CODE LOOKUP: ICD-9 ICD-10

Additional Diagnosis

537.9 ✕ ✕

+ Add Additional Diagnosis

2. SERVICE LINE

3. FINISH UP

12. When all of the diagnosis codes have been entered, click on **Next**.

The screenshot shows two side-by-side forms. The left form, titled 'Authorization For', has fields for 'DOB' and 'MEDICAID NBR'. It contains three informational boxes: one about urgent requests, one about after-hours admissions, and one asking to select a service type. The right form, titled 'Enter Authorization', has a tabbed interface with '1. PROVIDER REQUEST' selected. It contains fields for 'Outpatient Services' (dropdown), 'Requesting Provider' (text), 'NPI: 147', 'TIN:', 'Name: SMITH', 'Primary Diagnosis' (543.0), and 'Additional Diagnosis' (537.9). Below these are the text labels 'HYPERPLASIA OF APPENDIX' and 'UNSPEC DISORDER STOMACH&DUODENUM'. There is a '+ Add Additional Diagnosis' button and a 'NEXT >' button. A red arrow points to the 'NEXT >' button. At the bottom of the right form are tabs for '2. SERVICE LINE' and '3. FINISH UP'.

13. **Service Line** will open. The requesting provider information and the member's diagnosis display on the left side of the screen. Fields required for the service lines are on the right side on the form.

The screenshot shows the same two forms as before, but the '2. SERVICE LINE' tab is now selected in the 'Enter Authorization' form. The left form, 'Authorization For', now displays the 'PROVIDER REQUEST' information: 'Service Type: Outpatient Outpatient Services', 'SMITH', 'GENERAL SURGERY', 'Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX', 'Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM', 'NPI: 147', 'TIN:', and 'Phone:'. The right form, 'Enter Authorization', has the '2. SERVICE LINE' tab active. It contains fields for 'Now adding new service line', 'Servicing Provider' (with a checkbox for 'Same as Requesting Provider'), 'Servicing Provider NPI or Last Name', 'Start Date' and 'End Date' (date pickers), 'Units/Visits/Days', 'Primary Procedure' (with a 'Procedure Code' field and a 'CODE LOOKUP' link), '+ Add Additional Procedures', 'Select a Place Of Service' (dropdown), '+ Add New Service Line', and a '3. FINISH UP' tab at the bottom.

14. If the **Servicing Provider** is the same as the requesting provider, click the box. The provider information will auto-populate their name, NPI, and TIN. If the servicing provider is different, enter the provider's last name or NPI and search. When the names display, select the appropriate provider.

Authorization For

DOB: [REDACTED] | MEDICAID NBR: [REDACTED]

PROVIDER REQUEST

Service Type: Outpatient Outpatient Services
SMITH
GENERAL SURGERY
Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX
Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM
NPI: 147
TIN: [REDACTED]
Phone: [REDACTED]

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE

Now adding new service line

Servicing Provider
☒ Same as Requesting Provider
147
NPI: 147
TIN: [REDACTED]
Name: SMITH
Start Date - End Date
Units/Visits/Days
Primary Procedure
Procedure Code
[CODE LOOKUP](#)
[+](#) Add Additional Procedures
Select a Place Of Service [v](#)

3. FINISH UP

15. The **Start** and **End Date** fields have calendar widgets that appear when the user clicks inside the field.

Authorization For

DOB: [REDACTED] | MEDICAID NBR: [REDACTED]

PROVIDER REQUEST

Service Type: Outpatient Outpatient Services
SMITH
GENERAL SURGERY
Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX
Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM
NPI: 147
TIN: [REDACTED]
Phone: [REDACTED]

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE

Now adding new service line

Servicing Provider
☒ Same as Requesting Provider
147
NPI: 147
TIN: [REDACTED]
Name: SMITH
Start Date - End Date
Units/Visits/Days
Primary Procedure
Procedure Code
[CODE LOOKUP](#)
[+](#) Add Additional Procedures
Select a Place Of Service [v](#)

3. FINISH UP

16. The requested number of days, visits, or units will be entered under the service dates.

The screenshot shows the 'Enter Authorization' section of the form. The '2. SERVICE LINE' section is active, showing 'Now adding new service line'. The 'Servicing Provider' section is checked 'Same as Requesting Provider' with NPI: 147, TIN: [redacted], and Name: SMITH. The service dates are 07/14/2015 to 07/24/2015. The 'Primary Procedure' field contains the number '1', which is highlighted by a red arrow. Below this is a 'CODE LOOKUP' link and an 'Add Additional Procedures' button. The 'Select a Place Of Service' dropdown is set to a default value. The '3. FINISH UP' section is at the bottom.

17. **Primary Procedure** codes can be entered into the field or can be searched for by the code lookup.

The screenshot shows the 'Enter Authorization' section of the form. The '2. SERVICE LINE' section is active, showing 'Now adding new service line'. The 'Servicing Provider' section is checked 'Same as Requesting Provider' with NPI: 147, TIN: [redacted], and Name: SMITH. The service dates are 07/14/2015 to 07/24/2015. The 'Primary Procedure' field contains the code '44970', which is highlighted by a red arrow. Below this is a 'CODE LOOKUP' link and an 'Add Additional Procedures' button. The 'Select a Place Of Service' dropdown is set to a default value. The '3. FINISH UP' section is at the bottom.

18. The corresponding procedure name will appear under the procedure code. Additional procedure codes can be entered by clicking on the + sign.

Authorization For

DOB: | MEDICAID NBR: |

PROVIDER REQUEST

Service Type: Outpatient Outpatient Services
SMITH
GENERAL SURGERY
Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX
Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM
NPI: 147
TIN:
Phone:

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE

Now adding new service line

Servicing Provider
☒ Same as Requesting Provider
147
NPI: 147
TIN:
Name: SMITH
07/14/2015 - 07/24/2015
1
Primary Procedure
44970
LAPAROSCOPY RUSGICAL APPENEDECTOMY
[CODE LOOKUP](#)
+ Add Additional Procedures
3. FINISH UP

19. Scroll down to **Select a Place of Service** from a drop down menu. The menu will display locations available for that service outlined by the health plan.

Authorization For

DOB: | MEDICAID NBR: |

PROVIDER REQUEST

Service Type: Outpatient Outpatient Services
SMITH
GENERAL SURGERY
Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX
Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM
NPI: 147
TIN:
Phone:

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE

TIN:
Name: SMITH
07/14/2015 - 07/24/2015
1
Primary Procedure
44970
LAPAROSCOPY RUSGICAL APPENEDECTOMY
[CODE LOOKUP](#)
+ Add Additional Procedures
+ Add New Service Line
NEXT >
3. FINISH UP

Select a Place Of Service
Ambulatory Surgical Center
Outpatient Hospital
Unspecified

20. Under the place of service, the provider can **Add Service Lines** for more services by clicking the addition sign.

Authorization For

DOB: [REDACTED] MEDICAID NBR: [REDACTED]

PROVIDER REQUEST

Service Type: Outpatient Outpatient Services
SMITH
GENERAL SURGERY
Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX
Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM
NPI: 147
TIN: [REDACTED]
Phone: [REDACTED]

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE

TIN: [REDACTED]
Name: SMITH
07/14/2015 - 07/24/2015
1
Primary Procedure
44970
LAPAROSCOPY RUSGICAL APPENEDECTOMY
[CODE LOOKUP](#)
+ Add Additional Procedures
Ambulatory Surgical Center
+ Add New Service Line
NEXT >
3. FINISH UP

21. The first service line completed can be viewed in detail on the left side. If the first service line needed to be edited, click on underlined service line. If the service line needs to be removed, click the X.

Authorization For

DOB: [REDACTED] MEDICAID NBR: [REDACTED]

PROVIDER REQUEST

Service Type: Outpatient Outpatient Services
SMITH
GENERAL SURGERY
Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX
Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM
NPI: 147
TIN: [REDACTED]
Phone: [REDACTED]

SERVICE LINES

Service Line 1
SMITH
GENERAL SURGERY
Dates: 07/14/2015 - 07/24/2015
Units: 1
Primary Procedure: 44970: LAPAROSCOPY RUSGICAL APPENEDECTOMY
Place Of Service: Ambulatory Surgical Center
NPI: 147
TIN: [REDACTED]
Phone: [REDACTED]

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)


2. SERVICE LINE


Now adding new service line
Service Line 1: 1477554756 / 44970 (X)
Servicing Provider
☐ Same as Requesting Provider
Brown
Start Date - End Date
Units/Visits/Days
Primary Procedure
Procedure Code
[CODE LOOKUP](#)
+ Add Additional Procedures
Select a Place Of Service
+ Add New Service Line
3. FINISH UP

22. To start a second service line, the requesting provider will need to add the Requesting Provider. If the servicing provider is different than the requesting provider, search can be completed by entering the name of NPI number.

Authorization For

DOB:
MEDICAID NBR:

PROVIDER REQUEST

Service Type: Outpatient Outpatient Services
SMITH
GENERAL SURGERY
Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX
Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM
NPI: 147
TIN:
Phone:

SERVICE LINES
Service Line 1

SMITH
GENERAL SURGERY
Dates: 07/14/2015 - 07/24/2015
Units: 1
Primary Procedure: 44970: LAPAROSCOPY RUSGICAL APPENEDECTOMY
Place Of Service: Ambulatory Surgical Center
NPI: 147
TIN:
Phone:

Enter Authorization
1. PROVIDER REQUEST [EDIT](#)
2. SERVICE LINE
Now adding new service line
Service Line 1: 1477554756 / 44970
Servicing Provider
☐ Same as Requesting Provider
Brown
Start Date - End Date
Units/Visits/Days
Primary Procedure
Procedure Code
[CODE LOOKUP](#)
+ Add Additional Procedures
Select a Place Of Service
3. FINISH UP

23. Select the appropriate provider:

BROWN,	141	ORTHOPAEDIC SURGERY	Select
BROWN,	141	ORTHOPAEDIC SURGERY	Select
BROWN,	127	OB GYN	Select
BROWN,	127	OB GYN	Select
BROWN,	122	NURSE PRACTITIONERS	Select
BROWN,	196	INTERNAL MEDICINE	Select

24. The provider's Name, NPI and Tin will display. Complete the start and end dates of services, the requested number of days, visits or units and the procedure code.

Authorization For

DOB: [REDACTED] MEDICAID NBR: [REDACTED]

PROVIDER REQUEST

Service Type: Outpatient Outpatient Services
SMITH
GENERAL SURGERY
Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX
Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM
NPI: 147 [REDACTED]
TIN: [REDACTED]
Phone: [REDACTED]

SERVICE LINES

Service Line 1

SMITH
GENERAL SURGERY
Dates: 07/14/2015 - 07/24/2015
Units: 1
Primary Procedure: 44970: LAPAROSCOPY RUSGICAL APPENEDECTOMY
Place Of Service: Ambulatory Surgical Center
NPI: 147 [REDACTED]
TIN: [REDACTED]
Phone: [REDACTED]

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE

Now adding new service line

Service Line 1: 1477554756 / 44970

Servicing Provider

☐ Same as Requesting Provider

NPI: 196 [REDACTED]
TIN: [REDACTED]
Name: BROWN, [REDACTED]
07/14/2015 - 07/24/2015
2
Primary Procedure
99224
[CODE LOOKUP](#)
+ Add Additional Procedures
Select a Place Of Service
3. FINISH UP

25. The procedure name will appear under the CPT code. Select the Place of Service from the drop down menu.

Authorization For

DOB: [REDACTED] MEDICAID NBR: [REDACTED]

PROVIDER REQUEST

Service Type: Outpatient Outpatient Services
SMITH
GENERAL SURGERY
Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX
Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM
NPI: 147 [REDACTED]
TIN: [REDACTED]
Phone: [REDACTED]

SERVICE LINES

Service Line 1

SMITH
GENERAL SURGERY
Dates: 07/14/2015 - 07/24/2015
Units: 1
Primary Procedure: 44970: LAPAROSCOPY RUSGICAL APPENEDECTOMY
Place Of Service: Ambulatory Surgical Center
NPI: 147 [REDACTED]
TIN: [REDACTED]
Phone: [REDACTED]

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE

NPI: 196 [REDACTED]
TIN: [REDACTED]
Name: BROWN, [REDACTED]
07/14/2015 - 07/24/2015
2
Primary Procedure
99224
SUBSEQUENT OBSERVATION CARE
[CODE LOOKUP](#)
+ Add Additional Procedures
Select a Place Of Service
Ambulatory Surgical Center
Outpatient Hospital
Unspecified
+ Add New Service Line
NEXT
3. FINISH UP

26. Click **Next**.

The screenshot shows a two-pane interface. The left pane, titled 'Authorization For', contains a 'PROVIDER REQUEST' section for SMITH, GENERAL SURGERY, and a 'SERVICE LINES' section for Service Line 1. The right pane, titled 'Enter Authorization', shows steps 1, 2, and 3. Step 2, 'SERVICE LINE', is active and contains fields for NPI, TIN, Name, dates, units, primary procedure, and subsequent observation care. A red arrow points to the 'NEXT >' button at the bottom of the right pane.

Authorization For

DOB: | MEDICAID NBR: |

PROVIDER REQUEST

Service Type: Outpatient Outpatient Services
SMITH
GENERAL SURGERY
Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX
Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM
NPI: 147
TIN:
Phone:

SERVICE LINES

Service Line 1

SMITH
GENERAL SURGERY
Dates: 07/14/2015 - 07/24/2015
Units: 1
Primary Procedure: 44970: LAPAROSCOPY RUSGICAL APPENEDECTOMY
Place Of Service: Ambulatory Surgical Center
NPI: 147
TIN:
Phone:

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE [EDIT](#)

NPI: 196
TIN:
Name: BROWN,
07/14/2015 - 07/24/2015
2
Primary Procedure
99224
SUBSEQUENT OBSERVATION CARE
[CODE LOOKUP](#)
+ Add Additional Procedures
Ambulatory Surgical Center
+ Add New Service Line
NEXT >
3. FINISH UP

27. Once **Next** is clicked, scroll down on the left side. The second service line displays the provider information, service dates, days/visits/units, procedure code and place of service.

The screenshot shows the same two-pane interface. The left pane now displays Service Line 2 for BROWN, INTERNAL MEDICINE. The right pane shows steps 1, 2, and 3. Step 3, 'FINISH UP', is active and contains fields for contact information, questionnaire, and attachment.

Authorization For

DOB: | MEDICAID NBR: |
Phone: 7086848000

SERVICE LINES

Service Line 1

SMITH
GENERAL SURGERY
Dates: 07/14/2015 - 07/24/2015
Units: 1
Primary Procedure: 44970: LAPAROSCOPY RUSGICAL APPENEDECTOMY
Place Of Service: Ambulatory Surgical Center
NPI: 147
TIN:
Phone:

Service Line 2

BROWN,
INTERNAL MEDICINE
Dates: 07/14/2015 - 07/24/2015
Units: 2
Primary Procedure: 99224: SUBSEQUENT OBSERVATION CARE
Place Of Service: Ambulatory Surgical Center
NPI: 196
TIN:
Phone:

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE [EDIT](#)

3. FINISH UP

Contact
Jerome
Phone
(123) 456-7890
Fax
(098) 765-4321
Email
Questionnaire
Attachment:
Upload any relevant attachments. (5Mb limit)
Browse
Attach

28. **Finish Up** auto-populates the user's name, phone, fax, and email address.

Authorization For

DOB: [REDACTED] MEDICAID NBR: [REDACTED]

Phone: 7086848000

SERVICE LINES

Service Line 1

SMITH
GENERAL SURGERY
Dates: 07/14/2015 - 07/24/2015
Units: 1
Primary Procedure: 44970: LAPAROSCOPY RUSGICAL APPENEDECTOMY
Place Of Service: Ambulatory Surgical Center
NPI: 147 [REDACTED]
TIN: [REDACTED]
Phone: [REDACTED]

Service Line 2

BROWN,
INTERNAL MEDICINE
Dates: 07/14/2015 - 07/24/2015
Units: 2
Primary Procedure: 99224: SUBSEQUENT OBSERVATION CARE
Place Of Service: Ambulatory Surgical Center
NPI: 196 [REDACTED]
TIN: [REDACTED]
Phone: [REDACTED]

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE [EDIT](#)

3. FINISH UP

Contact
[REDACTED]

Phone
(123) 456-7890

Fax
(098) 765-4321

Email
[REDACTED]

Questionnaire

Attachment:
Upload any relevant attachments. (5Mb limit)
[REDACTED] [Browse](#)

[Attach](#)

29. The Questionnaire is opened by clicking in the icon.

Authorization For

DOB: [REDACTED] MEDICAID NBR: [REDACTED]

Phone: 7086848000

SERVICE LINES

Service Line 1

SMITH
GENERAL SURGERY
Dates: 07/14/2015 - 07/24/2015
Units: 1
Primary Procedure: 44970: LAPAROSCOPY RUSGICAL APPENEDECTOMY
Place Of Service: Ambulatory Surgical Center
NPI: 147 [REDACTED]
TIN: [REDACTED]
Phone: [REDACTED]

Service Line 2

BROWN,
INTERNAL MEDICINE
Dates: 07/14/2015 - 07/24/2015
Units: 2
Primary Procedure: 99224: SUBSEQUENT OBSERVATION CARE
Place Of Service: Ambulatory Surgical Center
NPI: 196 [REDACTED]
TIN: [REDACTED]
Phone: [REDACTED]

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE [EDIT](#)

3. FINISH UP

Contact
[REDACTED]

Phone
(123) 456-7890

Fax
(098) 765-4321

Email
[REDACTED]

Questionnaire

Attachment:
Upload any relevant attachments. (5Mb limit)
[REDACTED] [Browse](#)

[Attach](#)

30. The questionnaire that displays will vary based on the service type selected. If additional information is not applicable, N/A must be entered.

The screenshot shows a web form titled "Authorization For". At the top, there are fields for "DOB:" and "MEDICAID NBR:". Below these is a yellow warning box that reads: "Please make sure all edits are completed in all the steps before filling out the questionnaire. These are questions specific to Outpatient Services." The main section is titled "Outpatient Services" and contains the text: "Please provide any additional information that may assist us in making a decision on this authorization. If none is required, please enter N/A (Not Applicable)." Below this is a text input field labeled "Additional Information:". At the bottom right of this section is a black button labeled "CLOSE QUESTIONNAIRE". On the right side, there is a sidebar titled "Enter Authorization" with three steps: "1. PROVIDER REQUEST" (with an "EDIT" link), "2. SERVICE LINE" (with an "EDIT" link), and "3. FINISH UP". Below the steps are input fields for "Contact", "Phone" (with the value "(123) 456-7890"), "Fax" (with the value "(098) 765-4321"), and "Email". There is a "Questionnaire" icon and label, and an "Attachment:" section with the text "Upload any relevant attachments. (5Mb limit)" and a "Browse" button. At the bottom of the sidebar is an "Attach" button.

31. The questionnaire is a mandatory field. If it is not completed, an alert will appear.

This screenshot is similar to the previous one, but it shows a red alert message. In the "Additional Information:" text input field, there is a red border and a red label "Required Field" below it. In the sidebar, under the "Questionnaire" icon, there is a red alert message that reads: "Questionnaire must be complete". The rest of the form, including the "CLOSE QUESTIONNAIRE" button and the "Attachment:" section, remains the same.

32. Up to five **Attachments** can be added to the prior authorization request. Click on **Browse**.

Authorization For

DOB: MEDICAID NBR:

Phone: 7086848000

SERVICE LINES

Service Line 1

SMITH
GENERAL SURGERY

Dates: 07/14/2015 - 07/24/2015
Units: 1
Primary Procedure: 44970: LAPAROSCOPY RUSGICAL APPENEDECTOMY
Place Of Service: Ambulatory Surgical Center
NPI: 147
TIN:
Phone:

Service Line 2

BROWN,
INTERNAL MEDICINE

Dates: 07/14/2015 - 07/24/2015
Units: 2
Primary Procedure: 99224: SUBSEQUENT OBSERVATION CARE
Place Of Service: Ambulatory Surgical Center
NPI: 196
TIN:
Phone:

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE [EDIT](#)

3. FINISH UP

Contact

Phone
(123) 456-7890

Fax
(098) 765-4321

Email

Questionnaire

Attachment:
Upload any relevant attachments. (5Mb limit)

[Browse](#)

[Attach](#)

33. Highlight the appropriate document, image, smart sheet... Click **Insert**.

Insert File

Web Testing > Test Document and Photo

Organize New folder

Name	Date modified	Type
Achilles_Tendon_Repair_Complete_Tear	6/23/2014 12:41 PM	Adobe Acrobat
Smart Sheet for Testing	9/6/2013 12:42 PM	Adobe Acrobat
TR Photo Test Attachment	11/1/2012 10:35 AM	Microsoft Word
TruCare Word Test Attachment	11/1/2012 10:17 AM	Microsoft Word

File name: Smart Sheet for Testing

[Insert](#) [Cancel](#)

Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE [EDIT](#)

3. FINISH UP

Contact

Phone
(123) 456-7890

Fax
(098) 765-4321

Email

Questionnaire

Attachment:
Upload any relevant attachments. (5Mb limit)

[Browse](#)

[Attach](#)

[SUBMIT](#)

34. The document name will appear in the browse field

Authorization For

DOB:

MEDICAID NBR:

PROVIDER REQUEST

Service Type: Outpatient Outpatient Services

SMITH

GENERAL SURGERY

Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX

Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM

NPI: 147

TIN:

Phone:

SERVICE LINES

Service Line 1

SMITH

GENERAL SURGERY

Dates: 07/14/2015 - 07/24/2015

Units: 1

Primary Procedure: 44970: LAPAROSCOPY RUSGICAL APPENEDECTOMY

Place Of Service: Ambulatory Surgical Center

NPI: 147

TIN:

Phone:

Service Line 2

Enter Authorization

1. PROVIDER REQUEST

2. SERVICE LINE

3. FINISH UP

Phone

(123) 456-7890

Fax

(098) 765-4321

Email

Questionnaire

Attachment:

Upload any relevant attachments. (5Mb limit)

SmartSheet

Remove

Attach

SUBMIT

35. Verify that is the correct document. Click **Attach** and the document will appear below the button.

Authorization For

DOB:

MEDICAID NBR:

TIN:

Phone:

SERVICE LINES

Service Line 1

SMITH

GENERAL SURGERY

Dates: 07/14/2015 - 07/24/2015

Units: 1

Primary Procedure: 44970: LAPAROSCOPY RUSGICAL APPENEDECTOMY

Place Of Service: Ambulatory Surgical Center

NPI: 147

TIN:

Phone:

Service Line 2

Enter Authorization

1. PROVIDER REQUEST

2. SERVICE LINE

3. FINISH UP

(123) 456-7890

Fax

(098) 765-4321

Email

Questionnaire

Attachment:

Upload any relevant attachments. (5Mb limit)

Remove

Attach

Smart Sheet for Testing.pdf

Remove

SUBMIT

36. Click **Submit**. The request is assigned a confirmation number. This number should be recorded and used to determine the status of a missing authorization.

Success!

- Your confirmation number is **#1073867**.
- JACKSON, KRYSTAL
- DOB: 09/17/1985
- MEDICAID NBR: 053843769

Authorization For

DOB: | MEDICAID NBR: |

PROVIDER REQUEST

Service Type: **SMITH**
GENERAL SURGERY
Primary Doctor: **SMITH**
Additional Doctor: **SMITH**
NPI: 14772
TIN: 36210
Phone: 701

SERVICE LINES

Service Line 1
SMITH
GENERAL SURGERY
Dates: 07/14/2015 - 07/24/2015

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)
2. SERVICE LINE [EDIT](#)

jmulner@centene.com

Questionnaire

Smart Sheets

Smart sheets are evidence-based clinical guidelines that help providers determine if the desired treatment or procedure meets the criteria for approval. Completion provides the documentation required for clinical review and improves the turnaround time for determination of the prior authorization request.

1. Select **Authorizations** from the member.

Back to Eligibility Check

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Coordination of Benefits

Claims

This patient is eligible as of today, Jul 14, 2015.

Patient Information

Name
Gender F
Birthdate
Age
Member #
Address
Phone Number

PCP Information

Name
Address
Practice Type
Phone Number

[View PCP History](#)

[Care Gaps](#)

2. Click **Create a New Authorization**.

Back to Eligibility Check

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Coordination of Benefits

Claims

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

3. Click on **Smart Sheets**.

The screenshot shows the top navigation bar with tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this is a 'Viewing Authorizations For:' dropdown menu. A red arrow points to the 'Smart Sheets' button, which is highlighted in orange. To the right of the 'Smart Sheets' button is a 'Create Authorization' button. Below the navigation bar, the 'Authorization For' section contains fields for DOB and MEDICAID NBR. The 'Enter Authorization' section on the right shows '1. PROVIDER REQUEST' with an 'Urgent Request' checkbox and a 'Select a Service Type' dropdown menu. A 'NEXT >' button is visible at the bottom of the 'Enter Authorization' section.

4. The disclaimer will appear to be read and acknowledged at the bottom of the screen.

The screenshot displays the 'Centene Disclaimer and Provider Acknowledgement for InterQual SmartSheet Use' page. The page is divided into two main sections: 'Viewing Authorizations For:' on the left and the disclaimer text on the right. The left section includes a 'Display Terms and Conditions' button and a list of medical procedures under the heading 'InterQual SmartSheet'. The right section contains the disclaimer text, which states that Centene provides access to utilization management criteria and associated clinical content to its Providers subject to the terms and conditions contained in this agreement. The disclaimer also outlines the Provider's right to access and use the criteria/content, the Provider's obligation to protect the confidentiality of the information, and the Provider's acknowledgment that the criteria/content is provided 'AS IS, WITH ALL FAULTS, AND AS AVAILABLE'. At the bottom of the page, there is a green button labeled 'I have read and agree to these terms.'

5. Procedures are listed in alphabetical order. Click on appropriate hyperlink.

Eligibility Patients Authorizations Claims Messaging

Viewing Authorizations For : [Dropdown] [Dropdown]

Smart Sheets Create Authorization

Display Terms and Conditions

InterQual SmartSheets

SmartSheets for procedures or DME are available for your use. The use of SmartSheets is recommended as they provide us with the information we can use to complete your request.

Instructions: Find the appropriate SmartSheet, complete and add as an attachment to your web authorization request.

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

A

- [Abdominal Aortic Aneurysm \(AAA\) Resection and Graft](#)
- [Abdominal Perineal Resection \(APR\)](#)
- [Ablation/Excision Endometriosis Laparoscopic](#)
- [Achilles Tendon Repair Complete Tear](#)
- [Adenoidectomy](#)
- [Adenoidectomy \(Pediatric\)](#)
- [Adrenalectomy/Adrenal Mass Removal](#)
- [Aerosol Delivery Devices - Senior Administration set with small volume filtered pneumatic nebulizer](#)
- [Aerosol Delivery Devices - Senior Controlled dose inhalation drug delivery system](#)

6. The Smart Sheet will open. Print, complete and save to your computer.

InterQual®

2012.2 Procedures Adult Criteria
Achilles Tendon Repair, Complete Tear

2012.2 Procedures Adult Criteria

Achilles Tendon Repair, Complete Tear⁽¹⁾

PATIENT:	Name	D.O.B.	ID#	GROUP#
CPT/ICD9:	Code	Facility	Service Date	
PROVIDER:	Name	ID#	Phone#	
	Signature	Date		

ICD-9-CM: 83.64, 83.73, 83.99

INDICATIONS (choose one and see below)

☐ 100 Complete tear

☐ Indication Not Listed (Provide clinical justification below)

☐ 100 Complete tear **[Both]⁽²⁾**

☐ 110 Symptoms **[One]⁽³⁾**

☐ 111 Pain at site

☐ 112 Weakness of plantar flexion by Hx/PE

☐ 120 Findings **[One]**

☐ 121 Palpable defect/gap in tendon

☐ 122 Thompson's test abnormal⁽⁴⁾

Notes


(1)
These criteria address both acute and chronic rupture of the Achilles tendon. The goals of treatment are to restore length and tension of the tendon, thereby optimizing ultimate strength and function. There continues to be controversy as to whether operative or nonoperative treatment best achieves these goals. Several studies showed little difference in the recovery of normal function between operative and nonoperative cases (71% versus 63%). Operative repair can result in greater strength and a lower rate of rupture

7. Add this document to the attachments when submitting a prior authorization request. This process is outlined in submitting an authorization.

Authorization For

DOB: | MEDICAID NBR:


PROVIDER REQUEST



Service Type: Outpatient Outpatient Services
SMITH
GENERAL SURGERY
Primary Diagnosis: 5430: HYPERPLASIA OF APPENDIX
Additional Diagnosis: 5379: UNSPEC DISORDER STOMACH&DUODENUM
NPI: 147
TIN:
Phone:

SERVICE LINES

Service Line 1



SMITH
GENERAL SURGERY
Dates: 07/14/2015 - 07/24/2015
Units: 1
Primary Procedure: 44970: LAPAROSCOPY RUSGICAL APPENEDECTOMY
Place Of Service: Ambulatory Surgical Center
NPI: 147
TIN:
Phone:

Service Line 2

Enter Authorization

1. PROVIDER REQUEST

2. SERVICE LINE

3. FINISH UP

Phone

(123) 456-7890

Fax

(098) 765-4321

Email

Questionnaire

Attachment:

Upload any relevant attachments. (5Mb limit)

SmartSheet

Attach

52

Referrals

To submit a referral, the provider can select specialized services for a member.

1. Select Referral

Back to Eligibility Check

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

This patient is eligible as of today, Jun 9, 2015.

Patient Information

Name

Gender **M**

Birthdate

Age **14 years old**

Member #

Address

PCP Information

Name

Address

Practice Type

Phone Number

[View PCP History](#)

[Care Gaps](#)

None On File

[Allergies](#)

None On File

[View Clinical Information](#)

Eligibility History

Start Date	End Date	Product Name
Jan 1, 2015	Feb 28, 2015	Healthy Kids
Aug 1, 2014	Dec 31, 2014	Healthy Kids

[more](#)

2. The Source can be a drop down menu with available types of referrals to select.
3. Referral form auto-populates the date, time and user's name.

[Back to Eligibility Check](#)

Overview	<div> <div>*Source</div> <div>Child Welfare Svc</div> </div> <div> <div>*Date</div> <div>06/09/2015</div> <div>6</div> <div>14</div> <div>PM</div> </div> <div> <div>Last Name, First Name</div> <div>Auto-populates User's Name</div> </div> <div> <div>Phone Number, Extension</div> <div>() -</div> </div> <div> <div>Additional Comments</div> <div></div> </div> <div> <div>Reason(s) for Referral (select all that apply)</div> <div> <input type="checkbox"/> Behavioral Health Services <input type="checkbox"/> Care Planning Support <input type="checkbox"/> Coordination of Care (Part of 90 Day COC) <input type="checkbox"/> Dental Care <input type="checkbox"/> Discharge Planning <input type="checkbox"/> Healthy Behaviors Program <input type="checkbox"/> High Risk Member <input type="checkbox"/> Interdisciplinary Care Team Meeting <input type="checkbox"/> Medical Services <input type="checkbox"/> Member/Caregiver Education <input type="checkbox"/> Multidisciplinary Team Meeting <input type="checkbox"/> Placement Coordination <input type="checkbox"/> Routine/Well Care <input type="checkbox"/> Service Coordination <input type="checkbox"/> Transitioning from Child Welfare <input type="checkbox"/> Transitioning to Adult Services <input type="checkbox"/> Transportation <input type="checkbox"/> Welcome Packet and ID Card Delivered </div> </div> <div> <div>Submit</div> </div>
Cost Sharing	
Assessments	
Health Record	
Care Plan	
Authorizations	
Referrals	
Coordination of Benefits	
Claims	

4. Complete the phone number and extension
5. Additional comments are an optional field
6. Select one or more boxes for Referral Reasons

[Back to Eligibility Check](#)

Overview	*Source <input type="text" value="Child Welfare Svc"/>
Cost Sharing	*Date <input type="text" value="06/09/2015"/> <input type="text" value="6"/> <input type="text" value="14"/> <input type="text" value="PM"/>
Assessments	Last Name, First Name <input type="text" value="Auto-Populate Current User's Name"/>
Health Record	Phone Number, Extension <input type="text" value="(111) 111-1111"/> <input type="text" value="111111"/>
Care Plan	Additional Comments <input type="text" value="New member for Child Welfare Services at Community Based Care of Central Florida"/>
Authorizations	Reason(s) for Referral (select all that apply) <ul style="list-style-type: none"> <input type="checkbox"/> Behavioral Health Services <input checked="" type="checkbox"/> Care Planning Support <input type="checkbox"/> Coordination of Care (Part of 90 Day COC) <input checked="" type="checkbox"/> Dental Care <input type="checkbox"/> Discharge Planning <input checked="" type="checkbox"/> Healthy Behaviors Program <input checked="" type="checkbox"/> High Risk Member <input type="checkbox"/> Interdisciplinary Care Team Meeting <input type="checkbox"/> Medical Services <input type="checkbox"/> Member/Caregiver Education <input type="checkbox"/> Multidisciplinary Team Meeting <input type="checkbox"/> Placement Coordination <input type="checkbox"/> Routine/Well Care <input type="checkbox"/> Service Coordination <input type="checkbox"/> Transitioning from Child Welfare <input type="checkbox"/> Transitioning to Adult Services <input type="checkbox"/> Transportation <input type="checkbox"/> Welcome Packet and ID Card Delivered
Referrals	<input type="button" value="Submit"/>
Coordination of Benefits	
Claims	

7. Submit

[Back to Eligibility Check](#)

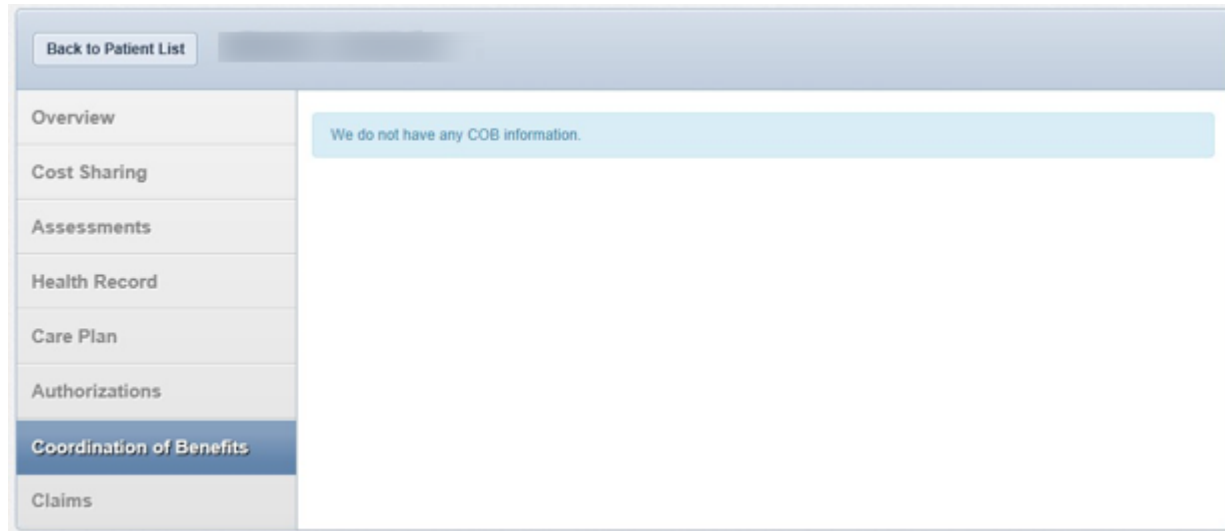
Overview	Your request is submitted Successfully
Cost Sharing	
Assessments	
Health Record	
Care Plan	
Authorizations	
Referrals	
Coordination of Benefits	
Claims	

Coordination of Benefits

To access the members coordination of benefits information from inside the patient record

1. Select Coordination of Benefits

The following screen appears showing no COB information is available for this member.



The screenshot displays a web application interface for a patient record. At the top, there is a header bar with a "Back to Patient List" button on the left and a blurred patient identifier on the right. Below the header is a sidebar menu with the following items: Overview, Cost Sharing, Assessments, Health Record, Care Plan, Authorizations, Coordination of Benefits (which is highlighted with a blue background), and Claims. The main content area to the right of the sidebar contains a light blue message box that reads: "We do not have any COB information."

Claims

To access Claim information from inside the patient record,

1. Select **Claims** on the left.

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

The following screen appears:

The screenshot shows the 'Claims' tab selected in the left sidebar. The main content area displays a table of claims for a patient. The table has columns: CLAIM NO., REFACCT NO., DOS RANGE, PAYMENT DATE, PAYMENT DATE, SERVING PROVIDER, BILLED/PAID, and STATUS. One claim is listed with a status of 'PAID'. Below the table, there is a green button labeled 'Create a New Claim'.

CLAIM NO. ↑	REFACCT NO. ↓	DOS RANGE ↓	PAYMENT DATE ↓	PAYMENT DATE ↓	SERVING PROVIDER ↓	BILLED/PAID ↓	STATUS ↓
0031042015		01/28/2015 - 01/28/2015	02/09/2015	01/31/2015		\$230.00 / \$53.44	PAID

One item found. Page 1/1 1

Create a New Claim

2. Click the Green Create a Claim button to begin a new claim for this patient.

The following screen appears:

The screenshot shows the 'Create a New Claim' screen. It features a 'Choose a Claim Type' section with two options: 'CMS 1500 Professional Claim' and 'CMS UB-04 Institutional Claim'. Both options are represented by green buttons with right-pointing arrows.

Choose Claim for:

Choose a Claim Type

CMS 1500
Professional Claim →

CMS UB-04
Institutional Claim →

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1. Select **Professional Claim** by clicking the green button.

The following screen appears.

The screenshot shows the 'General Info' section of a 'Professional Claim for' form. At the top, a progress bar indicates the current step. The section title is 'General Info' with a subtitle 'Information about the dates of the claim.' Below the title is a large empty text box with a 'Next' button to its right. A '* Required field' label is present. The form contains three rows of input fields: 1. 'Patient's Account Number*' with a text box containing 'XXXXXXXXXX' and a '26' character count indicator. 2. 'Date of current illness, injury, pregnancy (LMP)' with a 'Select Type...' dropdown and a 'MM/DD/YYYY' date box, with a '14' character count indicator. 3. 'Other Date' with a 'Select Type...' dropdown and a 'MM/DD/YYYY' date box, with a '15' character count indicator.

2. In the General Info section, populate the Patient's Account Number, and other information related to the patient's condition by typing into the appropriate fields.
3. Click **Next**.

Adding Diagnosis codes and coordination of benefits

4. Add the Diagnosis Codes for the patient in Box 21
5. Click the Add button to save the appropriate Diagnoses code for the patient

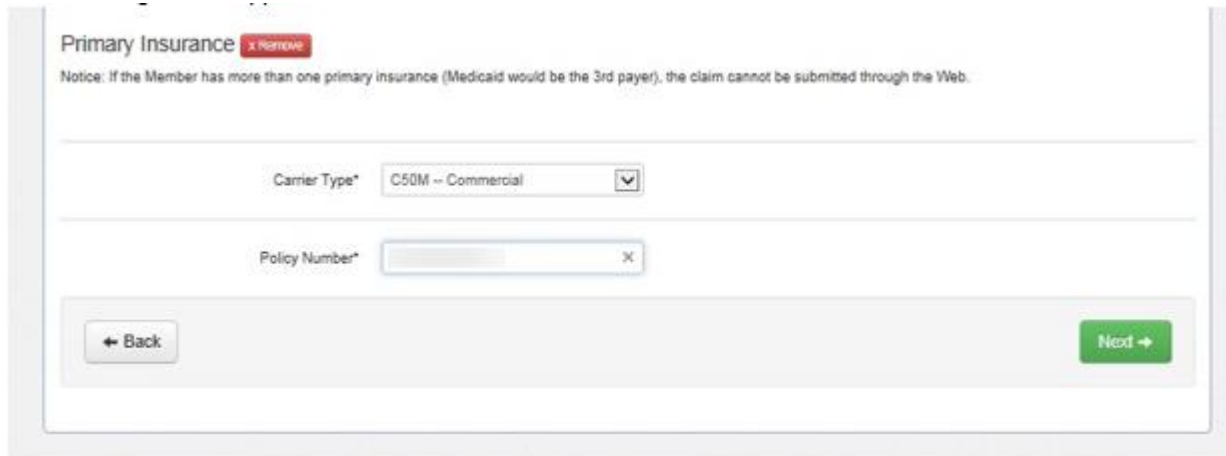
The screenshot shows the 'Diagnosis Codes' section of a 'Professional Claim for' form. The progress bar shows the current step. The section title is 'Diagnosis Codes' with a subtitle 'Diagnosis Code and Additional Insurance information.' Below the title is a 'Back' button and a 'Next' button. A '* Required field' label is present. The form contains: 1. 'ICD Version Indicator*' with a radio button selected for 'ICD 9' and a note: 'Please note that for the claim statement dates entered, valid ICD-9 codes only are accepted.' 2. 'Diagnosis Codes*' with a text box containing 'XXXX e.g. 140!', an 'Add' button, and a note: '(Enter diagnosis code and click on Add button)'. A '21' character count indicator is shown. 3. A list of added codes: '473 - CHRONIC SINUSITIS' with a 'Remove X' button. 4. An 'Add Coordination of Benefits' button. At the bottom, there are 'Back' and 'Next' buttons.

6. Click the **Coordination of Benefits Button** (if applicable) or the **Next** button.

Adding Coordination of Benefits

7. Click Add Coordination of Benefits to include any payments made by another insurance carrier (if applicable)

The following screen appears:



The screenshot shows a web application interface for adding primary insurance. At the top, there is a header "Primary Insurance" with a red "x Remove" button next to it. Below the header is a notice: "Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web." The main form area contains two fields: "Carrier Type*" with a dropdown menu showing "C50M -- Commercial" and a "Policy Number*" with a text input field and a clear "X" button. At the bottom of the form, there are two buttons: a "Back" button with a left arrow and a "Next" button with a right arrow.

8. Enter the Carrier Type and the Policy Number
9. Click **Next**

The following screen appears:

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.

Amount Allowed*

100.00

Deductible

XXXX.XX

Copay

XXXX.XX

Co-Insurance

XXXX.XX

Amount Paid

100.00

Service Line Denial Reasons
Select denied category, enter amount and click "Add Denied Reason" to add a denied amount to your claim.

Denied Category

Select...

▼

Denied Amount

XXXX.XX

Add Denied Reason

\$ 158.39 Non-Covered Service

Remove X

Delete

Save / Update

10. Enter the pertinent information from the primary insurance
11. Select Save/Update
12. Click Next

Adding Service Lines to the claim

The following screen appears:

Professional Claim for Your Progress

THIS SECTION: **Service Lines** Enter maximum of 50 service lines.

← Back Next →

Total: \$100.00 * Required field Delete Save / Update

Now Viewing 99214 / \$100.00

[+ New Service Line](#)

PROCEDURE / CHARGES

99214 / \$100.00

Dates of Service* From 03/03/2014 To 03/03/2014 24.a

Place of Service* 11 - PROVIDERS OFFICE 24.b

Procedure Code* 99214 24.d

Modifiers XX 24.e 24.f Add Please enter the modifier and click the Add button.

Diagnosis Code(s)* ☒ 473 - CHRONIC SINUSITIS 24.g

Charges* 100.00 24.h

Days / Units* 1 24.i

Family Planning Yes No EPSDT Select... 24.j

NDC NDC NDC

13. In the Service Lines section, add your service line information.

*****Note:** When entering charges for the service billed, include the decimal point to ensure the data is populated accurately. For example, 99.00 convert to \$99.00.

14. To add additional service lines, click the **Save/Update** button and then click the **New Service Line** button. Enter up to 99 service lines.

15. Click **Next**

Adding Provider Information to the claim

The following screen appears:

The screenshot displays a web application interface for adding provider information to a claim. At the top, a navigation bar includes icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this, a header section shows 'Viewing Claims For:' with dropdown menus and buttons for 'Upload EDI' and 'Create Claim'. The main content area is titled 'Professional Claim for' and features a 'Your Progress' bar with five steps, the second of which is highlighted. The section is labeled 'Providers' and 'Providers on this claim:'. It contains four main sections: 'Referring Provider' (with NPI, Last Name, and First Name fields), 'Rendering Provider' (with NPI, Medicaid Provider #, Tax ID, Last Name, and First Name fields), 'Billing Provider' (with Tax ID, Name, NPI, Medicaid Provider #, Address, City, State, and Zip fields), and 'Service Facility Location' (with Name, NPI, Address, City, State, and Zip fields). Each section has a 'Find Provider' button. A 'Back' button is at the top left, and a 'Next' button is at the bottom right. A sidebar on the right shows a list of steps with corresponding numbers: 17, 24, 33, and 32.

16. Enter referring and billing provider information
17. Enter Service Facility Location
18. Click **Next**

Adding Attachments to a claim.

The following screen appears:

The screenshot shows a web application interface for managing claims. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this is a section for 'Viewing Claims For' with two dropdown menus and a 'GO' button. To the right are buttons for 'Upload EDI' and 'Create Claim'. A progress bar indicates the current step is 'Professional Claim for' with a 'Your Progress' indicator showing five steps, with the first four being green and the fifth being orange.

The main section is titled 'THIS SECTION: Attachments' with the subtitle 'Add attachments to the claim (5MB limit)'. It also notes 'Supported types are .jpg, .tif, .pdf and .tiff'. Below this is a form area with the heading 'Attachments'. It contains a 'File*' input field with a 'Browse...' button, an 'Attachment Type*' dropdown menu with 'Select Type...' as the current selection, and an 'Attach' button. Below the form is a table with two columns: 'Attachment Name' and 'Type'. The table contains one row with 'Consent Form' in the 'Type' column and a 'Remove X' button to its right. At the bottom of the form area are a 'Back' button, the text 'If there are no attachments, click Next.', and a 'Next' button.

19. In the Attachments section you can **Browse** and **Attach** any documents to the claim as desired.

Note: If you have no attachments, skip this section

20. Click **Next**

The Review Section of the claim

The following screen appears:

Viewing Claims For :

Professional Claim for

Your Progress

THIS SECTION:

Review Please review your claim and submit.
You are correcting a claim for

Almost done!

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

Claim Id:

Member Record Number:

Member Claim Amount Paid:

Patient's Account Number:

General Info

Hospitalized From:
Hospitalized To:
Outside Lab?: No
Outside Lab Amount:
Prior Authorization Number:
CLIA Number:

Diagnosis Codes

95909 -- INJURY FACE&NECK OTHER&UNSPECIFIED
7231 -- CERVICALGIA
7245 -- UNSPECIFIED BACKACHE

Service Lines

Line	From	To	Place	Proc	Diagnosis	Amount	Days/Units	Family Plan	EPSDT	NDC	Supplemental Info
1	03/19/2015	03/19/2015	41	A0429 (SH)	95909,7231,7245	\$815.67	1	No			
2	03/19/2015	03/19/2015	41	A0425 (SH)	95909,7231,7245	\$175.88	12	No			

Providers

Provider Type	Name	Tax ID	NPI	Medicaid #	Address
ReferringProvider					
RenderingProvider					
BillingProvider					
Service Facility Location					

Attachments

21. In the Review section, you can review the claim once again
22. Click **Submit**.

Creating an Institutional Claims

Select the CMS UB-04 **Institutional Claim** button from the member record

The screenshot shows a web application interface for creating a claim. At the top, there is a navigation bar with icons and labels for 'Eligibility', 'Patients', 'Authorizations', 'Claims', and 'Messaging'. Below this, a 'Viewing Claims For:' section contains two dropdown menus and a 'GO' button. To the right of these are 'Upload EDI' and 'Create Claim' buttons. The main content area is titled 'Choose Claim for' and 'Choose a Claim Type'. It features two large buttons: 'CMS 1500 Professional Claim →' and 'CMS UB-04 Institutional Claim →'. At the bottom, there are links for 'Terms & Conditions', 'Privacy Policy', and a copyright notice for 'Copyright © 2015, Centene Corporation'.

Viewing Claims For :

Choose Claim for

Choose a Claim Type

CMS 1500
Professional Claim →

CMS UB-04
Institutional Claim →

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The following screen appears:

The screenshot shows the 'Institutional Claim for' form, specifically the 'General' section. At the top, there is a progress bar labeled 'Your Progress' with a series of arrows. Below this, the section is titled 'General' with the instruction 'Enter information for the Admission and Condition Codes'. The form is divided into three main sections: 'Required field', 'Admission', and 'Discharge'. Each section contains several input fields and a corresponding 'Claim Field Tab' on the right side of the form. The 'Required field' section includes 'Patient Control #' (1234), 'Medical Record #' (1222), 'Type Of Bill*' (121), 'Statement Dates*' (From 01/01/2015 To 01/30/2015), 'Prior Payments', and 'Prior Authorization Number'. The 'Admission' section includes 'Time*' (Date 01/01/2015, Hour 01), 'Type*' (1 - Emergent), and 'Source*' (5 - Transfer From A Skilled Nursing Facility). The 'Discharge' section includes 'Status*' (03 - Discharged/transferred to a skilled nursing facility (SNF)) and 'Hour' (14). A green 'Next' button is located at the bottom right of the form.

Institutional Claim for Your Progress

THIS SECTION
General Enter information for the Admission and Condition Codes

*** Required field**

Patient Control #* 1234 3.a

Medical Record # 1222 3.b

Type Of Bill* 121 4.

Statement Dates* From 01/01/2015 To 01/30/2015 6.

Prior Payments 54.

Prior Authorization Number 63.

Admission

Time* Date 01/01/2015 Hour 01 12-13.

Type* 1 - Emergent 14.

Source* 5 - Transfer From A Skilled Nursing Facility 15.

Discharge

Status* 03 - Discharged/transferred to a skilled nursing facility (SNF). 17.

Hour 14 16.

Next →

1. In the General section, populate the admission and condition code information. The fields displayed here reflect those on a UB-04 form.
2. Click **Next**

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

The following screen appears

Institutional Claim for

Your Progress

THIS SECTION:

Provider Details

Basic information about the patient's status and condition.

* Required field

Billing Provider

NPI*

Search

Taxonomy

Selected Provider

Pay-to Provider

Same As Billing Provider

NPI*

Taxonomy

IRS/Tax ID Number*

Pay-To Name*

Address*

City*

State*

Zip*

Attending Provider

NPI

Taxonomy

First Name

Last Name

IRS/Tax ID Number

56

57

2

76

67

Continued:

Rendering Provider

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

81

NPI

Find Provider

First Name

Last Name

Organization Name

Clear X

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

Other Provider

79

NPI

Taxonomy

First Name

Last Name

IRS/Tax ID Number

← Back

Next →

3. In the Provider Details section, enter the billing and other provider information in the appropriate fields.
4. Click **Next**

The following screen appears:

Total:\$30,000.00
Non-Covered : \$0.00

+ New Service Line

PROCEDURE / CHARGES

120 / \$30,000.00

* Required field

Delete Save / Update

Now Viewing 120 / \$30,000.00

Revenue Code*
120
Lookup
42.

HCPCS / Rate / HIPPS Code
44.

NDC
Guide

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

Service Date*
01/01/2015
45.

Service Units*
30
46.

Charge Amount*
30000
47.

Non-Charge Amount
XXXXXX.XX
48.

Delete Save / Update

Back

Next

5. In the Service Lines section, enter the information about the services provided.
6. Click **Save/Update**, and to add a new service line
7. Click the **+ New Service Line** button on the left to add additional service lines.
Note: You can enter up to 99 service lines. When all necessary service lines have been entered and saved
8. Click the **Next** button.

The following screen appears;

Viewing Claims For :

Institutional Claim for Your Progress

THIS SECTION:
Additional Insurance Enter additional insurance details.

You may skip this section if there is no additional insurance.

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

Policy Number

Amount Allowed

Deductible

Copay


Co-Insurance

Amount Paid

Denial Reasons Amount

9. In the Additional Insurance section, enter any additional insurance details as needed. If there is no additional insurance, you may skip this section.
10. Click **Next**.

The following screen appears:

Institutional Claim for Your Progress 

THIS SECTION:
Diagnosis Codes Enter all relevant diagnosis codes.

* Required field

ICD Version Indicator* ☒ ICD 9 Please note that for the claim statement dates entered, valid ICD-9 codes only are accepted.

Principal Diagnosis Code* POA Indicator Select... 67.

Diagnosis Codes (67A-Q) POA Indicator Select... Add 67.a-q

462-ACUTE PHARYNGITIS Remove X

Patient Reason for Visit Add 70.

External Cause of Injury Code (ECI) 72.

Prospective Payment Code 71.

Condition Codes Add 18-28.

Occurrence Codes and Span Codes From To Add 31-36.

11-OCCURRENCE CODE 10/17/2014 Remove X

Value Code Amount Add 39-41.

Procedure Codes Procedure Date Add 74.

← Back Next →

11. In the Diagnosis Codes section, enter all relevant diagnosis information.
12. Click **Next**.

The following screen appears:

The screenshot shows a web application interface for managing claims. At the top, there is a navigation bar with icons and labels for 'Eligibility', 'Patients', 'Authorizations', 'Claims', and 'Messaging'. Below this, a header area contains 'Viewing Claims For:' with two dropdown menus and a 'GO' button, along with 'Upload EDI' and 'Create Claim' buttons. The main content area is titled 'Institutional Claim for' and includes a 'Your Progress' indicator with a series of green and orange arrows. The current section is 'Attachments', with a sub-header 'THIS SECTION: Attachments'. Below this, there is a text prompt 'Add attachments to the claim (5MB limit)' and a note 'Supported types are .jpg, .tif, .pdf and .tiff'. The 'Attachments' section contains a form with two fields: 'File*' with a 'Choose File' button and 'Attachment Type*' with a 'Select Type...' dropdown. An 'Attach' button is positioned to the right of the dropdown. Below the form, a light blue box states 'There are no attached files.' At the bottom, there are 'Back' and 'Next' buttons, with a message 'If there are no attachments, click Next.' between them.

13. In the Attachments section, **Choose File** and **Attach** any relevant file to the claim.
14. Click **Next**

The following screen appears:

15. Review the claim

16. Click **Submit**

Eligibility

Requests

Authorizations

Claims

Messaging

Account

Viewing Claims For:

GO

Upload Edit

Create Claim

Institutional Claim for **L.A. Serrano, B. 1987-10-08**

Your Progress

THIS SECTION:

Review and Submit

Please review your claim before submitting.

Almost done!

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

Submit

Claim ID: 501645799

General Info

Patient Control #:

Medical Record #:

Type Of Bill: 137

Statement From Date: 10/17/2014

Statement To Date:

Prior Payments:

Prior Authorization Number:

Admission Date: 10/17/2014

Admission Hour: 00

Admission Type: 1

Admission Source: 1

Discharge Status: 01

Discharge Hour: 00

Provider Details

Provider Type	NPI	Taxonomy	Name	Tax ID	Address (1)	Address (2)	City	State	Zip

Provider Type	NPI	Taxonomy	First Name	Last Name	IRS/Tax ID Num	Organization
Attending Provider	1255422341		JOHN	O'BRIEN		
Rendering Provider						
Operating Provider						
Other Operating Provider						
Other Provider						

Service Lines

Line	Revenue Code	HCPCS/Rate/ICD9	Modifiers	NDC	Date	Units	Charge amount	Non-Charge Amount
1	251				10/17/2014	1	\$325.00	
2	251				10/17/2014	1	\$246.00	
3	271				10/17/2014	1	\$285.00	
4	306	87081			10/17/2014	1	\$125.00	
5	410	94840			10/17/2014	1	\$391.00	
6	850	99283	25		10/17/2014	1	\$748.00	

Primary Insurance

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

Uploading Documents for Quality Management / Medical Necessity Upload

To upload documents for quality management or medical necessity for a member's record,

1. Click on Quality Management / Medical Necessity Upload

The screenshot shows a web application interface for patient eligibility and document upload. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this is a section for 'Viewing Eligibility For' with two dropdown menus and a 'GO' button. A 'Back to Eligibility Check' button is also present. The main content area is divided into a left sidebar and a right main panel. The sidebar contains a list of menu items: Overview, Cost Sharing, Assessments, Health Record, Authorizations, Referrals, Coordination of Benefits, Claims, and Quality Management/Medical Necessity Upload. The 'Quality Management/Medical Necessity Upload' item is highlighted with a red border. The main panel displays a green message: 'This patient is eligible as of today, Dec 15, 2015.' Below this, there are sections for Patient Information and PCP Information. The Patient Information section includes fields for Name, Gender (F), Birthdate, Age, Member #, and Address. The PCP Information section includes fields for Name, Address, Practice Type (FAMILY PRACTICE), and Phone Number. There are also links for 'View PCP History', 'Care Gaps', and 'Allergies'. An 'Eligibility History' table is shown, with columns for Start Date, End Date, and Product Name. The table contains two rows: Jan 1, 2016 to Ongoing for TANF, and May 4, 2015 to Dec 31, 2015 for TANF. A 'more' link is available below the table. At the bottom, there is a link for 'View Clinical Information'.

Viewing Eligibility For: [] [] GO

Back to Eligibility Check

Overview

Cost Sharing

Assessments

Health Record

Authorizations

Referrals

Coordination of Benefits

Claims

Quality Management/Medical Necessity Upload

This patient is eligible as of today, Dec 15, 2015.

Patient Information

Name []

Gender F

Birthdate []

Age []

Member # []

Address []

PCP Information

Name []

Address []

Practice Type FAMILY PRACTICE

Phone Number []

[View PCP History](#)

[Care Gaps](#)

[Allergies](#)

HTN - Not seen in past 12 mos

None On File

Eligibility History

Start Date	End Date	Product Name
Jan 1, 2016	Ongoing	TANF
May 4, 2015	Dec 31, 2015	TANF

[more](#)

[View Clinical Information](#)

2. Providers can either Upload Documents or View Documents

[Back to Patient List](#)

Overview
Cost Sharing
Assessments
Health Record
Care Plan
Authorizations
Referrals
Coordination of Benefits
Claims
Quality Management/Medical Necessity Upload

Quality Management

Quality Management Upload

Medical Necessity Upload

View Quality Management Documents

View Medical Necessity Documents

- Document Type:
- Upload File: No file chosen
-

3. To Upload a Quality Management Document, click on **Quality Management Upload**

[Back to Patient List](#)

Overview
Cost Sharing
Assessments
Health Record
Care Plan
Authorizations
Referrals
Coordination of Benefits
Claims
Quality Management/Medical Necessity Upload

Quality Management

Quality Management Upload

Medical Necessity Upload

View Quality Management Documents

View Medical Necessity Documents

- Document Type:
- Upload File: No file chosen
-

4. Click Document Type and select the category for documentation

[Back to Patient List](#)

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Quality Management/Medical Necessity Upload

Quality Management

Quality Management Upload

Medical Necessity Upload

View Quality Management Documents

View Medical Necessity Documents

1.

Document Type: Audit

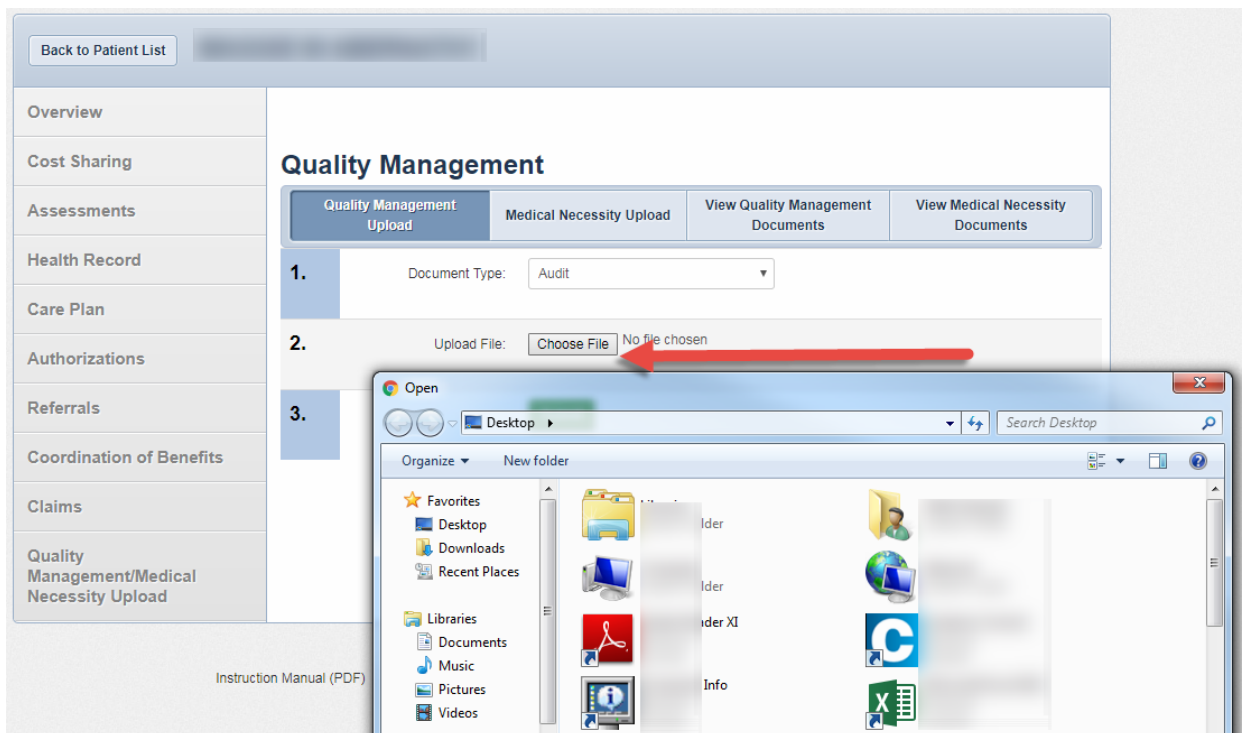
2.

Upload File: Choose File No file chosen

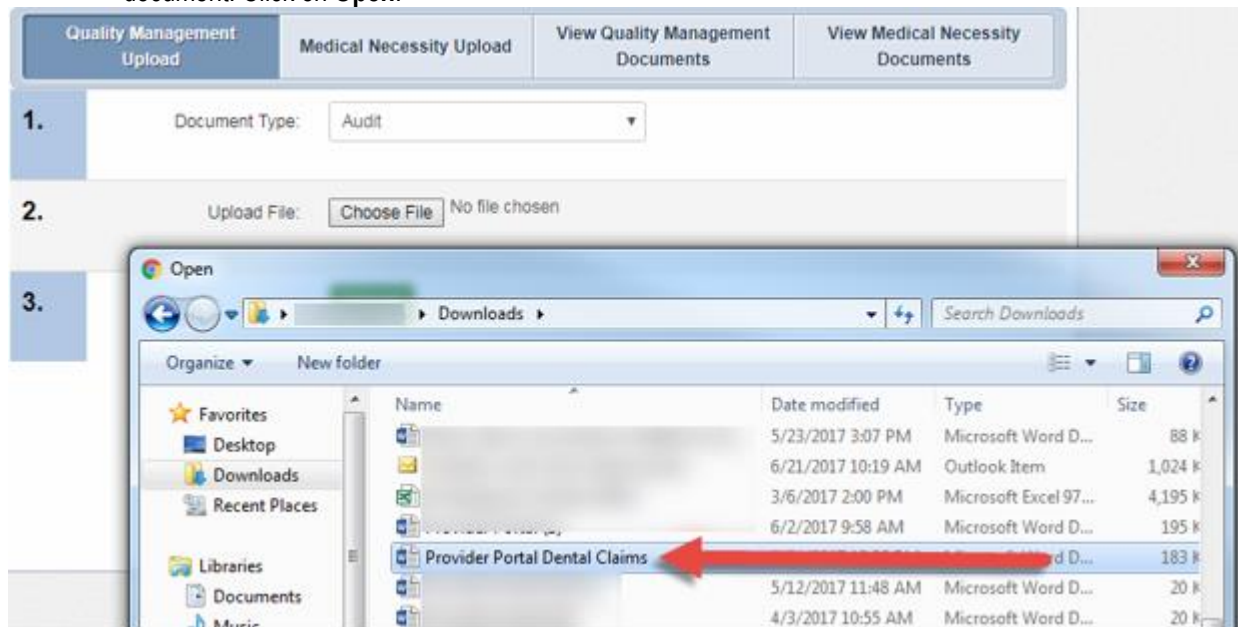
3.

Submit

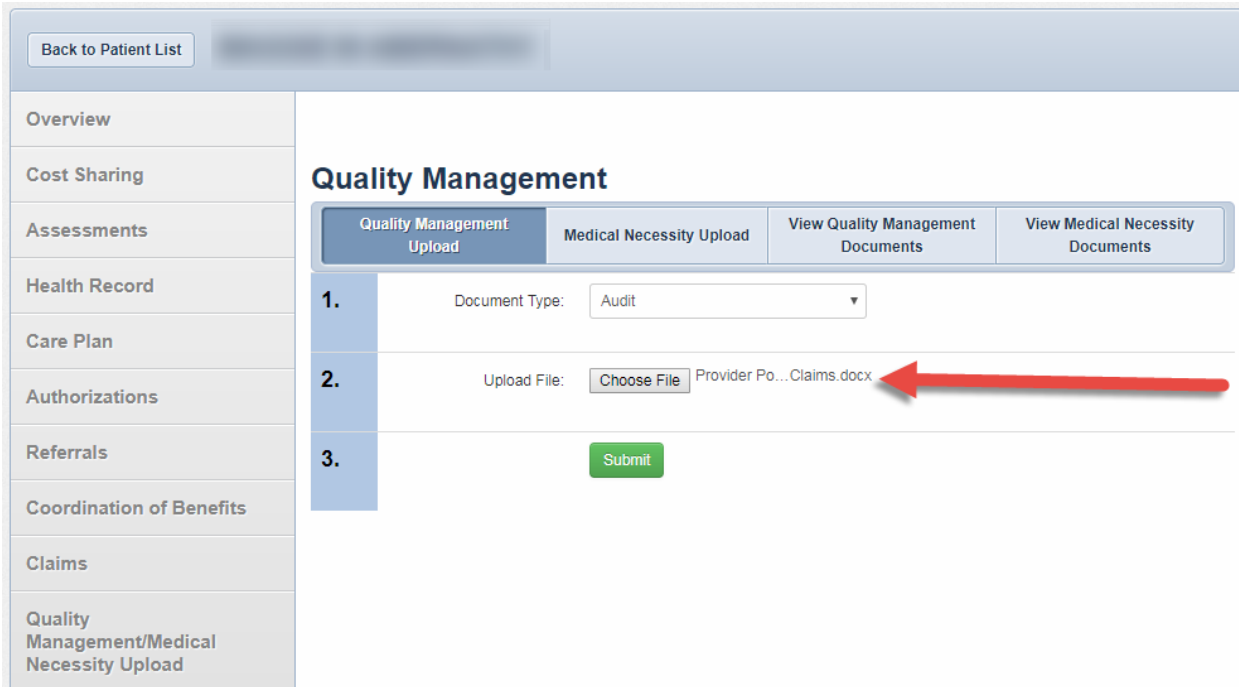
5. Click on Browse to open available documents



6. Highlight the document to be uploaded and the name will appear in the **File Name** field at the bottom of the document. Click on **Open**.



7. The document will appear in the browse window



8. Click **Submit**. File Accepted will appear with a success

[Back to Patient List](#)

Quality Management

Quality Management Upload	Medical Necessity Upload	View Quality Management Documents	View Medical Necessity Documents
1.	Document Type: <input type="text" value="Audit"/>		
2.	Upload File: <input type="button" value="Choose File"/> No file chosen		
3.	<input type="button" value="Submit"/>		

FILE ACCEPTED

To Upload a Medical Necessity Document for a member's record

1. Click on Medical Necessity Upload

[Back to Patient List](#)

Medical Necessity

Quality Management Upload	Medical Necessity Upload	View Quality Management Documents	View Medical Necessity Documents
1.	Document Type: <input type="text" value="Emergency Notes"/>		
2.	Upload File: <input type="button" value="Choose File"/> No file chosen		
3.	<input type="button" value="Submit"/>		

2. Click Document Type and select the category for documentation

Back to Patient List

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Quality Management/Medical Necessity Upload

Medical Necessity

Quality Management Upload **Medical Necessity Upload** View Quality Management Documents View Medical Necessity Documents

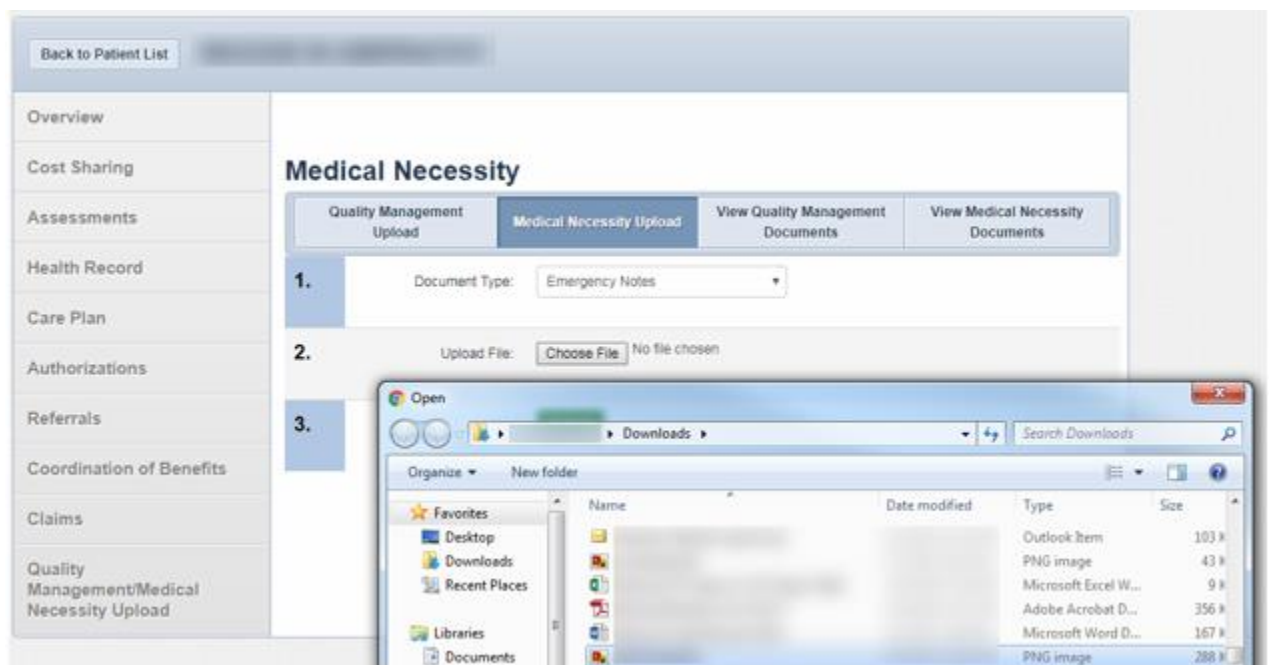
1. Document Type: Emergency Notes

2. Upload File:

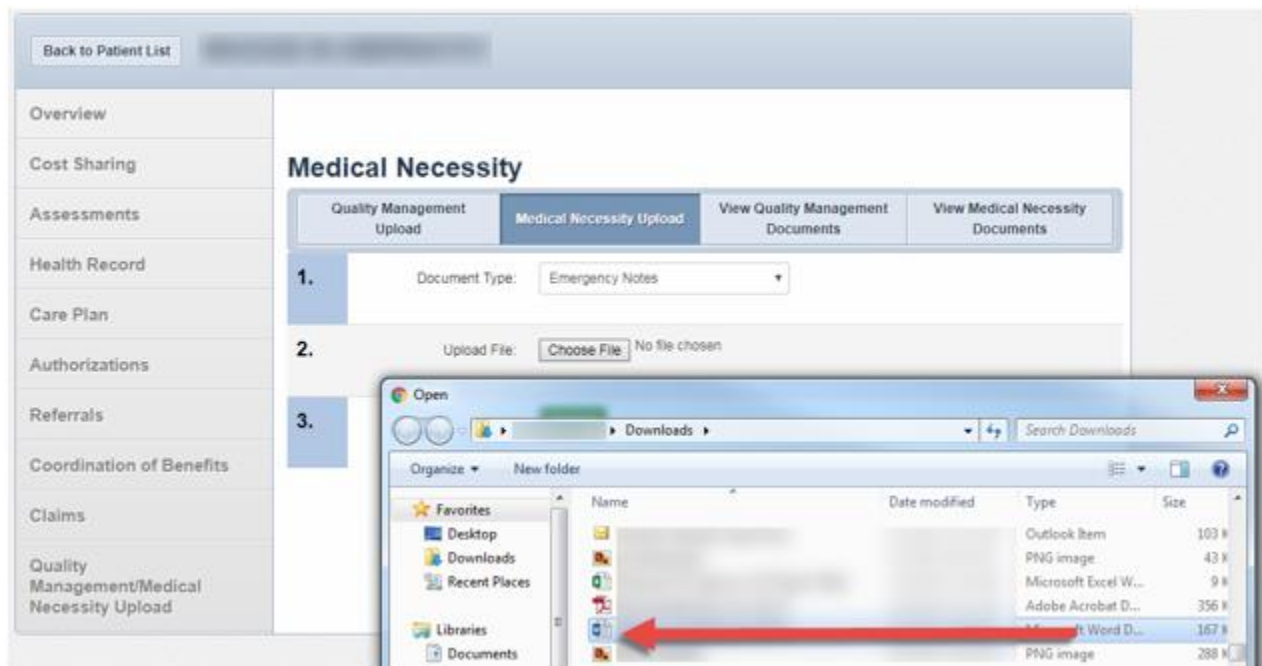
3. Submit

Emergency Notes
Inpatient Notes
InterQual Smart Sheets
Other

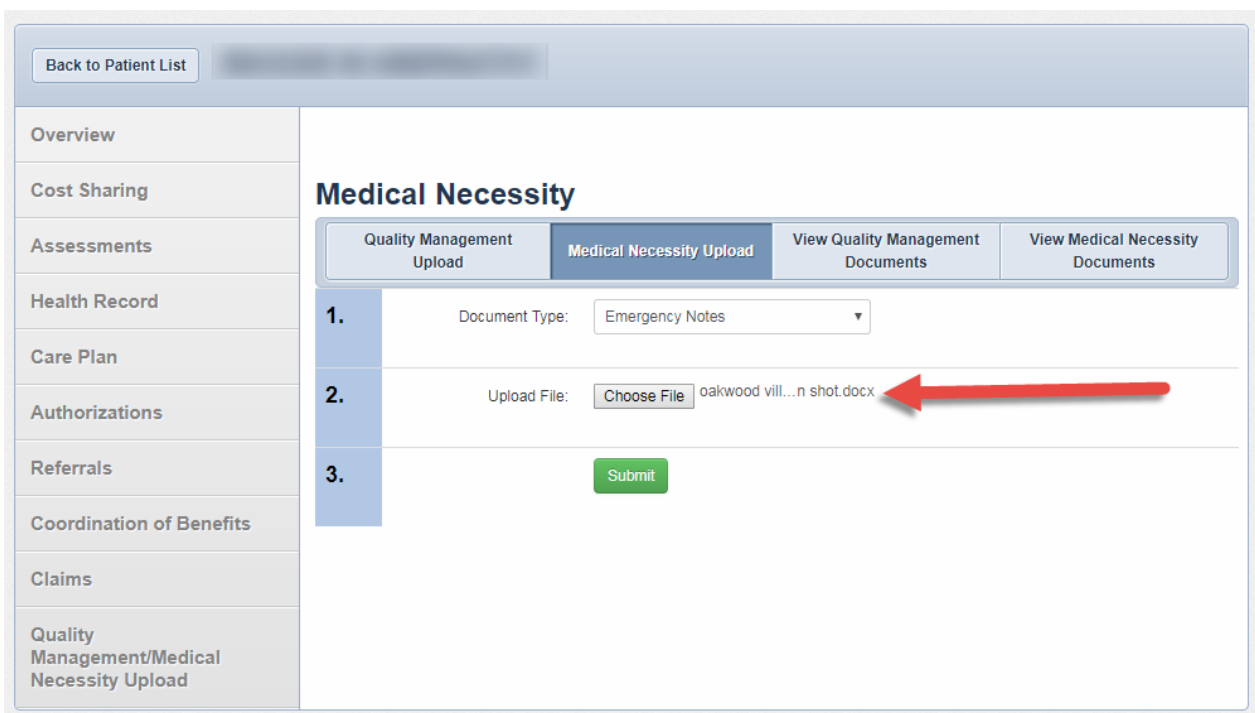
- Click on Browse to open available documents



- Highlight the document to be uploaded and the name will appear in the **File Name** field at the bottom of the document. Click on **Open**.



5. The document will appear in the browse window



6. Click **Submit**. File Accepted will appear with a success

[Back to Patient List](#)

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Quality Management/Medical Necessity Upload

Medical Necessity

Quality Management Upload **Medical Necessity Upload** View Quality Management Documents View Medical Necessity Documents

- Document Type:
- Upload File: No file chosen
-

FILE ACCEPTED

To View Uploaded Documents for Quality Management / Medical Necessity Upload

- From the member's record, select Quality Management/Medical Necessity Upload

Eligibility Patents Authorizations Claims Messaging

Viewing Eligibility For:

[Back to Eligibility Check](#)

Overview

Cost Sharing

Assessments

Health Record

Authorizations

Referrals

Coordination of Benefits

Claims

Quality Management/Medical Necessity Upload

This patient is eligible as of today.

Patient Information

Name

Gender F

Birthdate

Age

Member #

Address

PCP Information

Name

Address

Practice Type FAMILY PRACTICE

Phone Number

[View PCP History](#)

[Care Gaps](#)

[Allergies](#)

[View Clinical Information](#)

Eligibility History

Start Date	End Date	Product Name
Jan 1, 2016	Ongoing	
May 4, 2015	Dec 31, 2015	

[more](#)

HTN - Not seen in past 12 mos

None On File

2. Click on the type of document to be viewed

The screenshot shows a web application interface for Quality Management. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this is a 'Viewing For' section with two dropdown menus and a 'GO' button. A 'Back to Authorizations' button is located on the left side of the main content area. The main content area is titled 'Quality Management' and contains four tabs: 'Quality Management Upload', 'Medical Necessity upload', 'View Quality Management Documents', and 'View Medical Necessity Documents'. The 'View Quality Management Documents' and 'View Medical Necessity Documents' tabs are highlighted with a red box. Below the tabs, there are input fields for 'Start Date' and 'End Date', both with a placeholder 'MM/DD/YYYY' and a 'Search' button. A note below the input fields states 'Date span limited to a 3-month period.' On the left side of the interface, there is a vertical menu with the following items: Overview, Cost Sharing, Assessments, Health Record, Care Plan, Authorizations, Referrals, Coordination of Benefits, Claims, and Quality Management/Medical Necessity Upload.

3. Select the Start and End Date range.

This screenshot shows the same 'Quality Management' interface as the previous one, but with the 'Start Date' input field selected. A date picker calendar is open, showing the month of December 2015. The calendar has a grid with days of the week (Su, Mo, Tu, We, Th, Fr, Sa) and dates (1 through 31). The date '31' is highlighted in blue. The 'End Date' input field is still empty with the placeholder 'MM/DD/YYYY'. The 'Search' button is visible. The 'View Quality Management Documents' and 'View Medical Necessity Documents' tabs remain highlighted. The left sidebar menu is also visible.

- Click Search to display any documents submitted for that member

[Back to Authorizations](#)

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Quality Management/Medical Necessity Upload

Quality Management

Quality Management Upload

Medical Necessity upload

View Quality Management Documents

View Medical Necessity Documents

Start Date:

End Date:

12/31/2015

01/08/2016

Search

Date span limited to a 3-month period.

- If documents are available, the list will display

[Back to Eligibility Check](#)

Overview

Cost Sharing

Assessments

Health Record

Authorizations

Referrals

Coordination of Benefits

Claims

Quality Management/Medical Necessity Upload

Quality Management

Quality Management Upload

Medical Necessity upload

View Quality Management Documents

View Medical Necessity Documents

Start Date:

End Date:

MM/DD/YYYY

MM/DD/YYYY

Search

Date span limited to a 3-month period.

SUBMITTED DATE	TYPE	FILE NAME
12/15/2015	Audit	TR Photo Test Attachment.docx

- Click on the name of the document to open and review



- If there are not any documents to view, a message will appear.

[Back to Authorizations](#)

Overview	<h3>Quality Management</h3> <table><tr><td>Quality Management Upload</td><td>Medical Necessity upload</td><td>View Quality Management Documents</td><td>View Medical Necessity Documents</td></tr><tr><td colspan="4">Start Date: <input type="text" value="MM/DD/YYYY"/> End Date: <input type="text" value="MM/DD/YYYY"/> <input type="button" value="Search"/></td></tr><tr><td colspan="4">Date span limited to a 3-month period.</td></tr><tr><td colspan="4">No Data Found</td></tr></table>	Quality Management Upload	Medical Necessity upload	View Quality Management Documents	View Medical Necessity Documents	Start Date: <input type="text" value="MM/DD/YYYY"/> End Date: <input type="text" value="MM/DD/YYYY"/> <input type="button" value="Search"/>				Date span limited to a 3-month period.				No Data Found			
Quality Management Upload		Medical Necessity upload	View Quality Management Documents	View Medical Necessity Documents													
Start Date: <input type="text" value="MM/DD/YYYY"/> End Date: <input type="text" value="MM/DD/YYYY"/> <input type="button" value="Search"/>																	
Date span limited to a 3-month period.																	
No Data Found																	
Cost Sharing																	
Assessments																	
Health Record																	
Care Plan																	
Authorizations																	
Referrals																	
Coordination of Benefits																	
Claims																	
Quality Management/Medical Necessity Upload																	

Patient List

To view, and download a patient list from the Dashboard (available for PCP's/PMP only)

1. Click **Patients**
2. The Patient List appears

This view shows patient Eligibility Status, Member Name, Member ID #, DOB, Phone Number and Alerts

Viewing Patients For : [] [] GO Find Patient

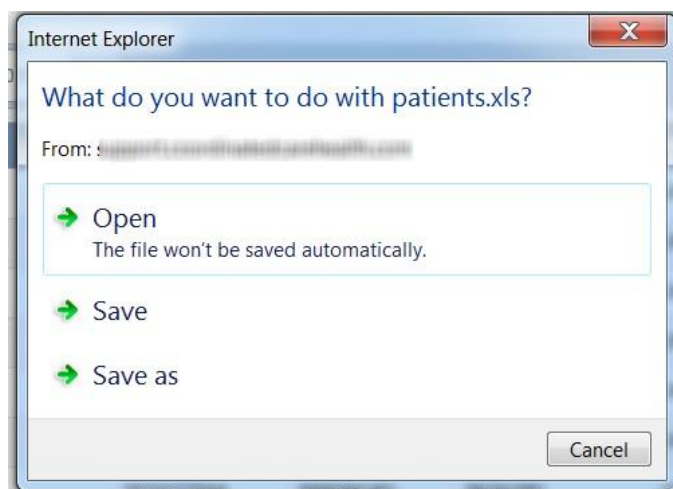
Patient List as of [] → Download Filter

Eligible	Member Name	Member ID	Member #	Date of Birth	Phone Number	ALERTS
✓						CG
✓						CG
✓						CG DM
✓						CG
✓						CG
✓						CG DM
✓						CG
✓						DM
✓						CG

739 items found, displaying 1 to 10. Page 1/74 1 2 3 4 5 6 7 8 Next Last

Downloading the Patient List

1. Click the Download Button



Note: A copy of the patient list in an Excel format will download.

Filter the Patient List

To filter the patient list

1. Click **Filter**
2. Multiple filters can be applied for based on the Provider's NPI, Medicaid Number, Specific Member's Last Name or Specific Alert.
3. Click **Go**

The screenshot shows the 'Patient List' interface with a filter section. The filter section includes a 'Filter By:' area with input fields for 'Provider NPI', 'Provider Medicaid Number', and 'Member Last Name'. Below these are checkboxes for 'Care Gaps', 'Case Management', 'Emergency Department' (checked), 'Special Needs', and 'Disease Management'. At the bottom of the filter section are 'Go' and 'Clear' buttons. A red arrow points to the 'Filter' button in the top right corner of the filter section.

The following screen will appear:

The screenshot shows the 'Patient List' interface with a table of patient data. The table has columns for 'Eligible', 'Member Name', 'Member ID', 'Date of Birth', 'Phone Number', and 'ALERTS'. There are 4 items found, displaying all items. The page is 1/1.

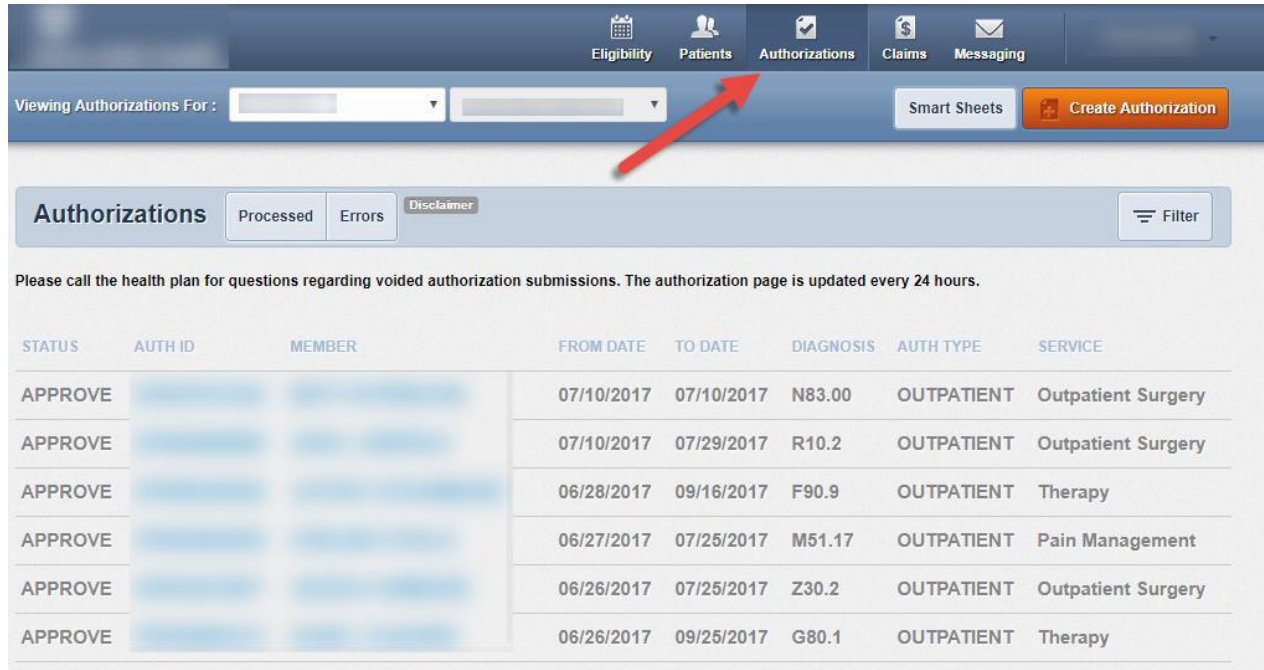
Eligible	Member Name	Member ID	Date of Birth	Phone Number	ALERTS
👍	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	CG ED
👍	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	CG ED
👍	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	CG ED
👍	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	CG ED

4 items found, displaying all items. Page 1/1

View Authorizations by TIN

1. Select **Authorization**
2. Authorizations will appear for that specific TIN and Product

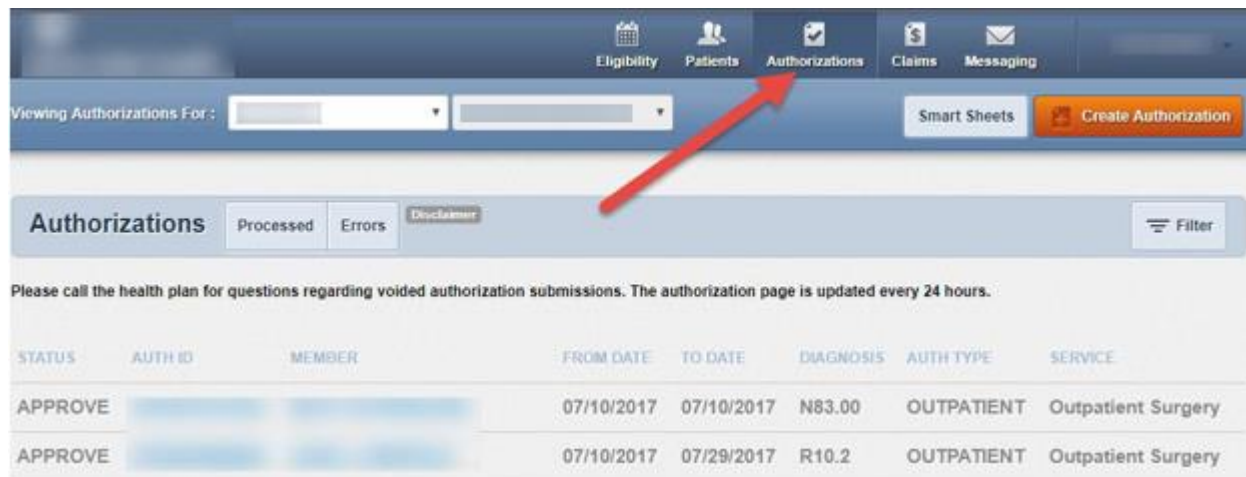
Prior authorization requests may take 24-48 hours to display on the authorization list. The authorizations will display for 90 days.



The screenshot shows the 'Authorizations' page in a web application. The top navigation bar includes tabs for 'Eligibility', 'Patients', 'Authorizations' (highlighted with a red arrow), 'Claims', and 'Messaging'. Below the navigation bar, there are two dropdown menus for 'Viewing Authorizations For:' and a 'Smart Sheets' button. A 'Create Authorization' button is also visible. The main section is titled 'Authorizations' and includes tabs for 'Processed', 'Errors', and a 'Disclaimer' button. A 'Filter' button is located on the right. A disclaimer message states: 'Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.' Below this is a table with columns: STATUS, AUTH ID, MEMBER, FROM DATE, TO DATE, DIAGNOSIS, AUTH TYPE, and SERVICE. The table contains six rows of data, all with a status of 'APPROVE'.

STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE			07/10/2017	07/10/2017	N83.00	OUTPATIENT	Outpatient Surgery
APPROVE			07/10/2017	07/29/2017	R10.2	OUTPATIENT	Outpatient Surgery
APPROVE			06/28/2017	09/16/2017	F90.9	OUTPATIENT	Therapy
APPROVE			06/27/2017	07/25/2017	M51.17	OUTPATIENT	Pain Management
APPROVE			06/26/2017	07/25/2017	Z30.2	OUTPATIENT	Outpatient Surgery
APPROVE			06/26/2017	09/25/2017	G80.1	OUTPATIENT	Therapy

3. Searching for Specific Authorization or Authorization



This screenshot is identical to the one above, showing the 'Authorizations' page. The red arrow points to the 'Authorizations' tab in the top navigation bar. The table in this screenshot shows only two rows of data:

STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE			07/10/2017	07/10/2017	N83.00	OUTPATIENT	Outpatient Surgery
APPROVE			07/10/2017	07/29/2017	R10.2	OUTPATIENT	Outpatient Surgery

1. Click **Authorizations**
2. Enter the Authorization # in the free text filter box.
3. Click **Go**

Eligibility

Patients

Authorizations

Claims

Messaging

Viewing Authorizations For :

Smart Sheets

Create Authorization

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

OP04

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.

STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE			07/10/2017	07/10/2017	N83.00	OUTPATIENT	Outpatient Surgery
APPROVE			07/10/2017	07/29/2017	R10.2	OUTPATIENT	Outpatient Surgery
APPROVE			06/28/2017	09/16/2017	F90.9	OUTPATIENT	Therapy
APPROVE			06/27/2017	07/25/2017	M51.17	OUTPATIENT	Pain Management
APPROVE			06/26/2017	07/25/2017	Z30.2	OUTPATIENT	Outpatient Surgery
APPROVE			06/26/2017	09/25/2017	G80.1	OUTPATIENT	Therapy

1. The specific authorization will appear.

EligibilityPatientsAuthorizationsClaimsMessaging

Viewing Authorizations For :

Smart Sheets

Create Authorization

Authorizations

ProcessedErrorsDisclaimer

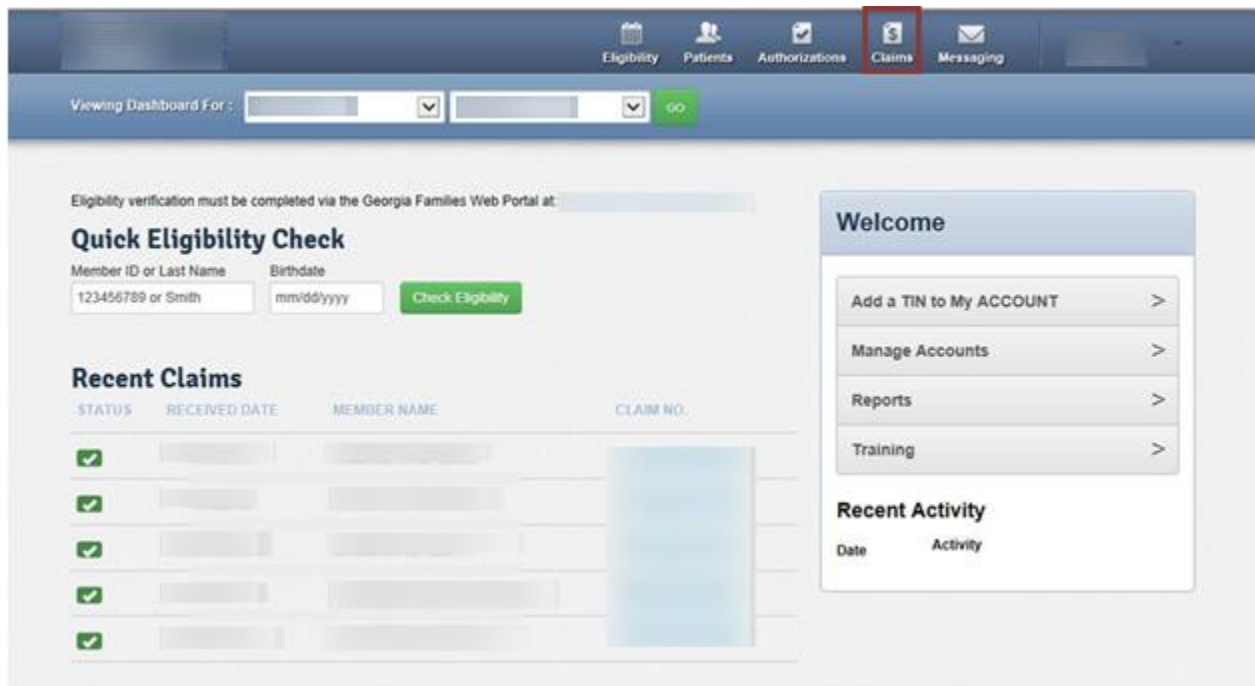
Filter

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

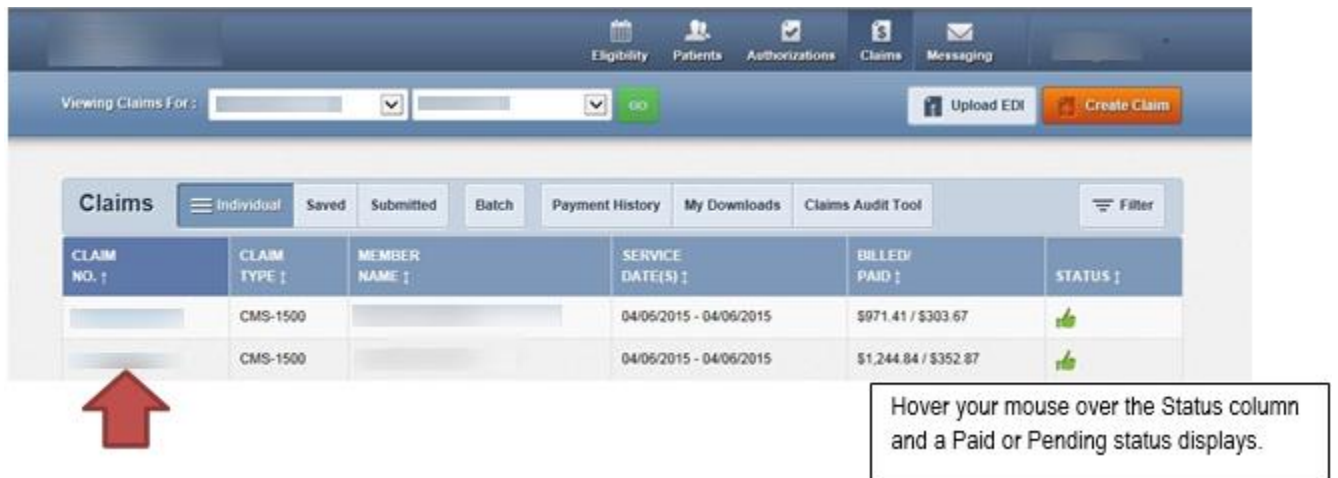
STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE			07/10/2017	07/10/2017	N83.00	OUTPATIENT	Outpatient Surgery

Viewing Claims:

1. Click **Claims** at the top of the dashboard.



2. Select **Individual**.



3. A list of individual claims appears and will display the following information:

- Claim Number
- Service Date
- Member Name
- Amounts Billed/Paid
- Status

To view the details of the Individual claim

1. Click the blue **Claim Number** to open the claim.

The following screen appears:

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

Back to home Correct Claim Copy Claim Claim No.: [redacted]

Ref/Acct No.: [redacted] Received Date: [redacted]
Member ID: [redacted] Billed Amount: [redacted]
Member Name: [redacted] Payment Amount: [redacted]
Member DOB: 01/01/1980 Payment Date: [redacted]
Servicing Provider: [redacted] Status: PAID
DOS Range: [redacted]

LINE	DOS	PROC	DX	MODIFIERS	PLACE OF SERVICE	CHARGED AMOUNT	PAYMENT DATE	CHECK NO.	STATUS	STATUS DESCRIPTION	
1	04/06/2015	A0427	78609	RH	41	\$955.15	\$303.67	04/20/2015	0900775286	PAID	PAID ACCORDING TO CONTRACT STATE PROCESSING GUIDELINES
2	04/06/2015	A0425	78609	RH	41	\$289.69	\$49.20	04/20/2015	0900775286	PAID	PAID ACCORDING TO CONTRACT STATE PROCESSING GUIDELINES

Note: The Claim Details appear allowing you to see which services were covered and which were denied. You can view the payment amount and payment date, along with check number.

Correct Claim

To correct a claim

1. Click **Correct Claim**

Back to home Correct Claim Copy Claim Claim No.: O106GAE09634


2. Proceed through the claims screens correcting the information that you may have omitted when the claim was originally submitted.
3. Continue clicking **Next** to move through the screens required to resubmit.
4. Review the claim information
5. Click **Submit**.

NOTE: Claim Corrections are not available if the provider data on the first submission is different than the corrected claim submission.

Copy Claim

To copy an existing claim:

1. Click **Copy Claim** to copy the information in the existing claim into a new claim.



Back to home Correct Claim **Copy Claim** Claim No.: O106GAE09634

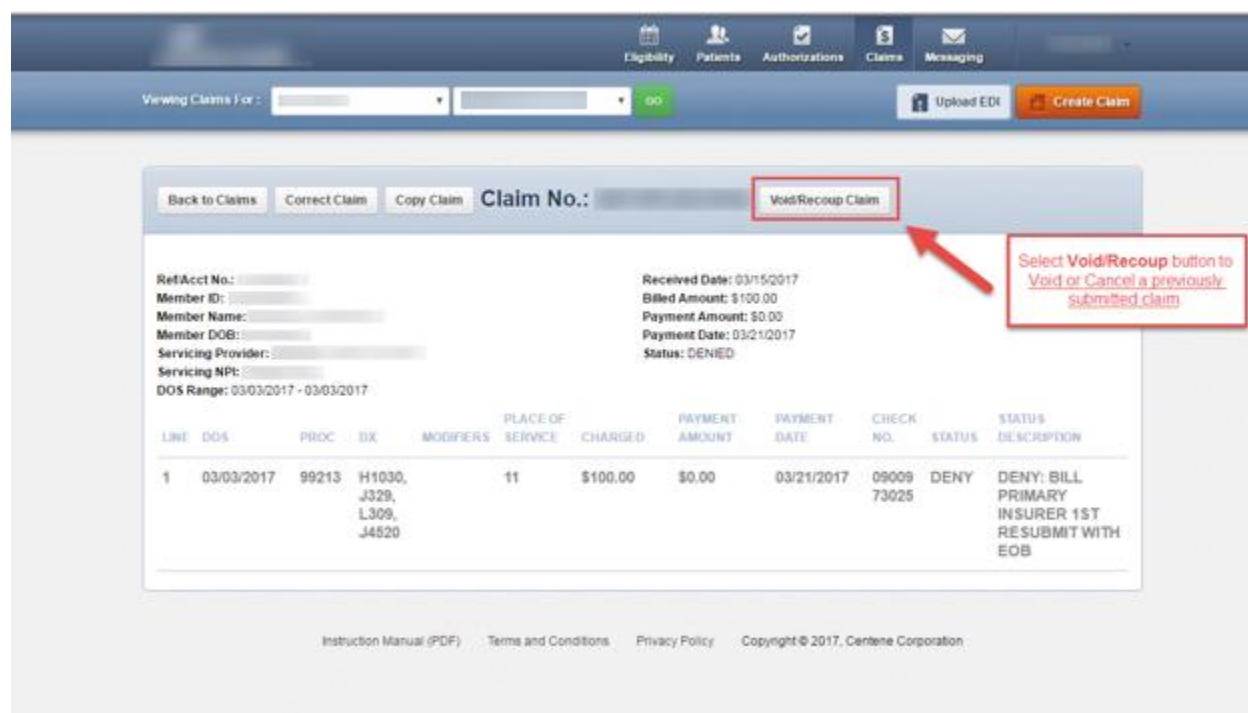
2. The copied claim information appears.
3. Proceed through the claims screens updating any information that may differ.
4. Click **Next** to move through the screens.
5. Review your claim
6. Click **Submit**.

Void/Recoup Button (if applicable)

Void/Recoup claims are utilized when a user wants to void an original claim that has already been processed, and request a full recoupment of payment.

*Please be advised, unless you are using the Void/Recoup function to void an original claim and full recoup of payment; the Correct Claim function should be used to correct how an original claim was submitted.

1. Select Void/Recoup button to Void or Cancel a previously submitted claim.



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

Back to Claims Correct Claim Copy Claim Claim No.: [] **Void/Recoup Claim**

RefAcct No.: [] Received Date: 03/15/2017
Member ID: [] Billed Amount: \$100.00
Member Name: [] Payment Amount: \$0.00
Member DOB: [] Payment Date: 03/21/2017
Serving Provider: [] Status: DENIED
Serving NPI: []
DOS Range: 03/03/2017 - 03/03/2017

LINE	DOS	PROC	DX	MODIFIERS	PLACE OF SERVICE	CHARGED	PAYMENT AMOUNT	PAYMENT DATE	CHECK NO.	STATUS	STATUS DESCRIPTION
1	03/03/2017	99213	H1030, J329, L309, J4520		11	\$100.00	\$0.00	03/21/2017	09009 73025	DENY	DENY: BILL PRIMARY INSURER 1ST RESUBMIT WITH EOB

Select Void/Recoup button to Void or Cancel a previously submitted claim

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Review appropriate claim information to be voided, and click Submit.

93

Review appropriate claim information to be voided, and click Submit.

94

Saved Claims

To view saved claims: Drafts, Professional or Institutional

1. Select **Saved**.

The following screen appears:

Claims	Individual	Saved	Submitted	Batch	Recurring	Payment History	My Downloads	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 †		
One item found. Page 1/1 1								

- **Drafts** - are those that have missing information or contain errors and have not been completed.
 - **Professional Ready to be Submitted** - are claims that have been completed but not submitted
 - **Institutional Ready to be Submitted** - are claims that have been completed but not submitted
2. Click **Edit** to view a claim
 3. Fix any errors or complete it before submitting.
OR
 4. Click **Delete** to delete a saved claim that is no longer necessary.
 5. Click **OK** to confirm the deletion.

Submitted Claims

To view submitted claims

1. Select Submitted

The following screen will show those claims created via the portal only

Claims	Individual	Saved	Submitted	Batch	Payment History	My Downloads	Claims Audit Tool	Filter
STATUS †	DATE SUBMITTED †	WEB #/ REF # †	CLAIM NUMBER †	CLAIM TYPE †	MEMBER NAME †	MEMBER ID †	ORIGINAL CLAIM # †	TOTAL CHARGES †
⌚								
⌚								

Batch Claims

To Submit Batch claims:

1. Select **Batch**

The following screen appears:

The screenshot shows the 'Claims' management interface. At the top, there are navigation tabs: Eligibility, Patients, Authorizations, Claims, and Messaging. Below these, there's a 'Viewing Claims For' section with two dropdown menus and a 'GO' button. To the right, there are two buttons: 'Upload EDI' (highlighted with a red circle) and 'Create Claim'. Below this, there's a 'Claims' section with tabs: Individual, Saved, Submitted, Batch (selected), Recurring, Payment History, My Downloads, and Claims Audit Tool. The main content area shows a 'Start Date' of 05/19/2015 and an 'End Date' of 05/26/2015. Below these, it says 'Date span limited to a 3-month period.' There's a 'Confirmation #' field and a 'Batch Claim Status' dropdown set to 'ALL', with a 'Search' button. A disclaimer at the bottom states: 'The last 18 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 E35 for your claims submission depending on your contract arrangement. For questions regarding errors please contact (800) 225-2573 ext 25525 for EDI Support or [contact us here](#).'

2. To upload a batch of claims, click the **Upload EDI** button.

3. On the Batch Claims Upload screen, select the File Type of either **837I** or **837P**.

The screenshot shows the 'Batch Claims Upload' screen. At the top, there are navigation tabs: Eligibility, Patients, Authorizations, Claims, and Messaging. Below these, there's a 'Viewing For' section with two dropdown menus and a 'GO' button. The main content area is titled 'Batch Claims Upload' and has a numbered list of steps: 1. File Type (with buttons for 837I and 837P), 2. Upload File (with a 'Choose File' button and 'No file chosen' text), 3. Check your codes (with detailed instructions for ISA06, ISA07, ISA08, and GS02/GS03), and 4. A 'Submit' button. To the right, there's a 'Resources' section with a note about accepting formatted 837 claims files only and applying HIPAA level 5 edits. It also includes links for 'Companion Guides' and 'Batch Claims FAQs'.

Note: For an Institutional Claims batch upload select 837I, for a Professional Claims batch upload select 837P.

4. Browse and **Attach** your batch claims file to upload. Be sure to check your codes before you click **Submit**.

Note: On the batch claims upload screen, companion guides and a list of FAQs are provided as resources. An EDI Support telephone line and email address is provided for additional support with EDI files.

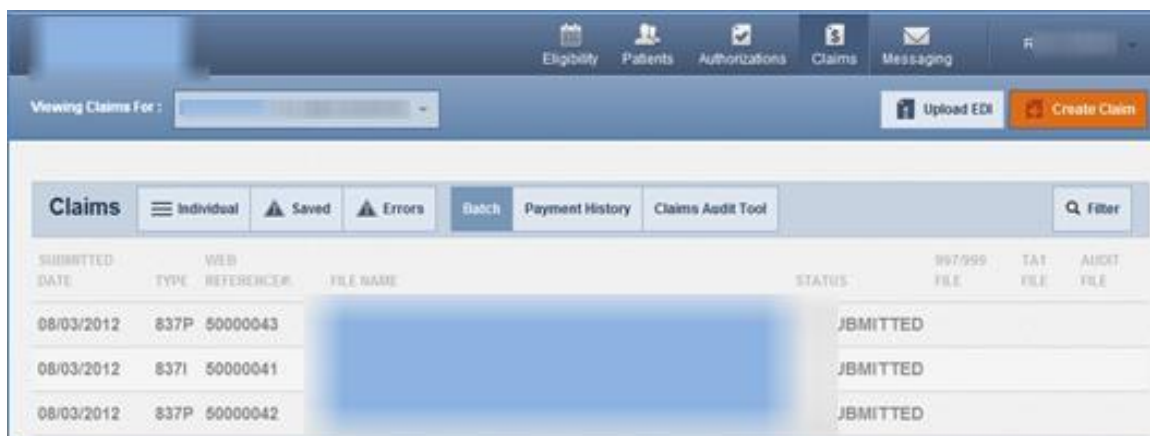
5. When a file is successfully uploaded, the Web Reference ID # is generated for your records.

To view submitted batch claims:

1. Click **Batch** to view batch claims submitted in a 3-month period.



2. Enter the information to filter your results by Start Date, End Date, Web Reference#, and Batch Claim Status. Click **Search**.



SUBMITTED DATE	TYPE	WEB REFERENCE#	FILE NAME	STATUS
08/03/2012	837P	50000043	[REDACTED]	JBMITTED
08/03/2012	837I	50000041	[REDACTED]	JBMITTED
08/03/2012	837P	50000042	[REDACTED]	JBMITTED

3. The submitted batch claims display showing: Submitted Date, Type, Web Reference #, File Name, and Status.

Note: Only the last 18 months of batch claims submission history is available online. You will receive an explanation of payment (EOP) or 835 for your claims submission depending on your contract arrangement.

Payment History

To view claims payment history:

1. Click **Claims** from the Dashboard
2. Select **Payment History** to view the claims payment history.

The following screen will appear:

CHECK DATE	CHECK NUMBER	CHECK CLEAR DATE	MAILING ADDRESS	PAYMENT AMOUNT
		EFT		
		EFT		
		EFT		
		EFT		
		EFT		
		EFT		
		EFT		

To view the Explanation of Payment details

1. Click the **check date**.

CHECK DATE	CHECK NUMBER	CHECK CLEAR DATE	MAILING ADDRESS	PAYMENT AMOUNT
		EFT		\$656.54

The following screen appears:

- The explanation of payment details displays the date and check number.
- This view shows each patient payment by service line detail made on the check.

Explanation of Payment Details

Check/Trace Number: Check Date:

Insured Name: Group: ID: Account: NPI:

Patient Name: ID: Account: NPI:

Control Number: NPI:

Service Provider: NPI:

View Service Line Details

Serv	Date	Diag#	Drug#	Proc#	Mod	Days/ Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Remit Codes	Payment
10	04/06/2015	78609		A0427	RH	0/1	955.15	303.67	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	92	303.67
20	04/06/2015	78609		A0425	RH	0/20	289.69	49.20	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	92	49.20
Sub Total:							\$1244.84	\$352.87	\$0.00/\$0.00	\$0.00	\$0.00/\$0.00	\$0.00/\$0.00	\$0.00	\$0.00		\$352.87

Remit Code Descriptions

92
PAID ACCORDING TO CONTRACT STATE PROCESSING GUIDELINES

Insured Name: Group: ID: Account: NPI:

Patient Name: ID: Account: NPI:

Control Number: NPI:

Service Provider: NPI:

View Service Line Details

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Downloading an Explanation of Benefits

To download the EOP

1. Click the Download (Excel Format) Button

Explanation of Payment Details

Check/Trace Number: Check Date:

Insured Name: Group: ID: Account: NPI:

Patient Name: ID: Account: NPI:

Control Number: NPI:

Service Provider: NPI:

View Service Line Details

Serv	Date	Diag#	Drug#	Proc#	Mod	Days/ Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Remit Codes	Payment
10	04/06/2015	78609		A0427	RH	0/1	955.15	303.67	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	92	303.67
20	04/06/2015	78609		A0425	RH	0/20	289.69	49.20	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	92	49.20
Sub Total:							\$1244.84	\$352.87	\$0.00/\$0.00	\$0.00	\$0.00/\$0.00	\$0.00/\$0.00	\$0.00	\$0.00		\$352.87

Remit Code Descriptions

92
PAID ACCORDING TO CONTRACT STATE PROCESSING GUIDELINES

Insured Name: Group: ID: Account: NPI:

Patient Name: ID: Account: NPI:

Control Number: NPI:

Service Provider: NPI:

View Service Line Details

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Claims Audit Tool

To use the Claims Audit Tool

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

Code Editing Assistant

Home State Health Plan has partnered with McKesson Information Solutions (McKesson) to provide you with a web-based code auditing reference tool designed to "mirror" how Home State Health Plan's code auditing products evaluate code combinations during the auditing of claims. Home State Health Plan can now share with our providers the claim auditing rules and clinical rationale we use to pay claims.

This tool offers many benefits:

- *Prospectively* access the appropriate coding and supporting clinical edit clarifications for services *before* claims are submitted.
- *Proactively* determine the appropriate code/code combination representing the service for accurate billing purposes
- *Retrospectively* access the clinical edit clarifications on a denied claim for billed services after an Explanation of Payment (EOP) has been received.

The tool will review what was entered and will determine if the code or code combinations are correct based on the age, sex, location and modifier (if applicable) or other code(s) entered.

DISCLAIMER
This tool is used to apply coding logic ONLY. It will not take into account individual fee schedule reimbursement, authorization requirements, or other coverage considerations. Whether a code is reimbursable or covered is separate and outside of the intended use of this tool.

PASS-THROUGH TERMS AND CONDITIONS

1. Home State Health Plan (Home State Health Plan), licenses a code auditing reference tool on the Web (the "Software") that enables Home State Health Plan to disclose its code auditing rules and associated clinical rationale to Providers. Home State Health Plan provides access to such Software to its Providers subject to the terms and conditions contained in this agreement ("Agreement"), which may be updated from time to time at Home State Health Plan or its licensors' sole discretion without notice.
2. Provider's right to access and use the Software is non-transferable, nonexclusive, and for the sole purpose of internal use within the United States.
3. Provider will limit access to the Software to (i) only employees and agents of Provider and (ii) only to the extent necessary to request the outcome of specific code combinations that Provider proposes to submit to Home State Health Plan regarding billing activity; and/or (iii) request information about submitted code combinations to evaluate the results of claims activity from Home State Health Plan only as related to Provider's practice management.
4. Provider shall protect the confidentiality of the information contained in and provided by the Software and that it has access to in this web site, by using at least the degree of care and security it uses to protect its own confidential information. Provider acknowledges and agrees that any unauthorized disclosure or distribution of the confidential information may result in irreparable injury to Home State Health Plan or licensor(s), entitling the injured entity to obtain immediate injunctive relief in addition to any other legal remedies available.
5. Provider shall not modify, translate, decompile, disclose, create nor attempt to create any derivative work of the Software.
6. Provider acknowledges that the Software is in no way intended to prescribe, designate or limit medical care to be provided, nor shall it be used for such purposes. Provider accepts responsibility for such decisions.

2. The Code Editing Assistant screen appears with terms and conditions to **Accept** or **Reject**.
3. Click **Accept**.

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.

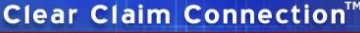
Line	Procedure	Quantity	Mod 1	Mod 2	Date of Service	Place of Service	Diagnosis
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-- select --	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>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

4. The Clear Claim Connection screen appears, allowing you to enter the Procedure Code, Quantity, Modifiers, Date and Place of Service, and Diagnosis for a claim proactively before you submit or retroactively after you submit.

Note: Date of Service defaults to today's date, and Place of Service defaults to 11 (Office) if not populated otherwise. Use the Tab key to move through the fields easily. If you have more than 5 procedure codes, click the **Add More Procedures** link.

1. Click the **Review Claim Audit Results** button.

Clear Claim Connection™

McKesson Edit DevelopmentGlossaryAboutHelpLogoff

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.

2. The results of the claim audit display the Recommendation Status of Allow, Disallow, or Review.
Note: The results displayed do not guarantee how the claim will be processed, but assist in claims submittal.
If the Recommendation Status states Disallow or Review, click the status for more clinical edit information.

Secure Messaging

To send a secure message:

1. Click **Messaging** from the Dashboard.
The Secure Messaging Inbox appears displaying any messages for that user.



Create a Secure Message

To create a secure message.

1. Click Create Message



In the New Message screen, the To field populates and you are able to select a **Subject** from the drop-down menu.

The screenshot shows the 'New Message' form. It has a title bar 'New Message'. Below the title bar, there are two rows of fields. The first row has a 'To' field with a dropdown menu showing 'Medicalaid' and a 'Member ID' field with the value '123456789'. The second row has a 'Subject' field with a dropdown menu showing 'Benefit Inquiry - Benefit Limits/Copay' and a 'Date of Birth' field with the placeholder 'mm/dd/yyyy'. Below these fields is a large text area labeled 'Your Message'. At the bottom left of the text area are 'send' and 'cancel' buttons. A note at the top right of the form says: 'If your message is about a specific member, please include their ID and Date of Birth below.'

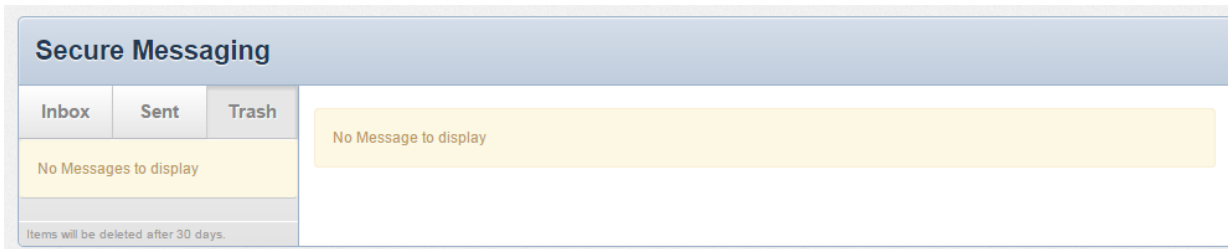
2. In the Your Message field you can free text type the message to the Health Plan staff.
3. Click **Send** when complete.
4. A confirmation message appears that your message successfully sent.

To view Sent messages:

1. Click **Sent**, and your sent messages appear.
2. To send to trash, click the **Send to trash** button Click Sent



To view messages sent to Trash:



3. Click **Trash**, and the messages sent to Trash appear.
Note: The messages sent to Trash will be deleted after 30 days.
4. If a message is not trash but is found under the Trash tab, you can reverse it by clicking the **not trash** button.