

Secure Provider Portal Overview



Agenda

- Introduction
- Registration and Provider Resources
- Account Management Role and Tasks
- Account Details
- Portal Features and Benefits:
 - Member Eligibility
 - Patient List (only PCP / PCP Organizations)
 - Viewing and Submitting Authorizations
 - Viewing Claims Information
 - Claim Submission

Secure Provider Portal Introduction

Secure Provider Portal Introduction

The Provider Portal allows providers to:

- Check eligibility
- Submit, correct, and check claim status
- Submit and view prior authorizations
- View patient care gaps
- And much more

All at no charge....***FREE!***

Secure Provider Portal General Information

- Driven by Tax ID Number (TIN)
- Performs best in the current version of Chrome
- Does **not** house member, provider, claim, or authorization data, it merely displays information from our back-end systems



Tip: Generally, when there is an issue, if the portal matches the back-end system, it is not a portal issue.



Provider Portal Registration & Login

Portal Registration

Features | Join Our Network | **CREATE ACCOUNT**

The Tools You Need Now!

Our site has been designed to help you get your job done.
Manage all products with ease in one location.

- Check Eligibility**
Find out if a member is eligible for service.
- Authorize Services**
See if the service you provide is reimbursable.
- Manage Claims**
Submit or track your claims and get paid fast.

Login

User Name (Email)

Password

Login

[Forgot Password / Unlock Account](#)

Need To Create An Account?

Registration is fast and simple, give it a try.

Create An Account

How to Register

Our registration process is quick and simple. Please click the button to learn how to register.

Provider Registration Video

Provider Registration PDF

HEALTH PLAN SHOWCASE

Register Provider

Your Progress ▶▶▶▶▶ Cancel

Your Details

Tax ID

First Name

Last Name

Email

Reverse Email

Password

Repeat Password

Next →


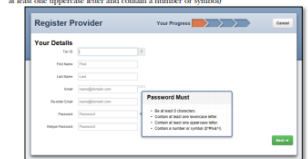
Close

CENTENE Corporation


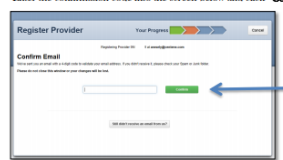
Secure Provider Website Registration

To register for the Secure Provider Portal, follow the instructions below:

- Browse to the public website. Go to "For Providers"
- Select "Login"
- On the Login Screen, click the button, "Create an Account"
- Start your registration: Enter your Tax ID, Name, and E-mail Address, and Create a Password. (Passwords must be at least 8 characters long, contain at least one lower case letter, contain at least one uppercase letter and contain a number or symbol)
- A registration code will be sent via email, once your data is in our system.
- Enter the confirmation code into the screen below and click "Confirm"
- Select your secret questions and provide your answers.

NOTE: If you receive the error message "We could not find your Tax ID in our system" and have not joined our network, please return to our public site and click "Join Our Network". Once your data is in our system you'll be able to create your account. If you have already joined our network, and received this error message, please contact provider services, so an incident ticket can be submitted.

NOTE: You will need these if you forget your password or lock your account.

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 for optimal performance.

Portal Login



Tip: When a TIN operates in more than one state, the portal user can register for each health plan's portal with the same user name (e-mail) and password.

The screenshot shows the portal's main interface. At the top right, there are links for 'Features', 'Join Our Network', and 'CREATE ACCOUNT'. The main heading is 'The Tools You Need Now!' with the subtext 'Our site has been designed to help you get your job done. Manage all products with ease in one location.' Below this are three service cards: 'Check Eligibility' (thumbs up icon), 'Authorize Services' (checkmark icon), and 'Manage Claims' (dollar sign icon). On the right side, there is a 'Login' form 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 login form are sections for 'Need To Create An Account?' with a 'Create An Account' button, and 'How to Register' with buttons for 'Provider Registration Video' and 'Provider Registration PDF'.

Portal Banner

The screenshot shows a dark blue portal banner. At the top left is a blurred area for the Health Plan / Product Logo. To its right are five icons with labels: Eligibility (calendar), Patients (person), Authorizations (checkmark), Claims (dollar sign), and Messaging (envelope). On the far right is a blurred area for the User's Name / Menu Options. Below these icons is a section titled 'Viewing Dashboard For :'. It contains two dropdown menus: 'TIN' with the value '4449' and 'Plan Type' with the value 'Medicaid'. A green 'GO' button is to the right of the dropdowns. Red dashed lines with arrows point from text labels to these elements: 'Health Plan / Product Logo' to the top left; 'Portal Functionalities' to the icons; 'Secure Messaging' to the Messaging icon; 'User's Name / Menu Options' to the top right; 'TIN(s) Listing' to the TIN dropdown; and 'Plan Type Option(s)' to the Plan Type dropdown.



Tips

- Portal functionality / access is based on the user's permissions
- **Plan Type** drop-down options are automatically assigned based on how the TIN is set-up in our systems

Portal Landing Page – Unverified Portal Account

The screenshot shows the portal landing page for an unverified account. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Messaging, and Help. Below this, a section titled "Viewing Dashboard For:" contains two dropdown menus: "TIN" (with a blank input field) and "Plan Type" (set to "Medicaid"). A green "GO" button is positioned to the right of the "Plan Type" dropdown. The main content area is mostly blank, with a right-hand sidebar containing three sections: "Welcome" with a button "Add a TIN to My ACCOUNT" and a right arrow; "Recent Activity" with a table header showing "Date" and "Activity"; and "Quick Links" with two links: "Provider Resources" and "Member Management Forms".



Tip: Once a portal account is registered, the portal user will only have access to Secure Messaging and Account Details, until their portal account is verified.

Portal Home Page – Verified Portal Account

Portal Banner

Eligibility Patients Authorizations Claims Messaging Help

Viewing Dashboard For : TIN [] Plan Type Medicaid [] GO

Quick Eligibility Check

Quick Eligibility Check for Medicaid

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

Check Eligibility

Last Five Received Claims

Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
\$	05/15/2020	[]	T136
\$	05/18/2020	[]	T139
\$	05/18/2020	[]	T139
\$	04/23/2020	[]	T114
\$	04/21/2020	[]	T112

Welcome

- Add a TIN to My ACCOUNT >
- Manage Accounts >
- Reports >
- Patient Analytics >
- Provider Analytics >

Welcome Center

Recent Activity

Date Activity

Quick Links

Portal Registration & Login Tips

- Registration is required for access to the portal
- Portal accounts cannot be shared
 - Each person within a provider organization who needs access to the portal, must complete the portal registration
- For a portal user to register, their TIN must be loaded in our systems
 - Allow at least two business days for portal to reflect updates in back-end systems
- There is no limit on the number of TINs a portal user can add to their portal account
- Portal users must log into the portal every 90 days to prevent their account from being locked due to inactivity
- The Forgot Password / Unlock Account link on the Secure Provider Portal login page, cannot be used to unlock a portal account, that is locked due to inactivity
- Options in the portal Plan Type drop-down are automatically assigned based on how the TIN is set-up in our back-end systems



Portal Account Manager

Portal Account Manager

- A Portal Account Manager is a role assigned to a primary contact within a provider organization
- The Account Manager is responsible for the day-to-day support of all Secure Provider Portal user accounts that are registered under the same TIN

Portal User Management

Eligibility Patients Authorizations Claims Messaging Help

Viewing For : Medicaid GO

Account Details
User Management

Search for User

Email Last Name Status

Verification Pending

Go! Clear

Invite a User

Email Address

Send Invitation

[Account Manager User Guide](#)

Email Address ↑	Last Name ↑	First Name ↑	TIN ↑	Telephone Number ↑	Status ↑	
					Active	Verify Account / Update User
					Active	Verify Account / Update User
					Active	Verify Account / Update User
					Active	Verify Account / Update User
					Active	Verify Account / Update User

24 items found, displaying 1 to 10. Page 1/3 1,2,3 Next Last

Portal Account Managers,
can click here to access the
**Account Manager User
Guide**

Portal Account Manager

SECURE PORTAL ACCOUNT MANAGER

WHAT YOU NEED TO KNOW

What is an Account Manager?

Account Manager is a role within the Secure Portal that is assigned to your health plan's primary contact within your practice. The purpose of this role is to help us maintain the safety and integrity of patient data.

The Account Manager is responsible for day-to-day support of all Secure Portal user accounts that are registered under the same Tax Identification Number (TIN). These responsibilities include:

- Approving access for new Secure Portal users
- Assigning permissions for users based on their job responsibilities
- Regularly adjusting the permissions of users whose roles may have changed
- Terminating users who no longer work at the practice.

Your health plan is responsible for verifying and setting up the original user/registrant for your TIN. Please contact your Provider Relations rep or Provider Services to get set up.

Accessing Account Manager Tasks

- 1) Click the **User Management** dropdown in order to complete Account Manager actions.
- 2) Search for a specific user by entering their name and email address, or view a list of all users in your practice.
- 3) For new user accounts that need to be verified, select the **Verification Pending** box, click the Verify Account button, and follow instructions on the back page.
- 4) To view and edit details of existing accounts, click the **Update User** button and follow instructions on the back page.

The screenshot shows the top navigation bar with 'User Management' highlighted. Below it, the 'Search for User' section is visible, featuring a table of users and a 'Verify Account' button. Red arrows and numbers 1-4 indicate the steps for accessing account management tasks.

Email Address	Last Name	First Name	TIN	Telephone Number	Status
hang@centene.com	Hang	Ng		(123) 123-1234	Active
jhuang@centene.com	Huang	Jeremy		(123) 123-1234	Locked

Account Manager Tasks

Within the Update User Status and Permissions screen as shown below, the Account Manager has three tasks:

1) Enabling and Disabling Users

- Account Managers will receive an email when a user from their practice creates a new user account. The Account Manager will click **Enable User** to grant access to the user.
- User accounts are disabled after 90 days of inactivity. Account Managers can use this button to re-enable these users.
- If a user leaves the practice or no longer needs access to the Secure Portal information for that specific TIN, the Account Manager will click **Disable User**.

2) Send email to verify user accounts and to reset passwords

- Once a user is enabled, their status will change to "Unverified." The Account Manager can click **Send Registration Email** for the user to be notified that they must complete their registration.
- If a user has forgotten their password, the account manager can click **Send Password Reset Email**.

3) Selecting/modifying access levels for users

- Account Managers are responsible for selecting and managing the appropriate access for each user in their practice.
- Access levels include:

Health Records: View a patient's health records for number and type of visits, medications, immunizations and labs, care gaps, etc.

Claims: View and submit claims.

Manage Account: Enable, disable, modify permissions for a specific TIN, and invite users to set up an account.

Eligibility: View and check eligibility for a specific patient.

Assessments: Complete or view a Health Risk Assessment (HRA) or Notification of Pregnancy (NOP) for a patient.

Authorizations: View and submit authorizations.

The screenshot shows the 'Update User status and permissions for Jeremy Huang' screen. It includes sections for User Information, Profile Information, and Update Status. Red arrows and numbers 1, 2, and 3 point to the 'Disable User', 'Send Password Reset Email', and 'Send Registration Email' buttons respectively. A callout box on the right says 'Please reach out to your Provider Relations rep or Contact Provider Services for Secure Portal assistance'.

Portal Account Manager Tips

- Each TIN should have at least two Account Managers
 - For large organizations, it is recommend to have at least two Account Managers per department.
 - There is no limit on the number of Account Managers allowed under a TIN
- Account Managers should *regularly* log into the portal to:
 - Verify new portal registrations
 - Send password reset email to users whose portal account is locked due to inactivity
 - Disable / Enable a user's portal access
 - Modify portal permissions based on the user's role within your organization
- Account Managers **cannot** manage their own portal account



Tip: Always disable portal users, who no longer need portal access, especially when they leave your company.

Portal Account Details

Portal Account Details

The screenshot shows the 'Account Details' page in a portal. At the top, there are navigation icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below these is a 'Go to Dashboard For:' section with a dropdown menu set to 'Medicaid' and a 'GO' button. A red box highlights the 'Account Details' link in the top right navigation menu. The main content area is divided into two sections: 'Account Details' and 'Add a TIN'. The 'Account Details' section contains fields for Name, User Name (Email), Password, Telephone Number, Fax Number, and three Secret Questions. A red arrow points to an 'Update Account' button with the text 'Click Update Account, to change account details'. The 'Add a TIN' section includes a note about validation, a 'Name TIN' field with 'Enter Name' placeholder, a 'Tax ID' field with '123456789' placeholder, and an 'Add TIN' button. A red box highlights this section with the text 'Use Add a TIN, to associate additional TIN(s) to your portal account'. Below these sections is the 'Your TINs' section, which has a link for 'Provider Demographic Update Instructions'. It contains a table of TINs: Allwell, Ambetter, Behavioral Health, and Medicaid. The Medicaid entry is marked as 'Current Primary'. Red arrows point to the 'Mark as Primary' buttons with the text 'Click Mark as Primary, to change TIN and Product login default'. Red arrows point to the 'X' icons in the table with the text 'Click X to remove a TIN'. A red arrow points to the 'Medicaid' entry with the text 'Click TIN / Product to view / update Provider Demographics'.

Your TINs, list the TIN(s) you added to your portal account

Click **Update Account**, to change account details

Use **Add a TIN**, to associate additional TIN(s) to your portal account

Click **Provider Demographic Update Instructions** to access instructions

Click **X** to remove a TIN

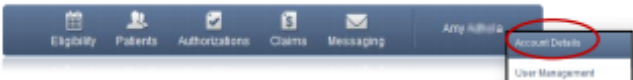

Click **Mark as Primary**, to change TIN and Product login default

Click **TIN / Product** to view / update Provider Demographics




Update Provider Demographic Information Instructions

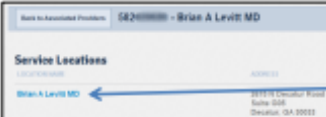

Update Provider Demographic Information

- From the Main Tool Bar - select **Account Details** under the Users Name.
 
- The **Account Details** screen appears.
 
- To modify information about the Specific TIN, click on the individual TIN to update.

Under each TIN, a list of associate providers will appear.

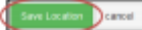

- To update information about one of the Associated Providers, click on the name.

A list of possible Service Locations will appear.


- Click on the name associated to the address to update.
 
- Click **Edit Location** to update the provider information – This information will update the Find A Provider website.

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 <ul style="list-style-type: none"> Address1 Address2 City 	Transaction Set #2 - Provider Location Phone <ul style="list-style-type: none"> Phone Fax
Transaction Set #3 - Provider Location Accessibility <ul style="list-style-type: none"> Accessibility (Yes or No) 	Transaction Set #4 - Provider Office Hours <ul style="list-style-type: none"> Monday- Sunday (? Data Attributes for each day)
Transaction Set #5 - Practitioner Gender <ul style="list-style-type: none"> Gender 	Transaction Set #6 - Practitioner Office Hours <ul style="list-style-type: none"> Monday- Sunday (? Data Attributes for each day)

For example: Changing the phone number and saving will cause a wait time of 24-36 hours in order to change the fax number. However, changing information in a different transaction set will not be limited to an additional wait time.
- Save changes by clicking on the **Save Location** button at the bottom of the screen.
 

ATTENTION: All Delegated Providers, please contact your delegate for any changes. All demographic updates for Delegated Providers must be routed through the delegate for submission to your health plan.

Portal Account Details and Demographic Update Tips

- Under Account Details, portal users can:
 - Update account details (i.e. change email address, name, password, etc.)
 - Select TIN/Product login default
 - Update specific demographic information for their organization(s)
 - ❖ The Provider Demographic Update is **not** available for Behavioral Health
 - Add a TIN
 - Remove TIN(s) from portal account



Tip: If an inactive TIN is removed from a portal account, it cannot be re-added.

Portal Functionality: Check Eligibility

Eligibility Check

Within Eligibility Check results, the Patient Overview displays patient demographic, claims, authorizations and other pieces of information. It can be used to identify Care Gaps, view ER visits, and PCP history.

Quick Eligibility Check

Eligibility Patients Authorizations Claims Messaging Help

Viewing Dashboard For : TIN Plan Type Medicaid GO

Quick Eligibility Check for Medicaid

Member ID or Last Name: 123456789 or Smith **1** Birthdate: mm/dd/yyyy **2** **Check Eligibility** **3**

Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
\$	05/15/2020		T136
\$	05/18/2020		T139
\$	05/18/2020		T139
\$	04/23/2020		T114
\$	04/21/2020		T112

Welcome

- Add a TIN to My ACCOUNT >
- Manage Accounts >
- Reports >
- Patient Analytics >
- Provider Analytics >

Recent Activity

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

Quick Links

Eligibility Check

The screenshot shows a web application interface for an eligibility check. At the top, there is a navigation bar with icons for Eligibility (1), Patients, Authorizations, Claims, and Messaging. Below this is a search bar with 'Viewing Eligibility For:' and two dropdown menus: 'TIN' and 'Plan Type' (set to 'Medicaid'). A green 'GO' button is to the right. The main section is titled 'Eligibility Check' and contains a form with fields for 'Date of Service' (05/27/2020), 'Member ID or Last Name' (123456789 or Smith) (2), and 'DOB' (mm/dd/yyyy) (3). A green 'Check Eligibility' button (4) and a 'Print' button are also present. Below the form is a table with the following columns: ELIGIBLE, DATE OF SERVICE, PATIENT NAME, DATE CHECKED, PRODUCT, CARE GAPS, and LOG ER VISIT. The table contains one row with a thumbs-up icon, the date 05/27/2020, a patient name with a blue highlight and a '>View details' link (5), the date 05/27/2020, the product 'Medicaid LTC Non-Dual', and the care gap 'Non-compliant for annual well visit.'. In the 'LOG ER VISIT' column, there is an 'ER Visit?' button and a 'Remove' button with an 'X' icon. A red dashed arrow points from the 'ER Visit?' button to a red text box at the bottom right.

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	PRODUCT	CARE GAPS	LOG ER VISIT
	05/27/2020	>View details (5)	05/27/2020	Medicaid LTC Non-Dual	Non-compliant for annual well visit.	ER Visit? (4) Remove

If Eligibility Check is for an ER visit, click **ER Visit?**

Patient Overview

The screenshot shows a web application interface for patient eligibility. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this is a header area with a dropdown menu for 'Viewing Eligibility For:' set to 'Medicaid' and a 'GO' button. A sidebar on the left contains a menu with 'Overview' highlighted in a red box, along with other options like Cost Sharing, Assessments, Health Record, Care Plan, Authorizations, Referrals, Coordination of Benefits, Claims, Document Resource Center, and Notes. The main content area features a green banner with a thumbs-up icon and the text 'This patient is eligible as of today, May 27, 2020.' Below this is a 'Print Eligibility Overview' link. The patient information is split into two columns: 'Patient Information' and 'PCP Information'. The 'Patient Information' column includes fields for Name, Gender (M), Birthdate, Age, Member #, and Address. The 'PCP Information' column includes fields for Name (TERRIE), Address, Practice Type (MEDICINE), and Phone Number. Below the patient information are links for 'View PCP History', 'EPSDT', and 'Care Gaps'. An 'Eligibility History' section contains a table with columns for Start Date, End Date, and Product Name. The table lists two entries: one from Dec 1, 2018 to Ongoing for SSI Non-Dual, and another from May 1, 2018 to Nov 30, 2018 for TANF. A 'more' link is present below the table, with a red dashed arrow pointing to it and a red text annotation: 'Click more, to view full Eligibility History'. Other links include 'View Clinical Information', 'Allergies', and 'Risk Category Alerts: COPD/Asthma'.

Viewing Eligibility For : Medicaid

[Back to Eligibility Check](#)

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

This patient is eligible as of today, May 27, 2020.

[Print Eligibility Overview](#)

Patient Information

PCP Information

Name

Gender M

Birthdate

Age

Member #

Address

Name TERRIE

Address

Practice Type MEDICINE

Phone Number

[View PCP History](#)

[EPSDT](#)

[Care Gaps](#)

Eligibility History

Start Date	End Date	Product Name
Dec 1, 2018	Ongoing	SSI Non-Dual
May 1, 2018	Nov 30, 2018	TANF

[more](#)

[View Clinical Information](#)

[Allergies](#)

Risk Category Alerts: COPD/Asthma

None On File

Click more, to view full Eligibility History

Patient Overview, cont.

[View Clinical Information](#) ←

→ **Three Most Recent ER Visits**

Primary Diagnosis	Date	Facility/Provider
EPISTAXIS	10/29/2019	MEDICAL CENTER INC...
EPISTAXIS	08/28/2018	MEDICAL CENTER INC...
PNEUMONIA UNSPECIFIED ORGANISM	07/20/2018	MEDICAL CENTER INC...

→ **Three Most Recent Inpatient Admissions**

Primary Diagnosis	Date	Facility/Provider
HYPERTROPHY TONSILS W/HYP ADENOIDS	06/10/2019	MEDICAL CENTER INC...
MOD PERSIST ASTHMA ACUTE EXACERBAT	04/30/2019	MEDICAL CENTER INC...

→ **Three Most Recent Office Visits**

Primary Diagnosis	Date	Facility/Provider
HYPERTROPHY TONSILS W/HYP ADENOIDS	11/13/2019	
HYPERTROPHY TONSILS W/HYP ADENOIDS	10/30/2019	
DELAYED MILESTONE IN CHILDHOOD	10/03/2019	

Top 5 Most Occurring Diagnosis ←

- MIX RECEPTIVE-EXPRESSV LANGUAGE D/O
- DELAYED MILESTONE IN CHILDHOOD
- SHORT STATURE CHILD
- MOD PERSIST ASTHMA ACUTE EXACERBAT
- HYPERTROPHY TONSILS W/HYP ADENOIDS

Recent Pharmacy Activity ←

- FLOVENT HFA AER 44MCG
- MUIPIROCIN OIN 2%
- CEFDINIR SUS 250/5ML

Patient Overview – Cost Sharing

Back to Eligibility Check

Overview

Cost Sharing

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Cost Sharing Summary

This member has no co-pay ← This member has no co-pay.

[Print Cost Sharing](#)

Patient Overview – Assessments

[Back to Eligibility Check](#)

Overview

Cost Sharing

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Notes

Please tell us about your patient's health

Child Welfare Referral Assessment
A Child Welfare Referral helps determine why a member is being referred to case management. [Fill Out Now!](#)

Person Centered Service Plan (PCSP) Signature Addendum
Please take a few minutes to fill out the form below. [Fill Out Now!](#)

Previous Assessments

You have not told us about anything yet. Please fill out a form.

If notice of pregnancy (NOP) were applicable for the member, it would be available.

Patient Overview – Health Record

Back to Authorizations

Overview

Cost Sharing

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Claims

Power Account Service Estimate

Document Resource Center

Notes

Visits Medications Immunizations Labs Allergies

Information displaying on the members health record is based on submitted claims.

Primary Diagnosis	Date	Visit Type	Claim Type	Facility/Provider
Low Back Pain	01/08/2020 - 01/08/2020	Home	Medical	
Low Back Pain	12/05/2019 - 12/05/2019	Home	Medical	
Low Back Pain	11/07/2019 - 11/07/2019	Home	Medical	
Htn Heart Disease W/Heart Fail	11/01/2019 - 11/01/2019	Inpatient Hospital	Medical	
Cellulitis Of Right Lower Limb	10/31/2019 - 11/01/2019	Inpatient Hospital	Medical	
Cellulitis Of Right Lower Limb	10/30/2019 - 10/30/2019	Inpatient Hospital	Medical	
Primary Osteoarthritis Rt Shoulder	10/30/2019 - 10/30/2019	Inpatient Hospital	Medical	
Oth Nonspecific Abn Find Lng Field	10/30/2019 - 10/30/2019	Outpatient Hospital	Medical	

Patient Overview – Care Plan

[Back to Authorizations](#)

Care Plans come from the clinical system.
These care plans are setup with the case manager(s) for the patient.

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

This member's care plan to treat: Case Worker

Integrated Care

05/12/2020 - OPEN

Member is hospitalized

Goal: **Member will transition from hospital to home setting with appropriate support in place. by 2020-06-16**

Member is a young adult and may still be dependent on older adults/ family members to successfully n may be a barrier to success

What we're doing:

2020-06-16	CM will communicate with member/member family &/or inpatient case management/discharge planning and assist with member's transition to home setting as needed.
2020-06-16	Member/ member family will communicate with inpatient case management/discharge planning/ CM regarding status of ongoing home health needs and preferences

Patient Overview – Authorizations

Back to Authorizations

When viewing a member's authorizations, the list will display the last 18 months, regardless of the submitting provider.

Overview

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Power Account Service Estimate

Document Resource Center

Notes

Authorizations

STATUS	AUTH NBR	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	IP190	02/04/2020	12/31/9999	E87.6	INPATIENT	Medical
APPROVE	IP179	10/29/2019	11/01/2019	I50.9	INPATIENT	Medical
APPROVE	IP167	07/19/2019	07/22/2019	L03.115	INPATIENT	Medical
APPROVE	OP16	07/09/2019	09/06/2019	Z48.01	OUTPATIENT	Home Health
PARTIAL_APPROVE	IP162	06/08/2019	06/25/2019	L03.90	INPATIENT	Medical
APPROVE	IP161	05/21/2019	05/24/2019	L03.90	INPATIENT	Medical
APPROVE	IP158	04/24/2019	04/29/2019	I50.9	INPATIENT	Medical

Create a New Authorization

Click an Auth NBR to view the authorization details

Click **Create a New Authorization**, to submit a web authorization request for the member

Patient Overview – Referrals

[Back to Authorizations](#) **XXXXX-XXXX**

- Overview
- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations
- Referrals**
- Coordination of Benefits
- Claims
- Power Account Service Estimate
- Document Resource Center
- Notes

*Source

*Date

Last Name, First Name

Phone Number, Extension

Additional Comments

Utilizing Referrals, allows providers to submit a member for assistance from child welfare services, behavioral or case management (options may vary by state).

Patient Overview – Coordination of Benefits

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[Print Coordination of Benefits](#)

Effective Date	Term Date	Policy Number	Group Number	Carrier Name	Coverage
07/01/2016	12/31/9999			BC BS	MEDICAL AND HOSPITAL MO

Coordination of Benefits (COB) information on file for the member displays here.

Patient Overview – Claims

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Claims: Recent

Click **Create a New Claim**, to submit a web claim for the member. -----> [Create a New Claim](#)

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

Show claims for [GO](#) [View most recent month](#)

CLAIM NO. ↑	REF/ACCT NO. ↑	DOS RANGE ↑	PAYMENT DATE ↑	RECEIVED DATE ↑	BILLED/ PAID ↑	STATUS ↑
T148		05/22/2020 - 05/22/2020	06/04/2020	05/27/2020	\$643.00 / \$1	PAID
T150		05/22/2020 - 05/22/2020	06/04/2020	05/29/2020	\$75.00 / \$2	PAID
T153		05/22/2020 - 05/22/2020		06/01/2020	\$145.00 / \$9	PAID

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

Click **Claim Number**, to view the claims details

Patient Overview – Document Resource Center

[Back to Eligibility Check](#)

Documents for the member can be uploaded here based on Document Category options. Options may vary by Health Plan.

Document Upload | **Document Review**

1. Document Category:
2. Document Type:
3. Upload File: No file chosen
4.

Document Resource Center

Notes



Tips: The 1st page of the document, should include:

- Reason for upload (i.e. Requested clinical documents, etc.)
- Authorization #, if applicable

Patient Overview – Document Resource Center

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Notes

Create a New Note

General Note [Write Note](#)

Previous Notes	Date
General Note	Oct 15, 2019
General Note	Jan 29, 2020

Allows portal users to create and view notes regarding the member.

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Eligibility Tips

- When checking eligibility, if the member does not pull up, verify data entered
- If Member ID + DOB does not pull up the member, try Member Last Name + DOB
- As best practice, always check member eligibility before creating a web authorization or web claim



Tip: The member drives your Plan Type selection. For example, an Ambetter member will not pull up under Medicaid.

Portal Functionality: Patients

Patient List

Primary Care Providers are able to view and download a list of their assigned members. The Patient List displays:

- Member Name
- Member ID #
- DOB
- Preferred language
- Eligibility status
- Phone number
- Alerts

Patient List

Eligibility **Patients** Authorizations Claims Messaging

Viewing Patients For : TIN 1799 Plan Type Medicaid GO Find Patient

Patient List as of 07/31/2020 Download Filter

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

Eligible	Preferred Language ↑	Member Name ↑	Member ID ↑	Date of Birth ↑	Phone Number ↑	ALERTS
👍						No HRA
👍						CG No HRA
👍						No HRA
👍						CG No HRA
👍						CG No HRA
👍						NM No HRA
👍						NM No HRA
👍						NM No HRA
👍						NM No HRA
👍						No HRA

2,146 items found, displaying 1 to 10. Page 1/215 1,2,3,4,5,6,7,8 Next Last

Click **Download** to export the Patient List into Excel.

Click **Filter** to access filter options.

Filter By:

Provider NPI Provider Medicaid Number

Member Last Name

- Care Gaps
- Case Management
- Emergency Department
- Special Needs
- Preferred Language
- Disease Management
- New Member
- No HRA

Go! Clear

Patients Tips

- Patients tab is only applicable to PCPs / PCP organizations
- Click on a member's name to access their eligibility, health record, etc. information
- Patients list can be exported to excel for more filtering options

Portal Functionality: Authorizations

Authorizations

Providers are able to use the portal to submit web authorization requests and view 18 months of authorization history.

Accessing Authorizations

To access authorization information or create and submit a web authorization request, click **Authorizations**. The Authorizations Summary displays.

The screenshot shows the Centene web portal interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations (highlighted with a red box), Claims, Messaging, and Help. Below the navigation bar, there is a section for 'Viewing Dashboard For : TIN' and 'Plan Type' (Medicaid), with a 'GO' button. The main content area is divided into three sections: 'Quick Eligibility Check for Medicaid' with input fields for Member ID or Last Name and Birthdate, and a 'Check Eligibility' button; 'Recent Claims' with a table showing claim details; and a 'Welcome' sidebar with navigation options like 'Add a TIN to My ACCOUNT', 'Manage Accounts', 'Reports', 'Patient Analytics', and 'Provider Analytics'. Below the sidebar is a 'Recent Activity' section.

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
\$	05/15/2020		T136
\$	05/18/2020		T139
\$	05/18/2020		T139
\$	05/18/2020		T139



Tip: The member drives your Plan Type selection. For example, an Ambetter member will not pull up under Medicaid. To find an Ambetter member, the Plan Type must be 'Ambetter'.

Authorizations Summary

Eligibility Patients **Authorizations** Claims Messaging Help

Viewing Authorizations For : TIN [] Plan Type Medicaid [] GO Create Authorization

Authorizations Processed Errors Disclaimer Filter

Displays authorizations submitted under TIN, for the last 90 days, regardless how they were submitted.

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	IP186		05/12/2020	12/31/9999	M16.11	INPATIENT	Surgical
APPROVE	IP190		02/28/2020	12/31/9999	Z79.2	INPATIENT	Skilled Nursing
APPROVE	OP18		02/27/2020	03/27/2020	M21.961	OUTPATIENT	Outpatient Surgery
APPROVE	OP18		02/19/2020	03/21/2020	S83.512A	OUTPATIENT	Outpatient Surgery
APPROVE	IP187		02/17/2020	12/31/9999	R10.2	INPATIENT	Surgical
PEND	IP190		02/11/2020	12/31/9999	D57.00	INPATIENT	Medical
APPROVE	IP190		02/08/2020	12/31/9999	J18.9	INPATIENT	Medical
APPROVE	OP19		02/07/2020	05/07/2020	E66.01	OUTPATIENT	Outpatient Services
APPROVE	IP190		02/07/2020	02/11/2020	J10.1	INPATIENT	Medical

Click an **Auth ID** to view authorization details

Click **Filter** to access filter options

Authorization Details

[Back to Authorizations](#)

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Auth Status: APPROVE
Auth Nbr: IP19[REDACTED]
Admit Date: 05/12/2020
Provider of Service(s): [REDACTED]
Diagnosis Code(s): T21.31XA

Explanation: Pay
Auth Type: INPATIENT
Service: Surgical
Discharge Date: 05/20/2020
Procedure Code(s): 99221

Notes & Attachments: [View](#)

Line Item	Service type	From Date	To Date	Stay Level	Location	Status	Medical Necessity	Decision Date
1	Medical	05/12/2020	05/13/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/13/2020
2	Medical	05/13/2020	05/14/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/14/2020
3	Medical	05/14/2020	05/15/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/15/2020
4	Medical	05/15/2020	05/18/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/18/2020
5	Surgical	05/18/2020	05/19/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/19/2020
6	Surgical	05/19/2020	05/20/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/20/2020

[Back to Authorization List](#)

Authorization Details Links and Pop-Up

Back to Authorizations

Overview

Auth Status: APPROVE
 Auth Nbr: IP19S
 Admit Date: 05/12/2020
 Provider of Service(s): HOSPITAL

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Explanation: Pay
 Auth Type: INPATIENT
 Service: Surgical
 Discharge Date: 05/20/2020

Diagnosis Code(s): T21.31XA
 R69
 T21.11XA

Procedure Code(s): 99221
 99231

Notes & Attachments: View

Click hyperlink(s) to view additional codes

Hover your mouse over a Line Item to view the CPT, REV or HCPC code associated with it

Line Item	Service type	From Date	Medical Necessity	Decision Date
1	Medical	05/12/2020	Met as requested	05/13/2020
2	Medical	05/13/2020	Met as requested	05/14/2020
3	Medical	05/14/2020	Met as requested	05/15/2020
4	Medical	05/15/2020	Met as requested	05/18/2020

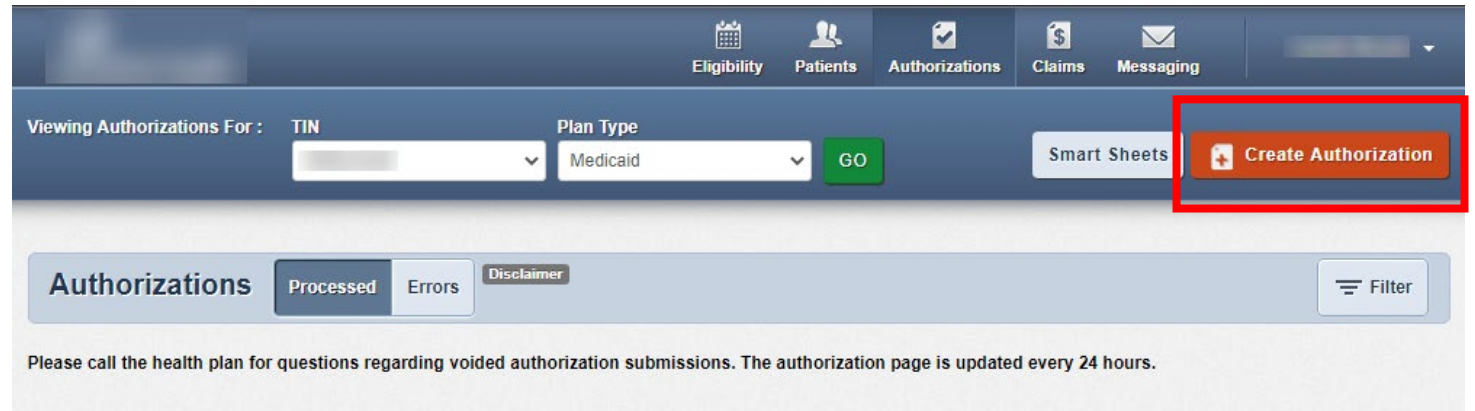
Diagnosis and Procedure Codes

Primary Diagnosis Code: T21.31XA
 Additional Diagnosis Codes: R69 T21.11XA
 Primary Procedure Code: 99221
 Additional Procedure Codes: 99221

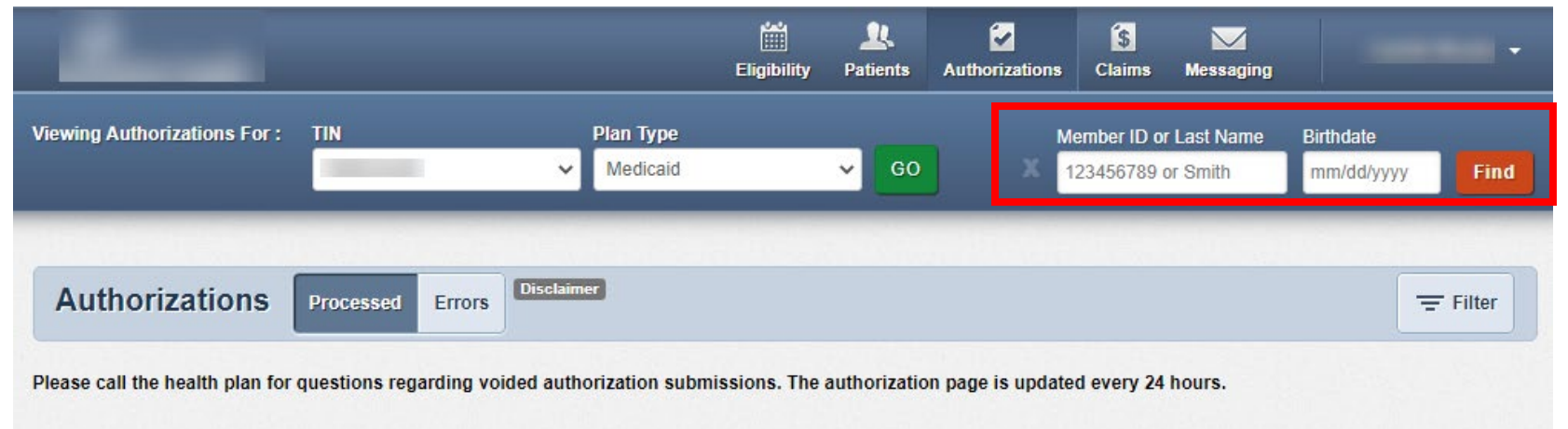
Create Authorization (Web Authorization Request)

To begin a web authorization request:

1. Click **Create Authorization**
2. Enter **Member ID or Last Name**
3. Enter Member's **Birthdate**
4. Click **Find**



The screenshot shows the top navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below the navigation bar, there are two dropdown menus for 'Viewing Authorizations For : TIN' and 'Plan Type' (set to Medicaid), followed by a green 'GO' button. To the right, there is a 'Smart Sheets' button and a red-bordered button labeled 'Create Authorization'. Below this, there are tabs for 'Authorizations', 'Processed', 'Errors', and 'Disclaimer', along with a 'Filter' button. A disclaimer message at the bottom reads: 'Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.'



The screenshot shows the same interface as above, but with the 'Find' button highlighted in red. The 'Find' button is located to the right of two input fields: 'Member ID or Last Name' (containing '123456789 or Smith') and 'Birthdate' (containing 'mm/dd/yyyy'). The 'GO' button is also visible to the left of these input fields. The rest of the interface, including the navigation bar and disclaimer, remains the same.



Tip: You cannot create a web authorization on an ineligible member.

Create Authorization (Web Authorization Request)

The screenshot shows a web application interface for creating an authorization. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations (marked with a red circle '1'), Claims, and Messaging. Below this is a search bar with 'Viewing Patients For:' and dropdowns for 'TIN' and 'Plan Type' (set to 'Medicaid'), followed by a 'GO' button. To the right are buttons for 'Smart Sheets' and 'Create Authorization' (marked with a red circle '2').

The main content area is divided into two columns:

- Authorization For:** Contains fields for 'DOB:' and 'MEDICAID NBR:'. Below these are two informational boxes: one with text about after-hours emergency requests and another that says 'Please select Service Type.'.
- Enter Authorization:** Contains a section titled '1. PROVIDER REQUEST' with a 'Select a Service Type' dropdown menu and a 'NEXT >' button. Below this are sections for '2. SERVICE LINE' and '3. FINISH UP'.

Tip: Use the **Tab** key (on your keyboard) to move to fields in a web authorization request.

Web Authorization Redesign

Web Authorization Redesign

- Authorization Type-driven
- Streamlined
- All Plan Types
 - Medicaid
 - Behavioral Health (BH) Medicaid
 - Allwell
 - Ambetter

The screenshot displays the redesigned web authorization interface. At the top, a navigation bar includes icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this, a search bar allows users to filter by TIN and Plan Type (currently set to Medicaid), with a GO button. A 'Smart Sheets' button and a 'Create Authorization' button are also present.

The main content area is divided into three sections, each with a dropdown menu for 'Select an Authorization Type' and a corresponding button:

- Medical:** The dropdown menu lists 'Inpatient Medical' and 'Outpatient Medical'.
- BH:** The dropdown menu lists 'Outpatient Behavioral' and 'Inpatient Behavioral'.
- Medical & BH:** The dropdown menu lists 'Inpatient Medical', 'Outpatient Medical', 'Inpatient Behavioral', and 'Outpatient Behavioral'.

To the right, a '1. PROVIDER REQUEST' section shows a 'Select an Authorization Type' dropdown and a 'NEXT >' button. A red dashed arrow points from the dropdown to the 'NEXT' button, and another red dashed arrow points from the 'NEXT' button back to the 'Medical & BH' button in the main content area. Below this, a '3. FINISH UP' section is partially visible.

Authorization Tips

- Always check the member's eligibility before submitting an authorization request
 - A web authorization **cannot** be submitted on an ineligible member
- Web authorizations generally load in processing queue within seconds of submission
- Up to five (5) separate documents can be attached to a web authorization request
- Always use the confirmation number to check the status of the request
 - This is the only way a portal user will see a web authorization error
 - Web authorization errors are uncommon, but when an error is encountered the web authorization request, will not load, and thereby will not be processed
 - ❖ Please submit the authorization request by phone or fax
 - ❖ Notify the Health Plan and provide the web authorization confirmation number for research

Portal Functionality: Claims

Claims

Providers are able to use the portal to:

- Access up to 24 months of claims-related history
- Submit new claim
- Correct claims
- Batch claims

Claims

Viewing Dashboard For : TIN [redacted] Plan Type [redacted] Medicaid

Eligibility Patients Authorizations **Claims** Messaging Help

The Claims section displays claim-related information and is divided into a series of tabs.

Quick Eligibility Check for Medicaid

Member ID or Last Name: Birthdate: [Check Eligibility](#)

Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
🇺🇸	05/15/2020	[redacted]	T136
🇺🇸	05/18/2020	[redacted]	T139
🇺🇸	05/18/2020	[redacted]	T139
🇺🇸	04/23/2020	[redacted]	T114
🇺🇸	04/21/2020	[redacted]	T112

Welcome

- Add a TIN to My ACCOUNT >
- Manage Accounts >
- Reports >
- Patient Analytics >
- Provider Analytics >

Recent Activity

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

Quick Links

Claims – Individual

The Individual tab displays claims on file under the TIN, regardless of how they were submitted.

Note: You can access up to 24 months of claim history.

Patients Authorizations Claims Messaging

Upload EDI Create Claim

Claims Individual Saved Submitted Batch Payment History Claims Audit Tool

Claims: Recent

Search: Date Range : 03/14/2021 to 04/14/2021 [Change dates](#) Filter Search

CLAIM NO.	CLAIM TYPE	MEMBER NAME	SERVICE DATE(S)	BILLED/PAID	CLAIM STATUS
U076	CMS-1500		03/14/2021 - 03/14/2021	\$49.00 / \$16.59	🇺🇸 Paid
U082	CMS-1500		03/14/2021 - 03/14/2021	\$183.00 / \$70.85	🇺🇸 Paid
U075	CMS-1500		03/15/2021 - 03/15/2021	\$297.00 / \$0.00	❌ Denied
U075	CMS-1500		03/15/2021 - 03/15/2021	\$80.00 / \$0.00	🕒 Pending
U075	CMS-1500		03/15/2021 - 03/15/2021	\$0.00 / \$2.11	🇺🇸 Paid

Click Claim Number to view claim details

Click **Change Dates** to search up to 24 months

Click **Filter** and/or **Search** for additional options

Claim Details

Back to Claims

Claim Details

Claim Details display a summary of what was billed, how it was billed, and the status of the claim.

🕒 Claim #U [REDACTED]: Pending

+ Copy Claim
🔄 Void/Recoup Claim

Claim Accepted In Process Paid/Denied

Member	Provider	Claim	Most Recent Payment
Member Name: [REDACTED]	Ref/Acct No.: [REDACTED]	DOS Range: 03/23/2021 - 03/23/2021	Payment Date: Pending Claim Amount: \$0.00
Member ID: [REDACTED]	Servicing Provider: [REDACTED]	Received Date: 04/14/2021	Check/EFT Number: Total Check Amount:
Member DOB: [REDACTED]	Servicing NPI: [REDACTED]	Billed Amount: \$348.00	Check Dated:

Service Lines

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Paid Amount	Payment Date	Check/EFT Number	Status
1	03/23/2021	G0439	Z0000	95	22	\$348.00	\$0.00			🕒 Pending
2	03/23/2021	G8510	Z0000		22	\$0.00	\$0.00			🕒 Pending

Claim Action Buttons

Claim Status Tracking

Claim Information

Claim Service Line(s)

Claim Details – Pending

Click **Copy Claim** to create an exact copy of this claim, as a shortcut. It is considered a new claim submission and will be processed as a 1st time claim

Back to Claims

Claim Details

🕒 Claim #U [REDACTED]: Pending

+ Copy Claim
🗑️ Void/Recoup Claim

Claim Details display a summary of what was billed, how it was billed, and the status of the claim.

Please Note: Pending, means the claim is in process.

Claim Accepted In Process Paid/Denied

Member

Member Name: [REDACTED]

Member ID: [REDACTED]

Member DOB: [REDACTED]

Provider

Ref/Acct No.: [REDACTED]

Servicing Provider: [REDACTED]

Servicing NPI: [REDACTED]

Claim

DOS Range: 03/23/2021 - 03/23/2021

Received Date: 04/14/2021

Billed Amount: \$348.00

Most Recent Payment

Payment Date: [REDACTED] Pending Claim Amount: \$0.00

Check/EFT Number: [REDACTED] Total Check Amount: [REDACTED]

Check Dated: [REDACTED]

Service Lines

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Paid Amount	Payment Date	Check/EFT Number	Status
1	03/23/2021	G0439	Z0000	95	22	\$348.00	\$0.00			🕒 Pending
2	03/23/2021	G8510	Z0000		22	\$0.00	\$0.00			🕒 Pending

Claim Details – Finalized

Back to Claims **Claim Details**

Claim #U: Paid

+ Copy Claim Correct Claim Void/Recoup Claim Reconsider Claim

Claim Accepted In Process Paid

Member	Provider	Claim	Most Recent Payment
Member Name: [REDACTED]	Ref/Acct No.: [REDACTED]	DOS Range: 03/15/2021 - 03/15/2021	Payment Date: 03/26/2021
Member ID: [REDACTED]	Servicing Provider: [REDACTED]	Received Date: 03/18/2021	Check/EFT Number: [REDACTED]
Member DOB: [REDACTED]	Servicing NPI: [REDACTED]	Billed Amount: \$468.00	Check Dated: 03/25/2021
Paid Claim Amount: \$ [REDACTED]		Total Check Amount: \$175.43	

Service Lines

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Paid Amount	Payment Date	Check/EFT Number	Status	Payment Codes
1	03/15/2021	99392	Z00129, Z6852	25	11	\$318.00	\$ [REDACTED]	03/26/2021	[REDACTED]	PAID	92
2	03/15/2021	90480	Z23		11	\$150.00	\$ [REDACTED]	03/26/2021	[REDACTED]	PAID	92
3	03/15/2021	90696	Z23		11	\$0.00	\$0.00	03/26/2021	[REDACTED]	DENY	IE
4	03/15/2021	90710	Z23		11	\$0.00	\$0.00	03/26/2021	[REDACTED]	DENY	IE

Payment Description

Payment Code	Description
92	PAID ACCORDING TO CONTRACT STATE PROCESSING GUIDELINES
IE	CPT NOT REIMBURSED SEPARATELY. INCLUDED AS PART OF INCLUSIVE PROCEDURE

Click **Correct Claim** to correct a finalized claim

Where available, click **Void/Recoup Claim** void an original claim that has already been processed, and request a full recoupment of payment

Payment Codes and Payment Description display on finalized claims

Reconsider Claim

Back to Claims **Claim Details**

Where available, the Reconsider Claim button will display, unless a web-initiated reconsideration is already in progress.

Claim #U [redacted]: Paid

+ Copy Claim / Correct Claim / Void/Recoup Claim / Reconsider Claim

Claim Accepted In Process Paid

Click **Reconsider Claim** to submit reconsideration request

Member	Provider	Claim	Most Recent Payment	
Member Name: [redacted]	Ref/Acct No.: [redacted]	DOS Range: 03/15/2021 - 03/15/2021	Payment Date: 03/26/2021	Paid Claim Amount: \$ [redacted]
Member ID: [redacted]	Servicing Provider: [redacted]	Received Date: 03/18/2021	Check/EFT Number: [redacted]	Total Check Amount: \$175.43
Member DOB: [redacted]	Servicing NPI: [redacted]	Billed Amount: \$468.00	Check Dated: 03/25/2021	

Service Lines

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Paid Amount	Payment Date	Check/EF T Number	Status	Payment Codes
1	03/15/2021	99392	Z00129	25	11	\$318.00	\$ [redacted]	03/26/2021		PAID	92



Tip: Reconsider Claim is for reconsiderations only. It cannot be used for Appeals/Claim Disputes.

Claims – Saved

The Saved tab displays web claims that were started, but never submitted.

Viewing Claims For: [Plan type: Medicaid] [GO] [Upload EDI] [Create Claim]

Claims [Individual] **Saved** Submitted Batch Payment History Claims Audit Tool

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

Drafts Professional Ready to be Submitted Institutional Ready to be Submitted

DATE CREATED ↑	CLAIM TYPE ↑	CLAIM ID ↓	MEMBER NAME ↑	MEMBER ID ↓	ORIGINAL CLAIM # ↓	TOTAL CHARGES ↓		
04/09/2021	CMS-1500					\$333.79	Edit	Delete
04/02/2021	CMS-1500					\$581.79	Edit	Delete
03/31/2021	CMS-1500					\$183.00	Edit	Delete
03/26/2021	CMS-1500					\$0.00	Edit	Delete
03/24/2021	CMS-1500					\$0.00	Edit	Delete
03/23/2021	CMS-1500					\$0.00	Edit	Delete
03/22/2021	CMS-1500					\$0.00	Edit	Delete

Click **Edit** to resume, complete, and submit web claim

Click **Delete** to delete the web claim draft



Tip: A Claim Number in the **Original Claim #** column, indicates it is a corrected claim draft.

Claims – Submitted

The Submitted tab displays individual web claims, submitted via the portal.

Note: You can access up to 24 months of individual web claim submissions.

Upload EDI Create Claim

Claims Individual Saved **Submitted** Batch Payment History Claims Audit Tool Filter

SUBMITTED STATUS ↑	DATE SUBMITTED ↓	WEB # / REF # ↑	CLAIM NUMBER ↓	CLAIM TYPE ↓	MEMBER NAME ↑	MEMBER ID ↓	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↓
Ⓛ	04/13/2021			CMS-1500				\$254.00
Ⓛ	04/13/2021			CMS-1500				\$276.00
Ⓛ	04/13/2021			CMS-1500				\$297.93
Ⓛ	04/12/2021			CMS-1500				\$561.72
👍	04/09/2021			CMS-1500				\$460.00
Ⓛ	04/07/2021			CMS-1500				\$199.00
Ⓛ	04/06/2021			CMS-1500				\$487.00
Ⓛ	03/26/2021			CMS-1500				\$199.00

Click **Filter** for additional search options



Tip: A Claim Number in the **Original Claim #** column, indicates it is a corrected claim submission.

Claims – Batch

The Batch tab displays 837 files and status for each file uploaded via the portal. Also, the 999, TA1 and/or Audit response files display for download.

Note: You can access up to 24 months of [EDI] batch claim file submissions and EDI response files.

Claims Individual Saved Submitted **Batch** Payment History Claims Audit Tool

Start Date: 04/07/2021 End Date: 04/14/2021
Date span limited to a 1-month period.

Confirmation #: Batch Claim Status: ALL Search

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

For questions regarding errors please contact the health plan.

SUBMITTED DATE	CONFIRMATION TYPE	CONFIRMATION #:	FILE NAME	STATUS	997/999 FILE	TA1 FILE	AUDIT FILE
04/12/2021	837P	51255083	51255083_	PARTIAL_REJECT	Download	Download	Download
04/12/2021	837P	51255085	51255085_	ACCEPTED	Download	Download	Download
04/12/2021	837P	51255084	51255084_	ACCEPTED	Download	Download	Download

The File status displays in Status. File status Rejected or Partial_Rejected indicates file-level EDI front-end rejections.

Action required to resolve file-level rejections:

- The errors must be corrected in your system
- Re-batch claims
- Resubmit (i.e. upload)

Note: Front-end EDI rejections will not be processed any further, therefore, the claims will never load for adjudication.

Claims – Batch, continued

The screenshot displays the 'Claims Batch' interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this, there are filters for 'Viewing Claims For : TIN' and 'Plan Type' (set to Medicaid), with a 'GO' button. To the right are 'Upload EDI' and 'Create Claim' buttons.

The main section is titled 'Claims' and includes tabs for Individual, Saved, Submitted, **Batch** (highlighted with a red box), Payment History, and Claims Audit Tool. Below these tabs are search filters for 'Start Date' (04/07/2021) and 'End Date' (04/14/2021), with a note: 'Date span limited to a 1-month period.' There is also a 'Confirmation #' field and a 'Batch Claim Status' dropdown set to 'ALL', with a 'Search' button.

A red dashed arrow points from the text 'Change Start Date and End Date to access up to 24 months of EDI response reports' to the End Date field.

Below the filters is a table of submitted claims. The table has columns for SUBMITTED DATE, TYPE, CONFIRMATION #, FILE NAME, STATUS, and a set of download links. The download links are highlighted in a red box. A red dashed arrow points from the text 'Click Download to export / view the EDI response reports' to the 'Download' link for the first row.

SUBMITTED DATE	TYPE	CONFIRMATION #	FILE NAME	STATUS	997/999 FILE	TA1 FILE	AUDIT FILE
04/12/2021	837P	51255083	51255083_...	PARTIAL_REJECT	Download	Download	Download
04/12/2021	837P	51255085	51255085_...	ACCEPTED	Download	Download	Download
04/12/2021	837P	51255084	51255084_...	ACCEPTED	Download	Download	Download

Claims – Payment History

The Payment History tab displays check history and PDF to links to Explanation of Payment (EOP) per check.

Note: You can access up to 24 months of claims payment history.

Viewing Claim

Upload EDI Create Claim

Claims Individual Saved Submitted Batch **Payment History** Claims Audit Tool Filter

Transactions

All activity posted to your account between 03/14/2021 and 04/14/2021 .

i **Instructions:** Click on the Check Date to view the PDF of payment details from your payment provider. The PDF will open in a new window where you can save or print it. If there are any discrepancies on your payment details, please contact Provider Services.

CHECK DATE ↑	CHECK NUMBER ↓	CHECK CLEAR DATE ↑	MAILING ADDRESS ↓	PAYMENT AMOUNT ↓
03/15/2021 (PDF)	9423	EFT		\$5,584.61
03/15/2021 (PDF)	9725	EFT		\$2,019.73
03/17/2021 (PDF)	1695	EFT		\$1,826.94
03/17/2021	1695	EFT		\$1,826.94

Click **Filter** for additional search options



Claims – Payment History, continued

The screenshot shows a web application interface for viewing claims payment history. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this, a filter bar allows users to view claims by TIN and Plan Type (Medicaid), with a GO button and buttons for Upload EDI and Create Claim. A secondary filter bar includes tabs for Claims, Individual, Saved, Submitted, Batch, Payment History (highlighted with a red box), and Claims Audit Tool, along with a Filter button. The main section is titled 'Transactions' and shows activity between 03/14/2021 and 04/14/2021. An information box provides instructions on clicking the Check Date to view PDF payment details. A table lists two transactions with columns for Check Date, Check Number, Check Clear Date, Mailing Address, and Payment Amount. A file download bar at the bottom shows a PDF file named 'Claim_...pdf' with an annotation pointing to it.

Viewing Claims For : TIN [dropdown] Plan Type Medicaid [dropdown] GO [button] Upload EDI [button] Create Claim [button]

Claims [Individual] [Saved] [Submitted] [Batch] [Payment History] [Claims Audit Tool] [Filter]

Transactions

All activity posted to your account between 03/14/2021 and 04/14/2021 .

i **Instructions:** Click on the Check Date to view the PDF of payment details from your payment provider. The PDF will open in a new window where you can save or print it. If there are any discrepancies on your payment details, please contact Provider Services.

CHECK DATE ↑	CHECK NUMBER ↓	CHECK CLEAR DATE ↑	MAILING ADDRESS ↓	PAYMENT AMOUNT ↓
03/15/2021 (PDF)	[blurred]	EFT	[blurred]	\$5,584.61
03/15/2021 (PDF)	[blurred]	EFT	[blurred]	\$2,019.73

Claim_...pdf [dropdown] [Show all] [X]

Click **Check Date** to view PDF of payment details

Click file to open PDF of payment details

Claims – Explanation of Payment PDF

Run Date: 3/15/2021 Page 1 of 79

EXPLANATION OF PAYMENT

Payment Date: 3/15/2021
 Payment #: [REDACTED]
 Payment Amt: \$5,584.61

Payee ID: [REDACTED]
 IRS#: [REDACTED]

PAY TO:
 [REDACTED]

Serv	Date	Proc #	Modifiers	Days/ Ct/Qty	Charged/ Allowed	Deduct	CoPay	Coinsur	Discount/ Interest	Med Allow / Med Paid	Third Party Payer	Denied	EXPL Codes	Payment/ Withheld
0100	2/22/2021	99391	EP 25	1.00	\$251.00 \$96.08	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	92	\$0.00
0200	2/22/2021	90460	EP	1.00	\$21.93 \$21.93	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	92	\$0.00
0300	2/22/2021	90686	EP	1.00	\$0.00 \$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	92	\$0.00
0400	2/22/2021	96110	EP	1.00	\$25.00 \$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$25.00	LS	\$0.00
Sub-total					\$297.93 \$118.01	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$25.00		\$118.01 \$0.00

Insured Name: [REDACTED] Mbr No: [REDACTED] MRN: [REDACTED] Claim/Ctrl No: [REDACTED]
 Patient Name: [REDACTED] SvcProv No: [REDACTED] PatCtrl No: [REDACTED]
 Servicing Provider: [REDACTED] NPI: [REDACTED] Group: [REDACTED]

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EXPLANATION OF PAYMENT

Payment Date: 3/15/2021
 Payment #: [REDACTED]
 Payment Amt: \$5,584.61

Payee ID: CMSP

Proc #	Modifiers	Days/ Ct/Qty	Charged/ Allowed	Deduct	CoPay	Coinsur	Discount/ Interest	Med Allow / Med Paid	Third Party Payer	Denied	EXPL Codes	Payment/ Withheld
161	EP 59	1.00	\$71.00 \$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$71.00	0B	\$0.00 \$0.00
Sub-total			\$561.72 \$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$561.72		\$0.00 \$0.00
Total			\$24,769.06 \$4,965.98	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$9,185.81		\$5,584.61 \$0.00

Click to print EOP

Click to download and save a copy of EOP



Tip: The Explanation Code and Description, displays after the last claim in the EOP.

Explanation Code	Description
09	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE
0B	ADJUST: CLAIM TO BE RE-PROCESSED CORRECTED UNDER NEW CLAIM NUMBER
0M	ADJUSTMENT TO PREVIOUSLY SUBMITTED CLAIM
18	DENY: DUPLICATE CLAIM SERVICE
1U	DENY: CODE COVERAGE REIMBURSEMENT NOT CURRENTLY OUTLINED BY MEDICAID
46	DENY: THIS SERVICE IS NOT COVERED
4u	PEND-HCI ADJUSTMENT
4v	PEND-CXT ADJUSTMENT
56	PAY: SERVICE ADDED BY CODE AUDITING SOFTWARE
59	PAY: PAYMENT REDUCED BASED ON MULTIPLE SURGERY RULES
92	PAID ACCORDING TO CONTRACT STATE PROCESSING GUIDELINES
9M	DFNY: THIS CPT CODE IS INVALID WHEN BILLI ED WITH THIS DIAGNOSIS

Portal Functionality: Claim Submission

Claim Submission – Upload EDI

Click **Upload EDI** to upload an EDI Batch (837I / 837P).

1. Check the codes in your file.
 - Ensure file name is less than 50 characters and does not contain special characters
2. Select **File Type**.
3. Click **Choose File**. A separate window will display.
4. Select file from your computer directory.
5. Click **Open**.
6. Click **Submit**.

Viewing Claims For: TIN Plan Type: Medicaid

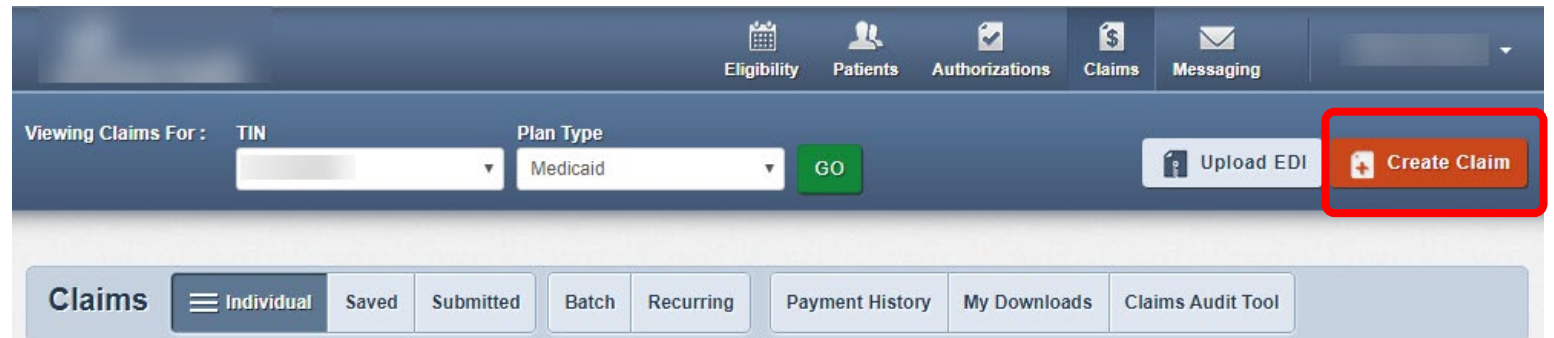
Batch Claims Upload

1. Check your codes: ISA05 = ZZ, ISA06 = WebBatch or WEBBATCH, ISA07 = 30, ISA08 = 421406317, GS02 = WebBatch or WEBBATCH, GS03 = 421406317. For additional EDI information, please refer to Resources.
2. File Type:
Please choose a file format of .dat, .edi, or .txt no larger than 5MB.
3. Upload File: No file chosen
File name should be 50 chars or less and should not contain any of the following special characters: ~!@#%&*()?/{}|\"'.,+; and be 50 characters or less.
4.

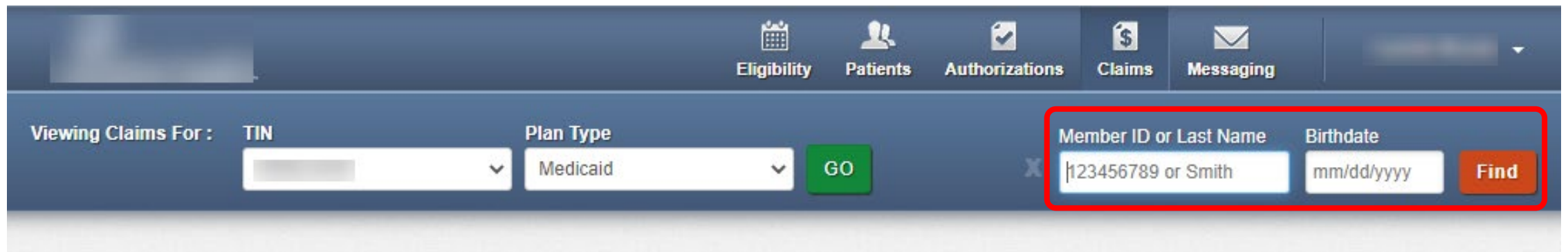
Claim Submission – Create Claim (Individual Web Claim)

To begin an individual web claim:

1. Click **Create Claim**
2. Enter **Member ID or Last Name**
3. Enter Member's **Birthdate**
4. Click **Find**



This screenshot shows the top navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below the navigation bar, there are two dropdown menus for 'Viewing Claims For : TIN' and 'Plan Type' (set to Medicaid), followed by a green 'GO' button. To the right, there is an 'Upload EDI' button and a red-bordered 'Create Claim' button.



This screenshot shows the same navigation bar as the previous image. Below it, the search filters are expanded. The 'Viewing Claims For : TIN' and 'Plan Type' (Medicaid) dropdowns are present, along with a green 'GO' button. To the right, there are two input fields: 'Member ID or Last Name' containing the text '|123456789 or Smith' and 'Birthdate' containing 'mm/dd/yyyy'. A red-bordered 'Find' button is located to the right of these fields.

Create Claim – Claim Type Selection

The screenshot displays a web application interface for creating a claim. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this, a header section contains a 'Viewing Claims For:' dropdown menu, a 'Medicaid' dropdown menu, and a green 'GO' button. To the right of these are two buttons: 'Upload EDI' and 'Create Claim'. A light blue bar below the header contains the text 'Choose Claim for' followed by a blurred dropdown menu. The main content area is titled 'Choose a Claim Type' and features two large green buttons: 'CMS 1500 Professional Claim →' and 'CMS UB-04 Institutional Claim →'. Two red dashed arrows point from the text 'Click desired Claim Type' to the top of each of these buttons. At the bottom of the main content area, there is an 'UPDATE' notice regarding ICD-10 regulations.

Viewing Claims For : Medicaid

Choose Claim for

Choose a Claim Type

CMS 1500

CMS UB-04

UPDATE: In order to be compliant with ICD-10 regulations, we will require claims with discharge dates or service dates on or after October 1, 2015, be coded with ICD-10 codes. This change applies to the date of service on the claim, not the submission date.

Create Claim – General Information

Professional Claim for [Redacted]

Your Progress [Progress Bar]

THIS SECTION:
General Info
Information about the dates of the

Throughout the claim submission process, the Progress bar will display which step you are on.

Note: On web claims, the numbered tabs in the right margin, correlate to the boxes on the:

- CMS 1500 Paper Claim Form (Professional)
- UB-04 Paper Claim Form (Institutional)

* Required field

Patient's Account Number* [XXXXXXXXXX] 26

Statement Dates* From [MM/DD/YYYY] To [MM/DD/YYYY]

Date of current Illness, Injury, Pregnancy (LMP) [Select Type...] [MM/DD/YYYY] 14.

Other Date [Select Type...] [MM/DD/YYYY] 15.

Hospitalization From [MM/DD/YYYY] To [MM/DD/YYYY] 18.

Next →

Hover mouse over tabs for additional information

Create Claim – Diagnosis Codes

Professional Claim for [REDACTED] Your Progress

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

← Back Next →

* Required field

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

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

L739 -- FOLLICULAR DISORDER UNSPECIFIED

←----- Click **Add Coordination of Benefits**, to submit a Secondary Claim

← Back Next →

Create Claim – Service Lines

Professional Claim for [redacted] Your Progress [Progress Bar]

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

← Back Provider Details →

Total: \$0.00 **3** Save / Update

3 + New Service Line

Your added service lines will appear here.

1 **A New Service Line**

* Required field

Dates of Service* From MM/DD/YYYY To MM/DD/YYYY 24.a

Place of Service* Select... 24.b

Emergency Yes No 24.c EMG

Procedure Code* XXXXX e,i 24.d

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

Diagnosis Code(s)*
 L739 - FOLLICULAR DISORDER UNSPECIFIED 24.e
 Z23 - ENCOUNTER FOR IMMUNIZATION

Click + **New Service Line** to enter additional Service Line(s).

After entering or editing a Service Line, click **Save/Update**.

Create Claim – Providers

Professional Claim for [REDACTED] Your Progress

THIS SECTION:
Providers
Providers on this claim.

[← Back](#) [Next →](#)

* Required field

Referring Provider

NPI: [XXXXXXXX] [Find Provider](#) Qualifier: [Select...] 17.

Last Name or Organizational Name: [Last Name] [Find Provider](#) First Name: [First Name]

Rendering Provider

Only enter rendering provider information if not the same as Billing Provider information. 24.j

NPI: [XXXXXXXX] Tax ID: [REDACTED] [Find Provider](#)

Taxonomy #: [XXXXXXXX] Last Name or Organizational Name: [Last Name] First Name: [First Name] [Clear X](#)

Billing Provider

Tax ID: [REDACTED] 33.

Name*: [Last Name] NPI: [XXXXXXXX] Taxonomy*: [XXXXXXXX]

Address*: [XXXXXXXX] City*: [XXXXXXXX] State*: [Select...] Zip*: [XXXXX]

Create Claim – Attachments

Professional Claim for [REDACTED] Your Progress

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

[← Back](#) If there are no attachments, click Next. [Next →](#)

Portal users can attach up to five (5) separate documents to their web claim submissions.

Attachments


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

File* **1** No file chosen Attachment Type* **2** [Attach **3**](#)

There are no attached files.

[← Back](#) If there are no attachments, click Next. [Next →](#)

Create Claim – Review and Submit

Professional Claim for [redacted] Your Progress 

THIS SECTION:
Review
Please review your claim.

[← Back](#) [Submit →](#)

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

Claim Id: 822 [redacted]
Member Record Number: [redacted]
Member Claim Amount Paid: [redacted]
Patient's Account Number: [redacted]

General Info [Edit](#)

Statement From Date: 01/02/2020
Statement To Date: 01/02/2020
Date of current illness, injury, pregnancy (LMP):
Other Date:
Hospitalized From:
Hospitalized To:
Additional Claim Information:
Outside Lab?: No
Outside Lab Amount:
Prior Authorization Number:
CLIA Number:

Diagnosis Codes and Primary Insurance [Edit](#)

Diagnosis Codes
L739 -- FOLLICULAR DISORDER UNSPECIFIED

An overview of the created claim displays for review. This is the last opportunity to edit the claim.

Click **Submit** to complete claim submission

Click **Edit**, to make changes to the claim

Create Claim – Submission Confirmation

The screenshot shows a web application interface for claim submission. At the top, there is a navigation bar with icons and labels for 'Eligibility', 'Patients', 'Authorizations', 'Claims', and 'Messaging'. Below this is a search area with 'Viewing Claims For :', two dropdown menus, and a 'GO' button. To the right are 'Upload EDI' and 'Create Claim' buttons. The main content area displays a success message: 'THIS SECTION: Success Congratulations!' followed by 'Your claim has been submitted' and 'Your confirmation ID is 800225232'. A callout box explains that this ID can be used to search for the claim on the Submitted tab.

Eligibility Patients Authorizations Claims Messaging

Viewing Claims For : GO

Upload EDI Create Claim

THIS SECTION:
Success Congratulations!

Your claim has been submitted
Your confirmation ID is 800225232

The Success page displays the web claim submission confirmation ID. This ID can be used to search for the claim on the Submitted tab.

Portal Functionality: Claim Tips

Claims – Submission Tips

- Always check the member's eligibility before submitting a claim
 - If a member is ineligible, claims can be submitted for DOS the member was eligible
- Hover mouse over tabs in the right margin for field-level help on web claims
- To submit a secondary web claim you must complete the Add Coordination of Benefits section on the Diagnosis Codes page and the Primary Insurance fields on the Service Lines page
- On the Service Lines page, always click Save/Update when creating or editing service line(s)
- NPI and Taxonomy should be entered on every claim, except some Atypical Providers
- Portal users can attach up to five (5) separate documents to their web claim submissions (first-time and corrected claims)

Claims – Submission Tips (Continued)

- Organizations that upload EDI Batches (i.e. 837P / 837I) via the portal, must monitor the **Claims → Batch** for EDI response reports (i.e. 999, Audit File, etc.)
- Regardless of submission method, all claims go through the EDI claims process, and are:
 - Accepted and loaded for adjudication, **or**
 - Rejected and will not be processed any further (i.e. front-end EDI rejection)
- Once a web claim goes through the EDI process, the claim number will display on the **Claims → Submitted**, under the Claim Number column (4th column from the left)
 - If the web claim was accepted, use the Claim # to track status on the Individual tab

Claims – Tracking / Status Tips

- Voided claims will not display in the portal
- When looking up a claim, the From Date must be on or before the first date of service (DOS) in the claim
- Portal users can access up to *24 months (from the current date) of claims history using the Filter buttons to change the date range
 - Date range is limited to one-month (at a time)

*** For TINs who contracted with the Health Plan less than 24 months (from current date), portal users should be able to access claim history back to initial claim submission.**

Claims – Date Range Criteria Tips

- The Date Range criteria varies by Claims tab:
 - **Individual** tab is by DOS
 - **Submitted** tab is by Date Submitted
 - **Batch** is by Submitted Date
 - **Payment History** is by Check Date

Benefits of Portal Utilization

- Portal available 24/7
- Cost savings, portal free to submit claims and authorizations
- Better management of patient's care, i.e. care gaps
- Efficiency of electronic authorizations and claim submissions
- Ability to view both patient and provider history/data
- Ability to correct claims

Thank you!