Secure Provider Portal User Guide

24-hour access to your patients' health information

Providers can:

- Manage multiple practices under one account
- Check member eligibility
- View quality reports and member gaps in care
- Submit and view the status of claims, reconsiderations, and prior authorizations
- Get a patient list

Benefits

Meridian Partners With You to Provide the Best Care

Our goal is to help you and your staff offer a higher level of service and save time with instant access to your patient's information.

Benefits of portal utilization:

- Available 24/7
- No cost to users
- Access up-to-date member information
- Verify eligibility, care gaps, and clinical information
- Document upload capability
- Submit and manage claims, including 837 batch files
- View and submit authorization requests
- View patient and provider data

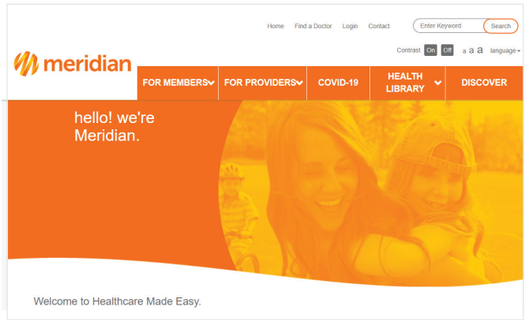
New functionalities

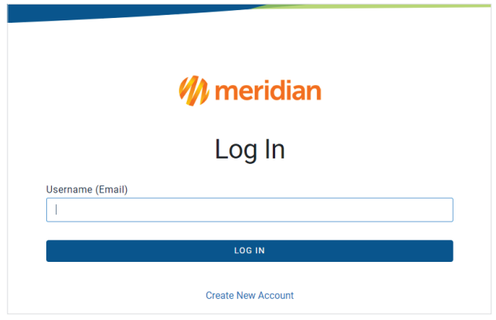
- Add locations to an existing contract
- View or change a practitioner's or group's demographic information

Navigating the Portal

Login or Register

Go to **ILmeridian.com**, Hover over "For Providers," Navigate to Login, and select.



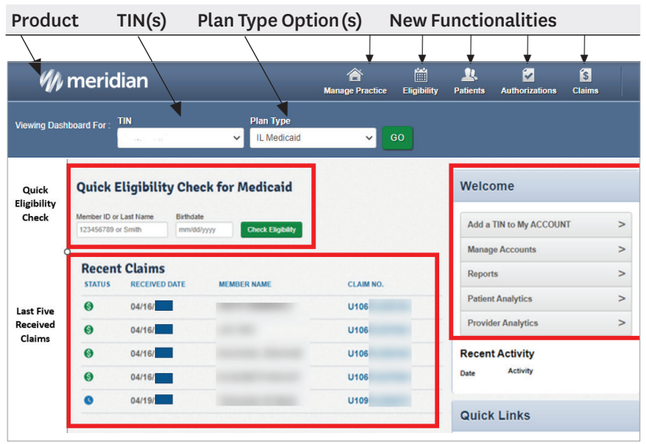


Secure Portal Registration & Login Tips

- Registration is required for portal access
- Portal accounts cannot be shared. Each person who requires access must complete the portal registration
- To register as a portal user, your TIN must be in our systems. Allow at least two business days for updates
- A portal user can have an unlimited number of TINs associated with their account
- Avoid inactivity lockout. Portal users must log in every 90 days to prevent a lockout
- The "Forgot password and Unlock account" link cannot be used to unlock an account due to inactivity

Enrollment/Self-Service

Portal Banner/Landing Page



- The "Plan Type" options are automatically assigned based on how the TIN is set up
- The "Patients" tab only applies to PCPs and PCP organizations
  - Click on a member's name to access their eligibility status and health record
- Patient lists can be exported to Excel for more filtering options

Provider Enrollment Tracker (ET)

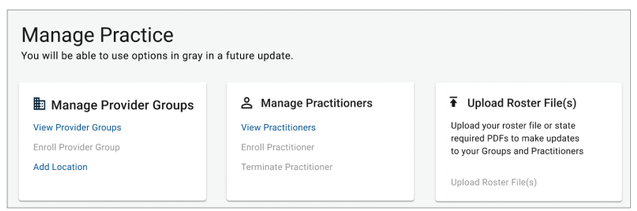
Our ET has greater flexibility for enrollment. You can,

1. Enroll or credential new practitioners and providers
2. Upload required documents and fix identified issues
3. View progress for new contracts
4. Update demographic status manually or with other sources

Our Convenient ET Self-Service Dashboard

Under the "Manage Practice" tab

- Providers can "view provider groups" and "add locations"
- In the "Manage Practitioners" area, you can view or change demographic information
- Functionalities comply with our 48-hour processing turnaround time

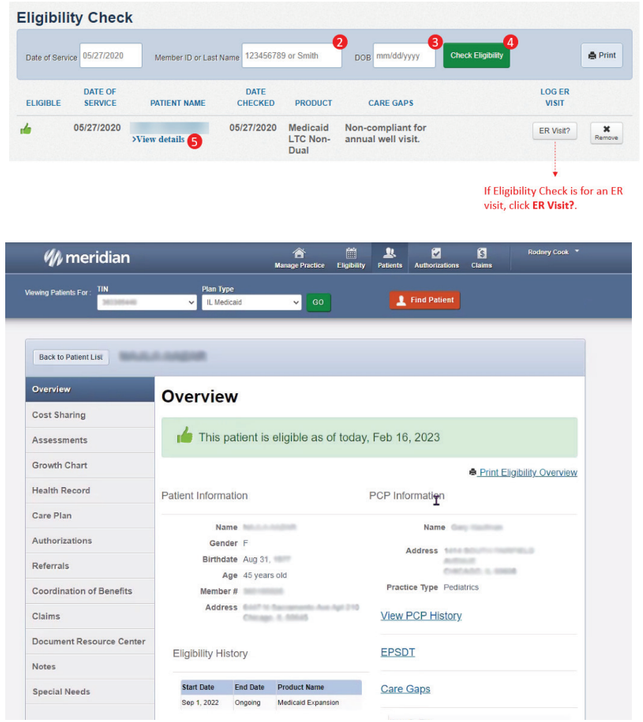


Eligibility

Member Eligibility. Look For the Green Thumbs-up Icon

Within “Eligibility Check,” the patient overview displays information like demographics, claims, and authorizations. It also shows care gaps, ER visits, and PCP history.

- When checking eligibility, verify the data entered
- If the member ID and DOB do not pull up the member, try the member’s last name and DOB
- As a best practice, please check member eligibility before creating a web authorization or claim



Tips

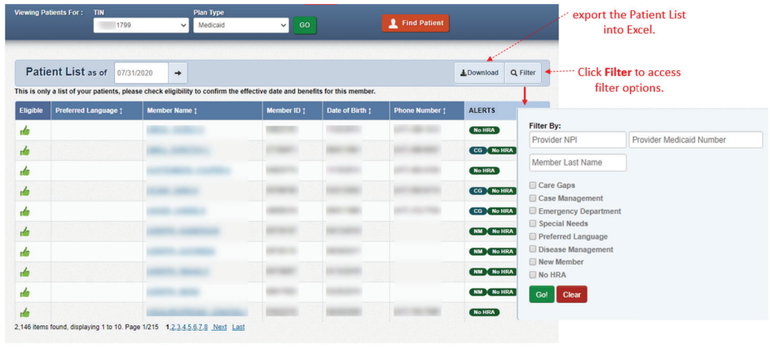
- Member enrollment drives the “Plan Type” selection. For example, an Ambetter member will not pull up under Medicaid
- In most cases, when there is an issue, if the portal matches the source system, it is not a portal issue

List Tab/Authorizations

Patient List Tab

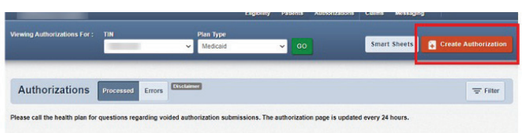
Primary Care Providers (PCP) can view and download a list of their assigned members. The “Patient List” displays the member’s preferred language, eligibility status, name, ID, DOB, phone number, and alerts.

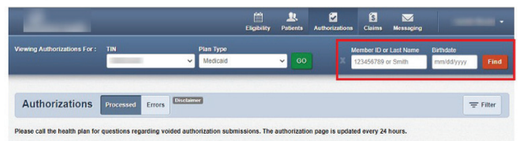
- The “Patients” tab is only applicable to PCPs and PCP organizations
- Click on a member’s name to access details
- The patient list can be exported to Excel



Creating a New Authorization

1. Click “Create Authorization”
2. Enter the member’s ID or last name
3. Enter the member’s birthdate
4. Click “Find”



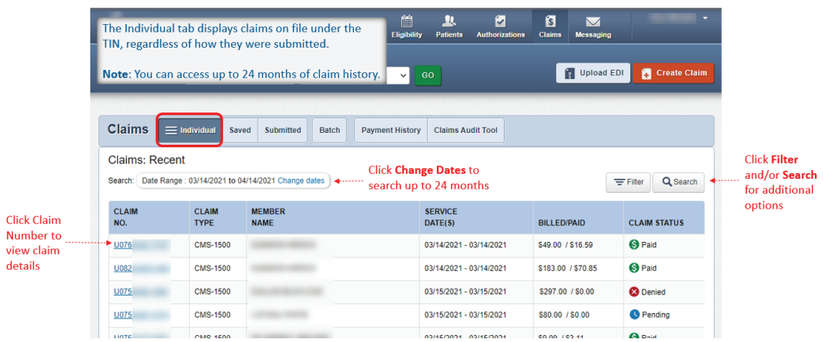


Authorization tips

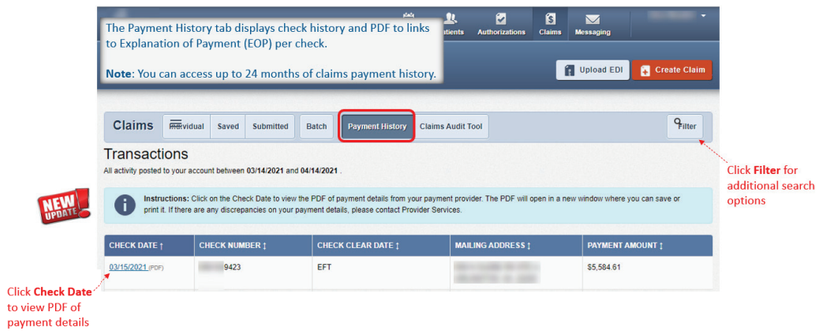
- A web authorization *cannot* be created for an ineligible person
- Always check the member’s eligibility first
- Up to five separate documents can be attached to a web authorization request
  - Each file can be up to 5MB
  - File names cannot contain spaces, special characters, or exceed 25 characters
  - It is highly recommended to include clinical or medical documentation
- Successfully submitted web authorizations generally process within seconds
- For status updates, check the “Authorizations” main page (i.e., Authorization Summary)
- You can submit web authorization requests and view 18 months of authorization history

Claims

Access up to 24 months of claims-related history and submit new, corrected, and batch claims.

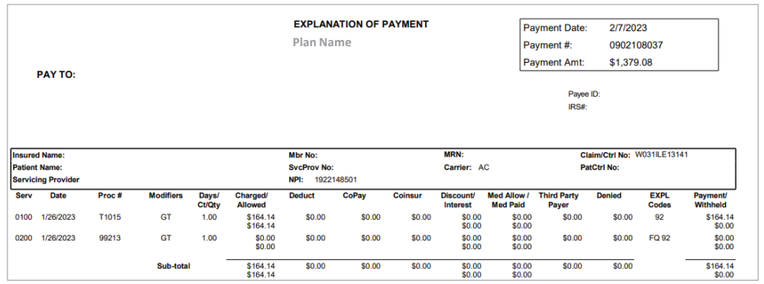


Claims Payment History



Claims

Claims Explanation of Payments (EOP)



EXPLANATION OF PAYMENT
Plan Name

Payment Date: 2/7/2023
Payment #: 0902108037
Payment Amt: $1,379.08

PAY TO:

Payee ID:
IRS#:

Insured Name:
Patient Name:
Servicing Provider
Mbr No:
SvcProv No:
NPI: 1922148501
MRN:
Carrier: AC
Claim/Ctrl No: W031LE13141
PatCtrl No:

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	1/26/2023	T1015	GT	1.00	$164.14 $164.14	$0.00	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$0.00	92	$164.14 $0.00
0200	1/26/2023	99213	GT	1.00	$0.00 $0.00	$0.00	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$0.00	FQ 92	$0.00 $0.00
			Sub-total		$164.14 $164.14	$0.00	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$0.00		$164.14 $0.00

Claim submission tips

- The “Explanation Code” and “Description” displays after the last claim in the EOP
- 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
- For a web claim to process as a secondary claim, the “Add Coordination of Benefits” section on the “Diagnosis Codes” page and the “Primary Insurance” fields on the “Service Lines” page must be completed
- On the “Service Lines” page, always click “Save and Update”
- Excluding atypical providers, NPI, and taxonomy should be entered on every claim
- Portal users can attach up to five separate documents
- Organizations that upload EDI batches (i.e., 837P / 837I) via the portal must monitor the “Claims → Batch” tab for EDI response reports (i.e., 999, Audit File, etc.)
- Regardless of the submission method, all claims go through the EDI claims process and are:
  - Accepted and loaded to Amisys for adjudication, or
  - Rejected and will not load to Amisys (i.e., front-end EDI rejection)
- Once a web claim goes through the EDI process, the claim number will display on the “Claims → Submitted” tab under the “Claim Number” column (fourth column from the left)
  - If the web claim was accepted, use the claim number to track the status