

Provider Portal: Submitting and Reviewing a Claim

ARMedicaid

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Home

Home

Tuesday 08/02/2016 10:30 AM CST

Login

*User ID

[Log In](#)[Forgot User ID?](#)[Register Now](#)[Where do I enter my password?](#)

What can you do in the Provider Portal

Through this secure and easy to use internet portal, healthcare providers can submit claims and inquire on the status of their claims, inquire on a patient's eligibility, upload files containing 837 transactions, and search for another provider. In addition, healthcare providers can use this site to locate claim forms, provider participation materials and other health plan information and resources.

[FAQs](#)[Links and Tools](#)[Learn More About](#)

Protect Your Privacy!

Always log off and close all of your browser windows

Would you like to enroll as a Provider or a Trading Partner?

[Provider](#)[Trading Partner](#)

Looking for a Doctor or Hospital near you?

[Search Providers](#)

DHS-703 form

[Fill out Medical Eligibility Application](#)[Check Status of Medical Eligibility](#)[Help us provide better service to you! Click here to give us your feedback.](#)[Website Requirements](#)[Provider Manual](#)

1

1. Go to the portal landing page and log in with the **User ID** and **password** previously created. If you do not have a User ID and password, click **Register Now** or see the JOB+AID "Registering on the Portal."

If you have already logged in, skip to step 2.



2

Home **Eligibility** **Claims** Care Management Provider Functions Files Exchange Resources

Home Tuesday 01/11/2022 09:40 AM CST

Provider Name PCP PROVIDER Role IDs **Provider - In Network - 111111112 (NP)**

User Details

Welcome PCP Provider

- My Profile
- Manage Accounts

Provider

Name PCP PROVIDER

Provider ID 111111112 (NPI)

Revalidation Date 03/01/2022

- Characteristics

Provider Services

- Search Payment History
- MAPIR

Welcome Health Care Professional!



We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers.

[Help us provide better service to you! Click here to give us your feedback](#)

[Authenticare Demo - For Personal Care Providers required to participate in Electronic Visit Verification](#)

[Contact Us](#)

[Secure Correspondence](#)

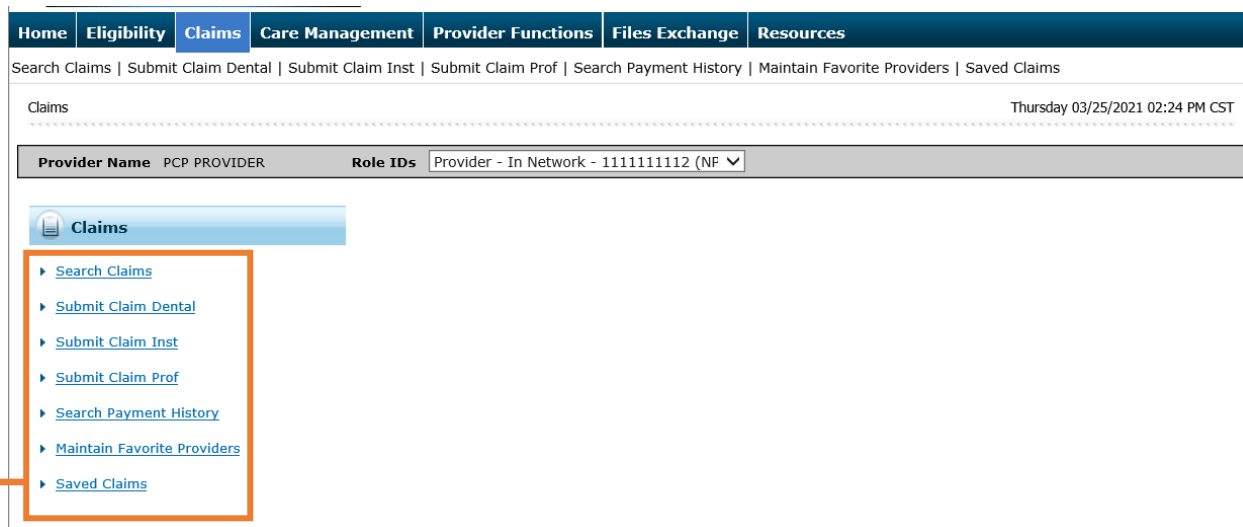
All Claim Inquiries should be submitted to the following Address:

Claims
Gainwell Technologies
PO BOX 8034
LITTLE ROCK, AR 72203

2. From the “Welcome Health Care Professional” Home page, select the Claims tab.



For more information call 1-800-457-4454



3. Select the type of claim form the data will be entered for: **Submit Claim Dental**, **Submit Claim Inst** (Institutional) or **Submit Claim Prof** (Professional).

You can also click **Search Claims** to search through claims you have previously submitted, or **Search Payment History** to search through your submitted claims that have already been paid.

NOTE: To find a claim that was previously entered, use the ICN or use the Member ID and DOS options.

Maintain Favorite Providers: The providers on this list will be available for selection as the Facility or Servicing provider when you are creating a claim. Up to 20 providers can be stored on your favorites list.

Save Claims: This function allows you to save a claim for later and resume where you left off. The claim will be saved for 90 days.

4a

Submit Professional Claim: Step 1 ?

The * (in red) indicates required fields when the ADD button is selected.

Claim Type v

Provider Information

Billing Provider ID v 	ID Type 	Name 	
Taxonomy 			
Select from Favorites v 			
Performing Provider ID 🔍	ID Type 	Name 	Add to Favorites <input type="checkbox"/>
Taxonomy 			
Select from Favorites v 			
Referring Provider ID 🔍	ID Type 	Name 	Add to Favorites <input type="checkbox"/>
Taxonomy 			
Select from Favorites v 			
Supervising Provider ID 🔍	ID Type 	Name 	Add to Favorites <input type="checkbox"/>
Taxonomy 			
Service Facility Location ID 🔍	ID Type 	Name 	
Taxonomy 			

4a. • After selecting your claim type, enter the following information for **Step 1** as shown on the **Submit a Claim** screen. *Please note that all three claim options will lead to the following screens: for the purpose of this job aid, we will walk through a professional claim, which is the most common type of claim:*

- **Provider Information** (enter at least one of the following):
Performing Provider ID and ID Type, Referring Provider ID and ID Type, Supervising Provider ID and ID Type, Service Facility Location ID and ID Type



NOTE: Performing providers (also known as Rendering providers) must enter their PIN or NPI number in the **Performing Provider ID** field.

Submit Professional Claim: Step 1

* Indicates a required field.

Claim Type: Professional

Provider Information

Billing Provider ID [] ID Type [] Taxonomy []

Performing Provider ID [] ID Type [] Taxonomy []

Referring Provider ID [] ID Type [] Taxonomy []

Supervising Provider ID [] ID Type [] Taxonomy []

Service Facility Location ID [] ID Type [] Name [] Taxonomy []

If there are multiple nine-digit provider IDs associated with the NPI, click the **magnifying glass** to select the correct one.

Provider ID Search

Search By ID | Search By Name | Search By Organization

The * (in red) indicates required fields when the ADD button is selected.

*Provider ID [] Provider ID Type []

Search Cancel

Search Results:

Provider ID	Provider Name	Provider Type	City	State	Zip Code
[] (NPI) (01/01/2017 - 12/31/2299) [] (Atypical/Medicaid ID) (01/01/2017 - 12/31/2299)	[]	Physician MD	[]	AS	[]
[] (NPI) (04/01/2017 - 12/31/2299) [] (Atypical/Medicaid ID) (04/01/2017 - 12/31/2299)	[]	Skilled nursing facility	[]	LITTLE ROCK	ARKANSAS []
[] (NPI) (04/01/2017 - 12/31/2299) [] (Atypical/Medicaid ID) (04/01/2017 - 12/31/2299)	[]	Hospital	[]	LITTLE ROCK	ARKANSAS []

To select the Provider ID, click on the NPI number in the first column.



For more information call 1-800-457-4454

4b

Beneficiary Information

*Beneficiary ID

*Last Name First Name

*Birth Date

Claim Information

Date Type Date of Current

Accident Related Admission Date

Patient Number Authorization Number

Therapy Code

EPSDT Condition Code

Local Education Agency

*Does the provider have a signature on file? Yes No

*Does the provider accept assignment for claim processing? Yes No Clinical Lab Services Only

*Are benefits assigned to the provider by the patient or their authorized representative? Yes No N/A

*Does the provider have a signed statement from the patient releasing their medical information? Yes No

Include Other Insurance

Total Charged Amount \$0.00

[Continue](#) [Finish Later](#) [Cancel](#)

4b. • Beneficiary Information: Beneficiary ID, Last Name, First Name, Birth Date

• **Claim Information** (enter all applicable information available): **Date Type, Date of Current, Accident Related, Admission Date, Patient Number, Authorization Number**, four “yes/no” questions

*Note: If the beneficiary has other insurance, check this box before clicking **Continue**. If there is no other insurance to enter, click **Continue** to complete this step.*

Fields marked with a red asterisk are required.



If you choose the "Include Other Insurance" option and select "Continue" on Step 1, it will bring you to the bottom of Step 2 in which it shows the panel for "Other Insurance Details."

If not applicable, proceed to Step #5.

Other Insurance Details

Click the **Remove** link to remove the entire row.

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Policy ID	Paid Amount	Paid Date	Action
1	SOUTHWIRE AND AFFILIATES	CI1	321654		-	Remove

Click to add a new other insurance.

[Back to Step 1](#) [Continue](#) [Finish Later](#) [Cancel](#)

Click on the number next to the correct primary payor to enter all of the other insurance information. If you do not see the correct carrier listed, simply click the + to add the appropriate carrier and other insurance details.

Other Insurance Details

Click the **Remove** link to remove the entire row.

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Policy ID	Paid Amount	Paid Date	Action
1	SOUTHWIRE AND AFFILIATES	CI1	321654		-	Remove

Carrier Name SOUTHWIRE AND AFFILIATES **Carrier ID** CI1

Policy Holder is Person

Policy Holder Last Name PUFF **First Name** PATTI **MI** -

Policy Holder Address 1234 MAIN STREET

City LITTLE ROCK **State** ARKANSAS

Zip Code 72255

Policy Holder ID

Policy ID 321654

Group Name

Responsibility U-Unknown **Patient Relationship to Insured** 18-Self

Paid Amount ***Paid Date**

***Claim Filing Indicator**

Release of Information

Assignment of Benefits

[Save Insurance](#) [Cancel Insurance](#)

Once the information has been entered and all questions have been answered, select **Save Insurance**.



For more information call 1-800-457-4454

Submit Professional Claim: Step 2

The * (in red) indicates required fields when the ADD button is selected.

Claim Type Professional

Provider Information

Billing Provider ID 1111111112	ID Type NPI	Name UNIVERSITY HOSPITAL
Taxonomy HOSPITALIST		

Patient and Claim Information

Beneficiary ID 4563217101	Gender Female
Beneficiary PATTI PUFF	Total Charged Amount \$0.00
Birth Date 07/15/1963	

[Expand All](#) | [Collapse All](#)

Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Instructions:
If values are required for submission, please fill in the required fields. Otherwise you may leave the field blank and proceed. These fields are required when the ADD button is selected.
Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	Action
1	*Diagnosis Type <input type="text" value="ICD-10-CM"/>	*Diagnosis Code <input type="text"/>	

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5. Continue filling out claim information for **Step 2** as shown on the **Submit a Claim** screen (information at the top of the screen will auto-populate based on what you entered in Step 1):

- **Diagnosis Codes:** Select **Diagnosis Type** (required) and enter a **Diagnosis Code** (required).
- Once the Diagnosis fields have been populated, click **Add**. Click **Reset** to remove diagnosis codes and start over.

Submit Professional Claim: Step 2 ?

The * (in red) indicates required fields when the ADD button is selected.

Claim Type Professional

Provider Information

Billing Provider ID **ID Type** NPI **Name**
Taxonomy

Patient and Claim Information

Beneficiary ID **Gender** Female
Beneficiary **Total Charged Amount** \$0.00
Birth Date

[Expand All](#) | [Collapse All](#)

Diagnosis Codes -

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Instructions:
 If values are required for submission, please fill in the required fields. Otherwise you may leave the field blank and proceed. These fields are required when the ADD button is selected.
 Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

#	Diagnosis Type	Diagnosis Code	Action
1	*Diagnosis Type <input type="text" value="ICD-10-CM"/>	*Diagnosis Code <input type="text"/>	Remove

Other Insurance Details -

Click the **Remove** link to remove the entire row.

[Refresh Other Insurance](#)

#	Carrier Name	Carrier ID	Policy ID	Paid Amount	Paid Date	Action
1	SOUTHWIRE AND AFFILIATES	CI1	321654		-	Remove

Click to add a new other insurance.

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- Click **Continue** to advance to Step 3. Click **Finish Later** if you want to save your claim. Click **Cancel** to cancel the claim or **Back to Step 1** to return to the first step.


 For more information call **1-800-457-4454**

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Diagnosis Codes

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.
Instructions:
 If values are required for submission, please fill in the required fields. Otherwise you may leave the field blank and proceed. These fields are required when the ADD button is selected.

Svc #	From Date	To Date	Place Of Service	Procedure Code	Charge Amount	Units	Action
1							

1 *From Date [] To Date [] *Place Of Service [] EMG []

*Procedure Code [] Modifiers [] *Diagnosis Pointers [] [] []

*Charge Amount [] *Units [] *Unit Type [] EPSDT [] Family Plan []

Clia Number []

Performing Provider ID [] ID Type [] Taxonomy [] State License # []

Referring Provider ID [] ID Type [] Taxonomy []

Ordering Provider ID [] ID Type [] Taxonomy []

Supervising Provider ID [] ID Type [] Taxonomy []

Fund Code []

NDCs for Svc. # 1

[Add] [Reset]

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to add attachment.					

[Back to Step 1] [Back to Step 2] [Submit] [Finish Later] [Cancel]

[Go to Top](#)

7. Continue filling out claim information for **Step 3** as shown on the **Submit a Claim** screen (information at the top of the screen will auto-populate based on what you entered in steps 1 and 2). NOTE: Not all fields are required; complete only those that are applicable:

- **Service Details:** Use this screen to add, edit, or remove services rendered to the beneficiary. To edit information previously entered, click on the numbered link appearing in the **Svc #** column. To remove information previously entered, click **Remove** in the action column.

To add a detail, click **Add** and populate any data that applies for the following fields: **From Date; To Date; Place of Service; EMG (Emergency); Procedure Code; Modifiers; Diagnosis Pointers; Charge Amount; Units, Unit Type; EPSDT or Family Plan; CLIA Number; Rendering Provider ID, ID Type and State License #; Referring Provider ID “Ordering Provider ID” and ID Type.**

Please Note: The Ordering Provider field should only be completed when the following services have been delivered: Audiology, Hearing, Laboratory, Radiology, or Therapy (OT PT, Speech).

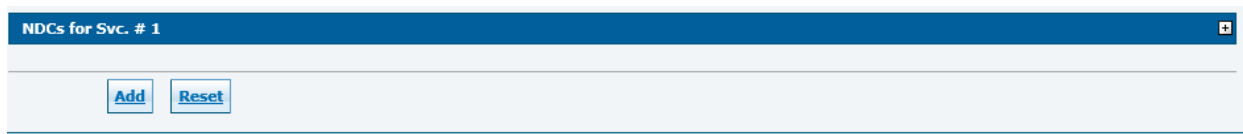


For more information call 1-800-457-4454

The following Provider Types and Specialties are excluded from this requirement:

- Physician MD(Group)/ INDIAN HEALTH SVCS HOSP OR TRIBAL 638 HEALTH FAC;
- Physician MD(Group)/INDIAN HEALTH SVS-TRIBAL 638 HEALTHFAC-OUTPAT;
- Dental Group/INDIAN HEALTH SVCS HOSP OR TRIBAL 638 HEALTH FAC;
- Dental Group/INDIAN HEALTH SVS-TRIBAL 638 HEALTHFAC-OUTPAT.

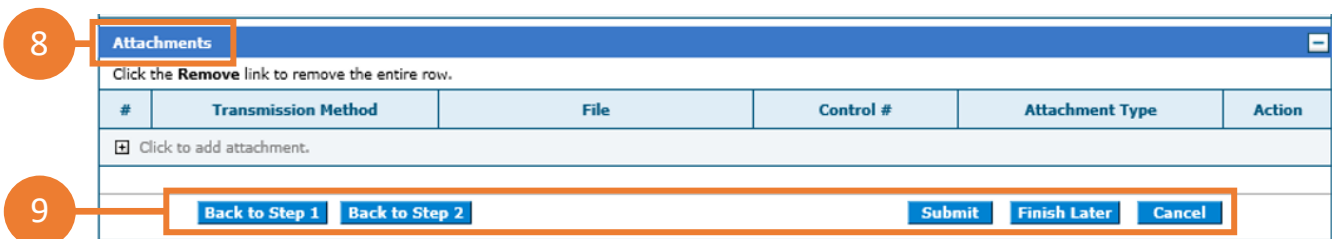
To remove data populated for a detail, but not yet added, click **Reset**.



NDCs for Svc. # 1

Add Reset

- **NDCs for Svc.** -NDC for service panel should be used only when an injection and/or drug that requires a NDC number to be entered. You will need to click on the + sign to the right to expand the panel.



8 Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to add attachment.					

9 Back to Step 1 Back to Step 2 Submit Finish Later Cancel

8. **Attachments:** Click the + to upload any attachments/documents that apply to the claim. Skip this step if there are no attachments.
9. Click **Submit** to move to the next step of the claim submission process. Click **Back to Step 1** or **Back to Step 2** to revisit previous steps. Click **Finish Later** if you want to save your claim. Click **Cancel** to cancel the claim submission process.



Confirm Professional Claim

Select Print Preview before you Confirm if you want to assure you view the claim as you entered it. After confirmation, Print Preview may reflect changes as the claim has been saved on the payer system.

Claim Type: Professional

Provider Information

Billing Provider ID [redacted] ID Type: NPI Name [redacted]
 Taxonomy [redacted]
 Performing Provider ID [redacted] ID Type [redacted] Name [redacted]
 Taxonomy [redacted]
 Referring Provider ID [redacted] ID Type [redacted] Name [redacted]
 Taxonomy [redacted]
 Supervising Provider ID [redacted] ID Type [redacted] Name [redacted]
 Taxonomy [redacted]
 Service Facility Location ID [redacted] ID Type [redacted] Name [redacted]
 Taxonomy [redacted]

Beneficiary Information

Beneficiary ID [redacted] Gender: Female
 Beneficiary [redacted]
 Birth Date [redacted]

Claim Information

Date Type [redacted] Date of Current [redacted]
 Accident Related [redacted] Admission Date [redacted]
 Patient Number [redacted] Authorization Number [redacted]
 Transport Certification: No
 Does the provider have a signature on file? Yes
 Does the provider accept assignment for claim processing? Yes
 Are benefits assigned to the provider by the patient or their authorized representative? Yes
 Does the provider have a signed statement from the patient releasing their medical information? Yes
 Total Charged Amount: \$200.00

[Expand All](#) | [Collapse All](#)

Diagnosis Codes

Service Details

#	From Date	To Date	Place Of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Family Plan	Charge Amount
1	08/02/2016	08/02/2016	11		99203		1	1.000 Unit	<input type="checkbox"/>	<input type="checkbox"/>	\$200.00

No Other Insurance Details exist for this claim
 No Attachments exist for this claim

10 [Back to Step 1](#) [Back to Step 2](#) [Back to Step 3](#) [Print Preview](#) [Confirm](#) [Cancel](#)

10. Review the information that has been keyed/submitted. Click **Back to Step 1**, **Back to Step 2** or **Back to Step 3** to correct or add any additional information. Click **Print Preview** to preview the claim details entered. Click **Confirm** to submit your claim. Click **Cancel** to cancel the claim submission process.



For more information call 1-800-457-4454

Submit Professional Claim: Confirmation

Professional Claim Receipt

Your Professional Claim was successfully submitted. The claim status is Deny.

The Claim ID: [redacted]

Click **Print Preview** to view the claim details as they have been saved on the payer's system.

Click **Copy** to copy member or claim data.

Click **Edit** to resubmit the claim.

Click **New** to submit a new claim.

Click **View** to view the details of the submitted claim.

Print Preview **Copy** **Edit** **New** **View**

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11. Once a claim is confirmed/submitted, the system will provide a claim receipt along with a 13-digit Claim ID.

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12. Click **Print Preview** to preview the claim details entered. Click **Copy** to copy claim. Click **Edit** to edit denied claim. Click **New** to submit a new claim. Click **View** to view the details of your submitted claim.