Provider Portal: Submitting and Reviewing a Claim

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. From the "Welcome Health Care Professional" **Home** page, select the **Claims** tab.

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

Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Search Payment History | Maintain Favorite Providers | Saved Claims

Claims   Thursday 03/25/2021 02:24 PM CST

Provider Name PCP PROVIDER   **Role IDs** Provider - In Network - 1111111112 (NP ▼)

Claims

3 ▸ Search Claims
   ▸ Submit Claim Dental
   ▸ Submit Claim Inst
   ▸ Submit Claim Prof
   ▸ Search Payment History
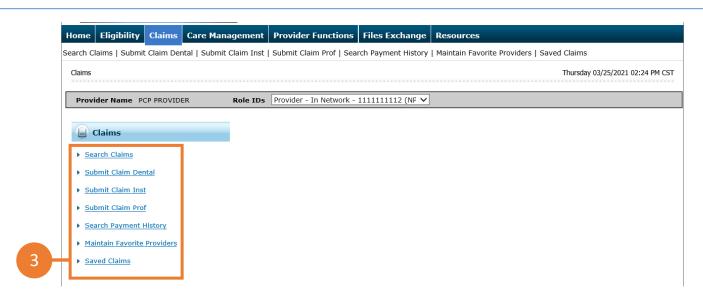   ▸ Maintain Favorite Providers
   ▸ Saved Claims

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.
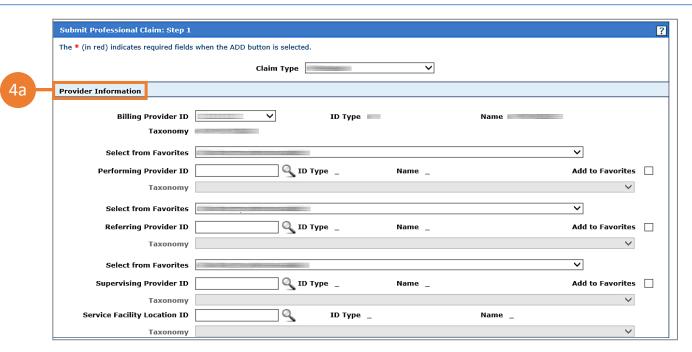
Submit Professional Claim: Step 1

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

Claim Type [_____ ▼]

4a

Provider Information

Billing Provider ID	[_____ ▼]	ID Type ▢	Name ▢	
Taxonomy	▢			
Select from Favorites	[_____ ▼]			
Performing Provider ID	[_____] 🔍	ID Type _	Name _	Add to Favorites ☐
Taxonomy	[_____ ▼]			
Select from Favorites	[_____ ▼]			
Referring Provider ID	[_____] 🔍	ID Type _	Name _	Add to Favorites ☐
Taxonomy	[_____ ▼]			
Select from Favorites	[_____ ▼]			
Supervising Provider ID	[_____] 🔍	ID Type _	Name _	Add to Favorites ☐
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**
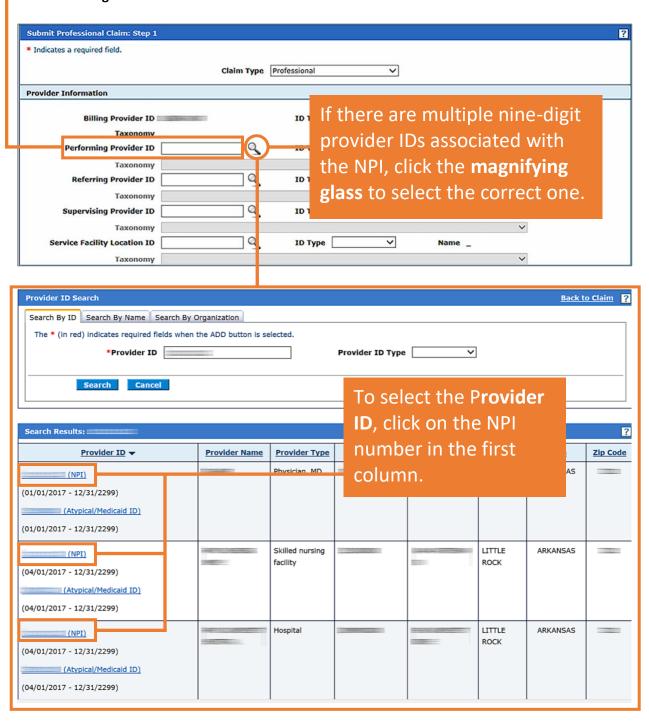
NOTE: Performing providers *(also known as Rendering providers)* must enter their PIN or NPI number in the **Performing Provider ID** field.

Submit Professional Claim: Step 1

* Indicates a required field.

Claim Type [Professional ▾]

Provider Information

Billing Provider ID		ID T
Taxonomy		
Performing Provider ID		ID T
Taxonomy		
Referring Provider ID		ID T
Taxonomy		
Supervising Provider ID		ID T
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   **Back to Claim**

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				Zip Code
_____ (NPI)	_____	Physician, MD			AS	_____
(01/01/2017 - 12/31/2299)						
_____ (Atypical/Medicaid ID)						
(01/01/2017 - 12/31/2299)						
_____ (NPI)	_____	Skilled nursing facility	_____	_____	LITTLE ROCK	ARKANSAS	_____
(04/01/2017 - 12/31/2299)						
_____ (Atypical/Medicaid ID)						
(04/01/2017 - 12/31/2299)						
_____ (NPI)	_____	Hospital	_____	_____	LITTLE ROCK	ARKANSAS	_____
(04/01/2017 - 12/31/2299)						
_____ (Atypical/Medicaid ID)						
(04/01/2017 - 12/31/2299)						

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

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.

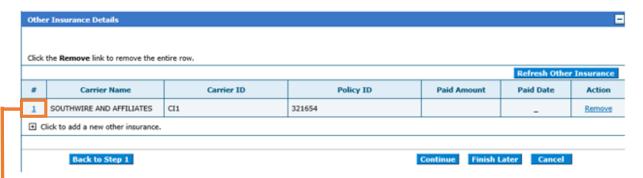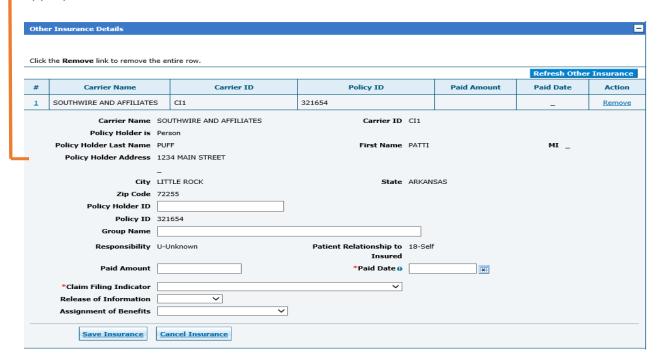*Fields marked with a red asterisk are required.*

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**.

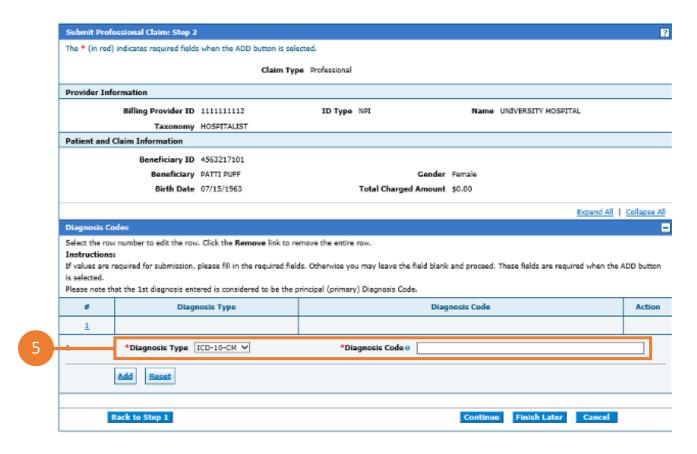| Submit Professional Claim: Step 2		?

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

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			

(5) *Diagnosis Type ICD-10-CM ⌄   *Diagnosis Code 🛈 [_____]

[Add] [Reset]

[Back to Step 1]   [Continue] [Finish Later] [Cancel]

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	
Beneficiary	Gender Female
Birth Date	Total Charged Amount $0.00

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			

1   *Diagnosis Type [ICD-10-CM ⌄]   *Diagnosis Code❶ [_____]

[Add] [Reset]

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.

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

6. 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.

Submit Professional Claim: Step 3

* Indicates a required field.

Claim Type Professional

Provider Information

Billing Provider ID ▒▒▒▒▒ ID Type NPI Name ▒▒▒▒▒
Taxonomy _

Patient and Claim Information

Beneficiary ID ▒▒▒▒▒
Beneficiary ▒▒▒▒▒ Gender Female
Birth Date ▒▒▒▒▒ Total Charged Amount $2.00

Expand All | Collapse All

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	08/10/2016	08/10/2016	12	99203-OFFICE OR OTHER OUTPATIENT VISIT FOR THE	$2.00	1.000 Unit	Remove
2							

2 *From Date 🛈 [   ] To Date 🛈 [   ] *Place Of Service [   ] EMG [ ]

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

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

Clia Number [   ]

Rendering Provider ID [   ] 🔍 ID Type [ ] Taxonomy [   ] State License # [   ]

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

NDCs for Svc. # 2

[Add] [Reset]

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** and **ID Type**.

  To remove data populated for a detail, but not yet added, click **Reset**.
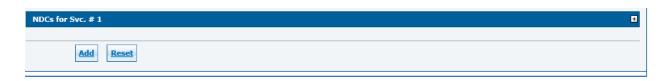
NDCs for Svc. # 1 ⊞

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 ▭	ID Type NPI	Name ▭
Taxonomy _		
Performing Provider ID _	ID Type _	Name _
Taxonomy _		
Referring Provider ID _	ID Type _	Name _
Taxonomy _		
Supervising Provider ID _	ID Type _	Name _
Taxonomy _		
Service Facility Location ID _	ID Type _	Name _
Taxonomy _		

Beneficiary Information

Beneficiary ID ▭	Gender Female
Beneficiary ▭	
Birth Date ▭	

Claim Information

Date Type _	Date of Current _
Accident Related _	Admission Date _
Patient Number _	Authorization Number _
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	☐	☐	$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.

Submit Professional Claim: Confirmation

Professional Claim Receipt

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

11 The Claim ID is

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.

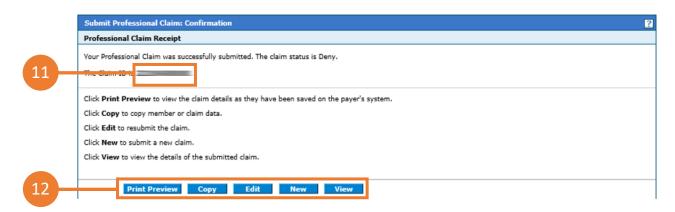**12** [Print Preview] [Copy] [Edit] [New] [View]

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

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.