PROVIDER PORTAL USER GUIDE

CHORUS
COMMUNITY HEALTH PLANS

Chorus Community Health Plans Provider Portal

The secure Chorus Community Health Plans Provider Portal allows users 24/7 access to resources and self-service applications to simplify everyday tasks, promote efficiencies in business, and streamline electronic transactions.

This Chorus Community Health Plans Provider Portal User Guide details how to use the self-service applications available in the Portal once a Provider Portal account is created. If an account has not been established, refer to the Chorus Community Health Plans Provider Portal Registration Guide for the registration process to create individual and organization Provider Portal accounts.

Google Chrome is recommended for optimum performance when using the Provider Portal.

Access the Chorus Community Health Plans Provider Claims Portal directly:
https://providerauth.cchpservices.com/

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CHORUS COMMUNITY HEALTH PLANS

A. Home Page

The Chorus Community Health Plans Provider Portal Home Page offers users access to:

- Self-service claims and authorization applications
- Secure Notifications
- Change Provider ID

Whenever present, clicking the CCHP logo located at the top of the page will return users to the Provider Portal Home Page.

Applications

Each user will only have access to the application(s) assigned to them by the Site Administrator for their organization. Available applications will be displayed on the Home Page, and can be updated by the Site Administrator at any time. The Provider Admin application is reserved for Site Administrators only.

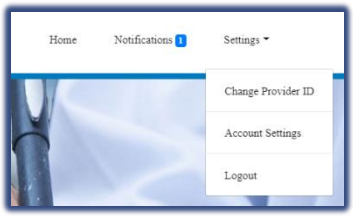
Notifications

The Notifications page stores all notifications that are delivered through the Provider Portal, including:

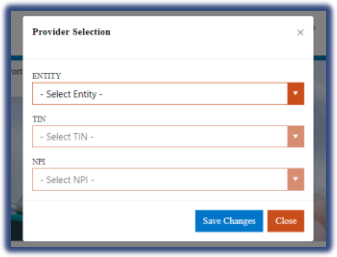
- Flash Messages
- Account Profile Updates
- New User Registration
- Claim Appeal Receipt Notice
- Claim Appeal Decision Notice

Change Provider ID

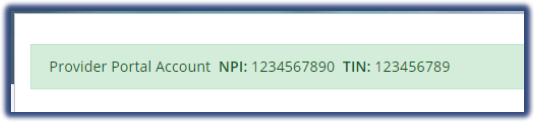
Users who have access to multiple Organization accounts can change their access without logging out. This can be done by selecting the Settings dropdown at the top, and click **Change Provider ID**.



The Organization Details box will appear. Select the Entity you would like to work under from the **Entity** dropdown. Then select the applicable Tax Identification Number (TIN) and National Provider Identifier (NPI) from the dropdowns and click **Save Changes**. Users will only be able to select a TIN and NPI that is registered under the Entity that is first selected, and will only have access to information available on that account.



The selected Organization information will appear in the green panel above the application tiles.



B. Eligibility

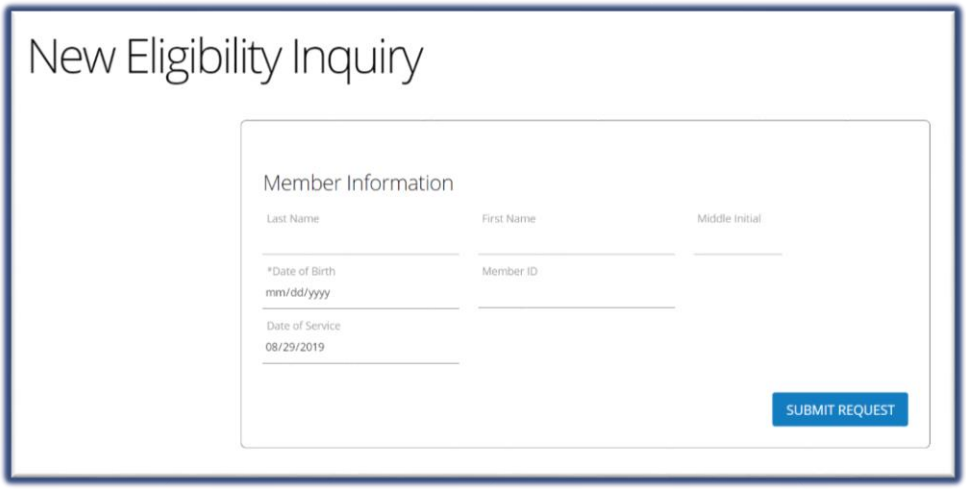
This application provides human readable real-time EDI 270/271 transactions. The information includes detail regarding Dean Health Plan eligibility and benefit plan coverage, co-payments, and deductibles. It also provides the member's primary health insurance carriers name, if applicable.

a. Access Eligibility

After logging into the Provider Portal select the **Eligibility** application located on Home Page.

b. Submit Real-Time 270 Eligibility Transaction

Users are taken to the **New Eligibility Inquiry** page



In order to successfully submit a 270 Eligibility Inquiry, the following fields must be filled:

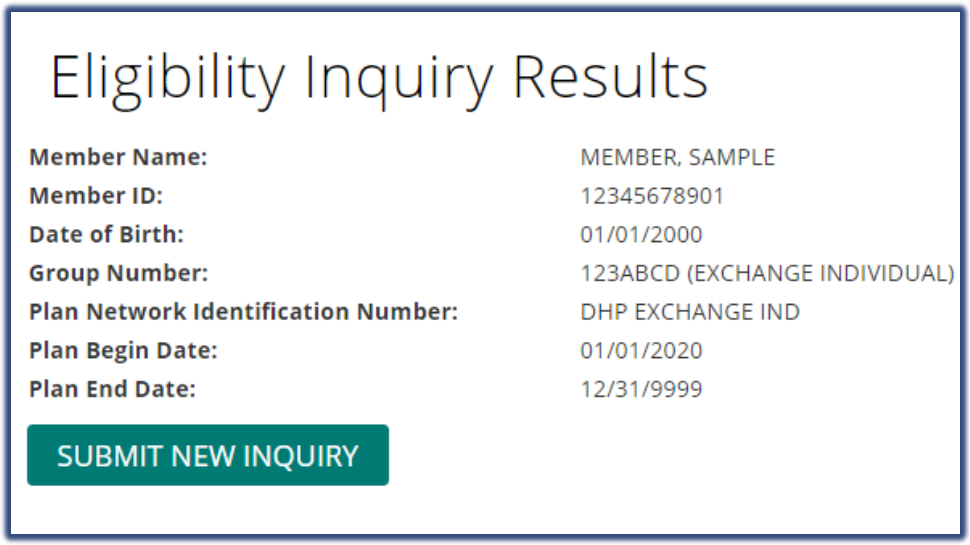
- Date of Service (this will be pre-populated with the current date)
- Member's Date of Birth
- Either the member's First and Last Name or the Member ID

The Date of service will default to the current date. Maximum eligibility lookup is 12 months.

Tip

Eligibility Inquiries can be submitted by searching by the member DOB and either their full name of their member ID.

c. Eligibility Inquiry Response



The member's policy information will appear in the top, left portion of the screen. Verify that the correct member is showing on the screen.

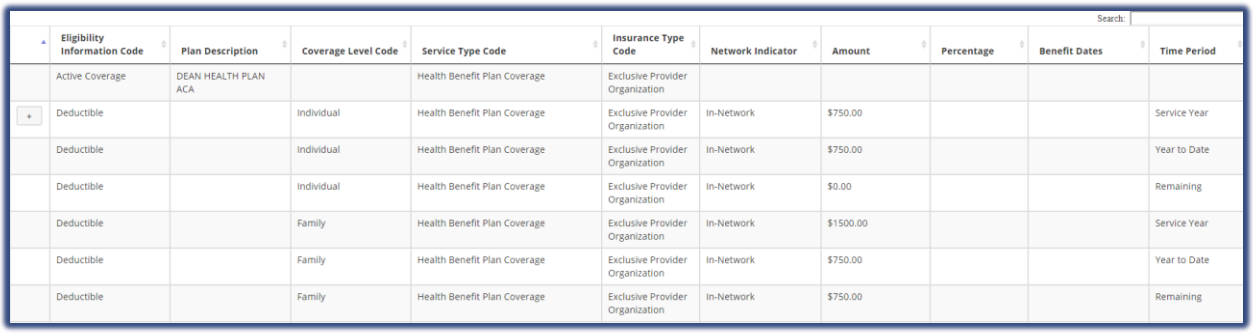
Other Primary Policy

Other health insurance (Primary) information will be returned:

- If the health insurance is listed as the primary payer
- As the subscriber level (Loop 2120C)
- If the other health insurance is effective at the requested Plan Date in the 270 eligibility request (DTP*291), and will only return the Organization Name (NM103)

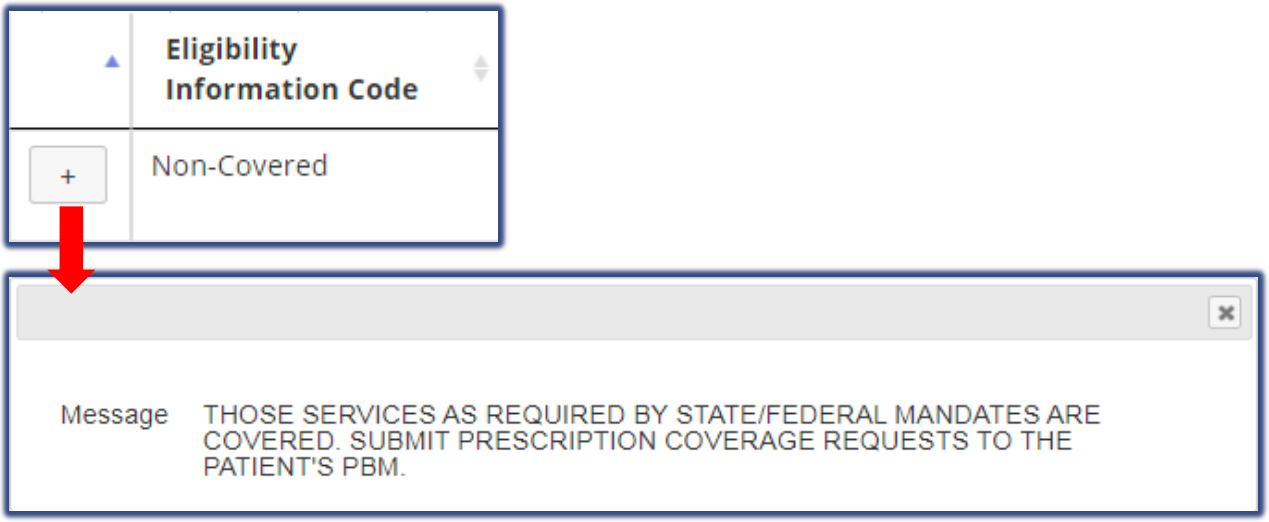
Coverage

The table will display member benefit information for the policy year that was searched.
Each column can be filtered alphabetically or numerically by selecting the arrows in the top row of each column.
There is a **Search** field located in the upper right corner of the page next to the table. Enter a keyword or dollar value into this field to filter results to only show fields that contain those keywords or values.



Eligibility Information Code	Plan Description	Coverage Level Code	Service Type Code	Insurance Type Code	Network Indicator	Amount	Percentage	Benefit Dates	Time Period
Active Coverage	DEAN HEALTH PLAN ACA		Health Benefit Plan Coverage	Exclusive Provider Organization					
Deductible		Individual	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	$750.00			Service Year
Deductible		Individual	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	$750.00			Year to Date
Deductible		Individual	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	$0.00			Remaining
Deductible		Family	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	$1500.00			Service Year
Deductible		Family	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	$750.00			Year to Date
Deductible		Family	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	$750.00			Remaining

Additional details may apply to specific benefits. These details are denoted by a box with a “+” in the left column of the table. Please select this box to review additional details that apply to this benefit.



Once benefits have been verified, users can submit a new inquiry by selecting the **Submit New Inquiry** under the member policy informationClick the Dean Health Plan banner at the top of the screen to return to the Home Page, or close the tab to exit entirely.

C. Claim Status

The Claim Status application provides human readable real time EDI (Electronic Data Interchange) 276/277 Claim Status Request and Response transactions that enables users to check the status of their submitted claims.

After logging into the Provider Portal click the **Claim Status** application located on Home Page.

Tip

Maximum claim status lookup is 12 months.

Users will be taken to the **New Claim Status Inquiry** page.

a. Submit Real-Time 276 Claim Status Transaction

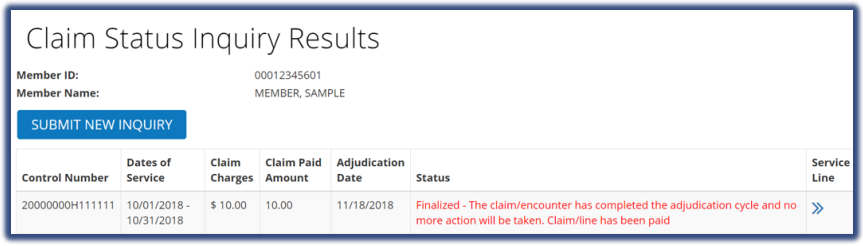
Select the Billing ID (NPI) from the Provider Billing ID dropdown. This should be the billing NPI that the claim(s) was submitted under. Enter information into all required fields denoted by (*):

- Member Last Name
- Member First Name
- Date of Birth
- Member ID
- Date of Service Start Date (If the start date is the not the exact date of service, the end date must also be entered.)

Once all required fields and desired optional fields have been filled, click **Submit Request**.

b. 277 Claim Status Response

All claims that meet the search criteria will be returned in the results.



The claim header will show:

- Chorus Community Health Plans claim number
- Dates of Service
- Claim Charges
- Claim Paid Amount
- Adjudication Date
- Status (Pending or Finalized)

Tip

For additional details relating to each service line, click the double arrow to the right of the record under **Service Line**. This will display each service line individually.

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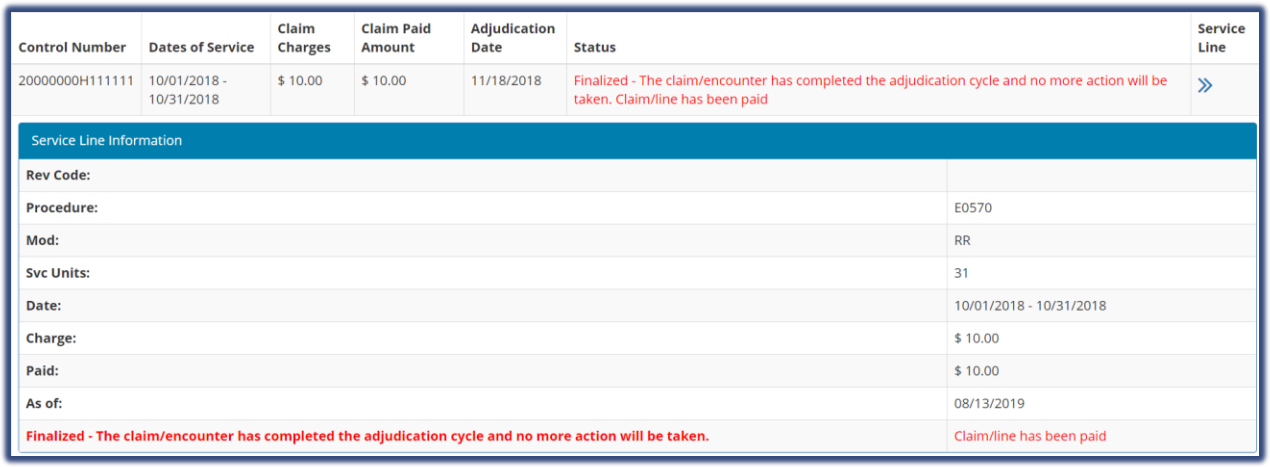


The Service Line Information will display the following information:

- Revenue Code
- Service Units
- Modifier (if applicable)
- Date of Service
- Billed Charges
- Paid Amount
- Final Review Date
- Status

Click **Submit New Inquiry** to review additional claims, or select the Dean Health Plan banner to return to the Home Page.

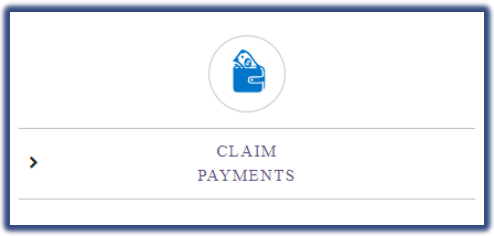
D. Claim Payments

The Claim Payments application provides access to claim payment information online and allows Dean Health Plan to deliver Electronic Remittance Advice (ERAs) or "remits" to providers online rather than mailing these documents. ERAs are statements from Chorus Community Health Plans documenting payments of claims.

> **Tip**
>
> It is recommended that date and patient information both be entered to return the most accurate search results.

a. Access Claim Payments

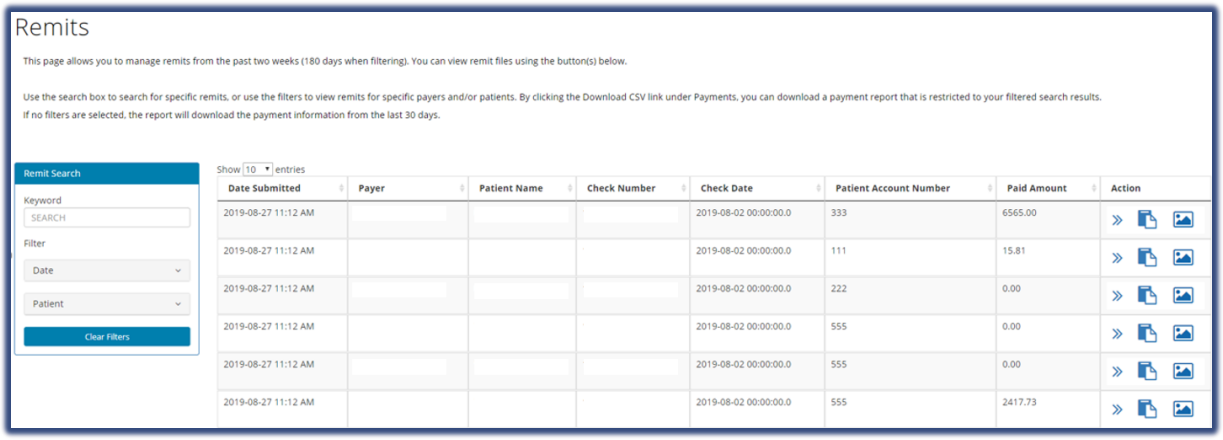
After logging into the Provider Portal select the **Claim Payments** application located on Home Page.



> **Tip**
>
> Remits from the past 180 days can be reviewed.

Remits

Use the **Remit Search** on the left side to filter for specific claim payments. If no search filters are selected, the report will default to payment information from the last 30 days.



Search Options:

- **Date** – select the check date (if known) by entering a specific date or date range
- **Patient** – enter member ID to name to search for a claim for a specific member's remits
- **Keyword** – enter Information related to a claim. Can include claim number, check number, servicing provider NPI1, servicing provider name, etc.

Claim results will display as search criteria is entered. Continue entering search criteria until desired results are achieved.

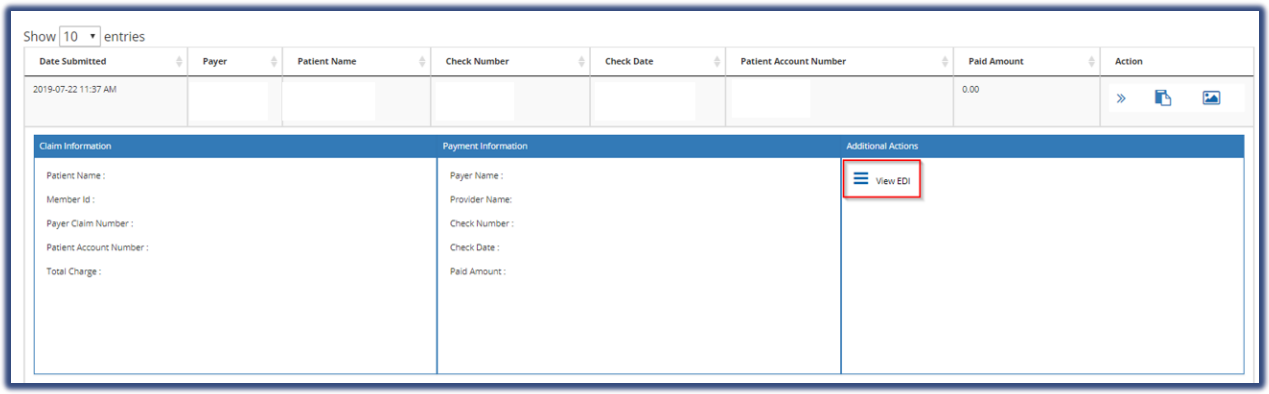
General claim information is available on this screen, but additional details are available through the **Action** items on the far right column of each record. Available **Actions** include:

- Show details
- Add notes
- View Image

Show Details

Select the double-arrow **Action** to expand the header line to view additional payment details including:

- Provider Information
- Payment Information
- EDI transactions



Add Notes

Select the clipboard and paper icon to enter payment specific notes that are viewable for all users with access to the same account.

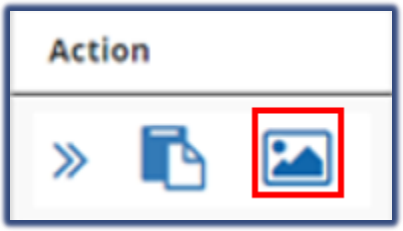
EOP

Tip

Once a note has been added to a payment, the note icon will turn green

Image

Select the picture icon to view the EOP. This is a sample only, and should not be used for business purposes.



E. Claim Appeals

Claims that have finished processing and are in a finalized status (paid/denied) can be appealed directly through the Provider Portal.

a. Access Claim Appeals

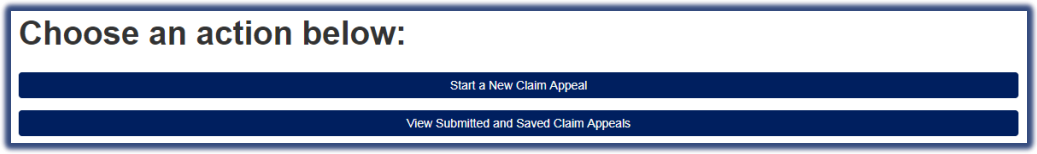
After logging into the Provider Portal select the **Claim Appeal** application

> **Tip**
>
> Corrected claims cannot be submitted via the Provider Portal.

The Claim Appeal feature has two options:

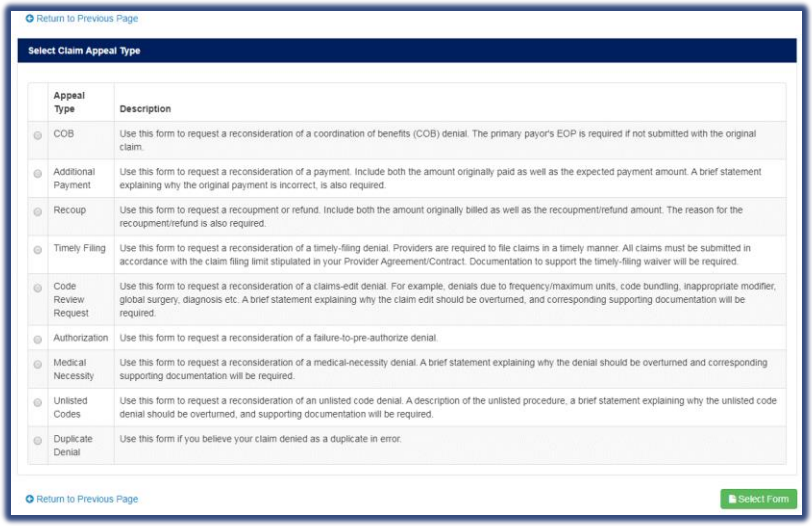
- **Start a New Claim Appeal** – allows the submission of a new Claim Appeal
- **View Submitted and Saved Claim Appeals** – allows the search for claim appeals that may have been started and saved or claim appeals that were submitted.

Note: Up to 500 submitted claim appeals within a six month period will be available to view.



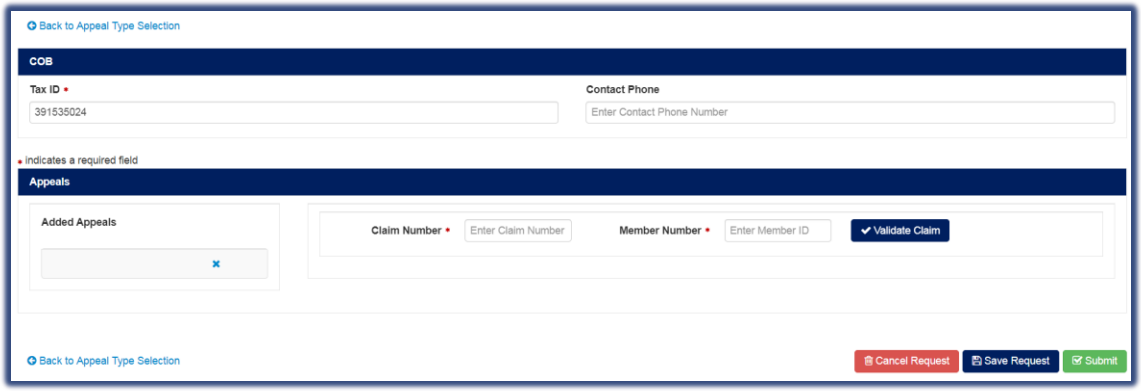
b. Start a New Claim Appeal

To start a new claim select the **Start a New Claim Appeal** action to prompt the **Select Claim Appeal Type** form to display. Select the radio button for the applicable claim appeal type and click **Select Form**.



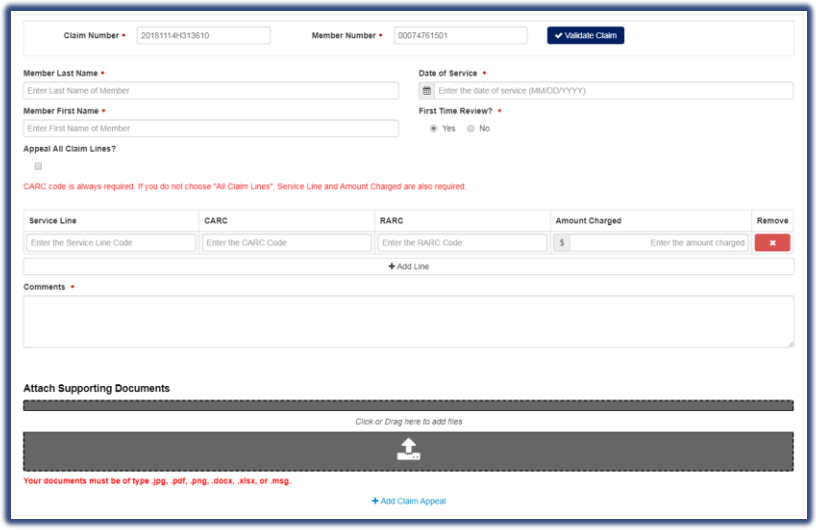
Validate Claim

After selecting the applicable Claim Appeal Type, a validation form will be prompted. Validate the claim by entering the Claim Number and Member Number and click **Validate Claim**. Once validated, additional appeal fields will populate.



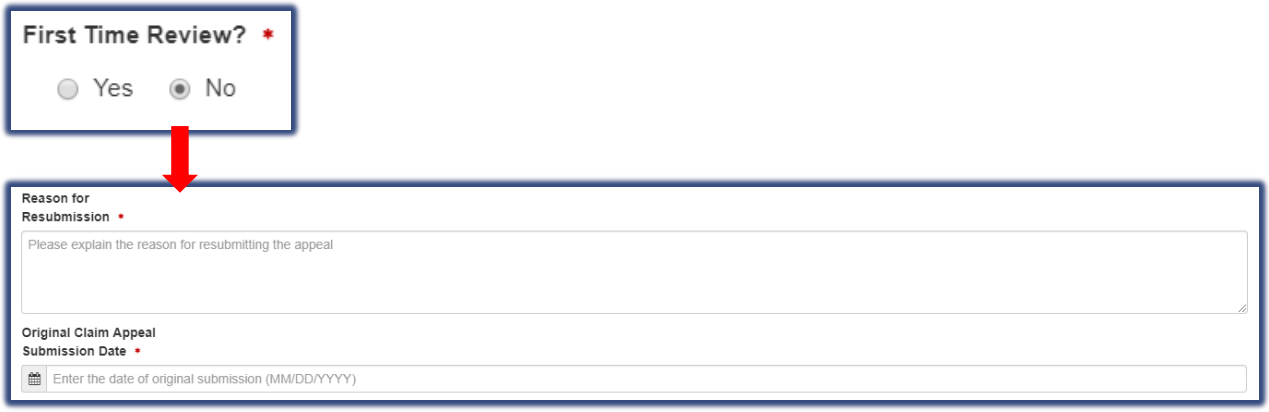
Although there is an option to Submit the appeal at the bottom of the page, claim appeals cannot be submitted until all required with a red asterisk "*" have been completed. Required Fields include:

- Member Name
- Date of Services
- First Time Review
- Selecting Claim Lines
- Comments
- Attach Supporting Documents



First Time Review

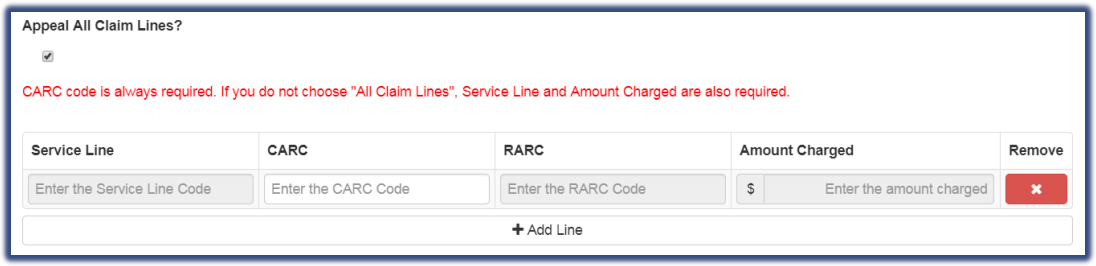
After entering the member name and date of services, select the appropriate radial button under First Time Review. If **No** is selected, you will be prompted to complete two additional fields – **Reason for Resubmission** and **Original Claim Appeal Submission Date**.



Appeal All Claim Lines

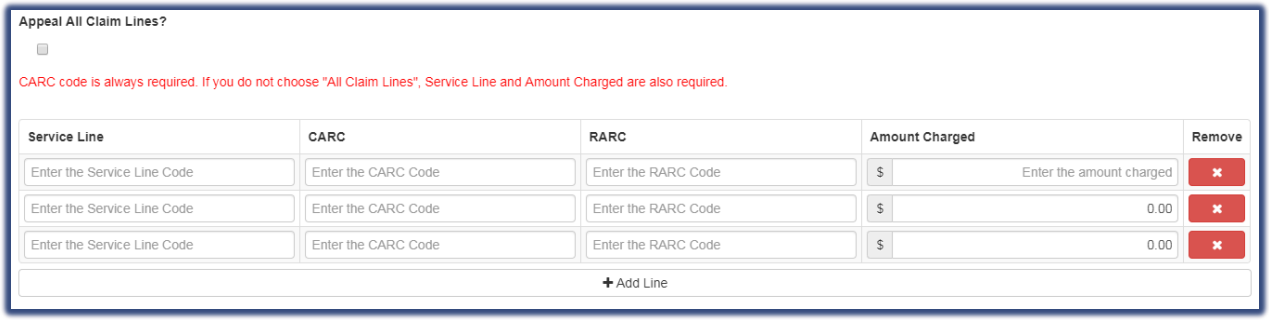
If the **Appeal All Claim Lines** box is selected, all data entry fields except for **CARC** (Claim Adjustment Reason Code) will be grayed out.

Note: Although there is not a red asterisk "*" by the **CARC** code data field, it is always required.



If you are not appealing all claim lines, all fields in the section must be completed.

Additional claim lines may be added by selecting (**+Add Line**) at the bottom of this section. These additional lines can also be removed by selecting the (x) box on the right.

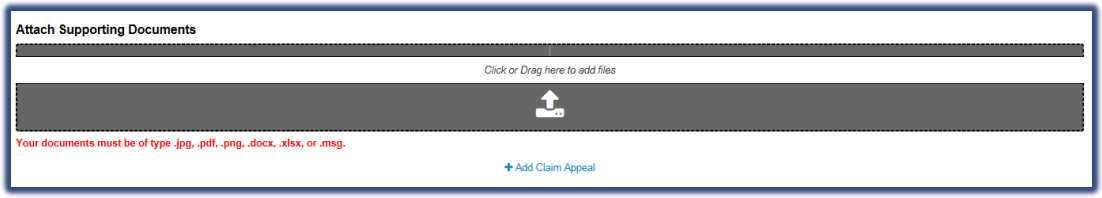


Comments

In the **Comments Field**, include a brief but detailed explanation as to why the claim is being appealed. The explanation should include information related to the appeal and should support why the original decision should be overturned. Be as detailed as necessary and include call reference numbers, if applicable.

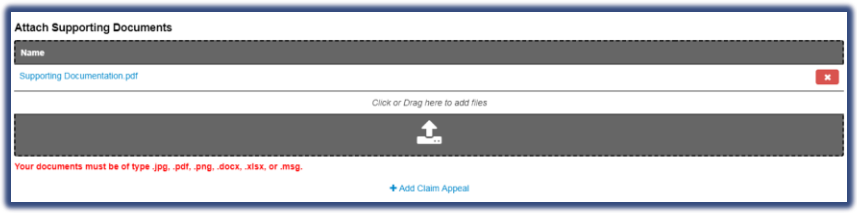
Attach Supporting Documents

- Attach only the documents that are applicable and will support the medical necessity. Required information must be legible and clearly marked. Do not use highlight markers as they do not always show up on scanned images.
- In adherence to the HIPAA Privacy Rule, only the minimum necessary documentation needed for review should be submitted. The member's entire record should not be submitted unless it can be specifically justified as needed for that purpose.
- Appropriate file types include .jpg, .pdf, .png, .docx, .xlsx, and .msg.



Drag and drop supporting documents directly into the appeal. The drop box will turn green when the documentation is in the appropriate location to be released.

Once the documents are attached, they will appear in the Attach Supporting Documents section. Attachments can be deleted by clicking the "X" in the red box.

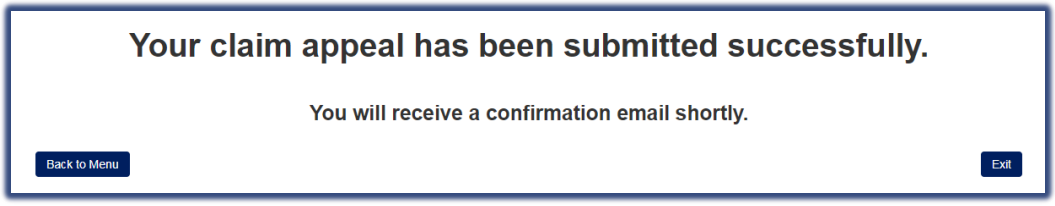


Add Claim Appeal

Multiple claim appeals can be added for the same claim type, such as COB, Timely Filing, Authorization, etc., by clicking the **+ Add Claim Appeal.** Clicking the **+ Add Claim Appeal** will prompt the process to start over with completing the validation and claim appeal form.

After completion of the Claim Appeal form, there are three options located at the bottom of the form:

- **Cancel Request** – Choosing this option will prompt the message, "Are you sure?" If you cancel the request, entered data will be lost. This will also remove the request if it was previously saved.
- **Save Request** – Choosing this option will prompt the message, "Appeal request has been saved."
- **Submit** – Choosing this option will prompt the message, "Your claim appeal has been submitted successfully."

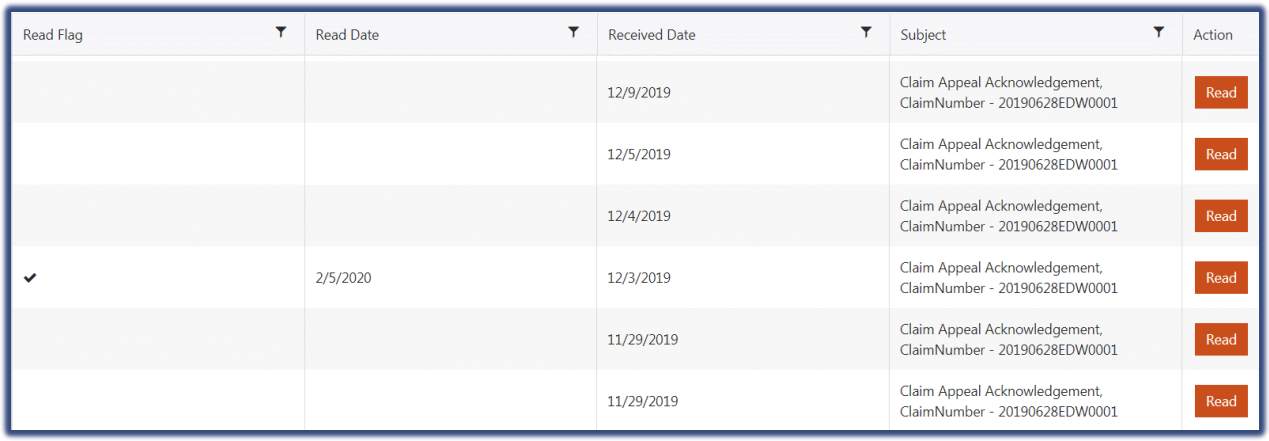


Once the appeal has been submitted, a Claim Appeal Acknowledgement will be sent through Notifications. Click **Notifications** on the Home Page to access this Acknowledgement.

Tip

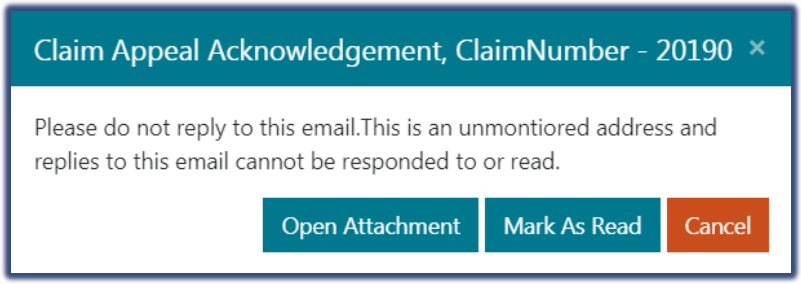
The number of unread Notifications are displayed in the Notifications field.

The most recent Notifications will be displayed at the top of the list and can be filtered by column. Look under the **Subject** column to find the **Claim Appeal Acknowledgement** with the applicable claim number identified and click **Read** to view the notification.



Read Flag	Read Date	Received Date	Subject	Action
		12/9/2019	Claim Appeal Acknowledgement, ClaimNumber - 20190628EDW0001	Read
		12/5/2019	Claim Appeal Acknowledgement, ClaimNumber - 20190628EDW0001	Read
		12/4/2019	Claim Appeal Acknowledgement, ClaimNumber - 20190628EDW0001	Read
✔	2/5/2020	12/3/2019	Claim Appeal Acknowledgement, ClaimNumber - 20190628EDW0001	Read
		11/29/2019	Claim Appeal Acknowledgement, ClaimNumber - 20190628EDW0001	Read
		11/29/2019	Claim Appeal Acknowledgement, ClaimNumber - 20190628EDW0001	Read

Click **Open Attachment** to download the Acknowledgement, and click on the pdf that appears at the bottom of the screen to view the Acknowledgement Letter.



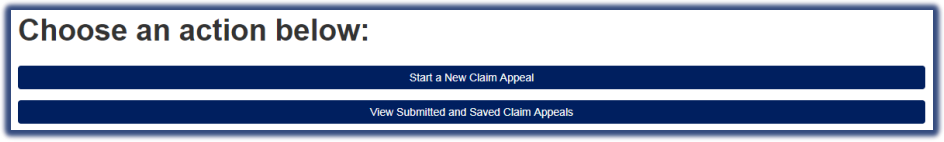
Once the appeal has been reviewed by the Health Plan, a **Determination Letter** will be sent through Notifications. This letter will indicate the review of the claim appeal was completed and the decision that was made.

Note: Claim appeal denial decisions can be re-appealed through online claim appeal submission. Denials should not be re-appealed if there is no new or supporting information to be reviewed.

c. View Submitted and Saved Claim Appeals

This feature enables the user to search for claim appeals that may have been started and saved, or active claim appeals that have been submitted.

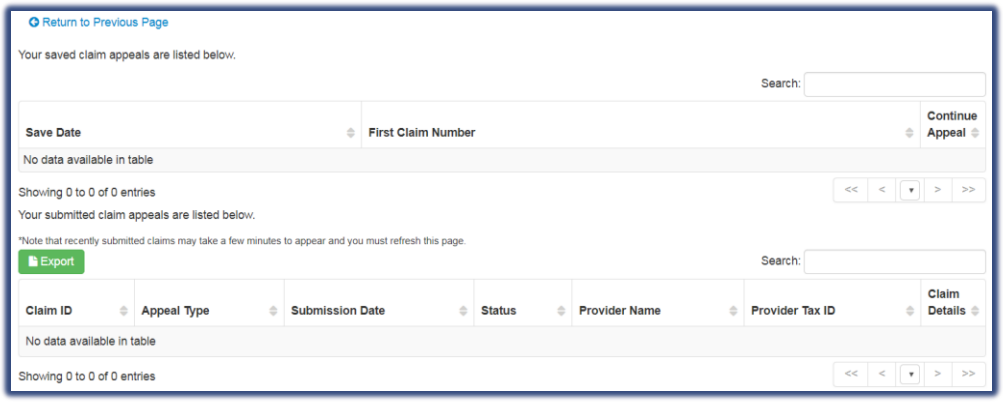
Select **View Submitted and Saved Claim Appeals** action.



Tip

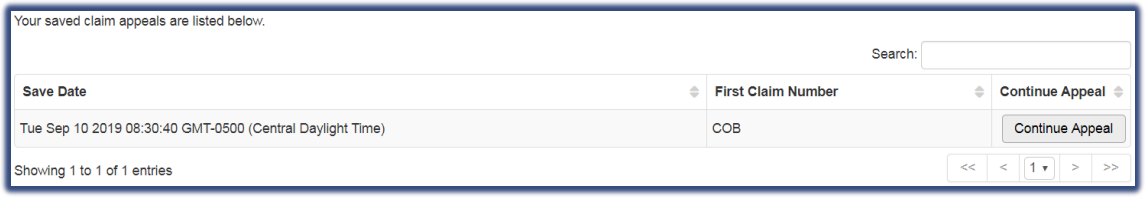
Up to 500 submitted claim appeals within a six month period will be available to view.

After selecting the **View submitted and Saved Claim Appeals** action the following screen will be prompted.



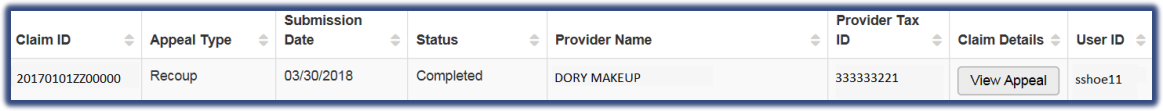
Saved Claim Appeals

Saved claim appeals are located at the top section. If a claim appeal is started but not submitted, a user can resume the process by clicking **Continue Appeal** at the end of the saved claim appeal record.



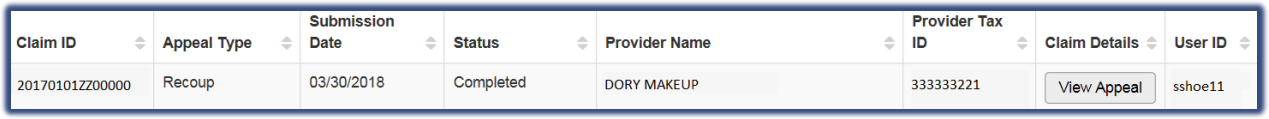
Submitted Claim Appeals

Submitted claim appeals are located at the bottom section. To view a submitted claim appeal select the **View Appeal** button located at the end of the submitted claim appeal record.

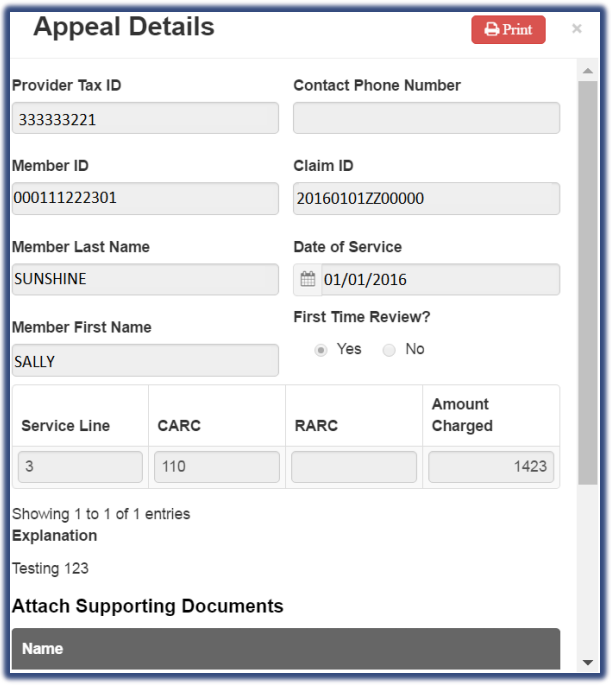


View Appeal

Select **View Appeal** to view the details of the claim appeal submitted.



After selecting to view appeal the Appeal Details will be displayed.



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