Provider Portal User Guide

For Individual and Family Plans

CHORUS COMMUNITY HEALTH PLANS

TPC101606 (10/2016)

1. Introduction

The **Provider OnLine (POL)** was created to provide online tools that allow providers to access patient's medical history, benefit and eligibility information and communicate with the Together with Chorus Community Health Plans Providers can access valuable information 24/7 including:

- Member eligibility search
- Claims search
- Online chat
- Secure messaging
- Claims Submission
- Document repository
- Online security management

Users can navigate POL by follow the instructions listed in the User Guide.

2. Main Menu

After logging in, the user can use the secure POL. The left-hand navigation menu appears on all POL screens. From this menu, the user can access the following features:

- User Guide
- Eligibility
- Claims Inquiry
- Enter Claims
- Create Batches
- Messages
- Documents
- Contact Us
- Chat with a Provider Services representative

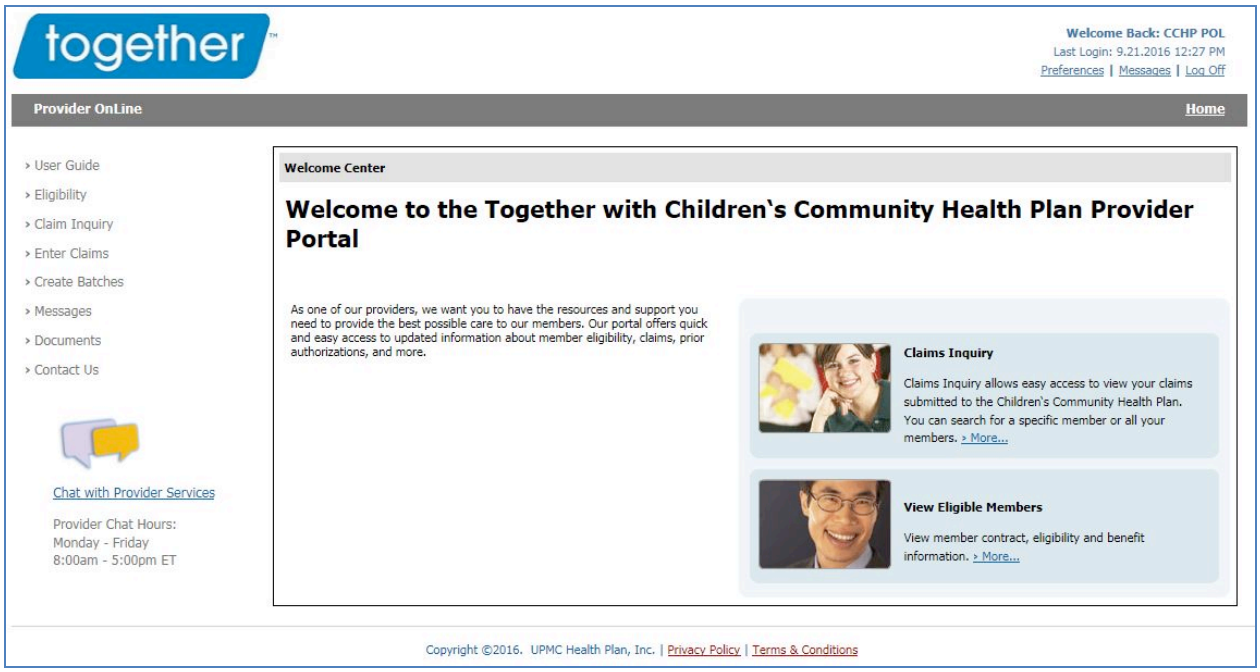

Figure 1: POL Main Screen

The user should select the appropriate hyperlink to access the desired function or information.

2.1 Eligibility

The **Eligibility** link takes the user to the section of POL where he or she is able to confirm the eligibility of Health Plan members as well as a member'' PCP and benefit information.

2.2 Claim Inquiry

The **Claim Inquiry** link takes the user to a feature of POL where he or she is able to view access to claims submitted to the Health Plan and to search for specific claims.

2.3 Enter Claims

The **Enter Claims** link takes the user to a feature of POL where the user can submit claims.

2.4 Create Batches

The **Create Batches** link takes the user to a feature of POL where the user can submit claims.

2.5 Documents

The **Documents** link takes the user to a feature of POL where various reference documents can be viewed.

2.6 Chat

The **Chat link** takes the user to the instant message system where users can communicate with Health plan provider services representatives.

3. Eligibility

The user is able to access/view specific member information by clicking on the **Eligibility** link on the left-hand navigation menu. The Eligibility screen is displayed below.

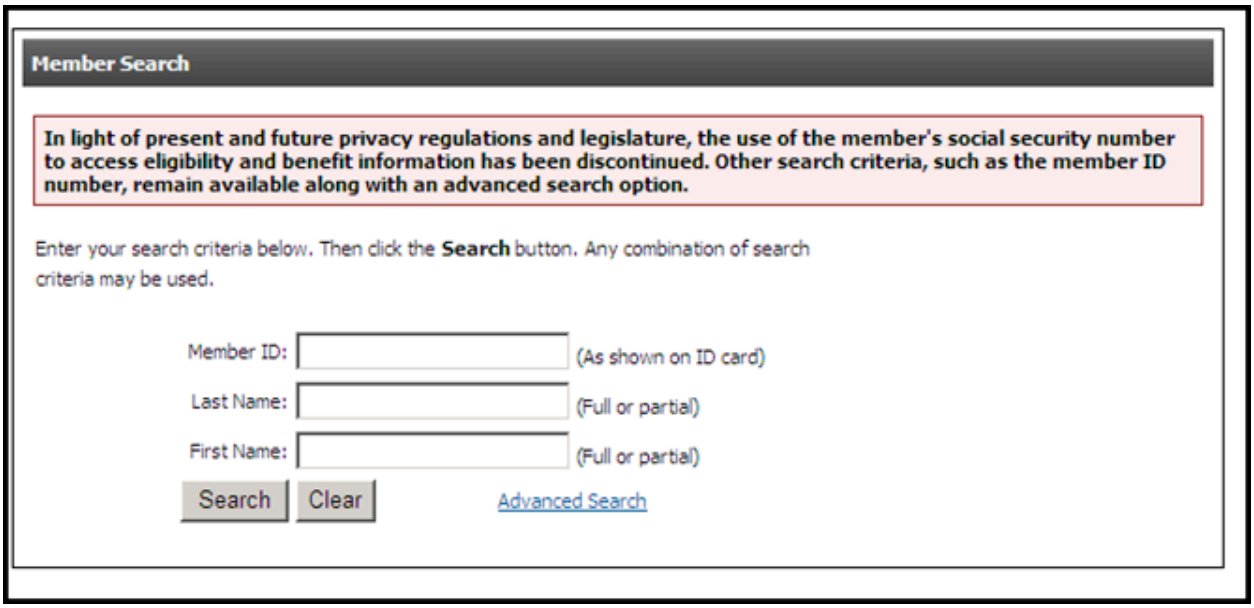

Figure 2: Eligibility Screen

The user can search for a member using either the Member ID or Last Name. (The Member ID is the nine-, ten-, or eleven-digit computer-generated number on the ID card.)

By selecting the **Submit** button, the results and the Eligibility Inquiry screen are displayed. By selecting the **Clear** button, any information entered in the Member ID or Last Name fields will be cleared.

Users have the ability to perform an advanced search for the Member Eligibility, as shown in the screen print below.

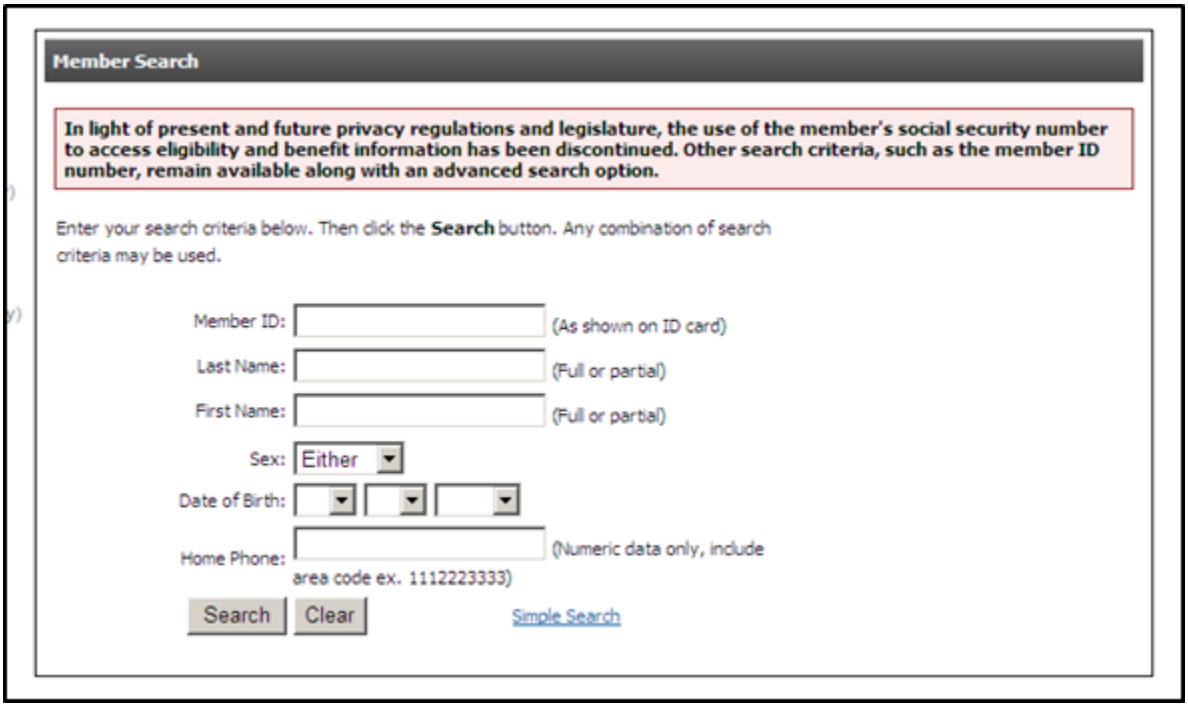

Figure 3: Advanced Search for Eligibility

When searching by Last Name, more than one result may be found. When multiple names are displayed, these are listed in alphabetical order. An example of this screen is shown below:

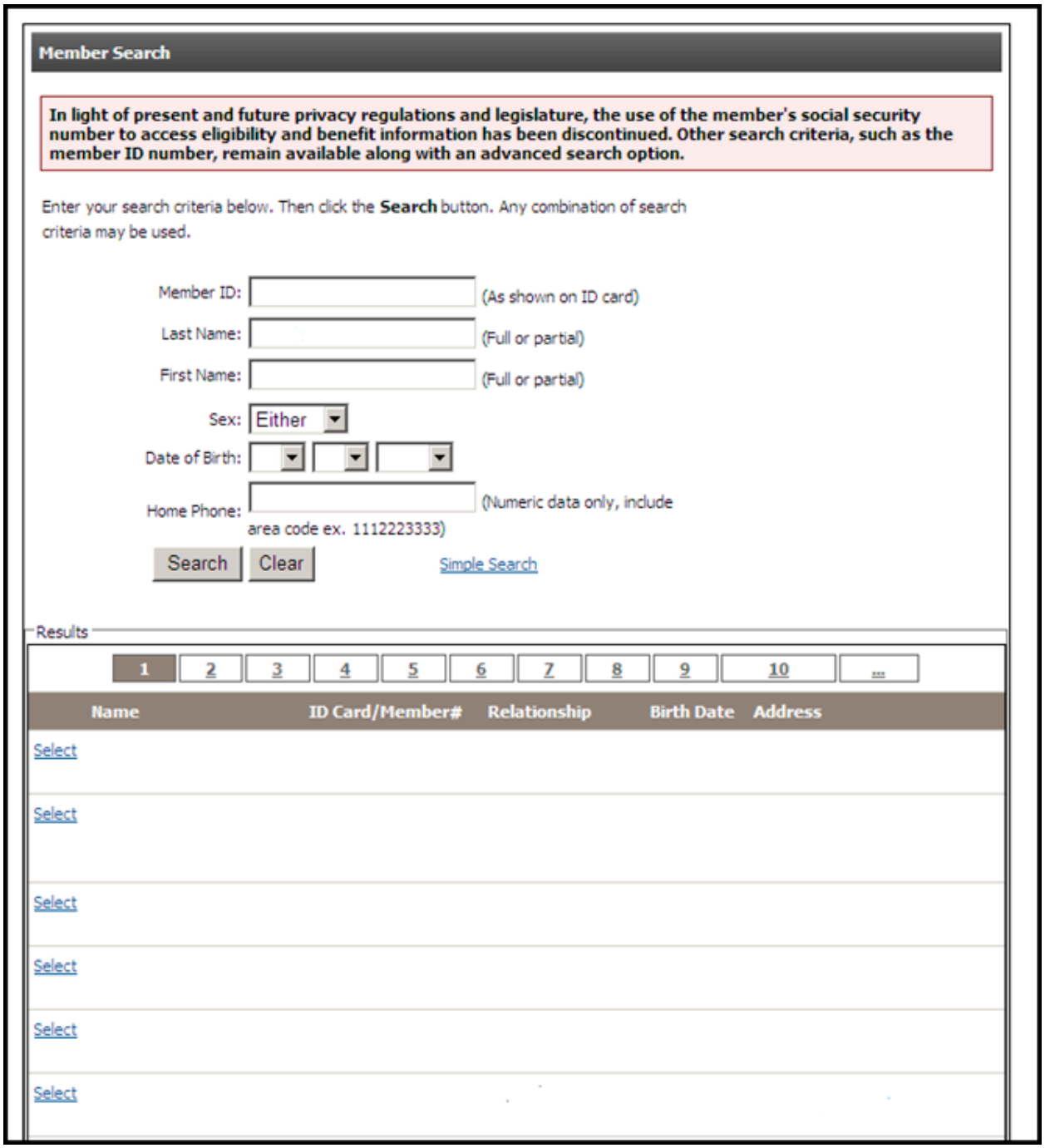

Figure 4: Eligibility Inquiry Result Screen

To view the Member Eligibility Detail Screen, users click on the **Select** link next to the appropriate member. (If only one match is returned during the search, the user will go directly to the Member Eligibility Detail Screen.)

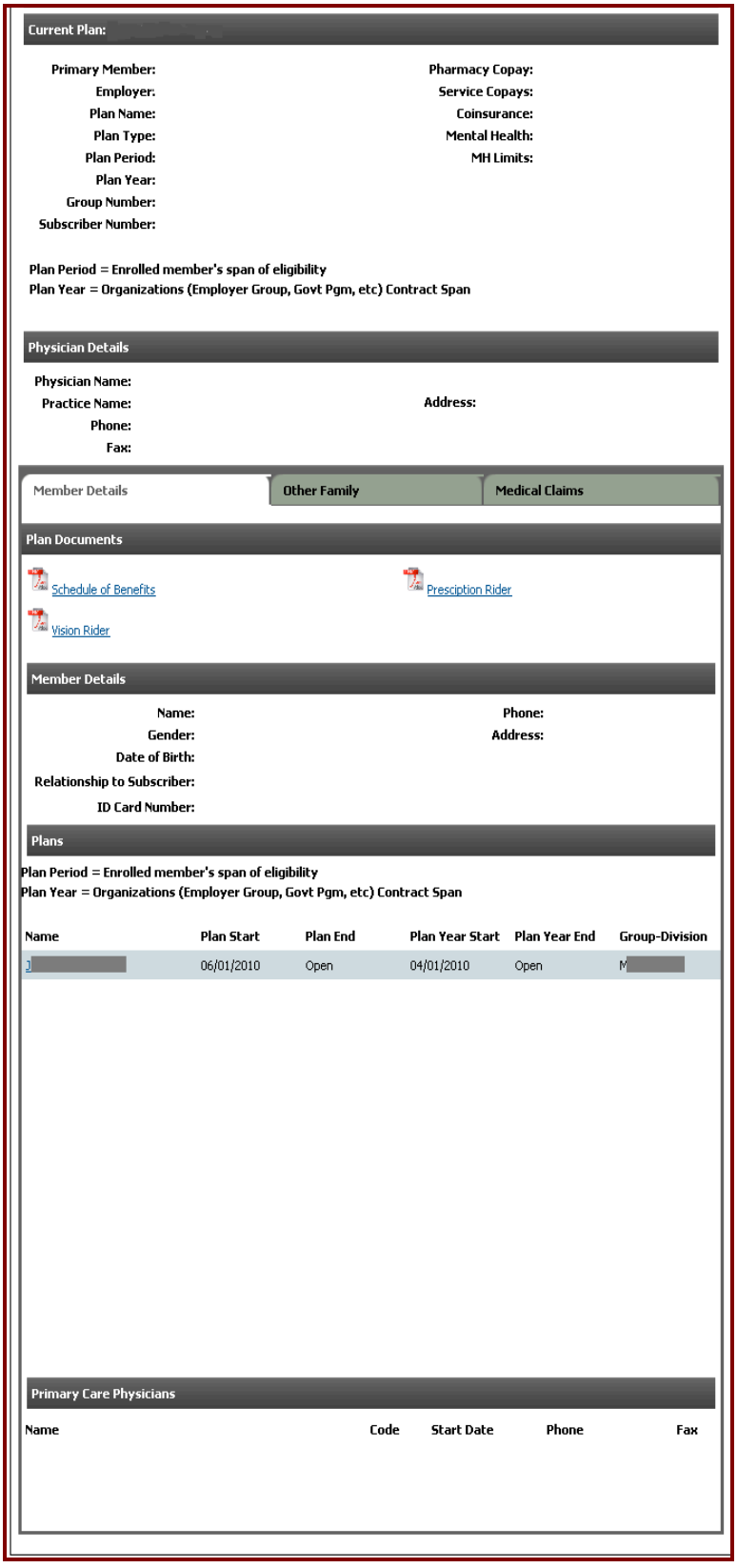

Figure 5: Member Eligibility Detail Screen

The following information can be viewed on the Member Eligibility Detail Screen, as shown above.

- Current plan information of the member — Primary member, plan name, deductible, and copayment information
- Plan documents — Links to PDFs of the member's schedule of benefits and other plan riders
- Plan information — Includes current start and end dates and previously held plans
- Utilization information — Includes deductible information for the member

3.1. Medical Claims

If the user would like to view medical claims on the member, he/she is able to do this from the member eligibility screen.

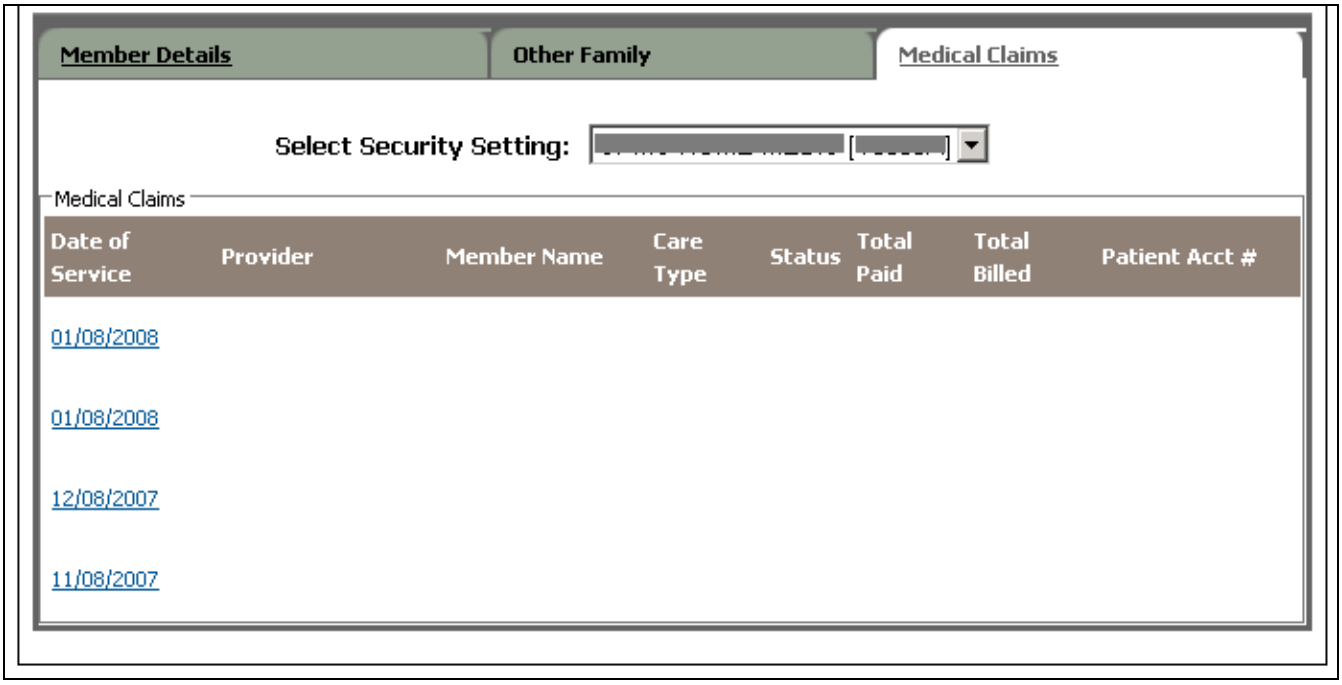

Figure 6: Viewing Medical Claims

The user is able to choose the appropriate facility by clicking the drop-down label for **Select Security Setting**. The values in this drop-down box are configured by the user's security and access settings on the back-office systems. Once the system is chosen, the user can click on the hyperlink for Medical Claims to view the medical claim information for this member.

The user is able to retrieve detailed information for particular medical claims by clicking on the hyperlink for that specific date.

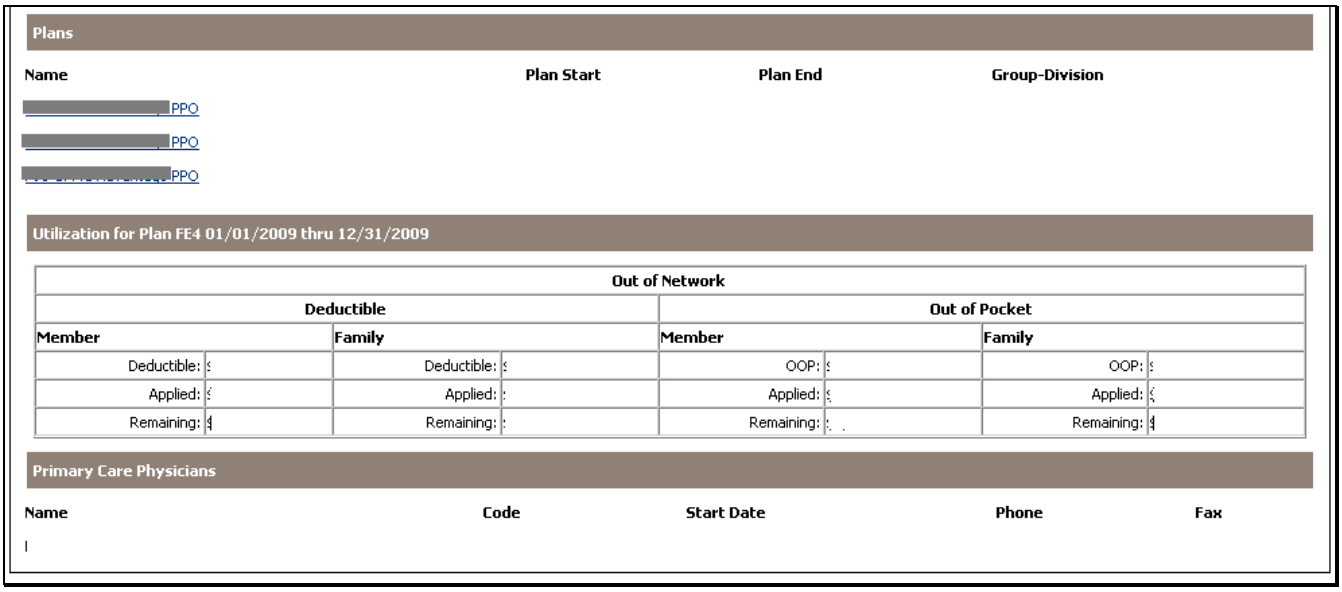

Figure 7: Medical Claim Detail

By clicking on the **Compose** button, a dialog box opens for the user to send a secure message to Provider Services regarding the claim.

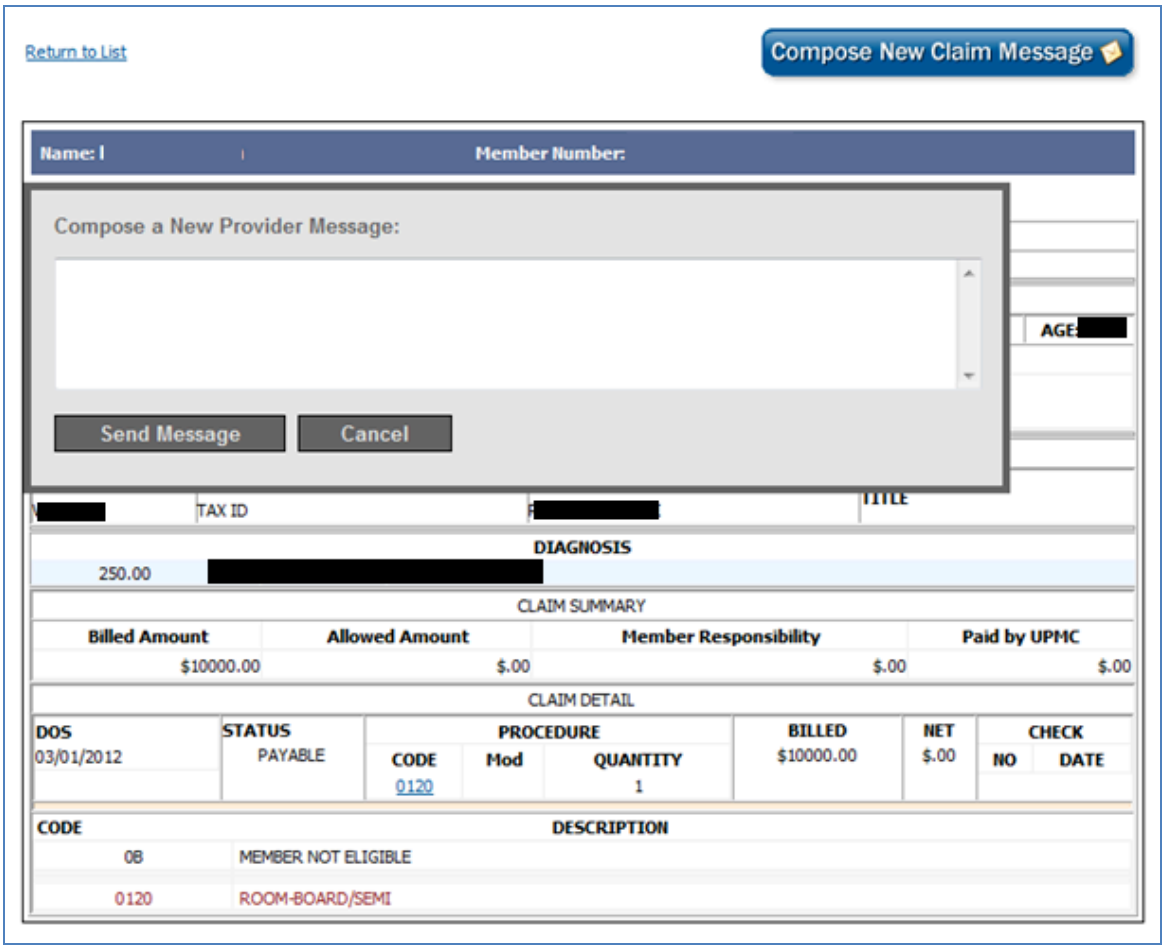

Figure 8: Opening a Secure Message Window

The user will type the message in the dialog box and click on the **Send Message** button. If the user chooses not to send a message, he or she can click on the **Cancel** button to close the dialog box.

The user is able to navigate back to the original list of Medical Clams by clicking on the hyperlink for **Return to List**.

3.2. Other Family Members

The user is able to view details of other family members by clicking on the **Other Family** hyperlink.

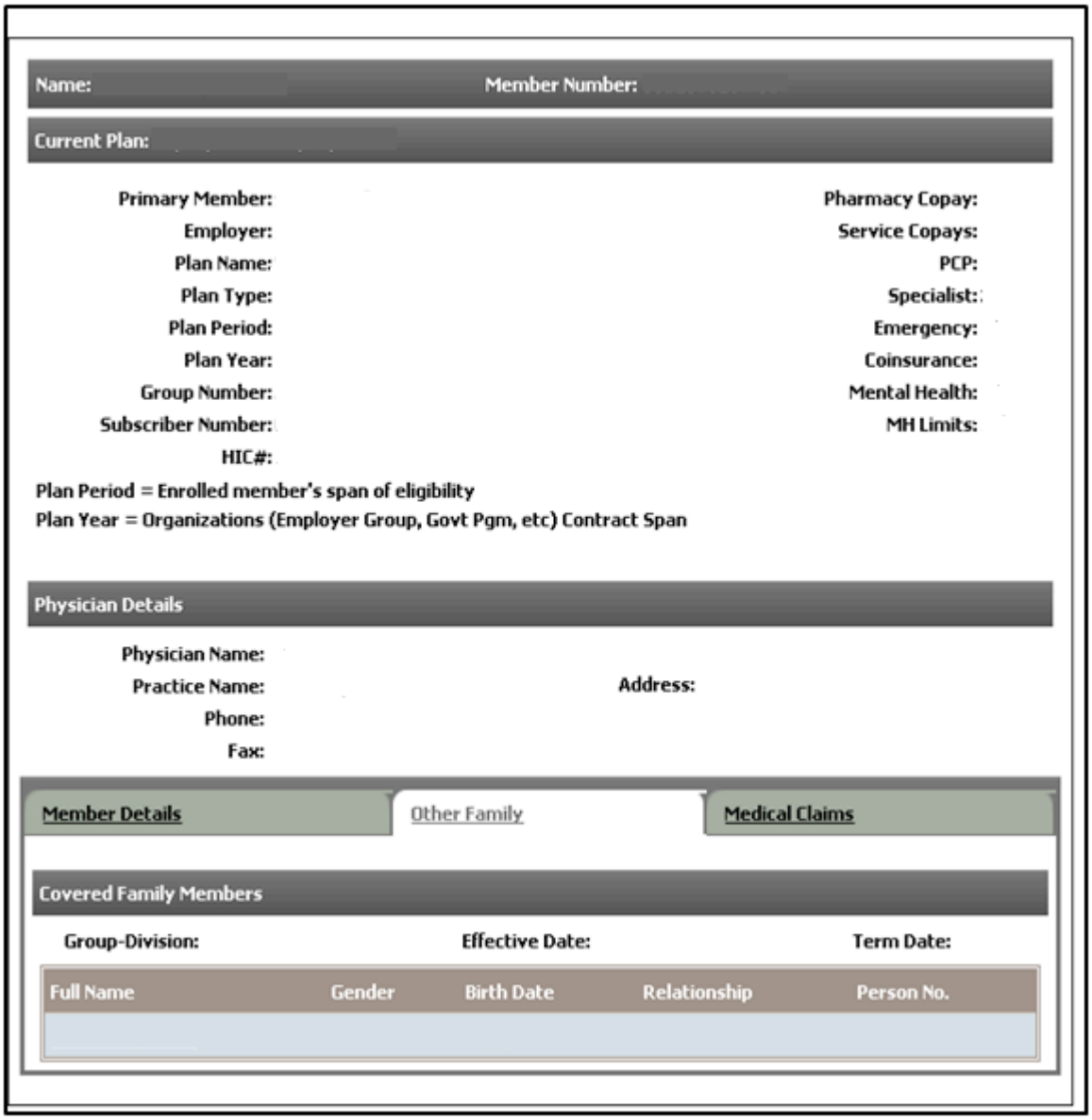

Figure 9: Accessing Other Family Information

This will open a view listing the Covered Family Members of the member.

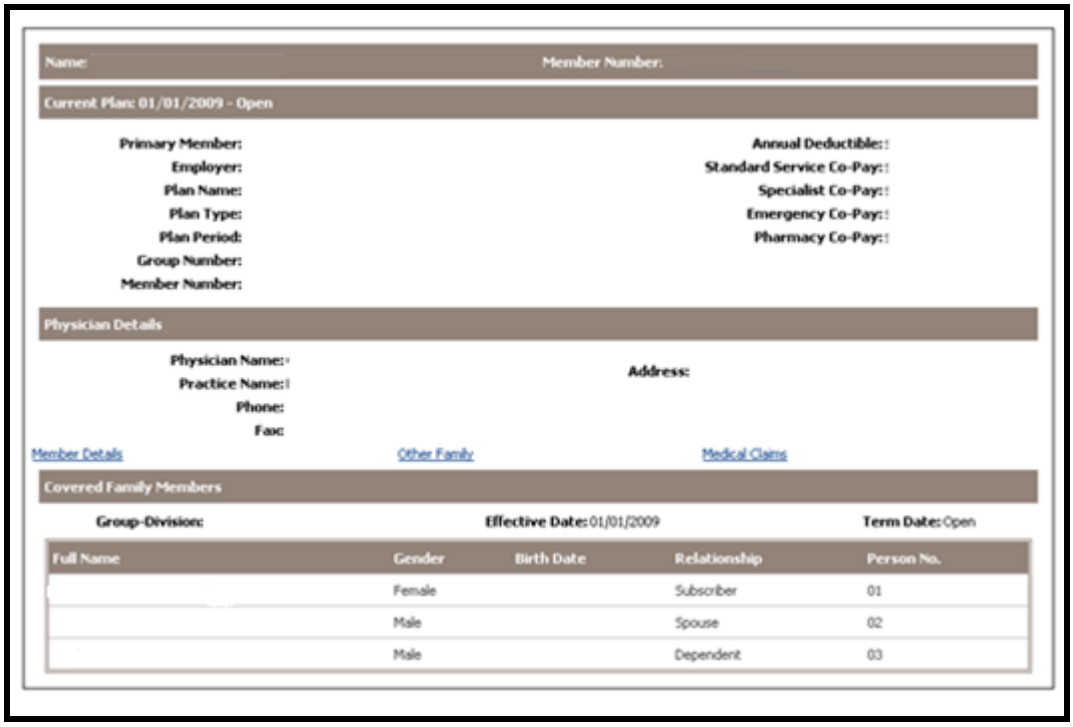

Figure 10: Covered Family Member View

The user can obtain a detailed view of the family member information by clicking on the hyperlink of the member's name.

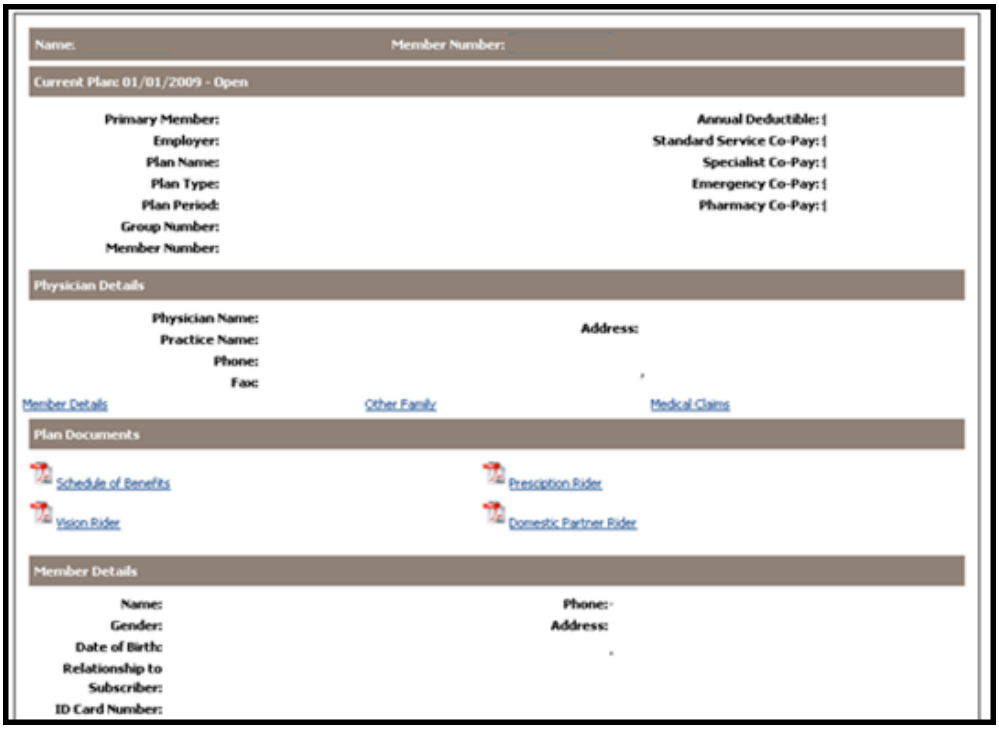

Figure 11: Family Member Detail Screen

4. Claims Inquiry

The user can search for a general list of all claims with their POL account by selecting the **Claims Inquiry** menu and option.

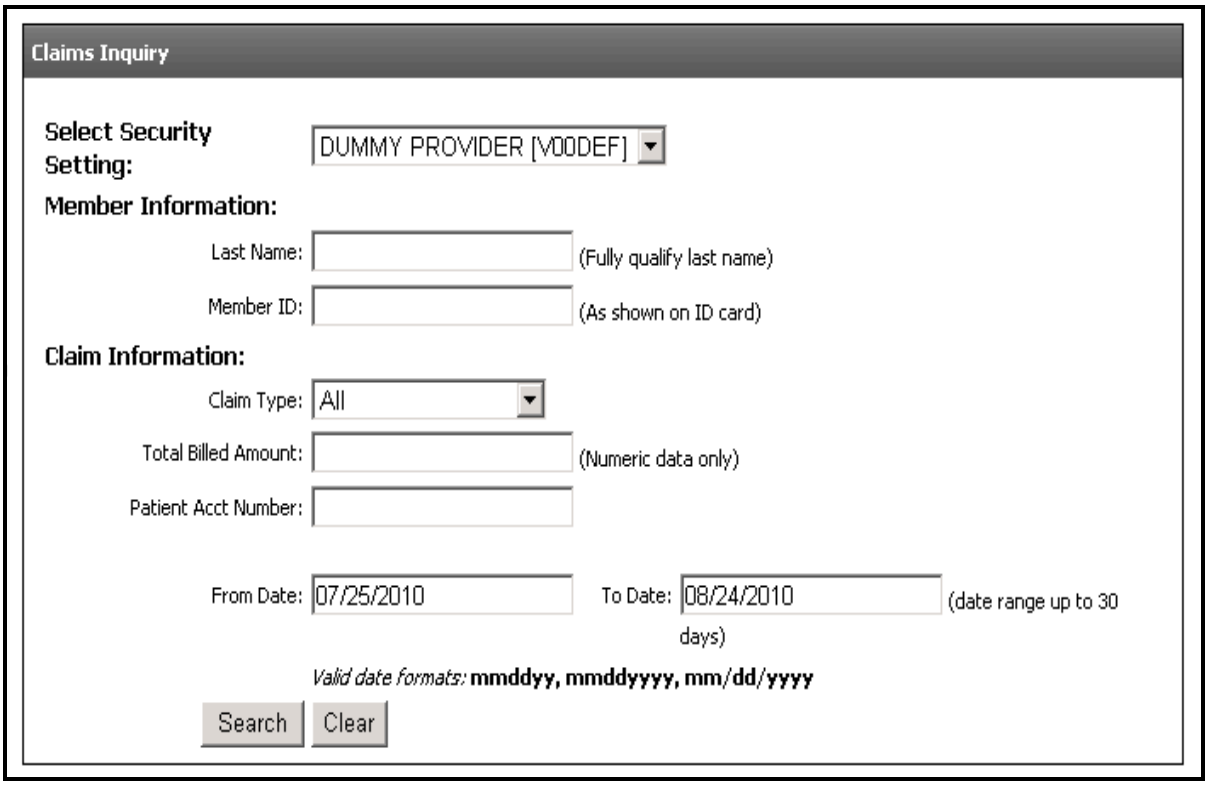

Figure 12: Claims Inquiry Screen

The user can search for claims by Member Last Name and/or Member ID Number. The searchable criteria that can be used to retrieve a claim is claim type (encounters or institutional), patient account number, total billed amount, and date range.

The user is able to search for claims by an appropriate facility by clicking on the drop-down label for "Select Security Setting." The values in this drop-down box are configured by the user's security and access settings.

The user will need to define the date range for the claims search. The From Date field can be set to any date; however, the date range is limited to 30 days from first date entered.

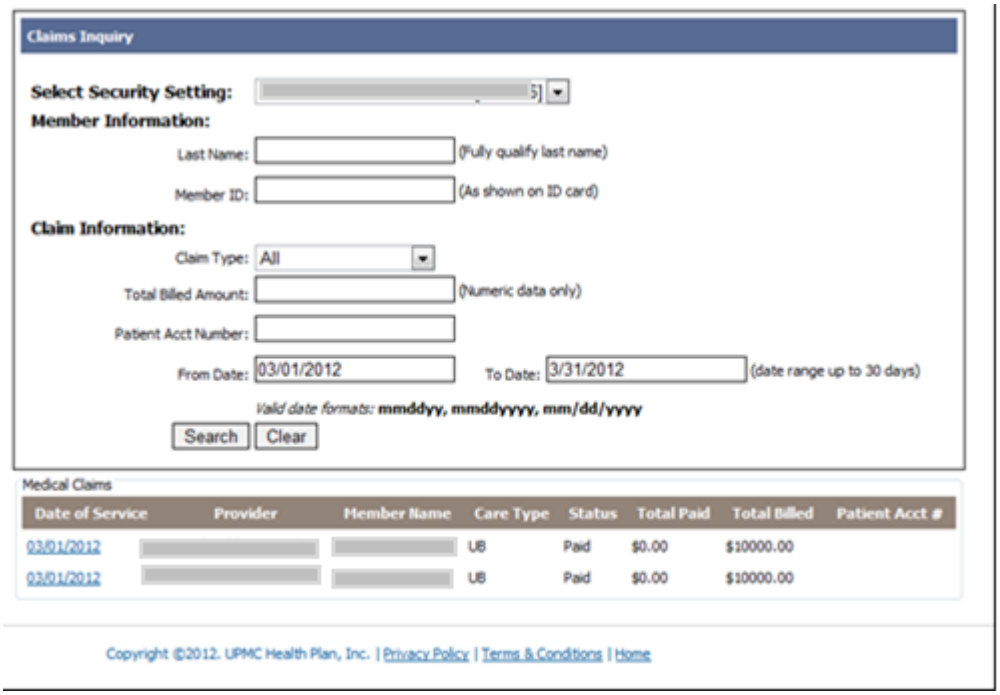

Figure 13: Claims Inquiry Result Screen

If there are multiple pages from the claims search results, there will be hyperlinked page numbers that appear at the top and the bottom of the search results of the user to navigate and view.

The user can view details of the claim by clicking on the hyperlink of the date of that particular claim.

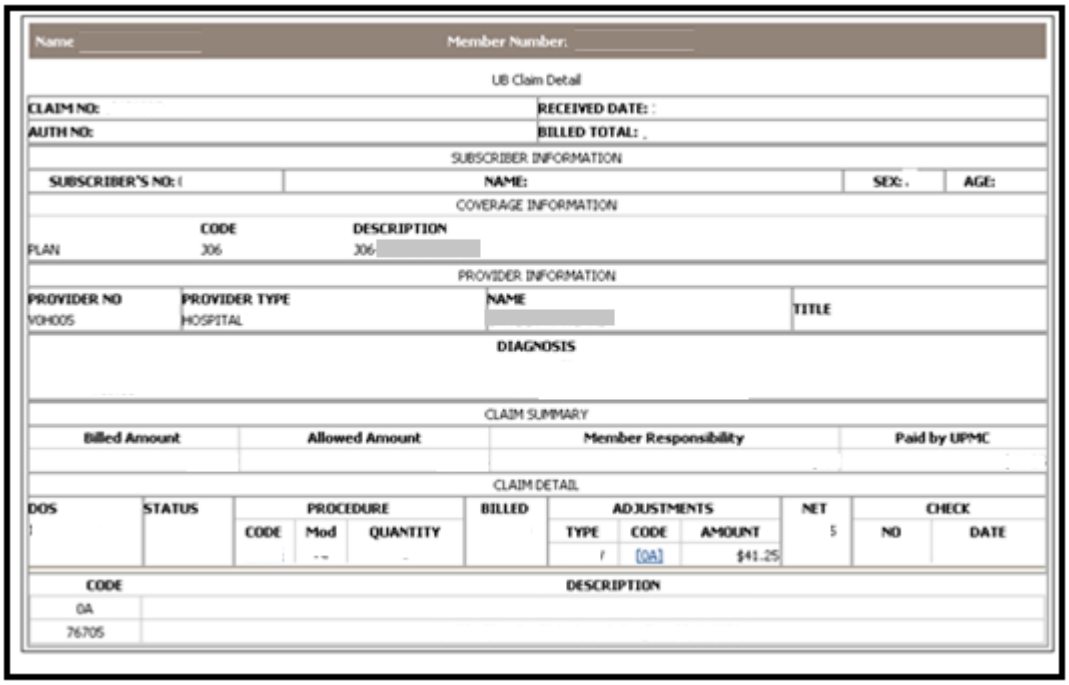

Figure 14: Claim Detail Screen

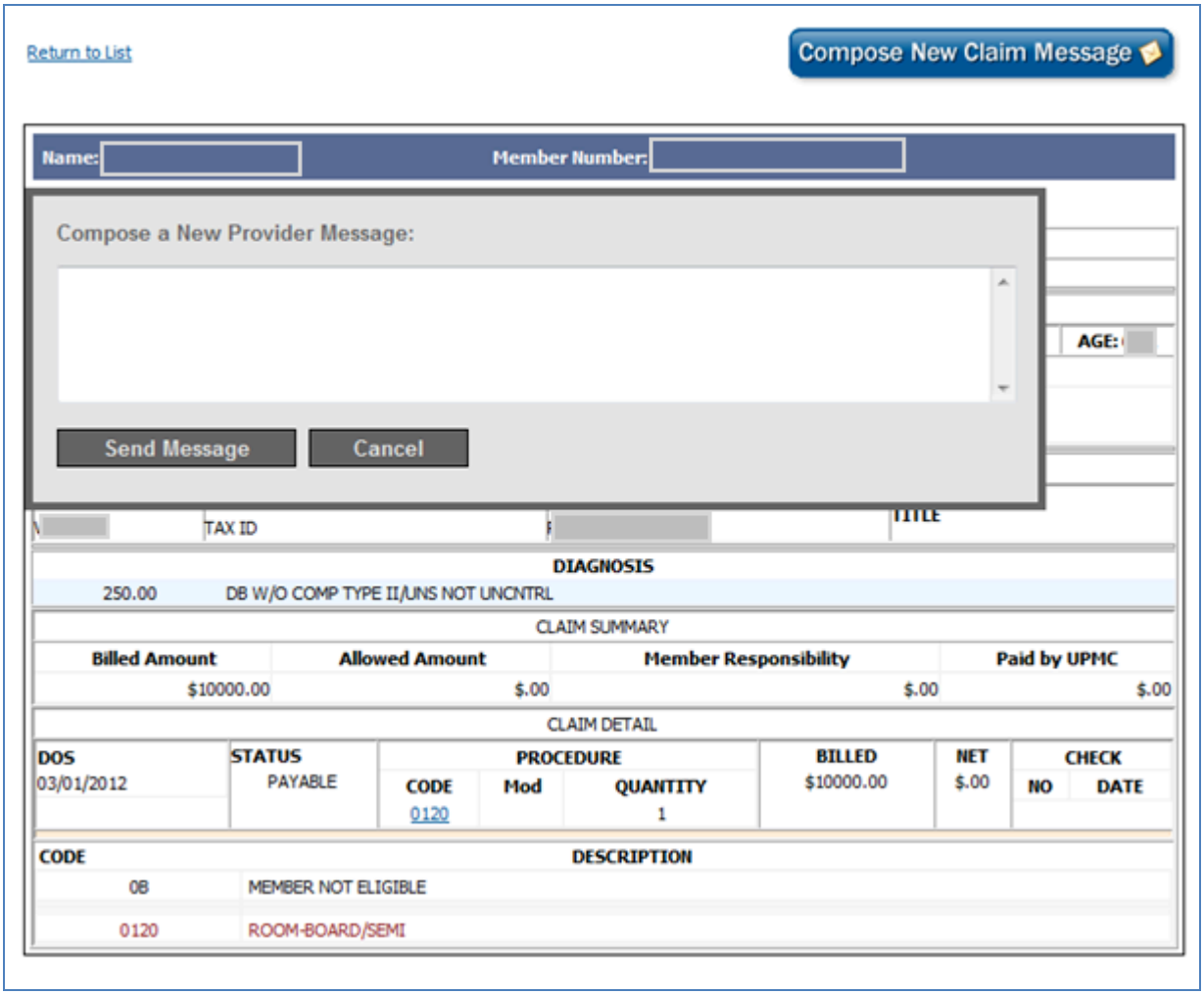

Figure 15: Claim Detail, Compose Message Screen

By clicking on the **Compose** button, a dialog box opens for the user to send a secure message to Provider Services regarding the claim.

The user will type the message in the dialog box, and click on the **Send Message** button. If the user chooses not to send a message, he or she can click on the **Cancel** button to close the dialog box.

The user is able to navigate back to the original list of Medical Clams by clicking on the hyperlink for **Return to List**.

The user can narrow the search results by entering multiple criteria, such as facility, last name, and the appropriate date range.

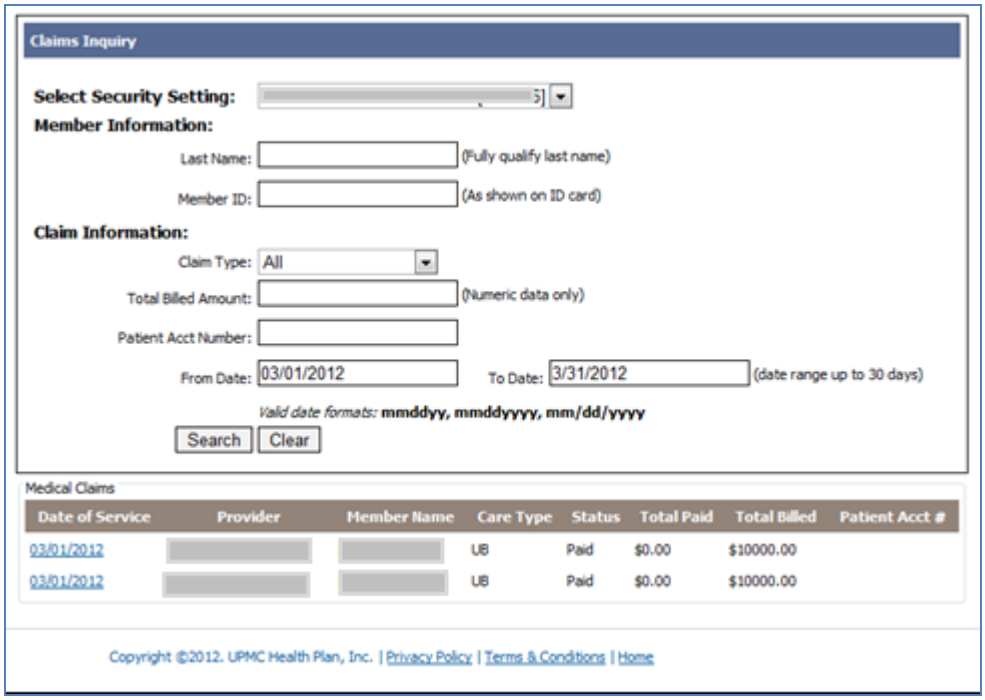

Figure 16: Narrowed Search Results

5. Messages

The user is able to access secure messages by clicking on the **Messages** button. If the user has unread messages, the number of unread messages is listed in parenthesis — next to the word messages.

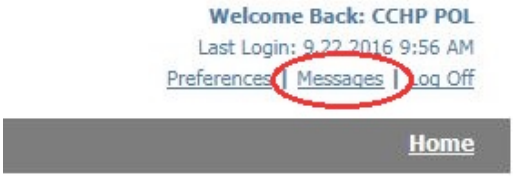

Figure 17: Access the Message Screen

The screen below is the main screen for the Message Center. There is a key to indicate read messages and unread messages

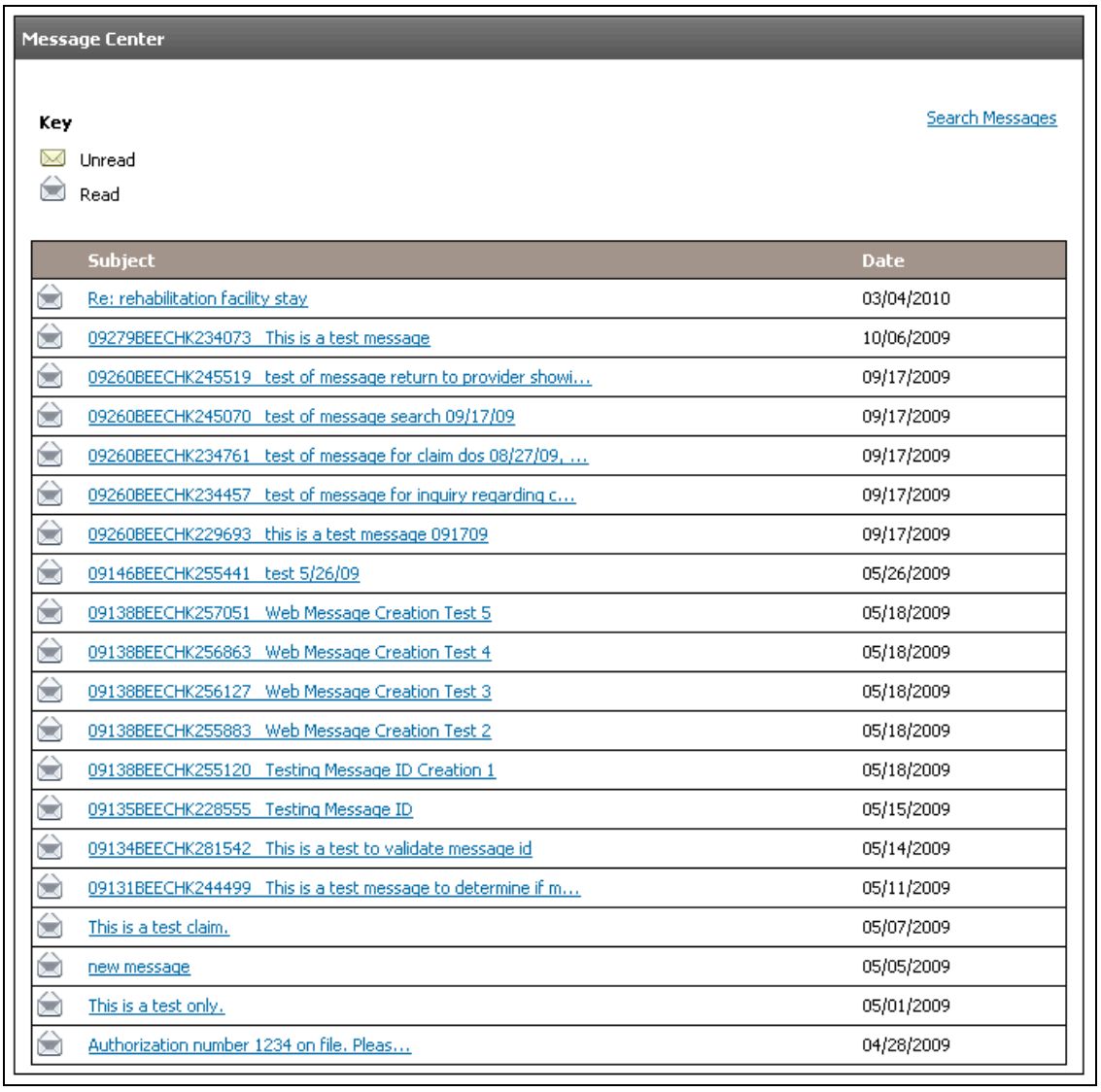

Figure 18: Message Center Main Screen

The user can access the details of a message by clicking on the hyperlink for the respective message's subject.

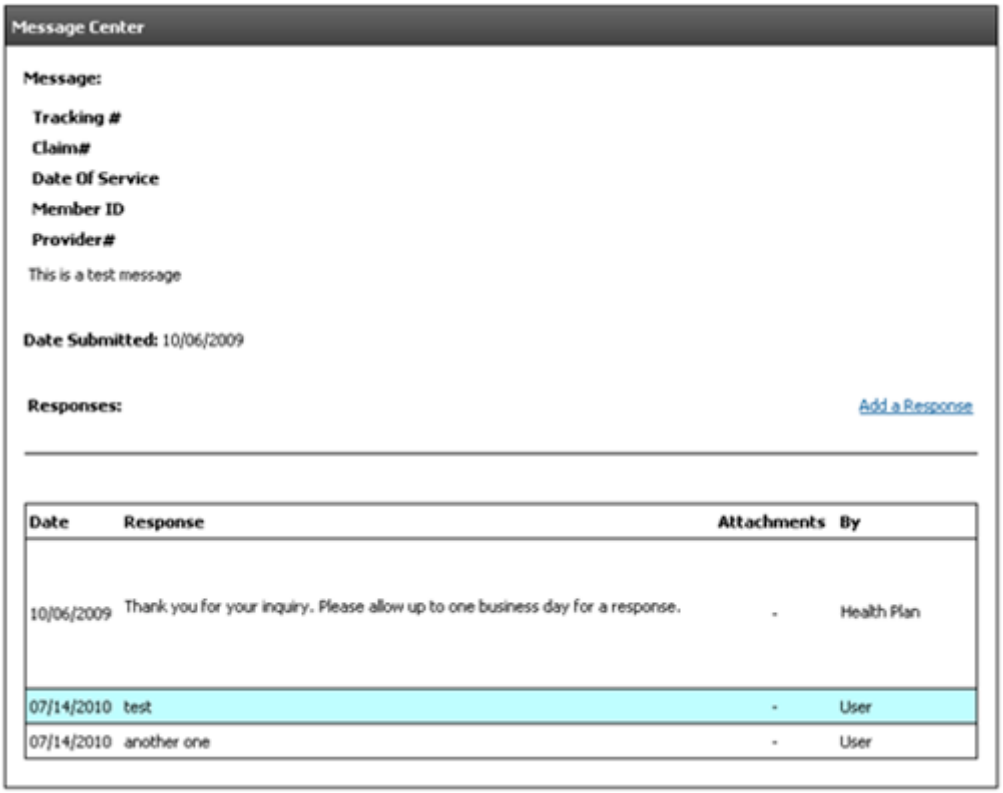

Figure 19: Detailed Message Screen

6. Chat

Providers have the ability to chat with Provider Services representatives on an assortment of topics. Topics include:

- Member eligibility
- Coverage of a Procedure Code
- Authorization Requirements
- Locate a Provider or facility
- Durable Medical Equipment
- Vision/dental/behavioral benefits
- Chiropractic benefits
- Home health benefits
- Explanation of payment
- Status of an appeal
- Unlisted topic

In order to initiate a chat, users should follow the steps below:

1. Click on the **Chat with Provider Services** link or the Callout icon. This will take the user to the "Select a topic for you chat" pop up.
2. If applicable type in the Member ID in the **Member's ID** field.
3. Select a topic and then click **Start Chat Session.** This will take the user to the "Live Chat Session" pop up.

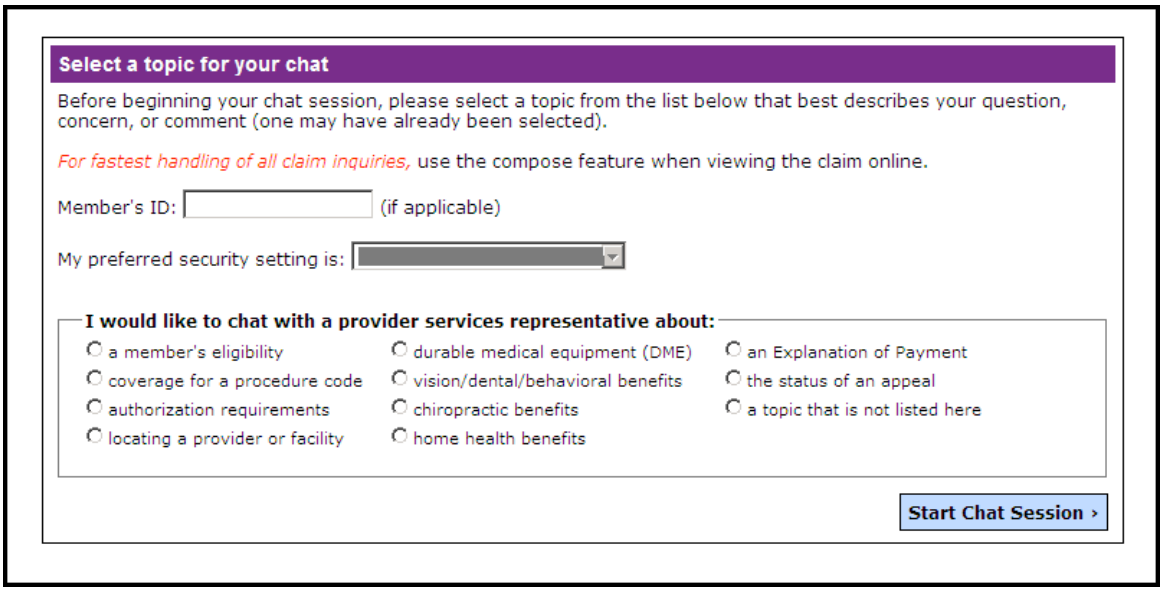

Figure 20: "Select a topic for your chat" Pop-up

4. A provider services representative will type a welcome message and the session can begin.
5. Once the session is over the user clicks on the **End Chat Session** link.
6. Before closing, the user can (but does not have to):

- Search for a claim
- Check for a member's eligibility
- View a member's schedule of benefits
- Search for a provider or facility
- Review Health plan's privacy and security policy
- Fill out a satisfaction survey
- Print the chat session

7. To close the popup click on the **Close Chat Window** link.

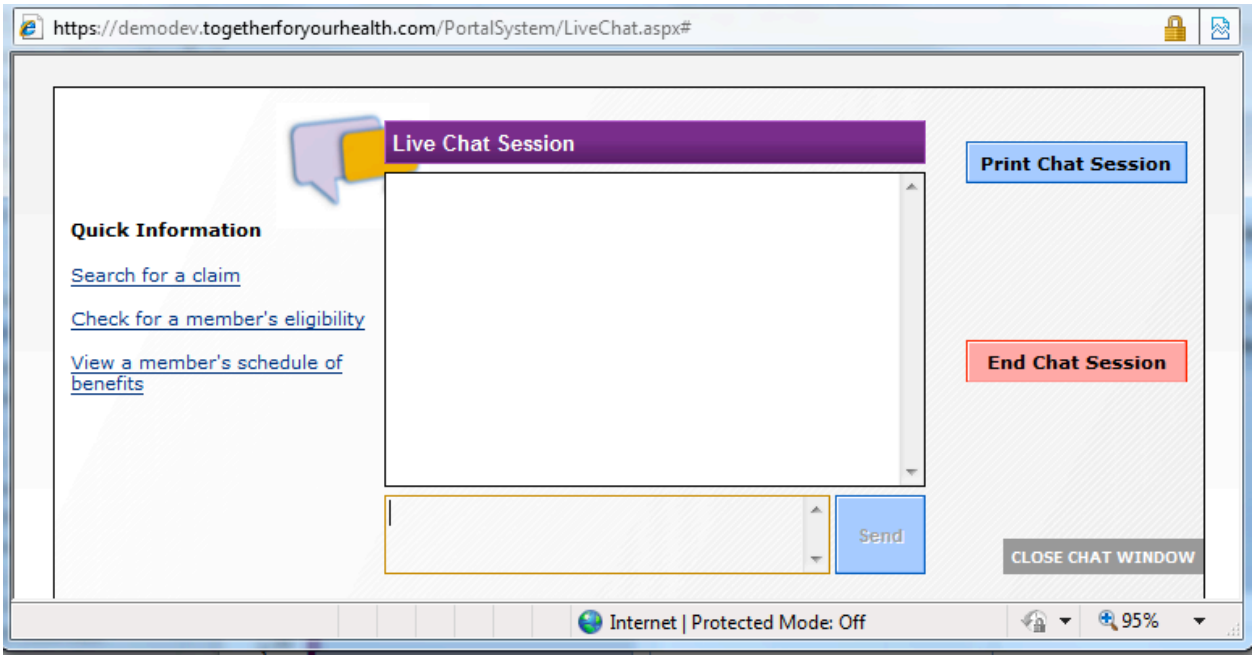

Figure 21: Live Chat Session Pop-up

7. Preferences

The user is able to update his or her name, e-mail, and telephone information by clicking on the **Preference** button.

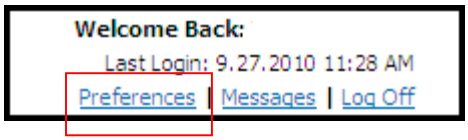

Figure 22: Choosing Preferences

The screen below will be displayed.

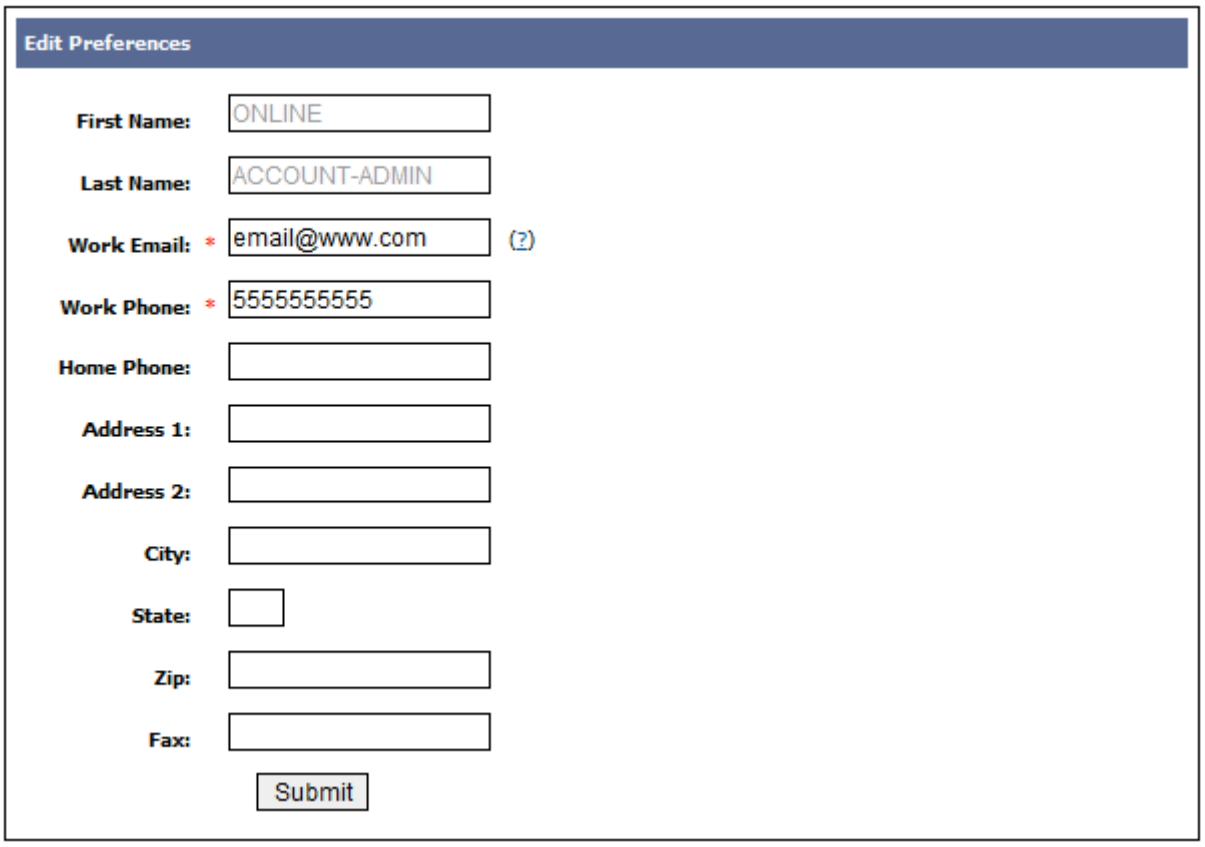

Figure 23: Preferences Screen

The red asterisks indicate required fields. For the Work Email field, if the user does not have an e-mail address, he or she is able to enter **No Email**.

8. Appendix A: Claim Submission Tool (CST) Information

8.1. Introduction to Health Plan OnLine CST

Health Plan OnLine CST (Claims Submission Tool) provides a complete Internet Portal solution for services provided by Health plan.

Health Plan OnLine is a website that gives anyone with access the ability to view transactions. A portion of its function can process claims via the Web.

Health Plan OnLine CST is the gateway into the MC400 system to input claims. All adjudication and rules are driven off MC400. The Data Warehouse does regular reporting on all claims and how they are initially received in the Health Plan.

Claims are submitted in the following methods and can be identified in MC400:

- EDI (Electronic Data Interchange) — claim files electronically sent to the Health Plan.
- OCR (Optical Character Recognition) — Formworks/RRI internally generated EDI files.
- MMO (Medical Mutual of Ohio) — Re-priced claims returned from MMO.
- EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) — claims that originate on custom forms loaded into an internal application.
- Prelog — Paper claims manually keyed into Prelog or claims directly submitted by a provider via the Web portal.

All claims are entered or submitted in batches. A Submitter can be any type of user that has been configured to process claims or other electronic inbound or outbound transactions. After a batch is posted to the MC400 system, the claims run through the MC400 adjudication process. Claim errors are returned to the batch indicating invalid data that would prevent the claim from moving into the MC400 system. Claim staff will be responsible for correcting the invalid data. After all data has been corrected, the claims will either adjudicate automatically or hold for review in the MC400 system.

Health Plan OnLine CST allows for the creation of an Administrator. The Administrator will have full and unlimited access to all the features of this program, including Maintenance and Security. The Administrator will be responsible for assigning user access, setting user parameters, processing requests, monitoring claim submissions and reports, communicating with users, and general control of all ongoing processes.

8.2. Getting Started

When you have logged in successfully, you will see the 'Welcome' message page.

- Click on **Enter Claims** to access the Claims Pre-Logging screen.
- **NOTE:** To log off the system, click on the **Log Off** sidebar menu option, or exit by clicking on the X at the top right of the screen.

The Claims Pre-logging screen has many fields of entry. Below are a few reminders before getting started.

- Health Plan OnLine CST is *case sensitive* (except in search screens); the Caps Lock key must be on.
- **Tab key** = Move field to field.
- **Shift + Tab** = Go back a field.
- *Decimal points* are used for dollar amounts and diagnosis codes.
- Fields marked with a red asterisk (*) are system-required fields of entry.
- Binoculars indicate a search field to aid in selecting or completing information. To display a search window, the cursor must be in the selected search field.

8.3. HCFA Claims Prelogging screen

Health Plan OnLine CST HCFA Claims – Field Descriptions (*) Denotes System-Required Field Yellow Fields are mandatory entry fields Green Fields are situational White fields are auto-populated or not required			
Prelog Field		**HCFA**	**Usage**
HCFA			Identifies the claim form type entered. Click on HCFA to create a separate batch for every physical batch entered.
Member Information			
Insured ID	*	1A	Member's 11-digit ID #. Enter the 11-digit Member # directly into the field — no dashes. If the member cannot be found, the member search screen is available. Click on the or press [Enter] to access.
Patients Name	*		Auto-populates with the member's name, based on the Insured ID entered.
Patients DOB	*		Auto-populates with the member's date of birth.
Patients Sex	*		Auto-populates with the member's gender.
Patient's Control #	*	26	Patient Account Number assigned to the patient by the billing provider. If not billed, press the space bar and tab to leave blank.
Provider Information			

Billing Provider ID	*	25	Vendor or Billing Provider. TAX ID is the only search method. To access the provider search screen, click on the or press [Enter]. If a match appears, verify the name and address of the provider. Some vendor's are listed twice in Prelog. If entering an HCFA claim, select the V0P Vendor # (P for provider). If entering a UB claim, select the V0H Vendor # (H for hospital).
Prov. FED. TAX ID #	*		Auto-populates with the Tax ID of the Billing provider (vender) entered.
Prov Name			Auto-populates with the billing provider's name.
Prov. Address			Auto-populates with the billing provider's address.
Prov. City			Auto-populates with the billing provider's city.
Prov. State			Auto-populates with the billing provider's state.
Prov. Zip			Auto-populates with the billing provider's Zip Code.
Prov Phone #			Auto-populates with the billing provider's Phone #.
Prov. PCP Flag			Not used at this time.
Servicing Prov ID	*	31	The individual provider who rendered the service. Identified in Prelog with a 6-digit provider number. Press to access the Provider Search screen. Click on the Search button. Search by provider's last name. Prelog is configured to return only the providers listed under the Vendors Tax ID # selected.
Referring Prov ID		17 17A	Referring Provider. The UPIN # search can only be done by accessing the Provider Search screen, click on the or press [Enter] to access. Enter the UPIN # in the UPIN field, press [Enter]. Verify the name of the referring provider, then select the provider by double-clicking on the provider "Select" line. The referring physician can be found by either the UPIN # or his or her name.
Ref Phys Name			Auto-populates with the Referring Physician's name.
Header Information			
From Date	*	24	Earliest date of service.
Through Date	*	24	Last Date of service.
Diagnosis 1-4	*	21	Diagnosis code(s). Decimal points are required after the 3rd character (ex. 7809 is entered 780.9). If the diagnosis code has only 3 characters drop the decimal (ex. 650 is entered as 650). Click on the or press [Enter] to access a search screen.
Total Amount Billed	*	28	Total charge billed on the claim. Decimal points are required (ex.: $150 billed, enter 150.00).

Notes			
Claim Paper Work			ONLY USED when billing corrected HCFA claims. Enter the value of **CC** in this field. IMPORTANT NOTE — corrected claims requiring Health Plan review of ANY paper documentation i.e., COB, Medical notes/certificates, CANNOT be entered via Prelog.
Claim Note 1		10d, 19	Not used at this time.
Claim Note 2		10d, 19	Not used at this time.
Service Line Information			
From Date of Service	*	24A	Earliest or only date of service billed. Date format is MMDDYY — no dashes or slashes.
To Date of Service		24A	System will default with the "From Date" of service.
Place of Service	*	24B	Place of Service indicates where services were rendered. Click on the or press [Enter] to access a list of standard codes.
Type of Service	*		Auto-populates with 01.
Diagnosis Reference	*	24E	Enter the number of the diagnosis code linked to the service line. There are four fields, enter the numbers 1234 that correspond with the diagnosis codes billed for the service line. Linking the correct diagnosis codes to a service line can affect payment.
CPT/HCPCS	*	24D	The 5-digit CPT or HCPCS procedure code billed. Click on the or press [Enter] to access a search screen.
Modifier 1st – 4th		24D	Modifiers are an extension to the CPT codes. Alpha characters must be entered in Upper Case (ex. AA).
Amount Billed	*	24F	The total amount billed for the individual service line. Decimal points are required for entry of dollar amounts. When a service line is billed with a zero dollar amount, enter $00.00 for the amount billed. If the service line is billed with $0, enter 00.00 in this field.
Days or Units	*	24G	Number of units/services for the procedure performed. System defaults to 1. Enter units billed **except on Anesthesia claims.**
OIC Allowed			Not used at this time.
OIC Paid			Not used at this time.
OIC Deductible			Not used at this time.
OIC Co-Ins			Not used at this time.
OIC Not Covered			Not used at this time.
OIC Carrier Group			Not used at this time.
Start Time (HHMM)		24	Anesthesia Start time (hours/minutes). Do not enter the (:) colon.
End Time (HHMM)		24	Anesthesia End time (hours/minutes). Do not enter (:) colon.
Total Minutes (MMMM)		24	Total Anesthesia Minutes billed. (Ex.: 2:45 – 3:45 = Enter 60 in this field).
EPSDT Indicator		24H	Required for EPSDT claims only. Click in box ☑ for pre-logged EPSDT claims to indicate 'Y" (yes). Electronic claims will arrive with an "EP" modifier on the detail line.

8.3.1. Member Search

Not entering the 11- digit member ID# in the Insured ID field of the Member Search screen, accessed by the binoculars, allows for several methods of searching for a member. Click on the binoculars in the Insured ID field, the following box will display.

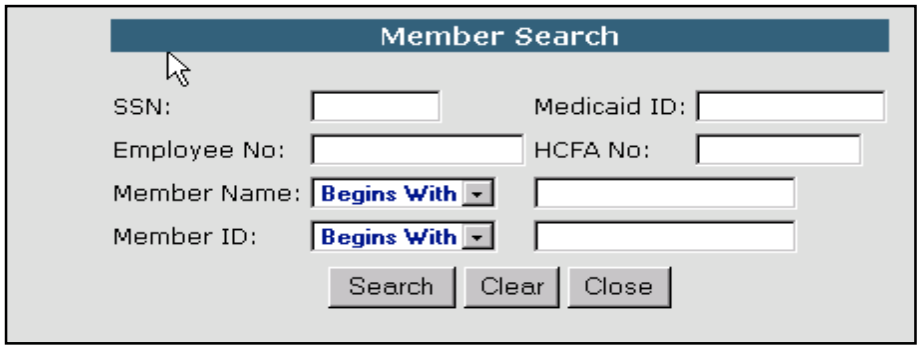

Figure 65: Member Search

Member Search Fields	
Field	**Usage**
SSN:	Commercial, Medicaid, Medicare – Search with member's Social Security Number
Medicaid ID:	Medicaid – Medicaid (9 digit) Case Number
Employee No:	Medicaid – Medicaid (10 digit) Recipient Number (commonly billed by provider) Medicare - (HCFA#) Social Security Number with an alpha character
HCFA No:	Medicare – (HCFA#) Social Security Number with an alpha character
Member Name:	Commercial, Medicaid, Medicare – Last Name, First Initial (comma, no spaces)
Member ID:	Commercial, Medicaid, Medicare – (9 digit) Contract Number

8.3.2. Provider Search

The Provider Search screen allows for several methods of searching for a provider.

Provider Directory Search Fields	
Field	**Usage**
Provider ID	Used to search with the provider's ID number.
Fed. Tax ID	Used to search by the provider's TAX ID number. **This is the only search method for the Billing Provider.**
Provider NPI	Used to search with provider's unique personal identification number. This is the search method for the referring provider.
Provider Name	Used to search with provider's name. Enter last name, press [Enter]. Can also use a partial name search. This is a search method for the Servicing, Referring, Admitting or Attending provider

8.4. HCFA - Claim Entry

The HCFA form is a standardized form designed to contain all information necessary for billing and/or claim payment. The HCFA form is used primarily by individual providers/groups.

If sufficient information is not on the HCFA form, it could delay claim payment or may cause an unnecessary denial of charges. In order to correctly process claims, you must be able to read, interpret, and understand all of the data contained on the HCFA form.

After clicking on **Enter Claims** from the sidebar menu option:

1. **HCFA** — click on **HCFA** to select the HCFA claim form type.
2. **Insured ID** — enter the member's 11-digit ID #, press [TAB]. Verify the member's name and date of birth. Click on  to access the Member Search screen if a search is needed, press [TAB].
3. Patient's Name, DOB, and Sex will auto-populate.
4. **Patient's Control #** — enter the patient account #, press [TAB].

5. **Billing Provider ID** — click on  to access the Provider Directory Search screen. Enter the Tax ID in the Fed.Tax ID field and click "Search." Click on the correct provider/vendor, ("select" button). Press [TAB]. Some Vendors are listed twice in Prelog. If entering a HCFA claim, select the V0P Vendor # (P for provider). If entering a UB claim, select the V0H Vendor # (H for hospital).

6. **Servicing Provider** — the individual provider who rendered the service. Identified in Prelog with a 6-digit provider number. Press on  to access the Provider Search screen. Click the Search button. Search by provider's last name. Prelog is configured to return only the providers listed under the Vendors Tax ID # selected.

7. **Referring Physician ID** — click on  to access the Provider Directory Search screen. Enter the referring providers UPIN # in the "UPIN" field, press [Enter]. Verify the providers name, click on the correct selection button to return to the Prelog screen. The Referring Physician Name will auto-populate. A name search can also be performed if not using UPIN. Press [TAB].

8. **Diagnosis 1** — enter the first diagnosis on the claim, press [TAB], decimal point required if code is greater than 3 characters.

9. **Diagnosis 2,3,4** — enter the second, third, and/or fourth diagnosis on the claim if applicable, after each, press [TAB].

10. **Total Amount Billed** — enter the total amount of the entire claim. Enter decimal points. Press [TAB].

11. **Total Amount Allowed** — not used at this time. Press [TAB].

12. **Claim Paper Work** — tab through this field.

13. **Claim Note 1** — tab through.

14. **Claim Note 2** — tab through.

15. **From Date of Service** — enter the initial date of service, press [TAB].

16. **To Date of Service** — system will default with the From Date of Service, press [TAB].

17. **Place of Service** — enter the place of service code, press [TAB].

18. **Type of Service** — system will auto populate with 01, press [TAB].

19. **CPT/HCPCS** — enter the five (5) character CPT or HCPCS code, press [TAB].

20. **Diagnosis Reference** — enter the number of the diagnosis code linked to the service line, press [TAB].

21. **1st Modifier** – enter the 1st modifier if applicable, press [TAB].

22. **2nd, 3rd, 4th, Modifier** — enter 2nd, 3rd, 4th modifier if applicable, press [TAB] after each.

23. **Amount Billed** — enter the total amount billed for the service line. Enter decimal point, press [TAB].

24. **Days or Units** — system will default to 1. Enter the number of units billed for the service line if different, press [TAB].

25. **OIC Allowed** — tab through this field.

26. **OIC Paid** — tab through this field.

8.4.1. Claim Detail entry (Anesthesia ONLY)

- **Note:** Unless the claim is for Anesthesia charges, the last entered field will be **Days or Units** before you tab to Add, and press Enter.
- The Anesthesia fields are required for Anesthesia claims only.
- Physical Status Codes: P3, P4, P5 are entered in the modifier field.
- Enter Start Time/End Time, OR Minutes, not both.
- The cursor will default to the Total Minutes field for entry of minutes billed. If the minutes are not billed, enter the Start Time and the End Time. The system will calculate the minutes and return an edit for verification. Example: Time billed 1:45 – 2:30, enter Start Time 145 End Time 230. Do not enter the minutes.

8.4.2. Adding/Finalizing a Service Line

- After the appropriate units are entered, tab to the "Add" field (highlighted yellow), and press enter. This will add the service line to Prelog.
- The cursor will move back up to the From Date of Service field to begin entering the second service line.
- After the service line has been entered and added, there will be a service line summary at the bottom of the page.
- Once a service is added, only the **Amt. Billed** and **Qty (Units)** fields can be edited in the summary lines.

8.4.3. Deleting a Service Line

If the service line needs to be deleted permanently or deleted and re-entered, the user will have the option to delete the line.

- To delete the service line, click on the ✕
- To make corrections to the member or the provider, click in the field selection to use the search function 🔭 to make any of the necessary changes.

8.4.4. Finalizing a Claim

Once all of the data has been entered on the claim:

- On the last service line entry, press or click on "Add" to add the service line.

- If all the services have been entered, press **F12** or click on "Save and Clear Form" button at the bottom of the screen. This will finalize the current claim and allow for another claim to be entered.

After the form (claim) has been saved and cleared, the following message appears: "A new HCFA claim record has been added to the pre-logging file." This indicates that Prelog system has accepted the claim.

- Press Enter, or click on OK to accept.
- The cursor will return to the Close Batch field (highlighted in yellow). You have the option to continue entering claims or close your Prelog batch. To continue entering claims within the same batch, tab to the Insured ID field to enter another claim. Clicking on the Close Batch button will close the Prelog Batch of entered claims.

8.4.5. Closing a Batch

The cursor will default to the **Close Batch** button (highlighted in yellow). Clicking on "Close Batch" will close out the Prelog Batch (radxxxxx) number and allow the user to create another. Once closed, all the claims are sitting in the Prelog claims database.

When do I close my batch?

- When you have completed entering the claims in your bundle of work.
- When the claim form type changes (HCFA/UB).
- When entering a new received date.
- When leaving your computer for any amount of time.

If not closing a batch, tab to the Insured ID field to enter another claim.

- Click on the **Close Batch** button to close the batch. If entering a new bundle of work, a new prelog batch will need created. Select a claim form type (HCFA or UB), click the New Batch button.

8.4.6. UB Claims Prelogging screen

Health Plan OnLine CST UB Claims — Field Descriptions (*) Denotes System-Required Field of Entry Yellow Fields are mandatory entry fields Green Fields are situational White Fields are auto-populated or not required			
Prelog Field		**UB**	**Usage**
UB	*		Identifies the claim form type entered. Click on UB.
Member Information			
Cert/ SSN/HIC/ Insured ID	*	60	Member's 11-digit ID #. Enter the 11-digit Member # directly into the field — no dashes. If the member cannot be found, the member search screen is available. Click on the or press [Enter] to access.
Patients Name	*		Auto-populates with the member's name.
Patients DOB	*		Auto-populates with the member Date of Birth.
Patients Gender	*		Auto-populates with the member's gender.
Patient's Control #	*	26	Patient Account Number assigned to the patient. If not entering, press the space bar and tab to leave blank.
Provider Information			
Billing Provider ID	*	5	Vendor or Billing Provider. TAX ID is the only search method. To access the provider search screen click on the or press [Enter]. If a match appears, verify the name and address of the provider. Some Vendors are listed twice in Prelog. If processing a HCFA claim, select the V0P Vendor # (P for provider). If processing a UB claim, select the V0H Vendor # (H for hospital).
Prov. FED. TAX ID #	*		Auto-populates with the Billing Provider's (Vendor) Tax ID number.
Prov. Name			Auto-populates with the billing provider's name.
Prov. Address			Auto-populates with the billing provider's address.
Prov. City			Auto-populates with the billing provider's city.
Prov. State			Auto-populates with the billing provider's state.
Prov. Zip			Auto-populates with the billing provider's Zip Code.
Prov. Phone #			Not used by the Health Plan.
Prov. PCP Flag			Not used by the Health Plan
Serv. Prov. ID		1	The cursor will bypass this field for UB entry. The servicing provider is the Billing Provider for UB entry.
Attending Phys ID		82	Attending Physician. Provider Search screen is available (UPIN look-up), click the to access. If Adm/Ref Provider cannot be found, leave blank
Admitting Phys ID		82	Admitting/Referring physician. Provider Search screen is available (UPIN look-up), click on the to access. If Adm/Ref Provider cannot be found, leave blank.

Facility ID	*	1	Enter the 6-digit provider number (not Vendor "V"#). Click on to access the Provider Directory Search screen. If needed, click on the Search button. Prelog is configured to return only the providers listed under the Vendors Tax ID # selected.
Header Information			
From Date	*	6	Admission Date or earliest date of service.
Through Date	*	6	Last date of service.
Admission Type	*	19	This is a code indicating priority of this admission/visit. (i.e., 1-Emergency, 2-Urgent, 3-Elective, 4-Newborn, 5-Trauma Center, 9-Info N/A)
Admit Date		17	Admission Date or earliest date of service.
Admission Hour		18	The hour of admission. System will default to 0.
Admission Source		20	This code indicates the source of this admission or outpatient registration.
Discharge Date	*	6	Last date of service on the claim.
Discharge Status	*	22	Discharge status. This code indicates the patient's status as of the "Through" date of the billing period. Field will default to 000.
Bill Type	*	4	Three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as the "frequency" code. (example 131 =Outpatient, 111=Inpatient).
Total Amount Billed	*	47	Total charge billed for the entire claim. Decimal point required. A system control record is set that requires all service lines to balance with the total billed amount at the header level.
Total OIC Allowed			Not used at this time.
Total OIC Paid			Not used at this time.
Occurrence Code 1-8			Not used at this time.
Principal Diagnosis Code	*	67	ICD-10 (diagnosis) code. Decimal point is required after the 3rd character when more than 3 are billed.
Admitting Diagnosis Code		76	Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization. Decimal point is required after the3rd character when more than 3 are billed.
Other Diagnosis Code 1-8		68-75	Additional diagnosis codes if applicable. Decimal point is required after the 3rd character when more than 3 are billed.
E Code		77	Begin with an "E"; E-Codes billed identify conditions related to poisoning and external causes of adverse effects of drugs and other chemical substances. Decimal point is required after the 4 character (example, enter E8585 as E858.5).
Procedure Code Method			Not used at this time. Cursor will bypass this field.

Principal Procedure Code		80	The ICD-10-CM code for the inpatient principle procedure. The principal procedure is the surgical procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of the complication. It is also the procedure most closely related to the principal diagnosis. Decimal point is required after 2nd digit.
Other Proc. Code 1-5		81	Other ICD-10-CM procedure codes other than the principal procedure. Decimal point is required after the 2nd digit.
Date			The date of each procedure code (the date that the surgery was performed).
Value Code 1-12		39, 40, 41 a-d	Value Code(s) and related dollar amount(s) identify data of a monetary nature monetary nature that are necessary for the processing of the claim. The codes are 2-digit alphanumeric. If more than one valued code is shown for a billing period, codes are shown in ascending alphanumeric sequence. There are four lines of data, line "a" through "d."
Value Code Amount			Amount associated with each Value Code.
Claim Paper Work			Not used at this time.
Claim Note 1-4		84	Not used at this time.
Claim Details Info			
Revenue Code	*	42	For each type of accommodation or ancillary, a Revenue Code is assigned. This is a 3-character field.
HCPCS Code		44	The 5 character HCPCS or CPT procedure code billed by the facility.
Date of Service	*		Date of service for the service line. (System will default with date from header.)
Days or Units	*	46	The number of times the procedure/service was performed, system will default to one.
1St – 4th Modifier		44	If applicable for the procedure. A modifier is an extension to the HCPCS/CPT code.
Amount Billed	*		The amount billed for that service line. Decimal point is required.
Amount Allowed			Not used by the Health Plan.
OIC Allowed			Not used at this time.
OIC Paid			Not used at this time.
OIC Deductible			Not used at this time.
OIC Co-Ins			Not used at this time.
OIC Not Covered			Not used at this time.
OIC Carrier Group			Not used at this time.
OIC Paid			Not used at this time.

8.4.7. UB - Claim Entry

The UB Form is used by hospitals and other hospital-type facilities for inpatient and outpatient billing.

From the sidebar menu: click **Enter Claims**

1. **UB** — click on **UB** to select the claim form type.
2. **Cert/SSN/HIC/ Insured ID #** — enter the member's 11-digit ID #, press [TAB]. Verify the member's name and date of birth that returns. Click on  to access the Member Search screen; if search is needed, press [TAB].
3. **Patient's Control #** — enter the patient account #, press [TAB].
4. **Billing Provider ID** — click on  to access the Provider Directory Search screen. Enter the Tax ID in the Fed. Tax ID field and click "Search." Click on the correct Vendor # ("select" button). The Providers Name, Address, City, ZIP, and State will auto-populate. Press [TAB]. Some Vendors are listed twice in Prelog. If processing a HCFA claim, select the V0P Vendor # (P for provider). If processing a UB claim, select the V0H Vendor # (H for hospital).
5. **Prov. PCP Flag** — will auto populate.
6. **Servicing Provider** — cursor will bypass the servicing provider field on the UB screen.
7. **Attending Physician ID** — enter the 6-digit provider #, or if not known click on  to access the Provider Directory Search screen. Enter the provider's UPIN in the Fed. Prov. ID (UPIN) field and click "Search." Click on the correct provider ("select" button). Press [TAB].
8. **Admitting Physician ID** — enter the 6-digit provider #, or if not known click on  to access the Provider Directory Search screen. Enter the provider's UPIN in the Fed. Prov. ID (UPIN) field and click "Search." Click on the correct provider ("select" button). Press [TAB].
9. **Facility ID** — enter the 6-digit provider number, (not Vendor "V"#). Click on  to access the Provider Directory Search screen; if needed, click the Search button. Prelog is configured to return only the providers listed under the Vendors Tax ID # selected.
10. **From Date** — enter the initial date of service for the claim, press [TAB].
11. **Through Date** —enter the last date of service for the claim, press [TAB].
12. **Admission Type** — enter admission type, system defaults to 01, press [TAB].
13. **Admit Date** — enter the admission date for the claim, press [TAB].
14. **Admission Hour** — enter admission hour, system defaults to 01, press [TAB].
15. **Admission Source** — enter admission source.

16. **Discharge Date** — enter the date of discharge for the claim, press [TAB].

17. **Discharge Status** — enter discharge status, press [TAB].

18. **Bill Type** — enter bill type.

19. **Total Amount Billed** — enter the total amount of the entire claim. Enter decimal point, press [TAB].

20. **Total OIC Allowed** — not used at this time. Press [TAB].

21. **Total OIC Paid** — not used at this time. Press [TAB].

22. **Occurrence Code** — not used at this time. Press [TAB].

23. **Principal Diagnosis Code** — enter the principal diagnosis code billed on the claim. Enter decimal point after 3rd character, press [TAB].

24. **Other Diagnosis Codes 1-8** — enter if applicable for claim. Enter decimal point after 3rd character, press [TAB].

25. **Admitting Diagnosis Code** — enter if applicable for claim. Enter decimal point after 3rd character, press [TAB].

26. **E Code** — enter E code if applicable for claim. Enter decimal point after 4th character. Press [TAB].

27. **Procedure Code Method** – not used at this time. Press [TAB].

28. **Principal Procedure Code** – enter code if applicable, enter decimal point after 2nd character, press [TAB].

29. **Date** — enter the date for the principal procedure code if applicable, press [TAB].

30. **Other Procedure Code 1-5** — enter additional codes if applicable, enter decimal point after 2nd character, and press [TAB].

31. **Date** — enter the date for the Other Procedure codes if applicable, press [TAB].

32. **Value Code 1-12** —**-** enter value codes if applicable. The cursor will only stop at the first value code. If additional value codes are being submitted, the fields must be re-entered.

33. **Amount** — enter the value code amount for each value code entered. Decimal point required. press [TAB].

34. **Claim Paper Work, Claim Note 1-4** — not used at this time. Press [TAB].

8.4.8. Claim Detail entry

1. **Revenue Code** — if applicable, enter the Revenue code for service line. press [TAB].

2. **HCPCS Code** — if applicable, enter the (5) character HCPCS/CPT code and press [TAB].

3. **1st – 4th Modifier** — enter if applicable for the service line, press [TAB].
4. **Date of Service** — enter the service date for the service line.
5. **Days or Units** — enter the number of units for the service line; system will default to 1, press [TAB].
6. **Amount Billed** — enter the total amount billed for the service line. Decimal point required, press [TAB].
7. **OIC Fields** — not used at this time. Press [TAB] through these fields.

8.4.9. Adding/Finalizing a Service Line

- After the appropriate Units are entered, tab to the "Add" (highlighted yellow) and press enter. This will add the service line to Prelog.
- The cursor will move back up to the Revenue Code field to begin entering the second service line.
- After the service line has been entered and added, there will be a service line summary at the bottom of the page. The screen print below illustrates this.
- Once a service is added, only the **Qty (Units)** and **Amt. Billed** fields can be edited in the summary lines.

8.4.10. Deleting a Service Line

If the service line needs to be deleted permanently or deleted and re-entered, the user will have the option to delete the line.

- To delete the service line, click on the ✕
- To make corrections to the member or the provider, click in the field to use the search function 🔭 to make any of the necessary changes.

8.4.11. Finalizing a Claim

Once all of the data has been entered on the claim

- On the last service line entry, press or click on "Add" to add the service line.
- If all the services have been entered, press **F12** or click on "Save and Clear Form" button at the bottom of the screen. This will finalize the current claim and allow for another claim to be entered.

After the form (claim) has been saved and cleared the following message appears: "A new UB claim record has been added to the pre-logging file." This indicates that Prelog has accepted the claim.

- Press Enter, or click on OK.

The cursor will return to the Close Batch field (highlighted in yellow). You have the option to continue entering claims or close your Prelog batch. To continue entering claims within the same batch, tab to the Cert/SSN/ HIC.ID# field to enter another claim. Clicking on the Close Batch button will close the Prelog Batch of entered claims.

8.4.12. Closing a Batch

The cursor will default to the **Close Batch** button (highlighted in yellow). **Close Batch** will close out the Prelog Batch (radxxxxx) number and allow the user to create another. Once closed, all the claims are sitting in the Prelog claims database.

When do I close my batch?

- When you have completed entering the claims in your bundle of work.
- When the claim form type changes (HCFA/UB).
- When entering a new received date.
- When leaving your computer for any amount of time.

If not closing the batch:

Continue entering claims within the same batch, tab to the Cert/ SSN/ ID. # field to enter another claim.

- Click the Close Batch button. If entering new bundle of work, a new batch will need created by clicking on the claim **form type (HCFA or UB)** and then clicking on **New Batch** button.

8.4.13. Create Batches

When the Prelog batch or batches (i.e. radxxxxx) are *Closed* (by clicking on the Close Batch button), the claims sit in the Prelog Claims table. The Create Batches function begins the editing process by consolidating all the Prelog Batches physically entered into one separate electronic batch number and automatically assigning an Internal Batch ID number and an Extended Batch ID. At the time this record is created, the data is validated against the MC400 system. The clean claims (claims without errors that pass through to MC400) will automatically Post to the MC400 System where they can be accessed by the "Form Number" (MC400 claim number). When validation and editing is complete, the system will return a batch status of "Awaiting Post Process" or "Post Complete." If there are errors within some of the claims in the batch, the MC400 system won't allow those claims to be posted. However, the claims with no errors will be posted.

From the sidebar menu: click **Create Batches**

Next, click on either Create UB Batch or Create HCFA Batch, or both, if claims were entered under each form type (box will be highlighted). At this time, the Prelog Claims table is read and the claims are combined into one electronic claims batch, creating a new batch number record. At the same time the claims are automatically submitted to the MC400 system for editing.

After clicking on Create UB Batch and/or Create HCFA Batch, notification is returned that "*All prelog batches have been consolidated into one batch and inserted into the database.*" When the Prelog batches are consolidated into the database, the system assigns an Internal Batch ID number (4-characters) and an Extended Batch ID number. The Extended Batch ID number generated by Prelog will have 6-characters and will start at one every day and be prefaced with the date value (example, 20040108000001, 2004010800002, etc.) This Extended Batch ID number will display in the upper right hand corner in the *Orig Batch/EntDate* field of both claims screen in MC400. Both the Internal and Extended Batch ID numbers can be used as a search method to access specific batches in Prelog.

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