



PROVIDER PORTAL DOCUMENT

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INTRODUCTION

The Provider Portal is a robust tool which allows providers to both submit and view data, as well as, communicate directly with the organization. Within the portal, providers can perform key tasks including entering and look up of authorization requests and claims. It also gives you a platform for performing eligibility verification of the patient.

The portal also allows providers to print EOBs on-demand. Each of these functions serve to make the provider staff happier and more efficient. To login to the Portal, go to <https://procaremso.quickcap.net> using Mozilla FireFox.

❖ AUTHORIZATION/REFERRAL

From the **Authorization/Referral** module, users are able to submit a new authorization and referral and check the status of an existing authorization.



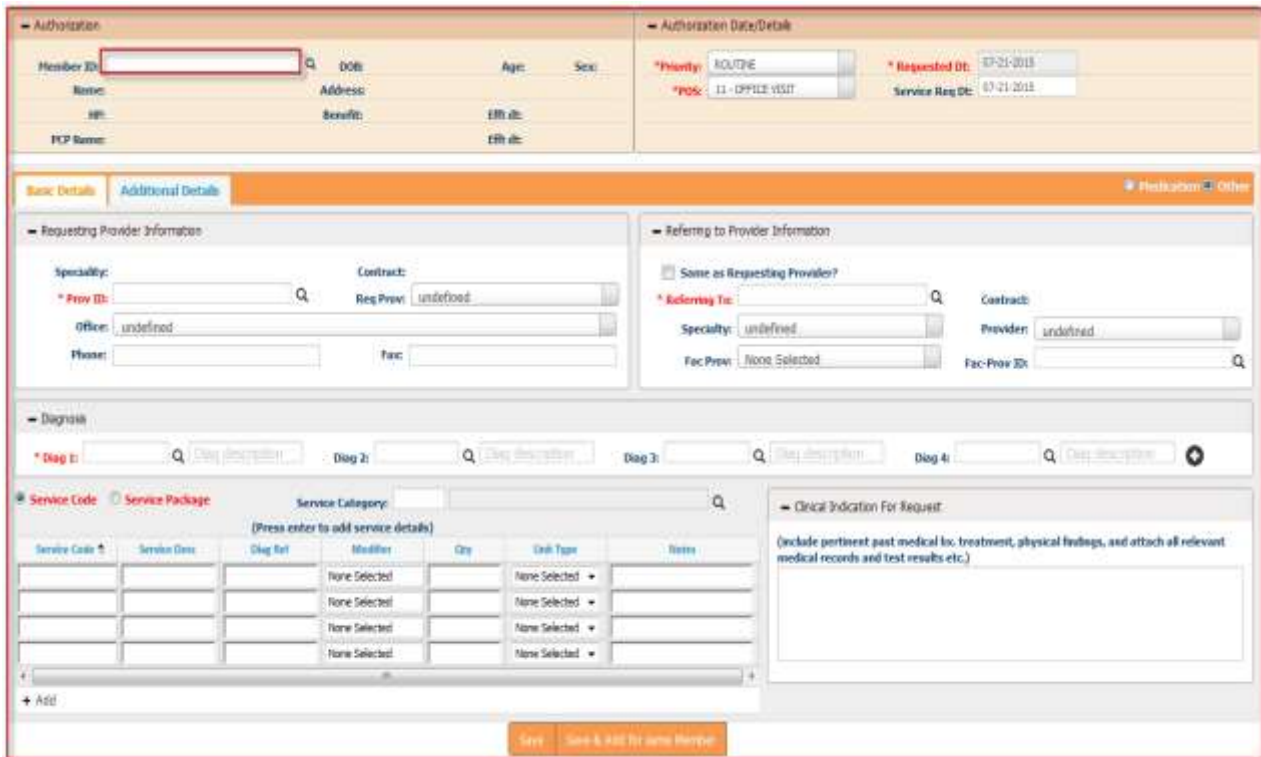
● SUBMITTING A NEW AUTHORIZATION

Step 1: From the **Authorization/Referral** list, select **New Auth Entry**.

To submit a new authorization, follow the steps below:



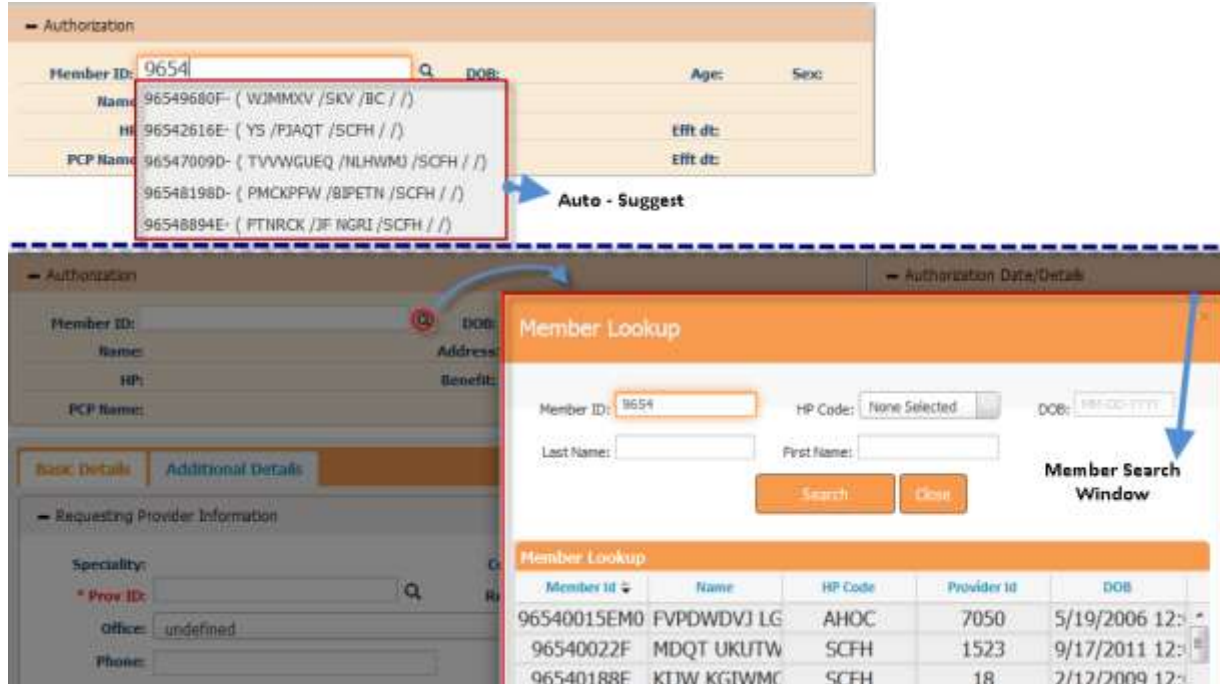
Step 2: The screen will display as shown below. On this screen, there are three subsections to add an authorization.



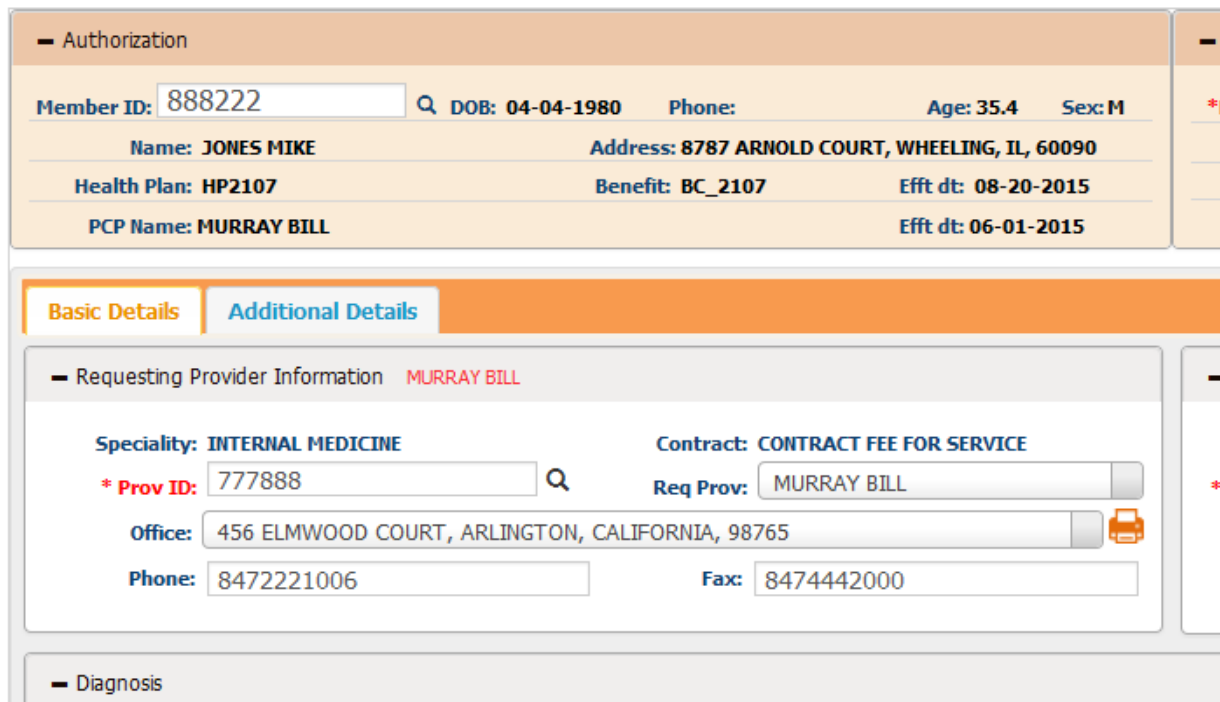
The screenshot shows a web-based authorization request form. At the top, there are two main sections: 'Authorization' and 'Authorization Date/Details'. The 'Authorization' section includes fields for Member ID (highlighted with a red box), Name, Address, Age, Sex, and HCP Name. The 'Authorization Date/Details' section includes Priority (ROUTINE), Requested Dt (07-21-2013), POS (II - OFFICE VISIT), and Service Req Dt (07-21-2013). Below these are tabs for 'Basic Details' and 'Additional Details'. The 'Basic Details' section is further divided into 'Requesting Provider Information' and 'Referring to Provider Information'. The 'Requesting Provider Information' section includes fields for Speciality, Contract, Prov ID, Reg Prov, Office, and Phone. The 'Referring to Provider Information' section includes a checkbox for 'Some as Requesting Provider?', Referring To, Contract, Speciality, Provider, Fac Prov, and Fac-Prov ID. The 'Diagnosis' section has four fields for Diag 1 through Diag 4, each with a search icon and a description field. The 'Service Code' section has a table with columns for Service Code, Service Desc, Diag Ref, Modifier, Qty, Unit Type, and Items. The 'Clinical Indication For Request' section has a text area for providing medical history and test results. At the bottom, there are 'Save' and 'Save & Add to same Request' buttons.

Step 3: The first section is the **Member Section**. Users can enter the member’s information in one of two ways:

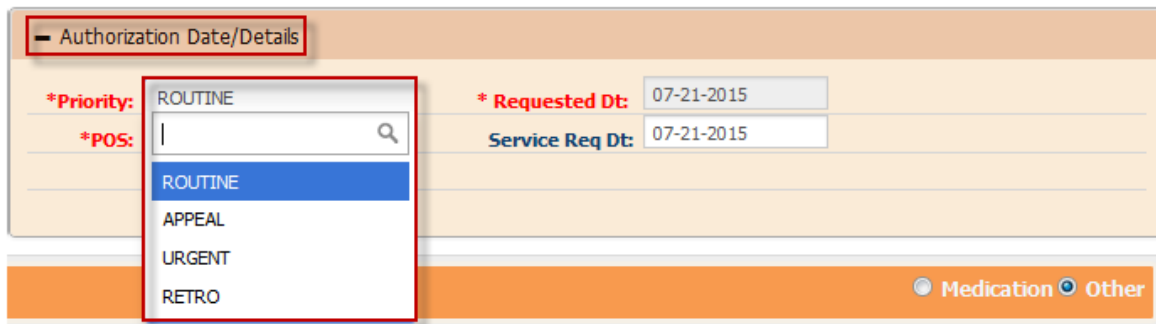
- Enter the **Member ID** for the specific member. The system will begin suggesting members once the user has entered part of an ID. Users can then select the correct ID to add the member’s information to the screen.
- Users can click on the **Magnifying Glass** icon to search for the member. The **Member Lookup** screen will open. From this screen, users can search using a combination of **Member ID, Health Plan, Name, and DOB** to find the record. Double click the correct record to add it to the authorization request.



Step 4: The details for the selected member will be populated on the screen. The system will default the **Requesting Provider** information matching the organization and provider logged in.



Step 5: The user can select the **Priority** and the **Place of Service** for the request.



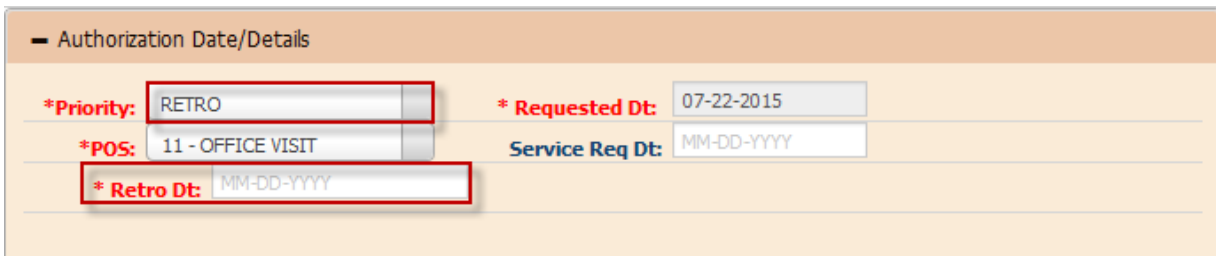
- Authorization Date/Details
 *Priority: ROUTINE
 *POS: |
 *Requested Dt: 07-21-2015
 Service Req Dt: 07-21-2015
 Medication Other

- Within the **Priority** dropdown menu, two options which will trigger a popup screen to appear or additional options.
 - **Urgent:** If selected, the **Required Information for Urgent Requests** screen will open. Enter the necessary information and click the **Add** button to complete this step.



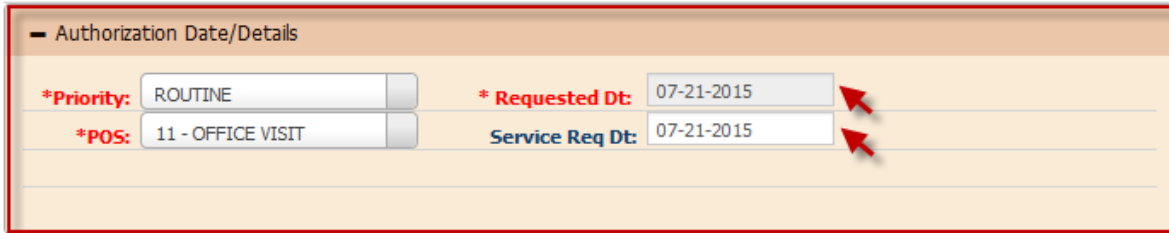
Required information for urgent requests
 ABUSE OF URGENT PA STATUS WILL BE MONITORED. Urgent Request MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient in the provider's best professional judgement. Please explain reason for urgency in Clinical Indications for Request section below.
 * Person Requesting: _____ * Phone Number: _____ * Fax Number: _____
 Email Address: _____
 Address: _____
 Reason for Request/Comments: _____
 Add

- **Retro:** If the services have already been provided, users should select **Retro**. A new field, **Retro Date**, will appear and require date entry.



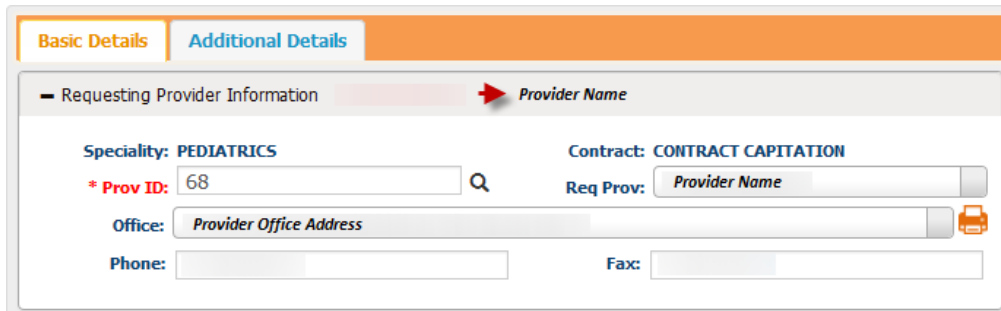
- Authorization Date/Details
 *Priority: RETRO
 *Requested Dt: 07-22-2015
 *POS: 11 - OFFICE VISIT
 Service Req Dt: MM-DD-YYYY
 *Retro Dt: MM-DD-YYYY

Step 6: The section to the right of the **Member Details** is the **Authorization Date/ Details**. The **Requested Date** is non-editable and will always default to the date of submission.

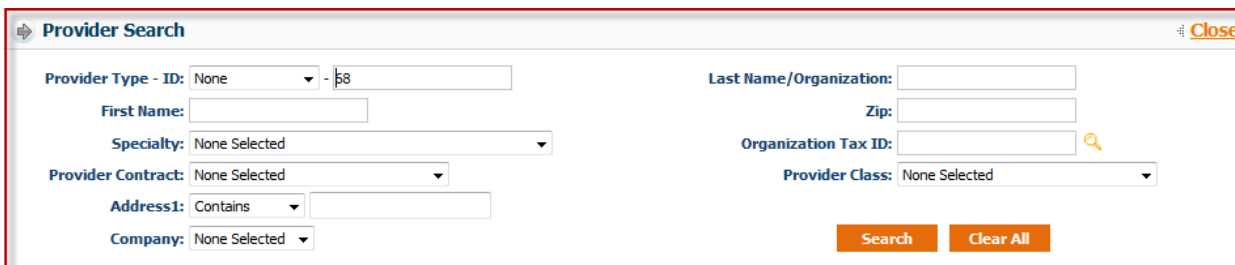


- The **Service Requested Date**, displayed in the **Service Req. Dt** field should be entered as the date that the service should be performed, scheduled for, or for the authorization to become effective. This date will be reviewed by Nivano Physicians internal staff and is subject to their discretion.

Step 7: The **Basic Details** tab displays the **Requesting Provider Information**. This screen includes the **Specialty, Contract Type, Provider ID, Requesting Provider Name**, and the contact information.



- Users can search for a requesting provider by clicking the **Magnifying Glass** icon on the right of the **Provider ID** field. The **Provider Search** screen will open as shown below. Search the provider by entering any of the available information. If you click on search without entering any parameter, all providers under your organization will show up.

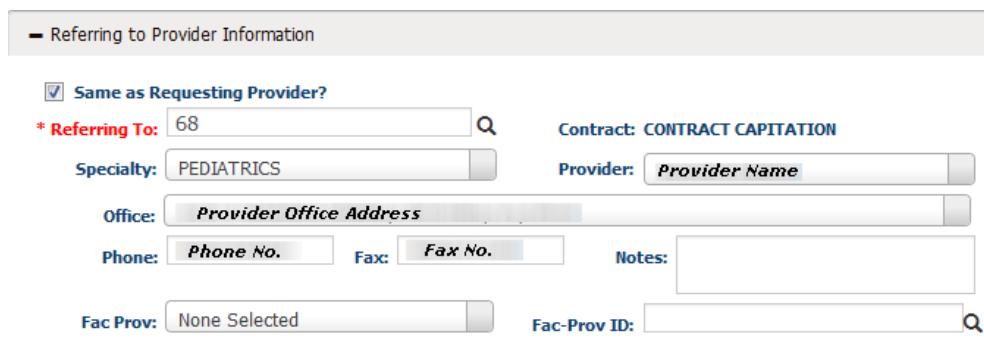


- Click the **Provider ID** indicated in orange to populate the details of the requesting provider on the authorization request.
- If the provider has multiple offices, users can select the correct office from the dropdown menu.

Step 8: The next section, **Referring to Provider Information**, allows users to enter the information for the provider that member is being referred to.



- For self-referrals, select the “Same as Requesting Provider” checkbox. This will auto-populate the information from the Requesting Provider screen.
- To search for a Referring To Provider, click the Magnifying Glass icon beside the Referring To field. The Provider Search screen will populate as shown in the above section. Users can search for the specific provider.
- Click the correct Provider ID to enter the details of the referring provider on the authorization request



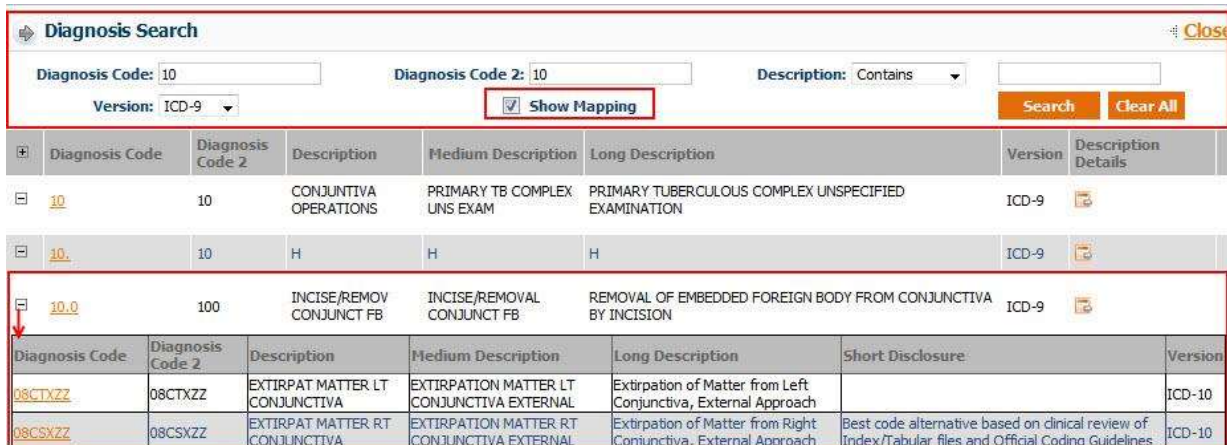
- Then, select the **Referring to Office** from the dropdown menu.

Step 9: This step is optional. Users can enter **Facility Provider Information** for the request, if needed.

Step 10: The next section, **Diagnosis**, is where users will enter all diagnosis details for a request.



- Enter all ICD codes related to the request in the **Diagnosis Code** field.
 - If the user knows the ICD code, they can enter it into the field and press **tab** on their keyboard. The system will populate the description to the right in the **Diag. Description** field. The system will auto suggest codes if they are partially entered.
 - To search for the diagnosis code, click the **Magnifying Glass** icon by the **Diagnosis Code** field. The **Diagnosis Search** screen will populate, as shown below.



Diagnosis Code	Diagnosis Code 2	Description	Medium Description	Long Description	Version	Description Details
10	10	CONJUNTIVA OPERATIONS	PRIMARY TB COMPLEX UNS EXAM	PRIMARY TUBERCULOUS COMPLEX UNSPECIFIED EXAMINATION	ICD-9	
10.	10	H	H	H	ICD-9	
10.0	100	INCISE/REMOV CONJUNCT FB	INCISE/REMOVAL CONJUNCT FB	REMOVAL OF EMBEDDED FOREIGN BODY FROM CONJUNCTIVA BY INCISION	ICD-9	
Diagnosis Code	Diagnosis Code 2	Description	Medium Description	Long Description	Short Disclosure	Version
08CTXZZ	08CTXZZ	EXTIRPAT MATTER LT CONJUNCTIVA	EXTIRPATION MATTER LT CONJUNCTIVA EXTERNAL	Extirpation of Matter from Left Conjunctiva, External Approach		ICD-10
08CSXZZ	08CSXZZ	EXTIRPAT MATTER RT CONJUNCTIVA	EXTIRPATION MATTER RT CONJUNCTIVA EXTERNAL	Extirpation of Matter from Right Conjunctiva, External Approach	Best code alternative based on clinical review of Index/Tabular files and Official Coding Guidelines	ICD-10

- From the **Diagnosis Search** screen:
 - Enter either the diagnosis code or description to search for the code.
 - Select the version of the code. ICD 9 codes will default. However, users can search for ICD 9, ICD 10, or for both codes.
 - Users can view the mapping between versions by selecting the **Show Mapping** checkbox.
 - Click the **Search** button.
 - Click the **+** icon to the left of each code to view the mapping.
 - Select the desired code by clicking on the correct **Diagnosis Code** shown in orange.

Note: Users can add 12 distinct diagnosis codes.

Step 11: The next section is used to enter the CPT/HCPCS codes for the requested services.

CPT/HCPCS Code Service Package

CPT/HCPCS Code	Service Desc	Diag Ref	Modifier	Qty	Unit Type	Notes
99201	OFFICE/OUTPATIENT	1	None Selected	1	None Selected	SAMPLE NOTES
		1	None Selected	1	None Selected	
		1	None Selected	1	None Selected	
		1	None Selected	1	None Selected	
		1	None Selected	1	None Selected	

(Press enter to add service details)

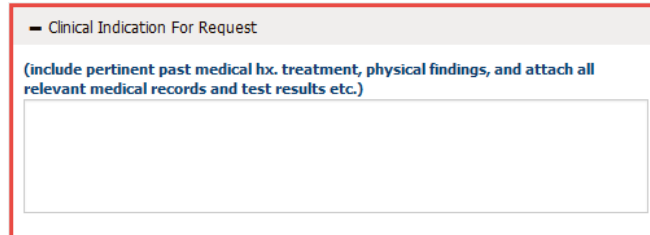
Service Code	Service Desc	Diag Ref	Modifier	Qty	Unit Type	Notes
99213	OFFICE/OUTPATIENT	1	None Selected	1	None Selected	
			None Selected		None Selected	

(Press enter to add service details)

Service Code	Service Desc	Diag Ref	Modifier	Qty	Unit Type	Notes
99213	OFFICE/OUTPATIENT	1	None Selected	1	None Selected	
			None Selected		None Selected	

- The option for **CPT/HCPCS Code** defaults for entry; users can select **Service Package** if it is enabled. This will be described further below.
- To utilize the **CPT/HCPCS Code** option, users can enter the service code or search for the service code by clicking **F2** on the keyboard.
- If **Service Package** is selected, users can select the package from the dropdown menu. **Service Packages** may consist of multiple codes that are affiliated. This can be used to identify certain services such as Office Visits or Consultation visits.
- After the code is entered, the description will auto populate into the **Service Desc** field.
- Users can enter the **Diagnosis Reference**. The system will default automatically to 1, which indicates that the code is linked to the first ICD code from the **Diagnosis** section. Users can change the digit corresponding to which diagnosis code the service should reference.
- Users can enter a quantity for the service and select the unit type. If none is selected, it will default to **None** and for 1 for the **Quantity**.
- Users can add any modifiers if needed. Modifiers can be selected from the dropdown menu or manually enter the code.
- Press **tab** on the keyboard to go to the next CPT (service) line.

Step 12: The next section is **Clinical Indication for Request**. In this section, users can add the member’s past medical history, physical findings, service notes being requested, or attach all relevant medical records and test results.



Step 13: The second information tab is **Additional Details**. Within this tab, three more sections will appear.

Step 14: The first section is **Documents**. Users can upload and attach documents to the referral request. Users are also able to fax documents to the organization. To upload documentation and submit it electronically with the referral request:

- Select the **Category** and **Priority** of the document.
- Click **Browse** to find the file from the computer directory
- Upload documents in the following formats: .doc, .docx, .xls, .xlsx, .pptx, .xps, .psd, .htm, .pdf, .tiff, .rtf, and text.
- Click the **Add Additional Documents** button to add multiple documents.
- Once users click **Save**, the document will send with the referral automatically.

Step 15: After verifying the data entered, users can save the request.

- To submit the referral request, click **Save**.
- To submit the referral request and add another request for the same member, click **Save and Add for Same Member**.



Note: When an authorization or referral request is submitted, users will receive a notification detailing the authorization request number with the status. Then on the **Authorization** screen, the recently submitted authorization number will be displayed automatically on the header portion.

Authorization - 20140722T8800001

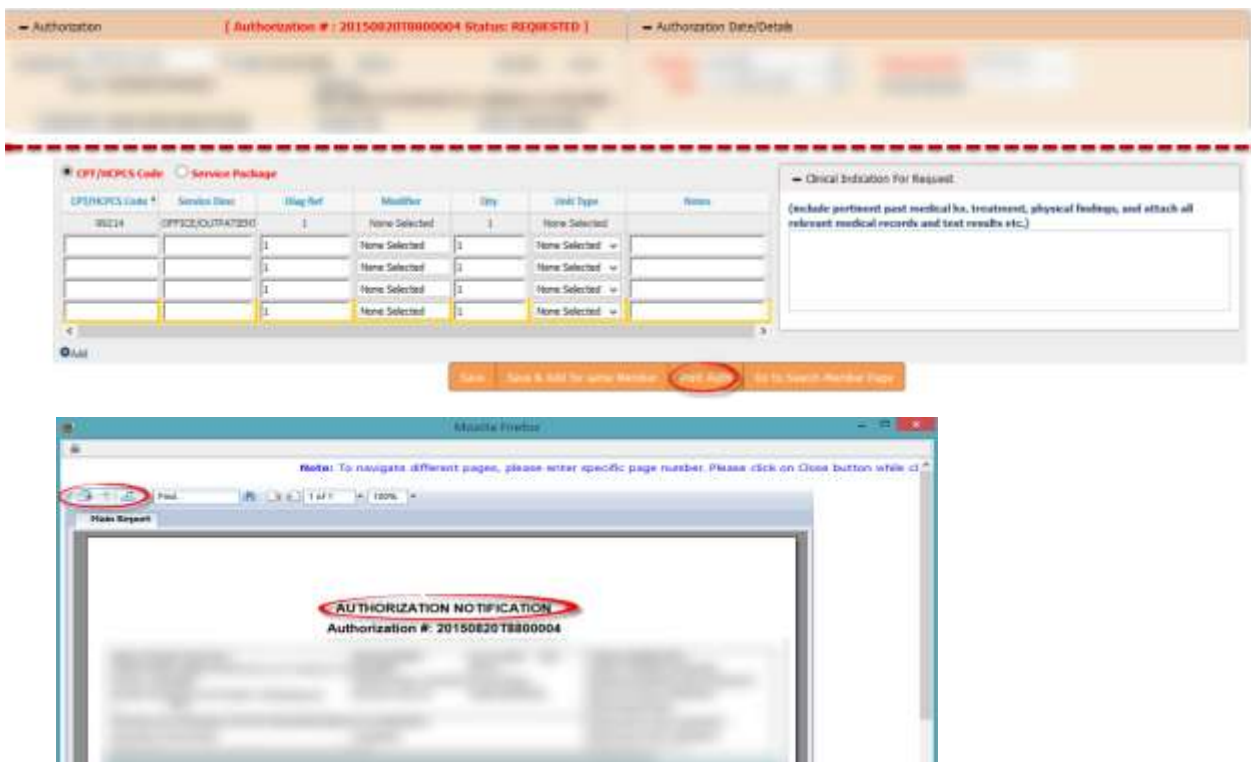
Member ID: DOB: _____ Age: _____ Sex: _____

Name: _____ Address: _____

Health Plan: _____ Benefit: _____ Eff dt: _____

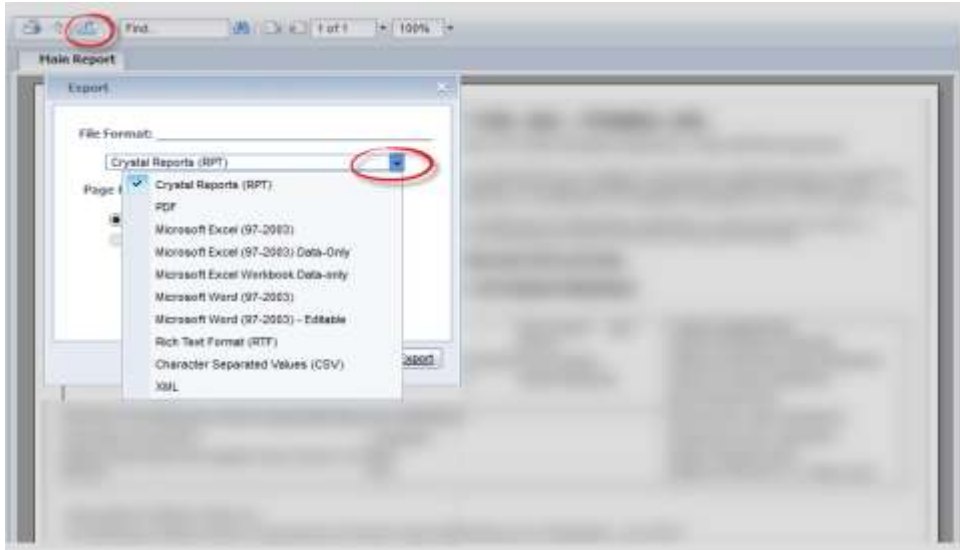
PCP Name: _____ Eff dt: _____

Step 16: Users have the option to **Print Auth** on the lower section of the screen once it is saved. This feature allows users to print authorization requests. The popup window gives options to print and export the request.



- **Export Options:** There are several options that the reports can be exported to:
 - Crystal Reports (RPT)
 - PDF
 - Excel 97 – 2003
 - Excel 97 – 2003 Data Only
 - Excel Workbook Data Only
 - Word 97 – 2003
 - Word 97 – 2003 Editable
 - Rich Text Format (RTF)
 - Character Separated Values (CSV)

- XML



• CHECKING THE STATUS OF AN AUTHORIZATION

To verify the status of an authorization, follow these steps:

Step 1: From the **Authorization/Referral** list, select **View/Search Authorization**.



Step 2: The **Authorization/Referral Status Search** screen will display as shown below:

Authorization/Referral-Status Search

Member ID: Last Name: First Name:
 Member SID: DOB: Auth. No:
 Request/Receive Date From: Request/Receive Date To:
 Auth. Date From: Auth. Date To:
 Referring physician ID: Referring To physician ID:
 Referring Org ID: Created By:
 Company: Health Plan:
 Place of Service: Priority/Session ID:
 Referring To Org ID:
 Search Clear All

No. of Authorizations: 7

Authorization No. Status	Member ID	DOB	Requesting Physician	Referring To Physician	Health Plan	Place of Service	Request	Comments
11000001 REQUESTED	110001 DOE JANE	01-01-1981	10001 Smith John (Medical Organization, Inc.)	10001 Smith John (Medical Organization, Inc.)	Commercial Health Plan	OFFICE VISIT (01/01/2015)	QUICKCAP	
Request/Receive Package:			Service/Package Description:	ICD9/ICD10/ICD9CM/ICD9PCS	ICD9	Description:		
110001			OFFICE VISIT/781781F VISIT SST					COUGH HEADACHE

Step 3: The first section is where users search for authorizations. Enter search criteria in any of the available fields. The search results will display in the results section below.

Step 4: Click the (+) icon to view the services requested in the authorization. The service information will be visible.

Step 5: The status of the authorization (requested, approved, denied) is displayed in the **Authorization No. Status** column.

Step 6: To view all of the information for a specific authorization, click on the row for the authorization. This will redirect users to the **Authorization/Referral Status Search** screen with all of the authorization details.

Note: This screen is only for viewing purposes. Only a few sections are enabled.

Authorization/Referral-Status Search Collaps All Back

Additional Details
Member History
Cancel Authorizations

Save
Print

The use specified previously in compliance with HIPAA regulations, your search results of the member on this web page will be limited to "active referral" from the primary care provider. Should you not have the patient's external referrals, please ask your patient to either log into an ePCP prior to your office appointment.

Authorization Details Request Type: Medication Other

Authorization No: 11000101000001
 Created By: Nancy McQueen Created Date From: 04/11/2015 12:00:00
 Member ID: 110001
 Place of Service: OFFICE VISIT
 Service Category:
 Advertiser ID:
 Valid From/Active Date: 01/14/2015
 Valid For: Day(s)
 Valid To/Authorization Date: 01/20/2015
 Challenge Date:
 Referral To Member: N/A
 Referral To Provider: N/A

Member Details Company: QUICKCAP

Member ID: 110001
 Member Name: DOE JANE
 DOB: 01-01-1981 Age: 33.8 Sex: F
 Member Address:
 PCP ID: 10001
 PCP Name: Smith John
 PCP Phone: (475)51234
 PCP Effective Date: 02-03-2015
 PCP Effective Date: 02-03-2015
 Language:
 Health Plan: Commercial Health Plan
 Call/Phone Number:
 PCP Fax: (475)51234
 PCP Approved: Yes No Unknown Rev: 001

Step 7: To add additional details to the current authorization request, click the **Additional Details** button. The **Additional Details** screen will populate as shown below.

Additional Details [Close](#)

Additional Details saved successfully.

General Details

* Review Date: User: Priority: Criteria:

* Notes:

Add

Edit	Date	User	Priority	Criteria	Status	Level of Care	Notes	Submitted Date	Delete
	09-14-2015		M		REQUESTED		The member requires additional care.	09-14-2015 14:08:09	

- In the **General Details** section, select the review date, priority of detail and criteria. Enter the information needed in the **Notes** field. Click the **Add** button to save the details.
- If you want to edit already added details, click the **Edit** icon.

Step 8: To view the member’s eligibility details, click the **Member Eligibility** button. The **Member Eligibility** screen will populate as shown below.

Member Eligibility [Close](#)

Auth No.: 20150914T8800001 and Requested Date: 09-14-2015 and Member: DOE JANE (111222) HCL1 - BCL1 - 01-01-1981 (34.8F - Adult)

Member Details **MOOP Details**

Member ID: 111222, Name: DOE JANE, DOB: 01-01-1981, Age: 34.700, Other Member ID: and Status:

Address	Address 2	City	State	Zip	Phone	Work Phone	Extension	Fax	Email	Language

Eligibility Details

Provider	Provider Name	PCP From Date	PCP To Date	Org Name	PCP Phone #	PCP Fax #
112233	Smith John	01-01-2015		Medical Organization, Inc.	8475551234	8475551234

Health Plan Details

HP Code	Health Plan Name	LOB	Benefit Code	Effective From Date	Effective To Date	Other Coverage?	Resp. Code	Policy #
HCL1	Commercial Health Plan	COMMERCIAL INSURANCE	BCL1	01-01-2015		No		

Benefit Code Details

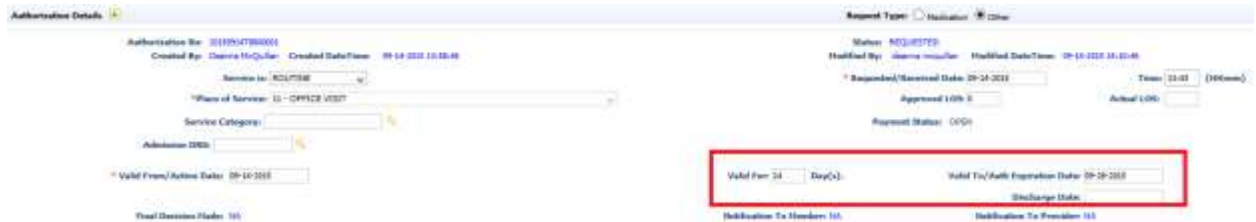
Benefit Code	Benefit Description	Copay Copy Instance Type	CoInsurance %	CoInsurance Instance Type	From Date	To Date	Benefit Notes
BCL1	Benefit Code Commercial	\$0.00			01-01-2015		

[Detail Option](#)

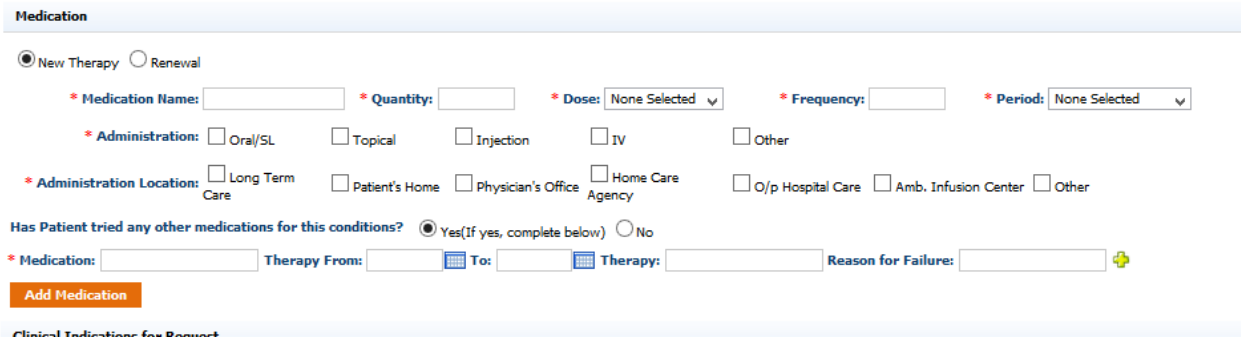
Step 9: If you want to extend the date of authorization, then click the **Extend Authorization** button. A message will pop up as follows.



- Click the **OK** button. This will redirect the user to the **Auth Expiration Date** field. Users can extend by either entering the new authorization expiration date or by entering the number of days in **Valid For** field.



Step 10: Users can add medication details and edit existing medication details from the **Medication** section.



Step 11: Users can send additional documentation related to the referral by adding the attachments in the **Documents** section.



Step 12: Click the **Save** button to save the updated request.



❖ CLAIMS

From the **Claims** module, users are able to submit a new claim view and search for previously submitted claims.



● SUBMITTING A NEW CLAIM

To submit a new claim, follow the below:

Step 1: From the **Claims** list, select **Provider – Direct Submission**.




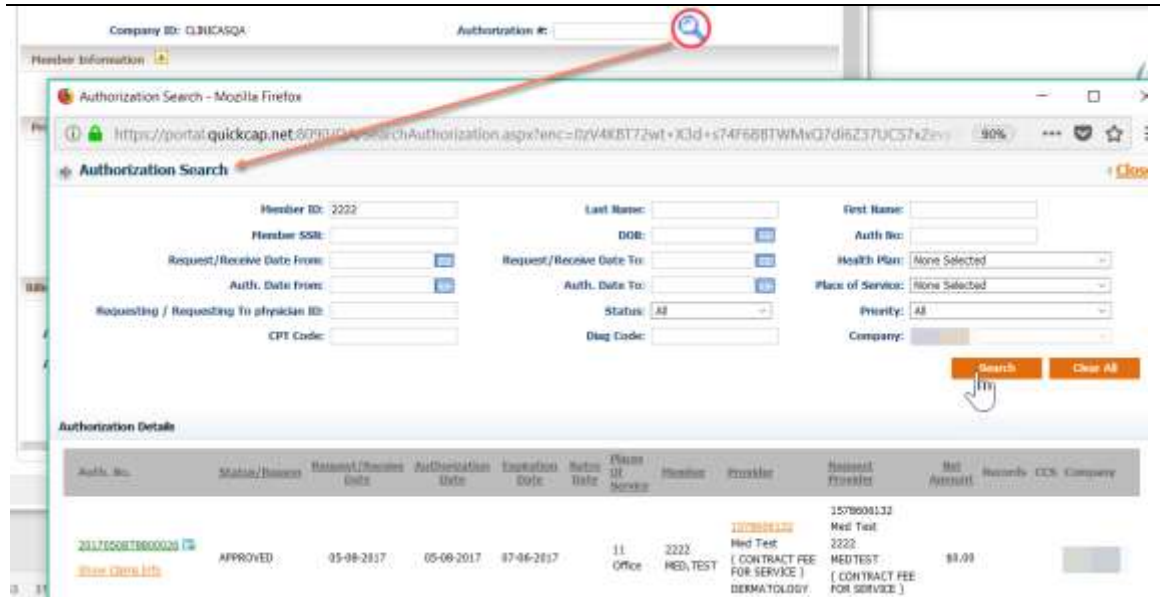
Step 2: The screen will display as shown below. Look up the member for which you want to add claim for, using Member ID or Last Name, DOB and HealthPlan, by adding details in search and clicking on search icon.



Step 5: Below are the steps to add details on the claim:

- Add **Authorization number** on the claim. You can click on the magnifying glass to look up an authorization from the system. Click on the Auth# to select the auth for this claim.

Company ID: Authorization #: 



Company ID: CLBCASQA Authorization #:

Member Information

Authorization Search - Mozilla Firefox

https://portal.quickcap.net:5070/CA/SEARCHAuthorization.aspx?enc=0zV4KBT72wt+X3d+s74F66BTWMvG7d6Z37UC57x2ev 90%

Authorization Search

Member ID: 2222 Last Name: First Name: Auth No: DOB: Request/Receive Date From: Request/Receive Date To: Health Plan: None Selected Auth. Date From: Auth. Date To: Place of Service: None Selected Requesting / Requesting To physician ID: Status: All Priority: All CPT Code: Diag Code: Company: Search Clear All

Authorization Details

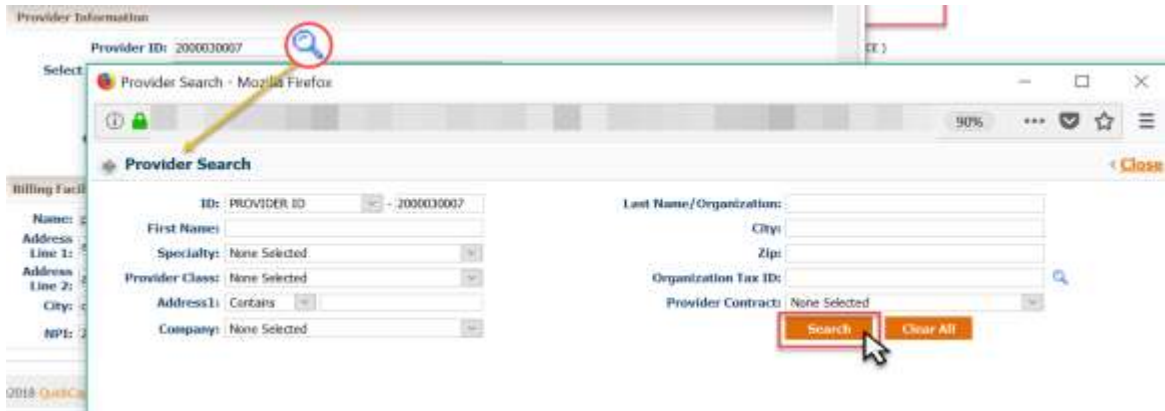
Auth. No.	Status/Reason	Request/Receive Date	Authorization Date	Expiration Date	Auto Date	PLAN ID	Member	Provider	Request Provider	Net Amount	Reasons	CCS	Company
211750818600021	APPROVED	05-08-2017	05-08-2017	07-06-2017	11	2222	MED_TEST	1579608132	Med Test	\$1.00			

- Basic **member information** will automatically populate, based on the member we selected initially before we clicked **Submit Claim**

Member Information

ID: 2222 Name: MED TEST
 DOB: 01-01-1965 Sex: M Health Plan: TestMed

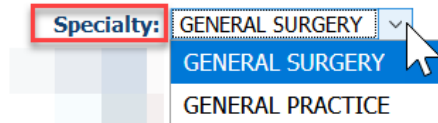
- Under **Provider Information** section, you can choose the rendering provider for the claim. Provider can be selected using two options
 - **Provider ID** search using magnifying glass, to look up provider using filters. Once you have the provider in result grid, click on the ID to select the provider.



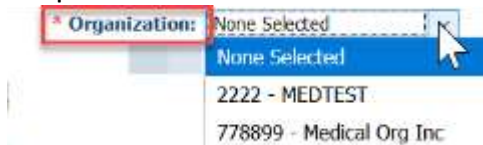
- Select the Provider drop down. which will show you all providers under your organization.



- Once you have selected the provider, all other details will be auto-populated.
- If you wish to change the specialty of the provider (In case the provider is multi-specialty), click on the specialty drop down.



- If you wish to change the organization (Billing entity) you can click on the drop down to choose from different organizations linked to this provider.



- **Addresses – Billing, Service and Pay to**

- These addresses will auto-populate based on the provider and organization selected. However, if you wish to manually override it, you can.



- **Additional Information** section will let you add additional details on this claim like
 - **Patient Account #**
 - **Patient paid amount**
 - **Purchase service amount**

- **Claim Details** will let you enter the **POS** of this claim.
 - When the POS added is an inpatient POS, it lets you add the admit and discharge date.



Note: In case of inpatient claim, it is mandatory to add Admit date.

- When the POS is Ambulance, the ambulance icon gives you pop up to add ambulance details. Fill in the details and click on OK to save the ambulance details.



- **Diagnosis** field lets you add 12 distinct diagnosis on the claim. You can either type in the diagnosis code (Tab Out) and hit add OR you can look up the diagnosis code using the magnifying glass.



- **Services** lets you add all the details for procedures to be billed on this claim.

Services Registered Values with mandatory errors exist.

Service Date-Time	Service Code	NDC Code - Qty - Unit	Mod/Fin	Diag. Ref.	Qty - Bill/pt	Other Insurance	Notes
From: 10-02-2017 14:30 To: 10-02-2017 15:05	0149 ANESTH KNEE RR...	11-digit 3-4-2 08021-8000 08 3 ML/oz	Final: 1 Final: 2	Ref: 1	Qty: 1 Bill: \$70.00	30	
From: 10-01-2017 To: 10-01-2017	09213 OFFICE/OUTPATIENT VISIT EST	NDC Code: 57520-05-0-06 Quantity: 2 Unit Type: ME	25	1	Qty: 1 Bill: \$70.00	30	
Totals:					Qty: 1 Bill: \$70.00		

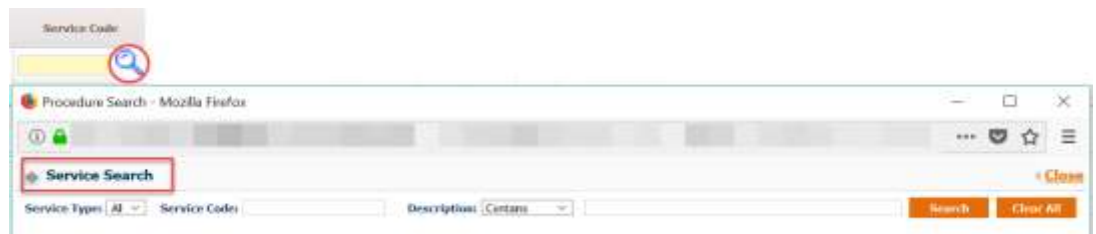
- Below are the details you can add on the service line
 - **Service From and Service To date and time.** (Advised to add time for Anesthesia claims)

Service Date-Time

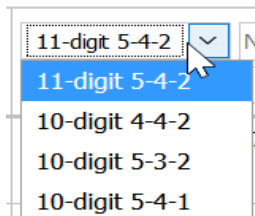
From:

To:

- **Service code/Procedure code.** You can type in or look up from the magnifying glass icon. Click on the code to add on claim.



- **NCD Code – QTY – Unit. (Mandatory to add for all J codes)**
 - You can add NDC code in different formats. Format can be selected from the drop down.



- Once you have selected the format, you can add your NDC code or look up using the magnifying glass.



- QTY is the space provided to define the number of quantity for the drug specified on NDC code
- Unit, lets you choose the unit for the code

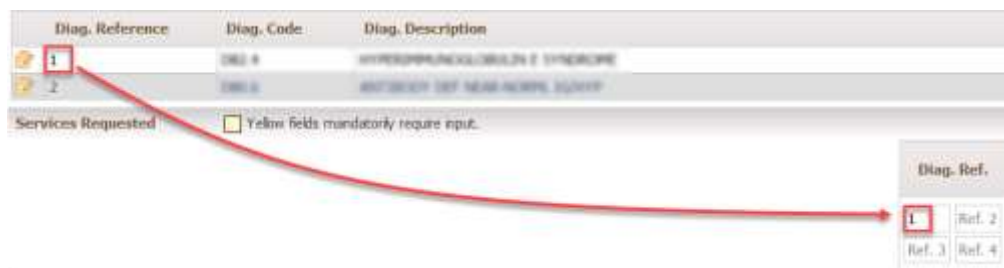
Quantity Unit

- **Modifier code** lets you add four modifiers on each service line

Modifier

Modif. 1	Modif. 2
Modif. 3	Modif. 4

- **Diagnosis code ref**, lets you add the diagnosis code indicator for each service line. Please add numeric value in this to indicate the diagnosis code place value you would like to add.



- **QTY** is the quantity for the procedure code you want to bill.
- **Billed** is the billed amount for this procedure code
- **Other Insurance** is the amount received from Primary insurance if this is secondary claim, etc.

- **Notes** lets you add service level note if needed. Any significant detail for this line item can be sent here.

Qty - Billed	Other Insurance	Notes
1		
Billed Amount		

Add

- **ADD** icon adds these details and makes these fields blank again for the next line item
- Once all details are added, you can see the detail lines added and their total below them.

Services Requested Yellow fields mandatorily require input.

Service Date-Time	Service Code	NDC Code - Qty - Unit	Modifier	Diag. Ref.	Qty - Billed	Other Insurance
From: <input type="text"/> To: <input type="text"/>	<input type="text"/>	11-dgt 5-4-2 NDC Code Quantity: <input type="text"/> Unit: <input type="text"/>	Modif. 1 Modif. 2 Modif. 3 Modif. 4	1 Ref. 2 Ref. 3 Ref. 4	1 Billed Amount: <input type="text"/>	<input type="text"/>
From: 10-01-2017 To: 10-01-2017	99213 - OFFICE/OUTPATIENT VISIT EST	NDC Code: 57520-0547-01 Quantity: 2 Unit Type: ME	25	1	Qty: 1 Bled: \$70.00	20
From: 10-02-2017 14:20 To: 10-02-2017 15:05	01440 - ANESTH KNEE ARTERIES SURG	NDC Code: 08021-0000-1B Quantity: 5 Unit Type: ML		1	Qty: 1 Bled: \$300.00	50
Totals:					Qty: 2 Bled: \$370.00	

Note: To delete a line item added in error please click on the Cross icon at the right end of each service line. To merely update the details, click on the edit the icon on extreme left of the service line.

- **Clinical Indication** is a section where you can add additional details to be submitted on the claim. This can contain patient’s history, medical findings or any relevant records.

Clinical indications for request
(include pertinent past medical history, treatment, physical findings, and attach all relevant medical records, test results, etc.)

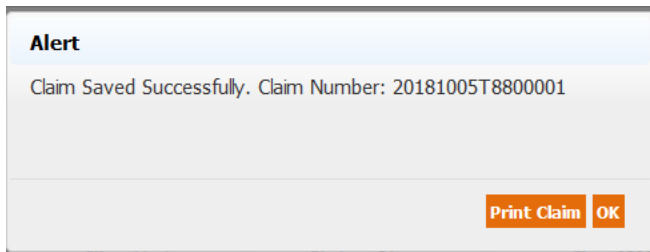
- **Documents** let you attach any relevant document about the claim being submitted. You can attach files with the type as mentioned on the screen.
 - To add document, click on Browse, to select a file from your machine.
 - To add more than one document click on the link for **+add more document**.
 - To **delete** a document attached before submitting claim, you can hit the cross on the right.



Step 6: Once all the details are added, click on **Save to submit the claim** for processing. You can also use **Save & add for same member** if you wish to add another claim for the same member.



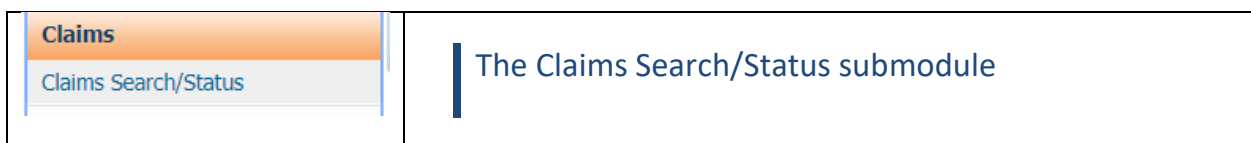
Note: Once the claim is saved it will give you a pop up with claim number, as shown below. You can click on **OK** to go back to the screen. If you wish to print the submitted claim as CMS 1500 click on **PRINT CLAIM**.



● CHECKING THE STATUS OF A CLAIM

To verify the status of a claim, follow these steps:

Step 1: From the **Claims** list, select **Claims Status/Search**.



Step 2: The screen will display as shown below. On this screen, there are three subsections to search claims by.

Claims Search Hide Search Options | Back

Search Claim No.

Claim # From: To: Authorization No.: Provider Claim/Patient Account #:

Search Member

Member ID: Company:

Optional Additional Details

Provider ID: Organization ID:

Service Code: Check No.:

Date of Service From: To:

Date Received:

Outcome: ALL
1 - HOME
2 - HOSPITAL

Diag Code:

Billed Amount:

Date Paid:

Group By:

Show Document Requested Claims

Step 3: Based on the criteria users have input, the search results will display in Claim Details section, as shown below.

Claim Details Notes: ** All blue text is clickable, N/A - Not Applicable.

Claim No.	Received Date	Service Date	Auth. No.	Place of Service	Member	Provider	Organization	Type	Billed Amount	Contract Amount	Net Amount	Company	Outcome					
30006218270900	07-19-2018	05-15-2018	31	OFFICE	3396291881 KAM KHAN	2396 DAN SENH	2198 Test Organization	Organization	\$1,800.00	\$0.00	0.00	PROT	HOME					
Service Date	Revenue Code	Modifier(s)	Req. Code	Financial Rptg.	Subject Dates	Prod Date	Check No.	STS	Billin	Contract	Copy	Commission	Nettable	Adjnt	Net	Adm. Fee/Retain	Status	
05-15-2018	99214					06-20-2018		1.00	508.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	PAID
05-15-2018	99213					06-20-2018		1.00	708.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	PAID

Health Plan Details PCP History

Health Plan	Effective From Date	Effective To Date	Other Coverage?	Plan Code	Policy #	Provider	Name	Effective From Date	Effective To Date
Test	06-06-2012		No			2198	DAN SENH	06-06-2012	

- The **Status** can be found on the right side in the last box. The adjustment code and net amount on the claim is not finalized and is subject to change until the **Status** is **Paid**.

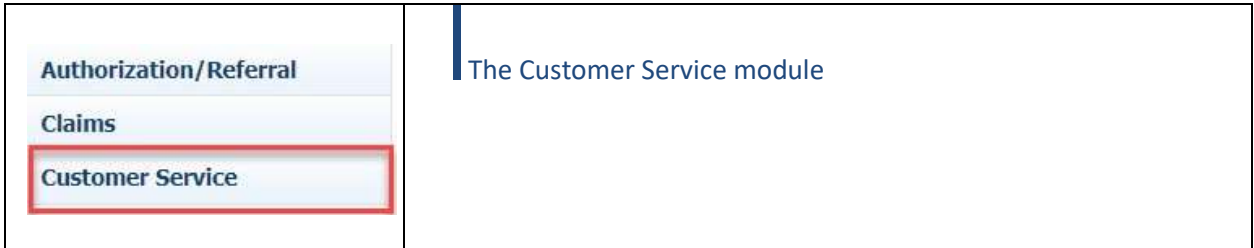
Step 4: To view and print the claim in CMS 1500 format, click the **Print CMS 1500** button.

Step 5: If the claim is in a **Paid** status, there will be an additional button for **Show EOB**.



❖ CUSTOMER SERVICE

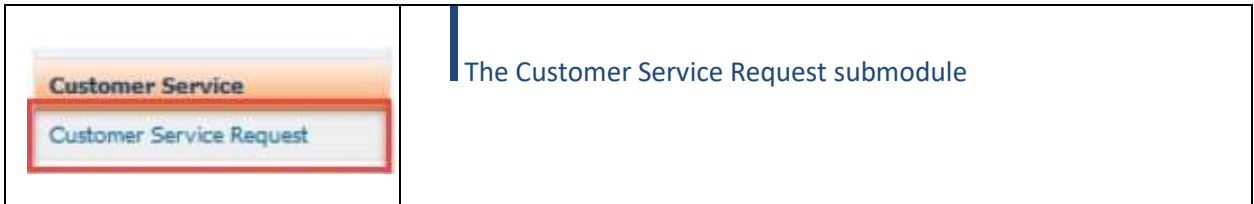
From the **Customer Service** module, users are able to add and view existing customer service requests for their organization. This module provides a request tracking system without the back and forth of telephone calls.



● Adding a Customer Service Request

To add a Customer Service Request, follow these steps:

Step 1: From the **Customer Service** list, select **Customer Service Request**.



Step 2: The screen will display as shown below.

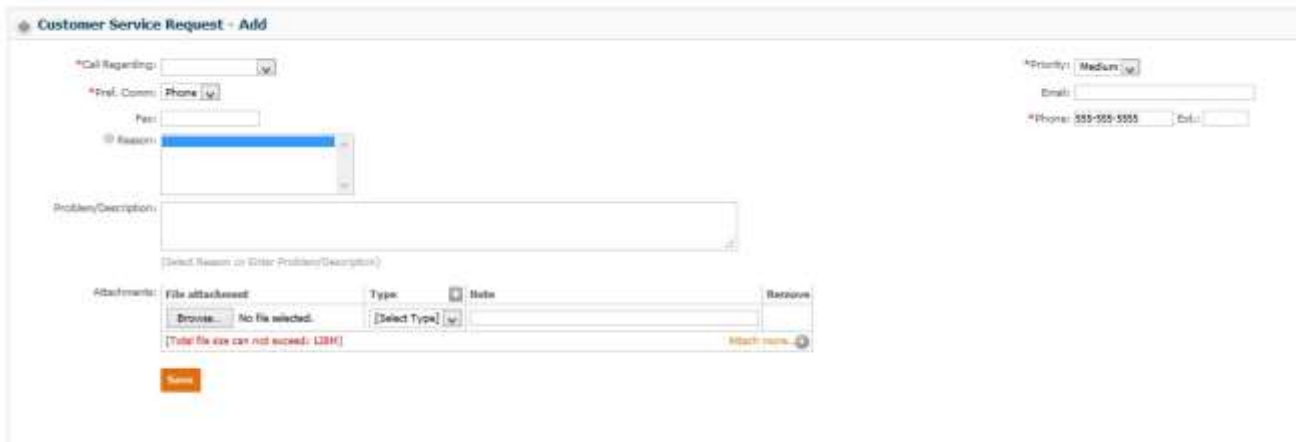


Step 3: Click the **Add** button.



Step 3: The **Customer Service Request – Add** screen will populate. Users can fill in the information below to submit a request. The fields with asterisks are required.

- **Call Regarding:** This dropdown menu allows users to select the purpose of the call. For example, the call could in regards to claims or authorizations.
- **Priority:** This allows users to select the severity between **low, medium, and high.**
- **Pref. Comm:** This field represents the best way to contact back incase follow up is needed. The selection includes **Fax, Email, and Phone.**
- **Reason:** This field indicates what the user was calling in regards to. Depending on the field selected above from the **Call Regarding** field, the **Reasons** will change.
- **Problem/Description:** Users can add a description to explain further the purpose of this request. This information will assist the representative reviewing the request.
- **Attachment:** Users can attach any documents that would aid the representative in completing the request.



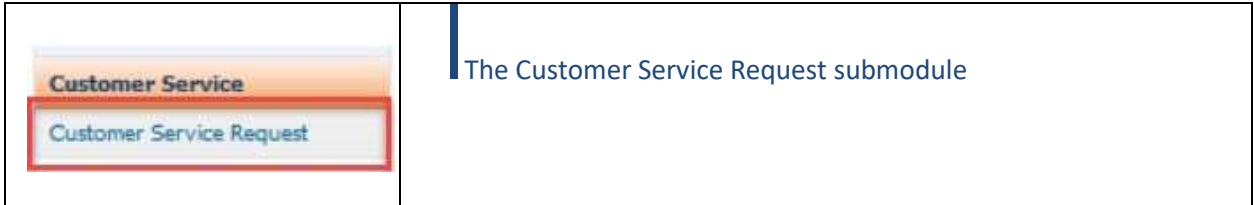
Step 4: Press **Save** to submit the request. A customer service request reference number will be given upon saving the request. This can be used later to check for updates.



● Searching a Customer Service Request

To verify the status of a Customer Service Request, follow these steps:

Step 1: From the **Customer Service** list, select **Customer Service Request**.



Step 2: The screen will display as shown below.



Step 3: Enter information in any of the below fields to populate the search results specific to your organization.

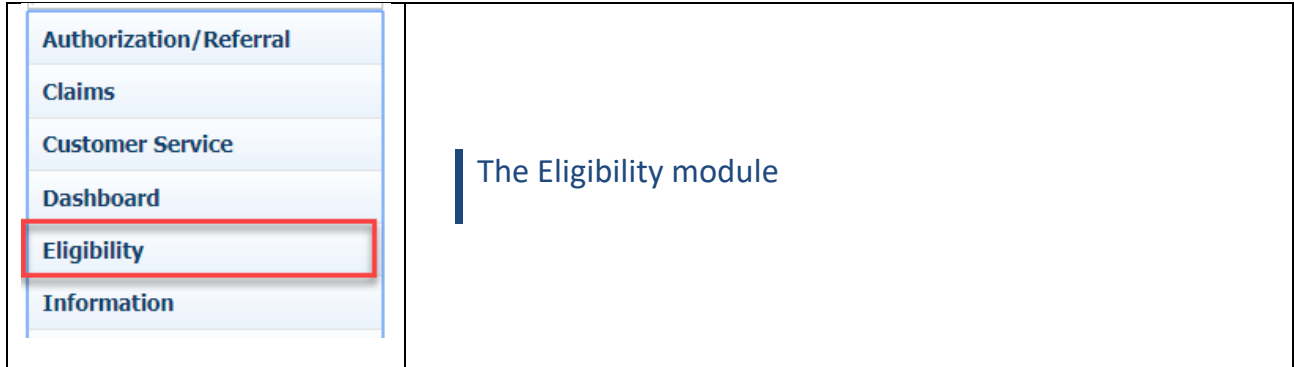


Step 4: Press **Search** to show the results. Click the **Reference Number** associated to the request to open the entire request. Users can update or add information to an existing request at this time.



❖ ELIGIBILITY

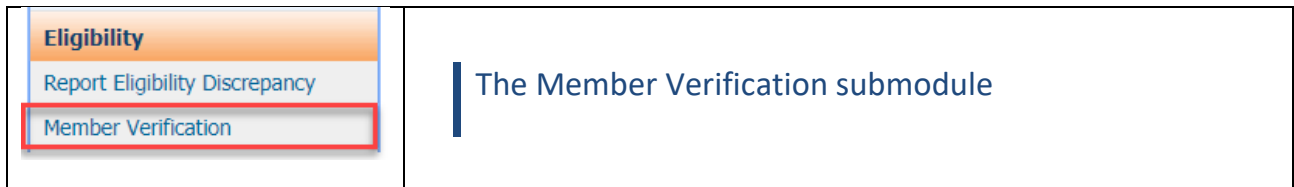
From the **Eligibility** module, users are able to verify a member's eligibility and report any discrepancies.



• VERIFYING ELIGIBILITY

To verify Eligibility for a member, follow these steps:

Step 1: From the **Eligibility** list, select **Member Verification**.



Step 2: The screen will display as shown below.



The screenshot shows the "Eligibility - Member Verification" form. The form contains the following fields and controls:

- * Member ID:
- (OR)
- * Last Name:
- First Name:
- SSN:
- * Gender:
- Health Plan:
- * Date of Birth:
- Service Date: 05-10-2018

At the bottom of the form, there are three buttons: **Verify Eligibility**, **Report Eligibility Discrepancy**, and **Clear All**.

Step 3: Users can search for members in two different ways:

- Search by entering the **Member ID** for the specific person.
- Search by entering the **Last Name, Date of Birth, and Gender** of the member; all three fields must be completed.
 - Users can add the **Health Plan, First Name, SSN, and Service Date** for a more detailed search.

Step 4: Select **Verify Eligibility**. If the member exists in the system, their details will be displayed as shown below.

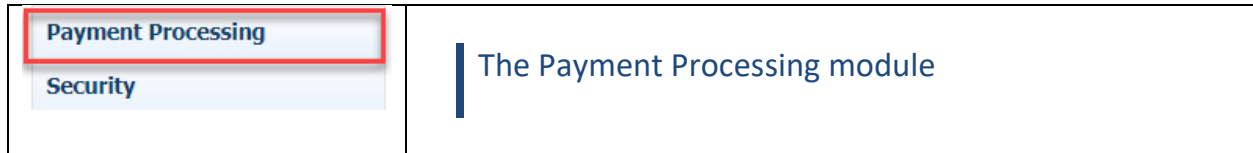
Details	Member ID	Name	Gender	Date of Birth	Member SSN	Health Plan	Provider ID	Phone	Other Coverage?	Res. Code	Policy #	HP Status	PCP Status
 			F			BC			No	Unknown		Inactive	Inactive

- To view additional details about the member’s eligibility, click the **magnifying glass** (first icon) under **Details**.
- To print the member’s eligibility, click the **Print** button (second icon) under **Details**.



❖ PAYMENT PROCESSING

From the **Payment Processing** module, users are able to generate Explanation of Benefits (EOBs) for members that claims have been submitted and paid for.



● CLAIMS EOB

To print a claims EOB, follow these steps:

Step 1: From the **Payment Processing** list, select **Claims EOB**.



Step 2: The screen will display as shown below.



The screenshot shows the "Claims - Explanation of Benefits" screen. It contains several input fields: "Member Name:", "* Organization Name:", "Check No:", and "* Paid Date From:" followed by a date picker and "To:" followed by a date picker. There are two buttons: "Retrieve Checks" and "Display EOB". A red arrow points to the "Display EOB" button. A note next to the "Retrieve Checks" button says: "*Click Retrieve Checks if you do not know the check number." There are also two magnifying glass icons for search.

Step 3: Enter the specific member's name that you want to generate the EOB for.

- **Note:** Users can skip this search criteria if they want to generate EOBs for multiple members from an organization.

Step 4: Enter the correct organization name or search the organization by clicking the magnifying glass icon. The **Organization Search** screen will be displayed as below. Only organizations that users are affiliated with will show in the search screen.

Organization Search [Close](#)

Organization ID:
 Name:
 Tax ID:

NPI:
 Category:
[Search](#)
[Clear All](#)

Organization ID	Name	Category	Tax ID	Address1	City	State	Zip	Email	Phone	Fax	NPI
778899	Medical Organization, Inc.	2 - Primary Care	7894561230	123 Main Road	Chicago	IL	60614				7894561230

- Search the organization by entering any of the available information.
- Select the organization by clicking the **Organization ID**.

Step 5: Enter the check number that the EOB was paid with. If the user does not know the check number, they can search for the check by clicking the **Retrieve Check** button. The **Check No Search** screen will display as shown below.

Check No Search [Close](#)

Check No.:

From Date:
 To Date:
[Search](#)
[Clear All](#)

Prefix	Check No	Paid Date	Amount
1	948230	09-13-2015	\$24.00
2525	1	09-02-2015	\$21.00

- Search the check by entering either the check number or by entering date ranges. To search for all checks ever paid, leave the fields blank and click the **Search** button.
- Select the check by clicking on the **Check No**.

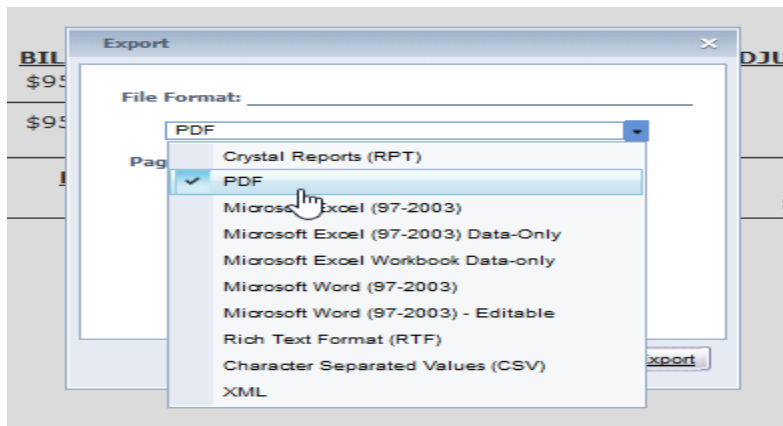
Step 6: By entering the check number, the **Paid Date** field will be populated with the dates automatically. Click the **Display EOB** button and the EOBs will be generated as shown below.

QuickCap 09/13/2015
 555 WEST CHICAGO AVENUE, CHICAGO, IL Page 1 of 2
EXPLANATION OF BENEFITS

ORGANIZATION: 778899 Medical Organization, Inc. CHECK NO: 948230
 PROVIDER: 999999 Smith, Micheal PAID DATE: 09/13/2015
 MEMBER: 555444 DOE JANE
 CLAIM #: 20150913T8800001

SERVICE CODE & DESCRIPTION	MOD	SYCDATE	BILLED	CNTRCT	COPAY	ADJUST	W/H	INT	NET	ADJUSTMENT CODE & DESCRIPTION
P-99213 - OFFICE/OUTPATIEN...		9/1/2015	\$95.00	\$24.00	\$0.00	\$0.00	\$0.00	\$0.00	\$24.00	
AUTH #:										
PROV ACCT:										
HEALTH PLAN:BLUE CROSS										
CLAIM TOTAL:			\$95.00	\$24.00	\$0.00	\$0.00	\$0.00	\$0.00	\$24.00	
ORGANIZATION TOTAL:			\$95.00	\$24.00	\$0.00	\$0.00	\$0.00	\$0.00	\$24.00	\$24.00

- To print the report, click the **Print** icon.
- To export the report, click the **Export** icon. An **Export** dialogue box will be populated as shown below.



- Select which file format to save the report in.
- Click the **Export** button. The report will be exported in the selected file format.

● CAPITATION EOB

To print a capitation EOB, follow these steps:

Step 1: From the **Payment Processing** list, select **Capitation Explanation of Benefits**.




Step 2: The screen will display as shown below.



Capitation - Explanation of Benefits

*Organization Name: 

Check No: **Retrieve Checks** *If you do not know the check number please press Retrieve Checks.

*Paid Date: 

Display EOB **Reconcile EOB**

Step 3: The name of the **Organization** should populate automatically.

Step 4: Enter the **Check Number**, this is an optional field.

Step 5: Enter the **Paid Date**.

Step 6: Click **Display EOB**.

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