



Web Portal Quick Reference Guide

www.dc-medicaid.com

Revised: 5/31/2023

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Accessing the Web Portal

Double click on the Internet Explorer shortcut located on your desktop and enter the following Web address in the address bar: www.dc-medicaid.com

District of Columbia	MAYOR	DC GUIDE	RESIDENTS	BUSINESS	VISITORS	GOVERNMENT	FOR KIDS
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User ID:
 Password: GO

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HOME

- [Online Security](#)
- [Terms of Usage](#)
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WEB REGISTRATION

PROVIDER

- [EHR Incentive Payments Program](#)
- [Fee Schedules](#)
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- [Provider Information & Forms](#)
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- [Trading Partner Information](#)
- [Training Material/CBT](#)
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RECIPIENT

<div style="background-color: #004a87; color: white; padding: 2px;">DC Medicaid/Alliance and Me</div> <div style="text-align: center; padding: 10px;"> <p style="color: red; font-weight: bold;">What is Medicaid?</p> <p style="color: red; font-weight: bold;">What is Alliance?</p> <p style="color: red; font-weight: bold;">Who is Eligible?</p> </div> <div style="background-color: #004a87; color: white; text-align: center; padding: 2px;">Answers and More>></div>	<div style="background-color: #004a87; color: white; padding: 2px;">Latest News</div> <ul style="list-style-type: none"> ▶ Retroactive Adjustments to the Fiscal Year (FY) 2014 ICF/ID Medicaid Per Diem Reimbursement Rates for Changes to the Living Wage and State Plan ▶ Changes in Medicaid Personal Care Aide (PCA) Rates ▶ Policy Regarding Medicaid Coverage to Promote Breast Feeding <div style="background-color: #004a87; color: white; text-align: center; padding: 2px;">All Late Breaking News>></div>	<div style="background-color: #004a87; color: white; padding: 2px;">What's Hot?</div> <div style="text-align: center; padding: 10px;"> <p style="color: red; font-weight: bold; font-size: 1.2em;">DC Medicaid Specialty Hospital Project</p> </div> <div style="background-color: #004a87; color: white; text-align: center; padding: 2px;"> Find Out More>> <<10 of 15>> </div>
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<div style="background-color: #004a87; color: white; padding: 2px;">Provider</div> <ul style="list-style-type: none"> Frequently Asked Questions General Billing Tips Provider Bulletins/Transmittals Provider Hotlinks <div style="text-align: center; padding: 10px;"> </div>	<div style="background-color: #004a87; color: white; padding: 2px;">Recipient</div> <ul style="list-style-type: none"> Recipient Information Forms Frequently Asked Questions Recipient Hotlinks <div style="text-align: center; padding: 10px;"> </div>
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Web Account Registration

To access the private side (i.e., recipient eligibility, online claims submission, requesting PA, accessing fee schedule, etc.) of the Web Portal, providers must establish a Web account for all provider IDs to view information associated with that provider ID.

To establish an account, click on *Web Registration* hyperlink located in the left navigational pane.

Figure 1: Web Account Registration

The screenshot shows a web form titled "Provider Account Registration". It contains several sections with instructions and input fields:

- Registration Instructions:** "To register as a Provider, please enter the following information. Please note that registration designates you as your organization's Master Administrator and you will be required to perform user maintenance duties. If you are not a registered Medicaid Provider, you can find out how to [ENROLL HERE](#)."
- Organization Type and Login ID:** Radio buttons for "Individual" (unselected) and "Group" (selected). A text field for "Login ID" contains "hhprovider".
- Medicaid Provider Information:** A section with a blue header "Please enter your Medicaid Provider ID or NPI information." containing fields for "Provider ID", "NPI" (with "000000000" entered), and "Taxonomy" (with "111A00000X" entered).
- EDI Submitter Information:** Fields for "EDI Submitter ID" and "EDI Password".
- Individual Information:** A section with a blue header "If you are registering as an individual, please enter your Last Name, First Name, Middle Initial and Last 4 digits of Social Security Number (SSN)." containing fields for "Last Name", "First Name", "Middle Initial", and "SSN (Last Four Digits)".
- Organization Information:** A section with a blue header "Please enter your Organization Name and EIN if you are registering as a group." containing fields for "Organization Name" (with "Home Health LLC" entered) and "EIN" (with "123456789" entered).
- Email and Hint Information:** A section with a blue header "Please enter your Email Address and select your hint question/answer." containing fields for "What is your Email Address?" (with "anyemail@mail.com" entered), "Verify your Email Address" (with "anyemail@mail.com" entered), "Hint Question" (with "Mother's maiden name" entered), and "Hint Answer" (with "Name" entered).
- Buttons:** "Submit" and "Clear All" buttons at the bottom.

[**Note:** *Must be an active provider to complete the registration process.*]

Upon successfully completing the registration process, the temporary password is sent immediately via email to the email addressed entered on the registration form.

Logging In

Users would enter the login ID created during registration in the user ID field and copy the temporary password from the email received and paste it in the password field. Click <Go>. The user will be prompted to change the password.

Figure 2: Web Portal Home Page – Login Screen

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District of Columbia
Department of Health Care Finance

Enter user ID and password here

User ID: Password: GO

HOME HELP CONTACT US Search GO

HOME
Online Security
Terms of Usage
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Forgot User ID/Password
Help

WEB REGISTRATION

PROVIDER
Frequently Asked Questions
General Billing Tips
Managed Care Information
Provider Bulletins/Transmittals

DC Medicaid/Alliance and Me
What is Medicaid?
Who is Eligible?
Answers and More>>

Latest News
MCO Contact List
NPI Quick Reference Guide
Banner Messages
NPI and NDC Requirements Go-Live!
Claim Submission and Payment Schedule
All Late Breaking News>>

What's Hot?
Changes in Transportation Services
Find Out More>> <<2 of 4>>

[**Note:** Three unsuccessful login attempts will result in your account being **disabled**. After the second unsuccessful attempt, click on “Forgot User ID/Password” located in the left navigational pane and answer the security question displayed. A change password link will be sent to the email address entered. If your account has been disabled, send an email to providerinquiry@conduent.com to request your account to be re-enabled.]

Once logged in, the provider will be able to access the private side of the Web Portal.

Inquiry Options

After successfully logging into the Portal, the following tasks may be performed on the Web Portal by clicking on the plus sign (+) beside <Inquiry Options>:

- Search for Referring providers
- Check claim status
- Verify recipient eligibility
- Check payment status
- Check PA status
- Search for PCA Aide Inquiry



Searching for Referring Providers

Registered Web Portal users may obtain enrollment information on Ordering/Referring Providers. Select <Referring Provider Inquiry> and enter the provider's NPI. If the provider is not enrolled, the message "No Records Found" will be displayed.

Ordering/Referring Provider Inquiry

Enter the Provider NPI you wish to locate

Provider Npi:

Provider List

The following list displays Search result of all Providers with the NPI entered.

Provider Name	DBA Name	Provider Type	Status	Effective Date	End Date
		A00 - Physician MD	00 - Active	07/01/2002	12/31/2016

Enrollment status displayed here

Only the following provider types are permitted to be Ordering/Referring providers:

- A00 Physician MD
- A01 Physician, Group Practice
- A02 Doctor of Osteopathy

- D00 Hospital, General
- R02 Crossover Claims Only 1500
- S00 Nurse Practitioner
- S01 Nurse Midwife
- X05 Clinic, Federal Qualified Health Center

Claim Status Inquiry

To check claim status, select <Claim Status Inquiry> and enter the TCN or Recipient ID, Service Begin Date, and Service End Date.

Enter your search criteria using **one (1)** of the following combinations and click <Submit>

- o TCN
- o Recipient ID, Service Begin Date, Service End Date

Claim Status

One of the following search criteria are required to inquire about claims:

TCN
-OR-
Recipient ID, Service Begin Date, Service End Date

Please enter dates in mm/dd/yyyy format.

Recipient ID :	<input type="text"/>
TCN:	<input type="text"/> <input type="checkbox"/> Check if before October 1,2009
Institutional Bill type:	<input type="text"/>
Medical Record:	<input type="text"/>
Total Claim Charge Amount: \$	<input type="text"/>
Date(s) of Service:	
Begin Date:	<input type="text"/>
End Date:	<input type="text"/>

Claims matching your search criteria will be displayed in the claim results list.

Claim Results

	Recipient Id	Billing Provider Id	TCN	Service Begin Date	Service End Date
<input type="radio"/>	70	200	1922	08/01/2019	08/01/2019
<input checked="" type="radio"/>	70	200	1922	08/01/2019	08/01/2019
<input type="radio"/>	70	200	1922	08/01/2019	08/01/2019

[View Details](#)

[Reset](#)

[New Inquiry](#)

To view the claim, click the “circle” and <View Details>. The claim details will be displayed.

Claim Status Inquiry

Claim Detail

TCN:	192
Effective Date:	08/22/2019
Recipient ID:	701

Recipient Information

Name:	
Gender:	Female
Date Of Birth:	01/03/1958

Claim Status

Service Period:	Begin:08/01/2019 End:08/01/2019
Status Category:	F2 - Finalized/Denial -- The claim has been denied.
Status:	D - Denied
Institutional Bill Type:	

DRG Information

Drp Code:	
DRG Code Weight	0.00000

Payment Information

Payment Amount:	0.00
Payment Method Code:	P-Paper Check
Payment Date:	08/19/2019
Adjudicated Date	08/16/2019
Check or EFT Trace Number:	0000000000

Line Items

Ln#	Service Dates		Product / Service id	Status Category	Status	Modifiers				Line Item Control Number	Revenue Code	Submitted Charges	Submitted Units	Amount Paid:\$
	Begin	End				1	2	3	4					
1	08/01/2019	08/01/2019	T1023	00087049	D-Denied	U3	52				256.90	1.0	0.00	

Line Items Exception *Move cursor over exception code for more information

Ln item #	Exception Code	Status
1	0605	3-Deny
1	PRIOR AUTHORIZATION HAS BEEN USED.	
1	5516	3-Deny

[New Inquiry](#)

For denied and suspended claims, you must place your cursor over the exception code to view the exception code description.

Eligibility Inquiry

To check recipient eligibility, select <Eligibility Inquiry> and enter the applicable search criteria. After logging in, select “Inquiry Options> Eligibility Inquiry”



Enter your search criteria using one (1) of the following combinations and click <Submit>

- Last Name, First Name and DOB
- SSN and DOB
- Recipient ID
- Last Name, First Name and SSN

Eligibility Inquiry

One of the following inquiry options is required for an Eligibility Inquiry Transaction.

Last Name/First Name/DOB
-OR-
SSN/DOB
-OR-
Recipient ID
-OR-
Last Name/First Name/SSN.

Please enter Service dates in mm/dd/yyyy format.

Recipient ID :	<input type="text"/>
Last Name:	<input type="text"/>
First Name:	<input type="text"/>
Date of Birth:	<input type="text"/>
SSN:	<input type="text"/>
Date(s) of Service:	
Begin Date:	<input type="text"/>
End Date:	<input type="text"/>

The eligibility results for the recipient entered will be displayed.

Eligibility Inquiry Result

Recipient Eligibility Information requested / verified on:

Recipient Detail	
Name:	<input type="text"/>
Recipient ID:	<input type="text"/>
Recipient Address:	<input type="text"/>
Ward/Quadrant:	<input type="text"/>
Gender:	<input type="text"/>
Date Of Birth:	<input type="text"/>

Field Name	Description
Recipient Eligibility Information Requested/Verified on:	Indicates the date of verification of eligibility was performed on
Name	Indicates name of recipient
Recipient ID	Indicates the Medicaid ID of the recipient
Recipient Address	Indicates the address of the recipient
Ward/Quadrant	Indicates the corresponding ward and/or quadrant associated with the above address
Gender	Indicates the gender of the recipient
Date of Birth	Indicates the date of birth of the recipient

Plan Coverage Information	
Plan Coverage:	
Program Code:	
Eligibility or Benefit Information:	
Begin Date:	
End Date:	
QMB Indicator:	

Service types

Service Type/Description	Coverage	Begin Date	End Date	Copay Amount	Coinsurance Amount	Deductible Amount	Coverage Code/Description
AD - Occupational Therapy	Child	01/01/1964	12/31/9999	0.00	0.00	0.00	1 - Active Coverage
AE - Physical Medicine	Child	01/01/1964	12/31/9999	0.00	0.00	0.00	1 - Active Coverage
AF - Speech Therapy	Child	01/01/1964	12/31/9999	0.00	0.00	0.00	1 - Active Coverage
AG - Skilled Nursing Care	Child	01/01/1964	12/31/9999	0.00	0.00	0.00	1 - Active Coverage
AI - Substance Abuse	Child	01/01/1964	12/31/9999	0.00	0.00	0.00	1 - Active Coverage
AL - Vision (Optometry)	Child	01/01/1964	12/31/9999	0.00	0.00	0.00	1 - Active Coverage
A0 - Prof(Phys) Visit - Outpatient	Child	01/01/1964	12/31/9999	0.00	0.00	0.00	1 - Active Coverage
A3 - Prof(Phys) Visit - Home	Child	01/01/1964	12/31/9999	0.00	0.00	0.00	1 - Active Coverage
A6 - Psychotherapy	Child	01/01/1964	12/31/9999	0.00	0.00	0.00	1 - Active Coverage
A7 - Psychiatric Inpatient	Child	01/01/1964	12/31/9999	0.00	0.00	0.00	1 - Active Coverage

Field Name	Description
Plan Coverage Information	If the recipient is inactive at the time of verification, this section will display N/A and the fields listed below will not be displayed.
Plan Coverage	Indicates the description of the corresponding program code that the recipient has been assigned by the Economic Security Administration (ESA).

Field Name	Description														
Program Code	Indicates the recipient's category of eligibility. A recipient's benefits/services may be limited or restricted by this code.														
Eligibility or Benefit Information	Indicates the Medicaid eligibility status of the recipient														
Begin Date	Indicates the begin date of the recipient's Medicaid eligibility														
End Date	Indicates the end date of the recipient's Medicaid eligibility Note: ➤ The date of 12/31/9999 means that the recipient's eligibility span is open-ended and may change at any time.														
QMB Indicator	Indicates if services are limited to payment of the recipient's Medicare Part A premium.														
Service Types <i>[Click on the plus "+" sign beside service types to expand this section.]</i>	Based upon the recipient's program code, the services that the recipient is eligible to receive will be listed.														
	<table border="1"> <tr> <td>Service Type/Description</td> <td>indicates the description of available services</td> </tr> <tr> <td>Coverage</td> <td>indicates the coverage type (child or adult)</td> </tr> <tr> <td>Begin/End Date</td> <td>effective dates of service type</td> </tr> <tr> <td>Copay Amount</td> <td>indicates the specified amount of out-of-pocket expenses the recipient would pay for healthcare services</td> </tr> <tr> <td>Coinsurance Amount</td> <td>indicates the coinsurance amount</td> </tr> <tr> <td>Deductible Amount</td> <td>indicates the amount the recipient would pay for health care services before Medicaid begins to pay.</td> </tr> <tr> <td>Coverage Code/Description</td> <td>indicates the status of the service type (active, inactive, etc..)</td> </tr> </table>	Service Type/Description	indicates the description of available services	Coverage	indicates the coverage type (child or adult)	Begin/End Date	effective dates of service type	Copay Amount	indicates the specified amount of out-of-pocket expenses the recipient would pay for healthcare services	Coinsurance Amount	indicates the coinsurance amount	Deductible Amount	indicates the amount the recipient would pay for health care services before Medicaid begins to pay.	Coverage Code/Description	indicates the status of the service type (active, inactive, etc..)
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	Coverage	indicates the coverage type (child or adult)													
	Begin/End Date	effective dates of service type													
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	Coinsurance Amount	indicates the coinsurance amount													
	Deductible Amount	indicates the amount the recipient would pay for health care services before Medicaid begins to pay.													
Coverage Code/Description	indicates the status of the service type (active, inactive, etc..)														

Service Management	
Service Management Type:	
Begin Date:	
End Date:	
Provider:	

Field Name	Description
Service Management	If the recipient is inactive or is not assigned to a managed care organization at the time of verification, this section will display N/A and the fields listed below will not be displayed.
Service Management Type	Indicates the type of managed care organization the recipient is assigned to: <ul style="list-style-type: none"> ➤ MCO = Managed Care Organization ➤ TRB = Transportation Broker ➤ EPS = EPSDT
Begin Date	Indicates the begin date of the recipient's MCO span
End Date	Indicates the end date of the recipient's MCO span
Provider	Indicates the name of the managed care organization

Medicare Information	
Part A/B Indicator:	
HIC Number:	
Begin Date:	
End Date:	

Field Name	Description
Medicare Information	If the recipient is inactive or does not have Medicare at the time of verification, this section will display N/A and the fields listed below will not be displayed.
Part A/B Indicator	If the recipient has Medicare, Part A and/or Part B will be indicated
HIC Number	Indicates the recipient's Medicare ID
Begin Date	Indicates the begin date of the recipient's Medicare eligibility
End Date	Indicates the end date of the recipient's Medicare eligibility

Long Term Care Information	
Begin Date:	
End Date:	
Provider Name:	

Field Name	Description
Long Term Care Information	If the recipient does not reside in a long-term care or intermediate care facility (ICF), this section will display N/A and the fields listed below will not be displayed.
Begin Date	Indicates the begin date if the recipient's long-term care lock-in span
End Date	Indicates the end date of the recipient's long-term care lock-in span
Provider Name	Indicates the name of the long-term care or intermediate care facility (ICF)

Third Party Liability Information	
<input type="button" value="TPL Update"/>	
Insurance Company Name:	
TPL Address:	
Policy Holder :	
Policy Number:	
Begin Date:	
End Date:	
Resouce Type:	
<input type="button" value="[-] Coverage Information"/>	
<input type="button" value="Dental"/>	

Remaining Service Limits
Please contact Xerox Provider Inquiry at (866)752-9233 or (202)906-8319 for inquiries on Procedure Specific limitations.

Field Name	Description
Third Party Liability Information	If the recipient is inactive or is not enrolled in an insurance plan at the time of verification, this section will display N/A and the fields listed below will not be displayed.
Insurance Company	Indicates the name of the primary payer (insurance company)

Name															
TPL Address	Indicates the address of the insurance company														
Policy Holder	Indicates the name of the primary insurance holder														
Policy Number	Indicates the policy number associated with this policy														
Begin Date	Indicates the begin date of the insurance policy														
End Date	Indicates the end date of the insurance policy														
Resource Type	Indicates the type of insurance plan														
Coverage Information <i>[Click on the plus "+" sign beside service types to expand this section.]</i>	Indicates the services that are available under the policy														
	<table border="1"> <tr> <td>Service Type Description</td> <td>indicates the description of available services</td> </tr> <tr> <td>Coverage</td> <td>indicates the coverage type (child or adult)</td> </tr> <tr> <td>Begin/End Date</td> <td>effective dates of service type</td> </tr> <tr> <td>Copay Amount</td> <td>indicates the specified amount of out-of-pocket expenses the recipient would pay for healthcare services</td> </tr> <tr> <td>Coinsurance Amount</td> <td>indicates the coinsurance amount</td> </tr> <tr> <td>Deductible Amount</td> <td>indicates the amount the recipient would pay for health care services before the insurance carrier begins to pay.</td> </tr> <tr> <td>Coverage Code/Description</td> <td>indicates the status of the service type (active, inactive, etc.)</td> </tr> </table>	Service Type Description	indicates the description of available services	Coverage	indicates the coverage type (child or adult)	Begin/End Date	effective dates of service type	Copay Amount	indicates the specified amount of out-of-pocket expenses the recipient would pay for healthcare services	Coinsurance Amount	indicates the coinsurance amount	Deductible Amount	indicates the amount the recipient would pay for health care services before the insurance carrier begins to pay.	Coverage Code/Description	indicates the status of the service type (active, inactive, etc.)
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	Coverage	indicates the coverage type (child or adult)													
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	Copay Amount	indicates the specified amount of out-of-pocket expenses the recipient would pay for healthcare services													
	Coinsurance Amount	indicates the coinsurance amount													
	Deductible Amount	indicates the amount the recipient would pay for health care services before the insurance carrier begins to pay.													
Coverage Code/Description	indicates the status of the service type (active, inactive, etc.)														

PA Inquiry

To check the status of a prior authorization request, select <**PA Inquiry**>. Enter your desired search criteria:

- Provider number
- PA Number
- Recipient ID
- Date Range

PA Inquiry

One of the following search criteria are required to inquire about PA's:

Provider Id

-OR-

PA Number

-OR-

Provider Id and Recipient ID

-OR-

Provider Id and Enter Date Range

Please enter dates in mm/dd/yyyy format.

Provider Number:	<input type="text"/>
PA Number:	<input type="text"/>
Recipient ID:	<input type="text"/>
From Date:	<input type="text"/>
To Date:	<input type="text"/>

Submit

Reset

The prior authorization information will be displayed.

PA Number :											
Provider Information											
Provider No. :											
Name of Provider :											
Address :											
City :											
State :											
Zip :											
Phone No.:											
Patient Information											
Name of Patient:				Family or Responsible Party Name:							
Address :				Address:							
City :				City:							
State:				State:							
Zip :				Zip:							
Recipient ID:				Phone No:							
DOB:											
Sex:											
Services Requested											
Diagnosis Code	Procedure Code	Procedure Description	Service Date		Requested Units	Requested Amount	Approved Units	Approved Amount	Used Units	Used Amount	Status
			Begin Date	End Date							
	T1023 U352	PROGRAM INTAKE ASSESSMENT	02/01/2017	01/31/2018	12.00	0.00	12.00	0.00	4.00	983.84	Approved

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Print

Payment Status Inquiry

To check payment status, select **<Payment Status Inquiry>** and a listing of payments will be displayed for the provider number logged in under.

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WEB REGISTRATION

PROVIDER - Secure Options

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 - Claims History
 - Claim Status Inquiry
 - Drug Rebate Inquiry
 - Drug Pricing Inquiry
 - Eligibility Inquiry
 - PA Inquiry
 - Payment Status Inquiry**
- Claims Entry
- Communication Options
- Prior Authorization
- Submission Options
 - TPL Update
 - MAC List
- Reports Online
- Message Admin Options
- User Admin Options

DELMARVA

PROVIDER

- Claim Templates

Payment:	RA Date:	Payment Cycle Date:
\$ 0.00	01/01/0001	02/13/2009
\$ 48556.40	02/12/2009	02/06/2009
\$ 15954.40	02/12/2009	01/30/2009
\$ 187.00	01/30/2009	01/23/2009
\$ 15474.23	01/26/2009	01/16/2009
\$ 7702.90	01/15/2009	01/09/2009
\$ 14175.40	01/08/2009	01/02/2009
\$ 818.00	12/31/2008	01/01/2009
\$ 4496.00	12/18/2008	12/12/2008
\$ 0.00	01/01/0001	12/05/2008
\$ 0.00	01/01/0001	12/01/2008
\$ 1451.00	12/05/2008	11/21/2008
\$ 52789.10	11/20/2008	11/14/2008
\$ 399.00	11/17/2008	11/07/2008
\$ 0.00	01/01/0001	10/01/2008
\$ 0.00	01/01/0001	09/19/2008

Searching for PCA Aide Inquiry

Registered Web Portal users may obtain enrollment information on PCA Aides. Select <PCA Aide Inquiry> and enter the aide’s NPI. If the aide is not enrolled, the message “No Records Found” will be displayed.

PCA Aide Inquiry

Enter the Provider NPI you wish to locate

Provider NPI:

Provider List

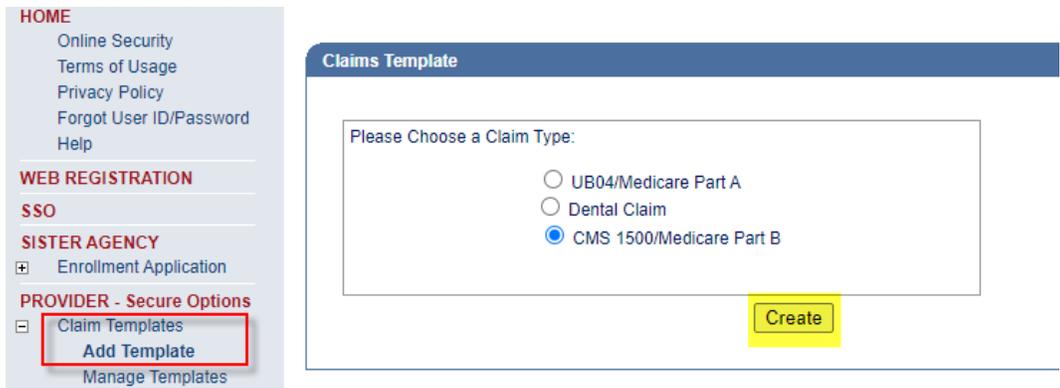
The following list displays Search result of all Providers with the NPI entered.

Provider Name	DBA Name	Provider Type	Status	Effective Date	End Date
		W05 - PCA Aide	00 - Active	03/06/2018	03/06/2023

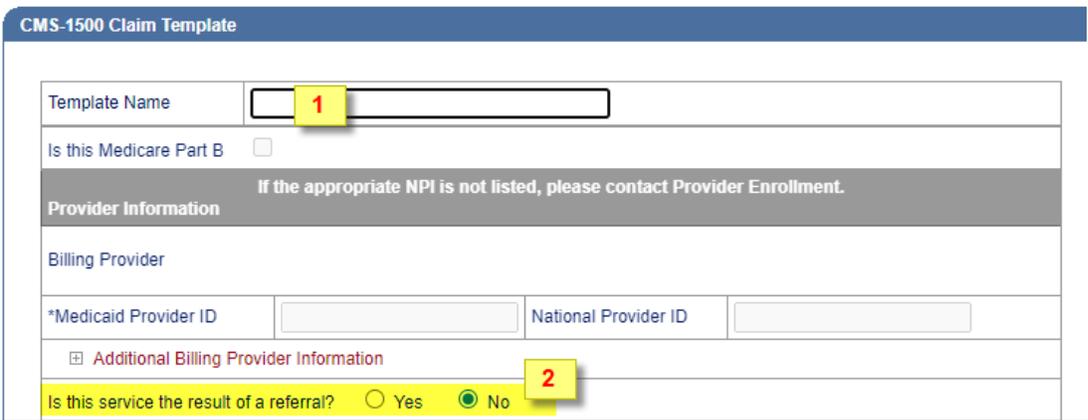
Creating CMS1500 Claim Template

Registered Web Portal users may create claim templates to minimize the amount of data being entered when submitting online claims for payment. *[Note: A maximum of three (3) claim templates may be saved.]*

After logging in, select Claim Templates > Add Template and select the CMS1500/Medicare Part B and click the <Create> button.



The CMS1500 claim form will be displayed. The following fields can be edited.



Field #	Field Name	Description
1	Template Name	Enter desired template name in the <Template Name> field. This will help you to identify the template from the pick list for claim entry.
2	Is service the result of a referral?	Select the appropriate response

Expand the 'Additional Claim Data' section

Claim Information	
Prior Authorization	<input type="text"/>
Timely Filing TCN	<input type="text"/>
<input type="checkbox"/> Relevant Dates	
<input checked="" type="checkbox"/> Additional Claim Data*	
Provider Signature on File	<input type="radio"/> Yes <input type="radio"/> No
Reserved for Local Use	<input type="text"/>
Provider Signature Date	<input type="text"/>
Diagnosis Codes (At least one entry required)	
1. <input type="text"/> 3	2. <input type="text"/> 3. <input type="text"/> 4. <input type="text"/>
5. <input type="text"/>	6. <input type="text"/> 7. <input type="text"/> 8. <input type="text"/>
9. <input type="text"/>	10. <input type="text"/> 11. <input type="text"/> 12. <input type="text"/>

Field #	Field Name	Description
3	Diagnosis Code	Enter at least one diagnosis code

Basic Line Item Information

Note: Please ensure you have entered any necessary claim information (found in the other sections of this or another page) before adding this service.

Add Service Line Item 4 If the appropriate NPI is not listed, please contact Provider Enrollment.

Service Dates		Procedure Codes	Provider ID	NPI	Modifiers				Diag Pointers				Submitted Charges	Units	Place of Service	NDC	Edit	Delete
Begin	End				1	2	3	4	1	2	3	4						

New Covered Individual

*Service Begin Date 5 *Service End Date 6

*Procedure Code 7 Description

*Rendering Provider ID 8 NPI

*Place Of Service 9

Units 10 EPSDT Indicator

*Fee 11 Diagnosis Pointers

NDC Modifiers 12

Co Ins Amount Deductible

Paid Amount Allowed Amount

Save 13

Field #	Field Name	Description
4	Add Service Line Item	Click this button to add claim line items
5	Service Begin Date	Enter the date of service begin date
6	Service End Date	Enter the date of service end date
7	Procedure Code	Enter CPT/HCPCS code of the service to be billed
8	Rendering Provider ID	Enter servicing provider ID
9	Place of Service	Select the appropriate place of service from the pick list
10	Units	Enter the total number of units being billed
11	Fee	Enter the total billed amount
12	Modifiers	Enter modifiers that will be billed with the procedure code if needed
13	Save	You must click <Save> to add the claim line. <i>[Note: Repeat the above steps if additional lines are needed.]</i>

Once all claim lines have been entered, click the **<Save Template>** button.

Summary	
Total Submitted Charges	<input type="text"/>
Are there TPL amounts to be entered?	<input type="radio"/> Yes <input type="radio"/> No
Balance	<input type="text"/>
<input type="checkbox"/> REQUIRED: I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for the procedures.	
<input type="checkbox"/> REQUIRED: I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction, and that the fees submitted are the actual fees I have charged and intend to collect for the payments.	

Once the template has been saved, a confirmation message will be displayed.

Claims Template

Template Saved Successfully

Please Choose a Claim Type:

- UB04/Medicare Part A
- Dental Claim
- CMS 1500/Medicare Part B

To use the template, you must go to **<Claims Entry>** and select the **CMS1500/Medicare Part B** claim form.

Enter the recipient ID and billing provider ID or NPI. Select the template from the pick list displayed.

- HOME**
- Online Security
- Terms of Usage
- Privacy Policy
- Forgot User ID/Password
- Help

- WEB REGISTRATION**

- SSO**

- SISTER AGENCY**
- + Enrollment Application

- PROVIDER - Secure Options**
- + Claim Templates
- + Inquiry Options
- Claims Entry
 - ADA Dental Claim Form
 - Adjustment/Void Form
 - CMS 1500/Medicare Part B**
 - LTC Group Claim
 - UB04/Medicare Part A/B

Claims - Enter Recipient Id

*Recipient ID and Provider ID or NPI must be entered to proceed.

Recipient ID :	<input type="text"/>
Provider ID:	<input type="text"/>
or	
NPI:	<input type="text"/>
Select Template:	<input type="text" value="Select One"/>
<input type="button" value="Submit"/> <input type="button" value="Clear All"/>	

The claim will be displayed with the contents entered in the template. [Note: The template information may be edited as needed.]

Proceed with completing the claim with the appropriate information, such as prior authorization number, provider signature date, dates of service, etc.

CMS-1500 Claim Form

Is this Medicare Part B <input type="checkbox"/>						
If the appropriate NPI is not listed, please contact Provider Enrollment.						
Provider Information						
Billing Provider						
*Medicaid Provider ID	<input type="text"/>	National Provider ID	<input type="text"/>			
⊕ Additional Billing Provider Information						
Is this service the result of a referral? <input type="radio"/> Yes <input checked="" type="radio"/> No						
Recipient Information						
* Medicaid ID	<input type="text"/>					
Last Name	<input type="text"/>	First Name	<input type="text"/>	MI	<input type="text"/>	
⊕ Additional Recipient Information						
Is Patient's Condition Related To	<input type="text"/>	Choose a Condition	<input type="text"/>	Accident Date	<input type="text"/>	
Other Insurance Info						
Add Insurance info						
Payer Name	Insured Name	Group Name	Unique ID	Group No	Emp Name	Delete
Claim Information						
Prior Authorization	<input type="text"/>					
Timely Filing TCN	<input type="text"/>					
⊕ Relevant Dates						
⊕ Additional Claim Data*						

Be sure to expand this section to select provider signature and signature date

Click <Submit> once the claim has been completed.

Claims Entry – CMS1500

After logging in, select Claims Entry > CMS1500/Medicare Part B



Enter the recipient's Medicaid ID and your NPI in the fields displayed and click <Submit>.

Claims - Enter Recipient Id

*Recipient ID and Provider ID or NPI must be entered to proceed.

Recipient ID :	<input type="text"/>
Provider ID:	<input type="text"/>
or	
NPI:	<input type="text"/>

The CMS1500 claim form will be displayed with the provider and recipient information pre-populated.

[Note: All fields with an asterisk (*) indicate required fields that must be completed.]

If submitting **Medicare Part B** claim charges, select "This is a Medicare Part B claim" by placing a check mark in the box and complete the fields displayed below

Is this Medicare Part B <input checked="" type="checkbox"/>					
*Co Insurance \$	<input type="text"/>	*Deductible \$	<input type="text"/>	*EOB Date	<input type="text"/>
*Paid Amount \$	<input type="text"/>	*Allowed Amount \$	<input type="text"/>		

Field Name	Description
Co insurance \$	Enter the coinsurance amount indicated on the EOMB
Paid Amount \$	Enter the Medicare payment amount as indicated on the EOMB
Deductible \$	Enter the Medicare deductible amount as indicated on the Medicare EOMB
EOB Date	Enter the payment date from the Medicare Explanation of Benefits (EOMB)
Allowed Amount \$	Enter the Medicare allowed amount as indicated on the Medicare EOMB

CMS-1500 Claim Form

Is this Medicare Part B

If the appropriate NPI is not listed, please contact Provider Enrollment.

Provider Information

Billing Provider

1 Medicaid Provider ID National Provider ID

Additional Billing Provider Information

Is this service the result of a referral? Yes No **Verify information displayed**

Recipient Information

* Medicaid ID 2

Last Name First Name MI

Additional Recipient Information

Is Patient's Condition Related To Accident Date

Other Insurance Info

Add Insurance info

Payer Name	Insured Name	Group Name	Unique ID	Group No	Emp Name	Delete

Field #	Field Name	Description
1	Billing Medicaid Provider ID & National Provider ID	Pre-populates the billing provider's Medicaid ID and corresponding NPI. <i>[Note: This information cannot be changed].</i>
2	Recipient Information	Verify the information displayed <i>[Note: This information cannot be changed.]</i>

Claim Information

Prior Authorization 3

Timely Filing TCN

⊕ Relevant Dates

☒ Additional Claim Data*

Provider Signature on File 4 Yes No

Reserved for Local Use 5

Provider Signature Date 6

Diagnosis Codes (At least one entry required)

1. <input type="text"/>	2. <input type="text"/>	3. <input type="text"/>	4. <input type="text"/>
5. <input type="text"/>	6. <input type="text"/>	7. <input type="text"/>	8. <input type="text"/>
9. <input type="text"/>	10. <input type="text"/>	11. <input type="text"/>	12. <input type="text"/>

7

Required Attachments

Does the Claim have Attachments? 8 Yes No

Field #	Field Name	Description
3	Prior Authorization	If applicable, enter the prior authorization number located on the PA letter received
4	Provider Signature on File	Select "Yes"
5	Reserve for Local Use	If submitting a claim for waiver related services, enter "09"
6	Provider Signature on Date	Enter the current date
7	Diagnosis	Enter at least one diagnosis code

Field #	Field Name	Description
8	Does the claim have attachments?	Select "No"

Basic Line Item Information

Note: Please ensure you have entered any necessary claim information (found in the other sections of this or another page) before adding this service line.

Add Service Line Item If the appropriate NPI is not listed, please contact Provider Enrollment.

Service Dates		Procedure Codes	Provider ID	NPI	Modifiers				Diag Pointers				Submitted Charges	Units	Place of Service	NDC	Edit	Delete
Begin	End				1	2	3	4	1	2	3	4						
New Covered Individual																		
*Service Begin Date	<input type="text"/>	<input type="text"/>	*Service End Date		<input type="text"/>													
*Procedure Code	<input type="text"/>	Description		<input type="text"/>														
*Rendering Provider ID	<input type="text"/>	NPI		<input type="text"/>														
*Place Of Service	Select One			▼														
*Units	<input type="text"/>	EPSDT Indicator		Select One														
*Fee	<input type="text"/>	Diagnosis Pointer		Select ▼ Select ▼ Select ▼ Select ▼														
NDC	<input type="text"/>	Modifiers		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>														
Co Ins Amount	<input type="text"/>	Deductible		<input type="text"/>														
Paid Amount	<input type="text"/>	Allowed Amount		<input type="text"/>														
<input type="button" value="Save"/>																		

Field #	Field Name	Description
	Add Service Line Item	Click this button to display claim detail fields
9	Service Begin Date	Enter the first date of service
10	Service End Date	Re-enter the first date of service
11	Procedure Code	Enter the applicable procedure code being billed. [Note: The description will auto-populate once you tab to the next field].
12	Rendering Provider ID	Enter the NPI of the servicing provider
13	Place of Service	Select the appropriate response from the list
14	Units	Enter the total number of units being billed for this procedure

Field #	Field Name	Description
15	Fee	Enter your usual and customary charges for the procedure being billed
16	Diagnosis Pointer	Select "1" from the list
17	Modifiers	If applicable, enter the appropriate modifier(s) for the above procedure code in all capital letters
	Save	Click to add the line item to the table above. If billing multiple lines, repeat steps 10-19 to add additional claim lines. YOU MUST CLICK <SAVE> AFTER EACH LINE.

Summary

Total Submitted Charges: 0.00 **18**

Are there TPL amounts to be entered? Yes No **19**

Balance: 0.00 **20**

21 REQUIRED: I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for the procedures.

21 REQUIRED: I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction, and that the fees submitted are the actual fees I have charged and intend to collect for the payments.

Field #	Field Name	Description
18	Total Submitted Charges	Auto populates overall claim total
19	TPL Amounts	Select "Yes" or "No" to this question. If you select "Yes", you must enter the payment amount received from the third party payer (i.e. private insurance, Medicare, etc.)
20	Balance	Auto populated the difference between the total submitted charges and TPL payments
21	Confirmation Statements	Click both text boxes
	Submit/Reset	Click <Submit> to submit the claim

Upon successful submission, the TCN (transaction control number) will be displayed at the top of your claim in addition to the claim status.

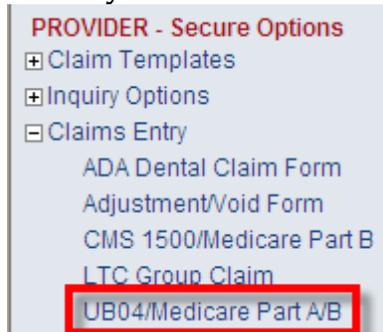
TCN	12258100010007147	Claim Status	Suspended
Line Number	Exception Code	Exception Description	Exception Status
0	0120	THE BILLING PROVIDER NUMBER (PAY TO PROVIDER) IS ZEROS.	Suspend
0	0313	CATEGORY OF SERVICE CANNOT BE DETERMINED	Suspend
0	5125	INVALID BILLING PROVIDER CHECK DIGIT NUMBER	Suspend
1	0429	PROVIDER LICENSE EXPIRED	Suspend

The following claim statuses may be displayed:

- **To be paid**
- **To be denied** – The exception code (denial reason) and description will be displayed. If you have the correct information, you may submit the corrected claim immediately.
- **To be suspended** – The exception code (pended status) and description will be displayed. **DO NOT RESUBMIT SUSPENDED CLAIMS.** Please allow up to 45 days for processing.

Claims Entry – UB04

After logging in, select Claims Entry > UB04/Medicare Part A/B



Enter the recipient's Medicaid ID and your NPI in the fields displayed and click <Submit>.

Claims - Enter Recipient Id

*Recipient ID and Provider ID or NPI must be entered to proceed.

Recipient ID :	<input type="text"/>
Provider ID:	<input type="text"/>
or	
NPI:	<input type="text"/>

The UB04 claim form will be displayed with the provider and recipient information pre-populated.

[Note: All fields with an asterisk (*) indicate required fields that must be completed.]

If submitting **Medicare Part A** claim charges, select "This is a Medicare Part A claim" by placing a check mark in the box and complete the fields displayed below.

This is a Medicare Part A claim

This is a Medicare Part B claim

Medicare

EOMB Dt	1	Coins Amt\$	2	Paid Amt\$	3
Deductible Amt\$	4	Allowed Amt\$	5	Blood Deductible\$	

Add Data

Pycd	*Provider Number	*Cert - SSN - HIC -ID	Prior Payment	Est Amount Due	Treatment Auth Code	Delete
------	------------------	-----------------------	---------------	----------------	---------------------	--------

Field #	Field Name	Description
1	EOMB Dt	Enter the payment date from the Medicare Explanation of Benefits (EOMB)
2	Coins Amt\$	Enter the coinsurance amount indicated on the EOMB
3	Paid Amt\$	Enter the Medicare payment amount as indicated on the EOMB
4	Deductible Amt\$	Enter the Medicare deductible amount as indicated on the Medicare EOMB
5	Allowed Amt\$	Enter the Medicare allowed amount as indicated on the Medicare EOMB
	Add Data	Click to add the line item to the table below.

If submitting **Medicare Part B** claim charges, select "This is a Medicare Part B claim" by placing a check mark in the box and complete the fields displayed below.

UB04 Form

This is a Medicare Part A claim

This is a Medicare Part B claim

Medicare

EOMB Dt	6	Coins Amt\$	7	Paid Amt\$	8
Deductible Amt\$	9	Allowed Amt\$	10	Blood Deductible\$	

Add Data

Pycd	*Provider Number	*Cert - SSN - HIC -ID	Prior Payment	Est Amount Due	Treatment Auth Code	Delete
------	------------------	-----------------------	---------------	----------------	---------------------	--------

Field #	Field Name	Description
6	EOMB Dt	Enter the payment date from the Medicare Explanation of Benefits (EOMB)
7	Coins Amt\$	Enter the coinsurance amount indicated on the EOMB

8	Paid Amt\$	Enter the Medicare payment amount as indicated on the EOMB
9	Deductible Amt\$	Enter the Medicare deductible amount as indicated on the Medicare EOMB
10	Allowed Amt\$	Enter the Medicare allowed amount as indicated on the Medicare EOMB
	Add Data	Click to add the line item to the table below.

***Note: Part A & B charges must be billed on separate claims.**

If the appropriate NPI is not listed, please contact [Provider Enrollment](#).

Provider Information

Billing Provider

*Medicaid Provider ID National Provider ID

Additional Billing Provider Information

Attending Provider

Medicaid Provider ID National Provider ID

Additional Attending Provider Information

Operating Provider

Medicaid Provider ID National Provider ID

Additional Operating Provider Information

Other Provider 1

Medicaid Provider ID National Provider ID

Additional Other Provider 1 Information

Other Provider 2

Medicaid Provider ID National Provider ID

Additional Other Provider 2 Information

Recipient Information

* Medicaid ID

Last Name First Name MI

Additional Recipient Information

Is Patient's Condition Related To Accident Date

Complete the highlighted section(s) as applicable.

*Note: Home Health providers must complete the highlighted fields in accordance to Transmittal #12-17

Field #	Field Name	Description
11	Medicaid Provider ID & National Provider ID	Pre-populates the billing provider's Medicaid ID and corresponding NPI. <i>[Note: This information cannot be changed].</i>
12	Attending Provider	If applicable, enter the Medicaid ID or NPI of the attending provider

13	Operating Provider	If applicable, enter the Medicaid ID or NPI of the operating provider
14	Other Provider 1	If applicable, enter the Medicaid ID or NPI
15	Other Provider 2	If applicable, enter the Medicaid ID or NPI
16	Recipient Information	Verify the information displayed <i>[Note: This information cannot be changed.]</i>
17	Is patient's condition related to	If applicable, select the appropriate response

Other Insurance Info							
Add Insurance info 18							
Payer Name	Insured Name	Group Name	Unique ID	Group No	Emp Name	Delete	
Claim Information							
Claim Data							
Patient CNTL #	<input type="text"/>	Medical Record #	<input type="text"/>	* Type Of Bill	<input type="text"/>	19	
*Service Dates	20						
From	<input type="text"/>	To	<input type="text"/>				
Treatment Authorization Code	<input type="text"/>	21	Timely Filing TCN	<input type="text"/>	22		
<input type="checkbox"/> Admission Information*							
Date	<input type="text"/>	*HR	<input type="text"/>	*Type	Select One	24	
*Src	Select One	25	Discharge Hr	<input type="text"/>	*Status	Select One 26	
<input type="checkbox"/> Condition Codes							
1.	<input type="text"/>	2.	<input type="text"/>	3.	<input type="text"/>	4.	<input type="text"/>
5.	<input type="text"/>	6.	<input type="text"/>	7.	<input type="text"/>		
<input type="checkbox"/> Occurrence Code Date							
Complete the highlighted section(s) if applicable.							
Code	<input type="text"/>	Date	<input type="text"/>	Code	<input type="text"/>	Date	<input type="text"/>
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
<input type="checkbox"/> Occurrence Span Data							
Code	<input type="text"/>	From	<input type="text"/>	To	<input type="text"/>		
Code	<input type="text"/>	From	<input type="text"/>	To	<input type="text"/>		

Field #	Field Name	Description
18	Add Insurance Info	Click <Add Insurance Info> if the patient has other insurance that should be reported to Economic Security Administration (ESA)
19	Type of Bill	Enter the four-digit type of bill code.
20	Service Dates	Enter the dates of services being billed
21	Treatment Authorization Code	If applicable, enter the prior authorization number located on the PA letter received

22	Timely Filing TCN	If resubmitting a claim, if applicable, enter the first TCN from the originally paid or denied claim
23	Admission HR	Enter the appropriate code identifying the hour the patient was admitted for care
24	Admission Type	Select the appropriate type of admission code from the pick list
25	Admission Src	Select the appropriate source of admission code from the pick list
26	Patient Status	Select the appropriate patient status code from the pick list

Value Codes **27**

Value Code	Amount	Value Code	Amount
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Diagnosis Codes* (At least one entry required)

* Principle Diagnosis **28** POA **29**

Admission Diagnosis

1. <input type="text"/>	POA <input type="text"/>	2. <input type="text"/>	POA <input type="text"/>
3. <input type="text"/>	POA <input type="text"/>	4. <input type="text"/>	POA <input type="text"/>
5. <input type="text"/>	POA <input type="text"/>	6. <input type="text"/>	POA <input type="text"/>
7. <input type="text"/>	POA <input type="text"/>	8. <input type="text"/>	POA <input type="text"/>
9. <input type="text"/>	POA <input type="text"/>	10. <input type="text"/>	POA <input type="text"/>
11. <input type="text"/>	POA <input type="text"/>	12. <input type="text"/>	POA <input type="text"/>
13. <input type="text"/>	POA <input type="text"/>	14. <input type="text"/>	POA <input type="text"/>
15. <input type="text"/>	POA <input type="text"/>	16. <input type="text"/>	POA <input type="text"/>
17. <input type="text"/>	POA <input type="text"/>	18. <input type="text"/>	POA <input type="text"/>
19. <input type="text"/>	POA <input type="text"/>	20. <input type="text"/>	POA <input type="text"/>

Other Procedures

Field #	Field Name	Description
27	Value Code	Enter the appropriate value code and amount
28	Principle Diagnosis	Enter the principal diagnosis code(s) provided at the time of admission as stated by the physician
29	POA	Select the appropriate present upon admission code from the pick list

Required Attachments

Does the Claim have Attachments? **30**

Yes No

Basic Line Item Information

Note: Please ensure you have entered any necessary claim information (found in the other sections of this or another page) before adding this service line.

Add Service Line Item

Rev Code	Procedure	Rate	Service Begin Date	Service End Date	Submit Units	Submitted Charges	Non-Covered Charge	Modifiers				NDC Code	Edit	Delete
								1	2	3	4			
0001						0.00								

New Covered Individual

*RevCode	31	RevCode Description	
*Procedure Code	32	Procedure Code Description	
Rate	33	Modifiers	34
Service Begin Date	35	End Date	36
*Submit Units	37	*Submitted Charges \$	38
NDC Code		Non Coverage Charges \$	

Save

Summary

Total Submitted Charges **39**

Are there TPL amounts to be entered? Yes No **40**

Balance **41**

REQUIRED: I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for the procedures.

REQUIRED: I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction, and that the fees submitted are the actual fees I have charged and intend to collect for the payments.

Submit **Reset**

Field #	Field Name	Description
30	Does the claim have attachments?	If billing Medicare Part A or B charges, select "yes" to upload the EOMB.
	Add Service Line Item	Click this button to display claim detail fields
31	Rev Code	Enter the applicable revenue code being billed [Note: The description will auto-populate once you tab to the next field].

32	Procedure Code	If applicable, enter the applicable procedure code being billed. <i>[Note: The description will auto-populate once you tab to the next field].</i>
33	Rate	Enter your usual and customary charges for the procedure being billed
34	Modifiers	If applicable, enter the appropriate modifier(s) for the above procedure code in all capital letters
35	Service Begin Date	Enter the first date of service
36	Service End Date	Re-enter the first date of service
37	Units	Enter the total number of units being billed for this procedure
38	Submitted Charges	Enter total charges for revenue/procedure code being billed
	Save	Click to add the line item to the table above. If billing multiple lines, repeat steps 10-19 to add additional claim line. YOU MUST CLICK <SAVE> AFTER EACH LINE.
39	Total Submitted Charges	Auto populates overall claim total
40	TPL Amounts	Select "Yes" or "No" to this question. If you select "Yes", you must enter the payment amount received from the third-party payer (i.e. private insurance, Medicare, etc.)
41	Balance	Auto populated the difference between the total submitted charges and TPL payments
	Confirmation Statements	Click both text boxes
	Submit/Reset	Click <Submit> to submit the claim

Upon successful submission, the TCN (transaction control number) will be displayed at the top of your claim in addition to the claim status.

TCN	12258100010007147	Claim Status	Suspended
Line Number	Exception Code	Exception Description	Exception Status
0	0120	THE BILLING PROVIDER NUMBER (PAY TO PROVIDER) IS ZEROS.	Suspend
0	0313	CATEGORY OF SERVICE CANNOT BE DETERMINED	Suspend
0	5125	INVALID BILLING PROVIDER CHECK DIGIT NUMBER	Suspend
1	0429	PROVIDER LICENSE EXPIRED	Suspend

The following claim statuses may be displayed:

- **To be paid**

- **To be denied** – The exception code (denial reason) and description will be displayed. If you have the correct information, you may submit the corrected claim immediately.
- **To be suspended** – The exception code (pending status) and description will be displayed. **DO NOT RESUBMIT SUSPENDED CLAIMS.** Please allow up to 45 days for processing.

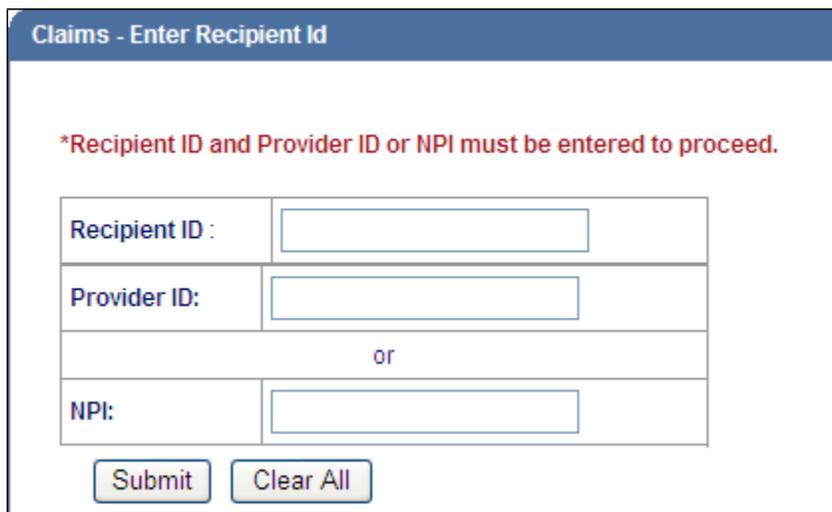
Claims Entry – ADA Dental

After logging in, select Claims Entry > ADA Dental Claim Form



A screenshot of a navigation menu titled "PROVIDER - Secure Options". The menu items are: Claim Templates, Inquiry Options, Claims Entry (highlighted with a red box), ADA Dental Claim Form, Adjustment/Void Form, CMS 1500/Medicare Part B, LTC Group Claim, and UB04/Medicare Part A/B.

Enter the recipient's Medicaid ID and your NPI in the fields displayed and click <Submit>. [Note: If you are billing for services rendered to a waiver recipient, enter your waiver provider ID.]



A screenshot of a web form titled "Claims - Enter Recipient Id". The form contains a red instruction: "*Recipient ID and Provider ID or NPI must be entered to proceed." Below this are three input fields: "Recipient ID:", "Provider ID:", and "NPI:". The "Provider ID:" field is followed by the word "or". At the bottom of the form are two buttons: "Submit" and "Clear All".

The ADA Dental claim form will be displayed with the provider and recipient information pre-populated.

ADA Dental Claim Form

If the appropriate NPI is not listed, please contact [Provider Enrollment](#).

Provider Information

Billing Provider

*Medicaid Provider ID: 999999998 National Provider ID: 1

Additional Billing Provider Information

Is the Billing Provider also the Treating Provider? Yes No 2

Is this service the result of a referral? Yes No 3

Recipient Information

* Medicaid ID: 70367887

Last Name: DOE First Name: BABY GIRL MI:

Additional Recipient Information

Is Patient's Condition Related To: Choose a Condition Accident Date:

Other Insurance Info

Payer Name	Insured Name	Group Name	Unique ID	Group No	Emp Name	Delete
------------	--------------	------------	-----------	----------	----------	--------

Field #	Field Name	Description
1	Medicaid Provider ID & National Provider ID	Pre-populates the billing provider's Medicaid ID and corresponding NPI. [Note: This information cannot be changed].
2	Treating Provider	Select "Yes" or "No" to this question. If you select "No", you must enter the treating provider's Medicaid ID or NPI.
3	Recipient Information	Verify the information displayed [Note: This information cannot be changed.]

Claim Information			
Prior Authorization	<input type="text"/>	4	
Timely Filing TCN	<input type="text"/>	5	
Claim Data			
Patient Account #	<input type="text"/>	Medical Record #	<input type="text"/>
Remarks	<input type="text"/>		
 Ancillary Claim Data	Click on the plus (+) sign to expand this section		
Place of Treatment*	<input type="text" value="Select"/>	6	
Number of Enclosures	Radiograph(s) <input type="text"/>	Oral Image (s) <input type="text"/>	Model(s) <input type="text"/>
Is Treatment For Orthodontics <input type="radio"/> Yes <input type="radio"/> No			
Replacement of Prosthesis <input type="radio"/> Yes <input type="radio"/> No			
Treatment Resulting from	<input type="text" value="Select"/>		
Provider Signature on File	<input type="radio"/> Yes <input type="radio"/> No		7
Provider Signature Date	<input type="text"/>	8	

Field #	Field Name	Description
4	Prior Authorization	If applicable, enter the prior authorization number located on the PA letter received
5	Timely Filing TCN	If applicable, enter the first TCN from the originally paid or denied claim
6	Place of Treatment	Select the appropriate response indicating where services were rendered
7	Provider Signature on File	Select "Yes"
8	Provider Signature Date	Enter the current date

Required Attachments

Does the Claim have Attachments?

Yes No

9

Basic Line Item Information

Note: Please ensure you have entered any necessary claim information (found in the other sections of this or another page) before adding this service line.

Add Service Line Item

10

Appropriate NPI is not listed, please contact Provider Enrollment.

Procedure Date	Area of Oral Cavity	Tooth Numbers or Letters	Tooth Surface	Procedure Code	Description	Units	Fee	Treating Provider ID	NPI	Diag Pointers				Edit	Delete
										1	2	3	4		

New Covered Individual				
*Procedure Date	11	Area of Oral Cavity	Select One	12
Tooth System	13	Tooth Numbers or Letters	Select One	14
Tooth Surface	15	Select One	Select One	Select One
*Procedure Code	16	Description		
*Units	17	*Fee	18	
EPSDT Indicator	Select One			
*Treating Provider ID		NPI	19	
Diagnosis Pointers	Select	Select	Select	Select
Save	20			

Field #	Field Name	Description
9	Claim Attachments	Select "No"
10	Add Service Line Item	Click this button to display claim detail fields
11	Procedure Date	Enter the date of service
12	Area of Oral Cavity	If applicable, select the appropriate response
13	Tooth System	If applicable, enter the appropriate response
14	Tooth Numbers or Letters	If applicable, select the appropriate response
15	Tooth Surface	If applicable, select the appropriate response
16	Procedure Code	Enter the dental procedure code being billed [Note: The description will auto-populate].
17	Units	Enter the total number of units being billed for the procedure code
18	Fee	Enter your usual and customary charges for the procedure being billed

19	Treating Provider ID	Enter the NPI of the treating provider
20	Save	Click to add the line item to the table above. If billing multiple lines, repeat steps 10-19 to add additional claim

Summary		
Total Submitted Charges	<input type="text" value="0.00"/>	21
Are there TPL amounts to be entered?	<input type="radio"/> Yes <input type="radio"/> No	22
Balance	<input type="text" value="0.00"/>	23
<input type="checkbox"/> REQUIRED: I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for the procedures. 24		
<input type="checkbox"/> REQUIRED: I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction, and that the fees submitted are the actual fees I have charged and intend to collect for the payments.		
<input type="button" value="Submit"/> <input type="button" value="Reset"/>		

Field #	Field Name	Description
21	Total Submitted Charges	Auto populates overall claim total
22	TPL Amounts	Select "Yes" or "No" to this question. If you select "Yes", you must enter the payment amount received from the third party payer (i.e. private insurance, Medicare, etc.)
23	Balance	Auto populated the difference between the total submitted charges and TPL payments
24	Confirmation Statements	Click both text boxes and click <Submit>

Upon submission, the TCN (transaction control number) will be displayed at the top of your claim in addition to the claim status.

TCN	12082100010002877		Claim Status	To be Denied
Line Number	Exception Code	Exception Description	Exception Status	
0	0120	THE BILLING PROVIDER NUMBER (PAY TO PROVIDER) IS ZEROS.	Suspend	
0	0313	CATEGORY OF SERVICE CANNOT BE DETERMINED	Suspend	
0	5125	INVALID BILLING PROVIDER CHECK DIGIT NUMBER	Suspend	
0	5410	TREATING PROVIDER MISSING. THE BILLING PROVIDER IS A "GROUP" AND THE TREATING PROVIDER NUMBER IS MISSING.	Suspend	
1	0135	CLAIM PRICED AT ZERO	Suspend	
1	0429	PROVIDER LICENSE EXPIRED	Suspend	
1	0437	PROCEDURE NOT VALID FOR SERVICE DATE	Deny	
1	5670	RENDERING/ATTENDING PROVIDER IS A HEALTHCARE PROVIDER AND MUST USE NPI	Suspend	

The following claim statuses may be displayed:

- **To be paid**
- **To be denied** – The exception code (denial reason) and description will be displayed. If you have the correct information, you may submit the corrected claim immediately.
- **To be suspended** – The exception code (pending status) and description will be displayed. **DO NOT RESUBMIT SUSPENDED CLAIMS.** Please allow up to 45 days for processing.

Submitting Adjustments/Voids

Adjustments and voids of previously paid claims may be submitted online through the Web Portal.

1. After successfully logging in, select Adjustment/Void form from the navigational pane
2. Enter the TCN of the claim being adjusted or voided.
3. Select desired action - Adjust or Void and click <Submit>

The screenshot shows the District of Columbia Department of Health Care Finance web portal. The navigation menu on the left includes sections for HOME, WEB REGISTRATION, and PROVIDER - Secure Options. Under PROVIDER - Secure Options, the 'Adjustment/Void Form' link is highlighted with a red box. The main content area is titled 'Adjustment/Void - Enter TCN' and contains a form with a 'TCN' input field, an 'Action' dropdown menu (with 'Adjust' and 'Void' options visible), and a 'Submit' button.

4. The claim will be displayed. If adjusting the claim, make the necessary modifications to units and/or submitted charges.
5. Enter the Timely Filing TCN

The screenshot shows the 'Claim Information' form. The 'Timely Filing TCN' field is highlighted with a red arrow pointing to it, with the text 'Enter TCN' written in yellow on a red banner.

6. Select the appropriate 'Description of the request' from the pick list indicating the appropriate adjustment or void reason.

Basic Line Item Information

Note: Please ensure you have entered any necessary claim information (found in the other sections of this or another page) before adding this service line.

Add Service Line Item If the appropriate TPI is not listed, please contact Provider Enrollment.

L#	Service Dates		Procedure Codes	Provider ID	SPN	Modifiers				Dig Points				Submitted Charges	units	Place of Service	NOC Code	Edit	Delete
	Begin	End				1	2	3	4	1	2	3	4						
1	01/16/2007	01/16/2007	92904	00087049						1				55.00	1	11		<input type="checkbox"/>	<input type="checkbox"/>
2	01/16/2007	01/16/2007	92915	00087049						1				15.00	1	11		<input type="checkbox"/>	<input type="checkbox"/>

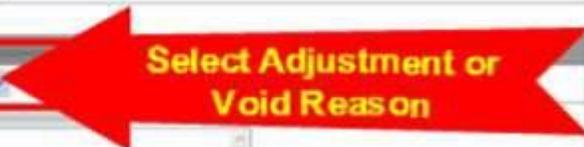
Summary

Total Submitted Charges:

Are there TPL amounts to be entered? Yes No

Balance:

Notes

Description of the request:  **Select Adjustment or Void Reason**

Other Explanation:

Upload File:

REQUIRED: I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees. I have obtained and intend to collect for the

7. Once all information has been completed, click <Submit>.
8. The TCN and status of the adjustment/void request will be displayed.

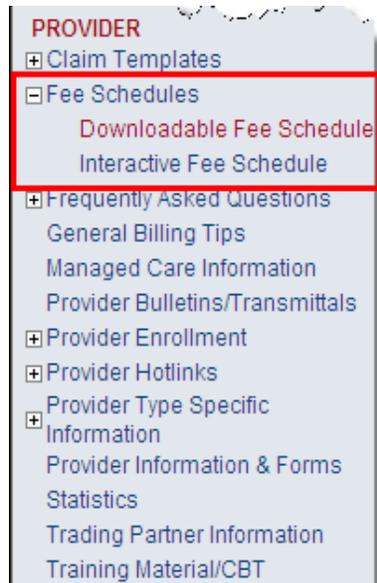
Helpful Tips:

- Only paid claims can be adjusted or voided.
- Once a TCN has been adjusted or voided, you can never adjust or void that TCN again. You must use the most current paid TCN for any additional adjustments or voids.
- Adjustments must be submitted within 365 days of the payment date.
- Voids may be submitted at any time.
- You may submit an adjustment or void online if the sixth digit (media type) of the TCN is 1, 2, 3, 5, 8 or 9.
- If the sixth digit of the TCN is a 4, 6 or 7, adjustments and voids for these claims must be submitted hardcopy on the appropriate original red UB-04 or CMS-1500 claim form.

Accessing Fee Schedules

The fee schedule is available on the Web Portal. Providers may download the fee schedule, which is in an Excel spreadsheet, or access the interactive fee schedule. The interactive fee schedule allows users to enter a specific procedure.

After successfully logging into the Portal, the following tasks may be performed on the Web Portal by clicking on the plus sign (+) beside <Fee Schedules>.



Downloadable Fee Schedule



Interactive Fee Schedule

You must include all criteria listed below. Please enter dates in mm/dd/yyyy format.

Prior authorization may be required. Please refer to policy.

Procedure Code:	<input type="text" value="T1019"/>
Date of Service:	<input type="text" value="10/17/2009"/>

Interactive Fee Schedule Response – Example

Interactive Fee Schedule Response

Information requested time: Sat Oct 17 16:43:20 EDT 2009

Price does not include cutbacks, assessment fees, etc. Payment is not guaranteed.

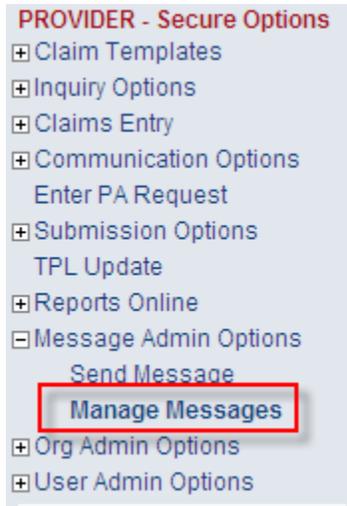
Price by Factor Code				
Procedure Code	Pricing Code	Begin Date	End Date	Price
T1019	Z1	2009-02-01	9999-12-31	4.08

Factor Code Description	
Z1	General Fee Schedule

Retrieving Remittance Advices

Remittance Advices are available online every Monday and will remain online for 90 days.

After logging in, select Message Admin Options > Manage Messages



All available remittance advices will be displayed. Please save your remittance advices.

Manage Messages

The following list contains a summary of all your messages. To read a message please click on the File Name. If messages are not deleted, they will be automatically deleted after 90 days.

To delete a message, please check the appropriate box and then select the appropriate button.

Select	File Name	Subject	From	Date Posted	Date Expired	View
--------	-----------	---------	------	-------------	--------------	------

Web Account Maintenance

What is the required timeframe for Password changes on the Web Portal?

Web Portal Password requirements:

- Users are required to change their password every 90 days.
- New password must meet the following password guidelines:
 - Your new password must be between 8 and 12 characters long.
 - Your new password must not be like your last 6 passwords.
 - Your new password must contain at least 1 number.
 - Your new password must contain at least 1 upper case letter.
 - Your new password must contain at least 1 lower case letter.
 - Your new password must contain at least 1 special character.

What are the password criteria and account expiration/lockout requirements for Web Portal user accounts?

Web Portal Expiration / Lockout out requirements:

- User accounts will become disabled (locked out) after entering password incorrectly three (3) times.
- User accounts will automatically become disabled if they have had no login activity in 60 days.
- Users will receive an email stating that their User ID will be inactivated in 10 days and a second email stating their User ID will be inactivated in 5 days prior to the 60-day timeframe.

Web Portal User ID Deletion:

- User accounts will be flagged for deletion if they have had no login activity in 120 days.
- After 120 days of inactivity, users will receive weekly email notifications informing them that the account will be deleted, and they will be required to re-register after account deletion to regain access to the Web Portal.
- User accounts will be automatically deleted if they have had no login activity in 180 days.

My account is locked out or has been marked 'inactive'. How do I regain access to the Web Portal?

Contact Provider Inquiry at (202) 906-8319 (inside DC metro area) or (866) 752-9233 (outside DC metro area) for assistance or you may send an email to providerinquiry@conduent.com. Locked and/or inactive Web Portal user accounts can only be unlocked or reactivated by the Conduent Web Portal Administrator.

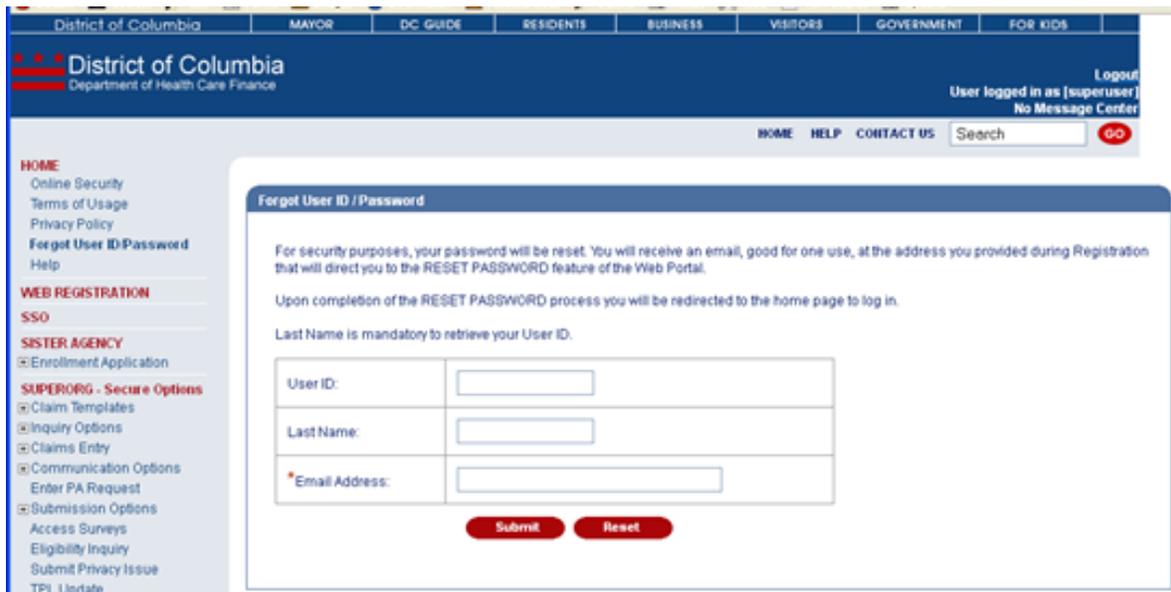
I've forgotten my Web Portal User ID or Password. How do locate my User ID or reset my password?

The Web Portal provides a facility for users to perform a search for their User ID and/or generate a password reset request. Open a browser and access the DC-Medicaid Web Portal at <https://www.dc-medicaid.com>.

Click on the 'Forgot User ID/Password' link and the Forgot User ID/ Password will be displayed.



To locate a forgotten User ID and/or generate a Password Reset request, enter your User ID and Email Address or your Last Name and Email Address. Click 'Submit'.



Enter the answer to your 'Hint Question' and click 'Submit'.

District of Columbia | MAYOR | DC GUIDE | RESIDENTS | BUSINESS | VISITORS | GOVERNMENT | FOR KIDS

District of Columbia
Department of Health Care Finance

Logout
User logged in as [superuser]
No Message Center

HOME HELP CONTACT US Search GO

HOME
Online Security
Terms of Usage
Privacy Policy
Forgot User ID/Password
Help

WEB REGISTRATION

SSO

SISTER AGENCY
Enrollment Application

SUPERORG - Secure Options
Claim Templates
Inquiry Options

Retrieve User ID / Password

Hint Question:	What is your Mother's Maiden Name?
*Answer:	<input type="text"/>

Submit Reset

Verify the Email Address for your account. If it is correct as displayed, click 'Submit'. Otherwise, click 'No' and enter the correct email address, then click 'Submit'.

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District of Columbia
Department of Health Care Finance

Logout
User logged in as [superuser]
No Message Center

HOME HELP CONTACT US Search GO

HOME
Online Security
Terms of Usage
Privacy Policy
Forgot User ID/Password
Help

WEB REGISTRATION

SSO

SISTER AGENCY
Enrollment Application

SUPERORG - Secure Options
Claim Templates
Inquiry Options

Retrieve User ID / Password

The email address that you provided during Registration is shown below.
If you want to update your email address, please click the 'No' option and update the address.

*Email Address:	FRANK.NORRIS@ACS-INC.COM	<input checked="" type="radio"/> Yes <input type="radio"/> No
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Submit Reset

The Retrieve User ID / Password Confirmation page is displayed with a reference number.

District of Columbia | MAYOR | DC GUIDE | RESIDENTS | BUSINESS | VISITORS | GOVERNMENT | FOR KIDS

District of Columbia
Department of Health Care Finance

Logout
User logged in as [superuser]
No Message Center

HOME HELP CONTACT US Search GO

HOME
Online Security
Terms of Usage
Privacy Policy
Forgot User ID/Password
Help

WEB REGISTRATION

SSO

SISTER AGENCY
Enrollment Application

Retrieve User ID / Password Confirmation

Your User ID has been successfully sent to your email address. For security reasons, we are unable to send your original password via email. The link contained within the email will provide entry into the RESET PASSWORD feature of the webportal.

Your Reference Number is: 1688124944

You will receive an email at the address you verified containing your User ID and a link to the Web Portal to be used if you need to reset your account password.

Note: The link contained within the email is for a single use and remains active for 24 hours.

The text of the email will resemble the following:

Your UserID is listed below. For security reasons, we are unable to send your original password via email. The link below is valid for 24 hours and will provide entry into the RESET PASSWORD feature of the webportal.

UserID: XXXXXXXX

[Click here](#) to create a new password.

I've received an email with my User ID and a link to create a new password. How do I proceed?

Click on the 'Click here' link contained within the email, and you will be directed to the Web Portal to enter a new password and a new hint question/answer.

Enter and confirm your new password and click 'Submit'.

The screenshot shows the District of Columbia Department of Health Care Finance web portal. The top navigation bar includes links for District of Columbia, MAYOR, DC GUIDE, RESIDENTS, BUSINESS, VISITORS, GOVERNMENT, and FOR KIDS. The main header displays the District of Columbia logo and the Department of Health Care Finance. A left sidebar menu lists categories: HOME (Online Security, Terms of Usage, Privacy Policy, Forgot User ID/Password, Help), WEB REGISTRATION, and PROVIDER (EHR Incentive Payments Program, Fee Schedules, Frequently Asked Questions, General Billing Tips, Managed Care Information, Provider Bulletins/Transmittals, Provider Enrollment, Provider Hotlinks, Provider Type Specific). The main content area features a 'Reset Password' form with the following text: 'To change your password, enter the data below and click: Submit. Your new password must be between 6 and 12 characters in length, alphanumeric. Passwords are case sensitive. Your new password must not be similar to your last 3 passwords.' The form contains two input fields: 'New Password:' and 'Confirm New Password'. Below the fields are two buttons: 'Submit' and 'Reset'.

Select a new Hint Question from the dropdown and enter an answer that you can remember later without writing it down.

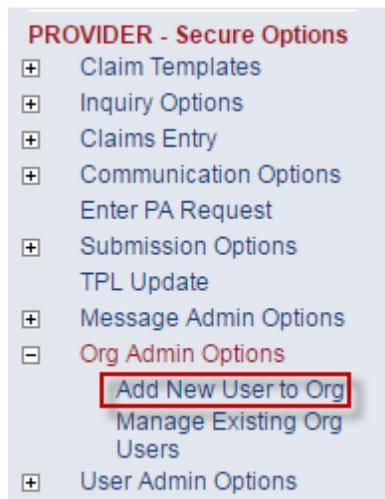


The Reset Password Confirmation page is displayed. You will be automatically redirected to the Web Portal homepage where you may log in.



How do I add users to my web account?

Only the master administrator for the web account can add additional users to an existing web account. To add users, click on 'Org Admin Options' and select 'Add New User to Org'.



Complete the fields marked with an asterisk and click <Submit>. [**Note: All users must have a unique user ID.**]

Add New User

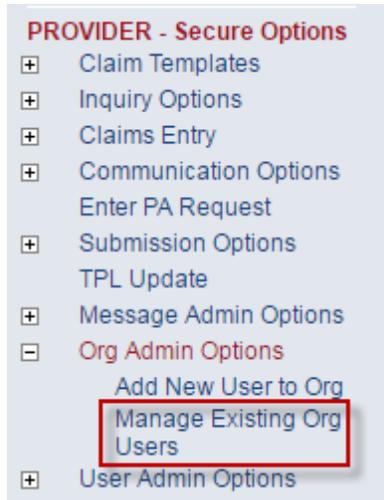
Enter the information below and click **Submit**.
Please make sure that the User ID is Alphanumeric and 6-14 characters long.

*Last Name:	<input type="text"/>
*First Name:	<input type="text"/>
Middle Initial	<input type="text"/>
*Email Address:	<input type="text"/>
*Verify Email Address:	<input type="text"/>
*Phone Number:	<input type="text"/>
Ext:	<input type="text"/>
*User ID:	<input type="text"/>

The user(s) will receive an email containing the user ID and temporary password.
[**Note: The temporary password is valid for 24 hours.**]

An employee is no longer affiliated with my organization. How do I remove their access?

Only the master administrator for the web account can delete users from an existing web account. To delete a user, select Org Admin Options > Manage Existing Org Users.



All users will be displayed.

Manage Existing Users

To edit the user's profile, click the user's last name. **Reset Password** will reset the corresponding user's password. **Remove** will remove the corresponding user from your organization.

If the user has an alert icon associated with him/her, this is due to the user's inactivity in the Web portal. If a user is inactive for 60 days their account will be automatically disabled. If a user is inactive for 180 days their account will be removed from the system. Click on the icon to renew the user's access. View Alert Icon Legend.

Alert	Last User Activity	User ID	First Name	Last Name	Status	Select
	06/05/2017				Active	Reset Password ▼ Continue
	05/30/2017				Active	Reset Password ▼ Continue
⊗	06/08/2016				Active	Reset Password ▼ Continue
	05/24/2017				Active	Reset Password ▼ Delete User Continue
	06/05/2017				Active	Edit Continue
	06/02/2017				Active	Reset Password ▼ Continue
⊗	05/27/2016				Active	Reset Password ▼ Continue
⊗	10/26/2016				Active	Reset Password ▼ Continue

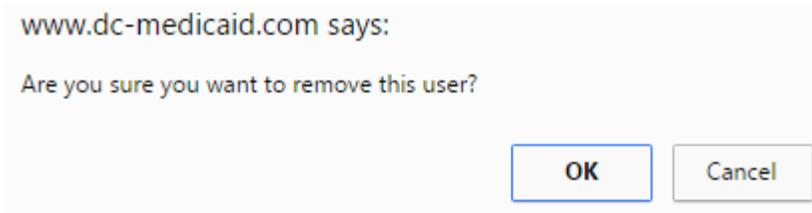
Page 1 of 1 Total Records: 8

The Master Administrator is denoted by MA. To reassign the Master Administrator's position, please contact your fiscal agent.

Alert Icon Legend

- 🔔 The user has been inactive in the system for 60 days. Please click the icon to renew this user's access.
- ⚠️ The user has been inactive for 65 days. Please click the icon to renew this user's access.
- ⊗ The user will be removed from your organization tomorrow. Please click the icon to renew this user's access.

Select Delete User from the user list of the user whose login should be deleted. Click 'Continue' and click <OK> to confirm the deletion.



A confirmation message of the deletion will be displayed.

User deleted successfully

To edit the user's profile, click the user's last name. **Reset Password** will reset the corresponding user's password. **Remove** will remove the corresponding user from your organization.

If the user has an alert icon associated with him/her, this is due to the user's inactivity in the Web portal. If a user is inactive for 60 days their account will be automatically disabled. If a user is inactive for 180 days their account will be removed from the system. Click on the icon to renew the user's access. [View Alert Icon Legend](#).