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

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

Provider Account Registration

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.

Please choose your type of organization and create your "Login ID", please note that your Login ID is case-sensitive and should consist of 6-14 alpha-numeric characters; example Login ID:"example123"

Individual	Group	Login ID
○	◉	hhprovider

Please enter your Medicaid Provider ID or NPI information.

Provider ID		NPI	Taxonomy
	OR	0000000000	111A00000X

To use the EDI Exchange feature, you must supply your EDI Submitter information below. If you are not registered as an EDI Submitter but wish to do so, please contact ACS EDI Gateway Services by phone at (866) 225-2502 or online at http://acs-gcro.com.

EDI Submitter ID	EDI Password

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).

Last Name	First Name	Middle Initial	SSN (Last Four Digits)

Please enter your Organization Name and EIN if you are registering as a group.

Organization Name	EIN
Home Health LLC	123456789

Please enter your Email Address and select your hint question/answer.

What is your Email Address?	Verify your Email Address	Hint Question	Hint Answer
anyemail@mail.com	anyemail@mail.com	Mother's maiden name	Name

Submit | Clear All

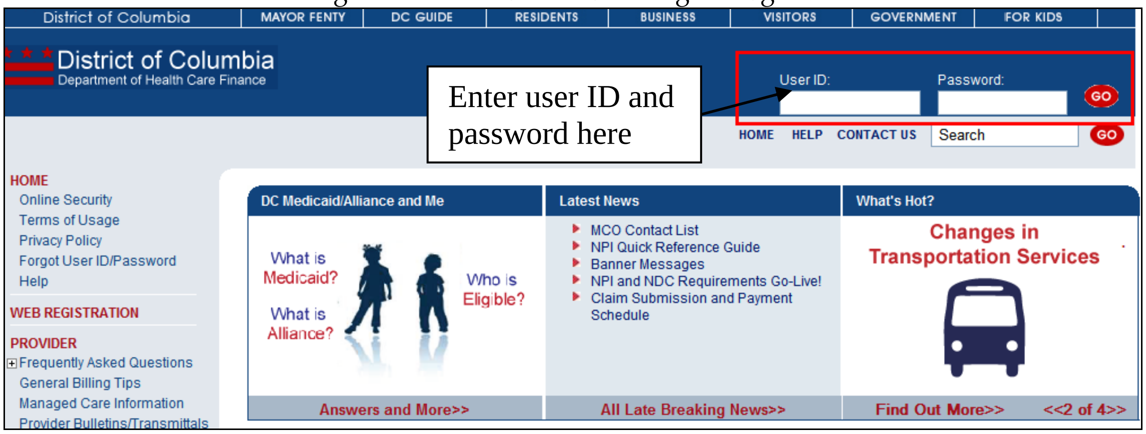
[**Note:** *Must be an active provider to complete the registration process.*]

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



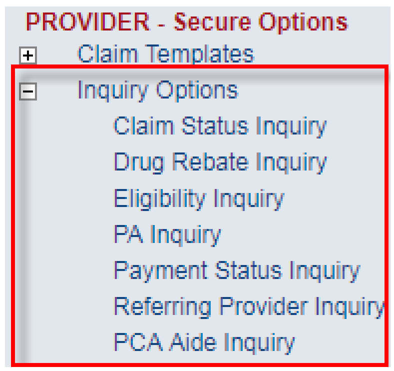
[**Note:** Three unsuccessful login attempts will result in your account being **disabled**. After the second unsuccessful attempt, click on "Forgot User ID/Password" located in the left navigational pane and answer the security question displayed. A change password link will be sent to the email address 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

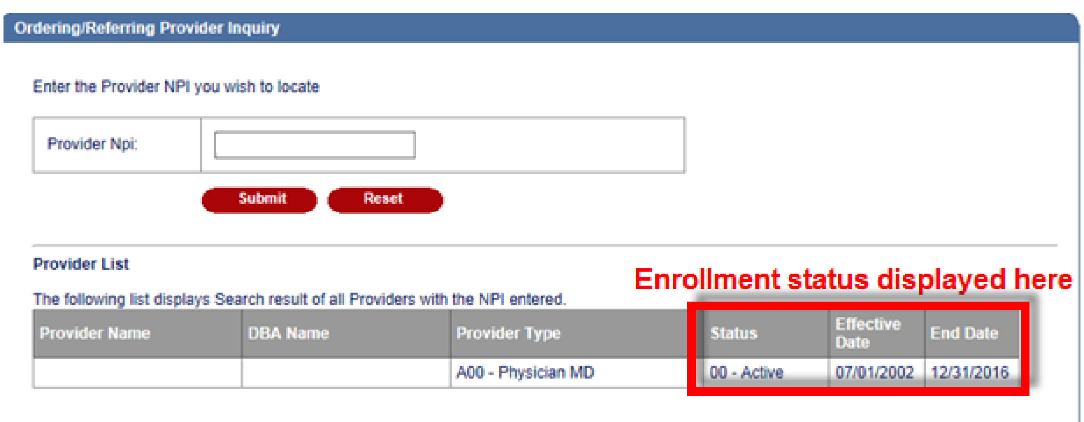
After successfully logging into the Portal, the following tasks may be performed on the Web Portal by clicking on the plus sign (+) beside <**Inquiry Options**>:

- 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.



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 <u>one (1)</u> of the following combinations and click <Submit>

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

Claim Status

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

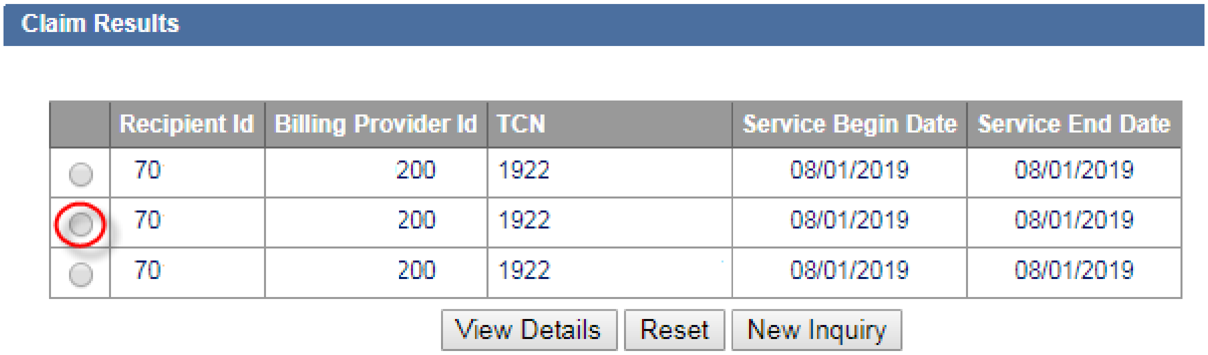
TCN
-OR-
Recipient ID, Service Begin Date, Service End Date

Please enter dates in mm/dd/yyyy format.

Recipient ID :	
TCN:	Check if before October 1,2009
Institutional Bill type:	
Medical Record:	
Total Claim Charge Amount: $	
Date(s) of Service:	
Begin Date:	
End Date:	

Submit Reset

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

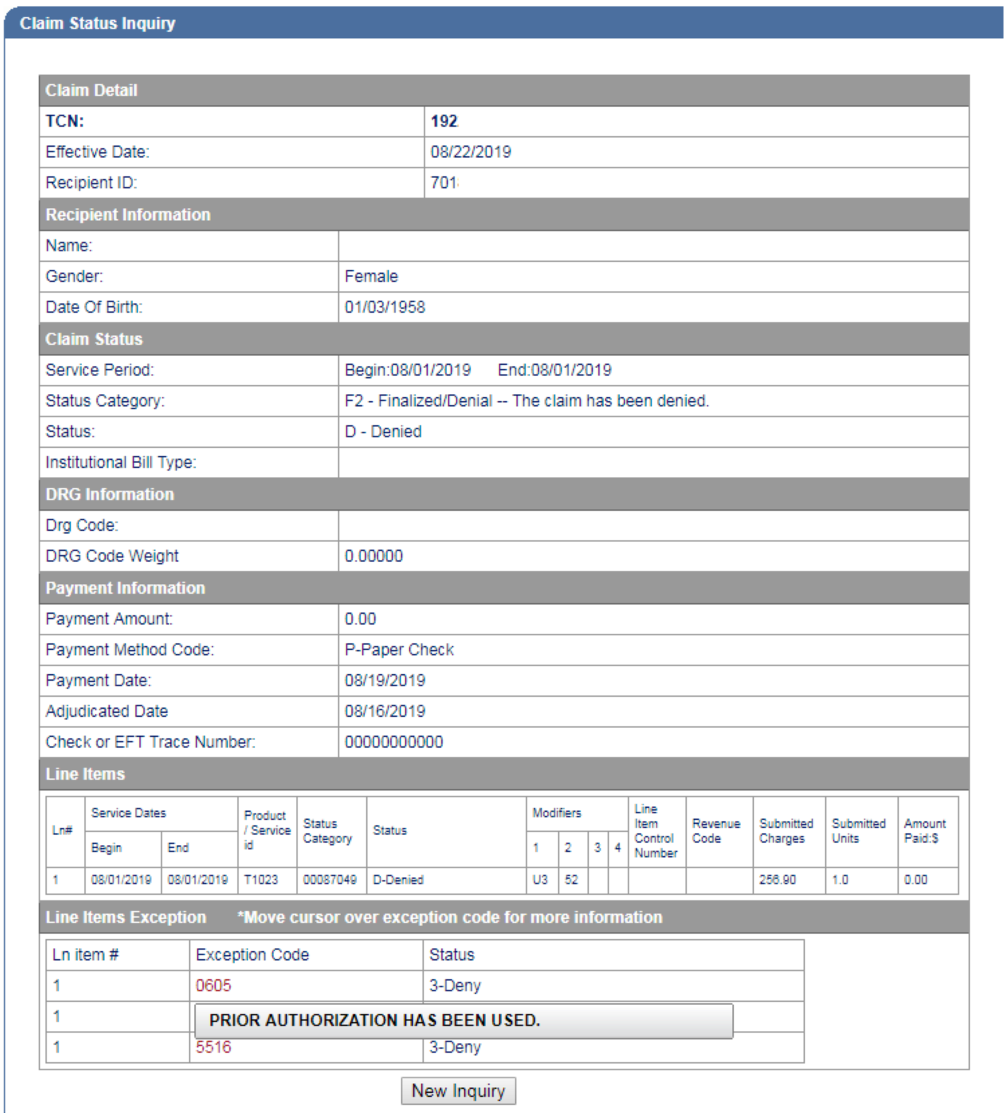


Claim Results

	Recipient Id	Billing Provider Id	TCN	Service Begin Date	Service End Date
○	70	200	1922	08/01/2019	08/01/2019
○	70	200	1922	08/01/2019	08/01/2019
○	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	
Drg 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:	00000000000

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

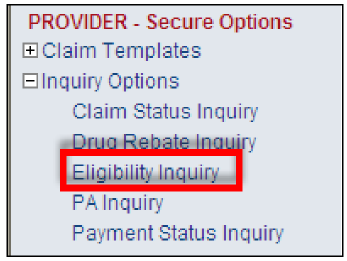
Ln item #	Exception Code	Status
1	0605	3-Deny
1	PRIOR AUTHORIZATION HAS BEEN USED.	
1	5516	3-Deny

New Inquiry

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

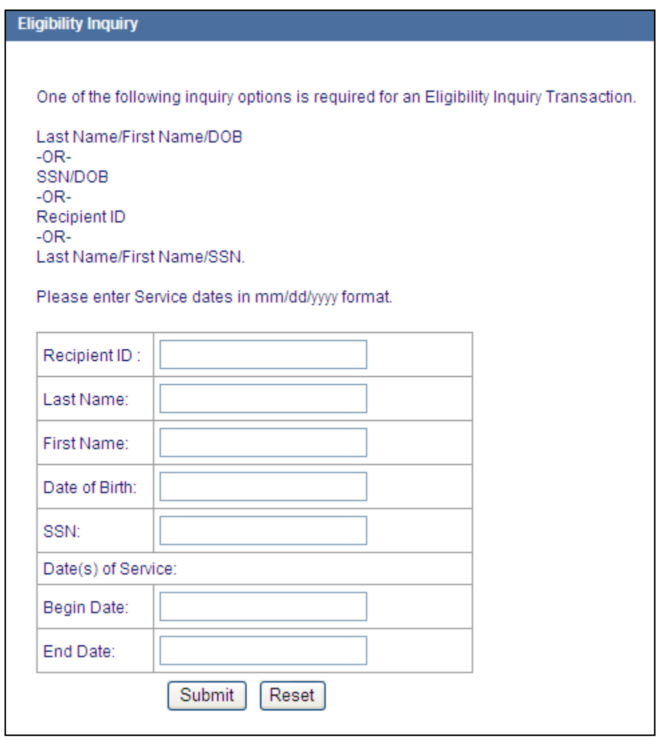
Eligibility Inquiry

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

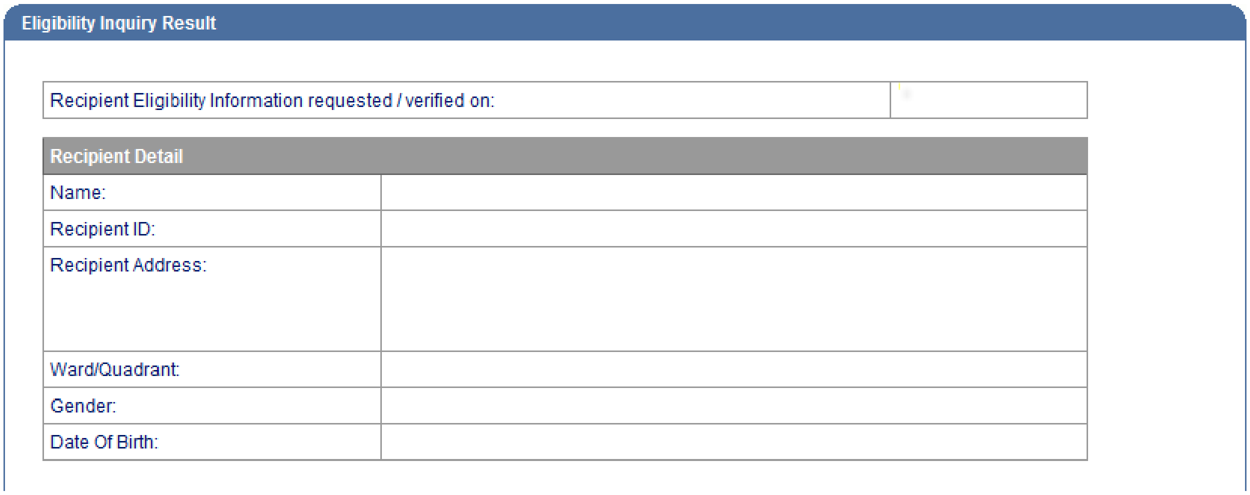


Enter your search criteria using one (1) of the following combinations and click <Submit>

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



The eligibility results for the recipient entered will be displayed.



Eligibility Inquiry Result

Recipient Eligibility Information requested / verified on:	

Recipient Detail	
Name:	
Recipient ID:	
Recipient Address:	
Ward/Quadrant:	
Gender:	
Date Of Birth:	

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).

<table>
<tr><th>Field Name</th><th>Description</th></tr>
<tr><td>Program Code</td><td>Indicates the recipient's category of eligibility. A recipient's benefits/services may be limited or restricted by this code.</td></tr>
<tr><td>Eligibility or Benefit Information</td><td>Indicates the Medicaid eligibility status of the recipient</td></tr>
<tr><td>Begin Date</td><td>Indicates the begin date of the recipient's Medicaid eligibility</td></tr>
<tr><td>End Date</td><td>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.</td></tr>
<tr><td>QMB Indicator</td><td>Indicates if services are limited to payment of the recipient's Medicare Part A premium.</td></tr>
<tr><td>Service Types
[Click on the plus "+" sign beside service types to expand this section.]</td><td>Based upon the recipient's program code, the services that the recipient is eligible to receive will be listed.

<table>
<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></td></tr>
</table>

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: ➢ 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	
TPL Update	
Insurance Company Name:	
TPL Address:	
Policy Holder :	
Policy Number:	
Begin Date:	
End Date:	
Resouce Type:	
⊟ Coverage Information	
Dental	

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

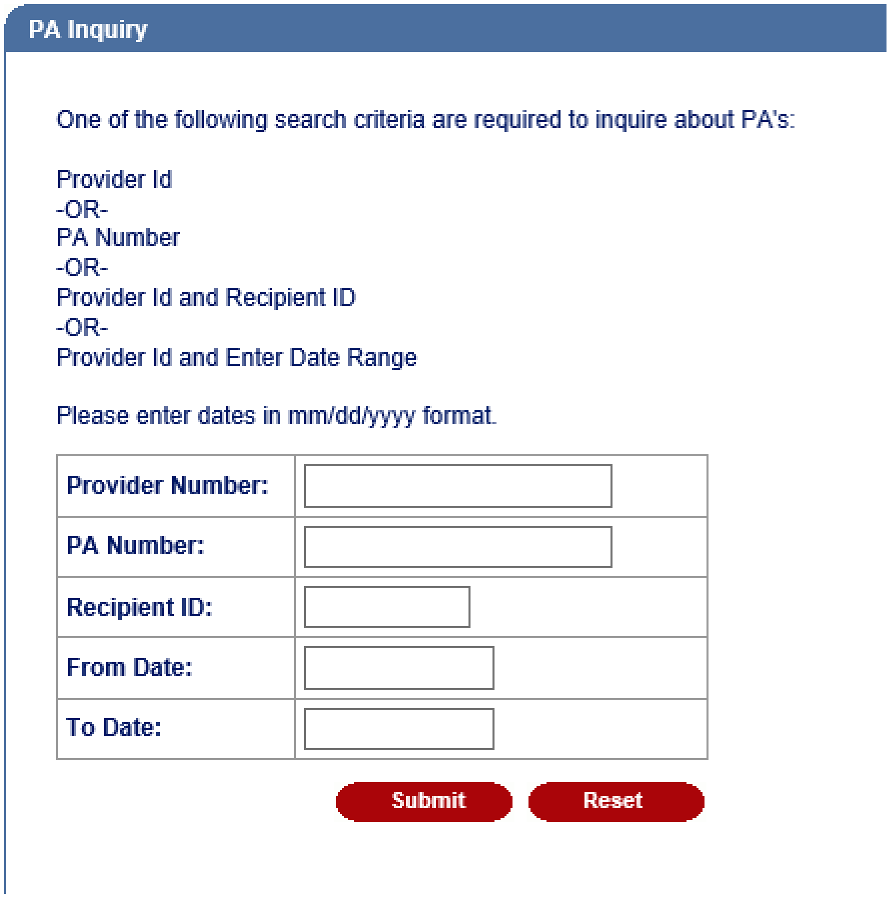
Field Name	Description
Third Party Liability Information	If the recipient is inactive or is not enrolled in an insurance plan at the time of verification, this section will display N/A and the fields listed below will not be displayed.
Insurance Company	Indicates the name of the primary payer (insurance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

<table>
<tr><td>Name</td><td></td></tr>
<tr><td>TPL Address</td><td>Indicates the address of the insurance company</td></tr>
<tr><td>Policy Holder</td><td>Indicates the name of the primary insurance holder</td></tr>
<tr><td>Policy Number</td><td>Indicates the policy number associated with this policy</td></tr>
<tr><td>Begin Date</td><td>Indicates the begin date of the insurance policy</td></tr>
<tr><td>End Date</td><td>Indicates the end date of the insurance policy</td></tr>
<tr><td>Resource Type</td><td>Indicates the type of insurance plan</td></tr>
<tr><td>Coverage Information
[Click on the plus "+" sign beside service types to expand this section.]</td><td>Indicates the services that are available under the policy
<table>
<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></td></tr>
</table>

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:	
PA Number:	
Recipient ID:	
From Date:	
To Date:	

Submit Reset

The prior authorization information will be displayed.

PA Inquiry - Prior Authorization Details

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:			

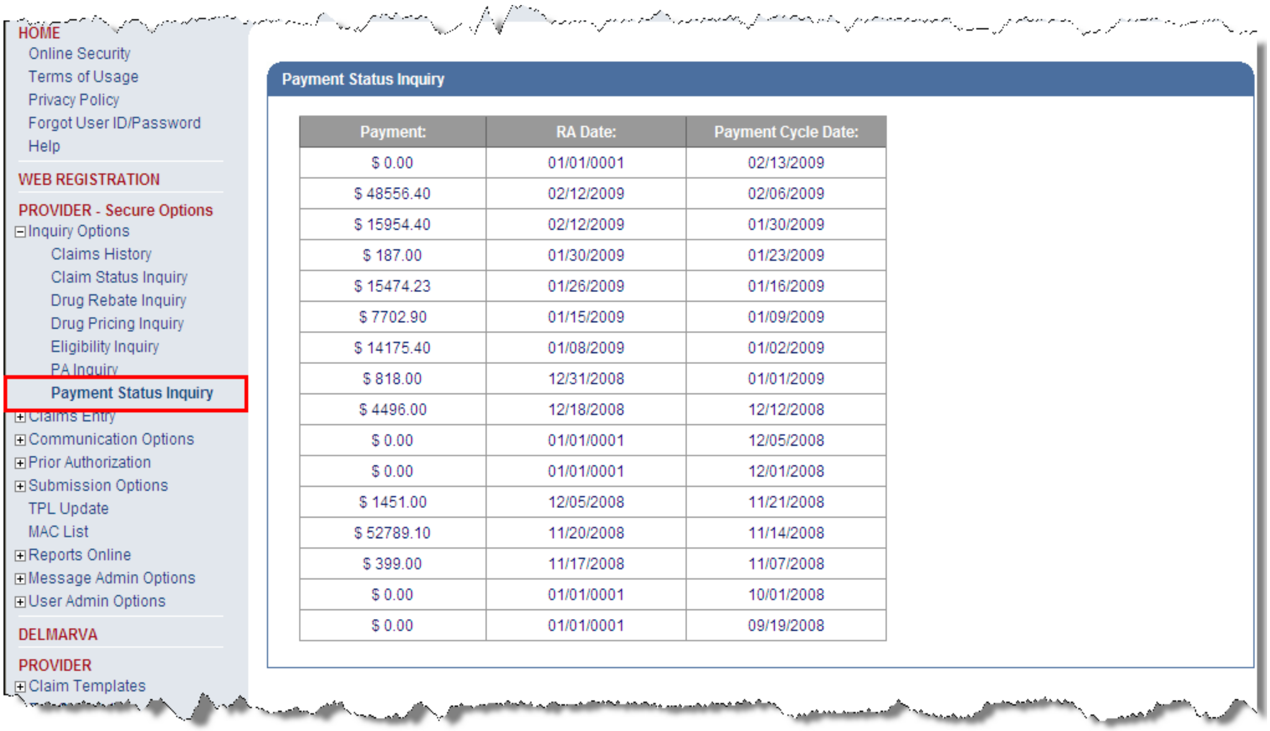
Services Requested

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 U3 52	PROGRAM INTAKE ASSESSMENT	02/01/2017	01/31/2018	12.00	0.00	12.00	0.00	4.00	983.84	Approved

Back 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.

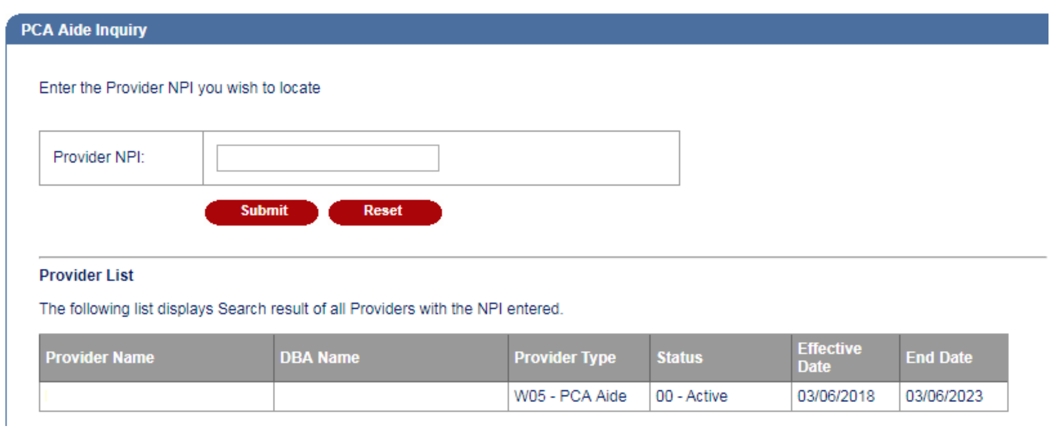

HOME
Online Security
Terms of Usage
Privacy Policy
Forgot User ID/Password
Help
WEB REGISTRATION
PROVIDER - Secure Options
Inquiry Options
Claims History
Claim Status Inquiry
Drug Rebate Inquiry
Drug Pricing Inquiry
Eligibility Inquiry
PA Inquiry
Payment Status Inquiry
Claims Entry
Communication Options
Prior Authorization
Submission Options
TPL Update
MAC List
Reports Online
Message Admin Options
User Admin Options
DELMARVA
PROVIDER
Claim Templates

Payment Status Inquiry

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:

Submit Reset

Provider List

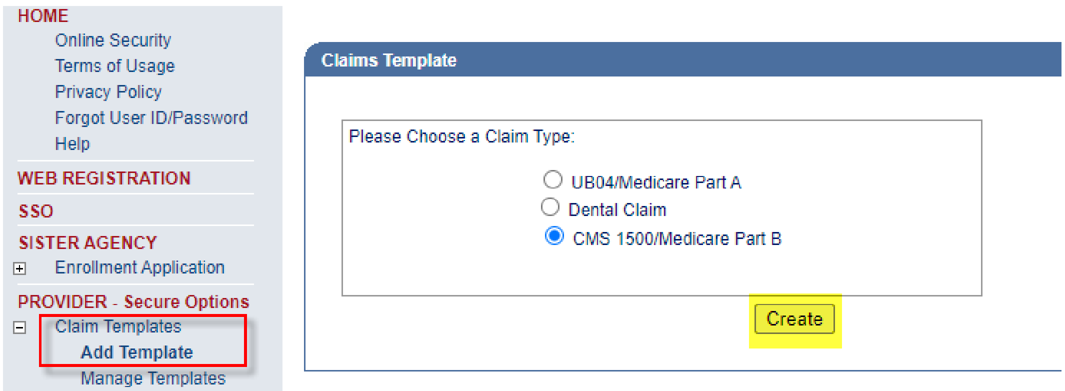
The following list displays Search result of all Providers with the NPI entered.

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

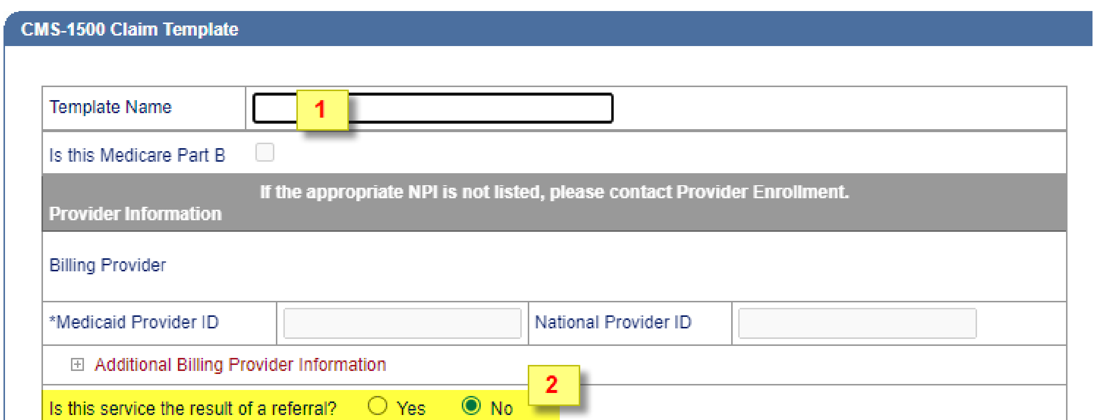
Creating CMS1500 Claim Template

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.

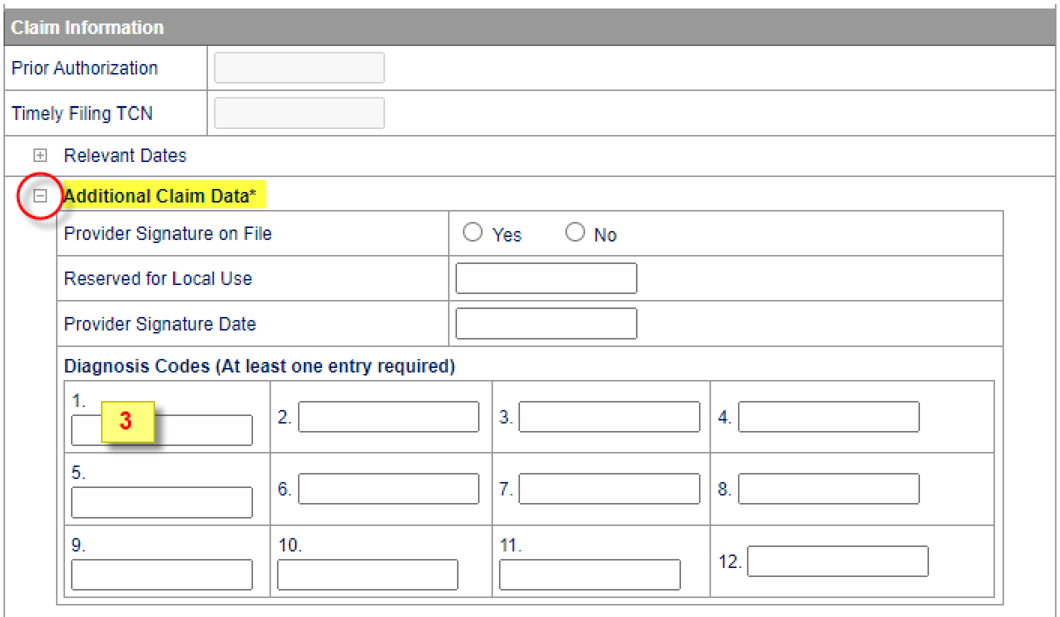


The CMS1500 claim form will be displayed. The following fields can be edited.

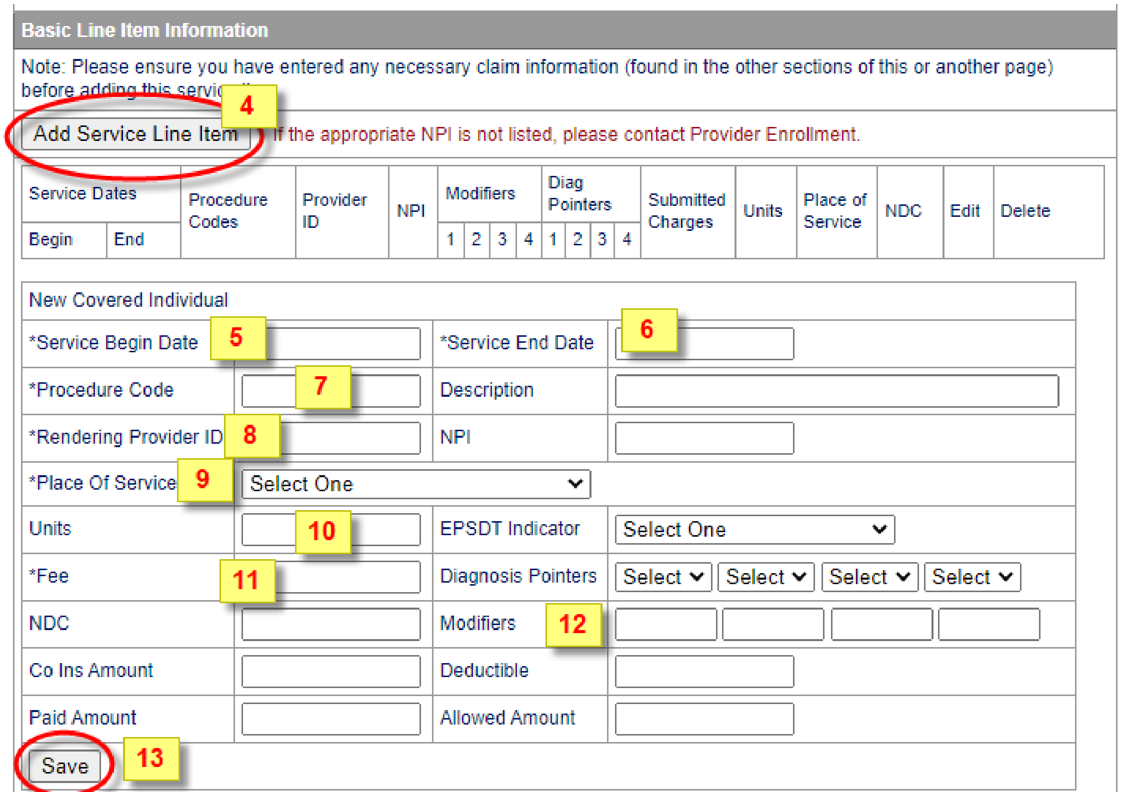


Field #	Field Name	Description
1	**Template Name**	Enter desired template name in the <Template Name> field. This will help you to identify the template from the pick list for claim entry.
2	**Is service the result of a referral?**	Select the appropriate response

Expand the 'Additional Claim Data' section

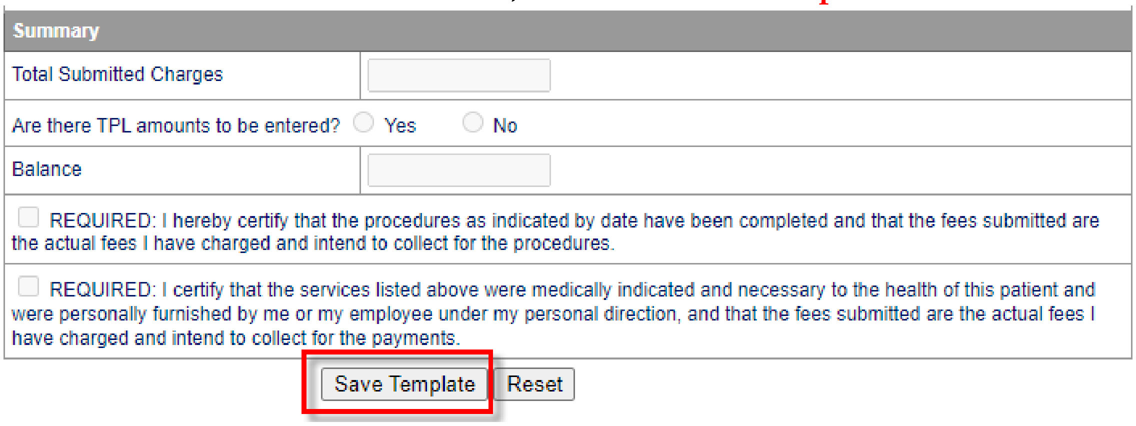


Field #	Field Name	Description
3	**Diagnosis Code**	Enter at least one diagnosis code



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. *[Note: Repeat the above steps if additional lines are needed.]*

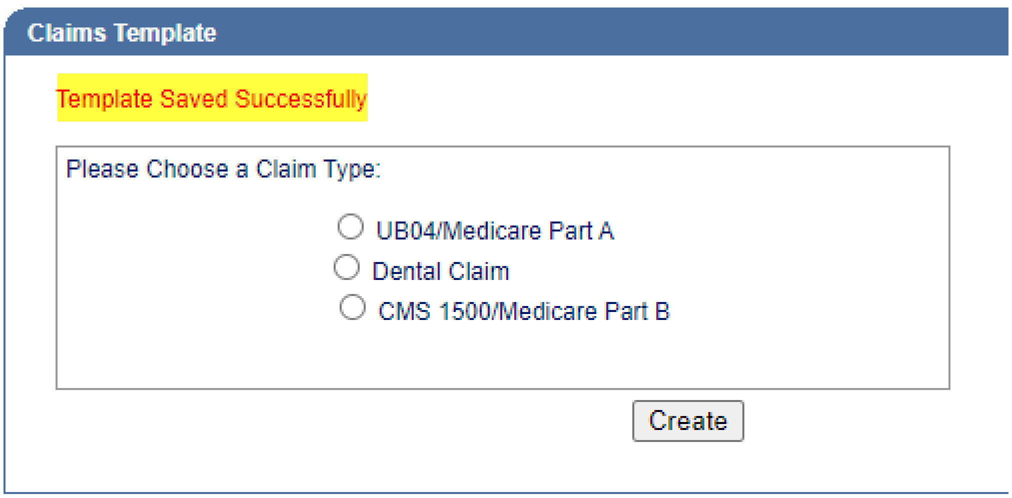
Once all claim lines have been entered, click the <Save Template> button.



Summary	
Total Submitted Charges	
Are there TPL amounts to be entered? ◯ Yes ◯ No	
Balance	
☐ 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.	

Save Template Reset

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



Claims Template

Template Saved Successfully

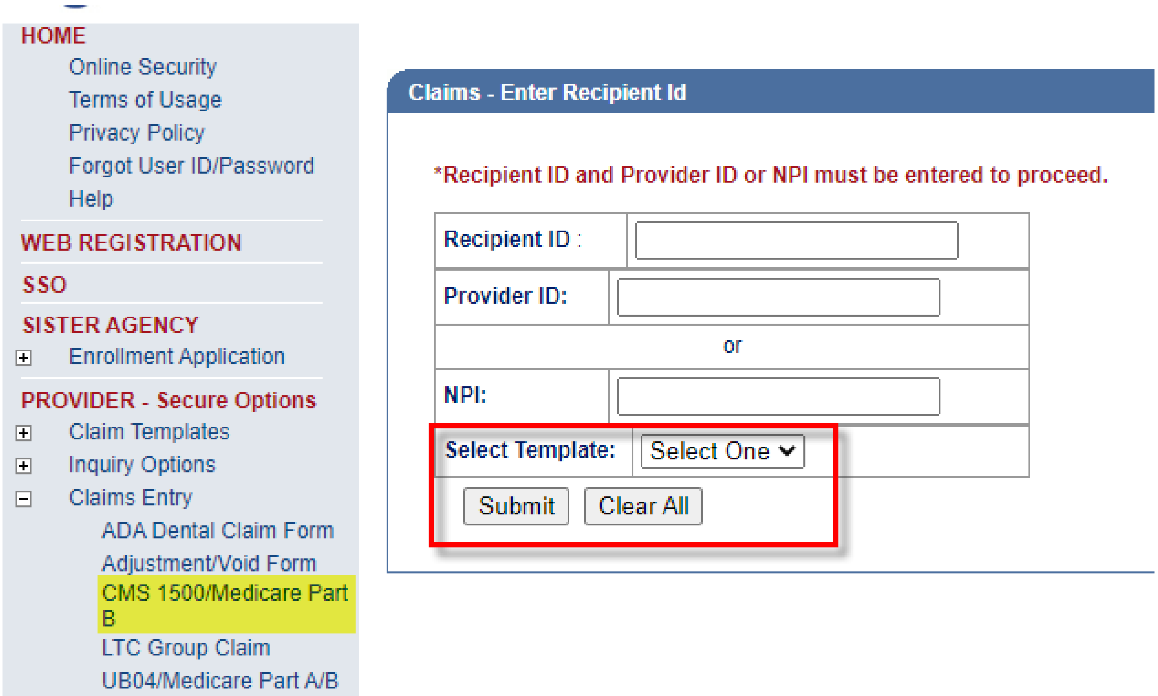
Please Choose a Claim Type:

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

Create

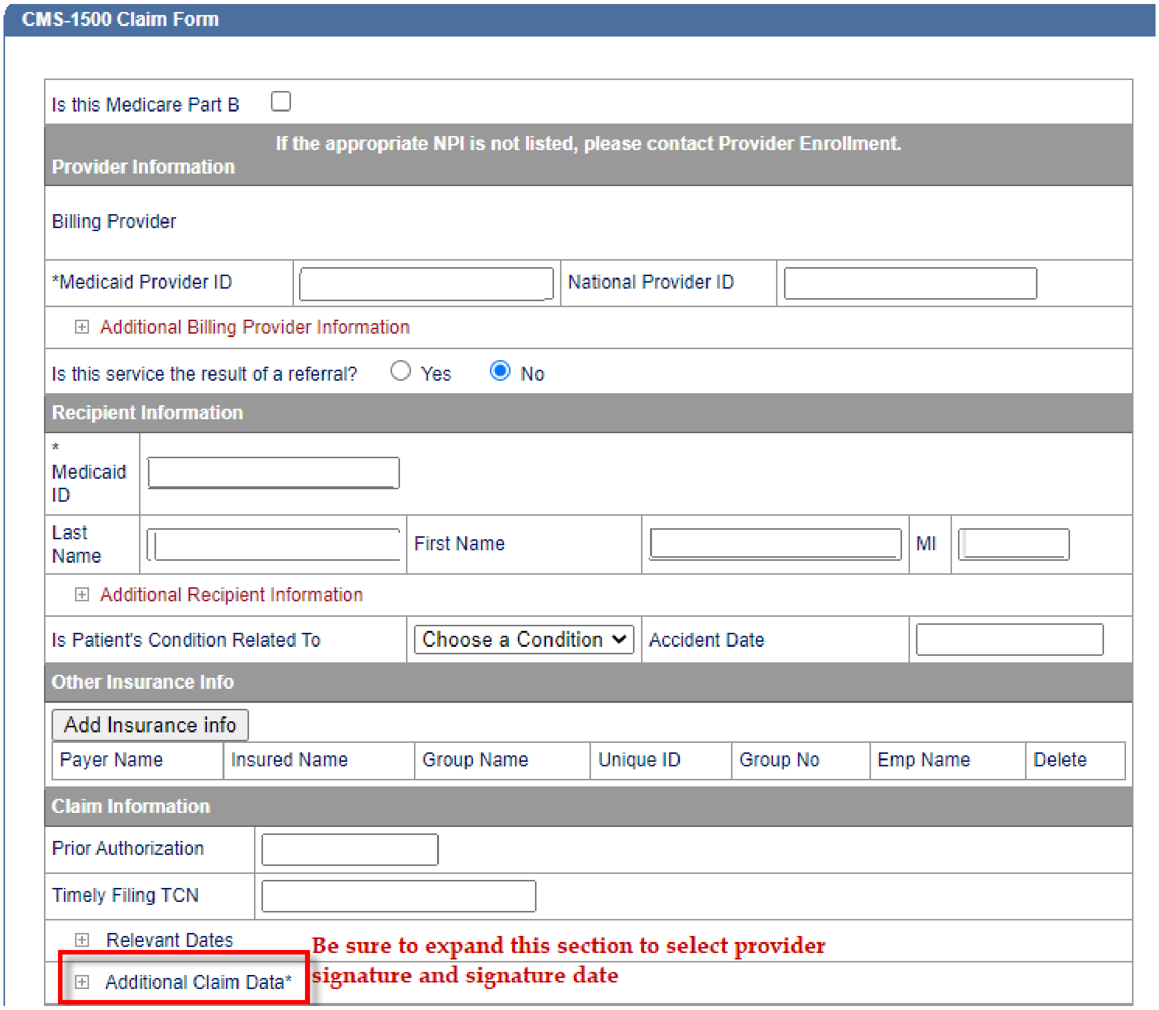
To use the template, you must go to <Claims Entry> and select the CMS1500/Medicare Part B claim form.

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



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

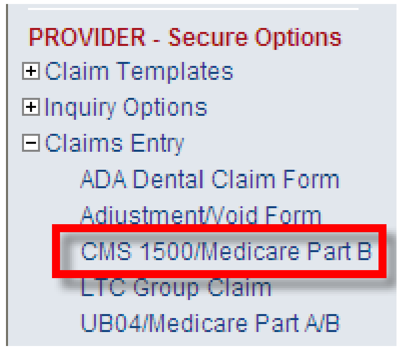
Proceed with completing the claim with the appropriate information, such as prior authorization number, provider signature date, dates of service, etc.



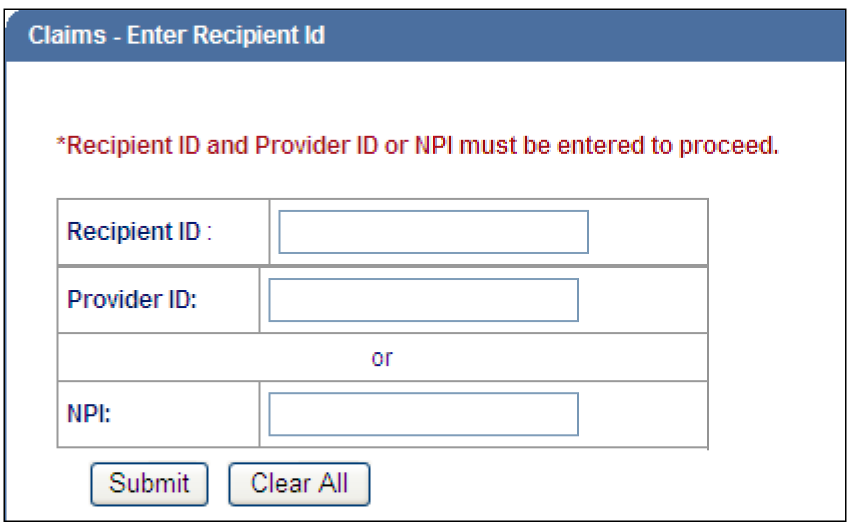
Click <Submit> once the claim has been completed.

Claims Entry – CMS1500

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



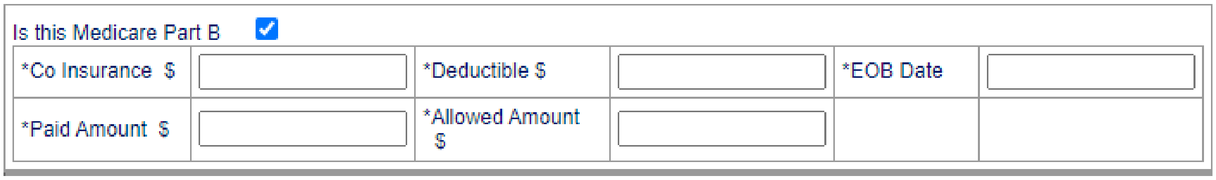
Enter the recipient's Medicaid ID and your NPI in the fields displayed and click <Submit>.



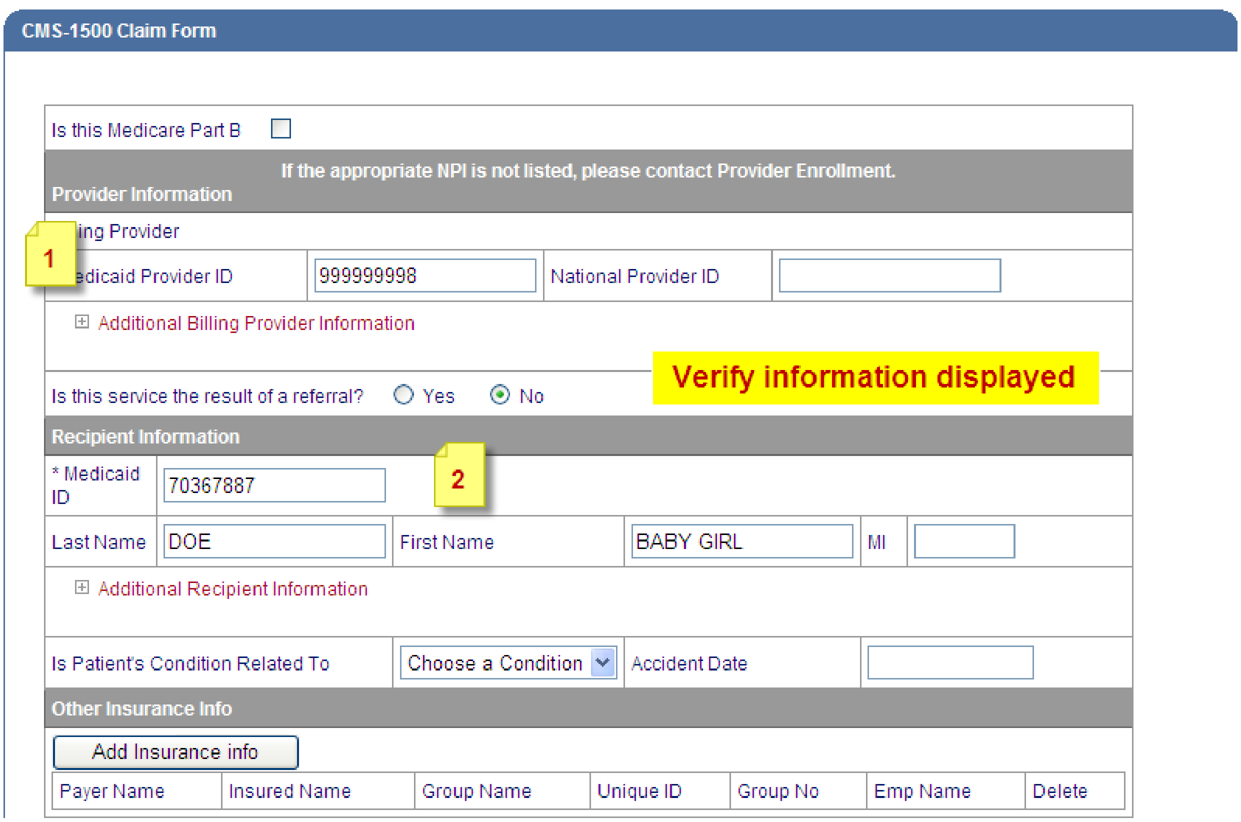
The CMS1500 claim form will be displayed with the provider and recipient information pre-populated.

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

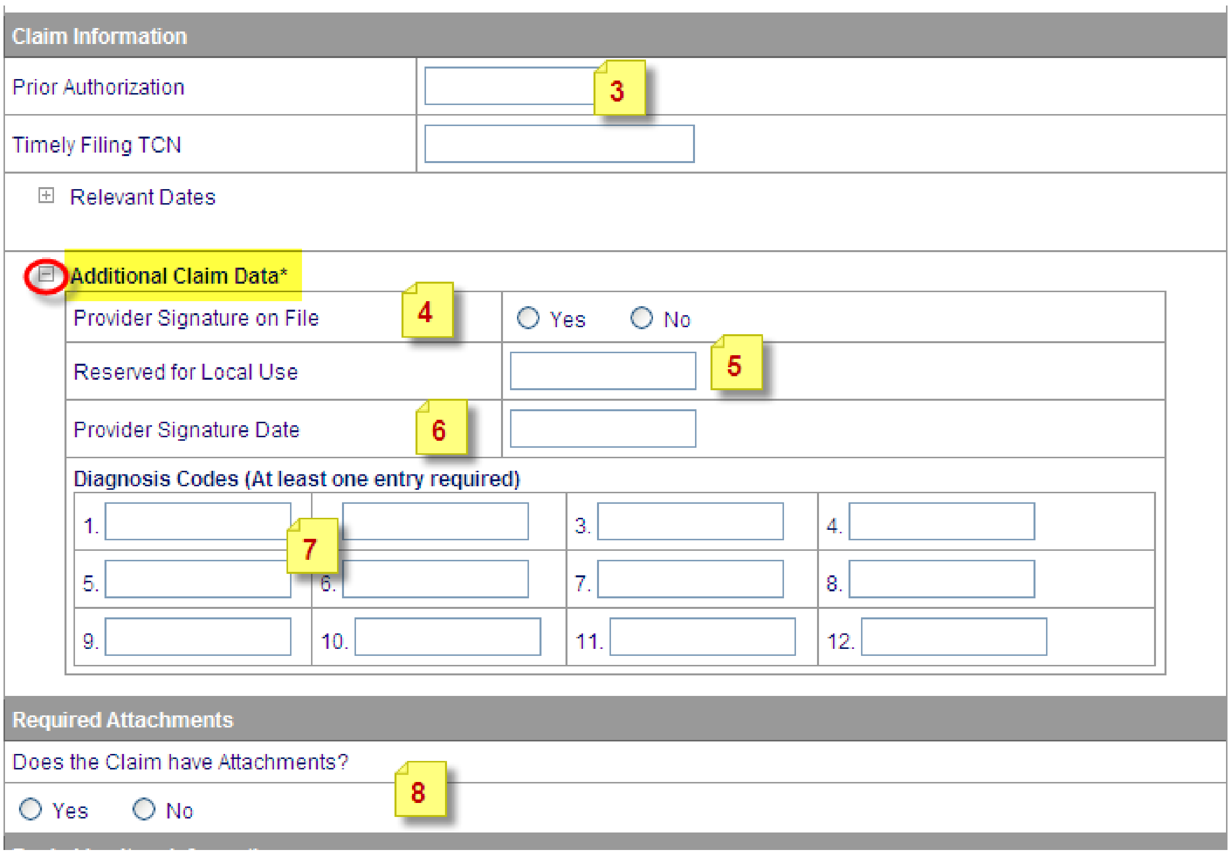
If submitting Medicare Part B claim charges, select "This is a Medicare Part B claim" by placing a check mark in the box and complete the fields displayed below



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

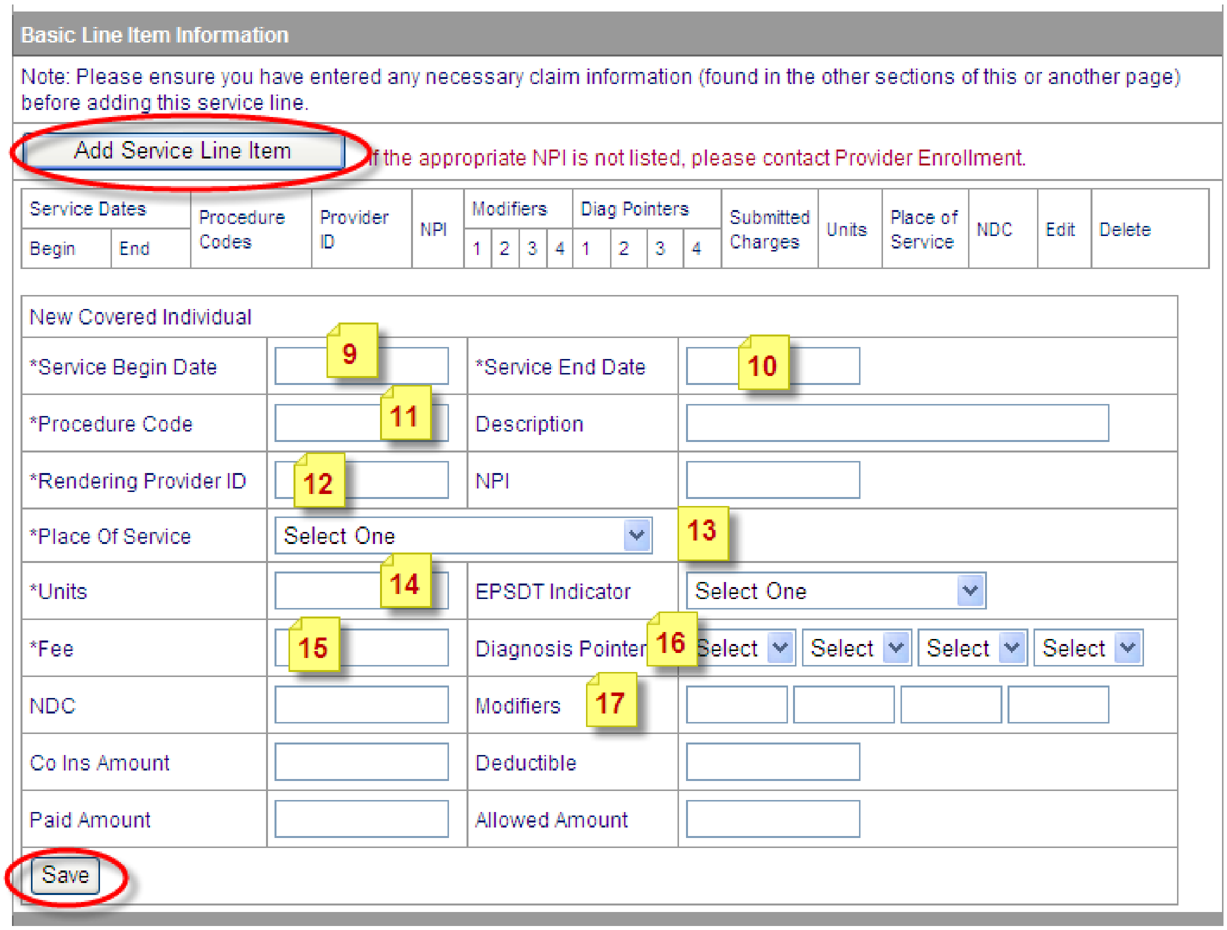


Field #	Field Name	Description
1	**Billing Medicaid Provider ID & National Provider ID**	Pre-populates the billing provider's Medicaid ID and corresponding NPI. *[Note: This information cannot be changed].*
2	**Recipient Information**	Verify the information displayed *[Note: This information cannot be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



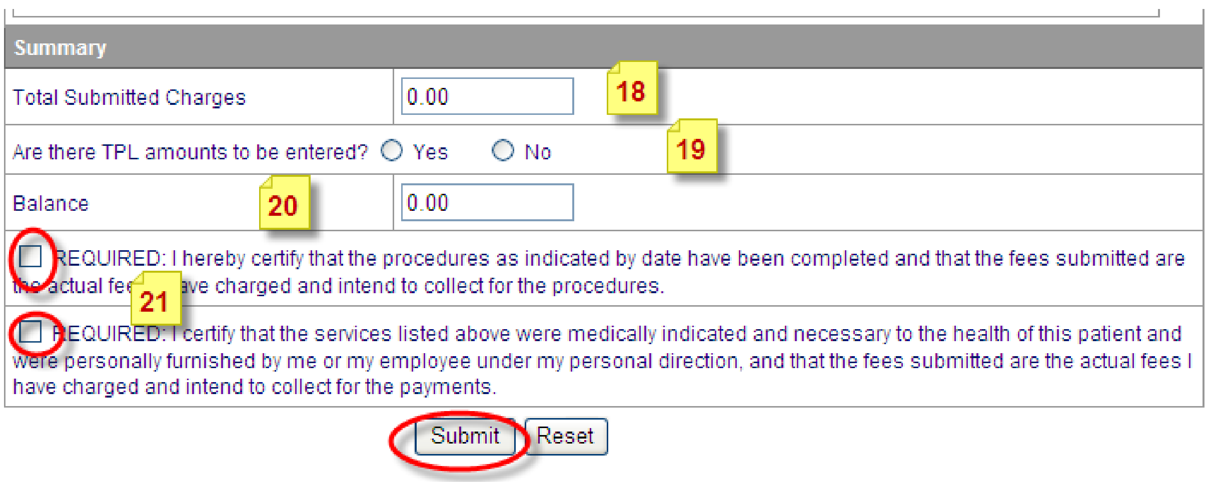
Field #	Field Name	Description
3	**Prior Authorization**	If applicable, enter the prior authorization number located on the PA letter received
4	**Provider Signature on File**	Select "Yes"
5	**Reserve for Local Use**	If submitting a claim for waiver related services, enter "09"
6	**Provider Signature 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"



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**.



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

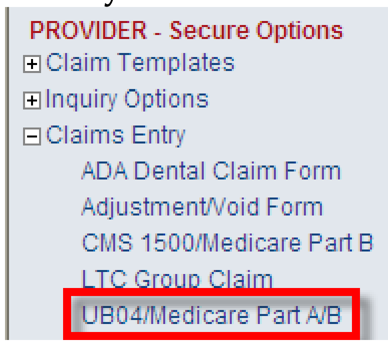
Line Number	Exception Code	Exception Description	Exception Status
0	0120	THE BILLING PROVIDER NUMBER (PAY TO PROVIDER) IS ZEROS.	Suspend
0	0313	CATEGORY OF SERVICE CANNOT BE DETERMINED	Suspend
0	5125	INVALID BILLING PROVIDER CHECK DIGIT NUMBER	Suspend
1	0429	PROVIDER LICENSE EXPIRED	Suspend

The following claim statuses may be displayed:

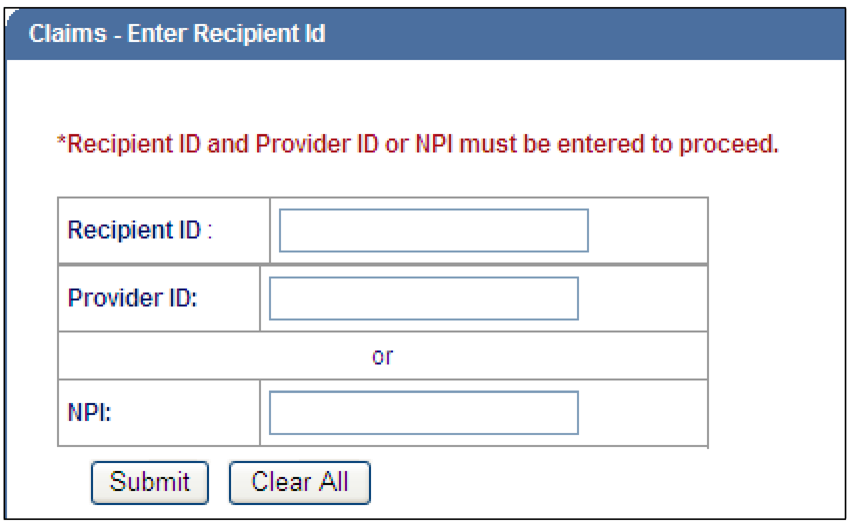
- **To be paid**
- **To be denied** – The exception code (denial reason) and description will be displayed. If you have the correct information, you may submit the corrected claim immediately.
- **To be suspended** – The exception code (pended status) and description will be displayed. **DO NOT RESUBMIT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

Claims Entry – UB04

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



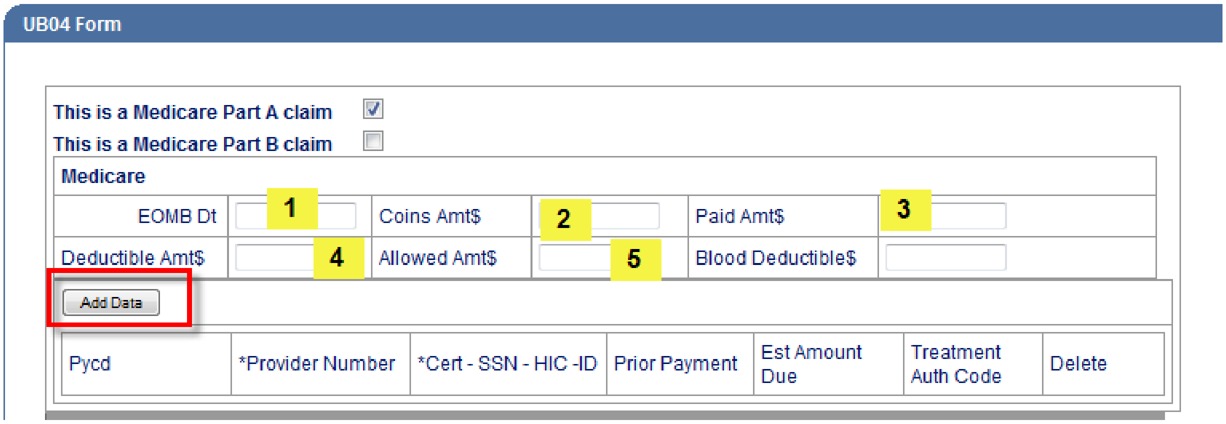
Enter the recipient's Medicaid ID and your NPI in the fields displayed and click <Submit>.



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

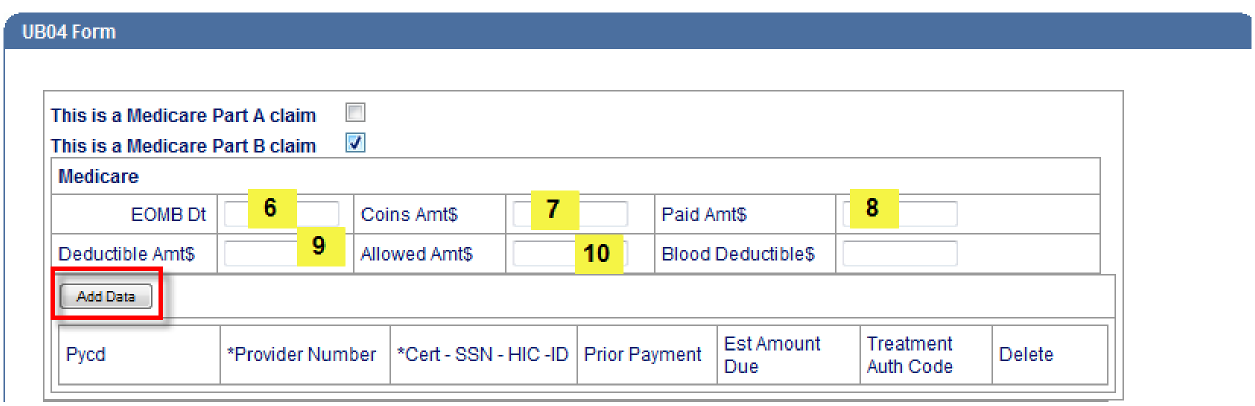
[Note: All fields with an asterisk (*) indicate required fields that must be completed.]

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.



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.

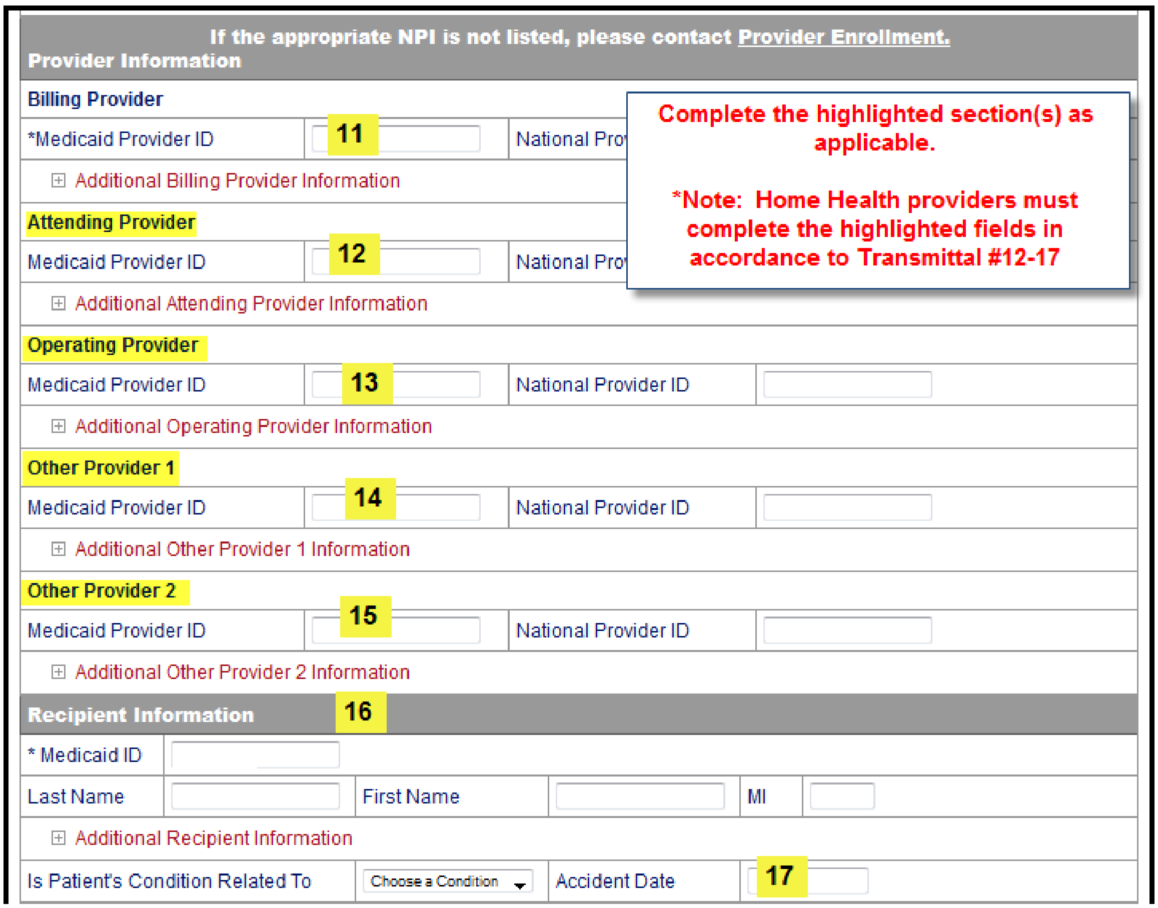
If submitting Medicare Part B claim charges, select "This is a Medicare Part B claim" by placing a check mark in the box and complete the fields displayed below.



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

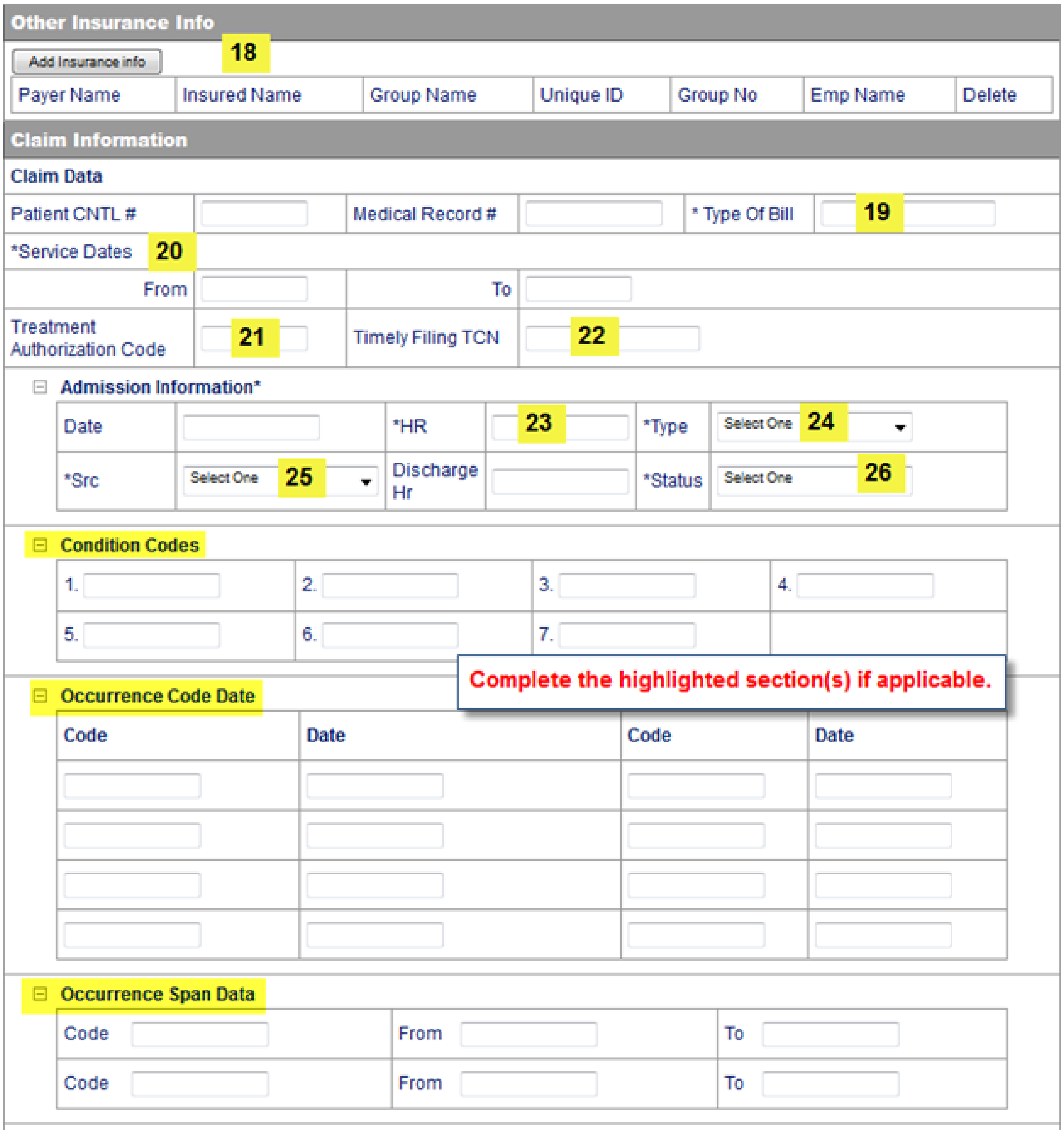
8	**Paid Amt$**	Enter the Medicare payment amount as indicated on the EOMB
9	**Deductible Amt$**	Enter the Medicare deductible amount as indicated on the Medicare EOMB
10	**Allowed Amt$**	Enter the Medicare allowed amount as indicated on the Medicare EOMB
	Add Data	Click to add the line item to the table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

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



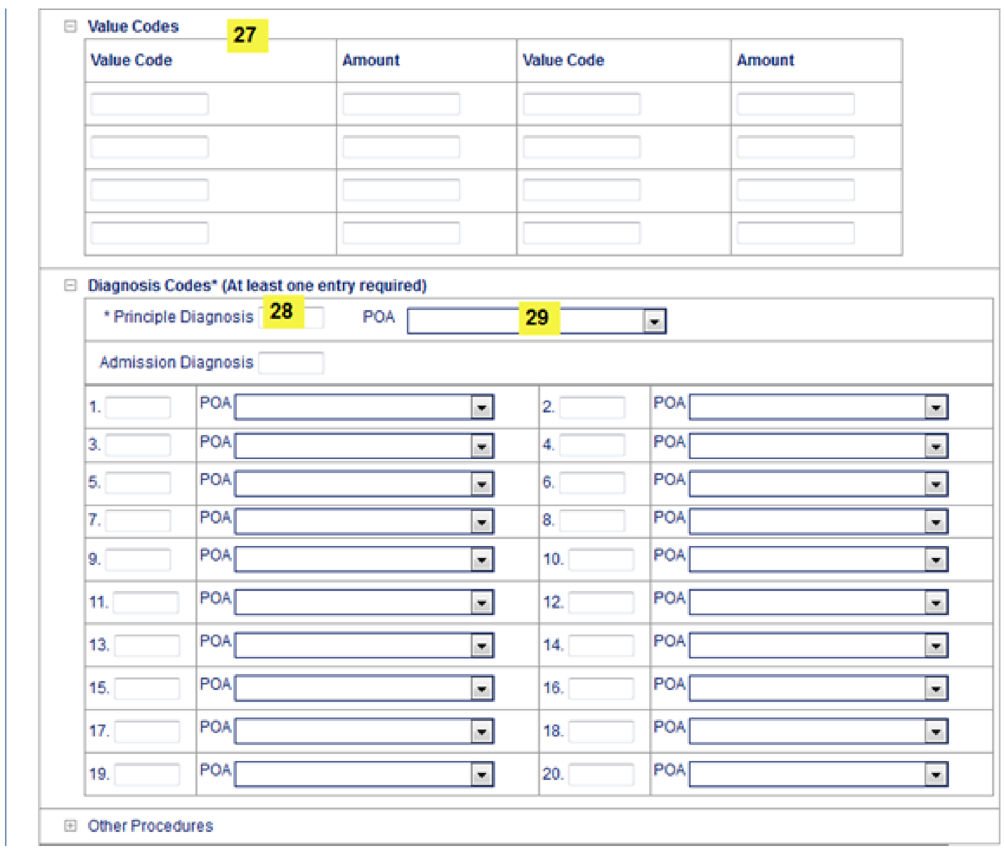
Field #	Field Name	Description
11	**Medicaid Provider ID & National Provider ID**	Pre-populates the billing provider's Medicaid ID and corresponding NPI. *[Note: This information cannot be changed].*
12	**Attending Provider**	If applicable, enter the Medicaid ID or NPI of the attending provider

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 *[Note: This information cannot be changed.]*
17	**Is patient's condition related to**	If applicable, select the appropriate response

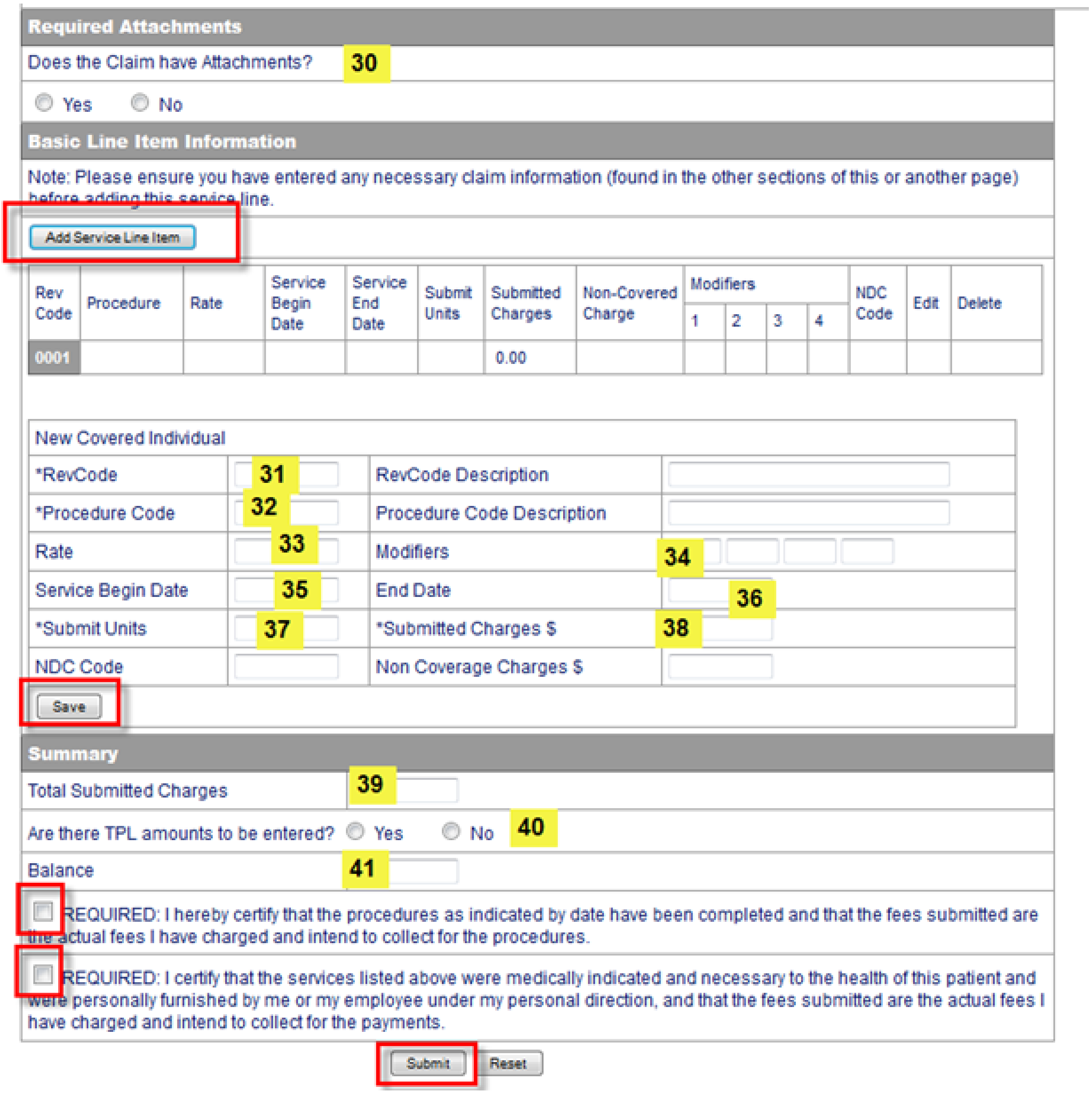


Field #	Field Name	Description
18	**Add Insurance Info**	Click <Add Insurance Info> if the patient has other insurance that should be reported to Economic Security Administration (ESA)
19	**Type of Bill**	Enter the four-digit type of bill code.
20	**Service Dates**	Enter the dates of services being billed
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



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 1	2	3	4	NDC Code	Edit	Delete
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. *[Note: The description will auto-populate once you tab to the next field].*
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:

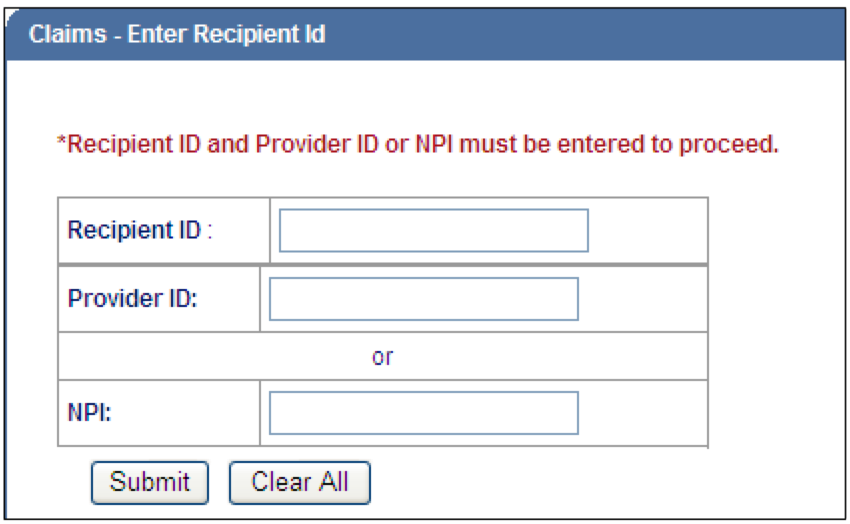
- **To be paid**

- **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 (pended status) and description will be displayed. **DO NOT RESUBMIT SUSPENDED CLAIMS**. Please allow up to 45 days for processing.

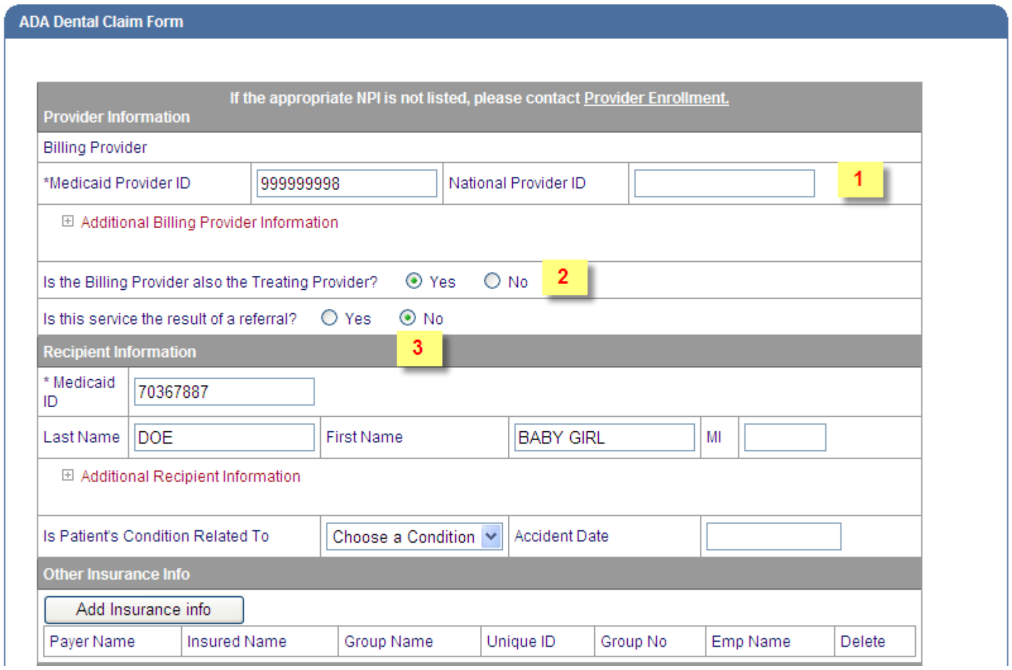
Claims Entry – ADA Dental

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

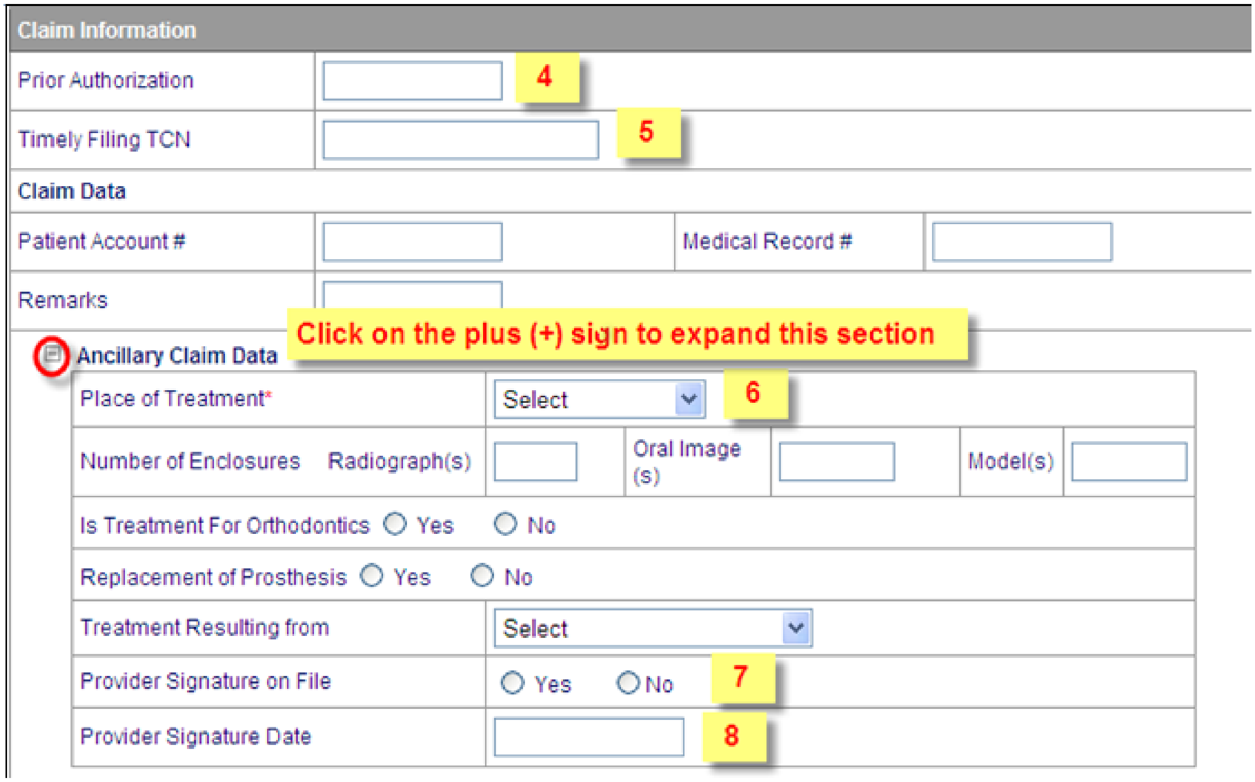
Enter the recipient's Medicaid ID and your NPI in the fields displayed and click <Submit>. *[Note: If you are billing for services rendered to a waiver recipient, enter your waiver provider ID.]*



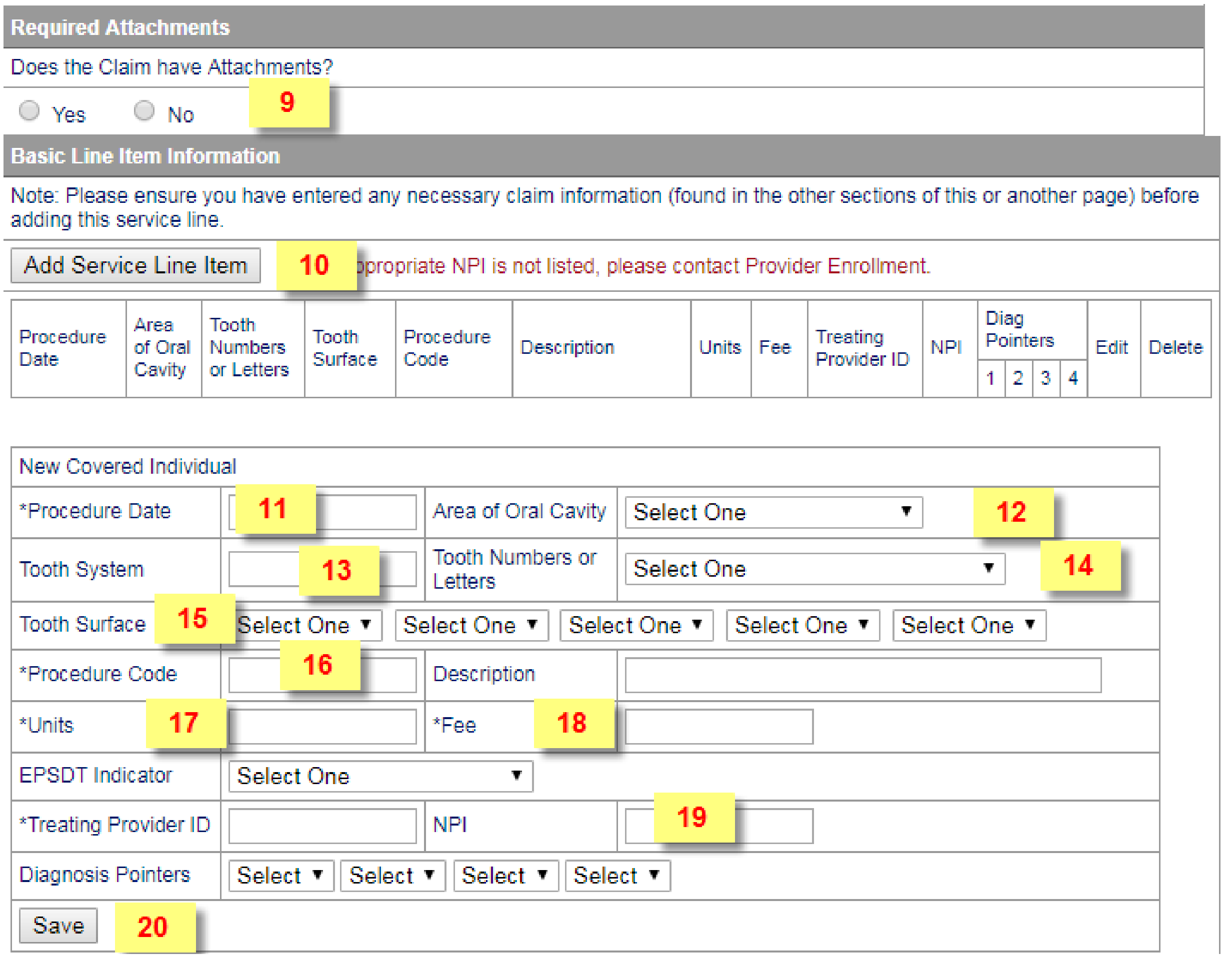
The ADA Dental claim form will be displayed with the provider and recipient information pre-populated.



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.]*

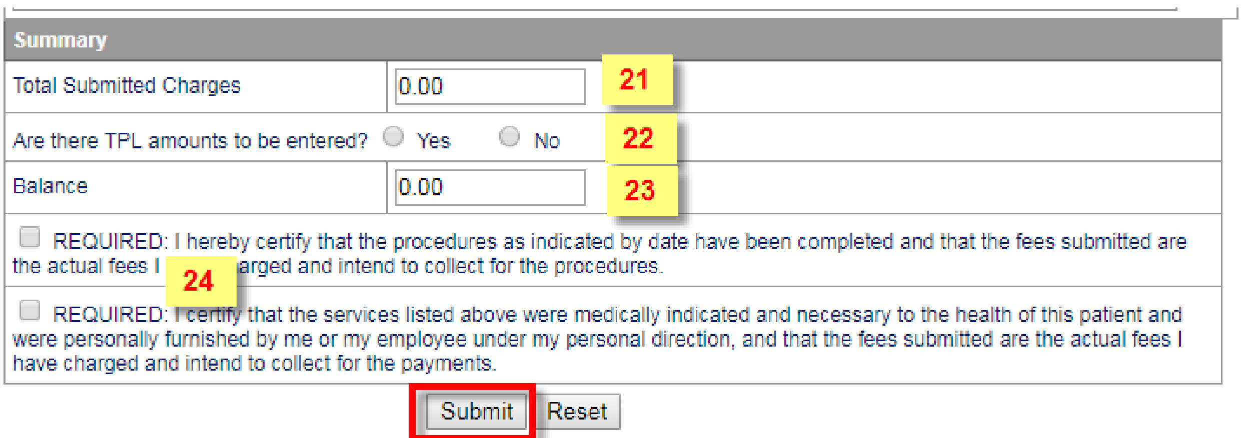


Field #	Field Name	Description
4	**Prior Authorization**	If applicable, enter the prior authorization number located on the PA letter received
5	**Timely Filing TCN**	If applicable, enter the first TCN from the originally paid or denied claim
6	**Place of Treatment**	Select the appropriate response indicating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



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



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

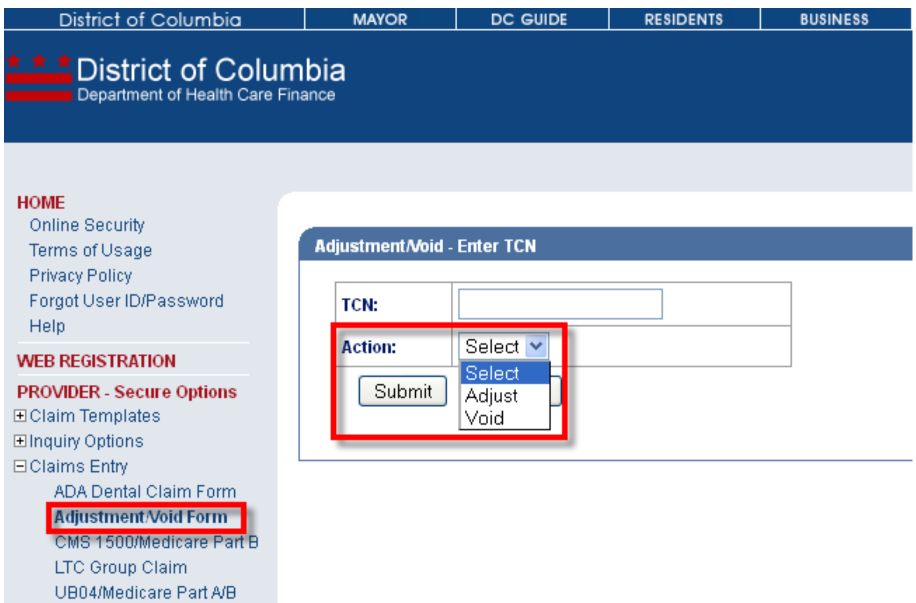
The following claim statuses may be displayed:

- **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 (pended status) and description will be displayed. **DO NOT RESUBMIT SUSPENDED CLAIMS**. Please allow up to 45 days for processing.

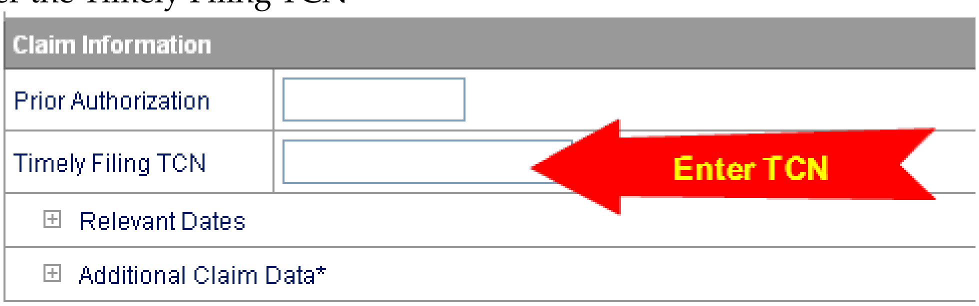
Submitting Adjustments/Voids

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

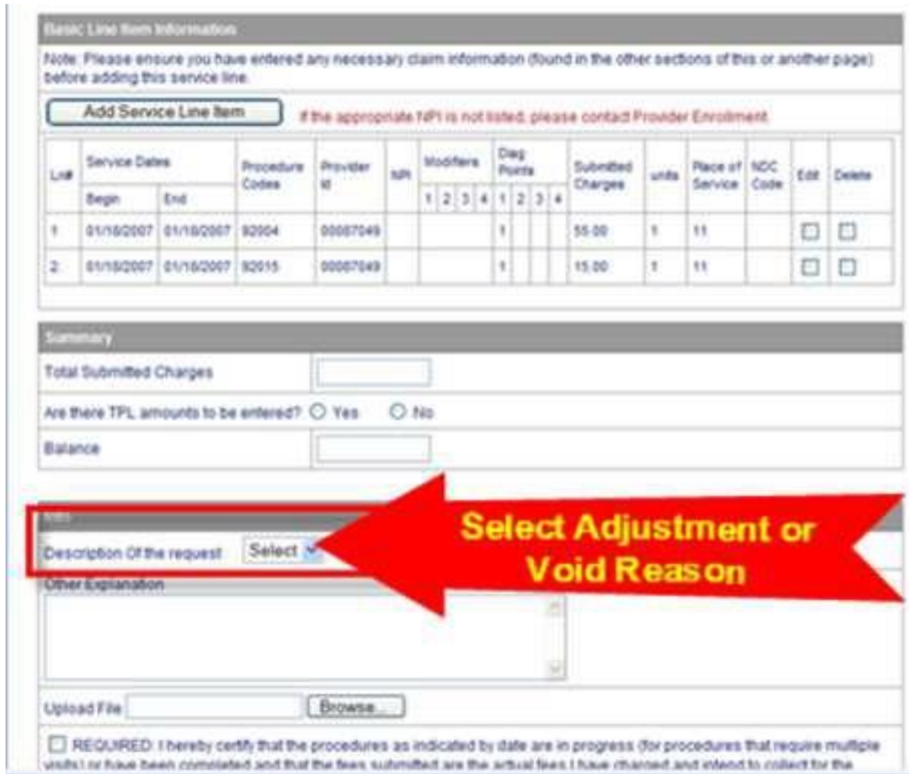
1. After successfully logging in, select Adjustment/Void form from the navigational pane
2. Enter the TCN of the claim being adjusted or voided.
3. Select desired action - Adjust or Void and click <Submit>



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



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



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

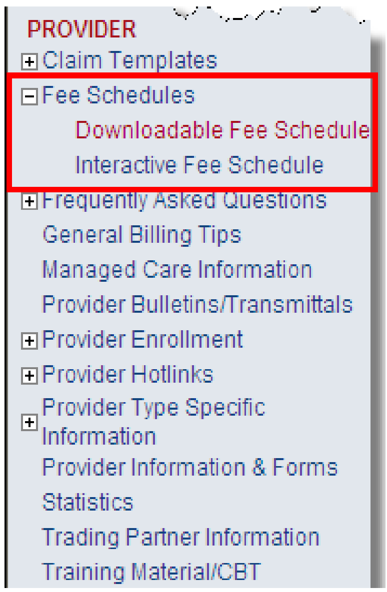
Helpful Tips:

- 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:	T1019
Date of Service:	10/17/2009

Interactive Fee Schedule | Reset

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

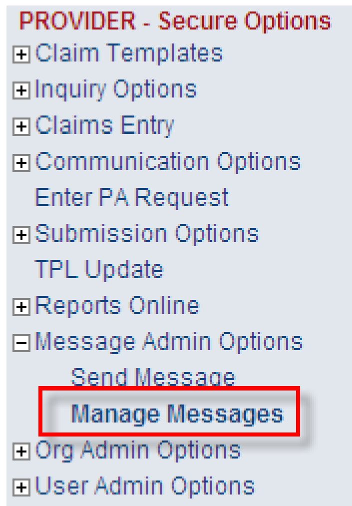
Factor Code Description	
Z1	General Fee Schedule

New Inquiry | Print

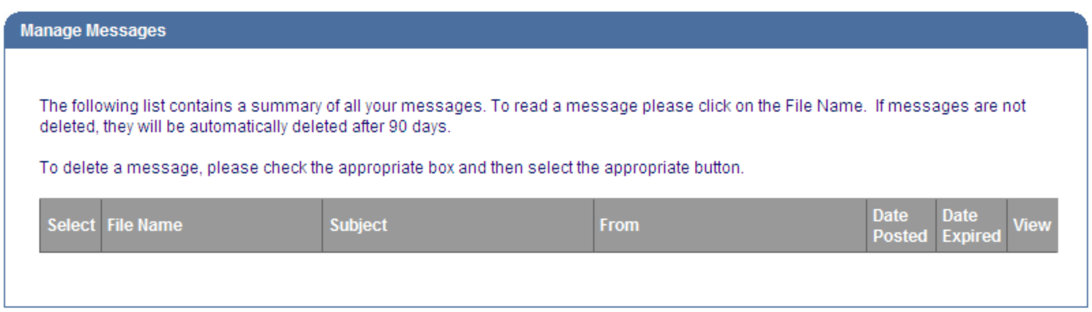
Retrieving Remittance Advices

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.



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?

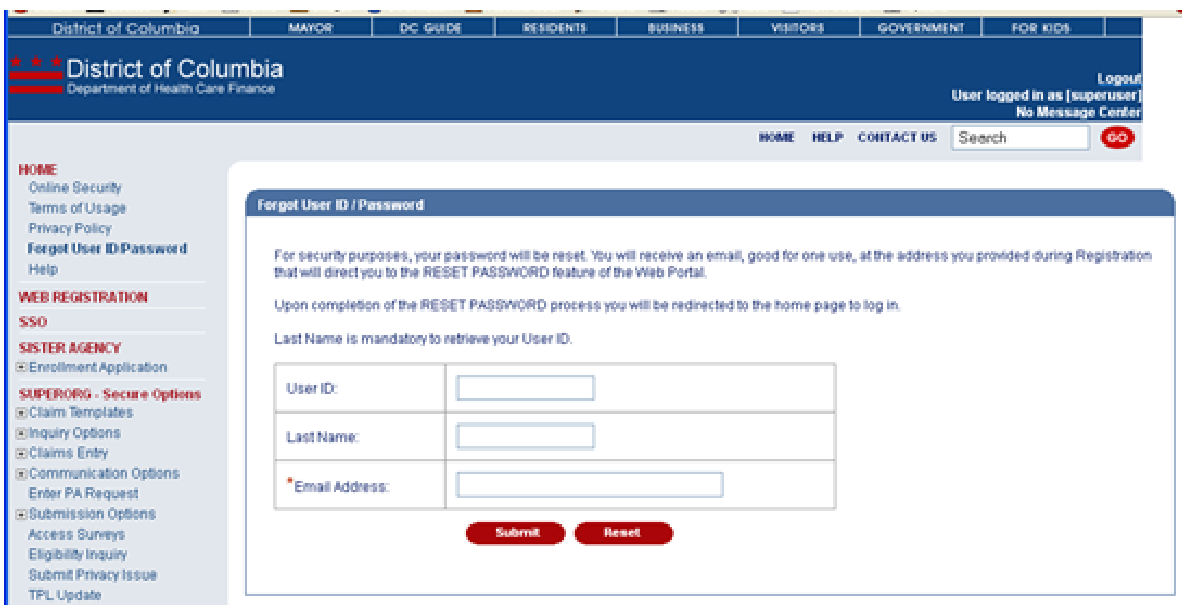
Contact Provider Inquiry at (202) 906-8319 (inside DC metro area) or (866) 752-9233 (outside DC metro area) for assistance or you may send an email to providerinquiry@conduent.com. Locked and/or inactive Web Portal user accounts can only be unlocked or reactivated by the Conduent Web Portal Administrator.

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

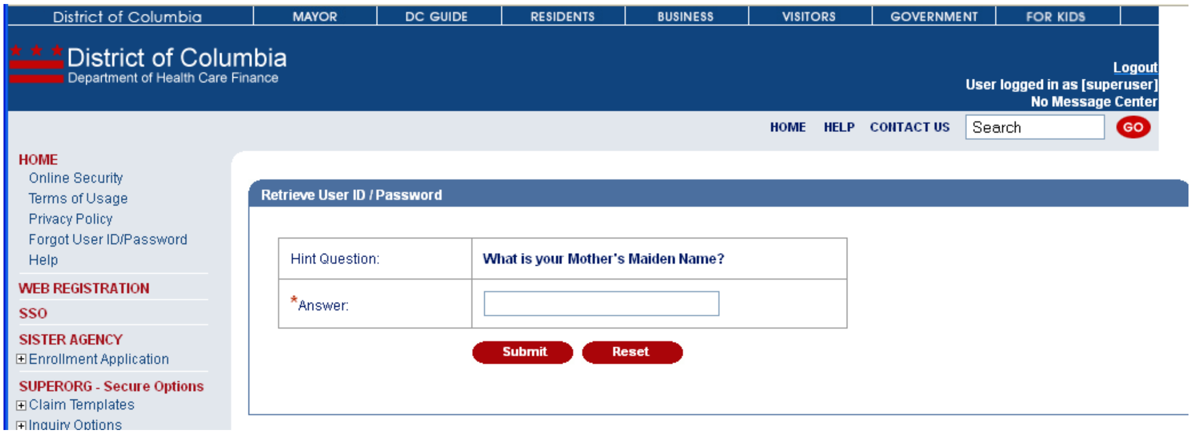
The Web Portal provides a facility for users to perform a search for their User ID and/or generate a password reset request. Open a browser and access the DC-Medicaid Web Portal at https://www.dc-medicaid.com.

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

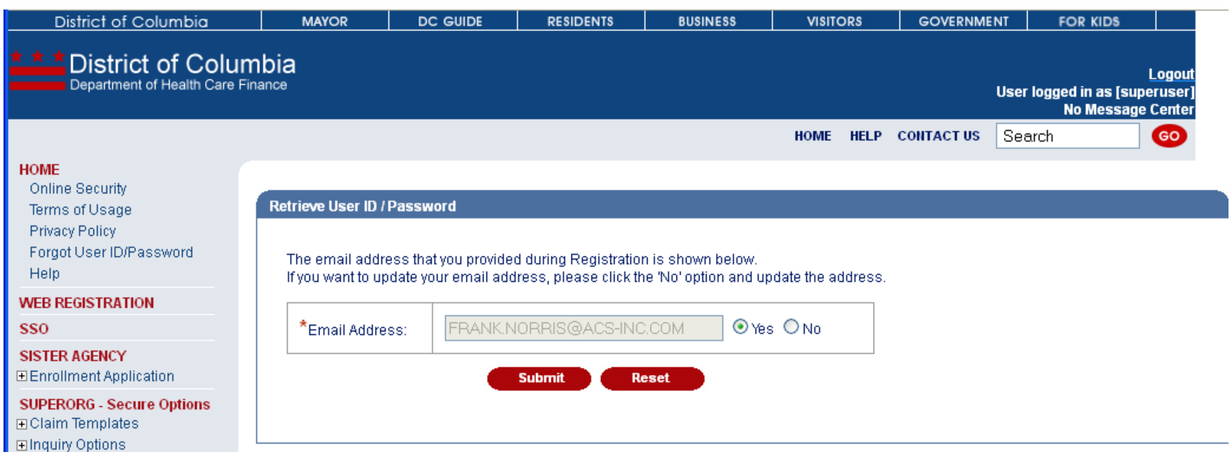
To locate a forgotten User ID and/or generate a Password Reset request, enter your User ID and Email Address or your Last Name and Email Address. Click ‘Submit’.



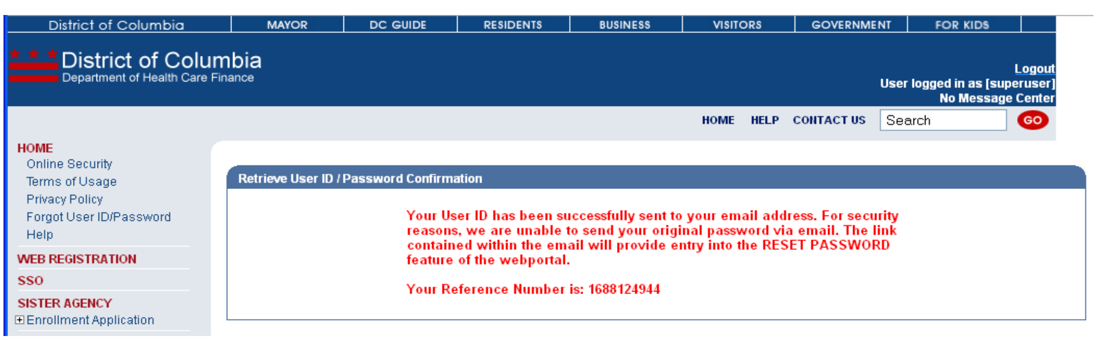
Enter the answer to your ‘Hint Question’ and click ‘Submit’.



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'.



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



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.

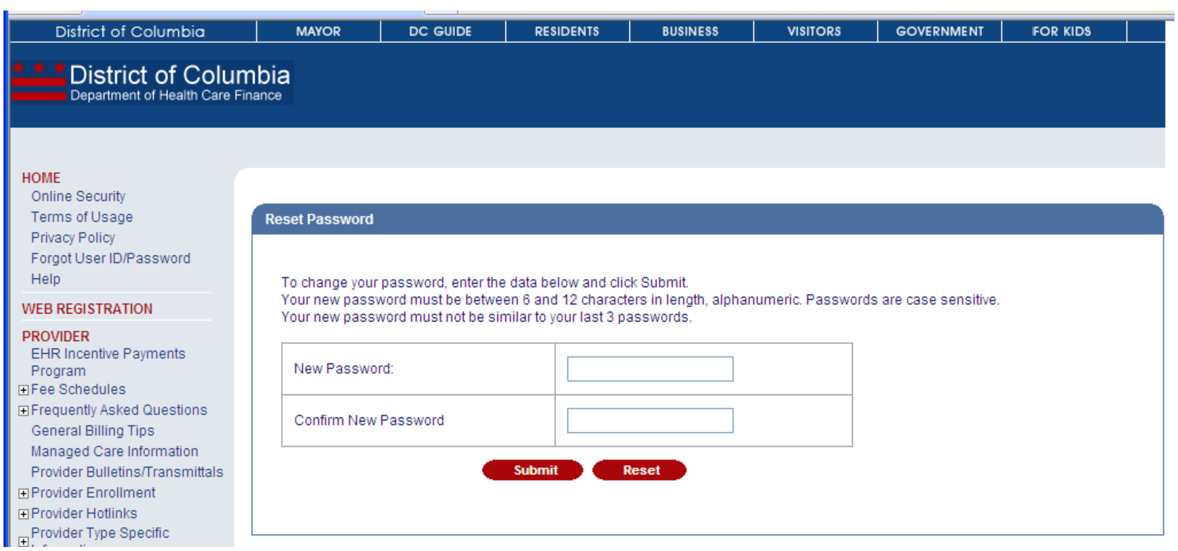
The text of the email will resemble the following:

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: XXXXXXX 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?

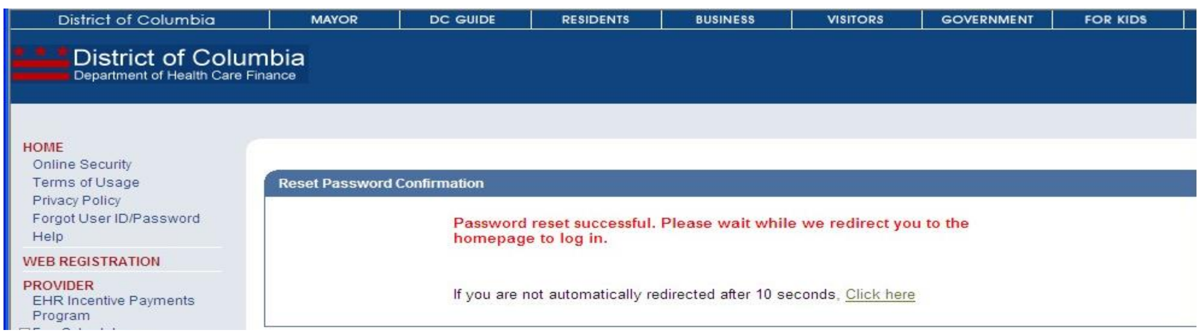
Click on the 'Click here' link contained within the email, and you will be directed to the Web Portal to enter a new password and a new hint question/answer.

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



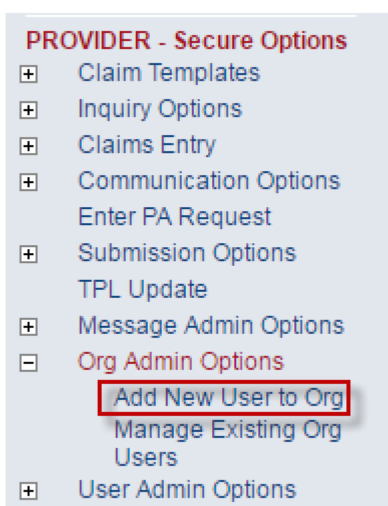
Select a new Hint Question from the dropdown and enter an answer that you can remember later without writing it down.

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

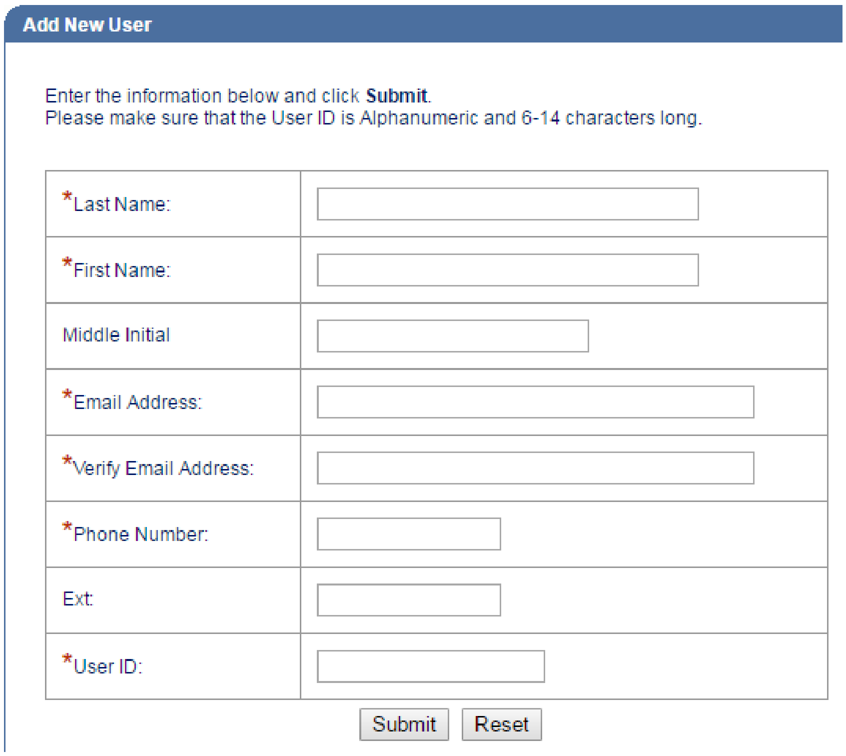


How do I add users to my web account?

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'.



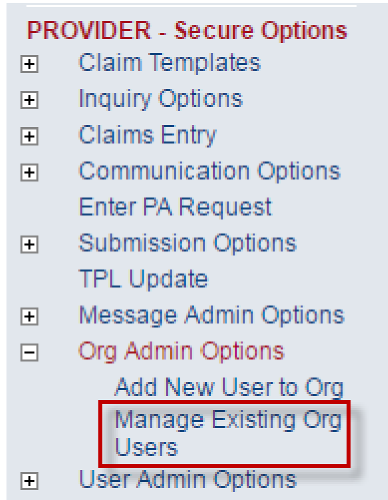
Complete the fields marked with an asterisk and click <Submit>. [**Note: All users must have a unique user ID.]**



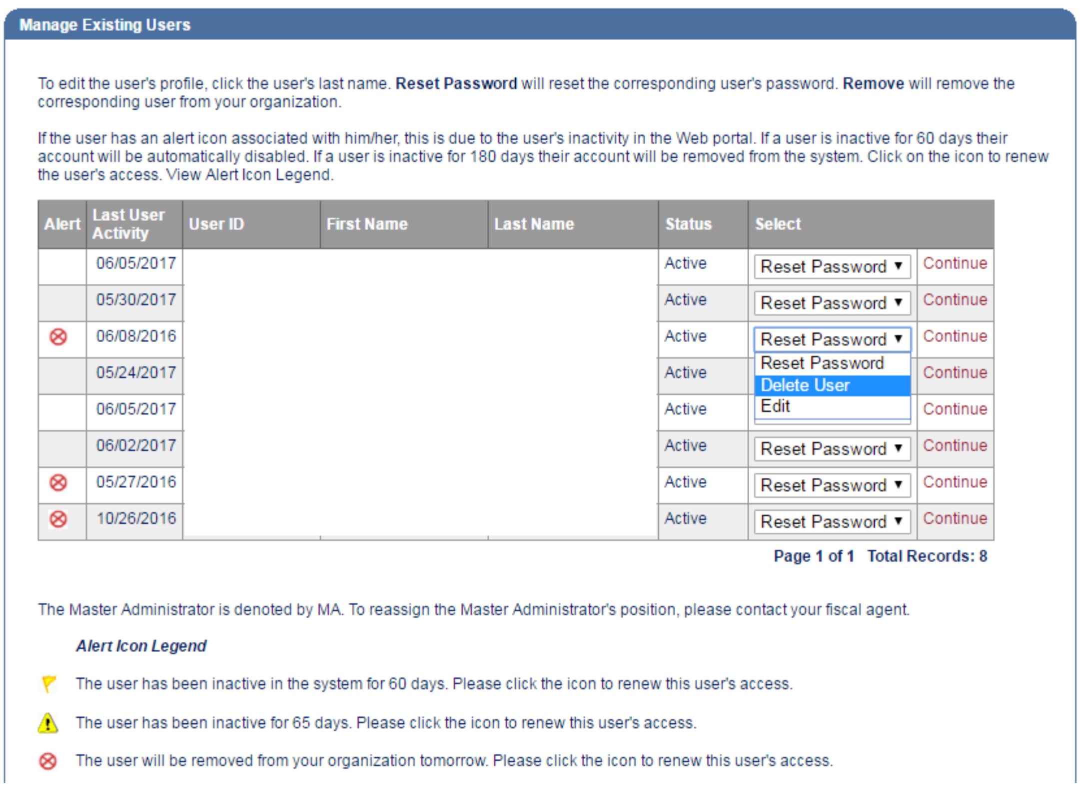
The user(s) will receive an email containing the user ID and temporary password. **[Note: The temporary password is valid for 24 hours.]**

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

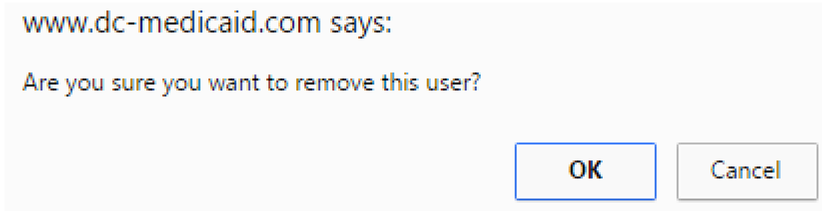
Only the master administrator for the web account can delete users from an existing web account. To delete a user, select Org Admin Options > Manage Existing Org Users.



All users will be displayed.



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.