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## **Web Portal Quick Reference Guide**

**[www.dc-medicaid.com](http://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](http://www.dc-medicaid.com)

District of Columbia	MAYOR	DC GUIDE	RESIDENTS	BUSINESS	VISITORS	GOVERNMENT	FOR KIDS
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**District of Columbia**  
Department of Health Care Finance

User ID:  Password:

Forgot UserID / Password

HOME HELP CONTACT US

**HOME**  
Online Security  
Terms of Usage  
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Help

**WEB REGISTRATION**

**PROVIDER**  
EHR Incentive Payments Program  
Fee Schedules  
Frequently Asked Questions  
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**DC Medicaid/Alliance and Me**  
  
**What is Medicaid?**  
**What is Alliance?**  
**Who is Eligible?**  
[Answers and More>>](#)

**Latest News**  

- ▶ 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

[All Late Breaking News>>](#)

**What's Hot?**  
  
[Find Out More>>](#) <<10 of 15>>

**Provider**  
Frequently Asked Questions  
General Billing Tips  
Provider Bulletins/Transmittals  
Provider Hotlinks  


**Recipient**  
Recipient Information  
Forms  
Frequently Asked Questions  
Recipient Hotlinks  


**RECIPIENT**

## 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

Please enter your Medicaid Provider ID or NPI information.

Provider ID  OR NPI  Taxonomy

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

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

What is your Email Address?  Verify your Email Address  Hint Question  Hint Answer

**[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](mailto: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:

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
		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>

- 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 :	<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"/>

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
<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

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

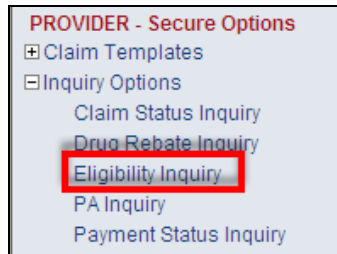
[New Inquiry](#)

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

**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:

Recipient ID:

Recipient Address:

Ward/Quadrant:

Gender:

Date Of Birth:

Field Name	Description
<b>Recipient Eligibility Information Requested/Verified on:</b>	Indicates the date of verification of eligibility was performed on
<b>Name</b>	Indicates name of recipient
<b>Recipient ID</b>	Indicates the Medicaid ID of the recipient
<b>Recipient Address</b>	Indicates the address of the recipient
<b>Ward/Quadrant</b>	Indicates the corresponding ward and/or quadrant associated with the above address
<b>Gender</b>	Indicates the gender of the recipient
<b>Date of Birth</b>	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
<b>Plan Coverage Information</b>	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.
<b>Plan Coverage</b>	Indicates the description of the corresponding program code that the recipient has been assigned by the Economic Security Administration (ESA).

Field Name	Description														
<b>Program Code</b>	Indicates the recipient's category of eligibility. A recipient's benefits/services may be limited or restricted by this code.														
<b>Eligibility or Benefit Information</b>	Indicates the Medicaid eligibility status of the recipient														
<b>Begin Date</b>	Indicates the begin date of the recipient's Medicaid eligibility														
<b>End Date</b>	<p>Indicates the end date of the recipient's Medicaid eligibility</p> <p><b>Note:</b></p> <ul style="list-style-type: none"> <li>➤ The date of 12/31/9999 means that the recipient's eligibility span is open-ended and may change at any time.</li> </ul>														
<b>QMB Indicator</b>	Indicates if services are limited to payment of the recipient's Medicare Part A premium.														
<b>Service Types</b> <i>[Click on the plus "+" sign beside service types to expand this section.]</i>	<p>Based upon the recipient's program code, the services that the recipient is eligible to receive will be listed.</p> <table> <tr> <td><b>Service Type/Description</b></td><td>indicates the description of available services</td></tr> <tr> <td><b>Coverage</b></td><td>indicates the coverage type (child or adult)</td></tr> <tr> <td><b>Begin/End Date</b></td><td>effective dates of service type</td></tr> <tr> <td><b>Copay Amount</b></td><td>indicates the specified amount of out-of-pocket expenses the recipient would pay for healthcare services</td></tr> <tr> <td><b>Coinsurance Amount</b></td><td>indicates the coinsurance amount</td></tr> <tr> <td><b>Deductible Amount</b></td><td>indicates the amount the recipient would pay for health care services before Medicaid begins to pay.</td></tr> <tr> <td><b>Coverage Code/Description</b></td><td>indicates the status of the service type (active, inactive, etc..)</td></tr> </table>	<b>Service Type/Description</b>	indicates the description of available services	<b>Coverage</b>	indicates the coverage type (child or adult)	<b>Begin/End Date</b>	effective dates of service type	<b>Copay Amount</b>	indicates the specified amount of out-of-pocket expenses the recipient would pay for healthcare services	<b>Coinsurance Amount</b>	indicates the coinsurance amount	<b>Deductible Amount</b>	indicates the amount the recipient would pay for health care services before Medicaid begins to pay.	<b>Coverage Code/Description</b>	indicates the status of the service type (active, inactive, etc..)
<b>Service Type/Description</b>	indicates the description of available services														
<b>Coverage</b>	indicates the coverage type (child or adult)														
<b>Begin/End Date</b>	effective dates of service type														
<b>Copay Amount</b>	indicates the specified amount of out-of-pocket expenses the recipient would pay for healthcare services														
<b>Coinsurance Amount</b>	indicates the coinsurance amount														
<b>Deductible Amount</b>	indicates the amount the recipient would pay for health care services before Medicaid begins to pay.														
<b>Coverage Code/Description</b>	indicates the status of the service type (active, inactive, etc..)														

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

Field Name	Description
<b>Service Management</b>	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.
<b>Service Management Type</b>	Indicates the type of managed care organization the recipient is assigned to: <ul style="list-style-type: none"> <li>➤ MCO = Managed Care Organization</li> <li>➤ TRB = Transportation Broker</li> <li>➤ EPS = EPSDT</li> </ul>
<b>Begin Date</b>	Indicates the begin date of the recipient's MCO span
<b>End Date</b>	Indicates the end date of the recipient's MCO span
<b>Provider</b>	Indicates the name of the managed care organization

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

Field Name	Description
<b>Medicare Information</b>	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.
<b>Part A/B Indicator</b>	If the recipient has Medicare, Part A and/or Part B will be indicated
<b>HIC Number</b>	Indicates the recipient's Medicare ID
<b>Begin Date</b>	Indicates the begin date of the recipient's Medicare eligibility
<b>End Date</b>	Indicates the end date of the recipient's Medicare eligibility

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

Field Name	Description
<b>Long Term Care Information</b>	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.
<b>Begin Date</b>	Indicates the begin date if the recipient's long-term care lock-in span
<b>End Date</b>	Indicates the end date of the recipient's long-term care lock-in span
<b>Provider Name</b>	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:	
<div> <div></div> <div>Coverage Information</div> </div>	
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
<b>Third Party Liability Information</b>	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.
<b>Insurance Company</b>	Indicates the name of the primary payer (insurance company)

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

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

**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

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## 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

Inquiry Options

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Payment Status Inquiry

Claims Entry

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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

Claim Information	
Prior Authorization	<input type="text"/>
Timely Filing TCN	<input type="text"/>
<input type="checkbox"/> Relevant Dates	
<input checked="" type="checkbox"/> <b>Additional Claim Data*</b>	
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"/>
<b>Diagnosis Codes (At least one entry required)</b>	
1. <input type="text"/> <b>3</b>	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.																			
<div> <div>4</div> Add Service Line Item <div>If the appropriate NPI is not listed, please contact Provider Enrollment.</div> </div>																			
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				Select One											
Units				10				EPSDT Indicator				Select One							
*Fee				11				Diagnosis Pointers				Select Select Select Select							
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.	
<div><div>Save Template</div><div>Reset</div></div>	

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.

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 :

Provider ID:

or

NPI:

Select Template:

Select One ▾

Submit

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" value="Choose a Condition"/>	Accident Date	<input type="text"/>			
Other Insurance Info						
<input type="button" value="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*						

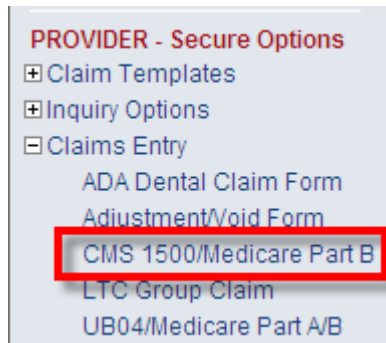
Be sure to expand this section to select provider signature and signature date

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
<b>Co insurance \$</b>	Enter the coinsurance amount indicated on the EOMB
<b>Paid Amount \$</b>	Enter the Medicare payment amount as indicated on the EOMB
<b>Deductible \$</b>	Enter the Medicare deductible amount as indicated on the Medicare EOMB
<b>EOB Date</b>	Enter the payment date from the Medicare Explanation of Benefits (EOMB)
<b>Allowed Amount \$</b>	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

1

Billing Provider

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

<b>Claim Information</b>			
Prior Authorization	<input type="text"/> <b>3</b>		
Timely Filing TCN	<input type="text"/>		
⊕ Relevant Dates			
📁 <b>Additional Claim Data*</b>			
Provider Signature on File	<b>4</b>	<input type="radio"/> Yes <input type="radio"/> No	
Reserved for Local Use	<input type="text"/>	<b>5</b>	
Provider Signature Date	<b>6</b>	<input type="text"/>	
<b>Diagnosis Codes (At least one entry required)</b>			
1. <input type="text"/>	<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"/>
<b>Required Attachments</b>			
Does the Claim have Attachments?			
<input type="radio"/> Yes <input type="radio"/> No <b>8</b>			

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

**Save**

Field #	Field Name	Description
	<b>Add Service Line Item</b>	Click this button to display claim detail fields
9	<b>Service Begin Date</b>	Enter the first date of service
10	<b>Service End Date</b>	Re-enter the first date of service
11	<b>Procedure Code</b>	Enter the applicable procedure code being billed. [Note: The description will auto-populate once you tab to the next field].
12	<b>Rendering Provider ID</b>	Enter the NPI of the servicing provider
13	<b>Place of Service</b>	Select the appropriate response from the list
14	<b>Units</b>	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. <b>YOU MUST CLICK &lt;SAVE&gt; AFTER EACH LINE.</b>

Summary

Total Submitted Charges 0.00 18

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

Balance 0.00 20

☐ 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.

Submit Reset

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.

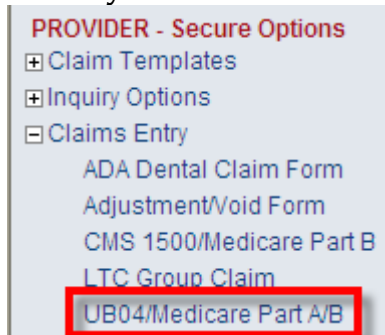
TCN	12258100010007147	Claim Status	Suspended
Line Number	Exception Code	Exception Description	Exception Status
0	0120	THE BILLING PROVIDER NUMBER (PAY TO PROVIDER) IS ZEROS.	Suspend
0	0313	CATEGORY OF SERVICE CANNOT BE DETERMINED	Suspend
0	5125	INVALID BILLING PROVIDER CHECK DIGIT NUMBER	Suspend
1	0429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

The following claim statuses may be displayed:

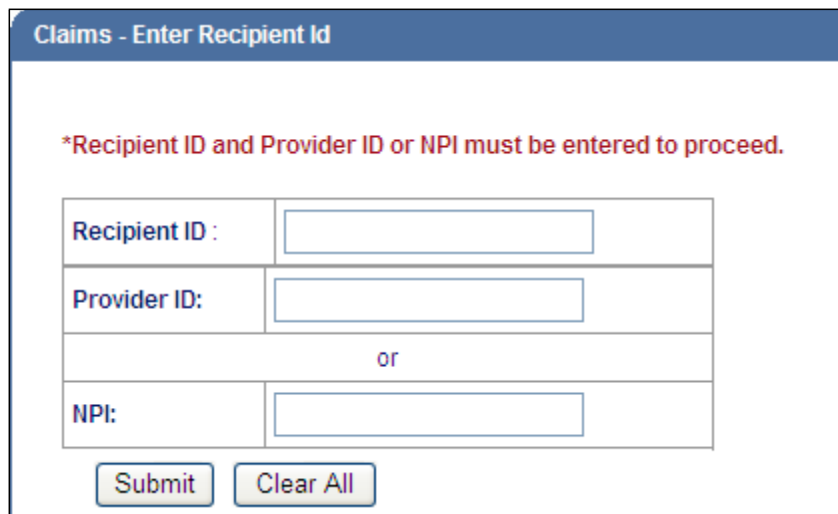
- **To be paid**
- **To be denied** – The exception code (denial reason) and description will be displayed. If you have the correct information, you may submit the corrected claim immediately.
- **To be suspended** – The exception code (pending status) and description will be displayed. **DO NOT RESUBMIT 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.

This is a Medicare Part A claim ☒

This is a Medicare Part B claim ☐

Medicare

EOMB Dt	<b>1</b>	Coins Amt\$	<b>2</b>	Paid Amt\$	<b>3</b>
Deductible Amt\$	<b>4</b>	Allowed Amt\$	<b>5</b>	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.

This is a Medicare Part A claim ☐

This is a Medicare Part B claim ☒

Medicare

EOMB Dt	<b>6</b>	Coins Amt\$	<b>7</b>	Paid Amt\$	<b>8</b>
Deductible Amt\$	<b>9</b>	Allowed Amt\$	<b>10</b>	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	<b>Paid Amt\$</b>	Enter the Medicare payment amount as indicated on the EOMB
9	<b>Deductible Amt\$</b>	Enter the Medicare deductible amount as indicated on the Medicare EOMB
10	<b>Allowed Amt\$</b>	Enter the Medicare allowed amount as indicated on the Medicare EOMB
	<b>Add Data</b>	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 11  National Provider ID

☐ Additional Billing Provider Information

**Attending Provider**

Medicaid Provider ID 12  National Provider ID

☐ Additional Attending Provider Information

**Operating Provider**

Medicaid Provider ID 13  National Provider ID

☐ Additional Operating Provider Information

**Other Provider 1**

Medicaid Provider ID 14  National Provider ID

☐ Additional Other Provider 1 Information

**Other Provider 2**

Medicaid Provider ID 15  National Provider ID

☐ Additional Other Provider 2 Information

**Recipient Information** 16

\* Medicaid ID

Last Name  First Name  MI

☐ Additional Recipient Information

Is Patient's Condition Related To  Choose a Condition  Accident Date 17

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

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

Other Insurance Info						
<input type="button" value="Add Insurance Info"/> <b>18</b>						
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"/> <b>19</b>	
*Service Dates	<b>20</b>					
From	<input type="text"/>	To	<input type="text"/>			
Treatment Authorization Code	<input type="text"/> <b>21</b>	Timely Filing TCN	<input type="text"/> <b>22</b>			
<input type="checkbox"/> Admission Information*						
Date	<input type="text"/>	*HR	<input type="text"/> <b>23</b>	*Type	Select One <b>24</b>	
*Src	Select One <b>25</b>	Discharge Hr	<input type="text"/>	*Status	Select One <b>26</b>	
<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						
<div style="border: 1px solid black; padding: 2px; color: red; text-align: center;">Complete the highlighted section(s) if applicable.</div>						
Code	Date	Code	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="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	<b>Timely Filing TCN</b>	If resubmitting a claim, if applicable, enter the first TCN from the originally paid or denied claim
23	<b>Admission HR</b>	Enter the appropriate code identifying the hour the patient was admitted for care
24	<b>Admission Type</b>	Select the appropriate type of admission code from the pick list
25	<b>Admission Src</b>	Select the appropriate source of admission code from the pick list
26	<b>Patient Status</b>	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	<b>Value Code</b>	Enter the appropriate value code and amount
28	<b>Principle Diagnosis</b>	Enter the principal diagnosis code(s) provided at the time of admission as stated by the physician
29	<b>POA</b>	Select the appropriate present upon admission code from the pick list

Required Attachments																																					
Does the Claim have Attachments? <b>30</b>																																					
<input type="radio"/> Yes <input type="radio"/> 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.																																					
<div style="border: 1px solid red; padding: 2px; display: inline-block;">Add Service Line Item</div>																																					
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																															
<div> <div>New Covered Individual</div> <table border="1"> <tr> <td>*RevCode</td> <td><b>31</b></td> <td>RevCode Description</td> <td></td> </tr> <tr> <td>*Procedure Code</td> <td><b>32</b></td> <td>Procedure Code Description</td> <td></td> </tr> <tr> <td>Rate</td> <td><b>33</b></td> <td>Modifiers</td> <td><b>34</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></td> </tr> <tr> <td>Service Begin Date</td> <td><b>35</b></td> <td>End Date</td> <td><b>36</b> <input type="text"/></td> </tr> <tr> <td>*Submit Units</td> <td><b>37</b></td> <td>*Submitted Charges \$</td> <td><b>38</b> <input type="text"/></td> </tr> <tr> <td>NDC Code</td> <td></td> <td>Non Coverage Charges \$</td> <td><input type="text"/></td> </tr> </table> <div> <div style="border: 1px solid red; padding: 2px; display: inline-block;">Save</div> </div> </div>														*RevCode	<b>31</b>	RevCode Description		*Procedure Code	<b>32</b>	Procedure Code Description		Rate	<b>33</b>	Modifiers	<b>34</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Service Begin Date	<b>35</b>	End Date	<b>36</b> <input type="text"/>	*Submit Units	<b>37</b>	*Submitted Charges \$	<b>38</b> <input type="text"/>	NDC Code		Non Coverage Charges \$	<input type="text"/>
*RevCode	<b>31</b>	RevCode Description																																			
*Procedure Code	<b>32</b>	Procedure Code Description																																			
Rate	<b>33</b>	Modifiers	<b>34</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																																		
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NDC Code		Non Coverage Charges \$	<input type="text"/>																																		
Summary																																					
Total Submitted Charges <b>39</b> <input type="text"/>																																					
Are there TPL amounts to be entered? <input type="radio"/> Yes <input type="radio"/> No <b>40</b>																																					
Balance <b>41</b> <input type="text"/>																																					
<input checked="" 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.																																					
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<div> <div style="border: 1px solid red; padding: 2px; display: inline-block;">Submit</div> <div style="padding: 2px; display: inline-block;">Reset</div> </div>																																					

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	<b>Procedure Code</b>	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	<b>Rate</b>	Enter your usual and customary charges for the procedure being billed
34	<b>Modifiers</b>	If applicable, enter the appropriate modifier(s) for the above procedure code in all capital letters
35	<b>Service Begin Date</b>	Enter the first date of service
36	<b>Service End Date</b>	Re-enter the first date of service
37	<b>Units</b>	Enter the total number of units being billed for this procedure
38	<b>Submitted Charges</b>	Enter total charges for revenue/procedure code being billed
	<b>Save</b>	Click to add the line item to the table above. If billing multiple lines, repeat steps 10-19 to add additional claim line. <b>YOU MUST CLICK &lt;SAVE&gt; AFTER EACH LINE.</b>
39	<b>Total Submitted Charges</b>	Auto populates overall claim total
40	<b>TPL Amounts</b>	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	<b>Balance</b>	Auto populated the difference between the total submitted charges and TPL payments
	<b>Confirmation Statements</b>	Click both text boxes
	<b>Submit/Reset</b>	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.

<b>TCN</b>	12258100010007147	<b>Claim Status</b>	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

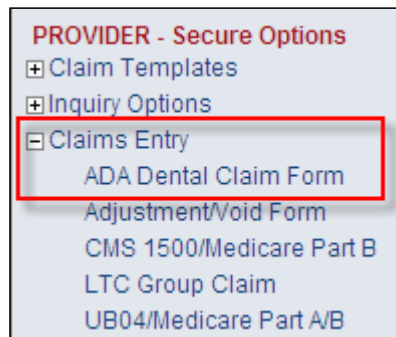
The following claim statuses may be displayed:

- **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

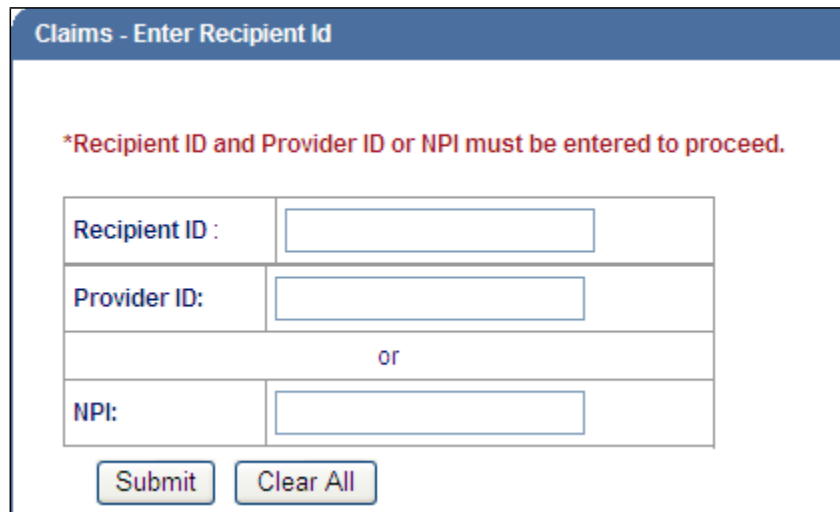
After logging in, select Claims Entry > ADA Dental Claim Form



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

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.]



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 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

**Recipient Information** 3

\* 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"/>		
<div>  <b>Ancillary Claim Data</b> </div> <div> <b>Click on the plus (+) sign to expand this section</b> </div>			
Place of Treatment*	<input type="text" value="Select"/>	6	
Number of Enclosures	<input type="text"/>	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	<b>Prior Authorization</b>	If applicable, enter the prior authorization number located on the PA letter received
5	<b>Timely Filing TCN</b>	If applicable, enter the first TCN from the originally paid or denied claim
6	<b>Place of Treatment</b>	Select the appropriate response indicating where services were rendered
7	<b>Provider Signature on File</b>	Select "Yes"
8	<b>Provider Signature Date</b>	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

If 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	<b>Treating Provider ID</b>	Enter the NPI of the treating provider
20	<b>Save</b>	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	<b>Total Submitted Charges</b>	Auto populates overall claim total
22	<b>TPL Amounts</b>	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	<b>Balance</b>	Auto populated the difference between the total submitted charges and TPL payments
24	<b>Confirmation Statements</b>	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 left navigation pane has a red box around the 'Adjustment/Void Form' link under the 'WEB REGISTRATION' section. The main content area displays the 'Adjustment/Void - Enter TCN' form. A red box highlights the 'Action' dropdown menu, which is open, showing 'Select', 'Adjust', and 'Void' options. The 'Submit' button is also visible.

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. The form includes fields for 'Prior Authorization', 'Timely Filing TCN', 'Relevant Dates', and 'Additional Claim Data\*'. The 'Timely Filing TCN' field is currently empty.

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 TPL is not listed, please contact Provider Enrollment.

L#	Service Dates		Procedure Codes	Provider ID	SPL	Modifiers				Diag Points				Submitted Charges	units	Place of Service	NCC 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:  

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 charged 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.

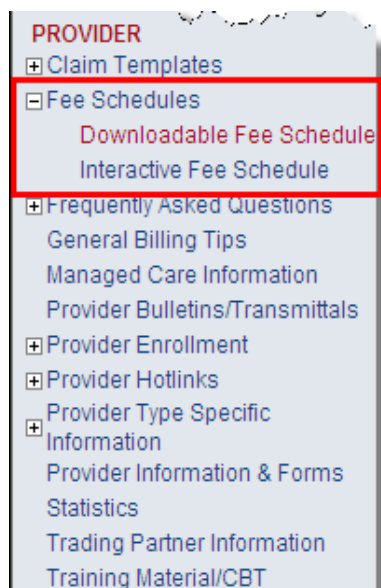
### Helpful Tips:

- 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

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	Factor Code Description
Z1	General Fee Schedule

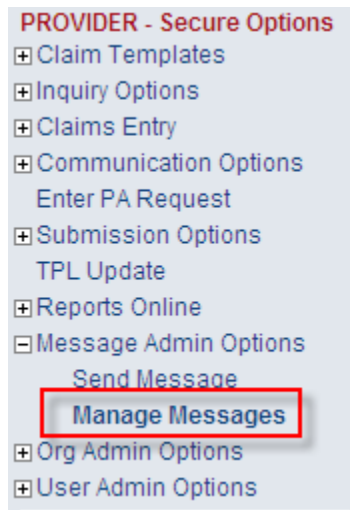
New Inquiry

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.

**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
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## 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](mailto: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'.

The screenshot shows the 'Forgot User ID / Password' form in the District of Columbia Department of Health Care Finance Web Portal. The form is titled 'Forgot User ID / Password' and contains the following text: 'For security purposes, your password will be reset. You will receive an email, good for one use, at the address you provided during Registration that will direct you to the RESET PASSWORD feature of the Web Portal. Upon completion of the RESET PASSWORD process you will be redirected to the home page to log in. Last Name is mandatory to retrieve your User ID.' The form includes three input fields: 'User ID:', 'Last Name:', and '\*Email Address:'. Below the input fields are two buttons: 'Submit' and 'Reset'.

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:

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'.

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**

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 Yes No

Submit Reset

The Retrieve User ID / Password Conformation 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 features the District of Columbia logo and the text 'District of Columbia Department of Health Care Finance'. A left sidebar contains a 'HOME' section with links to Online Security, Terms of Usage, Privacy Policy, Forgot User ID/Password, and Help. Below this is a 'WEB REGISTRATION' section with a 'PROVIDER' subsection containing links to EHR Incentive Payments Program, Fee Schedules, Frequently Asked Questions, General Billing Tips, Managed Care Information, Provider Bulletins/Transmittals, Provider Enrollment, Provider Hotlinks, and Provider Type Specific. The main content area displays a 'Reset Password' form. The form includes instructions: '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 has two input fields: 'New Password:' and 'Confirm New Password'. Below the fields are two red buttons labeled '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 screenshot shows the District of Columbia Department of Health Care Finance web portal. The top navigation bar includes links for MAYOR, DC GUIDE, RESIDENTS, BUSINESS, VISITORS, GOVERNMENT, and FOR KIDS. The left sidebar contains links for 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). The main content area is titled 'Hint Question' and contains a form with two fields: '\*Hint Question:' and '\*Answer:'. The '\*Hint Question:' field has a dropdown menu with options: 'Who is your Childhood Hero?', 'Who is your Childhood Hero?', 'What is your Place of Birth?', and 'What is your Mother's Maiden Name?'. The '\*Answer:' field is empty. Below the form are two buttons: 'Submit' and 'Reset'.

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

The screenshot shows the District of Columbia Department of Health Care Finance web portal. The top navigation bar includes links for MAYOR, DC GUIDE, RESIDENTS, BUSINESS, VISITORS, GOVERNMENT, and FOR KIDS. The left sidebar contains links for 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). The main content area is titled 'Reset Password Confirmation' and contains a message: 'Password reset successful. Please wait while we redirect you to the homepage to log in.' Below the message is a link: 'If you are not automatically redirected after 10 seconds, [Click here](#)'.

### 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'.

The screenshot shows a dropdown menu titled 'PROVIDER - Secure Options'. The menu items are: Claim Templates, Inquiry Options, Claims Entry, Communication Options, Enter PA Request, Submission Options, TPL Update, Message Admin Options, Org Admin Options, Add New User to Org, Manage Existing Org Users, and User Admin Options. The 'Org Admin Options' item is expanded, and the 'Add New User to Org' item is highlighted with a red box.

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"/>

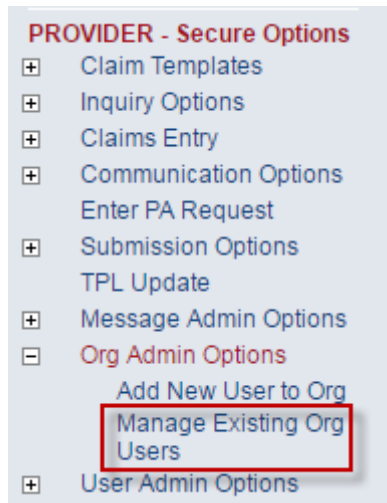
The user(s) will receive an email containing the user ID and temporary password.

[**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.

www.dc-medicaid.com says:  
Are you sure you want to remove this user?

OK

Cancel

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](#).