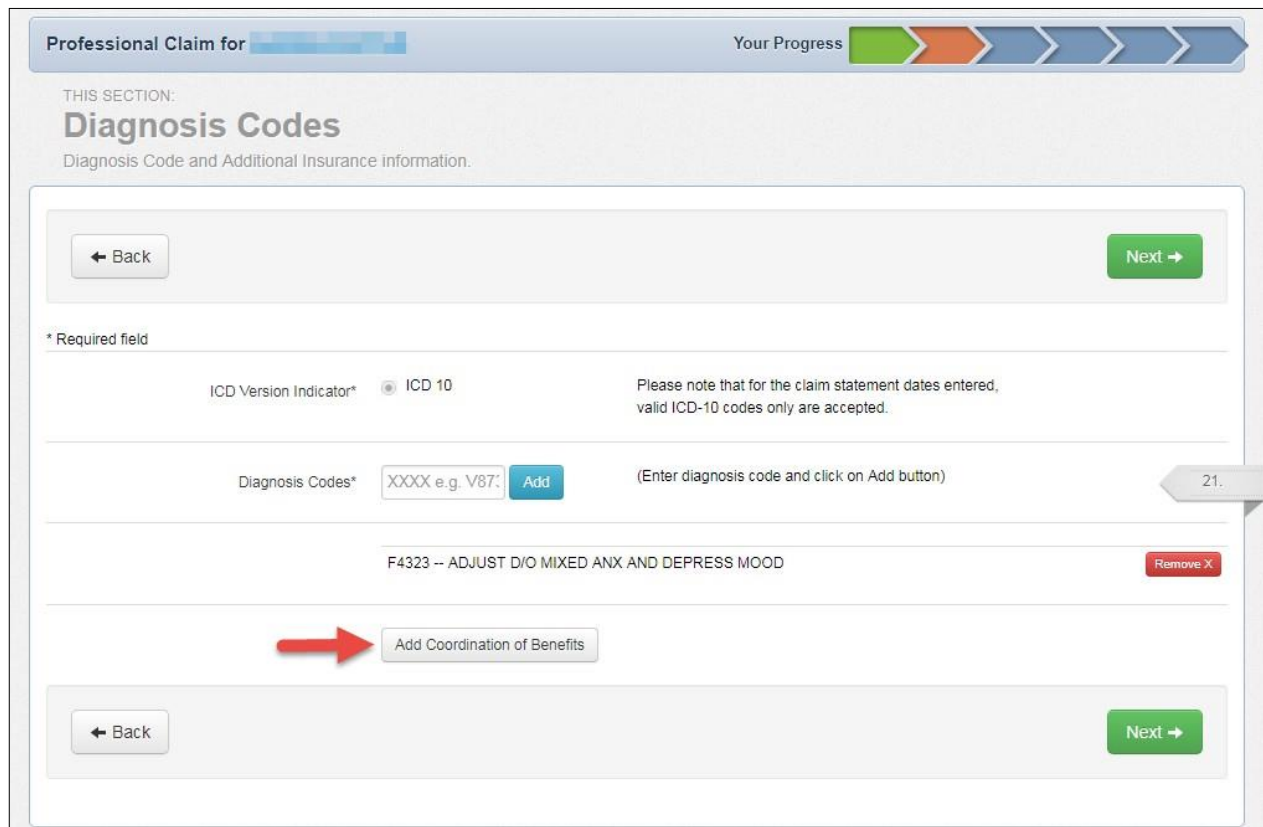


## Coordination of Benefits Entry Walkthrough

This guide serves as a walkthrough for entering Coordination of Benefits (COB) information on professional claims submitted via the Secure Provider Portal

### Step 1

On the Diagnosis Codes page, click **Add Coordination of Benefits**



Professional Claim for [REDACTED] Your Progress [Progress Bar]

THIS SECTION:  
**Diagnosis Codes**  
Diagnosis Code and Additional Insurance information.

← Back Next →

\* Required field

ICD Version Indicator\*  ICD 10 Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.

Diagnosis Codes\* XXXX e.g. V87 Add (Enter diagnosis code and click on Add button) 21.

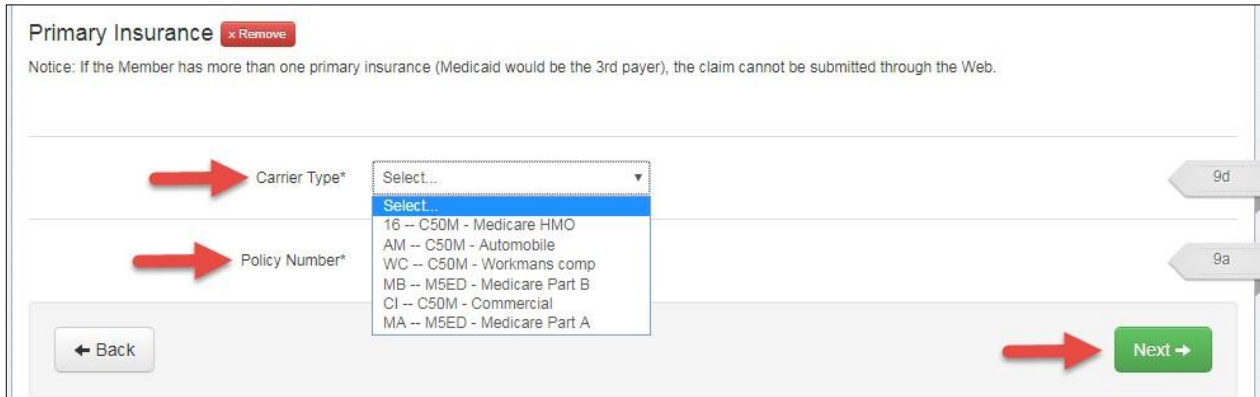
F4323 -- ADJUST D/O MIXED ANX AND DEPRESS MOOD Remove X

→ Add Coordination of Benefits

← Back Next →

## Step 2

Click **Carrier Type** drop-down to select the applicable carrier type and then enter the policy number. Once completed, click **Next**.



**Primary Insurance** x Remove

Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.

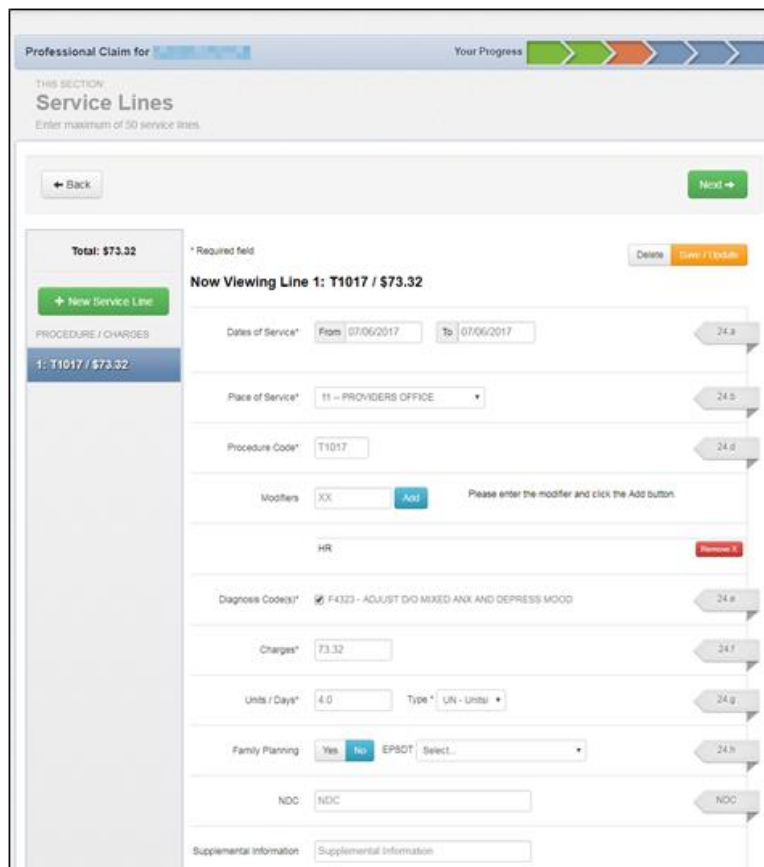
Carrier Type\* 9d

Policy Number\* 9a

Select...  
 Select...  
 16 -- C50M - Medicare HMO  
 AM -- C50M - Automobile  
 WC -- C50M - Workmans comp  
 MB -- M5ED - Medicare Part B  
 CJ -- C50M - Commercial  
 MA -- M5ED - Medicare Part A

## Step 3

Fill out Service Line information as per normal procedure. Then scroll down to complete the Primary Insurance fields.



Professional Claim for [Member Name] Your Progress

THIS SECTION:  
**Service Lines**  
Enter maximum of 30 service lines.

Total: \$73.32 \* Required field

**Now Viewing Line 1: T1017 / \$73.32**

PROCEDURE / CHARGES

1: T1017 / \$73.32

Dates of Service\* From: 07/06/2017 To: 07/06/2017 24.a

Place of Service\* 11 -- PROVIDERS OFFICE 24.b

Procedure Code\* T1017 24.c

Modifiers: XX  Please enter the modifier and click the Add button.

HR

Diagnosis Code(s)\*  F4322 -- ADJUST DIS MIXED ANK AND DEPRESS MOOD 24.e

Charges\* 73.32 24.f

Units / Day\* 4.0 Type\* UN - Units 24.g

Family Planning: Yes  No  EPSDT: Select... 24.h

NDC: NDC NDC

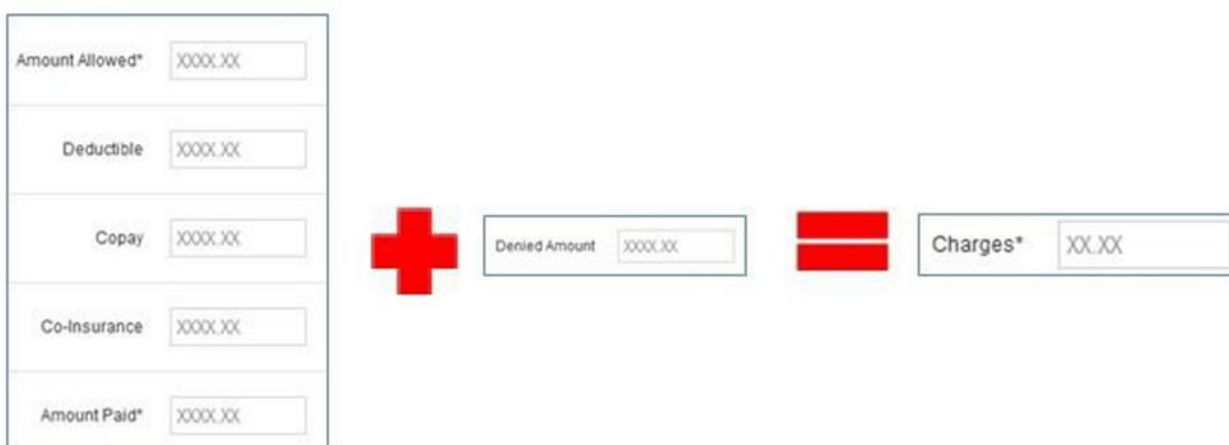
Supplemental Information: Supplemental Information

## Step 4

Enter the line items on the primary insurance in accordance with the rules of the section.

**COB entry rules:** The amount charged for services (entered by provider on line 24f) must equal the total of the line items from the Primary Insurance fields and the Service Line Denial Reason section. So the following must be true before moving forward:

Total of the **Primary Insurance** fields + **Denied Amount** = **Total Charges**



Another way to display the equation is:

**Charges** - Total of **Primary Insurance** Fields = **Denied Amount**



There are a number of scenarios that may be encountered when entering this information. Please review the following examples for more information.

### Example 1

Total Charges on line 24f =  
\$100 Amount Allowed by  
primary = \$60 Amount Paid  
by primary = \$60

In this example, the provider is charging \$100 and the primary paid \$60. This leaves a remainder of \$40, which should be entered in the Denied Amount field and a Denied Category must be selected.

Primary Insurance	
<small>Notice: If the Member has more than one primary insurance (Medicaid would be the</small>	
Amount Allowed*	<input type="text" value="60"/>
Deductible	<input type="text" value="XXXX.XX"/>
Copay	<input type="text" value="XXXX.XX"/>
Co-Insurance	<input type="text" value="XXXX.XX"/>
Amount Paid*	<input type="text" value="60"/>
Service Line Denial Reasons	
Denied Category	<input type="text" value="Over Allowable"/> ▼
Denied Amount	<input type="text" value="40"/>

### Example 2

Total charges on line 24f = \$100

Amount Allowed by primary = \$50

Member responsibility is a copay = \$20

Amount Paid by primary = \$30

In this example, the total charges are \$100. The primary Amount Allowed is \$50 and the member had a co-pay responsibility of \$20. Therefore, the primary paid the remaining \$30. (i.e. Amount Allowed (\$50) – Copay (\$20) = Amount Paid (\$30).

The amount received from the primary (\$30) and member (\$20) totals \$50. This leaves a remainder of \$50, which should be entered in the Denied Amount field and a Denied Category must be selected.

Primary Insurance	
Notice: If the Member has more than one primary insurance (Medicaid would be th	
Amount Allowed*	<input type="text" value="50"/>
Deductible	<input type="text" value="XXXX.XX"/>
Copay	<input type="text" value="20"/>
Co-Insurance	<input type="text" value="0"/>
Amount Paid*	<input type="text" value="30"/>
Service Line Denial Reasons	
Denied Category	<input type="text" value="Over Allowable"/> ▼
Denied Amount	<input type="text" value="50"/>


### Step 5

Click **Add Denied Reason**, to add the EOB information entered to the Service Line. Once clicked, the denied amount and category will appear below the button.

**Service Line Denial Reasons**  
Select denied category, enter amount and click "Add Denied Reason" to add a denied amount to your claim.

Denied Category

Denied Amount



\$ 50.00 Over Allowable

### Step 6

Click the **Save/Update**.

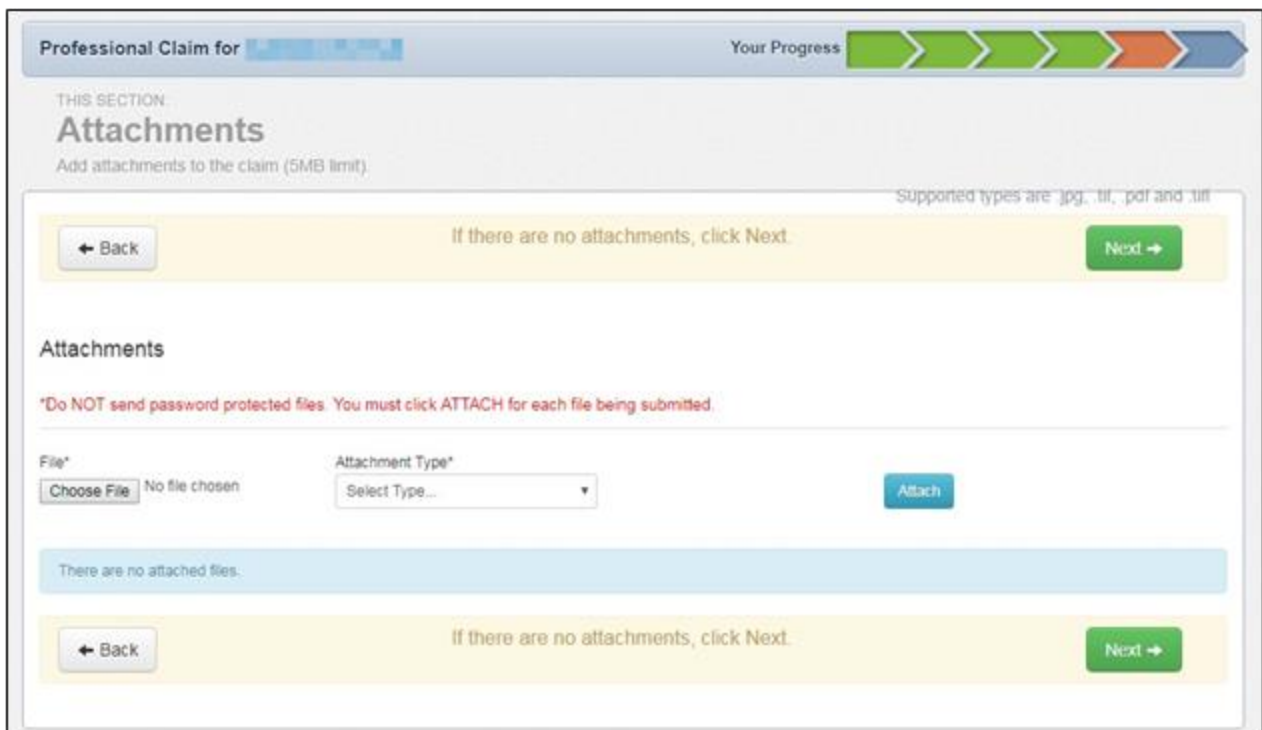
If everything was entered correctly, then there will be no error messages and you can continue to the next steps.

**Please Note:** Steps 4 – 6 must be completed for each Service Line on the web claim.

## Step 7

After entering the Provider Details on step 3 of claim submission, proceed forward to step 4 - Attachments. It is **not a requirement** to include a copy of the explanation of Benefits received from the primary payer when submitting a claim via the Secure Provider Portal. We offer this as an optional feature. For claims submitted outside the portal, the EOB is required.

Note: If the EOB is from Medicare and includes the EOB information for several other claims, this does not present a problem. You can attach the entire image



The screenshot shows a web interface for submitting a claim. At the top, it says "Professional Claim for [redacted]" and "Your Progress" with a progress bar showing 7 steps, with the 7th step highlighted in blue. Below this, the section is titled "Attachments" with the instruction "Add attachments to the claim (5MB limit)". A note says "Supported types are .jpg, .tif, .pdf and .tiff". The main area has a yellow bar with "← Back" and "Next →" buttons, and the text "If there are no attachments, click Next." Below this, there is a "File\*" field with a "Choose File" button and "No file chosen" text, and an "Attachment Type\*" dropdown menu with "Select Type..." text. An "Attach" button is to the right. A light blue box below contains the text "There are no attached files." At the bottom, another yellow bar contains "← Back" and "Next →" buttons with the text "If there are no attachments, click Next."