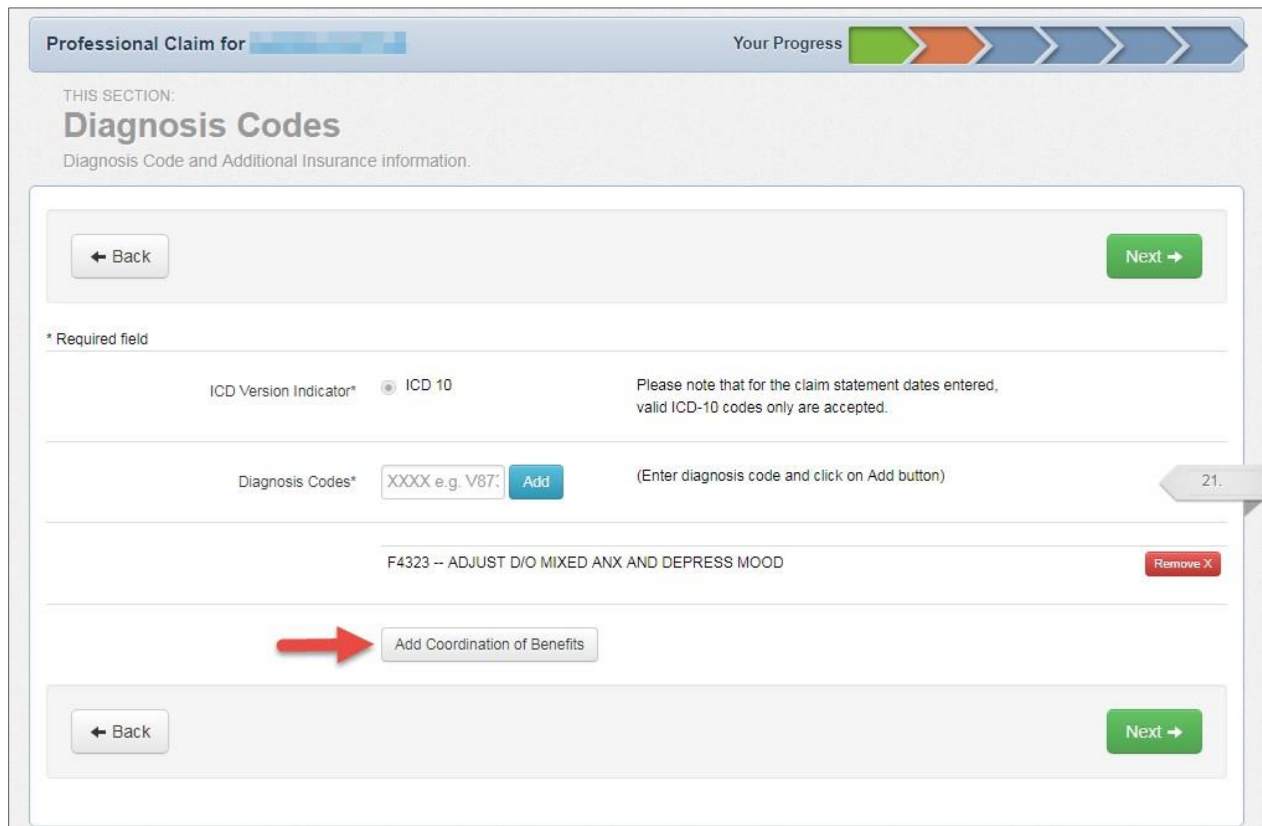
Coordination of Benefits Entry Walkthrough

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

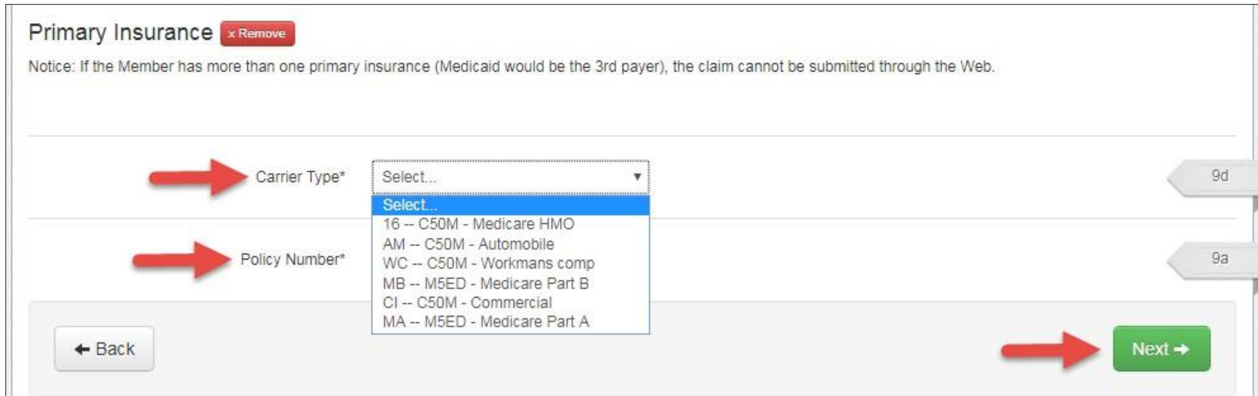
Step 1

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



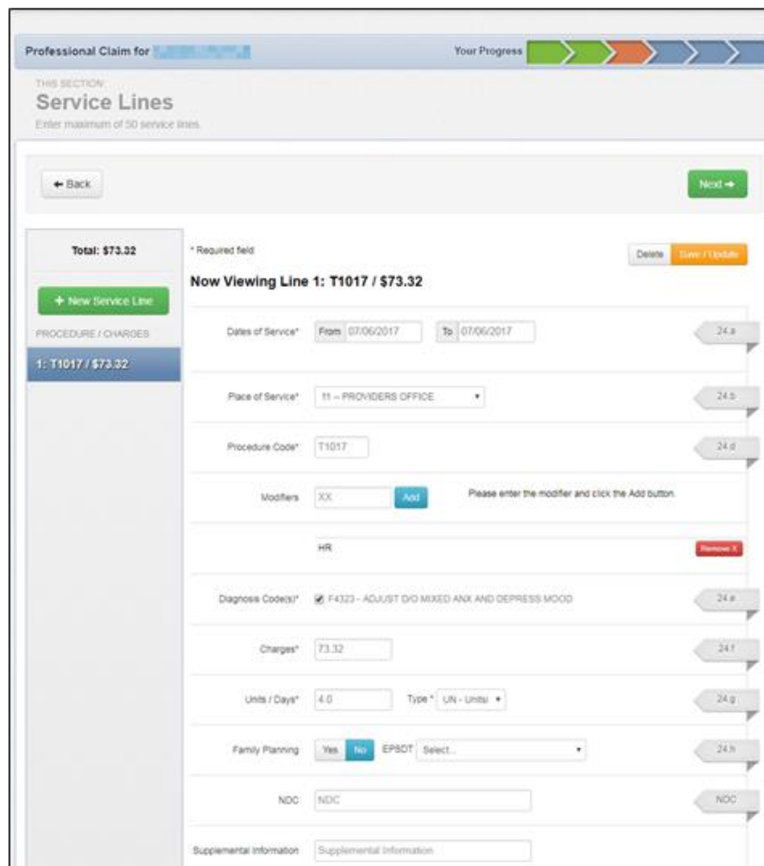
Step 2

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



Step 3

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



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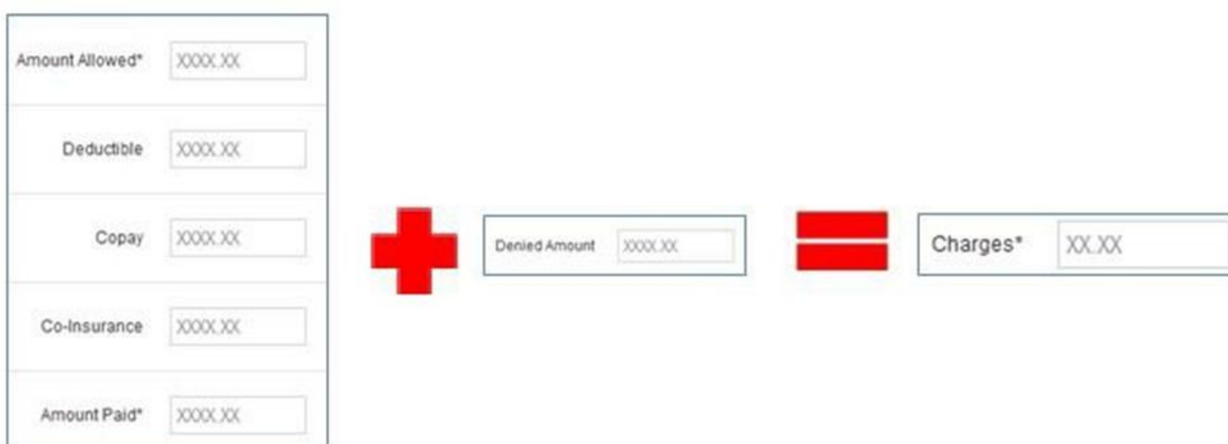
Step 4

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

Notice: If the Member has more than one primary insurance (Medicaid would be th

Amount Allowed*	60
Deductible	XXXX.XX
Copay	XXXX.XX
Co-Insurance	XXXX.XX
Amount Paid*	60

Service Line Denial Reasons

Denied Category	Over Allowable
Denied Amount	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

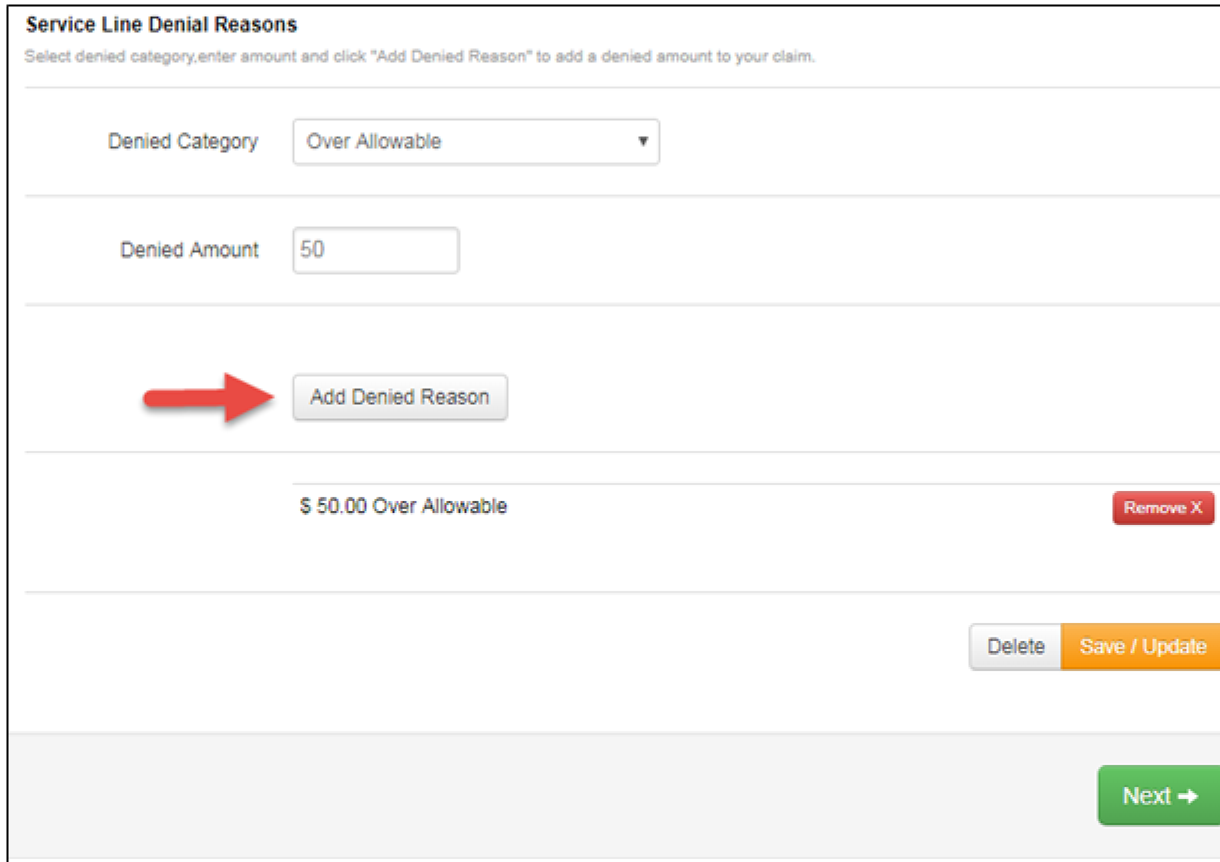
Amount Allowed*	50
Deductible	XXXX.XX
Copay	20
Co-Insurance	0
Amount Paid*	30

Service Line Denial Reasons

Denied Category	Over Allowable
Denied Amount	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.



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.

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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