



# Secure Provider Portal Overview

Last updated: December 2023

# Agenda

- Introduction
- Registration and Provider Resources
- Account Management Role and Tasks
- Account Details
- Portal Features and Benefits:
  - Member Eligibility
  - Patient List (only PCP / PCP Organizations)
  - Viewing and Submitting Authorizations
  - Viewing Claims Information
  - Claim Submission
- AMH Specific Information: Intro to Provider Analytics
- Q&A

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# Secure Provider Portal Introduction

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# Secure Provider Portal Introduction

The Provider Portal allows providers to:

- Check eligibility
- Submit, correct, and check claim status
- Submit and view prior authorizations
- View patient care gaps
- And much more

# Secure Provider Portal General Information

- Driven by Tax ID Number (TIN)
- Performs best in the current version of Chrome
- Does **not** house member, provider, claim, or authorization data, it merely displays information from CCH back-end systems

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# Provider Portal Registration & Login

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# Portal Registration: [provider.carolinacompletehealth.com](https://provider.carolinacompletehealth.com)

Tip: add [no-reply@mail.entrykeyid.com](mailto:no-reply@mail.entrykeyid.com) to your email contacts

## Log In

Username (Email)

LOG IN

Create New Account



[Help](#) [Privacy Policy](#) [Terms of Use](#) © 2021 Centene



## Create Your Account

Let's get started - creating an account is quick and easy.

Email

First Name

Last Name

Language Preference

Password

Passwords must be at least 8 characters and include three of the four items below:

- One uppercase letter
- One lowercase letter
- One number
- One special character (For example: &, \$, !, \*)

CREATE ACCOUNT

CANCEL

# Portal Login

## Log In

Username (Email)

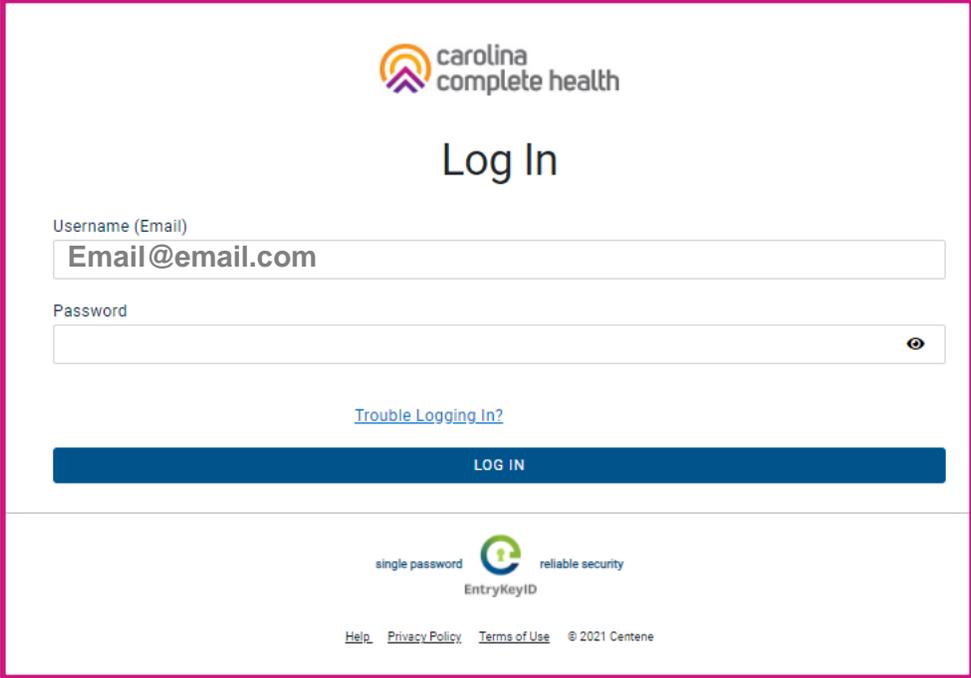
Email@email.com

LOG IN

[Create New Account](#)

single password  reliable security  
EntryKeyID

[Help](#) [Privacy Policy](#) [Terms of Use](#) © 2021 Centene



The screenshot shows the Carolina Complete Health login page. At the top right is the logo for Carolina Complete Health. Below it is the heading "Log In". There are two input fields: "Username (Email)" containing "Email@email.com" and "Password" which is currently empty. To the right of the password field is an eye icon for toggling visibility. Below the password field is a link for "Trouble Logging In?". At the bottom of the form is a blue "LOG IN" button. Below the form, there is a section for "single password" and "reliable security" with the "EntryKeyID" logo. At the very bottom, there are links for "Help", "Privacy Policy", and "Terms of Use", along with the copyright notice "© 2021 Centene".

# Portal Banner

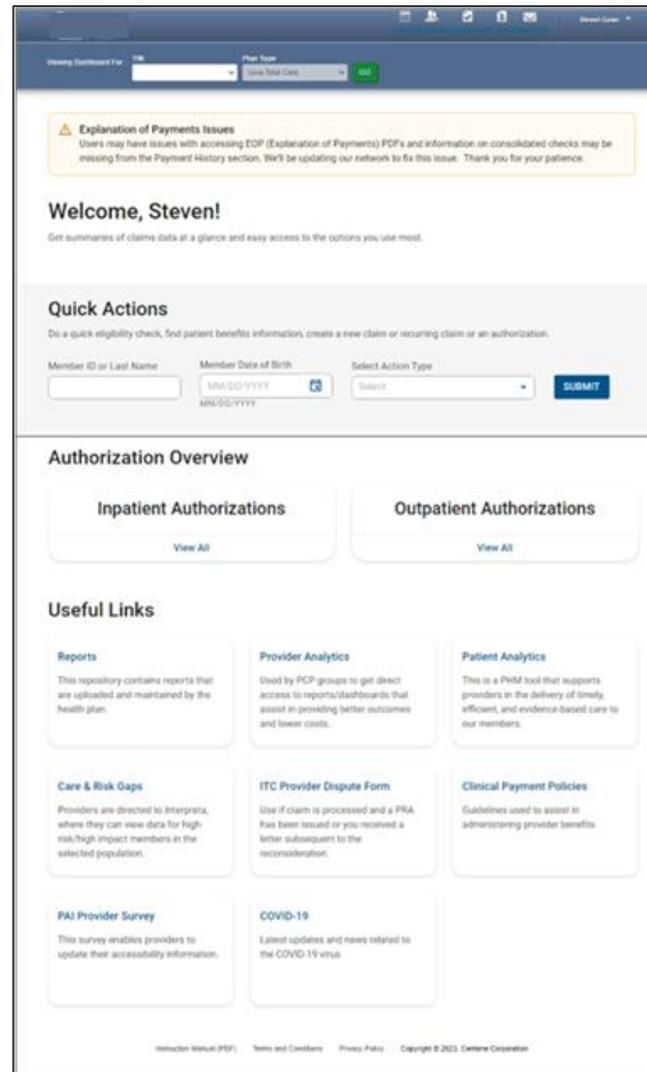
The screenshot shows a dark blue portal banner with several components. At the top left is a blurred area labeled "Health Plan / Product Logo". To the right are five icons with labels: "Eligibility" (calendar), "Patients" (person), "Authorizations" (checkmark), "Claims" (dollar sign), and "Messaging" (envelope). These are collectively labeled "Portal Functionalities". On the far right is a blurred area labeled "User's Name / Menu Options". Below the banner is a section titled "Viewing Dashboard For:" with two dropdown menus: "TIN" (containing "4449") and "Plan Type" (containing "Medicaid"), followed by a green "GO" button. Callouts point to the "TIN(s) Listing" and "Plan Type Option(s)".



## Tips

- Portal functionality / access is based on the user's permissions
- **Plan Type** drop-down options are automatically assigned based on how the TIN is set-up in our systems, and the products offered by the Health Plan

# Portal Home Page – Verified Portal Account



# Portal Registration & Login Tips

- Registration is required for access to the portal
  - Carolina Complete Health is responsible for verifying and setting up the original user/registrant for your TIN. This is your Account Manager. Reach out to your Provider Engagement Administrator for support setting up the Account Manager.
- Portal accounts cannot be shared
  - Each person within a provider organization who needs access to the portal, must complete the portal registration
- For a portal user to register, their TIN must be loaded in our systems
  - Allow at least two business days for portal to reflect updates in back-end systems
- There is no limit on the number of TINs a portal user can add to their portal account
- Portal users must log into the portal every 90 days to prevent their account from being locked due to inactivity
- The Forgot Password / Unlock Account link on the Secure Provider Portal login page, cannot be used to unlock a portal account, that is locked due to inactivity

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# Portal Account Manager

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# Portal Account Manager

- A Portal Account Manager is a role assigned to a primary contact within a provider organization
- **The Account Manager is responsible for the day-to-day support of all Secure Provider Portal user accounts that are registered under the same TIN**
- Email your Provider Engagement Administrator to establish the first account manager for your TIN

# Portal User Management: User Access

## Admin Settings

Add and manage user access and information.

**Add User**      **Edit User Access**      **Add a TIN**

### Search for User

Email:       Last Name:       Status:

Verification Pending

**Go!** **Clear**

### Invite a User

Email Address:

**Send Invitation**

[Account Manager User Guide](#)

					Active	Account Manager Access	
					PasswordExpired		
					Active	Account Manager Access	
					PasswordExpired		
					Active		

24 items found, displaying 1 to 10. Page 1/3    1,2,3    [Next](#)    [Last](#)

# Portal Account Manager Tips

- Each TIN should have at least two Account Managers
  - For large organizations, it is recommended to have at least two Account Managers per department.
  - There is no limit on the number of Account Managers allowed under a TIN
- Account Managers should *regularly* log into the portal to:
  - Verify new portal registrations
  - Disable / Enable a user's portal access
  - Modify portal permissions based on the user's role within your organization
- Account Managers **cannot** manage their own portal account



**Tip:** Always disable portal users, who no longer need portal access, especially when they leave your company.

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# Portal Account Details

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# Portal Account Details

The screenshot shows the 'Account Details' page in a web portal. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A dropdown menu is open, showing 'Account Details' (marked with a red '2') and 'User Management'. Below the navigation bar, there is a 'Go to Dashboard For:' section with a dropdown menu set to 'Medicaid' and a 'GO' button. The main content area is divided into two sections: 'Account Details' and 'Add a TIN'. The 'Account Details' section contains fields for Name, User Name (Email), Password, Telephone Number, Fax Number, and three Secret Questions. An 'Update Account' button is located to the right of these fields. The 'Add a TIN' section contains a text box for 'Name TIN' (with 'Enter Name' as a placeholder), a 'Tax ID' field with the value '123456789', and an 'Add TIN' button. Below these sections is the 'Your TINs' section, which includes a link for 'Provider Demographic Update Instructions' and a table of TINs. The table has columns for 'TIN', 'Product', and 'Action'. The products listed are Allwell, Ambetter, Behavioral Health, and Medicaid. Each row has a 'Mark as Primary' button and an 'X' button to remove the TIN. The 'Medicaid' row is marked as 'Current Primary'. Annotations with red arrows point to various elements: 'Update Account', 'Add a TIN' (circled in red), 'Mark as Primary' buttons, and the 'X' buttons.

Click **Update Account**, to change account details

**Your TINs**, list the TIN(s) you added to your portal account

Use **Add a TIN**, to associate additional TIN(s) to your portal account

**NOTE:** Carolina Complete Health providers must update demographic information with NCTracks

Click **Mark as Primary**, to change TIN and Product login default

Click **X** to remove a TIN

Click **TIN / Product** to view / update Provider Demographics

# Portal Account Details - Tips

- Under Account Details, portal users can:
  - Update account details (i.e. change email address, name, password, etc.)
  - Select TIN/Product login default
  - Add a TIN
  - Remove TIN(s) from portal account



**Tip:** If an inactive TIN is removed from a portal account, it cannot be re-added.

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# Portal Functionality: Check Eligibility

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# Eligibility Check

Within Eligibility Check results, the Patient Overview displays patient demographic, claims, authorizations and other pieces of information. It can be used to identify Care Gaps, view ER visits, and PCP history.

# Quick Eligibility Check

## Quick Actions

Do a quick eligibility check, find patient benefits information, create a new claim or recurring claim or an authorization.

**1** Member ID or Last Name \*

**2** Member Date of Birth    
MM/DD/YYYY

**3** Select Action Type \*

**SUBMIT**

- View Eligibility & Patient Information
- Create New Claim
- Create Recurring Claim
- Create Authorization

## Claims Overview

Shows claims for the last 30 days from today's date.

REJECTED DENIED PENDING

# Eligibility Check

The screenshot shows a web application interface for an eligibility check. At the top, there is a navigation bar with icons for Eligibility (1), Patients, Authorizations, Claims, and Messaging. Below this is a search bar with 'Viewing Eligibility For:' and two dropdown menus: 'TIN' and 'Plan Type' (set to 'Medicaid'). A green 'GO' button is to the right. The main section is titled 'Eligibility Check' and contains a form with fields for 'Date of Service' (05/27/2020), 'Member ID or Last Name' (123456789 or Smith) (2), and 'DOB' (mm/dd/yyyy) (3). A green 'Check Eligibility' button (4) and a 'Print' button are also present. Below the form is a table with the following columns: ELIGIBLE, DATE OF SERVICE, PATIENT NAME, DATE CHECKED, RECENT ADT, CARE GAPS, and LOG ER VISIT. The table contains one row with a thumbs-up icon, the date 05/27/2020, a patient name (5), the date 05/27/2020, 'NO', and the text 'Non-compliant for annual well visit.'. The 'LOG ER VISIT' column has an 'ER Visit?' button and a 'Remove' button. A red arrow points from the 'ER Visit?' button to a red text box at the bottom right.

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	RECENT ADT	CARE GAPS	LOG ER VISIT
	05/27/2020	<a href="#">View details</a> (5)	05/27/2020	NO	Non-compliant for annual well visit.	<a href="#">ER Visit?</a> <a href="#">Remove</a>

If Eligibility Check is for an ER visit, click **ER Visit?**

# Eligibility Tips

- When checking eligibility, if the member does not pull up, verify data entered
- If Member ID + DOB does not pull up the member, try Member Last Name + DOB
- As best practice, always check member eligibility before creating a web authorization or web claim



**Tip:** The member drives your Plan Type selection. For example, an Ambetter member will not pull up under Medicaid.

# Patient Overview

The screenshot shows a web application interface for patient eligibility. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this is a search bar with the text "Viewing Eligibility For:" and a dropdown menu set to "Medicaid", followed by a green "GO" button. A "Back to Eligibility Check" button is visible on the left. The main content area is divided into a left sidebar and a main panel. The sidebar contains a list of menu items: Overview (highlighted with a red box), Cost Sharing, Assessments, Health Record, Care Plan, Authorizations, Referrals, Coordination of Benefits, Claims, Document Resource Center, and Notes. The main panel features a green banner at the top stating "This patient is eligible as of today, May 27, 2020." with a thumbs-up icon and a red arrow pointing to the date. Below the banner is a "Print Eligibility Overview" link with a printer icon and a red arrow. The main panel is organized into two columns: "Patient Information" and "PCP Information", both with red arrows pointing to their respective sections. The "Patient Information" section includes fields for Name, Gender (M), Birthdate, Age, Member #, and Address. The "PCP Information" section includes fields for Name (TERRIE), Address, Practice Type (MEDICINE), and Phone Number. Below these sections are links for "View PCP History", "EPSDT", "Care Gaps", and "Allergies", each with a red arrow. An "Eligibility History" section contains a table with columns for Start Date, End Date, and Product Name. The table lists two entries: one from Dec 1, 2018 to Ongoing for SSI Non-Dual, and another from May 1, 2018 to Nov 30, 2018 for TANF. A "more" link is present below the table, with a red dashed arrow pointing to a red text annotation: "Click more, to view full Eligibility History". A "View Clinical Information" link is also present at the bottom left of the main panel.

Viewing Eligibility For :  Medicaid

[Back to Eligibility Check](#)

**Overview**

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

This patient is eligible as of today, May 27, 2020.

[Print Eligibility Overview](#)

Patient Information

PCP Information

Name

Gender M

Birthdate

Age

Member #

Address

Name TERRIE

Address

Practice Type  MEDICINE

Phone Number

[View PCP History](#)

[EPSDT](#)

[Care Gaps](#)

[Allergies](#)

Risk Category Alerts: COPD/Asthma

None On File

Start Date	End Date	Product Name
Dec 1, 2018	Ongoing	SSI Non-Dual
May 1, 2018	Nov 30, 2018	TANF

[more](#)

[View Clinical Information](#)

Click more, to view full Eligibility History

# Patient Overview, cont.

[View Clinical Information](#) ←

→ Three Most Recent ER Visits

Primary Diagnosis	Date	Facility/Provider
<a href="#">EPISTAXIS</a>	10/29/2019	
<a href="#">EPISTAXIS</a>	08/28/2018	
<a href="#">PNEUMONIA UNSPECIFIED ORGANISM</a>	07/20/2018	

→ Three Most Recent Inpatient Admissions

Primary Diagnosis	Date	Facility/Provider
<a href="#">HYPERTROPHY TONSILS W/HYP ADENOIDS</a>	06/10/2019	
<a href="#">MOD PERSIST ASTHMA ACUTE EXACERBAT</a>	04/30/2019	

→ Three Most Recent Office Visits

Primary Diagnosis	Date	Facility/Provider
<a href="#">HYPERTROPHY TONSILS W/HYP ADENOIDS</a>	11/13/2019	
<a href="#">HYPERTROPHY TONSILS W/HYP ADENOIDS</a>	10/30/2019	
<a href="#">DELAYED MILESTONE IN CHILDHOOD</a>	10/03/2019	

Top 5 Most Occurring Diagnosis ←

- MIX RECEPTIVE-EXPRESSV LANGUAGE D/O
- DELAYED MILESTONE IN CHILDHOOD
- SHORT STATURE CHILD
- MOD PERSIST ASTHMA ACUTE EXACERBAT
- HYPERTROPHY TONSILS W/HYP ADENOIDS

Recent Pharmacy Activity ←

- FLOVENT HFA AER 44MCG
- MUPIROCIN OIN 2%
- CEFDINIR SUS 250/5ML

# Patient Overview – Cost Sharing

Back to Eligibility Check

Overview

**Cost Sharing**

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

Cost Sharing Summary

This member has no co-pay ← This member has no co-pay.

[Print Cost Sharing](#)

# Patient Overview – Assessments

[Back to Eligibility Check](#)

**Overview**

**Cost Sharing**

**Assessments**

**Health Record**

**Care Plan**

**Authorizations**

**Referrals**

**Coordination of Benefits**

**Claims**

**Document Resource Center**

**Notes**

**Please tell us about your patient's health**

**Child Welfare Referral Assessment**  
A Child Welfare Referral helps determine why a member is being referred to case management. [Fill Out Now!](#)

**Person Centered Service Plan (PCSP) Signature Addendum**  
Please take a few minutes to fill out the form below. [Fill Out Now!](#)

**Previous Assessments**

You have not told us about anything yet. Please fill out a form.

If notice of pregnancy (NOP) were applicable for the member, it would be available.

# Patient Overview – Health Record

Back to Authorizations

Overview

Cost Sharing

Assessments

**Health Record**

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Power Account Service Estimate

Document Resource Center

Notes

Visits Medications Immunizations Labs Allergies

Information displaying on the members health record is based on submitted claims.

Primary Diagnosis	Date	Visit Type	Claim Type	Facility/Provider
<a href="#">Low Back Pain</a>	01/08/2020 - 01/08/2020	Home	Medical	
<a href="#">Low Back Pain</a>	12/05/2019 - 12/05/2019	Home	Medical	
<a href="#">Low Back Pain</a>	11/07/2019 - 11/07/2019	Home	Medical	
<a href="#">Htn Heart Disease W/Heart Fail</a>	11/01/2019 - 11/01/2019	Inpatient Hospital	Medical	
<a href="#">Cellulitis Of Right Lower Limb</a>	10/31/2019 - 11/01/2019	Inpatient Hospital	Medical	
<a href="#">Cellulitis Of Right Lower Limb</a>	10/30/2019 - 10/30/2019	Inpatient Hospital	Medical	
<a href="#">Primary Osteoarthritis Rt Shoulder</a>	10/30/2019 - 10/30/2019	Inpatient Hospital	Medical	
<a href="#">Oth Nonspecific Abn Find Lng Field</a>	10/30/2019 - 10/30/2019	Outpatient Hospital	Medical	

# Patient Overview – Care Plan

[Back to Authorizations](#)

Care Plans come from the clinical system  
These care plans are setup with the case manager(s) for the patient.

Overview

Cost Sharing

Assessments

Health Record

**Care Plan**

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

This member's care plan to treat: Case Worker

## Integrated Care

05/12/2020 - OPEN

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### Member is hospitalized

Goal: **Member will transition from hospital to home setting with appropriate support in place. by 2020-06-16**

**Member is a young adult and may still be dependent on older adults/ family members to successfully n may be a barrier to success**

**What we're doing:**

2020-06-16	CM will communicate with member/member family &/or inpatient case management/discharge planning and assist with member's transition to home setting as needed.
2020-06-16	Member/ member family will communicate with inpatient case management/discharge planning/ CM regarding status of ongoing home health needs and preferences

# Patient Overview – Authorizations

[Back to Authorizations](#) [Member ID]

When viewing a member's authorizations, the list will display the last 18 months, regardless of the submitting provider.

STATUS	AUTH NBR	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	IP190	02/04/2020	12/31/9999	E87.6	INPATIENT	Medical
APPROVE	IP179	10/29/2019	11/01/2019	I50.9	INPATIENT	Medical
APPROVE	IP167	07/19/2019	07/22/2019	L03.115	INPATIENT	Medical
APPROVE	OP16	07/09/2019	09/06/2019	Z48.01	OUTPATIENT	Home Health
PARTIAL_APPROVE	IP162	06/08/2019	06/25/2019	L03.90	INPATIENT	Medical
APPROVE	IP161	05/21/2019	05/24/2019	L03.90	INPATIENT	Medical
APPROVE	IP158	04/24/2019	04/29/2019	I50.9	INPATIENT	Medical

[Create a New Authorization](#)

Click an Auth NBR to view the authorization details

Click **Create a New Authorization**, to submit a web authorization request for the member

- Overview
- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations**
- Referrals
- Coordination of Benefits
- Claims
- Power Account Service Estimate
- Document Resource Center
- Notes

# Patient Overview – Referrals

[Back to Authorizations](#) **XXXXXX-XXXXXX**

- Overview
- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations
- Referrals**
- Coordination of Benefits
- Claims
- Power Account Service Estimate
- Document Resource Center
- Notes

\*Source

\*Date

Last Name, First Name

Phone Number, Extension

Additional Comments

Utilizing Referrals, allows providers to submit a member for assistance from care management(options may vary by state).

# Patient Overview – Coordination of Benefits

[Back to Authorizations](#)

**Overview**

**Cost Sharing**

**Assessments**

**Health Record**

**Care Plan**

**Authorizations**

**Referrals**

**Coordination of Benefits**

**Claims**

**Document Resource Center**

**Notes**

[Print Coordination of Benefits](#)

Effective Date	Term Date	Policy Number	Group Number	Carrier Name	Coverage
07/01/2016	12/31/9999			BC BS	MEDICAL AND HOSPITAL MO

Coordination of Benefits (COB) information on file for the member displays here.

# Patient Overview – Claims

[Back to Eligibility Check](#)

**Overview**

**Cost Sharing**

**Assessments**

**Health Record**

**Care Plan**

**Authorizations**

**Referrals**

**Coordination of Benefits**

**Claims**

**Document Resource Center**

**Notes**

**Claims: Recent**

Click **Create a New Claim**, to submit a web claim for the member. -----> [Create a New Claim](#)

The last one month of claims for this member are displayed below. To view more claims for this member, [visit the Claims page](#).

Show claims for   [GO](#) [View most recent month](#)

CLAIM NO. ↑	REF/ACCT NO. ↑	DOS RANGE ↑	PAYMENT DATE ↑	RECEIVED DATE ↑	BILLED/ PAID ↑	STATUS ↑
<a href="#">T148</a>		05/22/2020 - 05/22/2020	06/04/2020	05/27/2020	\$643.00 / \$1	PAID
<a href="#">T150</a>		05/22/2020 - 05/22/2020	06/04/2020	05/29/2020	\$75.00 / \$2	PAID
<a href="#">T153</a>		05/22/2020 - 05/22/2020		06/01/2020	\$145.00 / \$9	PAID

3 items found, displaying all items. Page 1/1 1

Click **Claim Number**, to view the claims details

# Patient Overview – Document Resource Center

Back to Eligibility Check

Documents for the member can be uploaded here based on Document Category options. Options may vary by Health Plan.

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

**Document Resource Center**

Notes

**Document Upload** | **Document Review**

1. Document Category:
2. Document Type:
3. Upload File:  No file chosen
4.



**Tips:** The 1<sup>st</sup> page of the document, should include:

- Reason for upload (i.e. Requested clinical documents, etc.)
- Authorization #, if applicable
- The file size limit for the Document Resource Center is 10MB.

# Patient Overview – Notes

[Back to Authorizations](#)

**Notes**

**Create a New Note**

General Note [Write Note](#)

Previous Notes	Date
<a href="#">General Note</a>	Oct 15, 2019
<a href="#">General Note</a>	Jan 29, 2020

Allows portal users to create and view notes regarding the member.

**Notes**

- Overview
- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations
- Referrals
- Coordination of Benefits
- Claims
- Document Resource Center

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# Document Resource Center: Sterilization Consent Form Submission

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# Secure Portal Submission Process for Sterilization Consent Forms

- Carolina Complete Health Providers can now submit Sterilization Consent Forms (SCFs) through the secure portal in advance of the claim submission.
- CCH providers can also view the status of SCF, both portal submitted and mail submitted, in the portal.
- Please refer to [Medicaid Clinical Coverage Policy 1E-3](#) for additional details and guidance around Sterilization Procedures and Consent Forms.

# Document Resource Center: Upload

- Under Document Resource Center, under Document upload. Must have to choose Document Category as “Consent Forms” and Document Type as “Correspondence” and choose file within the size limit.



**Tip:** Prior to uploading, save the file to your computer with ‘Consent-Form’ in the naming convention.

The screenshot shows the 'Document Resource Center' interface. On the left is a navigation menu with items: Overview, Cost Sharing, Assessments, Growth Chart, Health Record, NC Kids InCK Program, ADT, Care Plan, Authorizations, Referrals, Coordination of Benefits, Claims, Document Resource Center (highlighted with a red box), and Notes. The main content area is titled 'Document Resource Center' and has two tabs: 'Document Upload' (active) and 'Document Review'. The upload form contains four numbered steps:

1. Document Category \* (dropdown menu set to 'Consent Forms')
2. Document Type \* (dropdown menu set to 'Correspondence')
3. Upload File \* (button 'Choose File' next to 'No file chosen')
4. Submit (green button)

At the top of the page, there is a header with the Carolina Complete Health logo and navigation icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below the header, there are filters for 'Viewing Patients For: TIN' and 'Plan Type: Carolina Complete Health', along with a 'GO' button and a 'Find Patient' button.

# Document Resource Center

- After the file is successfully uploaded, you will see the message indicating 'Document Upload Accepted.'

The screenshot displays the 'Document Resource Center' interface. At the top, there is a navigation bar with the 'carolina complete health' logo and icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this is a search bar with fields for 'Viewing Patients For: TIN', 'Plan Type' (set to 'Carolina Complete Health'), 'Member ID or Last Name', and 'Birthdate' (set to '09/09/1964'). A 'GO' button and a 'Find' button are also present.

The main content area is titled 'Document Resource Center' and features a 'Document Upload' button and a 'Document Review' button. Below these buttons is a form with four steps:

1. Document Category \* (Please Select a category)
2. Document Type \* (Please Select one)
3. Upload File \* (Choose File) No file chosen
4. Submit

A green message box at the bottom of the form indicates a successful upload: 'Document Upload Accepted. If needed, this document ID can be used for tracking purposes: e27d1959-41af-45dc-980c-ca043d1d9cd5'. This message box is highlighted with a red border.

# Document Review

- To view the uploaded documents, select Document Review
- Select Document Category “consent Forms” and Date Range “Start Date” & “End Date”
- This will display the files from the search criteria
- The File Name is listed as “Correspondence\_{FileName}” with status indicated



**Tip:** The Document Review tab will also show the status of mailed Consent Forms

The screenshot shows the 'Document Resource Center' interface. On the left is a navigation menu with options like Overview, Cost Sharing, Assessments, Growth Chart, Health Record, NC Kids InCK Program, ADT, Care Plan, Authorizations, Referrals, Coordination of Benefits, Claims, Document Resource Center (highlighted), and Notes. The main content area has a 'Document Upload' tab and a 'Document Review' tab (highlighted). Below the tabs are search filters: 1. Document Category (set to 'Consent Forms'), 2. Date Range (Start Date: 08/07/2023, End Date: 08/14/2023), and 3. A 'Search Documents' button. A yellow note states: 'Please note: There may be a delay when downloading large files.' Below this is a table of documents:

FILE NAME	STATUS
Correspondence_9-MB.pdf	Submitted
Correspondence_2-kb-3.pdf	Submitted

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# Portal Functionality: Patients

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# Patient List

Primary Care Providers are able to view and download a list of their assigned members. The Patient List displays:

- Member Name
- Member ID #
- DOB
- Preferred language
- Eligibility status
- Phone number
- Alerts

# Patient List

Eligibility **Patients** Authorizations Claims Messaging

Viewing Patients For : TIN 1799 Plan Type Medicaid GO Find Patient

Patient List as of 07/31/2020 Download Filter

This is only a list of your patients, please check eligibility to confirm the effective date and benefits for this member.

Eligible	Preferred Language ↑	Member Name ↑	Member ID ↑	Date of Birth ↑	Phone Number ↑	ALERTS
👍		[blurred]	[blurred]	[blurred]	[blurred]	No HRA
👍		[blurred]	[blurred]	[blurred]	[blurred]	CG No HRA
👍		[blurred]	[blurred]	[blurred]	[blurred]	No HRA
👍		[blurred]	[blurred]	[blurred]	[blurred]	CG No HRA
👍		[blurred]	[blurred]	[blurred]	[blurred]	CG No HRA
👍		[blurred]	[blurred]	[blurred]	[blurred]	NM No HRA
👍		[blurred]	[blurred]	[blurred]	[blurred]	NM No HRA
👍		[blurred]	[blurred]	[blurred]	[blurred]	NM No HRA
👍		[blurred]	[blurred]	[blurred]	[blurred]	NM No HRA
👍		[blurred]	[blurred]	[blurred]	[blurred]	No HRA

2,146 items found, displaying 1 to 10. Page 1/215 1.2.3.4.5.6.7.8 Next Last

Click **Download** to export the Patient List into Excel.

Click **Filter** to access filter options.

Filter By:

Provider NPI Provider Medicaid Number

Member Last Name

- Care Gaps
- Case Management
- Emergency Department
- Special Needs
- Preferred Language
- Disease Management
- New Member
- No HRA

Go! Clear

# Patients Tips

- Patients tab is only applicable to AMHs / AMH organizations
- Click on a member's name to access their eligibility, health record, etc. information
- Patients list can be exported to excel for more filtering options

---

# Portal Functionality: Authorizations

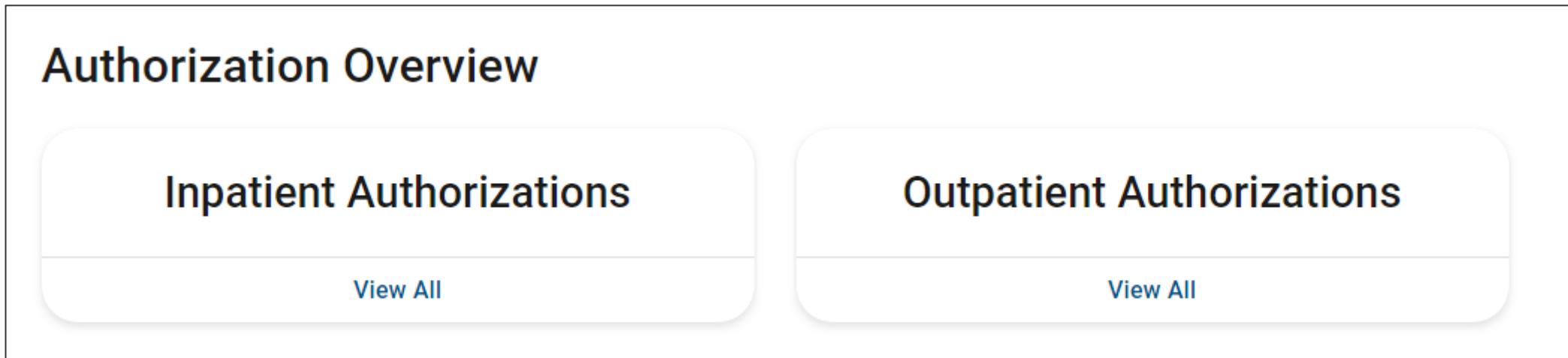
---

# Authorizations

Providers are able to use the portal to submit web authorization requests and view 18 months of authorization history.

# View Authorizations (Quick Actions)

On Landing Page, scroll down to Authorization Overview, and view Inpatient or Outpatient Authorizations



**Authorization Overview**

**Inpatient Authorizations**  
[View All](#)

**Outpatient Authorizations**  
[View All](#)

# View Authorizations

To access authorization information or create and submit a web authorization request, click **Authorizations**. The Authorizations Summary displays.



**Tip:** The member drives Plan Type selection. For example, an Ambetter member will not pull up under Medicaid. To find an Ambetter member, the Plan Type must be 'Ambetter'.

# Authorizations Summary

Eligibility Patients **Authorizations** Claims Messaging Help

Viewing Authorizations For : TIN [ ] Plan Type Medicaid [ ] GO Create Authorization

Authorizations Processed Errors Disclaimer Filter

Please call the health plan for questions regarding voided authorization

STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	IP186		05/12/2020	12/31/9999	M16.11	INPATIENT	Surgical
APPROVE	IP190		02/28/2020	12/31/9999	Z79.2	INPATIENT	Skilled Nursing
APPROVE	OP18		02/27/2020	03/27/2020	M21.961	OUTPATIENT	Outpatient Surgery
APPROVE	OP18		02/19/2020	03/21/2020	S83.512A	OUTPATIENT	Outpatient Surgery
APPROVE	IP187		02/17/2020	12/31/9999	R10.2	INPATIENT	Surgical
PEND	IP190		02/11/2020	12/31/9999	D57.00	INPATIENT	Medical
APPROVE	IP190		02/08/2020	12/31/9999	J18.9	INPATIENT	Medical
APPROVE	OP18		02/07/2020	05/07/2020	E66.01	OUTPATIENT	Outpatient Services
APPROVE	IP190		02/07/2020	02/11/2020	J10.1	INPATIENT	Medical

Displays authorizations submitted under TIN, for the last 90 days, in order based on From date, regardless how they were submitted.

Click **Filter** to access filter options

Click an **Auth ID** to view authorization details

# Authorization Details

[Back to Authorizations](#)

**Overview**

**Cost Sharing**

**Assessments**

**Health Record**

**Care Plan**

**Authorizations**

**Referrals**

**Coordination of Benefits**

**Claims**

**Document Resource Center**

**Notes**

**Auth Status:** APPROVE  
**Auth Nbr:** IP19: [REDACTED]  
**Admit Date:** 05/12/2020  
**Provider of Service(s):** [REDACTED]  
**Diagnosis Code(s):** T21.31XA

**Explanation:** Pay  
**Auth Type:** INPATIENT  
**Service:** Surgical  
**Discharge Date:** 05/20/2020  
**Procedure Code(s):** 99221

**Notes & Attachments:** [View](#)

Line Item	Service type	From Date	To Date	Stay Level	Location	Status	Medical Necessity	Decision Date
1	Medical	05/12/2020	05/13/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/13/2020
2	Medical	05/13/2020	05/14/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/14/2020
3	Medical	05/14/2020	05/15/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/15/2020
4	Medical	05/15/2020	05/18/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/18/2020
5	Surgical	05/18/2020	05/19/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/19/2020
6	Surgical	05/19/2020	05/20/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/20/2020

[Back to Authorization List](#)

# Authorization Details Links and Pop-Up

Back to Authorizations

**Overview**

Auth Status: APPROVE  
 Auth Nbr: IP19S  
 Admit Date: 05/12/2020  
 Provider of Service(s): HOSPITAL

**Cost Sharing**

**Assessments**

**Health Record**

**Care Plan**

**Authorizations**

**Referrals**

**Coordination of Benefits**

**Claims**

Explanation: Pay  
 Auth Type: INPATIENT  
 Service: Surgical  
 Discharge Date: 05/20/2020

Diagnosis Code(s): T21.31XA  
 R69  
 T21.11XA

Procedure Code(s): 99221  
 99231

Notes & Attachments: View

Click hyperlink(s) to view additional codes

Hover your mouse over a Line Item to view the CPT, REV or HCPC code associated with it

Line Item	Service type	From Date	Medical Necessity	Decision Date
1	Medical	05/12/2020	Met as requested	05/13/2020
2	Medical	05/13/2020	Met as requested	05/14/2020
3	Medical	05/14/2020	Met as requested	05/15/2020
4	Medical	05/15/2020	Met as requested	05/18/2020

**Diagnosis and Procedure Codes**

Primary Diagnosis Code: T21.31XA  
 Additional Diagnosis Codes: R69 T21.11XA  
 Primary Procedure Code: 99221  
 Additional Procedure Codes: 99221

# Create Authorization (Quick Actions)

From the portal landing page, under Quick Actions

1. Enter Member ID or Last Name
2. Enter Member DOB
3. Select Create Authorization from the 'Select Action Type' menu and hit submit

**Quick Actions**  
Do a quick eligibility check, find patient benefits information, create a new claim or recurring claim or an authorization.

Member ID or Last Name \*

Member Date of Birth    
MM/DD/YYYY

Select Action Type \*  
Select 

- View Eligibility & Patient Information
- Create New Claim
- Create Recurring Claim
- Create Authorization

**SUBMIT**

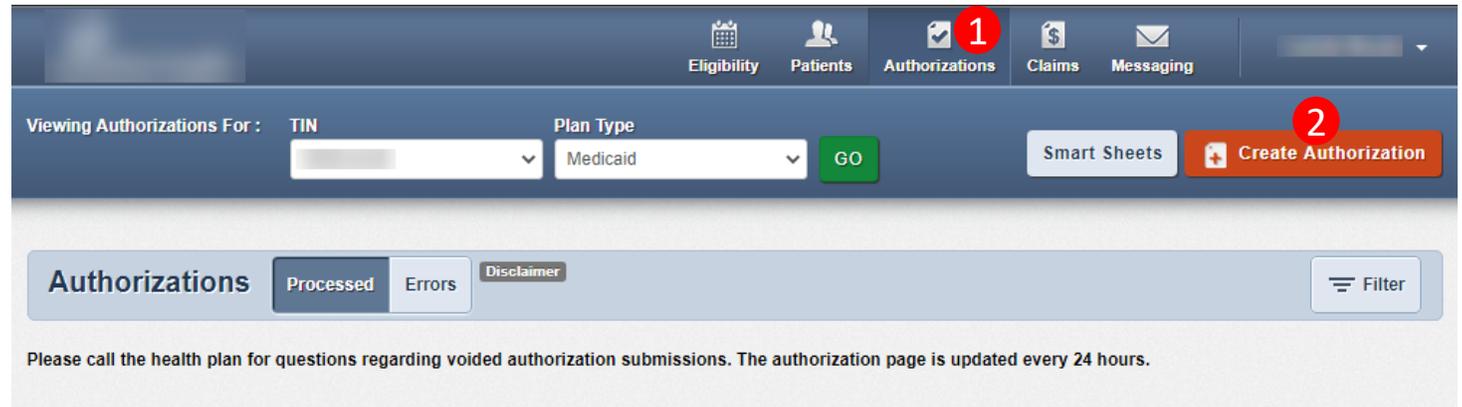
**Claims Overview**  
Shows claims for the last 30 days from today's date.

REJECTED DENIED PENDING

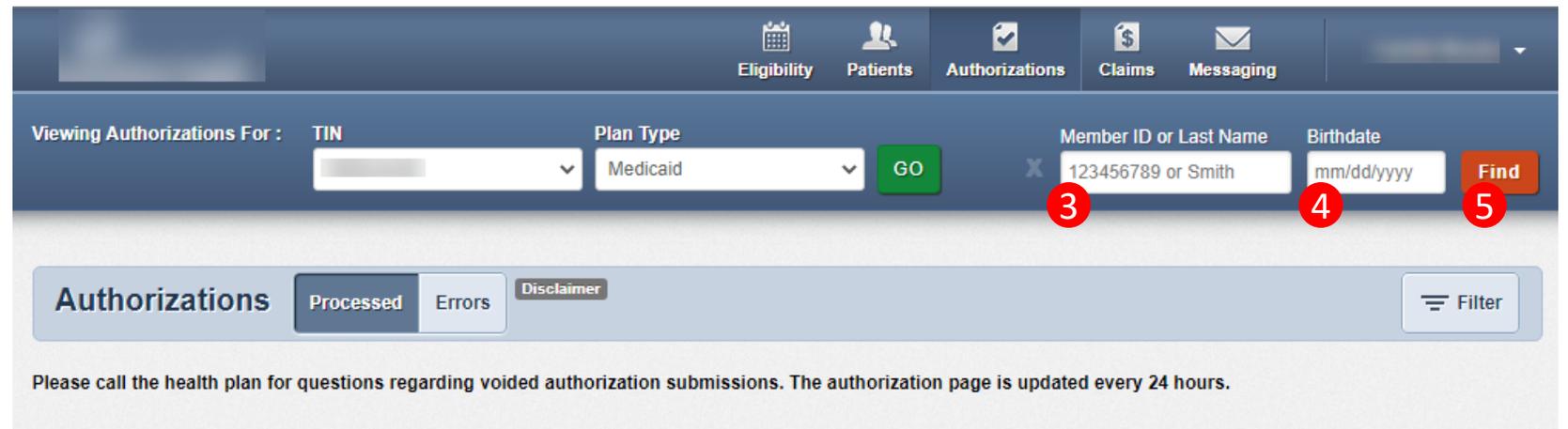
# Create Authorization (Web Authorization Request)

To begin a web authorization request:

1. Click **Authorizations**.
2. **Create Authorization**.
3. Enter **Member ID or Last Name**.
4. Enter Member's **Birthdate**.
5. Click **Find**. The web authorization request displays.



The screenshot shows the top navigation bar with 'Authorizations' highlighted and circled with a red '1'. Below the navigation bar, there are filters for 'Viewing Authorizations For : TIN' and 'Plan Type' (Medicaid), with a 'GO' button. To the right, there is a 'Smart Sheets' button and a red 'Create Authorization' button circled with a red '2'. Below this, there is a section for 'Authorizations' with tabs for 'Processed', 'Errors', and 'Disclaimer', and a 'Filter' button. A disclaimer message is visible at the bottom of the section.



The screenshot shows the same interface as the previous one, but with the 'Find' button circled with a red '5'. The search fields are now filled: 'Member ID or Last Name' contains '123456789 or Smith' (circled with a red '3') and 'Birthdate' contains 'mm/dd/yyyy' (circled with a red '4'). The 'GO' button is still present, and the 'Create Authorization' button is no longer visible.



**Tip:** You cannot create a web authorization on an ineligible member.

# Create Authorization (Web Authorization Request)

Viewing Patients For : TIN [ ] Plan Type Medicaid [ ] GO Smart Sheets Create Authorization

**Authorization For**

DOB: [ ] MEDICAID NBR: [ ]

After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 866-246-4358 for after-hours urgent admission, inpatient notifications or requests.

Please select Service Type.

**Enter Authorization**

**1. PROVIDER REQUEST**

Select a Service Type [ ]

NEXT >

**2. SERVICE LINE**

**3. FINISH UP**

**Tip:** Use the **Tab** key (on your keyboard) to move to fields in a web authorization request.

# Web Authorization

## Web Authorization

- Authorization Type-driven
- Streamlined

The screenshot displays a web application interface for managing authorizations. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this, a header section shows 'Viewing Authorizations For : TIN' and 'Plan Type' with a dropdown menu set to 'Medicaid' and a 'GO' button. To the right of the header are buttons for 'Smart Sheets' and 'Create Authorization'. The main content area is divided into two sections. On the left, a dropdown menu is open, showing the following options: 'Select an Authorization Type', 'Inpatient Medical', 'Outpatient Medical', 'Inpatient Behavioral', and 'Outpatient Behavioral'. On the right, a '1. PROVIDER REQUEST' section contains a 'Select an Authorization Type' dropdown menu, a 'NEXT >' button, and a red dashed arrow pointing from the dropdown menu to the 'NEXT >' button. Below this section is a '3. FINISH UP' section.

# Authorization Tips

- Always check the member's eligibility before submitting an authorization request
  - A web authorization **cannot** be submitted on an ineligible member
- **Web authorizations generally load in processing queue within seconds of submission**
- Up to five (5) separate documents can be attached to a web authorization request
- Always use the confirmation number to check the status of the request
  - This is the only way a portal user will see a web authorization error
  - Web authorization errors are uncommon, but when an error is encountered the web authorization request will not load, and thereby will not be processed
    - ❖ Please submit the authorization request by phone or fax
    - ❖ Notify the Health Plan and provide the web authorization confirmation number for research

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# Portal Functionality: Claims

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# Claims

Providers are able to use the portal to:

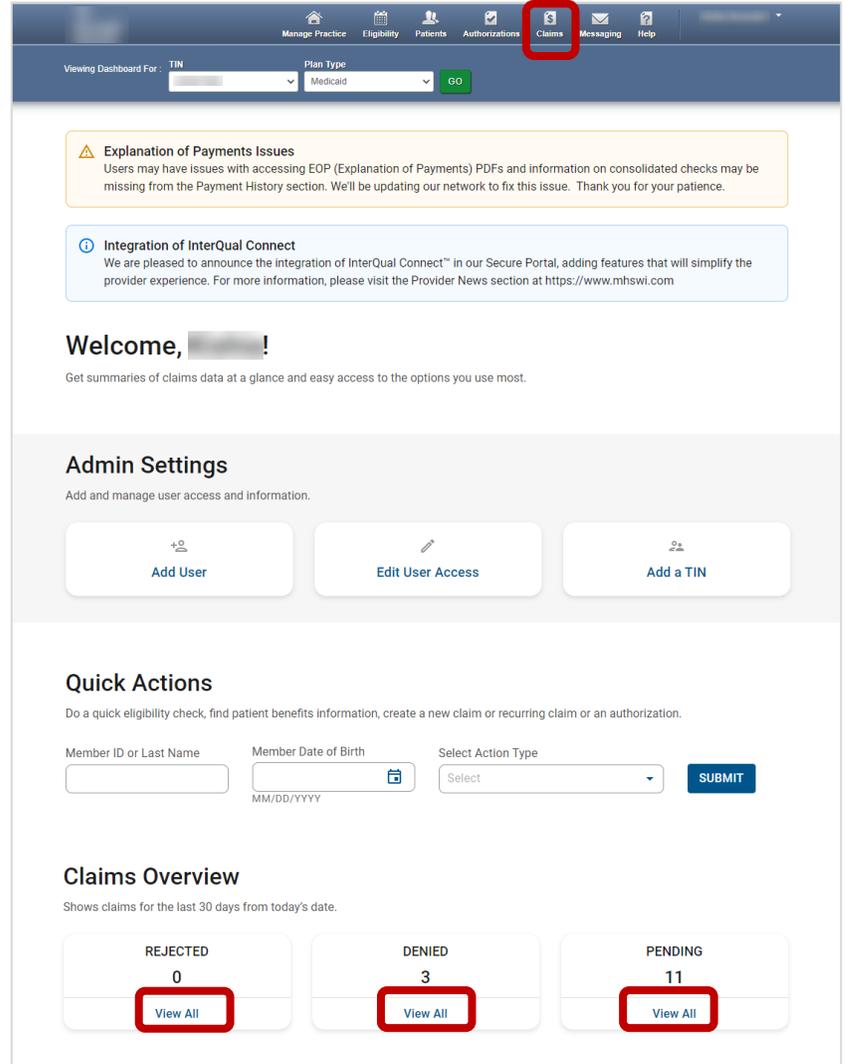
- Access up to 24 months of claims-related history
- Submit new claim
- Correct claims
- Batch claims

# Accessing Claims

To access all claim-related information, click **Claims** in the portal toolbar.

Under Claims Overview, to access claims in the associated status count, click **View All**.

 **Tip:** Navigating to Rejected, Denied, and/or Pending claims, [each] will open in a new tab or window. Once you are finished reviewing the selected information, close the tab or window to prevent system performance issues.



The screenshot shows the Claims portal interface. The top navigation bar includes links for Manage Practice, Eligibility, Patients, Authorizations, **Claims** (highlighted with a red box), Messaging, and Help. Below the navigation bar, there are filters for TIN and Plan Type (Medicaid) with a GO button. The main content area features several sections:

- Explanation of Payments Issues:** A warning message about missing PDFs and consolidated checks.
- Integration of InterQual Connect:** A blue informational message about new features.
- Welcome, [User Name]!** A greeting with a sub-header: "Get summaries of claims data at a glance and easy access to the options you use most."
- Admin Settings:** A section for adding and managing user access, containing buttons for "Add User", "Edit User Access", and "Add a TIN".
- Quick Actions:** A form for quick eligibility checks with fields for Member ID or Last Name, Member Date of Birth (MM/DD/YYYY), and a dropdown for Select Action Type, followed by a SUBMIT button.
- Claims Overview:** A section showing claims for the last 30 days, with three status categories: REJECTED (0), DENIED (3), and PENDING (11). Each category has a "View All" button (highlighted with a red box).

# Claims Dashboard

The screenshot displays the Claims Dashboard interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a header section allows filtering by TIN and Plan Type (Medicaid). The main content area is titled 'Claims' and features a date range selector (From: 01/19/2023, To: 02/18/2023) and a 'CHANGE DATES' button. Three status tiles are shown: REJECTED (0), DENIED (125), and PENDING (656), each with a 'View All' link. Below these is a 'Search for Claims' section with an 'ADVANCED SEARCH' link and a note about data availability. It includes two search methods: 'Check Status by Claim Number' and 'Search by Member Info'. The 'Create Claims' section offers options to 'Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim' or 'Upload EDI / Batch', along with a 'DRAFT CLAIMS' tile (0). The 'Manage Finances' section includes an 'Explanation of Payment (EOP)' link, 'Reports & Tools' (Batch Claims Report, Claim Audit Tool), and a 'PAID CLAIMS' tile (672). Finally, the 'Resources' section lists links for 'Updated Instruction Manual (PDF)', 'EDI Guide (PDF)', 'CMS-1500 Claim Form (PDF)', and 'CMS-UB-04 Claim Form'. A footer contains links for 'Instruction Manual (PDF)', 'Terms and Conditions', 'Privacy Policy', and 'Copyright © 2023, Centene Corporation'.

- The new Claims Dashboard provides an easy view and access to claims / claims-related information:
  - Claims Tiles by status
  - Claim Search options
  - Claim Submission Methods
  - Managing Finances (i.e., EOPs, Paid Claims, etc.)
  - Claim Audit Tool, *where available*
  - Resources

# Claims Dashboard – Change Dates

The screenshot shows a web application interface for a Claims Dashboard. At the top, there are navigation tabs: Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this is a header with 'Viewing Claims For' and 'Plan Type' dropdown menus, with 'Medicaid' selected. The main content area is titled 'Claims' and features a date range selector with 'From' (01/19/2023) and 'To' (02/18/2023) fields, both with calendar icons, and a 'CHANGE DATES' button. Below the date selector are three summary cards: 'REJECTED 0', 'DENIED 125', and 'PENDING 656', each with a 'View All' link. A note below these cards states 'Shows claims for the last 30 days, from today's date.' The 'Search for Claims' section includes an 'ADVANCED SEARCH' link and a note that data is limited to the last 30 days. It offers two search methods: 'Check Status by Claim Number' and 'Search by Member Info'. The 'Create Claims' section has options to 'Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim' or 'Upload EDI / Batch', with a 'DRAFT CLAIMS 0' card and 'View All' link. The 'Manage Finances' section includes 'Explanation of Payment (EOP)', 'Reports & Tools' (Batch Claims Report, Claim Audit Tool), and a 'PAID CLAIMS 672' card with 'View All' link. The 'Resources' section lists links for 'Updated Instruction Manual (PDF)', 'CMS-1500 Claim Form (PDF)', 'CMS-UB-04 Claim Form', and 'EDI Guide (PDF)'. The footer contains links for 'Instruction Manual (PDF)', 'Terms and Conditions', 'Privacy Policy', and 'Copyright © 2023, Centene Corporation'.

- Informational text displays immediately under the date fields providing required date format.
- Dates can be manually entered or pasted in the From / To boxes.
- Calendar pop-up makes it easier to change dates.
- Once a date is selected, informational text displays in red to provide guidance.

# Claims Dashboard – Change Dates Calendar Options

There are two ways to change the date range.

## Manually

1. Type desired date range in **From** and **To** fields.
2. Click **CHANGE DATES**. The page will refresh to display Rejected, Denied, and Pending counts for the new date range.

## Calendar Pop-Up

1. Click Calendar icon. The calendar pop-up displays.
2. Use the arrows to view and select desired date in **From** and **To** fields.
3. Click **CHANGE DATES**. The page will refresh to display Rejected, Denied, and Pending counts for the new date range.



## Claims

From: 10/09/2022 To: 11/08/2022 **CHANGE DATES**

MM/DD/YYYY MM/DD/YYYY

October 2022 **< >** DENIED 44 [View All](#)

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

October 2022

2012	2013	2014	2015
2016	2017	2018	2019
2020	2021	2022	2023
2024	2025	2026	2027
2028	2029	2030	2031



## Tips:

- Portal users can access up to 24 months of claim history. The key is the first DOS in the claim must be within the last 24 months from the current date.
- Date Range is limited to a 30-day span at a time.

# Claims Dashboard – Claim Status Tiles

The screenshot displays the Claims Dashboard interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a filter bar shows 'Viewing Claims For: TIN' and 'Plan Type: Medicaid'. The main section is titled 'Claims' and includes a date range selector from 01/19/2023 to 02/18/2023. A red box highlights three status tiles: REJECTED (0), DENIED (125), and PENDING (656). Below these are search options for 'Search for Claims' and 'Check Status by Claim Number'. The 'Create Claims' section includes links for 'Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim' and 'Upload EDI / Batch'. A red box highlights a 'DRAFT CLAIMS' tile showing 0. The 'Manage Finances' section includes 'Explanation of Payment (EOP)' and 'Reports & Tools'. A red box highlights a 'PAID CLAIMS' tile showing 672. The 'Resources' section lists various PDF guides. The footer contains links for 'Instruction Manual (PDF)', 'Terms and Conditions', 'Privacy Policy', and 'Copyright © 2023, Centene Corporation'.

- The Claims Status Tiles displays the count for the respective status.
- Informational note displays advising 30-day default display.
- Portal users click **View All** to access claims based on status.

# Claims Dashboard – Search for Claims

The screenshot displays the Claims Dashboard interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a header section allows users to filter claims by TIN and Plan Type (Medicaid). The main content area is divided into several sections:

- Claims:** A section with date filters (From: 01/19/2023, To: 02/18/2023) and a 'CHANGE DATES' button. It shows three categories: REJECTED (0), DENIED (125), and PENDING (656), each with a 'View All' link.
- Search for Claims:** A section highlighted with a red border, containing an 'ADVANCED SEARCH' link and a note about search limitations. It has two sub-sections: 'Check Status by Claim Number' with a 'CHECK' button, and 'Search by Member Info' with fields for Last Name or Member ID and Date of Birth, and a 'SEARCH' button.
- Create Claims:** A section with links for 'Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim' and 'Upload EDI / Batch'. It shows 'DRAFT CLAIMS' (0) with a 'View All' link.
- Manage Finances:** A section with links for 'Explanation of Payment (EOP)' and 'Reports & Tools' (Batch Claims Report, Claim Audit Tool). It shows 'PAID CLAIMS' (672) with a 'View All' link.
- Resources:** A section with links to 'Updated Instruction Manual (PDF)', 'EDI Guide (PDF)', 'CMS-1500 Claim Form (PDF)', and 'CMS-UB-04 Claim Form'.

At the bottom, there are links for 'Instruction Manual (PDF)', 'Terms and Conditions', 'Privacy Policy', and 'Copyright © 2023, Centene Corporation'.

- Claims search options from the claims dashboard.
- Portal users can search up to 10 claims at once, by adding a comma, after each Claim Number, but no space following the comma(s).
- Search button, replaced with a hyperlink, and renamed Advanced Search.

# Claims Dashboard – Claims Search Options

In the portal, there are three ways to search for claims:

1. Complete the **Check Status by Claim Number**
2. Complete the **Search by Member Info**, or
3. Use the **Advanced Search**

The screenshot displays the Claims Dashboard interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help, along with a user profile for Bruce Provider. Below the navigation bar, there are filters for 'Viewing Claims For:' with a TIN dropdown set to '12345678' and a Plan Type dropdown set to 'Iowa Total Care', followed by a green 'GO' button. The main section is titled 'Claims' and features a date range selector with 'From' (03/29/2022) and 'To' (04/28/2022) fields, each with a calendar icon, and a 'CHANGE DATES' button. Below this, three summary cards are shown: 'REJECTED' with a count of 08, 'DENIED' with a count of 23, and 'PENDING' with a count of 58. Each card has a 'View All' link. A note below the cards states: 'Shows claims for the last 30 days, from today's date.' At the bottom, there are two search sections. The 'Search for Claims' section is highlighted with a red box and contains a sub-section 'Check Status by Claim Number' with an input field for 'Enter Claim Number' and a 'CHECK' button. The 'Advanced Search' section is also highlighted with a red box and contains a sub-section 'Search by Member Info' with input fields for 'Enter Last Name or Member ID' and 'Date of Birth' (with a calendar icon), and a 'SEARCH' button.



**Tip:** In the Check Status by Claim Number, enter up to 10 Claim Numbers separated by commas, but no spaces. For example, you would enter V290XXP00010,V300XXE07468,V305XXE01234 (no space after the comma and upper-case letters).

# Claims Dashboard – Advanced Search

**Advanced Search** ×

Search by one or more of the following:  
Note: Last Name searches are more effective when member DOB is provided. Service Date Range is searchable 30 days at a time.

Member Last Name

Member ID

Member DOB  
   
MM/DD/YYYY

Provider NPI

Claim Number  
  
Enter up to 10, separated by commas

Reconsideration Number

**SEARCH**

- Search pop-up renamed “Advanced Search”.
- Right scrollbar added, to view available options.
- Can search up to 10 Claim Numbers by separating them by a comma, but no spaces.
- Portal users can search by Total Charged Amount.
- Field errors provide data and/or format guidance.

# Claims Dashboard – Advanced Search Onscreen Errors

Onscreen errors provide guidance on acceptable format and/or data.

**Advanced Search** [X]

Search by one or more of the following:  
Note: Last Name searches are more effective when member DOB is provided.

Member Last Name  
Smith9 [v]  
*Only enter letters, apostrophe, and hyphen in this field*

Member ID  
& [v]  
*Special characters are not accepted in this field*

Member DOB  
[calendar icon]  
MM/DD/YYYY

Provider NPI  
98765432A [v]  
*Only enter numbers in this field*

Claim Number  
& [v]  
*Special characters are not accepted in this field*

Reconsideration Number  
& [v]  
*Special characters are not accepted in this field*

Service Date Range  
From To  
01/10/2022 [v] 01/01/2022 [v]  
*Enter date prior to To date Enter date after From date*

Total Charged Amount  
Greater than Less than  
[input] [input]

SEARCH

**Advanced Search** [X]

Search by one or more of the following:  
Note: Last Name searches are more effective when member DOB is provided.

Member Last Name  
Smith9 [v]

Member ID  
[input]  
*Only enter letters and a hyphen in this field*

Member DOB  
[calendar icon]  
MM/DD/YYYY

Provider NPI  
98765432A [v]  
*Only enter numbers in this field*

Claim Number  
& [v]  
*Special characters are not accepted in this field*

Reconsideration Number  
& [v]  
*Special characters are not accepted in this field*

Service Date Range  
From To  
01/10/2023 [v] 01/31/2023 [v]  
*Date cannot be in the future Date cannot be in the future*

Total Charged Amount  
Greater than Less than  
[input] [input]

SEARCH

**Advanced Search** [X]

Search by one or more of the following:  
Note: Last Name searches are more effective when member DOB is provided.

Member Last Name  
Smith9 [v]

Member ID  
[input]  
*Only enter letters and a hyphen in this field*

Member DOB  
[calendar icon]  
MM/DD/YYYY

Provider NPI  
98765432A [v]  
*Only enter numbers in this field*

Claim Number  
& [v]  
*Special characters are not accepted in this field*

Reconsideration Number  
& [v]  
*Special characters are not accepted in this field*

Service Date Range  
From To  
01/10/2022 [input] [v]  
MM/DD/YYYY *Enter a date*

Total Charged Amount  
Greater than Less than  
[input] [input]

SEARCH

# Claims Dashboard – Create Claims

The screenshot displays the Claims Dashboard interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a header section allows filtering by TIN and Plan Type (Medicaid). The main content area is divided into several sections:

- Claims:** A summary section with date filters (From: 01/19/2023, To: 02/18/2023) and three status cards: REJECTED (0), DENIED (125), and PENDING (656). Each card has a 'View All' link.
- Search for Claims:** A section with an 'ADVANCED SEARCH' link and a note that data is limited to the last 30 days.
- Check Status by Claim Number:** A form to enter a claim number and a 'CHECK' button.
- Search by Member Info:** A form to enter a last name or member ID and a date of birth, with a 'SEARCH' button.
- Create Claims:** A section highlighted with a red border, containing two links: 'Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim' and 'Upload EDI / Batch'. It also features a 'DRAFT CLAIMS' card showing 0 claims and a 'View All' link.
- Manage Finances:** A section with links for 'Explanation of Payment (EOP)', 'Reports & Tools' (Batch Claims Report, Claim Audit Tool), and a 'PAID CLAIMS' card showing 672 claims.
- Resources:** A section with links to 'Updated Instruction Manual (PDF)', 'CMS-1500 Claim Form (PDF)', 'CMS-UB-04 Claim Form', and 'EDI Guide (PDF)'.

At the bottom, there are links for 'Instruction Manual (PDF)', 'Terms and Conditions', 'Privacy Policy', and 'Copyright © 2023, Centene Corporation'.

- From the landing page, scroll down to Create Claim options.
- Replaced Create Claim button, with “Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim”.
- Member Eligibility check added and required to create an Institutional or Professional claim.
- Easy access to Draft Claims, Recurring (*where available*), and Upload EDI / Batch.

# Claims Dashboard – Manage Finances

The screenshot shows the 'Claims' dashboard interface. At the top, there are navigation tabs: Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, there are filters for 'Viewing Claims For' (TIN) and 'Plan Type' (Medicaid), with a 'GO' button. The main section is titled 'Claims' and includes a date range selector (From: 01/19/2023, To: 02/18/2023) and a 'CHANGE DATES' button. Three summary cards are displayed: 'REJECTED 0', 'DENIED 125', and 'PENDING 656', each with a 'View All' link. Below this is a 'Search for Claims' section with an 'ADVANCED SEARCH' link and a note about data availability. There are two search options: 'Check Status by Claim Number' and 'Search by Member Info'. The 'Create Claims' section offers options to 'Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim' or 'Upload EDI / Batch', with a 'DRAFT CLAIMS 0' card. The 'Manage Finances' section, highlighted with a red box, includes 'Explanation of Payment (EOP)' with a 'View all EOP' link, 'Reports & Tools' with links for 'Batch Claims Report' and 'Claim Audit Tool', and a 'PAID CLAIMS 672' card with a 'View All' link. The 'Resources' section at the bottom lists links for 'Updated Instruction Manual (PDF)', 'CMS-1500 Claim Form (PDF)', 'CMS-UB-04 Claim Form', and 'EDI Guide (PDF)'. The footer contains links for 'Instruction Manual (PDF)', 'Terms and Conditions', 'Privacy Policy', and 'Copyright © 2023, Centene Corporation'.

- From Claims Dashboard, scroll to ‘Manage Finances’
- “View all EOPs” links to existing Payment History tab and information
- Batch Claims Reports link provides quick access to EDI Response Report (i.e., 999, TA1, etc.).
- Claim Audit Tool (*where available*) changed from a tab to a link.

# Claims Dashboard – Resources Links

The screenshot displays the Claims Dashboard interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a filter section shows 'Viewing Claims For: TIN' and 'Plan Type: Medicaid' with a 'GO' button. The main content area is divided into several sections:

- Claims:** A summary section with date filters (From: 01/19/2023, To: 02/18/2023) and a 'CHANGE DATES' button. It displays three summary cards: REJECTED (0), DENIED (125), and PENDING (656). Each card has a 'View All' link. A note below states: 'Shows claims for the last 30 days, from today's date.'
- Search for Claims:** Includes an 'ADVANCED SEARCH' link and a note: 'The data available for Search by Member Info is limited to the last 30 days. For specific date range search, please use the advanced search.'
- Check Status by Claim Number:** Features a text input for 'Enter Claim Number' and a 'CHECK' button. A note below says: 'Enter up to 10, separated by commas.'
- Search by Member Info:** Features inputs for 'Enter Last Name or Member ID' and 'Date of Birth' (with a calendar icon), and a 'SEARCH' button. A note below says: 'MM/DD/YYYY'.
- Create Claims:** Includes links for 'Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim' and 'Upload EDI / Batch'. It also has a 'DRAFT CLAIMS' card showing 0 and a 'View All' link. A note below says: 'Last 30 days, from today's date.'
- Manage Finances:** Includes links for 'Explanation of Payment (EOP)', 'Reports & Tools' (with sub-links for 'Batch Claims Report' and 'Claim Audit Tool'), and 'View all EOP'. It also has a 'PAID CLAIMS' card showing 672 and a 'View All' link. A note below says: 'Last 30 days, from today's date.'
- Resources:** A section highlighted with a red border, containing links for 'Updated Instruction Manual (PDF)', 'CMS-1500 Claim Form (PDF)', 'CMS-UB-04 Claim Form', and 'EDI Guide (PDF)'.

At the bottom of the dashboard, there is a footer with links for 'Instruction Manual (PDF)', 'Terms and Conditions', 'Privacy Policy', and 'Copyright © 2023, Centene Corporation'.

- From claims dashboard, scroll to Resources

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# Navigating Managing Finances

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# Claims Dashboard – Manage Finances: View all EOPs

To access Explanation of Payment (EOP) information, under Manage Finances, click **View all EOPs**. The legacy Payment History tab displays.

Click **Claims** at the top of any page to return to Claims Dashboard.

The screenshot displays the Claims Dashboard interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a filter section allows users to view claims for a specific TIN and Plan Type (Medicaid). The main content area is divided into several sections: 'Claims' with summary cards for REJECTED (0), DENIED (125), and PENDING (656); 'Search for Claims' with filters for date ranges and search criteria; 'Create Claims' with options for CMS forms and EDI/Batch uploads; 'Manage Finances' with links for 'Explanation of Payment (EOP)', 'Reports & Tools', and 'View all EOP'; and 'Resources' with links to various manuals and forms. A red arrow points from the 'View all EOP' link to the 'Payment History' tab in the 'Transactions' section. This section shows a table of payment transactions with columns for Check Date, Check Number, Check Clear Date, Mailing Address, and Payment Amount. The 'Claims' icon in the top navigation bar is highlighted with a red circle.

CHECK DATE ↓	CHECK NUMBER ↓	CHECK CLEAR DATE ↓	MAILING ADDRESS ↓	PAYMENT AMOUNT ↓
10/27/2022 (PDF)	0900	EFT		\$150.68
10/27/2022 (PDF)	0900	EFT		\$18,350.68
10/27/2022 (PDF)	0900	EFT		\$301.54
10/27/2022 (PDF)	0900	EFT		\$600.16



**Tip:** You can access up to 18 months of payment history. The key is the Check Date must be within the last 18 months from the current date.

# Claims Dashboard – Manage Finances: Batch Claims Reports

To access EDI Batch Responses (i.e., 999, TA1, etc.), under Reports & Tools, click **Batch Claims Report**. The legacy Batch tab displays.

Click **Claims** at the top of any page to return to Claims Dashboard.

The screenshot displays the Claims Dashboard interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a search bar allows filtering by TIN and Plan Type (Medicaid). The main content area is divided into several sections:

- Claims Summary:** Shows counts for REJECTED (0), DENIED (125), and PENDING (656) claims, with 'View All' links for each.
- Search for Claims:** Includes a date range selector (01/19/2023 to 02/18/2023) and a 'CHANGE DATES' button.
- Check Status by Claim Number:** A form to enter a claim number and click 'CHECK'.
- Search by Member Info:** A form to enter a last name or member ID and click 'CHECK'.
- Create Claims:** Options to start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim, and an 'Upload EDI / Batch' link.
- Manage Finances:** Includes 'Explanation of Payment (EOP)' and 'Reports & Tools' (with a red arrow pointing to the 'Batch Claims Report' link).
- Resources:** Links to various manuals and forms.

An inset window shows the 'Batch Claims Report' details. It features a 'Claims' tab with sub-tabs for Individual, Saved, Submitted, Batch, and Payment History. The 'Batch' tab is active, showing a date range (11/15/2022 to 11/22/2022) and a 'Batch Claim Status' dropdown set to 'ALL'. A table below lists submitted claims with columns for SUBMITTED DATE, TYPE, CONFIRMATION #, FILE NAME, STATUS, and download links for 999/999 FILE, TA1 FILE, and AUDIT FILE.

SUBMITTED DATE	TYPE	CONFIRMATION #	FILE NAME	STATUS	999/999 FILE	TA1 FILE	AUDIT FILE
11/21/2022	837P	51512056	51512056_... 11.21.22.DAT	ACCEPTED	Download	Download	Download
11/21/2022	837P	51512050	51512050_... 11.21.22.DAT	ACCEPTED	Download	Download	Download
11/21/2022	837P	51512057	51512057_... 11.21.22.DAT	ACCEPTED	Download	Download	Download



**Tip:** Batch Claims Reports are only applicable to organizations, who upload EDI Claim Batches (i.e., 837P / 837I) via the Secure Provider Portal.

# Claims Dashboard – Manage Finances: Claim Audit Tool

To access the Claim Audit Tool (where available), under Reports & Tools, click **Claim Audit Tool**. The legacy Pass-Through Terms and Conditions displays in a new tab or window.

Close the new tab or window to return to the Claim Dashboard.



Navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the icons, there are dropdown menus for 'Viewing Claims For: TIN' and 'Plan Type: Medicaid', followed by a green 'GO' button.

## Claims

From: 01/19/2023 To: 02/18/2023 [CHANGE DATES](#)  
MM/DD/YYYY MM/DD/YYYY

REJECTED 0 <a href="#">View All</a>	DENIED 125 <a href="#">View All</a>	PENDING 656 <a href="#">View All</a>
---	---	--

Shows claims for the last 30 days, from today's date.

## Search for Claims

The data available for Search by Member Info is limited to the last 30 days. For specific date range search.

### Check Status by Claim Number

Enter Claim Number  
 [CHECK](#)  
Enter up to 10, separated by commas

### Search by Member Info

Enter Last Name or Member ID Date  
 (mm/DD)  
 (MM/DD)

## Create Claims

- [Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim](#)
- [Upload EDI / Batch](#)

## Manage Finances

### Explanation of Payment (EOP)

View all recent payment transactions, including downloadable EOPs, check numbers, dates and payment amounts.

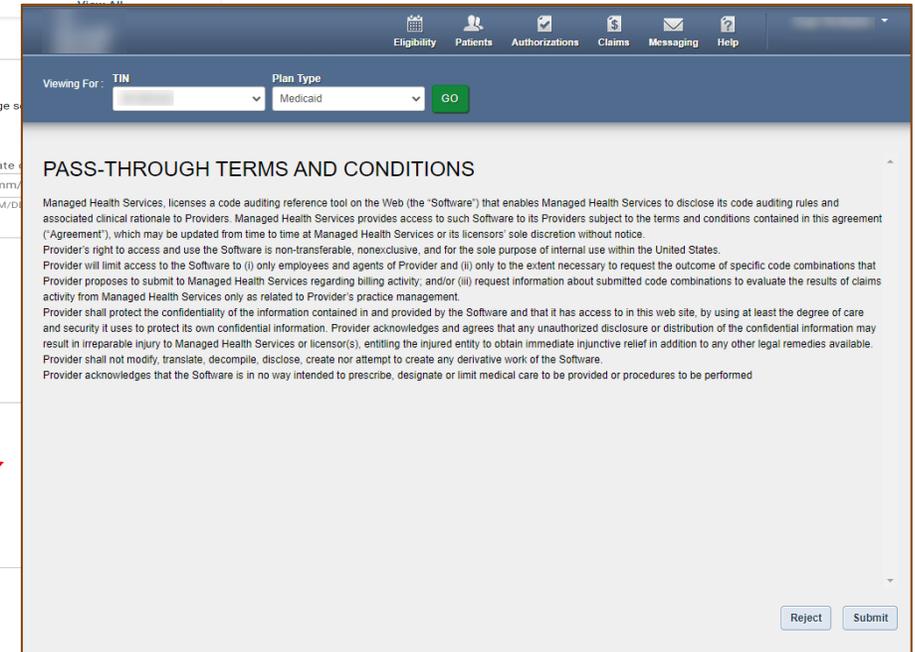
[View all EOP](#)

### Reports & Tools

- [Batch Claims Report](#)
- [Claim Audit Tool](#)

## Resources

- [Updated Instruction Manual \(PDF\)](#)
- [CMS-1500 Claim Form \(PDF\)](#)
- [EDI Guide \(PDF\)](#)



Modal window titled 'PASS-THROUGH TERMS AND CONDITIONS'. It contains a scrollable text area with legal terms and conditions. At the bottom right, there are 'Reject' and 'Submit' buttons. The modal is overlaid on the main dashboard content.

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# Claim Status Pages

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# Claim Status Tiles

The Rejected, Denied, Pending, Draft Claims, and Paid Claim Status Tiles, display on the Claims Dashboard, and provides the claim count for each status. Please note:

- Initial default count for each status, are for claims where the first Date of Service (DOS) is within the last 30 days, from the current date.
- The Rejected tile, is only applicable to individual web claims submitted via the portal, which received a front-end EDI rejection. If your Provider organization does not submit individual web claims via the portal or does not have any rejected web claims, the Rejected tile, will be zero (0).
- The Draft Claims tile, is only applicable to individual web claims started in the portal, but not submitted.

The screenshot displays the Claims Dashboard interface. At the top, there are navigation icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a header section allows filtering by TIN and Plan Type (currently set to Medicaid). The main content area is titled 'Claims' and features a date range selector (From: 01/19/2023, To: 02/18/2023) and a 'CHANGE DATES' button. A prominent red box highlights three status tiles: REJECTED (0), DENIED (125), and PENDING (656). Below these are search options for 'Check Status by Claim Number' and 'Search by Member Info'. Another red box highlights the 'DRAFT CLAIMS' tile (0). The 'Manage Finances' section includes links for 'Explanation of Payment (EOP)', 'Reports & Tools', and 'View all EOP'. A third red box highlights the 'PAID CLAIMS' tile (672). The 'Resources' section at the bottom provides links to various manuals and forms. The footer contains copyright information for Centene Corporation.

Status	Count
REJECTED	0
DENIED	125
PENDING	656
DRAFT CLAIMS	0
PAID CLAIMS	672

# Accessing Claim Status Pages

To access a Claim Status page, click **View All**. The respective page displays.

Viewing Claims For  Plan Type

## Claims

From  To

<b>REJECTED</b> 0 <a href="#">View All</a>	<b>DENIED</b> 125 <a href="#">View All</a>	<b>PENDING</b> 656 <a href="#">View All</a>
--	--	---

Shows claims for the last 30 days, from today's date.

### Search for Claims

[ADVANCED SEARCH](#)

The data available for Search by Member Info is limited to the last 30 days. For specific date range search, please use the advanced search.

**Check Status by Claim Number**

Enter Claim Number    
Enter up to 10, separated by commas

**Search by Member Info**

Enter Last Name or Member ID  Date of Birth    
MM/DD/YYYY

### Create Claims

[Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim](#) [Upload EDI / Batch](#)

<b>DRAFT CLAIMS</b> 0 <a href="#">View All</a>
--

Last 30 days, from today's date.

### Manage Finances

**Explanation of Payment (EOP)**  
View all recent payment transactions, including downloadable EOPs, check numbers, dates and payment amounts.  
[View all EOP](#)

**Reports & Tools**  
[Batch Claims Report](#)  
[Claim Audit Tool](#)

<b>PAID CLAIMS</b> 672 <a href="#">View All</a>
---

Last 30 days, from today's date.

### Resources

[Updated Instruction Manual \(PDF\)](#) [CMS-1500 Claim Form \(PDF\)](#) [CMS-UB-04 Claim Form](#)  
[EDI Guide \(PDF\)](#)

[Instruction Manual \(PDF\)](#) [Terms and Conditions](#) [Privacy Policy](#) [Copyright © 2023, Centene Corporation](#)

# Claim Status Pages – Layout

The Claim Status Pages layout are all the same. Please note, the Claims Display and Options may vary, based on the status of the claim.



**Tip:** Claims Display and Options may vary, based on the status of the claim.

Claim Status Page

Claim Status Options

Date Range

Claims Display & Options

Row Count Options

The screenshot displays a web interface for viewing denied claims. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging, along with a user profile for Bruce Provider. Below this, a search bar allows filtering by TIN (12345678) and PLAN TYPE (Medicaid), with a GO button. The main heading is 'Denied Claims'. Below the heading, there are three filter sections: 'Claim Status' (set to Denied Claims), 'Date Range' (From 01/01/2022 to 01/31/2022), and a 'Filter' button. The main content is a table of denied claims with columns for Claim Number, Claim Type, Claim Submission Date, Member Name, Member ID, Service Dates, Total Charges, and Status. The table contains 10 rows of data. At the bottom, there are 'Row Count Options' (Rows per page: 10) and 'Pagination' (1-10 of 90).

Claim Number	Claim Type	Claim Submission Date	Member Name	Member ID	Service Dates	Total Charges	Status
T123	Professional CMS-1500	01/01/2022			01/01/2022-01/02/2022	\$234.09	Denied
T123	Professional CMS-1500	01/01/2022			01/01/2022-01/02/2022	\$456.98	Denied
T123	Professional CMS-1500	01/12/2022			01/01/2022-01/02/2022	\$32.25	Denied
T123	Professional CMS-1500	01/01/2022			01/01/2022-01/02/2022	\$976.55	Denied
T123	Professional CMS-1500	01/10/2022			01/01/2022-01/02/2022	\$90.45	Denied
T123	Institutional CMS UB-04	01/19/2022			01/01/2022-01/02/2022	\$875.65	Denied
T123	Institutional CMS UB-04	01/18/2022			01/01/2022-01/02/2022	\$45.00	Denied
T123	Professional CMS-1500	01/21/2022			01/01/2022-01/02/2022	\$321.33	Denied
T123	Professional CMS-1500	01/21/2022			01/01/2022-01/02/2022	\$55.65	Denied
T123	Professional CMS-1500	01/15/2022			01/01/2022-01/02/2022	\$125.90	Denied

Filter

Pagination

# Claim Status Pages – General Navigation

General navigation on the Rejected, Denied, Pending, Draft Claims, and Paid Claim Status pages is the same.



## Tips:

- You can access up to 24 months of claim history, but the first DOS in a claim must be within 24 months of the current date.
- Date Range is limited to a 30-day span at a time.

The screenshot shows the 'Pending Claims' interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging, along with a 'Bruce Provider' dropdown. Below this, there are search filters for 'Viewing Claims For' with fields for TIN (12345678) and PLAN TYPE (Medicaid), and a 'GO' button. The main section is titled 'Pending Claims' and contains a 'Claim Status' dropdown menu set to 'Pending Claims' with a 'GO' button. Below that are date range filters: 'From' (01/01/2022) and 'To' (01/31/2022) with calendar icons and a 'CHANGE DATES' button. A 'Filter' button is also present. The main content is a table with columns: Claim Number, IT, Claim Type, Claim Submission Date, Member Name, Member ID, Service Dates, Total Charges, and Status. The table lists 11 claims, all with a 'Pending' status. At the bottom, there is a 'Rows per page' dropdown set to 10, a '1-10 of 90' indicator, and navigation arrows. Red dashed lines with text annotations point to various elements: 'Click drop-down arrow to select/change status' points to the Claim Status dropdown; 'Click Calendar icon, or manually type desired date(s)' points to the date range filters; 'Click GO to navigate to selection' points to the GO button; 'Click CHANGE DATES to view selected date range' points to the CHANGE DATES button; 'Click Filter to filter claims' points to the Filter button; 'Click to change row count' points to the Rows per page dropdown; and 'Use pagination to navigate list' points to the pagination controls.

Click drop-down arrow to select/change status

Click Calendar icon, or manually type desired date(s)

Click GO to navigate to selection

Click CHANGE DATES to view selected date range

Click Filter to filter claims

Click to change row count

Use pagination to navigate list

Claim Number	IT	Claim Type	Claim Submission Date	Member Name	Member ID	Service Dates	Total Charges	Status
T123		Professional CMS-1500	01/01/2022			01/01/2022 - 01/02/2022	\$234.09	Pending
T123		Professional CMS-1500	01/01/2022			01/01/2022 - 01/02/2022	\$456.98	Pending
T123		Professional CMS-1500	01/12/2022			01/01/2022 - 01/02/2022	\$32.25	Pending
T123		Professional CMS-1500	01/01/2022			01/01/2022 - 01/02/2022	\$976.55	Pending
T123		Professional CMS-1500	01/10/2022			01/01/2022 - 01/02/2022	\$90.45	Pending
T123		Institutional CMS UB-04	01/19/2022			01/01/2022 - 01/02/2022	\$875.65	Pending
T123		Institutional CMS UB-04	01/18/2022			01/01/2022 - 01/02/2022	\$45.00	Pending
T123		Professional CMS-1500	01/21/2022			01/01/2022 - 01/02/2022	\$321.33	Pending
T123		Professional CMS-1500	01/21/2022			01/01/2022 - 01/02/2022	\$55.65	Pending
T123		Professional CMS-1500	01/15/2022			01/01/2022 - 01/02/2022	\$125.90	Pending

# Claim Status Pages – Navigating Rejected Claims

Rejected Claims is only applicable to individual web claims (i.e., new, corrected, reconsider, etc.) submitted via the portal, which received a front-end EDI rejection.



## Tips:

- Front-end EDI rejections will not be processed any further, therefore, rejected claims will not be adjudicated.
- You can access up to 24 months of web claim rejection history, but the Submission Date must be within 24 months of the current date.
- Date Range is limited to a 30-day span at a time.

Click arrow to view / hide reject reason

Web# / Ref#	Claim Submission Date	Claim Type	Member Name	Member ID	Total Charges	Status
800307863	11/16/2022	Professional CMS-1500			\$132.66	Rejected
800307845	11/16/2022	Institutional CMS UB-04			\$132.66	Rejected
800306987	11/02/2022	Professional CMS-1500			\$100.50	Rejected
800306958	11/02/2022	Professional CMS-1500			\$132.66	Rejected
<b>Claim Number:</b> [REDACTED] <b>Rejected Reason:</b> 09 - Mbr not valid at DOS						
800306942	11/02/2022	Professional CMS-1500			\$120.00	Rejected
800306946	11/02/2022	Professional CMS-1500			\$100.50	Rejected
800306905	11/02/2022	Professional CMS-1500			\$100.50	Rejected
800306913	11/02/2022	Institutional CMS UB-04			\$132.66	Rejected
800306875	11/02/2022	Institutional CMS UB-04			\$132.66	Rejected
800306811	11/01/2022	Professional CMS-1500			\$132.66	Rejected

Click **Fix** to resolve the reason for the rejection and resubmit claim

# Claim Status Pages – Navigating Denied, Pending, and Paid Claims

Regardless of submission method, claims on file under the TIN in a denied, pending, or paid status, will display on the respective Claims Status Page.

Viewing Claims For: TIN: 12345678 PLAN TYPE: Medicaid GO

### Denied Claims

Claim Status: Denied Claims GO

From: 01/01/2022 To: 01/31/2022 CHANGE DATES Filter

Claim Number	Claim Type	Claim Submission Date	Member Name	Member ID	Service Dates	Total Charges	Status
T123	Professional CMS-1500	01/01/2022			01/01/2022-01/02/2022	\$234.09	Denied
T123	Professional CMS-1500	01/01/2022			01/01/2022-01/02/2022	\$456.98	Denied
T123	Professional CMS-1500	01/12/2022			01/01/2022-01/02/2022	\$32.25	Denied
T123	Professional CMS-1500	01/01/2022			01/01/2022-01/02/2022	\$976.55	Denied
T123	Professional CMS-1500	01/10/2022			01/01/2022-01/02/2022	\$90.45	Denied
T123	Institutional CMS UB-04	01/19/2022			01/01/2022-01/02/2022	\$875.65	Denied
T123	Institutional CMS UB-04	01/18/2022			01/01/2022-01/02/2022	\$45.00	Denied
T123	Professional CMS-1500	01/21/2022			01/01/2022-01/02/2022	\$321.33	Denied
T123	Professional CMS-1500	01/21/2022			01/01/2022-01/02/2022	\$55.65	Denied
T123	Professional CMS-1500	01/15/2022			01/01/2022-01/02/2022	\$125.90	Denied

Rows per page: 10 1-10 of 90 < > >|

Click a **Claim Number** to view claim details



#### Tips:

- You can access up to 24 months of claim history, but the first DOS in a claim must be within 24 months of the current date.
- Date Range is limited to a 30-day span at a time.

# Claims Status – Draft Claims

Viewing Claims For: TIN [dropdown] Plan Type: Medicaid [dropdown] GO

## Claims

From: 01/19/2023 To: 02/18/2023 CHANGE DATES

REJECTED 0 DENIED 125 PENDING 656

View All View All View All

Shows claims for the last 30 days, from today's date.

## Search for Claims

ADVANCED SEARCH

The data available for Search by Member Info is limited to the last 30 days. For specific date range search, please use the advanced search.

Check Status by Claim Number Search by Member Info

Enter Claim Number [input] CHECK

Enter Last Name or Member ID [input] Date of Birth [input] SEARCH

## Create Claims

Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim Upload EDI / Batch

**DRAFT CLAIMS 0**

View All

Last 30 days, from today's date.

## Manage Finances

Explanation of Payment (EOP) Reports & Tools PAID CLAIMS 672

View all recent payment transactions, including downloadable EOPs, check numbers, dates and payment amounts. Batch Claims Report Claim Audit Tool

View all EOP

Last 30 days, from today's date.

## Resources

Updated Instruction Manual (PDF) CMS-1500 Claim Form (PDF) CMS-UB-04 Claim Form EDI Guide (PDF)

Instruction Manual (PDF) Terms and Conditions Privacy Policy Copyright © 2023, Centene Corporation

- Saved tab changed to Draft Claims Tile.
- Claim drafts created in the last 30 days from current date, display regardless where the claim was exited without submitting it.

# Claim Status Pages – Navigating Draft Claims

A claim draft is automatically created and saved, for any individual web claim started, but not submitted. This includes correct and reconsider claim drafts, and where available, void/recoup and/or appeal drafts.



**Tip:** A Claim Number in the **Original Claim Number** column, identifies correct, reconsider, void/recoup, or appeal claim drafts.

Manage Practice Eligibility Patients Authorizations Claims Messaging

Viewing Dashboard For: TIN [redacted] Plan Type: Medicaid [GO]

### Draft Claims

Claim Status: Draft Claims [GO]

From: 10/23/2022 To: 11/22/2022 [CHANGE DATES] Filter

Draft ID	Claim Type	Member Name	Member ID	Original Claim Number	Created Date	Status
801680082	Institutional CMS UB-04	[redacted]	[redacted]	N/A	11/22/2022	Draft [Pencil] [Trashcan]
801678986	Institutional CMS UB-04	[redacted]	[redacted]	N/A	11/16/2022	Draft [Pencil] [Trashcan]
801678859	Professional CMS-1500	[redacted]	[redacted]	N/A	11/15/2022	Draft [Pencil] [Trashcan]
801677551	Professional CMS-1500	[redacted]	[redacted]	N/A	11/02/2022	Draft [Pencil] [Trashcan]
801677550	Professional CMS-1500	[redacted]	[redacted]	N/A	11/02/2022	Draft [Pencil] [Trashcan]
801677437	Professional CMS-1500	[redacted]	[redacted]	N/A	11/02/2022	Draft [Pencil] [Trashcan]
801677436	Professional CMS-1500	[redacted]	[redacted]	N/A	11/02/2022	Draft [Pencil] [Trashcan]
801677251	Professional CMS-1500	[redacted]	[redacted]	N/A	11/01/2022	Draft [Pencil] [Trashcan]
801677249	Professional CMS-1500	[redacted]	[redacted]	N/A	11/01/2022	Draft [Pencil] [Trashcan]
801677085	Professional CMS-1500	[redacted]	[redacted]	N/A	11/01/2022	Draft [Pencil] [Trashcan]

Rows per page: 10 1-10 of 11 [Navigation icons]

Click Pencil icon to resume, complete, and submit web claim

Click Trashcan icon to delete the web claim draft

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# Claim Details

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# Accessing Claim Details – Denied, Pending, and Paid Claims

Regardless of claims submission method, claims on file under the TIN in a denied, pending, or paid status, will display on the respective Claims Status Page.

When you click a Claim Number, the Claim Details page displays.



## Tips:

- You can access up to 24 months of claim history, but the first DOS in a claim must be within 24 months of the current date.
- Date Range is limited to a 30-day span at a time.

Click a **Claim Number** to view claim details

Viewing Dashboard For: TIN [redacted] Plan Type: Medicaid [GO]

Manage Practice Eligibility Patients Authorizations Claims Messaging

### Pending Claims

Claim Status: Pending Claims [GO]

From: 06/01/2022 To: 06/30/2022 [CHANGE DATES] Filter

Claim Number	Claim Type	Claim Submission Date	Member Name	Member ID	Service Dates	Total Charges	Status
V206	Institutional CMS UB-04	07/25/2022	[redacted]	[redacted]	06/24/2022 - 06/24/2022	\$480.00	Pending
V201	Institutional CMS UB-04	07/20/2022	[redacted]	[redacted]	06/19/2022 - 06/28/2022	\$96,611.48	Pending
V235	Institutional CMS UB-04	08/23/2022	[redacted]	[redacted]	06/13/2022 - 06/13/2022	\$828.00	Pending
V257	Professional CMS-1500	09/14/2022	[redacted]	[redacted]	06/10/2022 - 06/10/2022	\$37.00	Pending
V263	Professional CMS-1500	09/20/2022	[redacted]	[redacted]	06/10/2022 - 06/10/2022	\$37.00	Pending
V265	Professional CMS-1500	09/22/2022	[redacted]	[redacted]	06/10/2022 - 06/10/2022	\$253.00	Pending
V265	Professional CMS-1500	09/22/2022	[redacted]	[redacted]	06/10/2022 - 06/10/2022	\$253.00	Pending
V257	Professional CMS-1500	09/14/2022	[redacted]	[redacted]	06/10/2022 - 06/10/2022	\$253.00	Pending
V263	Professional CMS-1500	09/20/2022	[redacted]	[redacted]	06/10/2022 - 06/10/2022	\$37.00	Pending
V265	Professional CMS-1500	09/22/2022	[redacted]	[redacted]	06/10/2022 - 06/10/2022	\$37.00	Pending

Rows per page: 10 1-10 of 32

# Claims Details

Viewing Dashboard For  TIN  Plan Type  Medicaid

Most Recent Payment details do not show final claim status until a payment date is available. Check back before your timely filing deadline.

**Claim: U145**  
Status: DENIED

Submitted  Denied

**Member**

Member Name   
Date of Birth   
Member ID   
Medicaid ID   
Plan Type Medicaid

**Type and Dates**

Type CMS-1500  
Service Dates 05/09/2021 - 05/09/2021  
Submit Date 05/17/2021

**Payment**

Billed \$53.00  
Paid \$0.00  
Payment Date 06/09/2021

Check # / EFT 090000000000  
Check Date 06/08/2021  
Total Check Amount \$0.00

[+ COPY](#) [+ VOID/RECOUP](#)

**Claim Info**

Original Claim U145  
Status Denied  
Type CMS-1500  
Service Dates 05/10/2021 - 05/10/2021  
Submit Date 05/18/2021

**Provider**

Ref/Account #   
Billing Provider   
Billing NPI   
TIN

**Service Lines**

Line	Date of Service	Proc	Diag	Mod	Place of Service	Charged	Paid	Check #	Payment Codes	Status
1	05/09/2021	S5125	R69		LC12	\$53.00	\$0.00	090000000000	A1	Denied

ADJ: Adjustment Rows per page 10 1-1 of 1

**Payment Codes Description**

A1 DENY: NO AUTHORIZATION ON FILE THAT MATCHES SERVICE(S) BILLED

**Reference Numbers**

Reference Type Reference Number  
Referral  
Prior Authorization  
Original Claim Number U145

- Claim Status Tracker will display current claim status and include Reconsideration and Appeal information, when applicable.
- Member Name is a hyperlink for quick access to the Patient Record.
- Claim Type displays under Type and Dates.
- On finalized claims, in the Payment section, Billed [Claim Amount], Check # / EFT, and Total Check Amount displays.
- Copy Claim button replaced with link and renamed +Copy.
- Void/Recoup Claim button replaced with link and renamed +Void/Recoup.
- Dispute button added with additional claim action capabilities.
- Claim Info will display Claim # and additional information on associated submitted reconsideration and/or appeal requests.
- In the Reference Numbers section, on claims with submitted reconsideration and/or appeal requests, the associated reference number(s) display.

# Claim Details Overview

The Claim Details page provides a wholistic view of a claim.

Please note, the following only displays on finalized claims (i.e., Paid, Denied, etc.):

- Payment Information
- Dispute Button
- Payment Codes & Description

Claim # and Status

Member & Date(s)

Payment Info

Claim Action Option(s)

Reference Numbers

The screenshot shows a web interface for claim details. At the top, there are navigation tabs: Manage Practice, Eligibility, Patients, Authorizations, Claims, and Messaging. Below the navigation, there are dropdown menus for 'Viewing Dashboard For' (TIN) and 'Plan Type' (Medicaid), followed by a 'GO' button. A yellow banner at the top states: 'Most Recent Payment details do not show final claim status until a payment date is available. Check back before your timely filing deadline.'

The main content area is divided into several sections, each highlighted with a red box:

- Claim # and Status:** Displays 'Claim: U145' and 'Status: DENIED'.
- Claim Status Tracker:** A progress bar showing 'Submitted' (U145) with a green checkmark and 'Denied' (U145) with a red X.
- Member & Date(s):** A table with columns for 'Member' and 'Type and Dates'.
 

Member	Type and Dates
Member Name	Type
Date of Birth	Service Dates
Member ID	Submit Date
Medicaid ID	
Plan Type	
- Payment Info:** A table with columns for 'Payment' and 'Check # / EFT'.
 

Payment	Check # / EFT
Billed	090000000000
Paid	Check Date
Payment Date	Total Check Amount
- Claim Action Option(s):** A row of buttons: '+ COPY', '+ VOID/RECOUP', and 'DISPUTE'.
- Claim & Provider Information:** A section for 'Claim Info' and 'Provider'.
 

Original Claim	U145
Status	Denied
Type	CMS-1500
Service Dates	05/10/2021 - 05/10/2021
Submit Date	05/18/2021

Provider information includes Ref/Account #, Billing Provider, Billing NPI, and TIN.
- Claim Service Lines:** A table with columns for 'Line', 'Date of Service', 'Proc', 'Diag', 'Mod', 'Place of Service', 'Charged', 'Paid', 'Check #', 'Payment Codes', and 'Status'.
 

Line	Date of Service	Proc	Diag	Mod	Place of Service	Charged	Paid	Check #	Payment Codes	Status
1	05/09/2021	S5125	R69		LC12	\$53.00	\$0.00	090000000000	A1	Denied
- Payment Codes & Descriptions:** A table with columns for 'Payment Codes Description'.
 

Payment Codes Description
A1 DENY: NO AUTHORIZATION ON FILE THAT MATCHES SERVICE(S) BILLED
- Reference Numbers:** A table with columns for 'Reference Type' and 'Reference Number'.
 

Reference Type	Reference Number
Referral	
Prior Authorization	
Original Claim Number	U145

Claim Status Tracker

Claim & Provider Information

Claim Service Lines

Payment Codes & Descriptions

# Claim Details

Viewing Dashboard For: TIN [redacted] Plan Type Medicaid GO

Most Recent Payment details do not show final claim status until a payment date is available. Check back before your timely filing deadline.

## Claim: V005 [redacted]

Status: DENIED

Submitted V005 [redacted] Denied V005 [redacted] Reconsideration Completed V242 [redacted]

### Member

Member Name [redacted]  
 Date of Birth [redacted]  
 Member ID [redacted]  
 Medicaid ID [redacted]  
 Plan Type Medicaid

### Type and Dates

Type UB-04  
 Service Dates 12/29/2021 - 12/29/2021  
 Received Date 01/04/2022

### Payment

Billed \$124.00 Check # / EFT 040000000000  
 Paid \$0.00 Check Date 04/21/2022  
 Payment Date 04/21/2022 Total Check Amount \$0.00

+ COPY + VOID/RECOUP DISPUTE

### Claim Info

**Reconsiderer V242 [redacted]**  
 Status Reconsideration completed  
 Type Reconsideration  
 Created Date 05/16/2022

**Reconsiderer V242 [redacted]**  
 Status Open  
 Type Reconsideration  
 Created Date 08/30/2022

**Original Claim V005 [redacted]**  
 Status Denied  
 Type UB-04  
 Service Dates 12/29/2021 - 12/29/2021  
 Received Date 01/05/2022

### Provider

Referral # [redacted]  
 Billing Provider [redacted]  
 Billing NPI [redacted]  
 TIN [redacted]

### Service Lines

Line	Date of Service	Proc	Org	Med	Place of Service	Charge	Rate	Check #	Transfer	Status
1	12/29/2021	8000	8318	LC02	802.00	39.56	040000000000	EA		Denied
2	12/29/2021	9443	8318	LC02	802.00	39.56	040000000000	EA		Denied

ALL Adjustment Rates per page 10 of 1-2-21 10 1 1 1

### Payment Codes Description

L4 000V BILL PRIMARY INSURER 1ST RESUBMIT W/ EOB OR INSURANCE EXPLAN CODE

### Reference Numbers

Reference Type Reference Number  
 Referral [redacted]  
 Prior Authorization [redacted]  
 Original Claim Number V005 [redacted]



Tip: Payment information only displays on finalized claims.

# Claim Details, *continued*

Claim: V005  
Status: DENIED

Member  
Member Name  
Date of Birth  
Member ID  
Medical ID  
Plan Type

Type and Dates  
Type: UB-04  
Service Dates: 12/30/2021 - 12/30/2021  
Received Date: 01/05/2022

Payment  
Billed: \$124.00  
Paid: \$0.00  
Payment Date: 04/21/2022

Check # / EFT: 0400000000  
Check Date: 04/21/2022  
Total Check Amount: \$0.00

**Claim Info**

Reconsider  
Reconsider #: V242  
Status: Resolved-completed  
Type: Reconsideration  
Created Date: 09/06/2022

Reconsider  
Reconsider #: V242  
Status: Open  
Type: Reconsideration  
Created Date: 08/30/2022

Original Claim  
Original Claim #: V005  
Status: Denied  
Type: UB-04  
Service Dates: 12/30/2021 - 12/30/2021  
Received Date: 01/05/2022

Provider  
Ref/Account #  
Billing Provider  
Billing NPI  
TIN

Service Lines

Line	Date of Service	Proc	Qty	Med	Place of Service	Charge1	Rate	Check #	Transfer	Status
1	12/30/2021	8000	8319	U022	800.00	80.00	0400000000	EA		Denied
2	12/30/2021	8043	8319	U022	800.00	80.00	0400000000	EA		Denied

Payment Codes Description  
L4: 000V-BILL-PRIMARY INSURER 1ST RESUBMIT W/ EOB OR INSURANCE EXPLAN CODE

Reference Numbers  
Reference Type: Reference Number  
Prior Authorization  
Original Claim Number: V005

[COPY](#) [VOID/RECOUP](#) [DISPUTE](#)

---

### Claim Info

Reconsider: V242  
Status: Resolved-completed  
Type: Reconsideration  
Created Date: 09/06/2022

Reconsider: V242  
Status: Open  
Type: Reconsideration  
Created Date: 08/30/2022

Original Claim: V005  
Status: Denied  
Type: UB-04  
Service Dates: 12/30/2021 - 12/30/2021  
Received Date: 01/05/2022

---

### Provider

Ref/Account #  
Billing Provider  
Billing NPI  
TIN

# Claim Details, *continued*

Claim: V005  
Status: DENIED

Member  
Member Name  
Date of Birth  
Member ID  
Medical ID  
Plan Type

Type and Dates  
Type: US-04  
Service Dates: 12/29/2021 - 12/29/2021  
Received Date: 01/18/2022

Payment  
Billed: \$124.00  
Paid: \$0.00  
Payment Date: 04/21/2022

Check # / EFT: 040000000000  
Check Date: 04/21/2022  
Total Check Amount: \$0.00

Claim Info  
Reconsiderer: V242  
Status: Reconsideration completed  
Type: Reconsideration  
Created Date: 08/30/2022

Original Claim: V005  
Status: Denied  
Type: US-04  
Service Dates: 12/29/2021 - 12/29/2021  
Received Date: 01/05/2022

Provider  
Referral #  
Billing Provider  
Billing NPI

**Service Lines**

Line	Date of Service	Proc	Diag	Mod	Place of Service	Charged	Paid	Check #	Payment Codes	Status
1	12/29/2021	80053	E119		LC22	\$92.00	\$0.00	040000000000	L6	Denied
2	12/29/2021	36415	E119		LC22	\$32.00	\$0.00	040000000000	L6	Denied

ADJ: Adjustment

Rows per page: 10 | 1-2 of 2

**Payment Codes Description**

L6 DENY: BILL PRIMARY INSURER 1ST. RESUBMIT W EOB OR INSURANCE EXPLAIN CODE

**Reference Numbers**

Reference Type	Reference Number
Prior Authorization	
Original Claim Number	V005

## Service Lines

Line	Date of Service	Proc	Diag	Mod	Place of Service	Charged	Paid	Check #	Payment Codes	Status
1	12/29/2021	80053	E119		LC22	\$92.00	\$0.00	040000000000	L6	Denied
2	12/29/2021	36415	E119		LC22	\$32.00	\$0.00	040000000000	L6	Denied

ADJ: Adjustment

Rows per page: 10 | 1-2 of 2

## Payment Codes Description

L6 DENY: BILL PRIMARY INSURER 1ST. RESUBMIT W EOB OR INSURANCE EXPLAIN CODE

## Reference Numbers

Reference Type	Reference Number
Referral	
Prior Authorization	
Original Claim Number	V005



**Tip:** Payment Codes and Payment Codes Description only display on finalized claims.

# Claim Details: Service Lines With Adjustments

When an adjustment occurs on a claim or Service Line(s), the adjustment will appear as a child line item detailing the changes. The child line items are identified by ADJ, which means adjustment. Please note:

- On the lines without “ADJ” the Paid, Payment Codes, and Status columns reflect the finalized adjustment. However, the Check # is the original Check #.
- ADJ lines are read from the top, down.
- ADJ 1.1, 2.1 (i.e., X.1), contains the finalized adjustment Check #. This will be the Check # displayed in the Payment section of the Claim Details page.

Service Lines										
Line	Date of Service	Proc	Diag	Mod	Place of Service	Charged	Paid	Check #	Payment Codes	Status
1	12/29/2022	E2365	Q897	NU,R B	LC12	\$327.90	\$		56,92	🟢 Paid
ADJ 1.0	12/29/2022	E2365	Q897	NU,R B	LC12	\$327.90	\$0.00		0B	🔴 Denied
ADJ 1.1	12/29/2022	E2365	Q897	NU,R B	LC12	(\$327.90)	(\$)		JU,92	🟢 Paid
ADJ 1.2	12/29/2022	E2365	Q897	NU,R B	LC12	\$327.90	\$		56,92	🟢 Paid
2	12/29/2022	E2365	Q897	NU,R B	LC12	\$327.90	\$0.00		yo	🔴 Denied
ADJ 2.0	12/29/2022	E2365	Q897	NU,R B	LC12	\$327.90	\$0.00		0B	🔴 Denied
ADJ 2.1	12/29/2022	E2365	Q897	NU,R B	LC12	(\$327.90)	\$0.00		JU	🟢 Paid
ADJ 2.2	12/29/2022	E2365	Q897	NU,R B	LC12	\$327.90	\$0.00		yo	🔴 Denied
3	12/29/2022	E2386	Q897	NU,R	LC12	\$126.85	\$0.00		35	🔴 Denied

# Claim Details – Claim Action Buttons: + Copy

Click **+ Copy**, to create an exact duplicate of the claim. All the information within the claim can be edited, allowing you to simply change the needed information (i.e., Date(s) of Service, Diagnosis Code(s), Procedure Code(s), etc.) to submit a new claim.

Once it is submitted, it is considered a new claim submission and will be processed as a first-time claim.

The screenshot shows a web interface for claim details. At the top, it displays 'Claim: V005' and 'Status: DENIED'. Below this is a progress bar with three stages: 'Submitted' (green checkmark), 'Denied' (red X), and 'Reconsideration Completed' (green checkmark). The main content area is divided into several sections: 'Member' (Member Name, Date of Birth, Member ID, Plan Type), 'Type and Dates' (Type, Service Dates, Received Date), 'Payment' (Billed, Paid, Payment Date, Check # / IPT, Check Date, Total Check Amount), 'Chain Info' (Reconsiderer details), 'Original Claim' (Status, Type, Service Dates, Received Date), 'Provider' (Bill Recipient #, Billing Provider, Billing NPI, TIN), 'Service Lines' (a table with columns for Line, Date of Service, Proc, Diag, Mod, Place of Service, Charge, Paid, Check #, Payment Code, Status), 'Payment Codes Description' (L4: 0001 BILL PRIMARY INSURER 1ST RESUBMIT W/EOB OR INDEMNITY EXPLAIN CODE), and 'Reference Numbers' (Reference Type, Reference Number).

A close-up view of the action buttons from the screenshot. The buttons are arranged horizontally and are: '+ COPY' (highlighted with a red box), '+ VOID/RECOUP', and 'DISPUTE'.

# Claim Details – Claim Action Buttons: + Copy Workflow

Viewing Dashboard For: TIN [redacted] Plan Type: Medicaid GO

Most Recent Payment details do not show final claim status until a payment date is available. Check back before your timely filing deadline.

### Claim: V005 [redacted]

Status: DENIED

Submitted (V005) → Denied (V005) → Reconsideration Completed (V242)

Member		Type and Dates	
Member Name	[redacted]	Type	UB-04
Date of Birth	[redacted]	Service Dates	12/29/2021 - 12/29/2021
Member ID	[redacted]	Received Date	01/04/2022
Medical ID	[redacted]		
Plan Type	Medicaid		

Payment			
Billed	\$124.00	Check # / EFT	040000000000
Paid	\$0.00	Check Date	04/21/2022
Payment Date	04/21/2022	Total Check Amount	\$0.00

+ COPY + VOID/RECoup DISPUTE

Claim Info	
Reconsider	V242 [redacted]
Status	Resolved-completed
Type	Reconsideration
Created Date	09/06/2022

Click +Copy to create copied claim

Viewing Claims For: TIN [redacted] Plan Type: Medicaid GO Upload EDI Create Claim

### Professional Claim for [redacted]

Your Progress [Progress Bar]

THIS SECTION: **General Info**  
Information about the dates of the claim.

Next →

\* Required fields

Patient's Account Number\* [redacted] 26

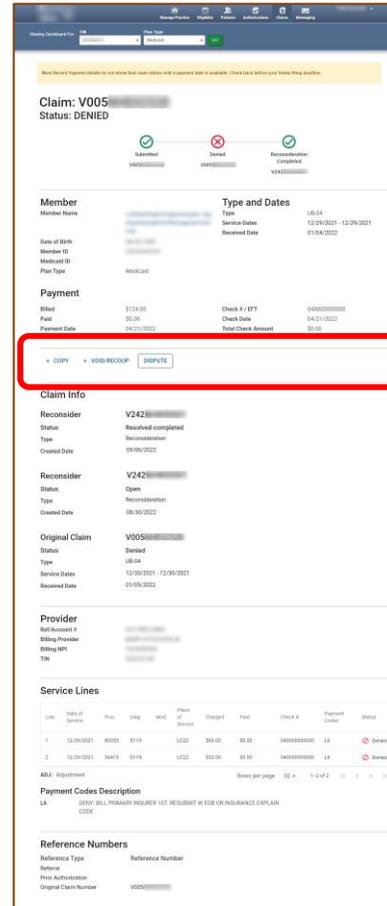
Statement Dates\* From 11/14/2022 To 11/14/2022

Date of current illness, Select Type... MM/DD/YYYY 14

# Claim Details – Claim Action Buttons: + Void/Recoup

Where available, click **+ Void/Recoup** to request to void claim, and full recoupment of payment, if applicable.

+



# Claim Details – Claim Action Buttons: + Void/Recoup Workflow

Viewing Dashboard For: TIN [redacted] Plan Type: Medicaid [GO]

Most Recent Payment details do not show final claim status until a payment date is available. Check back before your timely filing deadline.

**Claim: V005**  
Status: DENIED

Submitted (V005) — Denied (V005) — Reconsideration Completed (V242)

Member		Type and Dates	
Member Name	[redacted]	Type	UB-04
Date of Birth	[redacted]	Service Dates	12/29/2021 - 12/29/2021
Member ID	[redacted]	Received Date	01/04/2022
Medicaid ID	[redacted]		
Plan Type	Medicaid		

Payment			
Billed	\$124.00	Check # / EFT	040000000000
Paid	\$0.00	Check Date	04/21/2022
Payment Date	04/21/2022	Total Check Amount	\$0.00

+ COPY + VOID/RECOUP DISPUTE

Claim Info	
Reconsider	V242 [redacted]
Status	Resolved-completed
Type	Reconsideration
Created Date	09/06/2022

Click **+Void/Recoup** to submit void/recoup claim request

Viewing Claims For: TIN [redacted] Plan Type: Medicaid [GO] Upload EDI Create Claim

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

THIS SECTION: **Review**  
Please review your claim and submit.

You are voiding a claim for V320 [redacted] [Submit]

**Almost done!**  
You can go back to review your claim or submit now.

Warning: Using the Void/Recoup function will void the original claim and result in a full recoupment of payment.  
Please use the correct claim function instead if you are attempting to correct billing on the original claim.

Claim Id: 834238764  
Member Record Number: [redacted]  
Member Claim Amount Paid: [redacted]  
Patient's Account Number: [redacted]

General Info  
Statement From Date: 11/14/2022  
Statement To Date: 11/14/2022  
Date of current illness, injury, pregnancy (LMP): [redacted]

# Claim Details – Claim Action Buttons: Dispute

The Dispute button only displays on finalized claims (i.e., Paid, Denied, etc.).

When applicable, click **Dispute** to view options.

The screenshot shows a web interface for claim details. At the top, it displays 'Claim: V005' and 'Status: DENIED'. Below this is a progress bar with three stages: 'Submitted' (green checkmark), 'Denied' (red X), and 'Reconsideration Completed' (green checkmark). The 'Member' section includes fields for Member Name, Type, and Dates. The 'Payment' section shows a table with columns for Bill, Paid, Payment Date, Check #, and Check Date. A red box highlights the action buttons: '+ COPY', '+ VOID/RECoup', and 'DISPUTE'. Below this are sections for 'Claim Info', 'Reconsider' (twice), 'Original Claim', 'Provider', 'Service Lines', 'Payment Codes Description', and 'Reference Numbers'.

A close-up view of the action buttons from the screenshot. It shows three buttons: '+ COPY', '+ VOID/RECoup', and 'DISPUTE'. The 'DISPUTE' button is highlighted with a red rounded rectangle.



**Tip:** Dispute Button only displays on finalized claims.

# Claim Details – Claim Action Buttons: Dispute, continued

Claim: V005  
Status: DENIED

Submitted (V005) → Denied (V005) → Reconsideration Completed (V005)

**Member**  
Member Name: [REDACTED]  
Type: US-04  
Service Dates: 12/29/2021 - 12/29/2021  
Received Date: 01/04/2022

**Payment**  
Check # / EFT: 9400000000  
Check Date: 04/11/2022  
Total Check Amount: \$0.00

+ COPY + VOID/RECoup **DISPUTE**

**Claim Info**

**Reconsiderer V242**  
Status: Resolved-completed  
Type: Reconsideration  
Created Date: 09/30/2022

**Reconsiderer V242**  
Status: Open  
Type: Reconsideration  
Created Date: 09/30/2022

**Original Claim V005**  
Status: Denied  
Type: US-04  
Service Dates: 12/29/2021 - 12/29/2021  
Received Date: 01/04/2022

**Provider**  
Ref Account #:  
Billing Provider:  
Billing NPI:  
TIN:

**Service Lines**

Line	Date of Service	Proc	Org	Med #	Place of Service	Original	Final	Check #	Payment Code	Status
1	12/29/2021	8020	E119	L022	\$0.00	\$0.00	9400000000	LA		Denied
2	12/29/2021	8043	E119	L022	\$0.00	\$0.00	9400000000	LA		Denied

ADJ: Adjustment Rows per page: 10 • 1-2-3-4-5 10 15 20

**Payment Codes Description**  
LA 0007 BILL PRIMARY INSURER 1ST RESUBMIT W EOB OR INSURANCE EXPLAIN CODE

**Reference Numbers**

Reference Type	Reference Number
Billing	
Prior Authorization	
Original Claim Number	V005

+ COPY + VOID/RECoup **DISPUTE**

Dispute Claim: W086 [REDACTED]

**SELECT** Option 1: Correct the Claim  
Most providers use this option when there is a mistake on the submitted claim

**SELECT** Option 2: Informally Dispute the Claim  
A dispute is an informal review performed by the claims department

- A response will be issued within 30 calendar days of submission.
- You will still have the option to select Option 3: Appeal the claim if the decision is upheld.
- You should **Not** use this option if an authorization is not obtained and/or need to review for medical necessity.
- Please refer to the [Provider Manual](#) on filling a necessity medical appeal.

**SELECT** Option 3: Appeal the claim  
An appeal is a formal review of your claim

- Appeal responses will be issue in writing within 30 calendar days of submission in accordance with 405 IAC 1-1-6
- Your appeal will be review by a panel of one or more individual who are knowledgeable in the policy, legal, and/or clinical issues in the matter subject of the appeal.
- The panel was not involved in any previous consideration of the matter of the appeal.
- Please refer to the [Provider Manual](#) for more information.

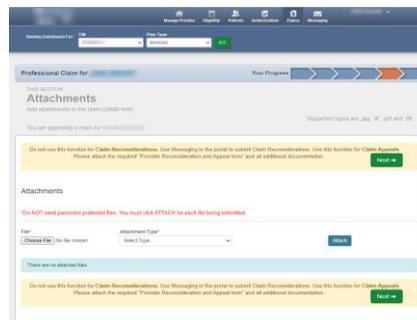
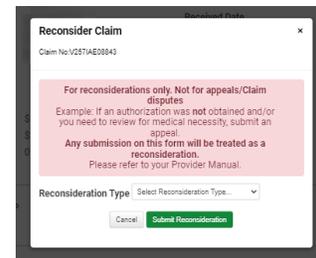
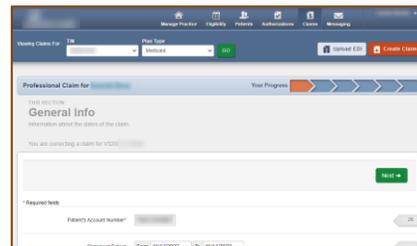


**Tip:** Follow onscreen instructions.

\*Example only- verbiage and definitions may vary depending on Health Plan specifications

# Claim Details – Claim Action Buttons: Dispute Workflows

When you click **Select**, if there are no errors, the applicable legacy screen displays.



Dispute Claim: W086

**SELECT** Option 1: Correct the Claim  
Most providers use this option when there is a mistake on the submitted claim

**SELECT** Option 2: Informally Dispute the Claim  
A dispute is an informal review performed by the claims department

- A response will be issued within 30 calendar days of submission.
- You will still have the option to select Option 3: Appeal the claim if the decision is upheld.
- You should **Not** use this option if an authorization is not obtained and/or need to review for medical necessity.
- Please refer to the [Provider Manual](#) on filling a necessity medical appeal.

**SELECT** Option 3: Appeal the claim  
An appeal is a formal review of your claim

- Appeal responses will be issue in writing within 30 calendar days of submission in accordance with 405 IAC 1-1-6
- Your appeal will be review by a panel of one or more individual who are knowledgeable in the policy, legal, and/or clinical issues in the matter subject of the appeal.
- The panel was not involved in any previous consideration of the matter of the appeal.
- Please refer to the [Provider Manual](#) for more information.



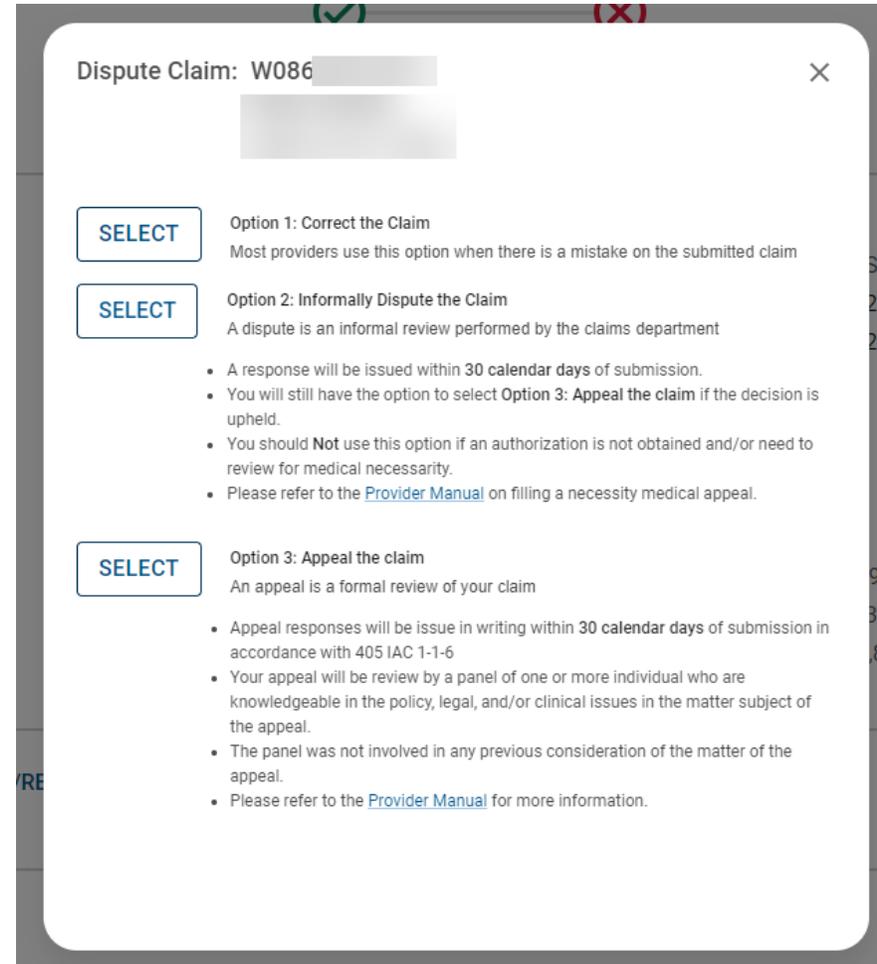
**Tip:** Dispute options may vary by Health Plan.

\*Example only- verbiage and definitions may vary depending on Health Plan specifications

# Claim Details – Claim Action Buttons: Dispute Claim Errors

When you click **Select**, and there is a dispute claim draft, the Claim Details page will display an error message, “This Claim has an Adjusted Claim that is not yet submitted.” To resolve:

1. Click **Claims** (at the top of any page). The Claims Dashboard displays.
2. Click **Draft Claims**. The Draft Claims Status Page displays. On the Draft Claims page, a Claim Number in the Original Claim Number column identifies correct, reconsider, claim drafts, and where available, void/recoup and/or appeal claim drafts.
3. Locate the claim, and click:
  - a) **Pencil icon**, to resume claim, complete and submit, or
  - b) **Trashcan icon** to delete claim draft.



Dispute Claim: W086

**SELECT** Option 1: Correct the Claim  
Most providers use this option when there is a mistake on the submitted claim

**SELECT** Option 2: Informally Dispute the Claim  
A dispute is an informal review performed by the claims department

- A response will be issued within **30 calendar days** of submission.
- You will still have the option to select **Option 3: Appeal the claim** if the decision is upheld.
- You should **Not** use this option if an authorization is not obtained and/or need to review for medical necessity.
- Please refer to the [Provider Manual](#) on filling a necessity medical appeal.

**SELECT** Option 3: Appeal the claim  
An appeal is a formal review of your claim

- Appeal responses will be issue in writing within **30 calendar days** of submission in accordance with 405 IAC 1-1-6
- Your appeal will be review by a panel of one or more individual who are knowledgeable in the policy, legal, and/or clinical issues in the matter subject of the appeal.
- The panel was not involved in any previous consideration of the matter of the appeal.
- Please refer to the [Provider Manual](#) for more information.

\*Example only- verbiage and definitions may vary depending on Health Plan specifications

# Claim Details – Claim Action Buttons: Dispute Claim Errors, continued

When a disputed web claim is exited from the **Review** page, without a submission, the claim draft is only accessible on the legacy **Professional Ready to be Submitted** or **Institutional Ready to be Submitted** tab. To access/resolve:

1. Click **Claims** (at the top of any page). The Claims Dashboard displays.
2. Under Manage Finances, click **View all EOPs**. The legacy Payment History [tab] displays.
3. Click **Saved**. The **Saved** tab displays.
4. Based on the claim draft, click **Professional Ready to be Submitted** or **Institutional Ready to be Submitted**.
5. Locate claim draft with the Claim Number (being disputed) in the Original Claim Number column.
6. Click:
  - a) **Edit**, to resume claim, complete and submit, or
  - b) **Delete** to delete claim draft.

The screenshot shows the Claims Dashboard interface. At the top, there are navigation tabs: Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below these, there are filters for 'Viewing Claims For' (TIN) and 'Plan Type' (Wellcare by Allwell), along with a 'GO' button and 'Upload EDI' and 'Create Claim' buttons. The main content area has a 'Claims' header with tabs for 'Individual', 'Saved', 'Submitted', 'Batch', and 'Payment History'. The 'Saved' tab is highlighted with a red box. Below the tabs, there is a message: 'Claims listed below have missing information or contain errors. Click 'Edit' to view a claim, then fix any errors or complete it before submitting.' There are three tabs for 'Drafts': 'Drafts', 'Professional Ready to be Submitted', and 'Institutional Ready to be Submitted'. The 'Professional Ready to be Submitted' tab is highlighted with a red box. Below the tabs is a table with columns: SELECT ALL, DATE CREATED ↑, CLAIM TYPE ↑, CLAIM ID ↑, MEMBER NAME ↑, MEMBER ID ↑, ORIGINAL CLAIM # ↑, TOTAL CHARGES ↑, and two empty columns. The table contains one row with the following data:  in the SELECT ALL column, 02/09/2023 in the DATE CREATED column, Institutional in the CLAIM TYPE column, 835165921 in the CLAIM ID column, [redacted] in the MEMBER NAME column, [redacted] in the MEMBER ID column, V306 in the ORIGINAL CLAIM # column, \$904.01 in the TOTAL CHARGES column, and Edit and Delete buttons in the last two columns. Below the table, it says 'One item found. Page 1/1 1'. At the bottom right, there is a green 'Submit' button with a right arrow.

SELECT ALL	DATE CREATED ↑	CLAIM TYPE ↑	CLAIM ID ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑		
<input type="checkbox"/>	02/09/2023	Institutional	835165921	[redacted]	[redacted]	V306	\$904.01	Edit	Delete

---

Create Claim

---

# Create Claim

Viewing Claims For: TIN [ ] Plan Type: Medicaid [GO]

### Claims

From: 01/19/2023 To: 02/18/2023 [CHANGE DATES]

REJECTED 0 [View All]	DENIED 125 [View All]	PENDING 656 [View All]
-----------------------------	-----------------------------	------------------------------

Shows claims for the last 30 days, from today's date.

### Search for Claims

ADVANCED SEARCH

The data available for Search by Member Info is limited to the last 30 days. For specific date range search, please use the advanced search.

**Check Status by Claim Number**

Enter Claim Number [ ] [CHECK]

**Search by Member Info**

Enter Last Name or Member ID [ ] Date of Birth [mm/dd/yyyy] [ ] [SEARCH]

### Create Claims

[Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim] [Upload EDI / Batch]

DRAFT CLAIMS  
0  
[View All]

Last 30 days, from today's date.

### Manage Finances

**Explanation of Payment (EOP)**

View all recent payment transactions, including downloadable EOPs, check numbers, dates and payment amounts.

[View all EOP]

**Reports & Tools**

[Batch Claims Report] [Claim Audit Tool]

PAID CLAIMS  
672  
[View All]

Last 30 days, from today's date.

### Resources

Updated Instruction Manual (PDF) CMS-1500 Claim Form (PDF) CMS-UB-04 Claim Form EDI Guide (PDF)

Instruction Manual (PDF) Terms and Conditions Privacy Policy Copyright © 2023, Centene Corporation

- On the Claims Dashboard, web claim creation options grouped in Create Claims section.
- Create Claim button replaced with a link and renamed, Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim.
- Recurring Claim link (*where available*), directs to legacy recurring claim creation page.
- Upload EDI button replaced with a link and renamed, Upload EDI / Batch.

# Create Claim – Individual Web Claim

To begin an individual web claim:

- Click **Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim**. The Check Member Eligibility pop-up displays.
- Enter **Member ID or Last Name**.
- Enter Member's **Date of Birth (DOB)**.
- Click **Search**. If the Member is found, the legacy Choose Claim Type page displays.
- Click **Professional Claim** or **Institutional Claim**.

The screenshot illustrates the process of creating a claim. It shows the 'Create Claims' page with a red box highlighting the 'Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim' button. A red arrow points from this button to the 'Check Member Eligibility' pop-up window. The pop-up contains a 'Member Search' section with input fields for 'Member ID or Last Name' and 'Date of Birth' (MM/DD/YYYY), and a 'SEARCH' button. Another red arrow points from the 'SEARCH' button to the 'Choose Claim Type' page. This page displays two options: 'CMS 1500 Professional Claim' and 'CMS UB-04 Institutional Claim', each with a green button and a right-pointing arrow. A 'DRAFT CLAIMS' box in the top right corner shows '12' claims and a 'View All' link. The top navigation bar includes 'Eligibility', 'Patients', 'Authorizations', 'Claims', and 'Messaging'.



**Tip:** In the Check Member Eligibility pop-up, if the Member is not found by Member Last Name and DOB, use the Member's Medicaid ID and DOB.

# Create Claim – Recurring Claim

Where available, to begin a Recurring Claim, click **Recurring Claim**. The legacy Recurring, Get Started page displays.

The screenshot displays the 'Create Claims' interface. On the left, a box titled 'Create Claims' contains a list of options: 'Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim', 'Recurring Claim' (highlighted with a red box), and 'Upload EDI / Batch'. A red arrow points from the 'Recurring Claim' option to the 'Recurring' tab in the 'Claims' section of the main dashboard. The dashboard includes a navigation bar with icons for 'Manage Practice', 'Eligibility', 'Patients', 'Authorizations', 'Claims', and 'Messaging'. Below this, there are filters for 'Viewing Dashboard For : TIN' and 'Plan Type' (set to 'Medicaid') with a 'GO' button. The 'Claims' section has tabs for 'Individual', 'Saved', 'Submitted', 'Batch', 'Recurring', 'Payment History', and 'Claims Audit Tool'. Below the tabs, there is a 'Get Started' section with the text 'Used only by LTC and ADC Providers.' and a 'Your Progress' indicator with three arrows. At the bottom, there is a 'Claim Type:' dropdown menu and a call to action: 'Select a Template to Start Your Claim' with a document icon and the text 'Our preset templates help speed up the claims process.'

# Create Claim – Upload EDI / Batch

Click **Upload EDI / Batch** to upload an EDI Batch (837I / 837P). The legacy Batch Claims Upload page displays. Follow onscreen instructions.

**Create Claims**

- Start a CMS 1500 / Professional or CMS UB-04 / Institutional Claim
- Recurring Claim
- Upload EDI / Batch**

**Batch Claims Upload**

Viewing Dashboard For: TIN [ ] Plan Type: Medicaid [ ] GO

1. Check your codes: ISA05 = ZZ, ISA06 = WebBatch or WEBBATCH, ISA07 = 30, ISA08 = 421406317, GS02 = WebBatch or WEBBATCH, GS03 = 421406317. For additional EDI information, please refer to Resources.
2. File Type: 837I 837P  
Please choose a file format of .dat, .edi, or .txt no larger than 25 MB containing less than 5,000 claims
3. Upload File: Choose File No file chosen  
File name should be 50 chars or less and should not contain any of the following special characters: -!@#%&\*'()/?\|,.; and be 50 characters or less.
4. Submit →

**Resources**

Please note that we currently accept formatted 837 claims files only. We apply HIPAA level 5 edits. If you are not familiar with generating or submitting an 837 file, please use a clearinghouse or our single claims submission module. We are continually developing new claims submission tools to allow you other formats by which to submit claims to use directly both individually and in bulk.

- Companion Guides >
- Batch Claims FAQs >



**Tip:** Provider organization must have software to create HIPAA-compliant EDI Batch files.

---

# Submitting Attachments to Pending Claims

---

# Claims Attachment (post claims submission)

Step 1: Locate the claim on the Claims Status Page

Step 2: Navigate to the Pending claim details and select upload document

**Claim: T350MOE12346**  
**Status: PENDING**

  Claim Submitted T350MOE12346  Denied  Reconsideration Submitted V444INW11129

---

<b>Member</b>		<b>Type and Dates</b>	
Member Name	-----	Type	CMS 1500
Date of Birth	12/09/2002	Service Dates	10/11/2022 - 10/11/2022
Member ID	9543155610	Submit Date	11/15/2022
Medicaid ID			
Plan Type	Medicaid		

---

<b>Payment</b>			
Billed	\$12,000,909.00	Check # / EFT	091232415
Paid	\$8,250,000.00	Check Date	11/13/2022
Payment Date	11/15/2022	Total Check Amount	\$11,775,045.55

---

+ COPY + VOID / RECOUP **DISPUTE**

---

**Claim Info**

Original Claim	T350MOE12346
Status	Pending
Type	CMS 1500
Service Dates	10/11/2022 - 10/11/2022
Submit Date	11/15/2022

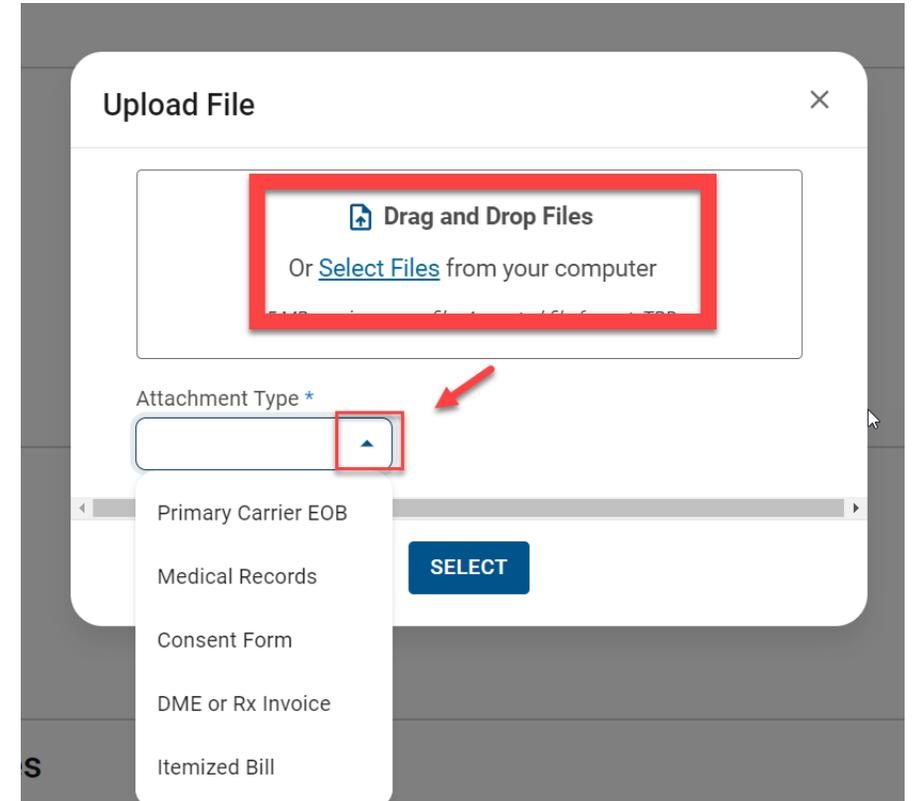
Associated Documents

**UPLOAD DOCUMENT**



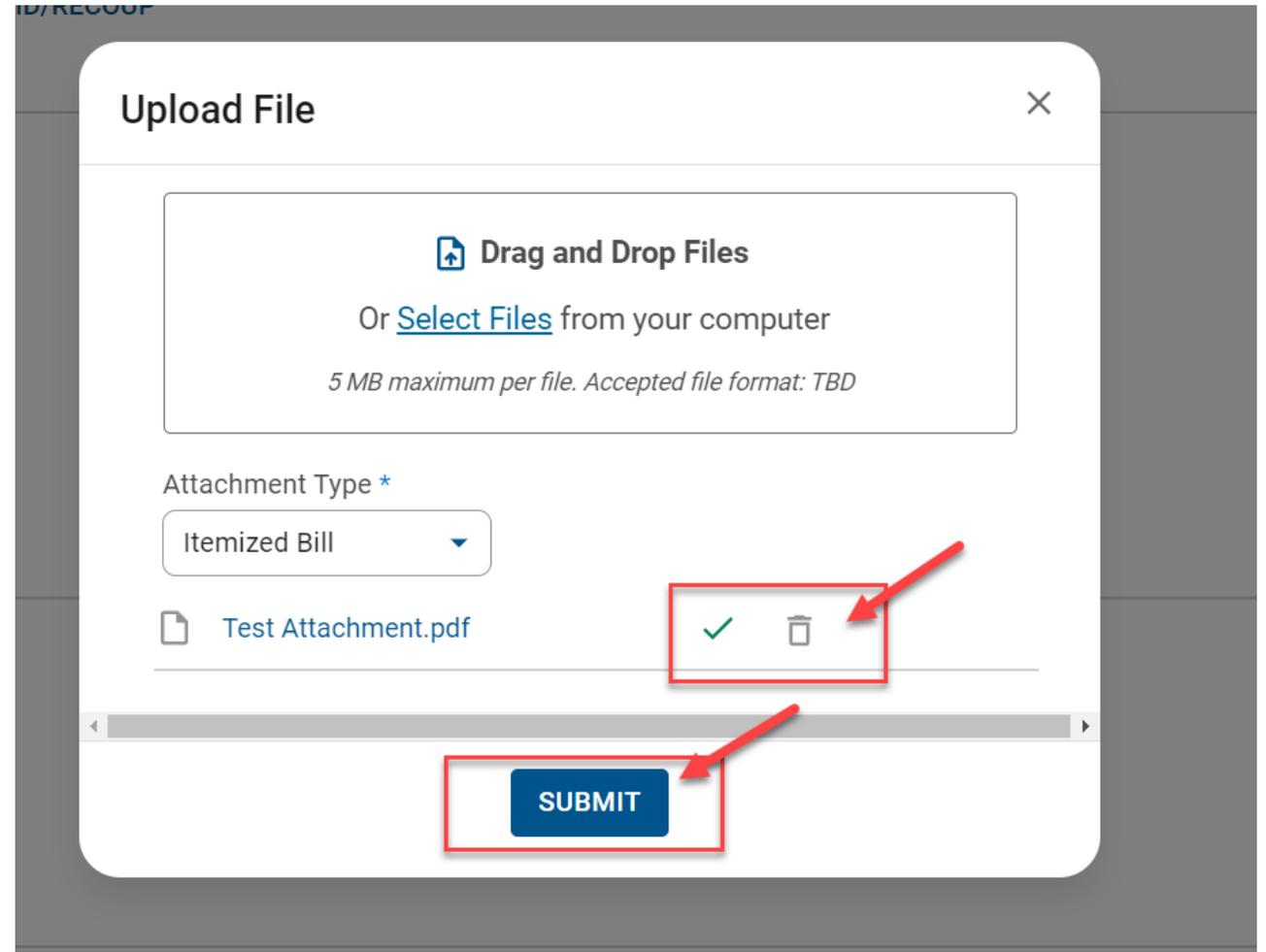
# Claims Attachment (post claims submission)

Step 3: Add documents via drag and drop or by selecting a file.



# Claims Attachment (post claims submission)

Step 4: Use trash can to delete upload if needed or click submit.



The screenshot shows a modal window titled "Upload File" with a close button (X) in the top right corner. Inside the modal, there is a large box with a file icon and the text "Drag and Drop Files" and "Or [Select Files](#) from your computer". Below this, it says "5 MB maximum per file. Accepted file format: TBD". Underneath is a dropdown menu labeled "Attachment Type \*" with "Itemized Bill" selected. Below the dropdown is a file entry for "Test Attachment.pdf" with a document icon. To the right of the file name are a green checkmark icon and a trash can icon. A red box highlights the trash can icon, with a red arrow pointing to it. At the bottom of the modal is a blue "SUBMIT" button, also highlighted with a red box and a red arrow.

# Claims Attachment (post claims submission)

Step 5: Confirmation appears at the top of the screen; document is immediately available to see.

✓ Your file was submitted successfully. ✕

**Claim:** T350MOE12346  
**Status:** PENDING

Claim Submitted T350MOE12346

Denied

Reconsideration Submitted V444INW11129

---

# Portal Functionality: Claim Tips

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# Claims – Submission Tips

- Always check the member's eligibility before submitting a claim
  - If a member is ineligible, claims can be submitted for DOS the member was eligible
- Hover mouse over tabs in the right margin for field-level help on web claims
- To submit a secondary web claim you must complete the Add Coordination of Benefits section on the Diagnosis Codes page and the Primary Insurance fields on the Service Lines page
- On the Service Lines page, always click Save/Update when creating or editing service line(s)
- NPI and Taxonomy should be entered on every claim, except some Atypical Providers
- Portal users can attach up to five (5) separate documents to their web claim submissions (first-time and corrected claims)

## Claims – Submission Tips (Continued)

- Organizations that upload EDI Batches (i.e. 837P / 837I) via the portal, must monitor the **Claims → Batch** for EDI response reports (i.e. 999, Audit File, etc.)
- Regardless of submission method, all claims go through the EDI claims process, and are:
  - Accepted and loaded for adjudication, **or**
  - Rejected and will not be processed any further (i.e. front-end EDI rejection)
- Once a web claim goes through the EDI process, the claim number will display on the **Claims → Submitted**, under the Claim Number column (4<sup>th</sup> column from the left)
  - If the web claim was accepted, use the Claim # to track status on the Individual tab

# Claims – Tracking / Status Tips

- Voided claims will not display in the portal
- When looking up a claim, the From Date must be on or before the first date of service (DOS) in the claim
- Portal users can access up to 24 months (from the current date) of claims history using the Filter buttons to change the date range
  - Date range is limited to one-month (at a time)

# Claims – Date Range Criteria Tips

- The Date Range criteria varies by Claims tab:
  - **Individual** tab is by Date of Service
  - **Submitted** tab is by Date Submitted
  - **Batch** is by Submitted Date
  - **Payment History** is by Check Date

# Benefits of Portal Utilization

- Portal available 24/7
- Cost savings, portal free to submit claims and authorizations
- Better management of patient's care, i.e. care gaps
- Efficiency of electronic authorizations and claim submissions
- Ability to view both patient and provider history/data
- Ability to correct claims

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ADVANCED MEDICAL HOMES

# Additional Portal Features

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# Portal Functionality: PMPM Payment Reports

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# Portal Functionality: PMPM Payment Reports

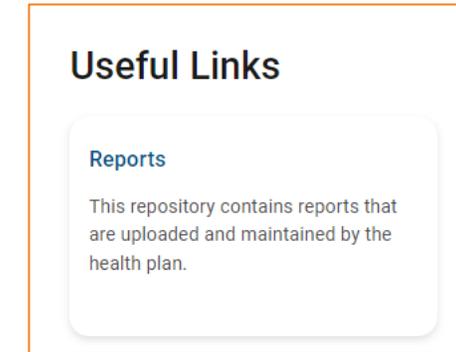
---

# Portal Home Page – Reports

On the Home Screen, under the ‘Useful Links’ dashboard, click ‘Reports’.

[View our How-to Guide for accessing Payment Reports for more information](#)

The types of Capitation Reports found in this module have two different document endings .xlsx and .txt. For details on converting the .TXT file into an excel file that can be sorted and analyzed, view our [how-to guide](#)



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# Portal Functionality: Provider Analytics

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# Provider Analytics

## Useful Links

To view Provider Analytics

1. Click **Provider Analytics**
2. **Agree to HIPAA terms**

### Reports

This repository contains reports that are uploaded and maintained by the health plan.

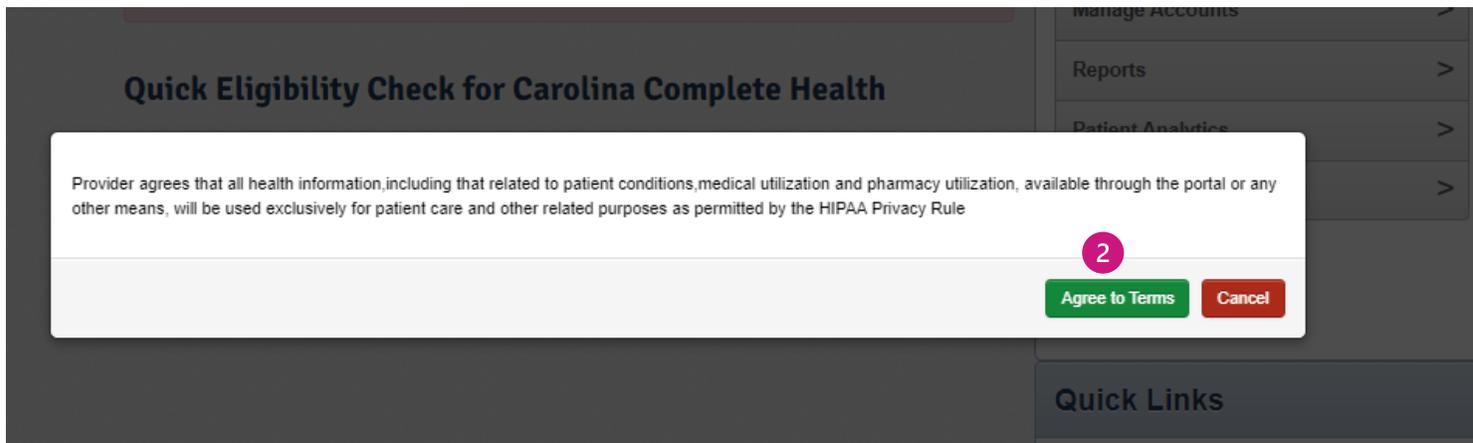
### Patient Analytics - Coming Soon

This is a PHM tool that supports providers in the delivery of timely, efficient, and evidence-based care to our members.

1

### Provider Analytics [↗](#)

Used by PCP groups to access data/reports/dashboard that assist in providing better health outcomes and lower cost.



# Supplemental Reports

## Provider Analytics



### Resources

- Case Study Support Resource
- FAQ
- Tool Navigation Guide

### Supplemental Reports

COVID-19 Detail	12-06-2021	
Daily IP & Discharge	No Report	...
Weekly Med Claims	12-05-2021	...
Weekly Rx Claims	12-05-2021	...

### P4P and Quality Reporting

Quality

- 2021 NC Med (Adults)
- 2021 NC Medicaid (Peds)

### Dashboards

No data returned for this view. This might be because the applied filter excludes all data.



Reference Materials  
[Data Dictionary](#)

# P4P and Quality Reporting

The screenshot displays the 'Provider Analytics' dashboard. At the top, there is a 'Resources' section with links for 'Case Study Support Resource', 'FAQ', and 'Tool Navigation Guide'. Below this, the dashboard is divided into three main sections: 'Supplemental Reports', 'P4P and Quality Reporting', and 'Dashboards'. The 'P4P and Quality Reporting' section is highlighted with a pink box and contains links for 'Quality', '2021 NC Med (Adults)', and '2021 NC Medicaid (Peds)'. The 'Dashboards' section shows a message: 'No data returned for this view. This might be because the applied filter excludes all data.' At the bottom left, there is a 'Reference Materials' section with a link to 'Data Dictionary'.

Supplemental Reports	
COVID-19 Detail	12-06-2021
Daily IP & Discharge	No Report ...
Weekly Med Claims	12-05-2021 ...
Weekly Rx Claims	12-05-2021 ...

P4P and Quality Reporting	
Quality	
2021 NC Med (Adults)	
2021 NC Medicaid (Peds)	

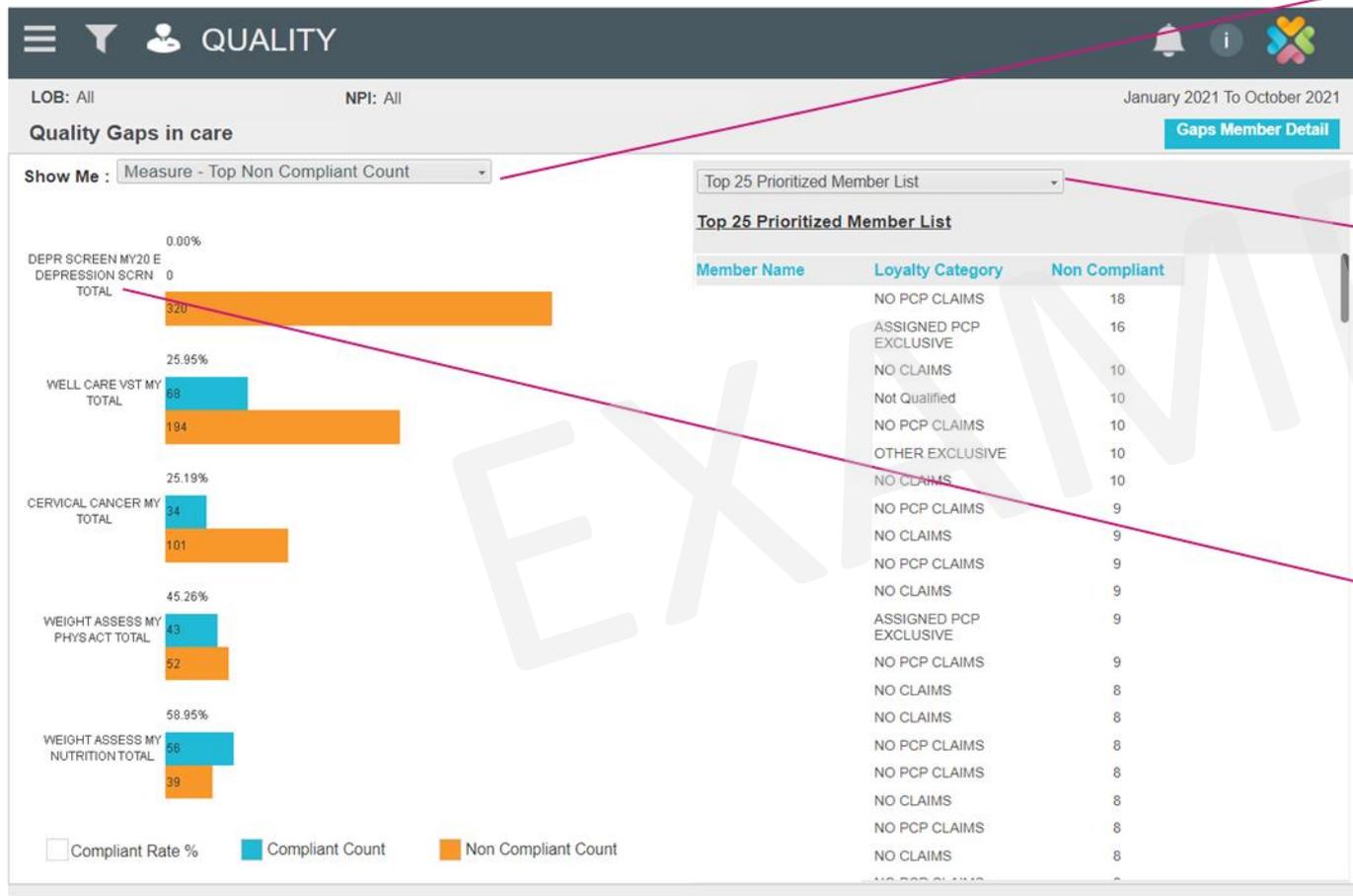
**Dashboards**  
No data returned for this view. This might be because the applied filter excludes all data.

**Reference Materials**  
[Data Dictionary](#)

**Quality:** All AMHs have Quality care gap and measure report available that includes all priority measures.

**P4P:** All AMHs have a standard P4P available except those within practice entities that are involved in a broad value-based payment arrangement.

# Quality Measures



**QUALITY**

LOB: All NPI: All

**Quality Gaps in care**

Show Me: Measure - Top Non Compliant Count

- Measure - Top Non Compliant Count
- Measure - Top Compliant Count
- Measure - Top Compliant Rate %
- Measure - All
- NPI - Top Non Compliant Count
- NPI - Top Compliant Count
- NPI - Top Compliant Rate %
- NPI - All

Top 25 Prioritized Member List

- Top 25 Prioritized Member List
- CIS Combo 10 - Sub Measure Member Details
- Well Child 15 - Sub Measure Member Details

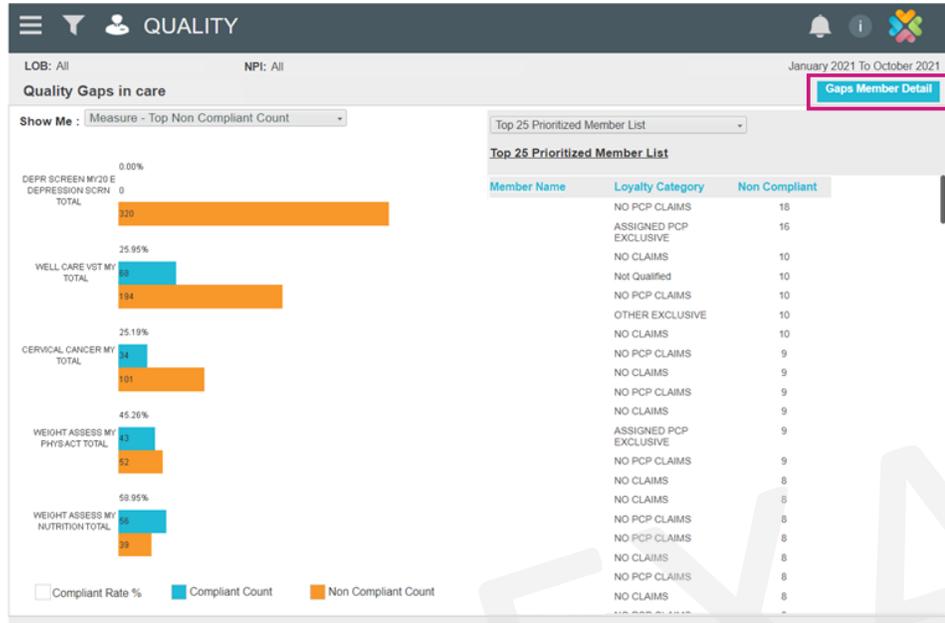
**NPI by Measure Report**

Measure: CHILD AND ADOLESCENT WELL-CARE VISITS MY Total Qualified Members: 262

Sub Measure: TOTAL

NPI	Qualified Count	Compliant Count	Non Compliant Count	Compliant Rate %
	35	8	27	22.86%
	116	36	80	31.03%
	50	15	35	30.00%
	12	3	9	25.00%
	8	0	8	0.00%
	19	3	16	15.79%
	6	0	6	0.00%
	9	2	7	22.22%
	7	1	6	14.29%

# Quality Gaps- Member Detail



Top 25 Prioritized Member List

Member Name	Loyalty Category	Non Compliant
	NO PCP CLAIMS	18
	ASSIGNED PCP EXCLUSIVE	16
	NO CLAIMS	10
	Not Qualified	10
	NO PCP CLAIMS	10
	OTHER EXCLUSIVE	10
	NO CLAIMS	10
	NO PCP CLAIMS	9
	NO CLAIMS	9
	NO PCP CLAIMS	9
	NO CLAIMS	9
	ASSIGNED PCP EXCLUSIVE	9
	NO PCP CLAIMS	9
	NO CLAIMS	8
	NO CLAIMS	8
	NO PCP CLAIMS	8
	NO PCP CLAIMS	8
	NO CLAIMS	8
	NO PCP CLAIMS	8
	NO CLAIMS	8

Gaps Member Detail

## Member Detail

Year	LOB	NPI	Measure	Sub Measure	Compliant (Y/N)	Loyalty Category
All	All	All	All	All	All	All
2020	MARKETPLACE		ADULTS ACCESS MY ANTIDEPRESS RX MY APP TREAT URI MY BREAST CANCER MY CERVICAL CANCER MY CHILDHOOD IMM MY CHLAMYDIA SCR N MY COMP DIAB N MCR MY	ADULTS ACCESS MY - TOTAL ANTIDEPRESS RX MY - ACUTE PHASE ANTIDEPRESS RX MY - CONTINUATION PHASE APP TREAT URI MY - TOTAL BREAST CANCER MY - NON-MCR TOTAL CERVICAL CANCER MY - TOTAL CHILDHOOD IMM MY - COMBO 10 CHILDHOOD IMM MY - COMBO 2	Y	ASSIGNED PCP EXCLUSIVE MULTIPLE PCP WITH ASSIGN NO CLAIMS NO PCP CLAIMS NOT QUALIFIED OTHER EXCLUSIVE
2021	MEDICAID				N	

### All Member Detail Datasets

TIN	NPI	NPI Name	Measure	Sub Measure	Ambetter Id	Medicaid Id	Medicare Id	Line of Business
			CBPMYB CONTROLLING HIGH BLOOD PRESSURE NON-MEDICARE MY	TOTAL				MEDICAID
			DSFMYE DEPRESSION SCREENING AND FOLLOW-UP FOR ADOLESCENTS AND ADULTS MY 2020 ECDS	DEPRESSION SCREENING TOTAL				MEDICAID
			W30MY WELL CHILD VISITS IN THE FIRST 30 MONTHS OF LIFE	WELL CHILD VISITS FOR AGE15-30 MONTHS				MEDICAID
			WCVMY CHILD AND ADOLESCENT WELL-CARE VISITS MY	TOTAL				MEDICAID
			CCSMY CERVICAL CANCER SCREENING MY	TOTAL				MEDICAID
			DSFMYE DEPRESSION SCREENING AND FOLLOW-UP FOR ADOLESCENTS AND ADULTS MY 2020 ECDS	DEPRESSION SCREENING TOTAL				MEDICAID

Export to PDF  
Export to Excel

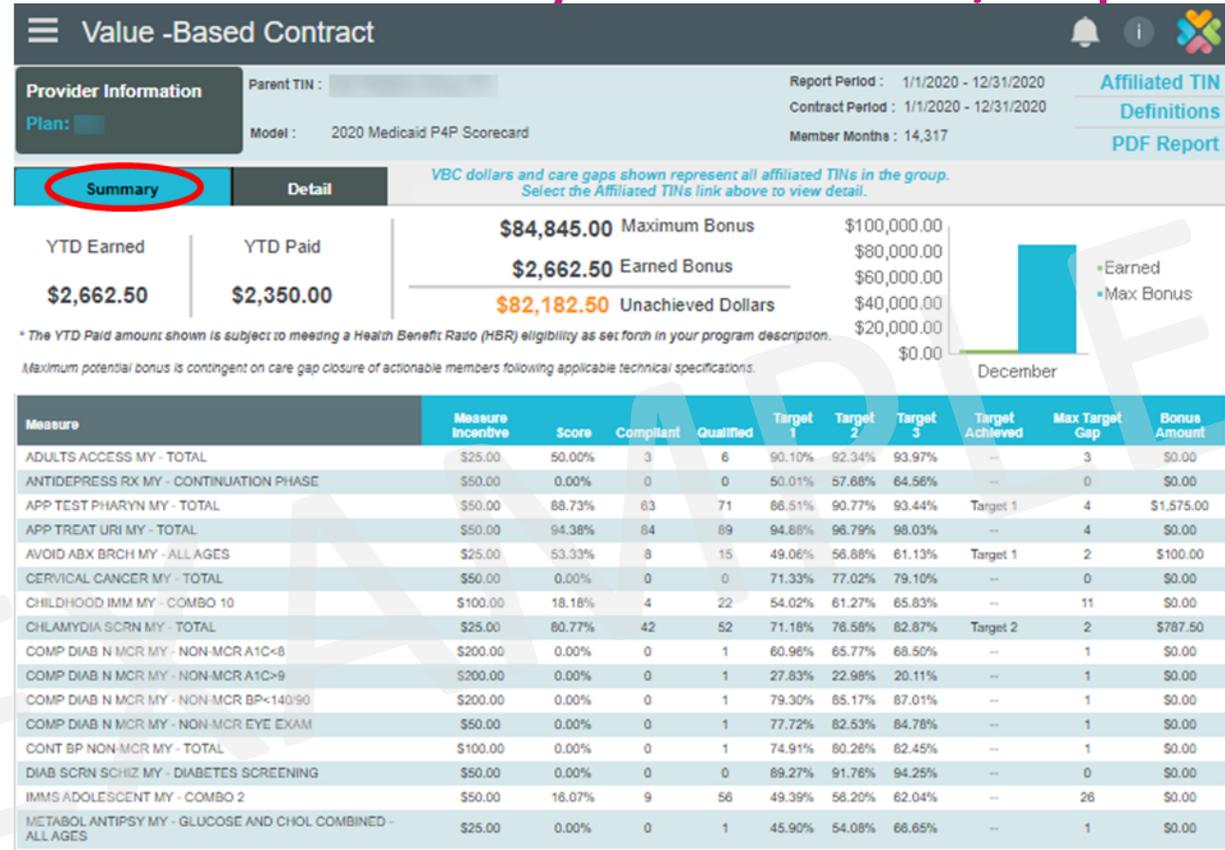
---

# Portal Functionality: Pay-for-Performance Scorecards

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# Value-Based Contract – Summary Scorecards/Reports

P4P and Quality Reporting  
Quality  
2021 NC Med (Adults)  
2021 NC Medicaid (Peds)



- Sub Measure = HEDIS measures in P4P
- Maximum Incentive = Payout for each compliant event
- Score = Compliant/Qualified (also known as rate)
- Targets = set by plan to earn payout
- Target Achieved = current performance
- Max Target Gap = # of additional compliant events needed to get to the highest target (max payout)
- Bonus Amount = earned through report date

**NOTE:** This is a summary report you can scroll through the measures and sort the columns but there is no drill down capabilities. For a hard copy to go the "PDF Report". For drill down capabilities go to the "Detail" tab

# P4P Scorecard

**Value -Based Contract**

**Provider Selection**  
Plan: NO

Parent TIN :  
Model : 2021 NC Med (Adults)

Report Period : 1/1/2021 - 10/31/2021  
Contract Period : 1/1/2021 - 12/31/2021  
Member Months :

[Affiliated TIN](#)  
[Definitions](#)  
[PDF Report](#)

**Summary** | **Detail**

*VBC dollars and care gaps shown represent all affiliated TINs in the group. Select the Affiliated TINs link above to view detail.*

**Qualifying Measures :**  
Measures Receiving Payment :  
Minimum Qualified Measure :

PMPM Rate :  
Member Months :  
Paid Amount :

Earned Amount : \$0.00  
Unearned Amount : \$  
Maximum Bonus : \$

*Maximum potential bonus is contingent on care gap closure of actionable members following applicable technical specifications.*

Measure	Measure Incentive	Score	Compliant	Qualified	Min Member Threshold	Target 1	Target 2	Target Achieved
CERVICAL CANCER MY - TOTAL	\$0.40							
CHILDHOOD IMM MY - COMBO 10	\$0.40							
CHLAMYDIA SCR N MY - TOTAL	\$0.40							
COMP DIAB N MCR MY - NON-MCR A1C>9	\$0.40							
CONT BP NON-MCR MY - TOTAL	\$0.60							
IMMS ADOLESCENT MY - COMBO 2	\$0.40							
WELL CARE VST MY - TOTAL	\$0.60							
WELL CHILD 30 MY - WELL CHILD VISITS FOR AGE15-30 MONTHS	\$0.40							
WELL CHILD 30 MY - WELL CHILD VISITS IN THE FIRST 15 MONTHS	\$0.40							

**PDF Report Export**

Parent TIN :  
Model : 2021 NC Med (Adults)

**Report Year** : 2021

**Report Period Date Range**  
2021-01-01 - 2021-10-31  
2021-01-01 - 2021-09-30

**Member Detail Export**

Report Period : 1/1/2021 - 10/31/2021  
Contract Period : 1/1/2021 - 12/31/2021

[Affiliated TIN](#)  
[Definitions](#)  
[PDF Report](#)

October  
Max Bonus

Max Target Gap	Bonus Amount
4	\$0.00
124	\$0.00
42	\$0.00

# P4P Gaps- Member Detail

Report Period : 1/1/2021 - 10/31/2021

Affiliated TIN ▶  
 Definitions ▶  
 PDF Report ▶

PDF Report Export

Parent TIN :

Model : 2021 NC Med (Adults)

Report Year : 2021  
 Report Period Date Range : 2021-01-01 - 2021-10-31  
 2021-01-01 - 2021-09-30

Member Detail Export

Max Target Gap	Bonus Amount
4	\$0.00
124	\$0.00
42	\$0.00

## VBC Member Detail

LOB	NPI	Measure	Sub Measure	Compliant (Y/N)	Loyalty Category
All MEDICAID		All CERVICAL CANCER MY CHILDHOOD IMM MY CHLAMYDIA SCRNM MY COMP DIAB N MCR MY CONT BP NON-MCR MY IMMS ADOLESCENT MY WELL CARE VST MY WELL CHILD 30 MY	CHILDHOOD IMM MY - COMBO 10 CHLAMYDIA SCRNM MY - TOTAL COMP DIAB N MCR MY - NON-MCR A1C>9 CONT BP NON-MCR MY - TOTAL IMMS ADOLESCENT MY - COMBO 2 WELL CARE VST MY - TOTAL WELL CHILD 30 MY - WELL CHILD VISITS FOR AGE 15- WELL CHILD 30 MY - WELL CHILD VISITS IN THE FIRS	All N Y	All ASSIGNED PCP EXCLUSIVE MULTIPLE PCP WITH ASSIG MULTIPLE PCP WITH NO AS NO CLAIMS NO PCP CLAIMS NOT QUALIFIED OTHER EXCLUSIVE

Member Detail

Click drop down menu to export

Parent TIN	TIN	NPI	NPI Name	Measure	Sub Measure	Ambetter Id	Medicaid Id
				W30MY WELL CHILD VISITS IN THE FIRST 30 MONTHS OF LIFE	WELL CHILD VISITS IN THE FIRST 15 MONTHS		
				W30MY WELL CHILD VISITS IN THE FIRST 30 MONTHS OF LIFE	WELL CHILD VISITS IN THE FIRST 15 MONTHS		
				W30MY WELL CHILD VISITS IN THE FIRST 30 MONTHS OF LIFE	WELL CHILD VISITS IN THE FIRST 15 MONTHS		

Export to PDF  
 Export to Excel

# Thank you!