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Building Community Well-Being.

Trillium
HEALTH RESOURCES

carolina
complete health

Physical Health Provider Orientation

Hosted by: Carolina Complete Health Network

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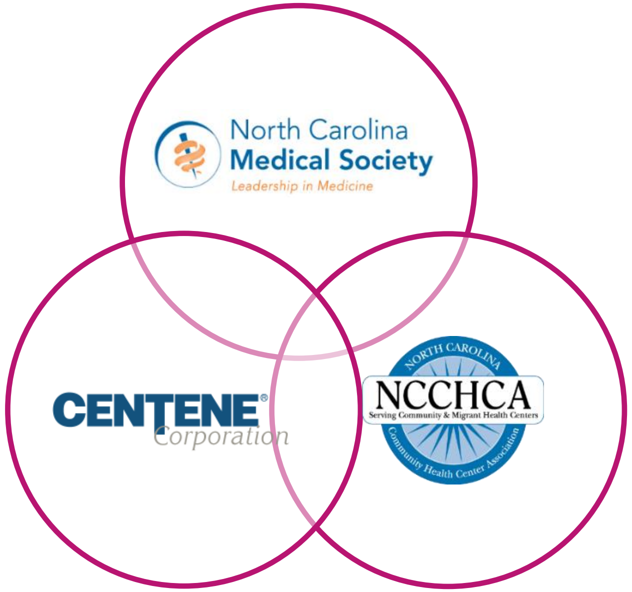
NCQA
HEALTH PLAN
INTERIM

Agenda:

- **General Overview**
- Who We Are – North Carolina's Provider Led Plan
- **Operational Information**
- Website and Secure Portal
- Prior Authorization
- Claims, Billing and Payments
- Complaints, Grievances and Appeals
- Specialty Companies and Vendors

About Carolina Complete Health

Carolina Complete Health is the first and only Provider-Led Entity (PLE) in North Carolina, established through a joint venture between the Centene Corporation, the North Carolina Medical Society (NCMS), the North Carolina Community Health Center Association (NCCHCA). Since July 1, 2021, Carolina Complete Health has provided Medicaid in 41 counties. We believe that providers are essential to providing leadership and strategic direction to Medicaid Managed Care and are committed to giving them a voice in key policymaking.

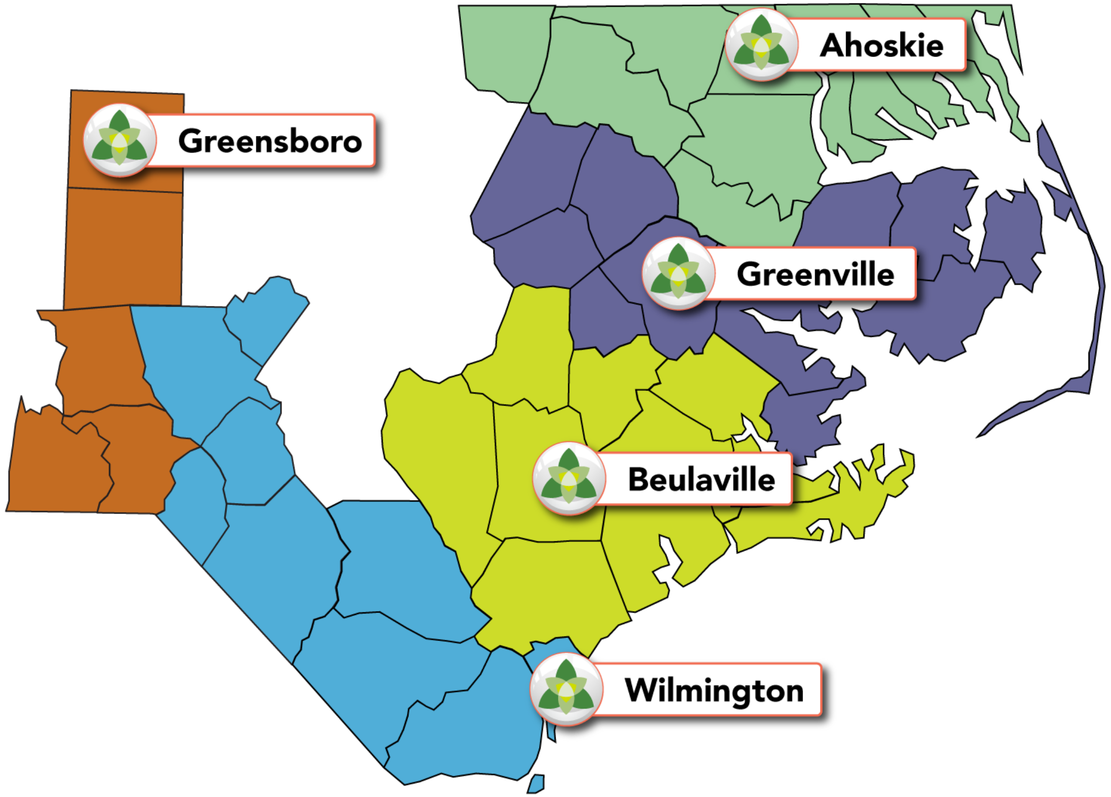

North Carolina Medical Society
Leadership in Medicine
CENTENE Corporation
NORTH CAROLINA NCCHCA Serving Community & Migrant Health Centers
Community Health Center Association

Centene Corporation	• **Fortune 25** company with over 30 years of Medicaid experience • **#1 in Medicaid and #1 in Marketplace** in the U.S., operating in **50** states • Insure over **26 million** members
NC Medical Society	• **8,000+** members including doctors and physician assistants • Lead health policy in North Carolina • Engaged in practice transformation and provider recruitment strategies • Advocate for medically underserved and rural populations
NC Community Health Center Association	• **39** health center grantees and look-alike organizations • Serving over **500,000** underinsured and uninsured • **270** clinical sites across 100 counties in North Carolina

Our Partnership with Trillium Health Resources

Trillium is working with Carolina Complete Health to build and support the physical health provider network.

This includes contracting, physical health claims processing, physical health authorization review, physical health provider engagement, and more!



Ahoskie
Greensboro
Greenville
Beulaville
Wilmington

Key Contacts

Billing Questions/Support	Trillium Provider Support Service Line: 1-855-250-1539 *(Have your TIN and NPI ready for provider verification) Once you are working with your assigned CCHN Provider Relations Coordinator, you can contact them directly.
Authorization Submissions/Questions	Call Trillium at 1-855-250-1539 and wait on the line for Provider Support Service Line. Request to be transferred to the CCH Physical Health UM Team.
Member and Recipient Service Line	1-877-685-2415
Submitting Trillium's 3051 Form	LTSS@trilliumnc.org
Questions about PCS?	If you have questions about PCS, you may call Trilliums' Provider Support Service Line at 1-855-250-1539 or you can submit questions online at through the PCS inquiry form
HHAeXchange Client Support	Client Support Portal
Technical Support for the Trillium PH Portal	CCHN Provider Engagement Team: ProviderEngagement@cch-network.com

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Portal, Claims, Payment, Prior Auth

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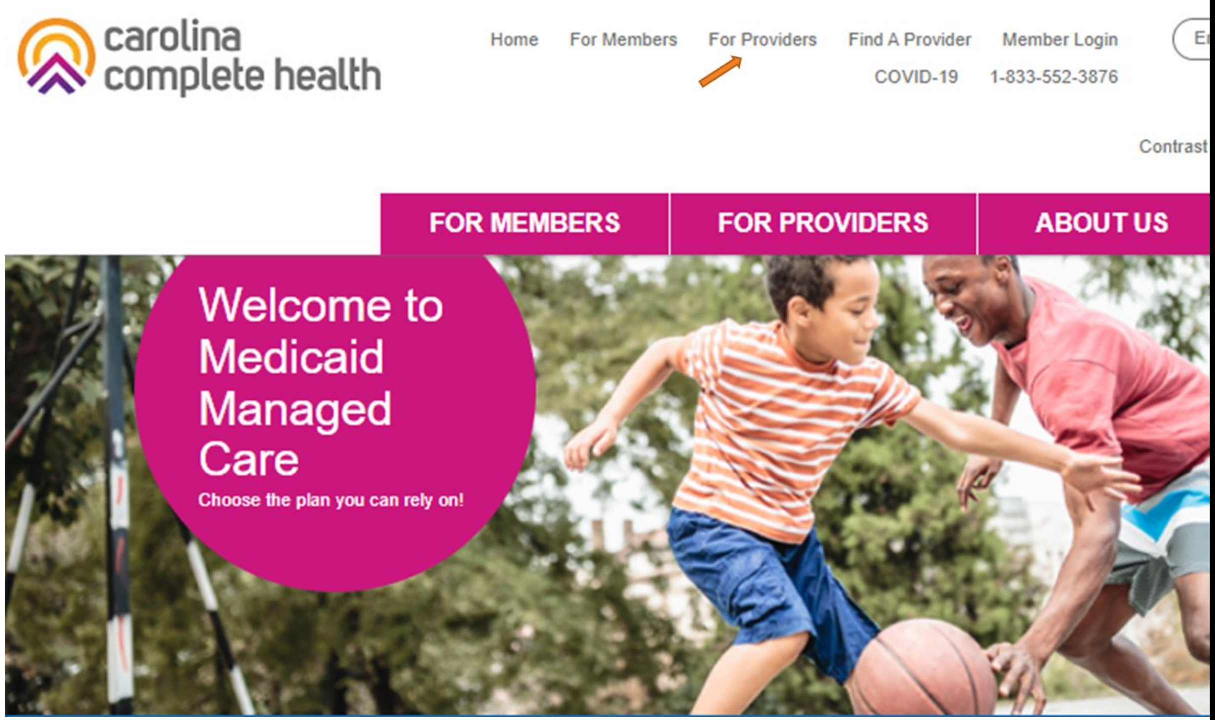
FULL

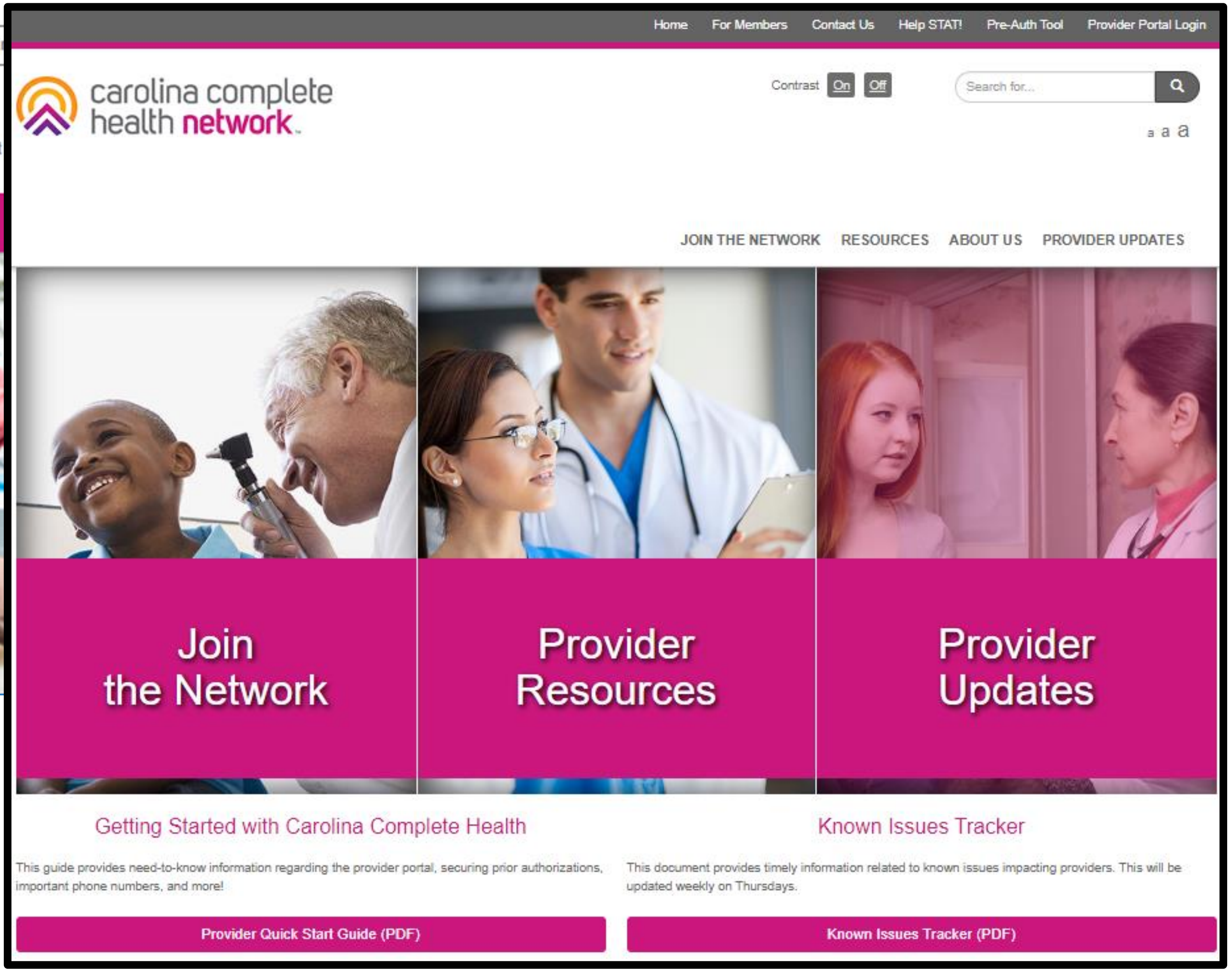
CCH Provider Website (Public)


carolina complete health
Home
For Members
For Providers
Find A Provider
Member Login
COVID-19
1-833-552-3876
Contrast
FOR MEMBERS
FOR PROVIDERS
ABOUT US

Welcome to Medicaid Managed Care

Choose the plan you can rely on!

network.carolinacompletehealth.com


Home
For Members
Contact Us
Help STAT!
Pre-Auth Tool
Provider Portal Login
carolina complete health network
Contrast On Off
Search for...
a a a
JOIN THE NETWORK
RESOURCES
ABOUT US
PROVIDER UPDATES
Join the Network
Provider Resources
Provider Updates
Provider Quick Start Guide (PDF)
Known Issues Tracker (PDF)

Getting Started with Carolina Complete Health

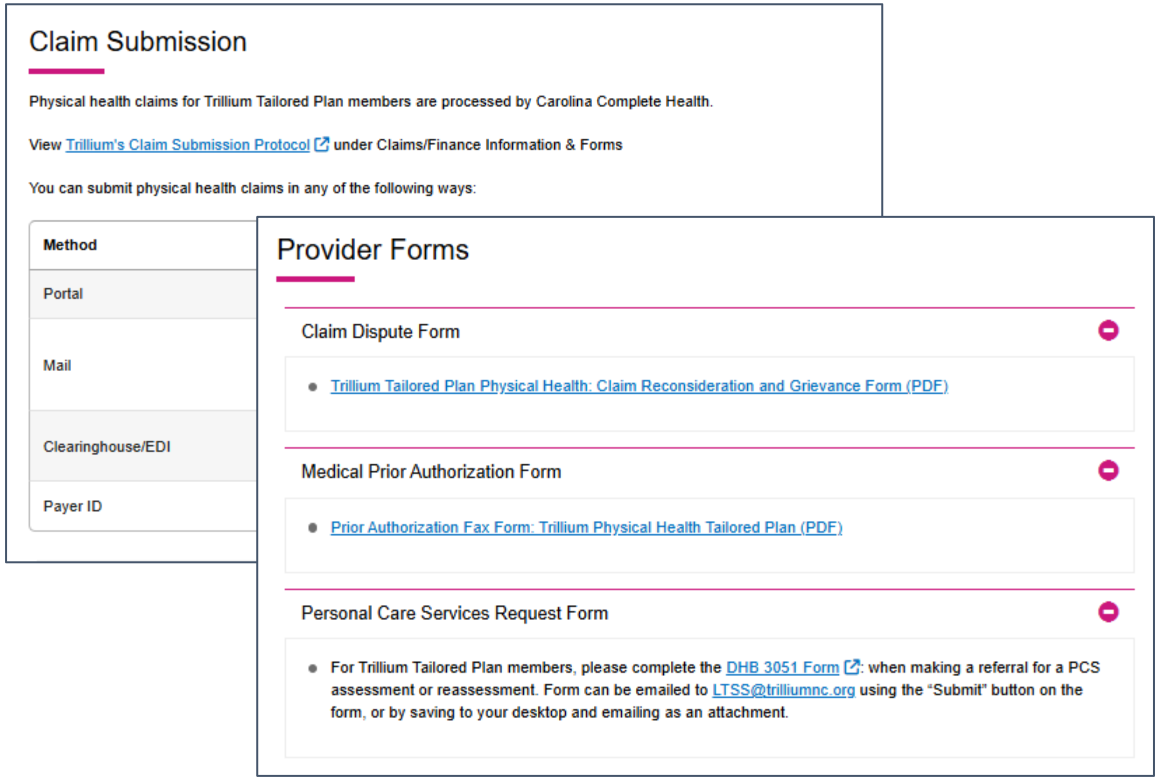
This guide provides need-to-know information regarding the provider portal, securing prior authorizations, important phone numbers, and more!

Known Issues Tracker

This document provides timely information related to known issues impacting providers. This will be updated weekly on Thursdays.

Physical Health Provider Resources

- network.carolinacompletehealth.com/Trillium



Claim Submission

Physical health claims for Trillium Tailored Plan members are processed by Carolina Complete Health.

View Trillium's Claim Submission Protocol under Claims/Finance Information & Forms

You can submit physical health claims in any of the following ways:

Method
Portal
Mail
Clearinghouse/EDI
Payer ID

Provider Forms

Claim Dispute Form

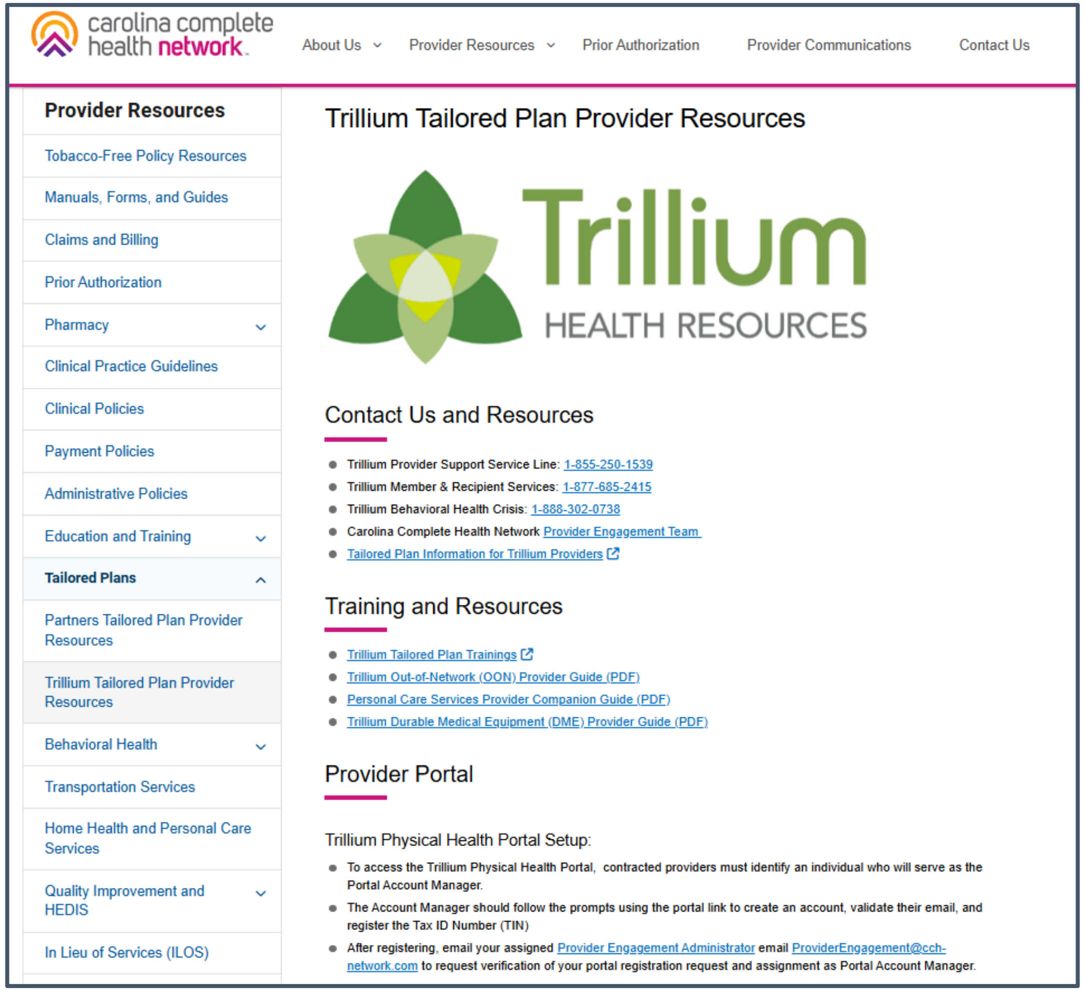
- Trillium Tailored Plan Physical Health: Claim Reconsideration and Grievance Form (PDF)

Medical Prior Authorization Form

- Prior Authorization Fax Form: Trillium Physical Health Tailored Plan (PDF)

Personal Care Services Request Form

- For Trillium Tailored Plan members, please complete the DHB 3051 Form: when making a referral for a PCS assessment or reassessment. Form can be emailed to LTSS@trilliumnc.org using the "Submit" button on the form, or by saving to your desktop and emailing as an attachment.


carolina complete health network
About Us
Provider Resources
Prior Authorization
Provider Communications
Contact Us
Provider Resources
Tobacco-Free Policy Resources
Manuals, Forms, and Guides
Claims and Billing
Prior Authorization
Pharmacy
Clinical Practice Guidelines
Clinical Policies
Payment Policies
Administrative Policies
Education and Training
Tailored Plans
Partners Tailored Plan Provider Resources
Trillium Tailored Plan Provider Resources
Behavioral Health
Transportation Services
Home Health and Personal Care Services
Quality Improvement and HEDIS
In Lieu of Services (ILOS)
Trillium HEALTH RESOURCES

Trillium Tailored Plan Provider Resources

Contact Us and Resources

- Trillium Provider Support Service Line: 1-855-250-1539
- Trillium Member & Recipient Services: 1-877-685-2415
- Trillium Behavioral Health Crisis: 1-888-302-0738
- Carolina Complete Health Network Provider Engagement Team
- Tailored Plan Information for Trillium Providers

Training and Resources

- Trillium Tailored Plan Trainings
- Trillium Out-of-Network (OON) Provider Guide (PDF)
- Personal Care Services Provider Companion Guide (PDF)
- Trillium Durable Medical Equipment (DME) Provider Guide (PDF)

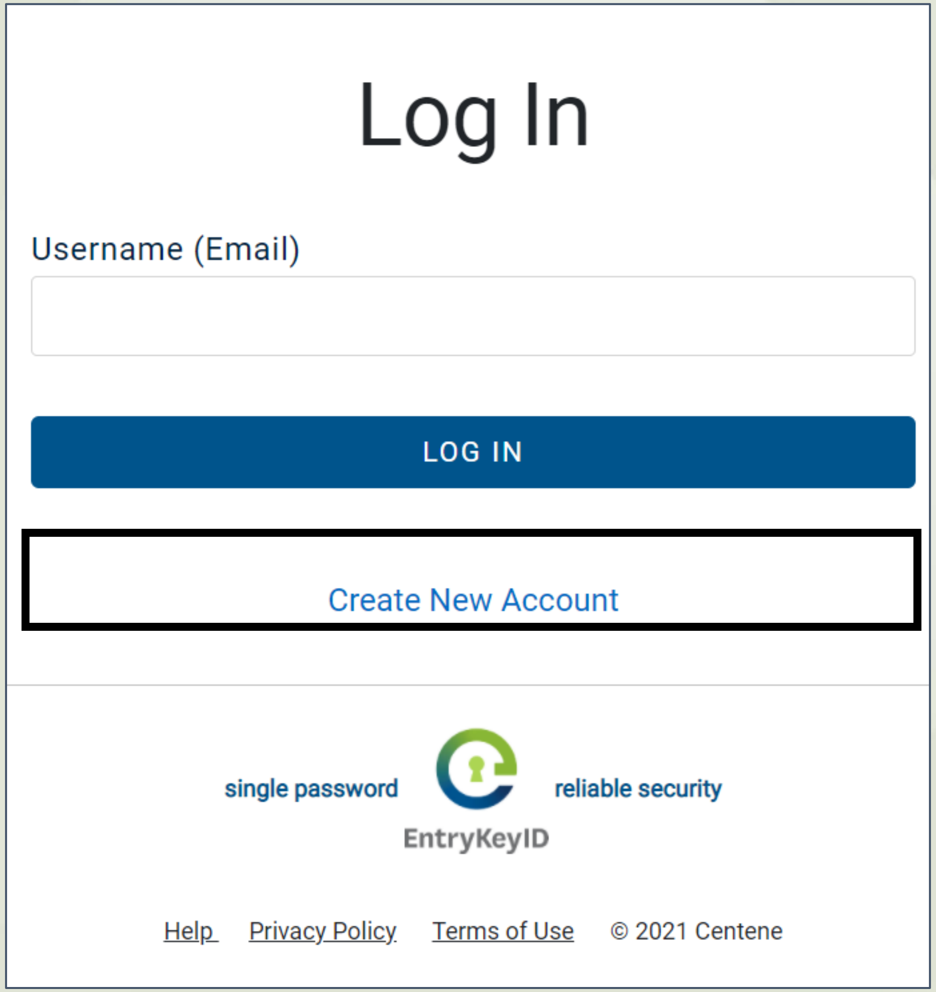
Provider Portal

Trillium Physical Health Portal Setup:

- To access the Trillium Physical Health Portal, contracted providers must identify an individual who will serve as the Portal Account Manager.
- The Account Manager should follow the prompts using the portal link to create an account, validate their email, and register the Tax ID Number (TIN)
- After registering, email your assigned Provider Engagement Administrator email ProviderEngagement@cch-network.com to request verification of your portal registration request and assignment as Portal Account Manager.

Create New Account: https://provider.trilliumhealthresources.org/

Tip: add no-reply@mail.entrykeyid.com **to your email contacts**



Log In

Username (Email)

LOG IN
Create New Account
single password
reliable security
EntryKeyID
Help
Privacy Policy
Terms of Use

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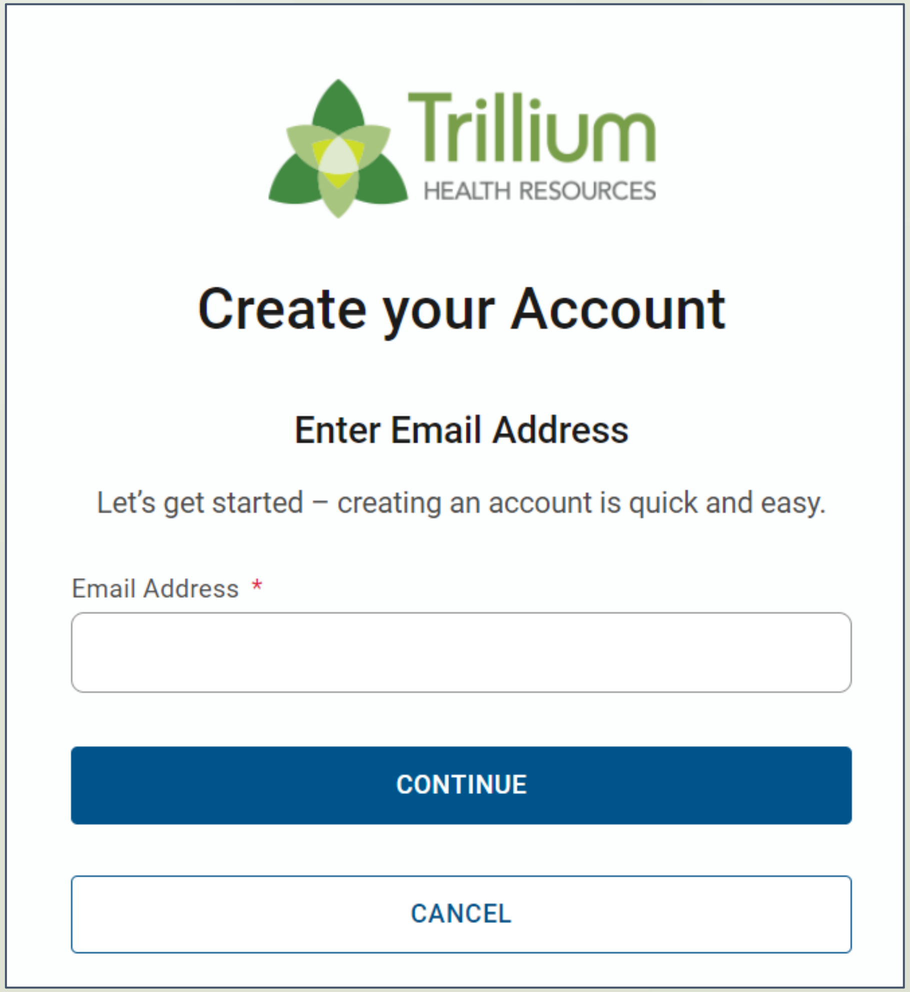

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Create your Account

Enter Email Address

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

Email Address *

CONTINUE
CANCEL

Initial Portal Registration

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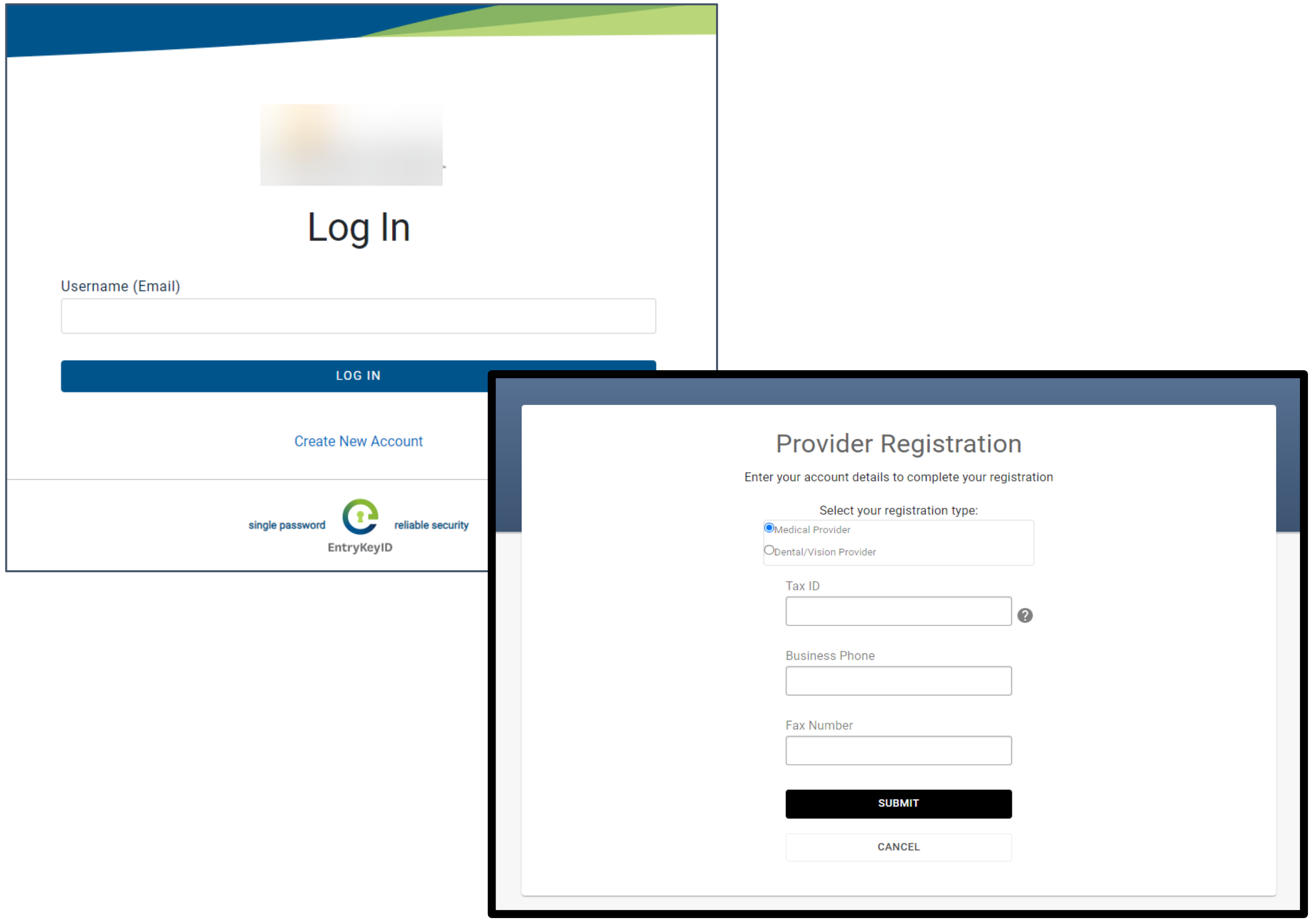
- **Portal Registration**: Once the EntryKeyID account setup is completed, the portal user will log in with their Username and password. The Portal Registration page will display.
- Once you have completed registration, your portal **Account Manager** can verify your access.
- **If an Account Manager is not yet established,** that individual should reach out to CCHN Provider Engagement for set-up.



Log In

Username (Email)

LOG IN

Create New Account

single password EntryKeyID reliable security

Provider Registration

Enter your account details to complete your registration

Select your registration type:

● Medical Provider

○ Dental/Vision Provider

Tax ID

Business Phone

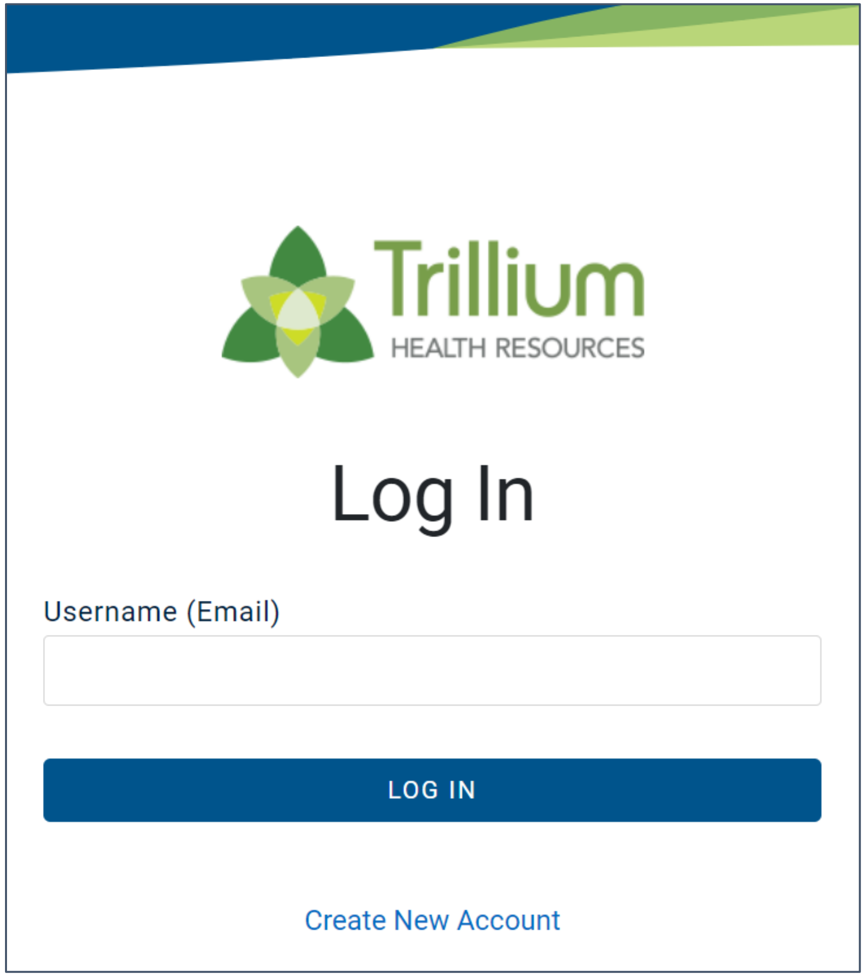
Fax Number

SUBMIT

CANCEL

Tip: To register for the portal, the provider organization's TIN ***must*** be loaded in our back-end system(s).

Overview: Physical Health Portal Set-up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Log In

Username (Email)

Secure Portal address: https://provider.trilliumhealthresources.org/

1. **Assign Portal Account Manager:** To access the Trillium Physical Health Portal, in-network contracted providers must identify one individual who will serve as the Portal Account Manager. The Account Manager will be responsible for managing all other users for that provider organization.
2. **Create an account:** Visit provider.trilliumhealthresources.org to create a new account associated with your email address.
3. **Verify email:** Verify your email address by entering the one time code sent by EntryKeyID.
4. **Register TIN:** Under the 'Success!' message, click continue to enter the Tax ID for the contracted entity, business phone and fax. Click 'Submit.'
5. **Email Provider Engagement:** After registering, email your assigned Provider Engagement Administrator to request verification of your portal registration request and assignment as Portal Account Manager. **CCHN Is responsible for verifying/setting up the first Account Manager.**

Note: Providers should not use the Carolina Complete Health Standard Plan portal to submit Tailored Plan claims.

Availity Essentials: Additional Secure Portal Option

Centene has chosen Availity Essentials as a new, secure provider portal. Current Availity Essentials functions include:

- Submit claims
- Check claim status
- Submit authorizations

- Our current secure portal is still available for other functions that providers use today. For providers new to Availity Essentials, getting their Essentials account is the first step toward working on Availity.

- The provider organization’s designated Availity administrator is the person responsible for registering their practice in Essentials, managing user accounts, and should have legal authority to sign agreements for their organization.
- Administrators can register with Availity Essentials here:
    - **www.Availity.com/documents/learning/LP_AP_GetStarted**
    - Providers needing additional assistance with registration can call Availity Client Services at **1-800-AVAILITY (282-4548),** Monday through Friday, 8 a.m. – 8 p.m. ET.
- For general questions, providers can reach out to their health plan Provider Engagement representative.

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Portal Account Manager

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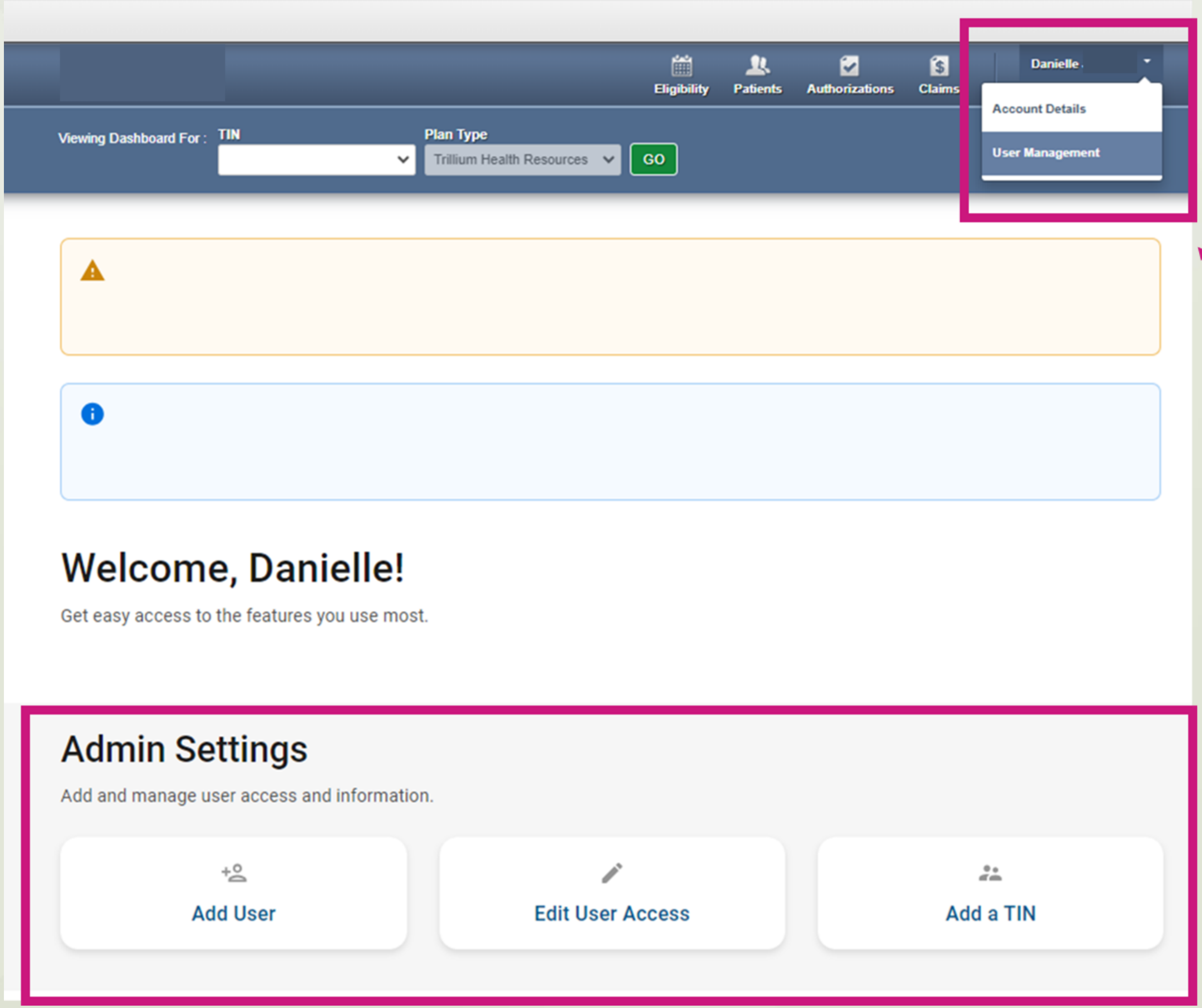
Portal Account Manager

- 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 assigned Provider Engagement Administrator or ProviderEngagement@cch-network.com to establish the first account manager for your TIN


Eligibility
Patients
Authorizations
Claims
Danielle
Account Details
User Management
Viewing Dashboard For :
TIN
Plan Type
Trillium Health Resources
GO
Add User
Edit User Access
Add a TIN

Welcome, Danielle!

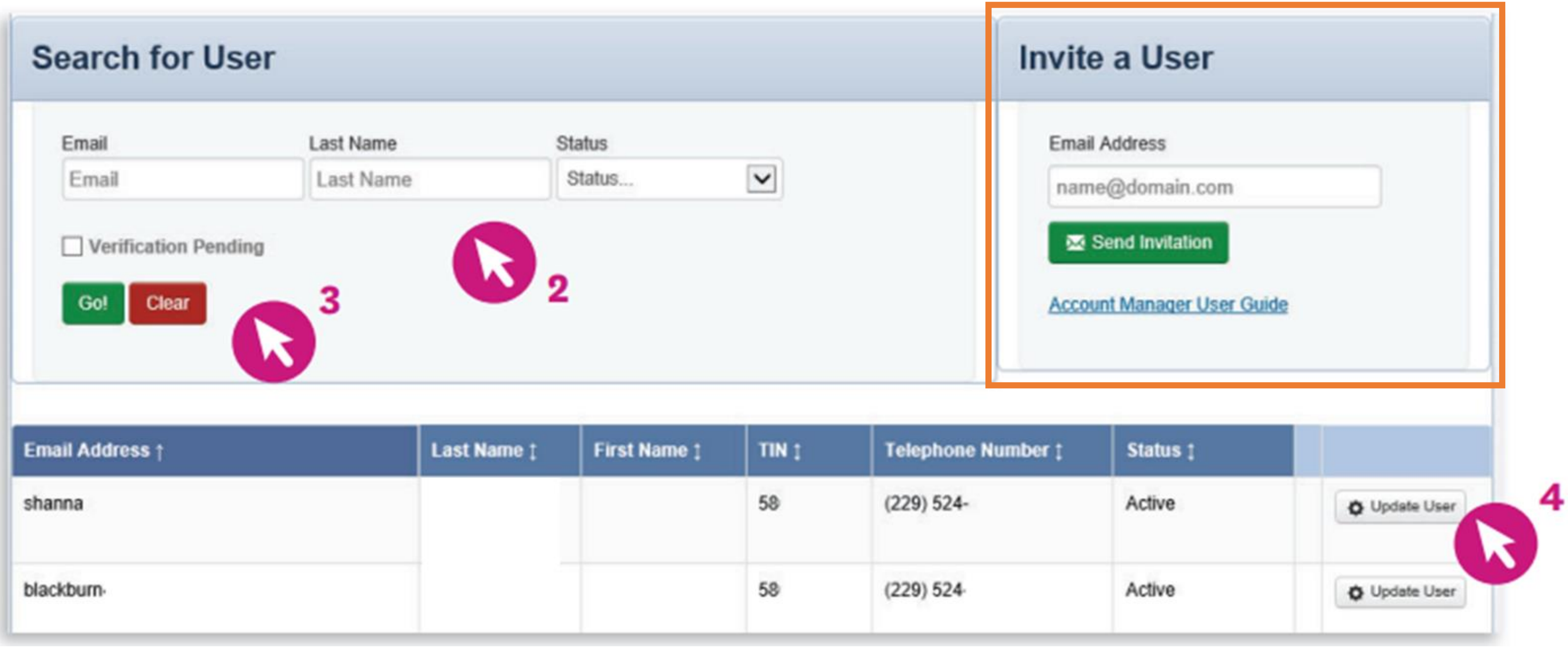
Get easy access to the features you use most.

Admin Settings

Add and manage user access and information.

1

User Management


Search for User
Email
Last Name
Status
Status...
☐ Verification Pending
Go!
Clear
3
2
Invite a User
Email Address
name@domain.com
Send Invitation
Account Manager User Guide
4
Update User

Email Address ↑	Last Name ↕	First Name ↕	TIN ↕	Telephone Number ↕	Status ↕	
shanna			58	(229) 524-	Active	Update User
blackburn-			58	(229) 524-	Active	Update User

Portal Account Manager Tips

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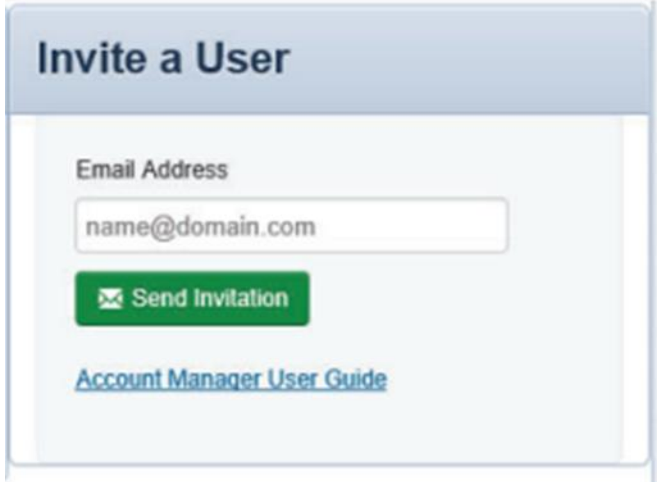
- Each TIN should have at least two Account Managers
  - For large organizations, it is recommended to have at least two Account Managers per department.
  - There is no limit on the number of Account Managers allowed under a TIN
- Account Managers should *regularly* log into the portal to:
  - Verify new portal registrations
  - Send password reset email to users whose portal account is locked due to inactivity
  - 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.

Portal Access for Third-party Billers

- Third-party billing entities supporting Trillium providers third-party have accounts to the Secure Provider Portal when validated by the practice's **Portal Account Manager.**
- The Account Manager should Invite a User by sending an invitation to the email address for the third-party biller.
- This generates an email link to the Trillium PH Secure Provider Portal.
- User should continue to Create an Account, verifying their email, then returning to enter TIN, Phone, and Fax.
- **After this point, the third-party biller should contact the Portal Administrator at the practice to verify their account request.**
- Upon verification, the user will be able to login to the portal and have functionality to submit and view claims.



Invite a User

Email Address

name@domain.com

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Prior Authorizations

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How to Secure a Prior Authorization

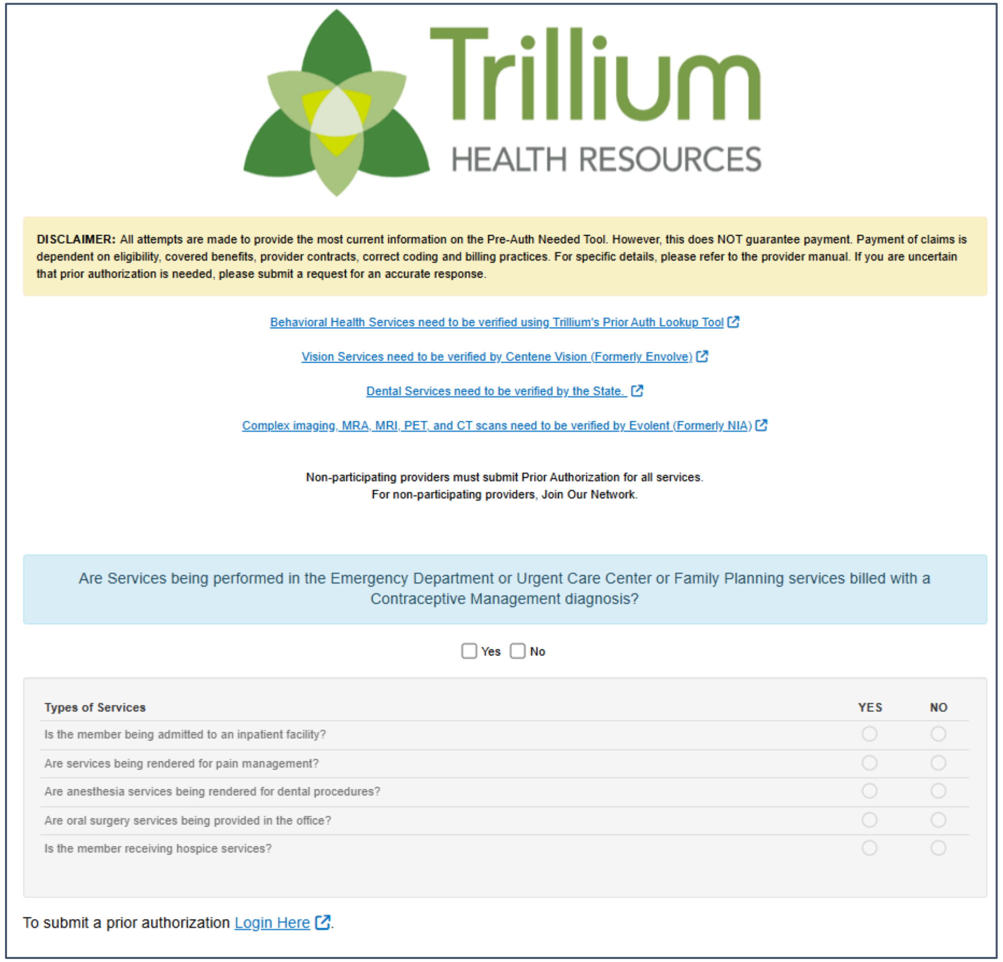
Emergency services, family planning, post stabilization services, and tabletop x-rays do not require prior authorization.

Electronic Submission (Preferred)	Manual Submission
Secure Provider Portal: • Provider.trilliumhealthresources.org	Phone: 1-855-250-1539 • Connect with Trillium Provider Support Service Line and request a transfer to the Physical Health Utilization Management Team

Availity Essentials
• https://www.availity.com/providers/
	Fax
	• Use the Trillium PA Fax Form (PDF) and submit to one of the following:
	  • Outpatient: 833-875-0930
	  • Inpatient medical: 833-875-0650
	  • Concurrent review: 833-875-2264
	  • Transplant: 866-753-5659
	  • Physician Administered Drug Program (PADP): 833-754-0251

Is Prior Authorization Needed?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.
- Will be available on the provider section of the Carolina Complete Health website
- carolinacompletehealth.com/trillium-preauth.html



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DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Behavioral Health Services need to be verified using Trillium's Prior Auth Lookup Tool

Vision Services need to be verified by Centene Vision (Formerly Envolve)

Dental Services need to be verified by the State.

Complex imaging, MRA, MRI, PET, and CT scans need to be verified by Evolent (Formerly NIA)

Non-participating providers must submit Prior Authorization for all services.
For non-participating providers, Join Our Network.

Are Services being performed in the Emergency Department or Urgent Care Center or Family Planning services billed with a Contraceptive Management diagnosis?

☐ Yes ☐ No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	○
Are services being rendered for pain management?	○	○
Are anesthesia services being rendered for dental procedures?	○	○
Are oral surgery services being provided in the office?	○	○
Is the member receiving hospice services?	○	○

To submit a prior authorization Login Here.

Services Requiring Prior Authorization

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All out-of-network (non-par) services and providers require prior authorization, *excluding emergency services, family planning, post stabilization services, and table top x-rays*

Ancillary Services

- Air Ambulance Transport (non-emergent fixed wing airplane)
- DME purchases costing $500 or more or rental of $250 or more
- Home healthcare services including home hospice, home infusion, skilled nursing, personal care services, and therapy
- Orthotics/Prosthetics billed with an “L” code costing $500 or more or rental of $250 or more
- Hearing Aid devices including cochlear implants
- Genetic Testing

Inpatient Services

- All elective/scheduled admissions at least 14 business days prior to the scheduled date of admit (including deliveries) Note: Normal newborns do not require an authorization unless the level of care changes or the length of stay is greater than normal newborn
- All services performed in out of network facility
- Hospice care
- Rehabilitation facilities
- Skilled nursing facility
- Transplant related support services including pre-surgery assessment and post-transplant follow up care
- Notification for all Urgent/Emergent Admissions:
- Within one (1) business day following date of Admission Newborn Deliveries must include birth outcomes

Procedures/Services

- All procedures and services performed by out-of-network providers (except ER, urgent care, family planning, and treatment of communicable disease)
- Potentially Cosmetic including but not limited to:
    - bariatric surgery, blepharoplasty, mammoplasty, otoplasty, rhinoplasty, septoplasty, varicose vein procedures
- Experimental or investigational
- High Tech Imaging (i.e. CT, MRI, PET)
- Hysterectomy
- Oral Surgery
- Pain Management

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

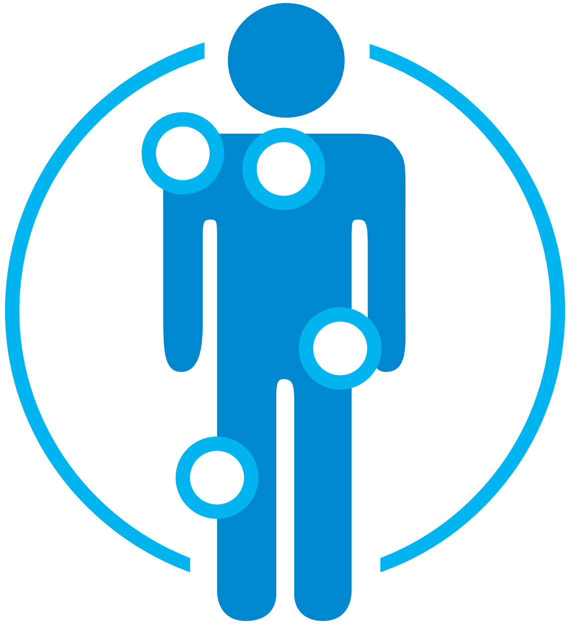
PA, Notification, and Determination Timeframes

Authorization Type	Timeframe for Provider to Notify Trillium Physical Health	Timeframe for Determination by Trillium Physical Health upon receipt of medical necessary medical information.
Standard Service Auth (inpatient)	Prior Authorization required at least fourteen (14) business days prior to the scheduled admission date	Within fourteen (14) business days from receipt of necessary medical information.
Standard Service Auth (outpatient)	Prior Authorization required at least fourteen (14) business days prior as soon as the need for service is identified	Within fourteen (14) business days from receipt of necessary medical information.
Emergent	Notification within one (1) business day of the admission for ongoing concurrent review and discharge planning	For urgent/expedited requests, a decision and notification is made within seventy-two (72) hours of the receipt of the request.
Urgent	Notification within one (1) business day of the admission for ongoing concurrent review and discharge planning	For urgent/expedited requests, a decision and notification is made within seventy-two (72) hours of the receipt of the request.
Retrospective Review	If the request is received within 90 days from the date of service (DOS) or the date of admission (DOA) and extenuating circumstances are clearly defined, the request will be reviewed for medical necessity	The health plan will have 30 calendar days to review and finalize a decision. If the request lacks clinical information, Carolina Complete Health may extend the retrospective review time frame for up to 15 calendar days (total 45 calendar days for review).

High Tech Radiology Utilization Management Program

- Trillium, through its partnership with CCH, will use Evolent, formerly National Imaging Associates, Inc. (NIA), to provide the management and prior authorization of **non-emergent, advanced, outpatient imaging services.**
- **Effective February 1, 2025:** Any services rendered on and after Feb 1, 2025 will require authorization. Only non-emergent procedures performed in an outpatient setting require authorization with Evolent.

- CT/CTA
- CCTA
- MRI/MRA
- PET Scan
- MUGA Scan
- Myocardial Perfusion Imaging
- Stress Echocardiography
- Echocardiography



Excluded from the Program Procedures Performed in the following Settings:

- Hospital Inpatient
- Observation
- Emergency Room

High Tech Radiology Utilization Management Program

- Please visit NIA's website for Trillium Health Resources to download policies and procedures specific to both ordering providers and imaging facilities. These include quick reference guides and FAQs. You can also view information designed to assist you in using the RadMD Website to obtain and check authorizations.

Item	Key Point(s)
RadMD Access & Features	▪ **Prior authorization requests can be made online at: www1.RadMD.com** ▪ RadMD Website – Available 24/7 (except during maintenance) ▪ Request authorization (ordering providers only) and view authorization status ▪ Upload clinical information ▪ View NIA's Clinical Guidelines ▪ Frequently Asked Questions ▪ Quick Reference Guides ▪ Checklist ▪ RadMD Quick Start Guide ▪ Claims/Utilization Matrices ▪ View and manage Authorization Requests with other users (Shared Access) ▪ Requests for additional Information and Determination Letters ▪ Clinical Guidelines ▪ Other Educational Documents To sign up for RadMD Go to: **www1.RadMD.com** Click the New User button and set up a unique username/account ID and password for each individual user in your office. NIA-Carolina Complete Health educational documents: **www1.RadMD.com**

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Personal Care Services

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How to Initiate and Continue PCS

- To request an independent assessment for a Trillium member, the MD caring for the member should complete Trillium's 3051 Form. The completed form should be emailed to LTSS@trilliumnc.org
  - *The form must have the referring practitioner's signature. Signature stamps are not acceptable. The signature must be handwritten to be acceptable.*
- The member's medical provider should re-submit the 3051 form on an annual basis and as needed for a change in medical/functional condition which often occurs during a hospitalization or changes in support.
  - *All new referrals and medical change of status requests will require the referring entity to provide both the medical diagnosis description and diagnosis codes.*
- Providers do not need to request re-authorization of PCS services. This is supported by LTSS Care Managers and the Utilization Management team directly.
  - *Providers may receive a request to submit an updated 3051. Please respond promptly if requested to continue services.*

3051 Review Process and Eligibility Criteria

- All required areas must be completed.
- Forms signed by Medical provider (MD, NP, or PA)
- Form is legible.
- Last visit to physician is within 90 days of receipt.*
- Beneficiary must have active Medicaid with Trillium Tailored Plan.
- The beneficiary must reside in an allowed setting (primary private residence or licensed residential setting per policy 3L).

* If a beneficiary has not been seen by their PCP within 90 days of the request date, the patient must schedule an appointment with the doctor and resubmit the referral with the new date before the request can be processed.

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Claims and Payment

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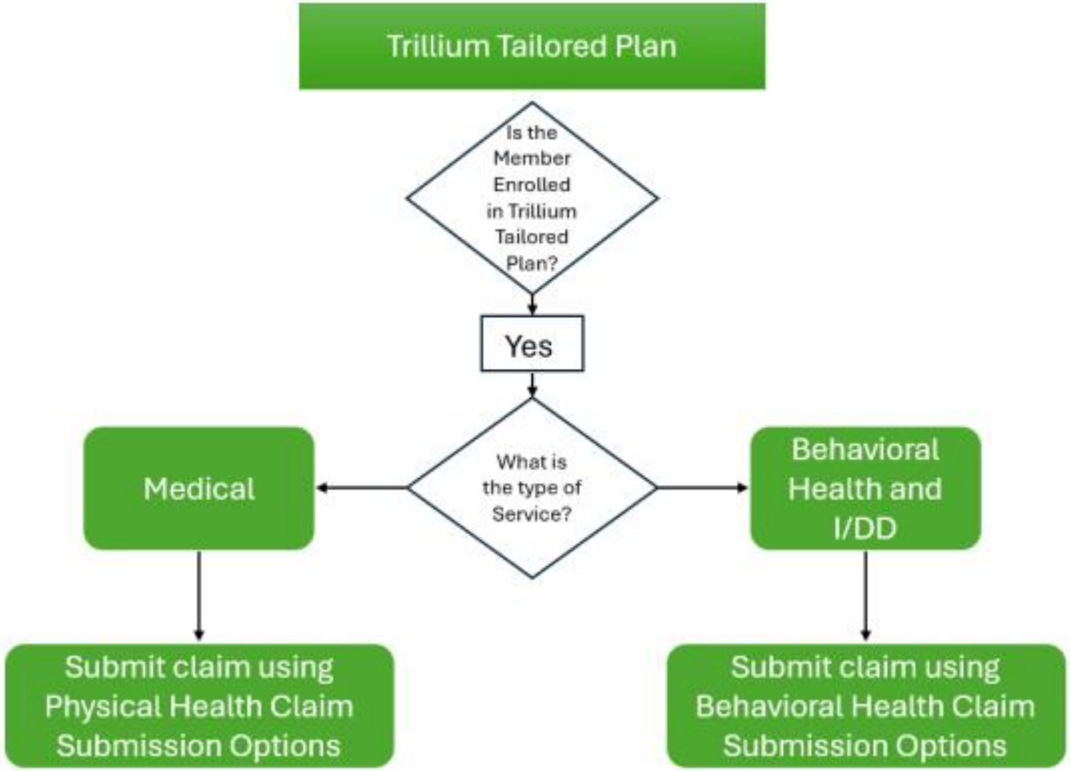
Physical vs. Behavioral Health Billing

- On 11/25/24, NC Medicaid released updated health plan billing guidance effective 10/01 that outlined BH vs PH claim guidance.
- Health Plan Billing Guidance was since updated on 1/10/25
  - View this page for latest versions: medicaid.ncdhhs.gov/health-plan-billing-guidance
- “Claims with a primary care billing or rendering provider taxonomy will be considered Physical Health” (Level 5, Primary Care Physicians)
- Also view: Trillium Claim Submission Protocol
- Please note: Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) billing behavioral health as part of the core services identified in NC Medicaid Policy 1D-4 will continue billing these as **Medical**.



Trillium Tailored Plan

Is the Member Enrolled in Trillium Tailored Plan?

Yes

What is the type of Service?

Medical

Behavioral Health and I/DD

Submit claim using Physical Health Claim Submission Options

Submit claim using Behavioral Health Claim Submission Options

Claims and Payment

- Contracted providers have 365 calendar days from the date of service (professional) or date of discharge (hospital) to file first time claim or claim corrections.
- Trillium physical health claim payments are issued weekly. Check run is Wednesday with payment issued to providers the following day. Clean claims will be resolved (finalized paid or denied) 95% within 15 calendar days and 99% within 30 calendar days following receipt of the claim.
- **Definitions:**

Paid in Full	The claim has been adjudicated, processed and reimbursed in accordance and with the executed provider contract on file including the coordination of benefits, as applicable per claim.
Clean Claim	A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation or particular circumstance requiring special treatment that prevents timely payment

Submission Methods for Physical Health Submit Claims

Secure Provider Portal

- Provider.trilliumhealthresources.org
- Individual claims (professional and institutional) and batch claim submission

Availity Essentials

- https://www.availity.com/providers/

Clearinghouse/EDI

- Use Payer ID 68069
- The preferred clearinghouse is Availity. If the provider's clearinghouse connects to Availity, the claim can be passed on to CCH.

Mail

- Paper claim submission and claim correspondence (i.e. reconsiderations and grievances) can be mailed on the appropriate form to:
  PO Box 8003 Farmington, MO 63640-8003

Timely Filing Guidelines

Initial Filing for Contracted Providers	365 calendar days from the date of service (Professional) or date of discharge (Hospital)
Claims Corrections	365 calendar days from the date of service to file a timely corrected claim
Claims Reconsideration (Level I Claim Dispute)	365 calendar days from the date of the EOP or ERA
Claims Grievance (Level II Claim Dispute)	30 calendar days from the date of the EOP or ERA

Claim Corrections and Disputes

Action	Definition	Timely Filing	How
Claim Correction	For claims that include a correction to the initial claim submission. For example, to correct a invalid or incorrect information in the initial submission.	Contracted Providers: submitters have 365 calendar days from the date of service to file a timely corrected claim. Non-Contracted Providers: submitters have 180 calendar days from the date of service to file a timely corrected claim.	• Provider Portal: View claim details and select 'correct claim' • EDI/Clearinghouse • Paper via form Trillium Health Resources PO Box 8003 Farmington, MO 8003
Claim Reconsideration (Level I Claim Dispute)	To dispute original claim determination, complete and submit dispute to request additional review.	Contracted Providers: Providers must submit claim reconsiderations within 365 calendar days from the date of the EOP or ERA. Non-Contracted Providers: Providers must submit claim reconsiderations within 180 calendar days from the date of the EOP or ERA.	• Provider Portal: View claim details and select 'Dispute' then 'Reconsideration' • Paper via form and include the original EOP Trillium Health Resources PO Box 8003 Farmington, MO 8003
Claim Grievance (Level II Claim Dispute)	To express dissatisfaction regarding the amount reimbursed or the denial of a particular service following the exhaustion of the claim reconsideration process.	Providers must submit claim grievances within 30 calendar days from the date of the Reconsidered EOP or ERA.	• Provider Portal: View claim details and select 'Dispute' then 'Grievance' • Paper via form and include the EOP Trillium Health Resources PO Box 8003 Farmington, MO 8003

Claim Denial Trends

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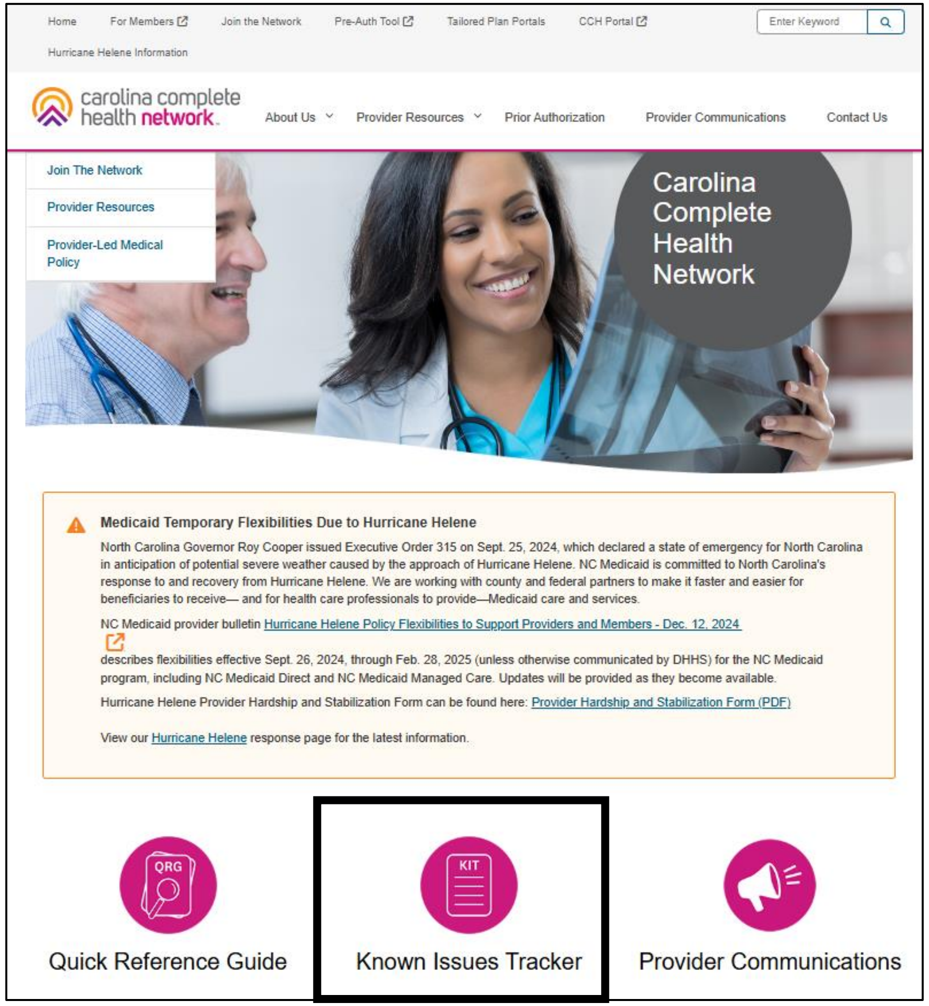
Claim Denial	Guidance
SERVICE FACILITY NPI NOT ON MEDICAID FILE/NOT ACTIVE ON SVS	Provider data on the claim must match what is in NCTracks. Provider Guide: https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH-Prvr-Taxonomy-Guide.pdf
SERVICE OR SERVICE/MODIFIER COMBO NOT FOUND ON FEE SCHEDULE	Trillium Health Resources adheres to the State Fee Schedule for physical health claim processing. See State website for fee schedules, covered services, and appropriate modifiers: https://ncdhhs.servicenowservices.com/fee_schedules
DENY: BILL PRIMARY INSURER 1STRESUBMIT WITH EOB	Prior to submitting claim, verify member's eligibility to determine if there is a primary payer. Federal regulations require Medicaid to be the "payer of last resort," meaning that all third-party insurance carriers must pay before Medicaid processes the claim. Please refer to Coordination of Benefits Walkthrough (PDF) for guidance on submitting COB claims in the Trillium Physical Health Portal.
DENY-BILL NPI+TAXONOMY NOT ON MEDICAID FILE OR NOT ACTIVE ON SVC DATES	Provider data on the claim must match what is in NCTracks. Missing rendering and/or missing billing taxonomy is a common cause of claim processing delays and denials. Taxonomy numbers must also align with your provider data in NCTracks. Please also advise your Clearinghouse to make sure the changes made to taxonomy placement are permanent on your account going forward. Provider Guide: https://network.carolinacompletehealth.com/content/dam/centene/carolinacompletehealth/pdfs/CCH-Prvr-Taxonomy-Guide.pdf
DENY: DUPLICATE CLAIM SERVICE	The claim adjudication process will evaluate billed claims to determine if there is a previously paid claim for the same enrollee and provider in history that is a duplicate to the billed claim. The claims will be reviewed across different providers to determine if another provider was paid for the same procedure, for the same enrollee on the same date of service. Instead of submitting the same claim twice, providers can correct a previously submitted claim or void the previously submitted claim. Please reference Claims Guide- Duplicate Submissions (PDF) for additional guidance.

Importance of Provider Data in NCTracks

- NCTracks is the “system of record” for provider enrollment data, which is then shared with health plans to inform contracting and provider directories.
- In alignment with NCDHHS, Carolina Complete Health (CCH) recommends that Providers complete their enrollment with NCTracks prior to the claim submission as it will impact claim processing, and risk claim denial if enrollment is not complete.
- Provider data on a claim is also analyzed against the Provider Data received from NC Medicaid via the Provider Enrollment File (PEF).
- One of the more common inaccuracies among individual provider data is the individual to organization affiliation. Many Medicaid provider records seemingly contain active former employer affiliations or an excessive number of affiliations; or have affiliation data that has not been updated in over a year
- View more information: [Provider Enrollment and Data (PDF)]()

Known Issues Tracker (KIT)

- Updated weekly by Friday AM
- Found on the homepage of: network.carolinacompletehealth.com
  Or
  trilliumhealthresources.org/for-providers/provider-documents-forms
  under “Claims/Finance Information & Forms”
- Updated weekly, this document provides timely information related to known issues impacting providers.


Home
For Members
Join the Network
Pre-Auth Tool
Tailored Plan Portals
CCH Portal
Enter Keyword
Hurricane Helene Information
carolina complete health network.
About Us
Provider Resources
Prior Authorization
Provider Communications
Contact Us
Join The Network
Provider Resources
Provider-Led Medical Policy
Carolina Complete Health Network

Medicaid Temporary Flexibilities Due to Hurricane Helene

North Carolina Governor Roy Cooper issued Executive Order 315 on Sept. 25, 2024, which declared a state of emergency for North Carolina in anticipation of potential severe weather caused by the approach of Hurricane Helene. NC Medicaid is committed to North Carolina's response to and recovery from Hurricane Helene. We are working with county and federal partners to make it faster and easier for beneficiaries to receive— and for health care professionals to provide—Medicaid care and services.

NC Medicaid provider bulletin Hurricane Helene Policy Flexibilities to Support Providers and Members - Dec. 12, 2024 describes flexibilities effective Sept. 26, 2024, through Feb. 28, 2025 (unless otherwise communicated by DHHS) for the NC Medicaid program, including NC Medicaid Direct and NC Medicaid Managed Care. Updates will be provided as they become available.

Hurricane Helene Provider Hardship and Stabilization Form can be found here: Provider Hardship and Stabilization Form (PDF)

View our Hurricane Helene response page for the latest information.

QRG
Quick Reference Guide
KIT
Known Issues Tracker
Provider Communications

Provider Payments

- Clean claims will be resolved (finalized paid or denied) 95% within 15 calendar days and 99% within 30 calendar days following receipt of the claim.
- Carolina Complete Health AMH payments are paid out on the 20th of every month
- Trillium physical health check run is weekly on Wednesdays, with payment issued to providers the following day.
- Remittance Advice, also referred to as an 835 or Explanation of Payment (EOP), are issued with payment and can be accessed several ways:
  - Portal: https://provider.trilliumhealthresources.org/
  - Payspan: https://www.payspanhealth.com/
  - Physical copy if you receive paper check

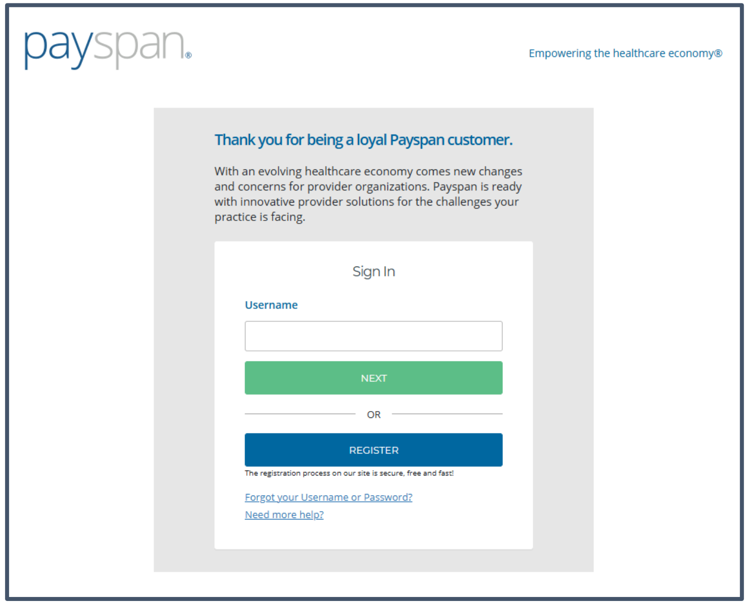
Electronic Funds Transfer

To contact Payspan: Call 1-877-331-7154, Option 1 – Monday thru Friday 8:00 am to 8:00 pm est.

Payspan offers monthly training sessions for providers covering the following topics:

- How to register with Payspan (New User)
- How to add additional registration codes to an existing Payspan account
- How to navigate through the Payspan web portal
- How to view a payment
- How to find a remit
- How to change bank account information
- How to add new users

For training links visit our website under [Education and Training]()



payspan®
Empowering the healthcare economy®

Thank you for being a loyal Payspan customer.

With an evolving healthcare economy comes new changes and concerns for provider organizations. Payspan is ready with innovative provider solutions for the challenges your practice is facing.

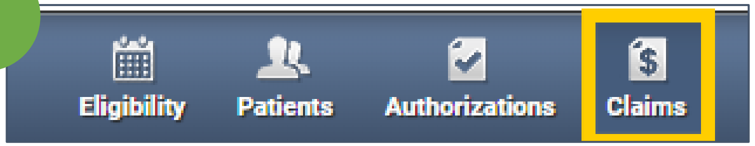
Sign In
Username
NEXT
OR
REGISTER

The registration process on our site is secure, free and fast!

Forgot your Username or Password?
Need more help?

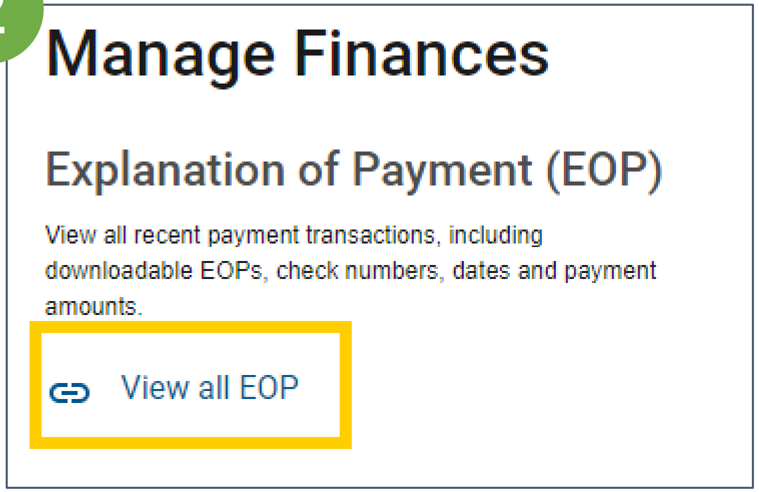
Access EOPs in Physical Health Portal

1


Eligibility
Patients
Authorizations
Claims

Click 'Claims' in the header menu

2


Manage Finances

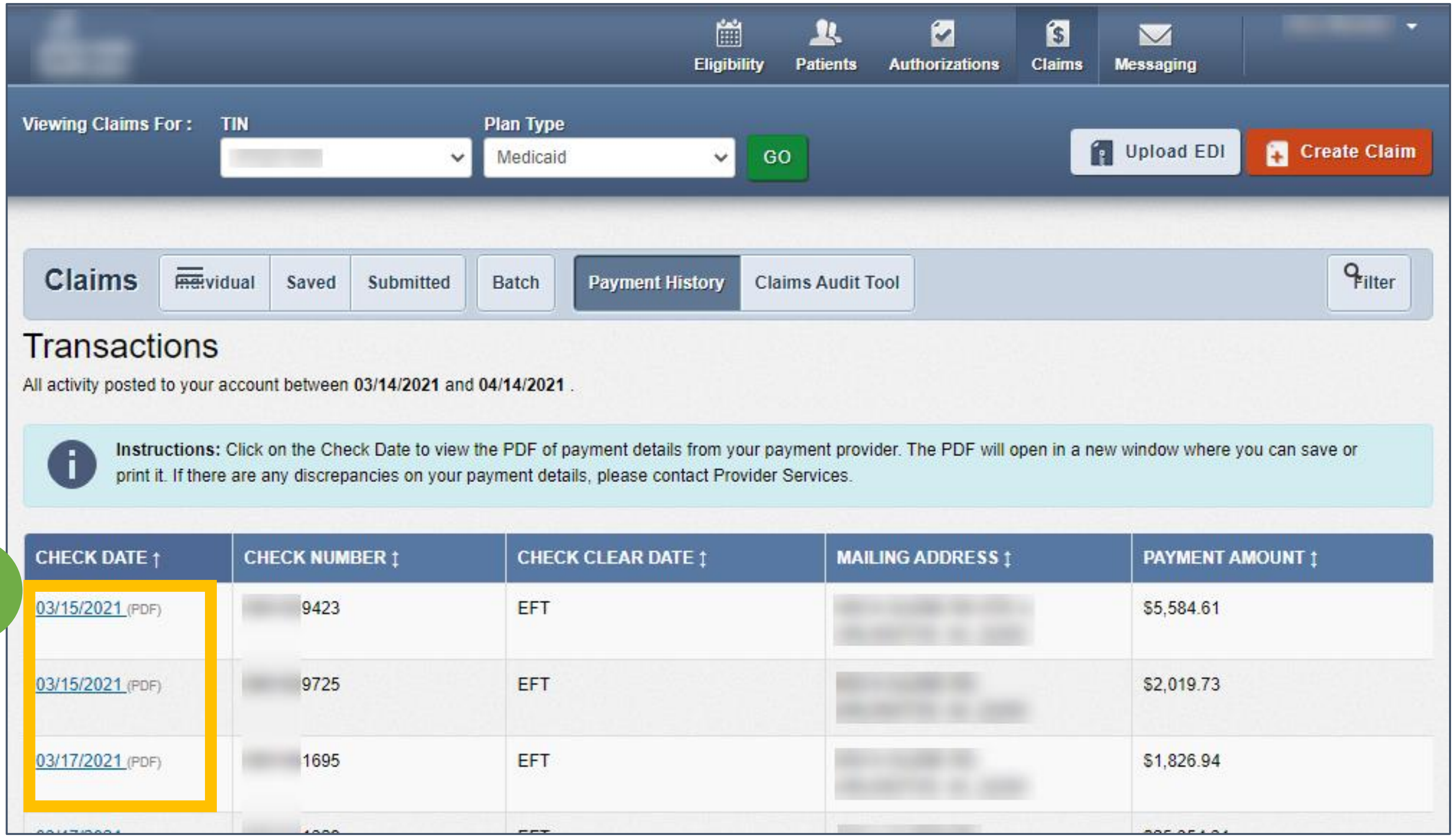
Explanation of Payment (EOP)

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

View all EOP

Scroll down and click 'View all EOP'

3


[redacted]
Eligibility
Patients
Authorizations
Claims
Messaging
[redacted]
Upload EDI
Create Claim
Claims
Individual
Saved
Submitted
Batch
Payment History
Claims Audit Tool
Filter

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

Transactions

All activity posted to your account between **03/14/2021** and **04/14/2021** .

Instructions: Click on the Check Date to view the PDF of payment details from your payment provider. The PDF will open in a new window where you can save or print it. If there are any discrepancies on your payment details, please contact Provider Services.

CHECK DATE ↕	CHECK NUMBER ↕	CHECK CLEAR DATE ↕	MAILING ADDRESS ↕	PAYMENT AMOUNT ↕
03/15/2021 (PDF)	[redacted]9423	EFT	[redacted]	$5,584.61
03/15/2021 (PDF)	[redacted]9725	EFT	[redacted]	$2,019.73
03/17/2021 (PDF)	[redacted]1695	EFT	[redacted]	$1,826.94

Click the Check Date links which will download a PDF of the EOP

Access ERA in Payspan

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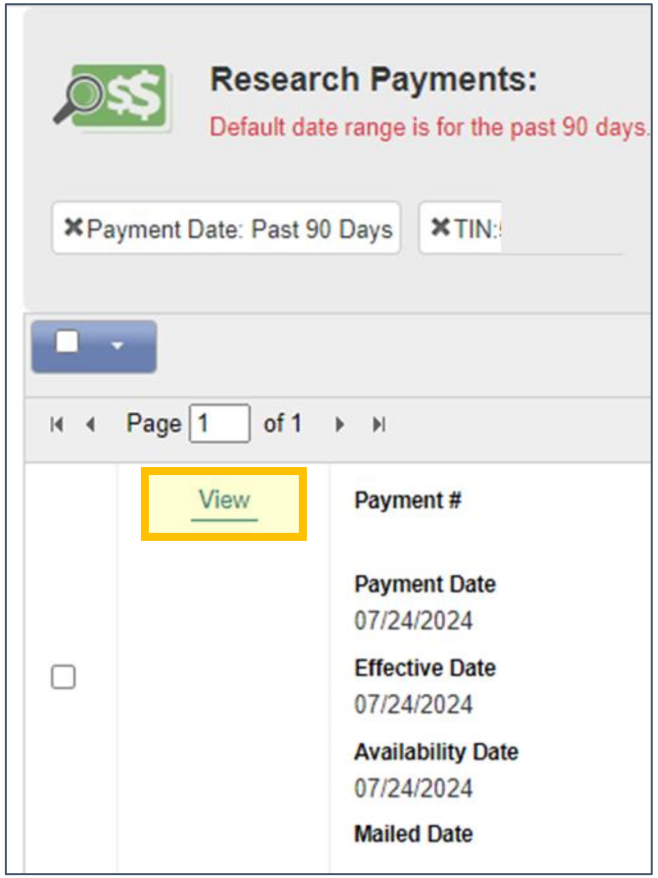
1



Research Payments:

Default date range is for the past 90 days.

✖Payment Date: Past 90 Days

✖TIN:

☐
Page 1 of 1
View

☐

Payment #

Payment Date
07/24/2024

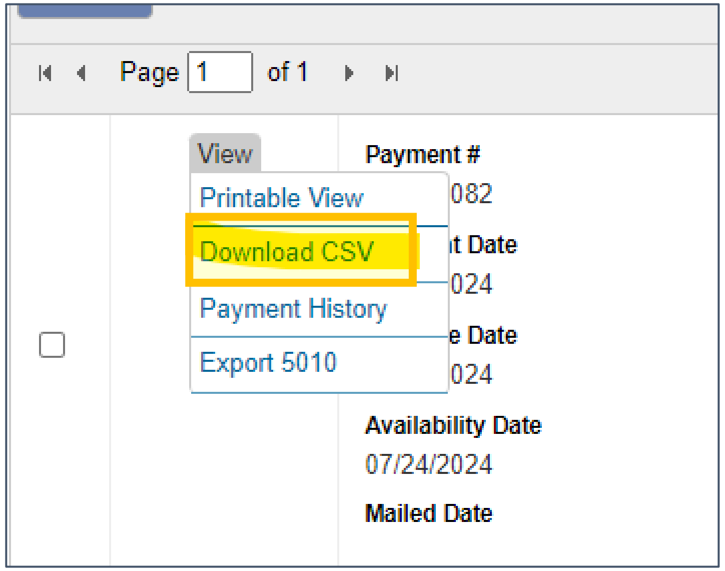
Effective Date
07/24/2024

Availability Date
07/24/2024

Mailed Date

Scroll down and click ‘View all EOP’

2



Page 1 of 1
View
Printable View
Download CSV
Payment History
Export 5010

☐

Payment #
082

t Date
024

e Date
024

Availability Date
07/24/2024

Mailed Date

Download CSV

carolina complete health

Medical Home Payment and Reporting

Where can practices find their Medical Home fee Capitation Reports?	Via Payspanhealth.com. For providers not yet enrolled, visit https://www.payspanhealth.com/ and click register or contact Payspan: Call 1-877-331-7154, Option 1 – Monday thru Friday 8:00am to 8:00pm EST. Also see attached guide. Using Payspan to Access Medical Home Payments (PDF)
What section of that portal should they be directed to?	In Payspan, under Payment details, click View, then Download CSV. Open the excel document and save a copy for your records.
What system or portal do they need access to, to obtain said reporting? On what date of the month is the enrollment count for the Medical Home PMPM payment captured?	1st of the month
When does your plan project that these payments will be made to practices each month?	20th of each month. First couple of months may be close to end of the month.

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Clinical Policy

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NCQA
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HEALTHCARE ORGANIZATION
FULL

Physical Health Clinical Coverage Policies

- Clinical policies are one set of guidelines used to assist in administering health plan benefits, either by prior authorization or payment rules.
- Trillium Health Resources Tailored Plan Physical Health providers are subject to the applicable physical health Clinical Policies for Carolina Complete Health:
- https://network.carolinacompletehealth.com/resources/clinical-policies.html

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Provider Resources

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Recommended Provider Trainings and Manuals

- Tailored Plan Billing with Partners and Trillium for Physical Health Providers (PDF)
- CCH Billing Manual
- CCH Billing Guides
- Payspan Guide
- Payspan Trainings

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Contact Us

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FULL

Key Contacts and Resources

Trillium Member Support Line	1-877-685-2415
Trillium Provider Support Line	1-855-250-1539
Technical support for the Trillium Physical Health Portal	CCHN Provider Engagement Team: ProviderEngagement@cch-network.com
General Questions/Support	Trillium Provider Support Service Line: 1-855-250-1539 *(Have your TIN and NPI ready for provider verification)
CCHN Provider Relations	NetworkRelations@cch-network.com (once you are connected with your assigned rep, they can be your single point of contact for claims and contracting questions)

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Questions

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Appendix

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Trillium Physical Health Secure Provider Portal Introduction

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FULL

Secure Provider Portal General Info

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

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Provider Portal Registration & Login

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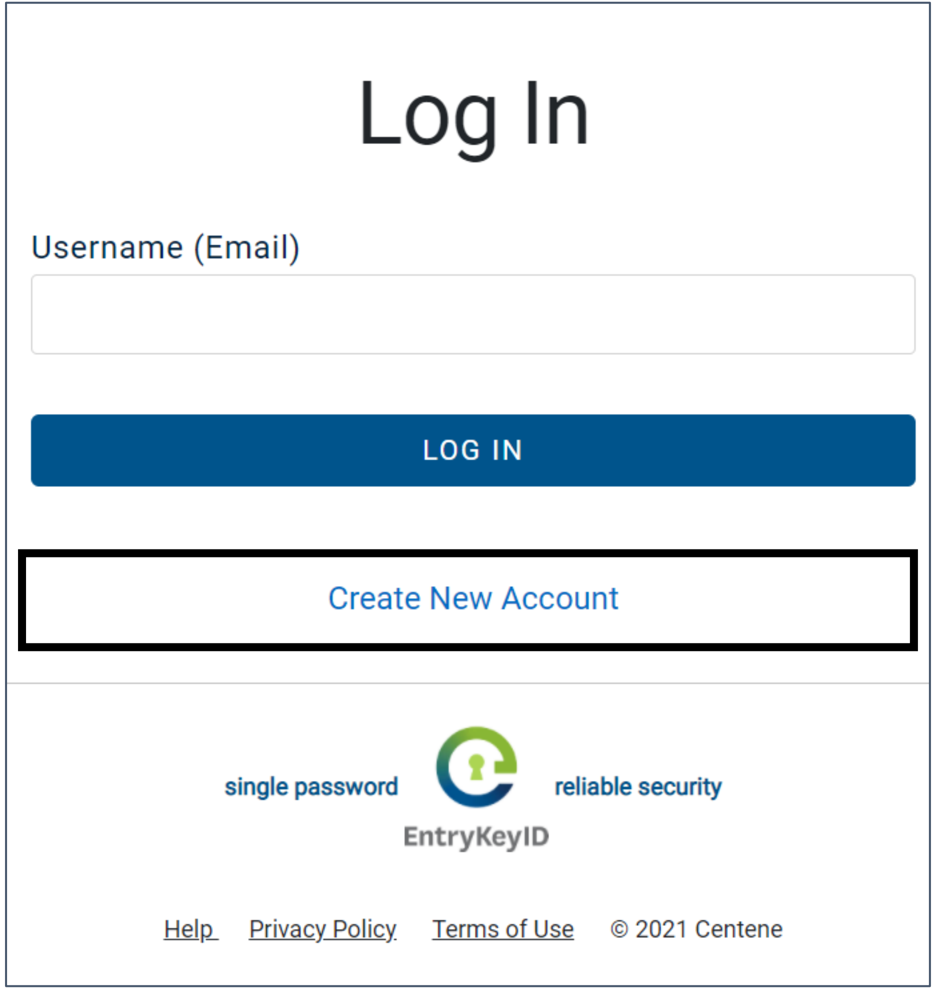
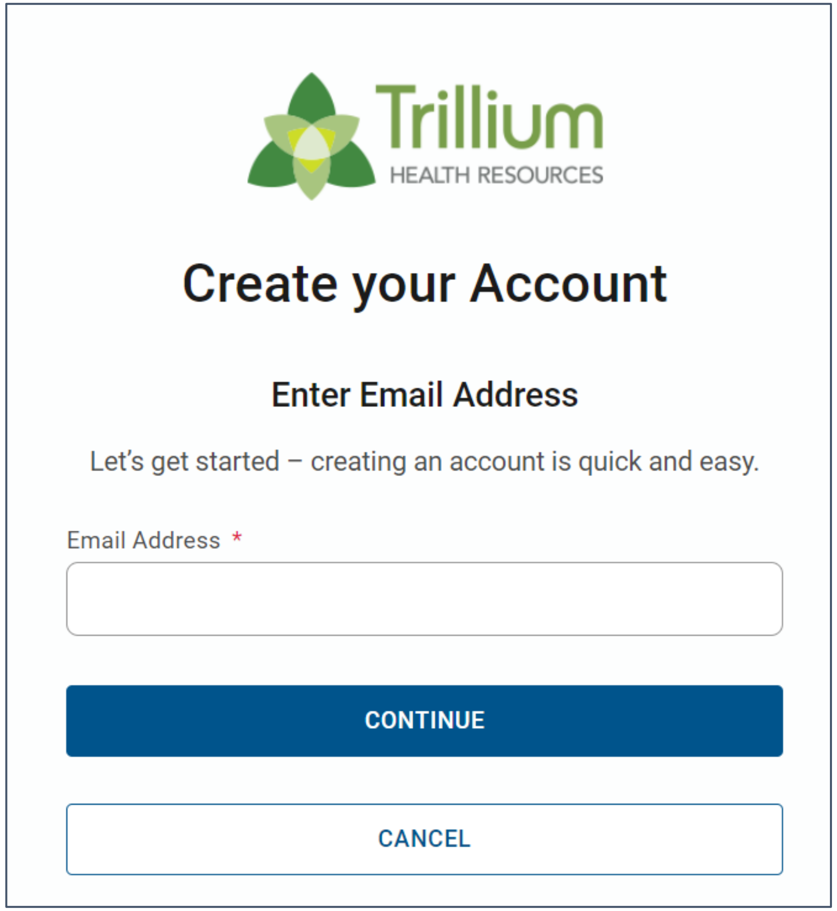
MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION
FULL

Create New Account: provider.trilliumhealthresources.org/

Tip: add no-reply@mail.entrykeyid.com to your email contacts


Log In
Username (Email)
LOG IN
Create New Account
single password
reliable security
EntryKeyID
Help
Privacy Policy
Terms of Use
© 2021 Centene


Trillium
HEALTH RESOURCES
CONTINUE
CANCEL

Create your Account

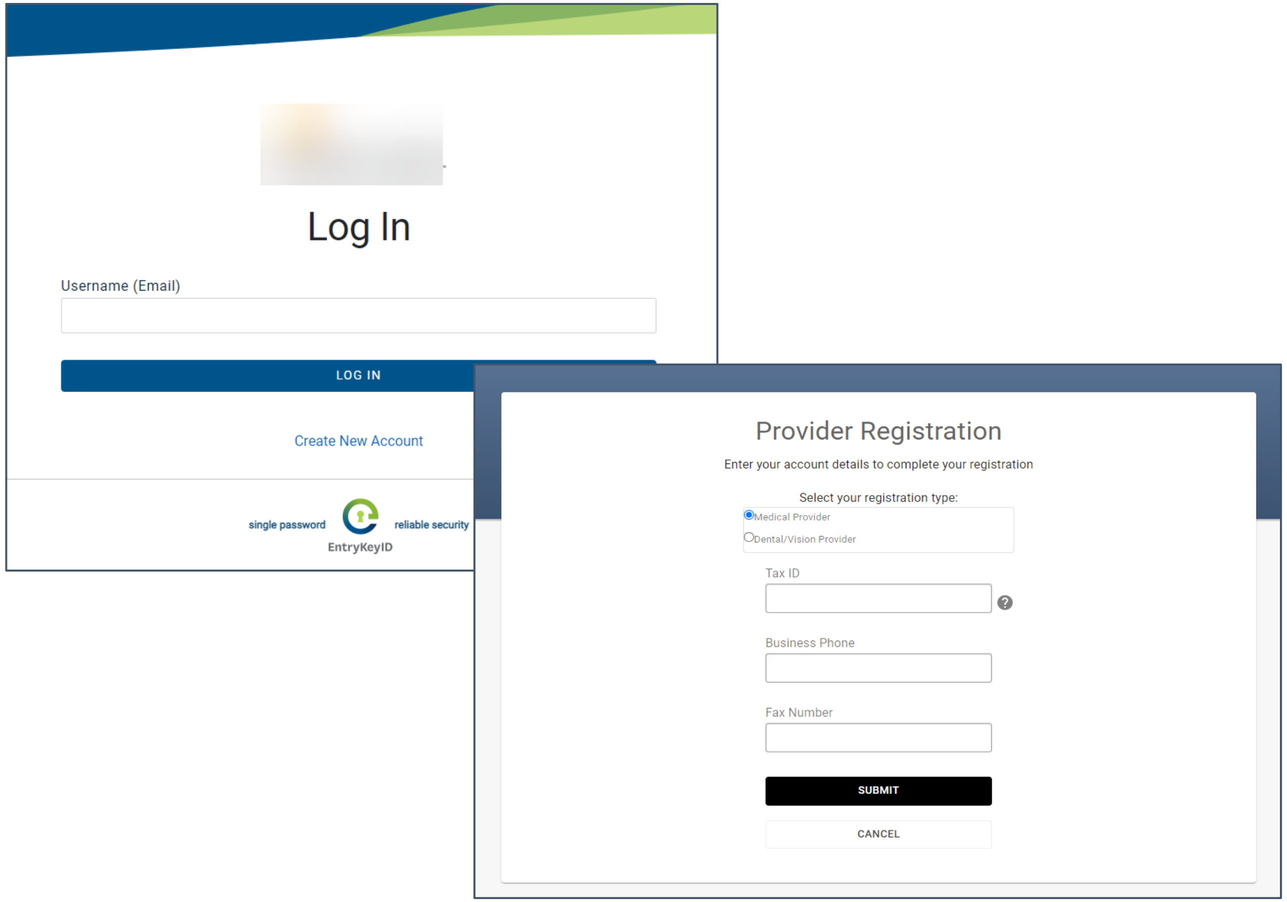
Enter Email Address

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

Email Address *

Initial Portal Registration

- **Portal Registration**: Once the EntryKeyID account setup is completed, the portal user will log in with their Username and password. The Portal Registration page will display.



Log In

Username (Email)

LOG IN
Create New Account
single password
EntryKeyID
reliable security

Provider Registration

Enter your account details to complete your registration

Select your registration type:

● Medical Provider

○ Dental/Vision Provider

Tax ID

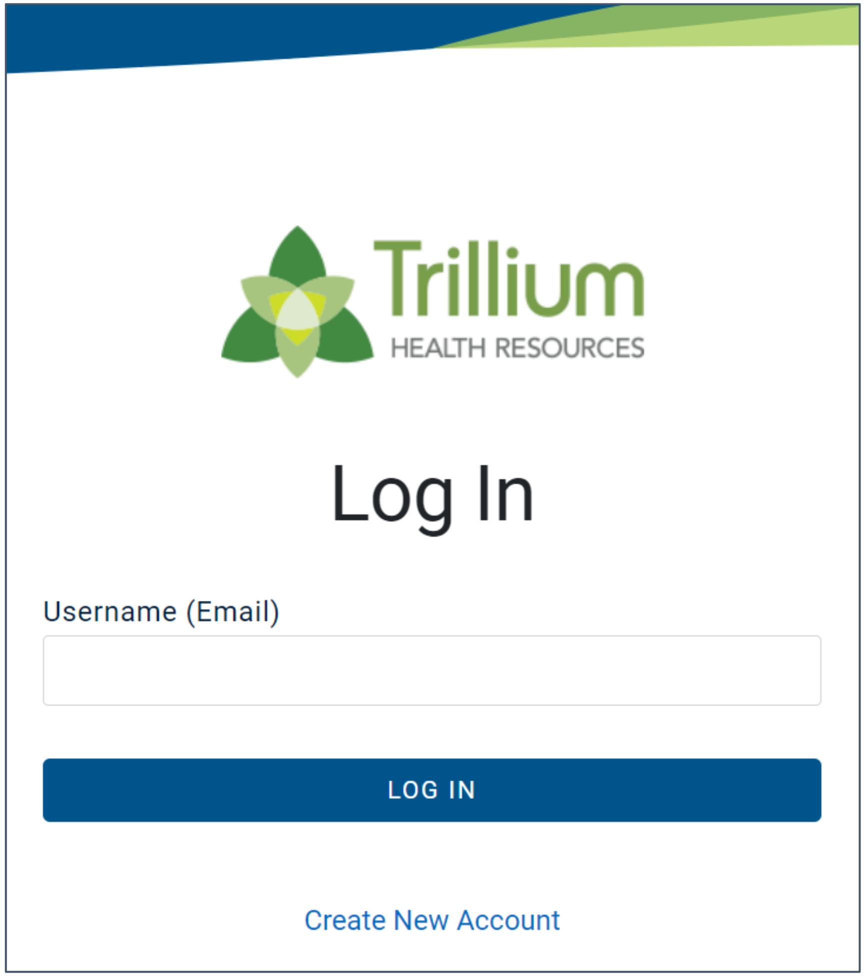
Business Phone

Fax Number

SUBMIT
CANCEL

Tip: To register for the portal, the provider organization's TIN ***must*** be loaded in our back-end system(s).

Trillium Physical Health Secure Portal



Log In

Username (Email)

Secure Portal address: https://provider.trilliumhealthresources.org/

1. **Assign Portal Account Manager:** To access the Trillium Physical Health Portal, in-network contracted providers must identify one individual who will serve as the Portal Account Manager. The Account Manager will be responsible for managing all other users for that provider organization.
2. **Create an account:** Visit provider.trilliumhealthresources.org to create a new account associated with your email address.
3. **Verify email:** Verify your email address by entering the one time code sent by EntryKeyID.
4. **Register TIN:** Under the 'Success!' message, click continue to enter the Tax ID for the contracted entity, business phone and fax. Click 'Submit.'
5. **Email Provider Engagement:** After registering, email your assigned Provider Engagement Administrator to request verification of your portal registration request and assignment as Portal Account Manager.

Note: Providers should not use the Carolina Complete Health Standard Plan portal to submit Tailored Plan claims.

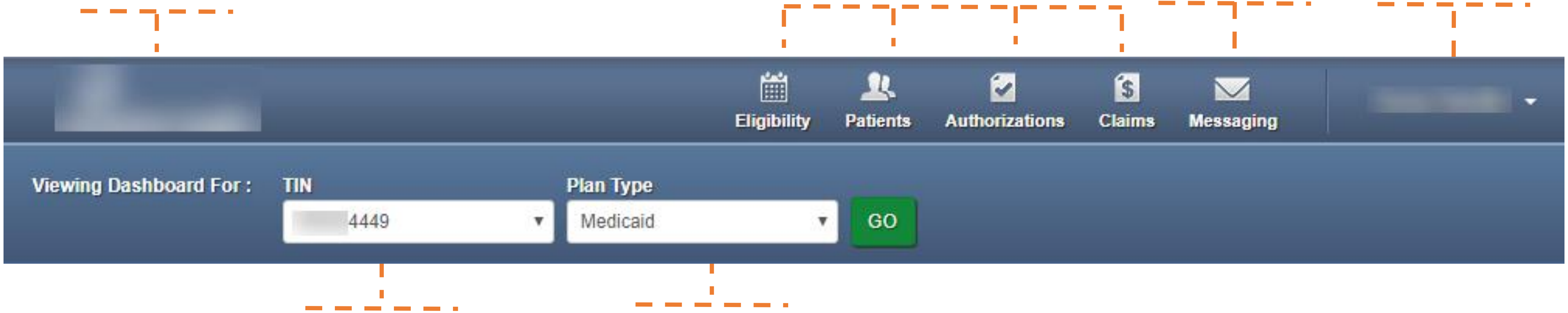
Portal Banner

Health Plan / Product Logo

Portal Functionalities

Secure Messaging

User's Name / Menu Options


Eligibility
Patients
Authorizations
Claims
Messaging
GO

Viewing Dashboard For :

TIN: 4449

Plan Type: Medicaid

TIN(s) Listing

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 Registration & Login Tips

- Registration is required for access to the portal
- Portal accounts cannot be shared
    - Each person within a provider organization who needs access to the portal, must compete 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 Functionality: Check Eligibility

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Quick Actions: Check Eligibility, Submit Auths, and Create Claims

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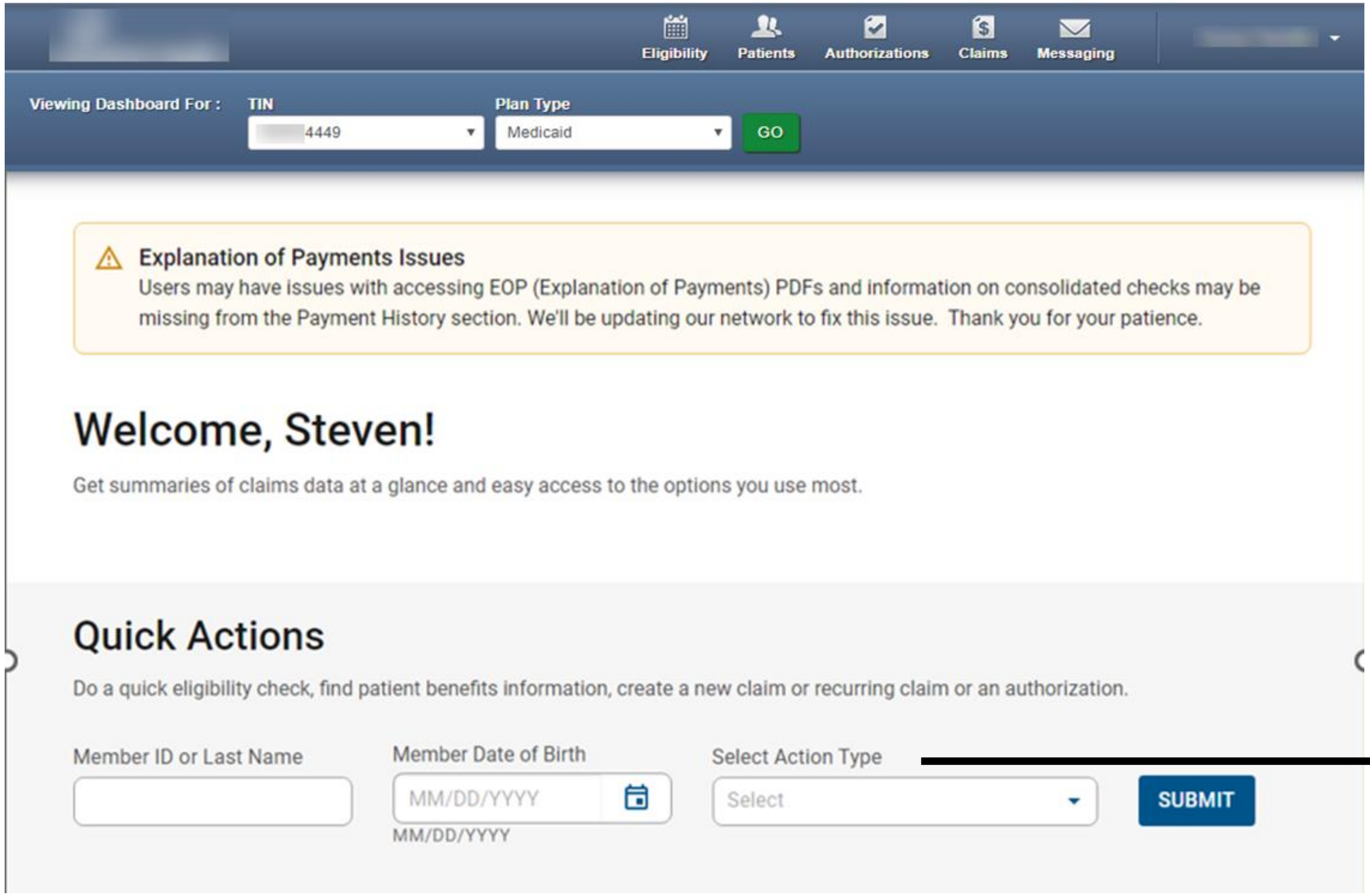

[redacted]
Eligibility
Patients
Authorizations
Claims
Messaging
[redacted]

Viewing Dashboard For : TIN [redacted]4449 Plan Type Medicaid GO

Explanation of Payments Issues
Users may have issues with accessing EOP (Explanation of Payments) PDFs and information on consolidated checks may be missing from the Payment History section. We'll be updating our network to fix this issue. Thank you for your patience.

Welcome, Steven!

Get summaries of claims data at a glance and easy access to the options you use most.

Quick Actions

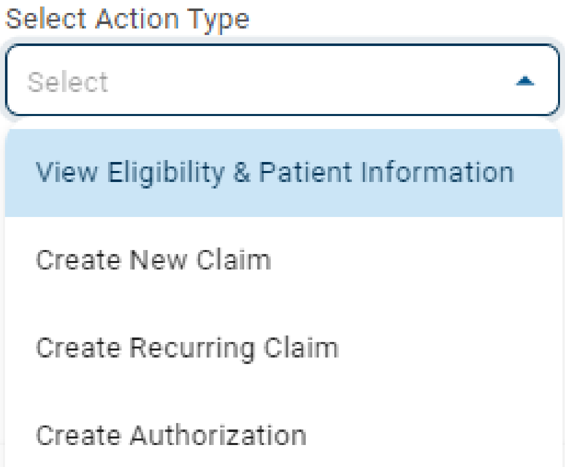
Do a quick eligibility check, find patient benefits information, create a new claim or recurring claim or an authorization.

Member ID or Last Name:
Member Date of Birth: MM/DD/YYYY
MM/DD/YYYY
Select Action Type: Select

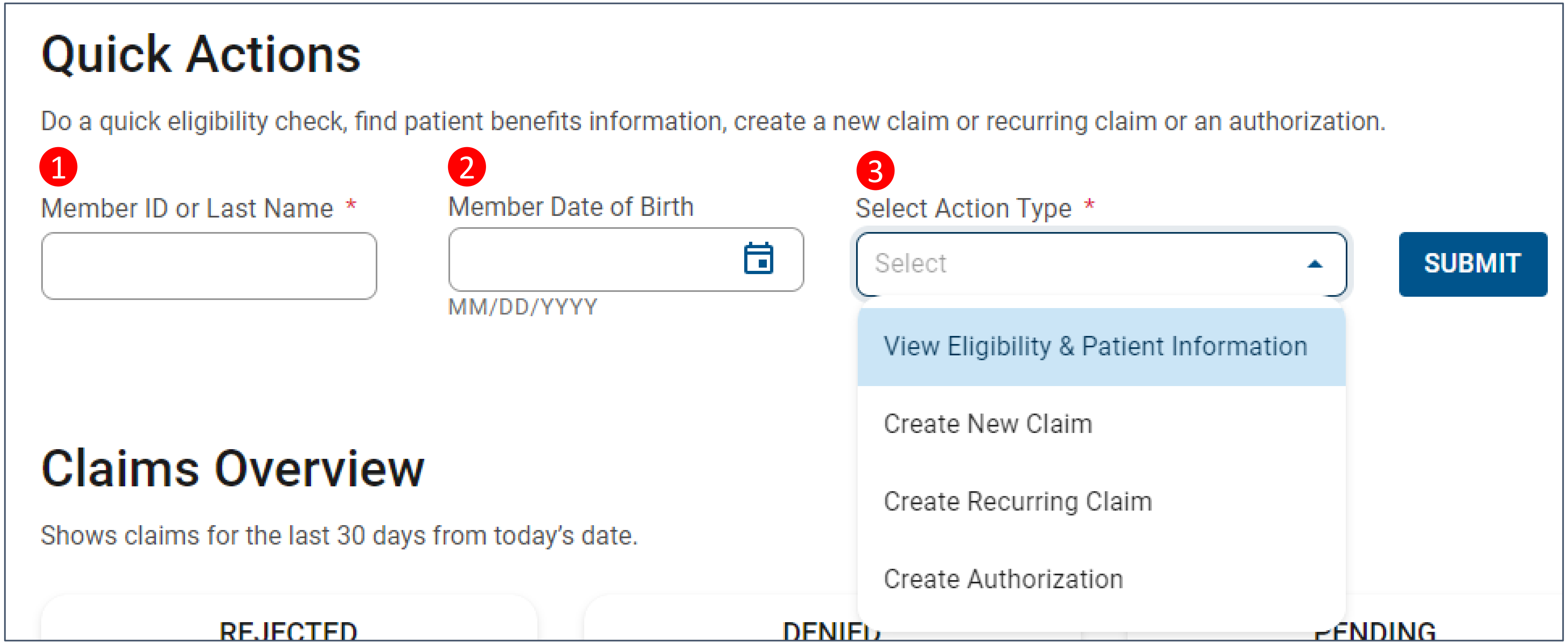
With two data points:
1. Member ID / Last Name
2. Date of Birth

Providers are now able:

1. *Check Eligibility*
2. *Create a New Claim*
3. *Create a Recurring Claim*
4. *Create an Authorization*


Select Action Type
Select
View Eligibility & Patient Information
Create New Claim
Create Recurring Claim
Create Authorization

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 *
Select
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

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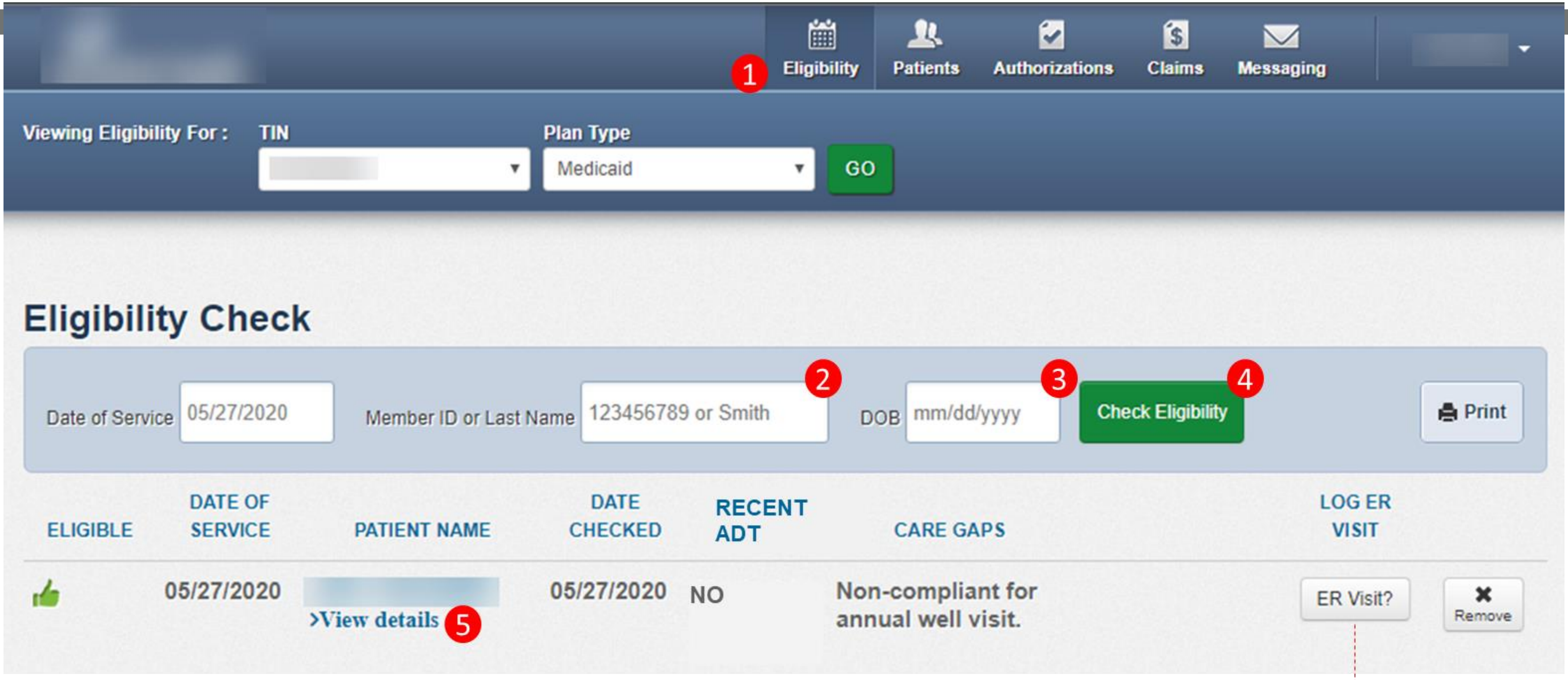

1
Eligibility
Patients
Authorizations
Claims
Messaging
GO
2
3
Check Eligibility
4
Print
ER Visit?
Remove
>View details
5

Viewing Eligibility For : TIN Plan Type: Medicaid

Eligibility Check

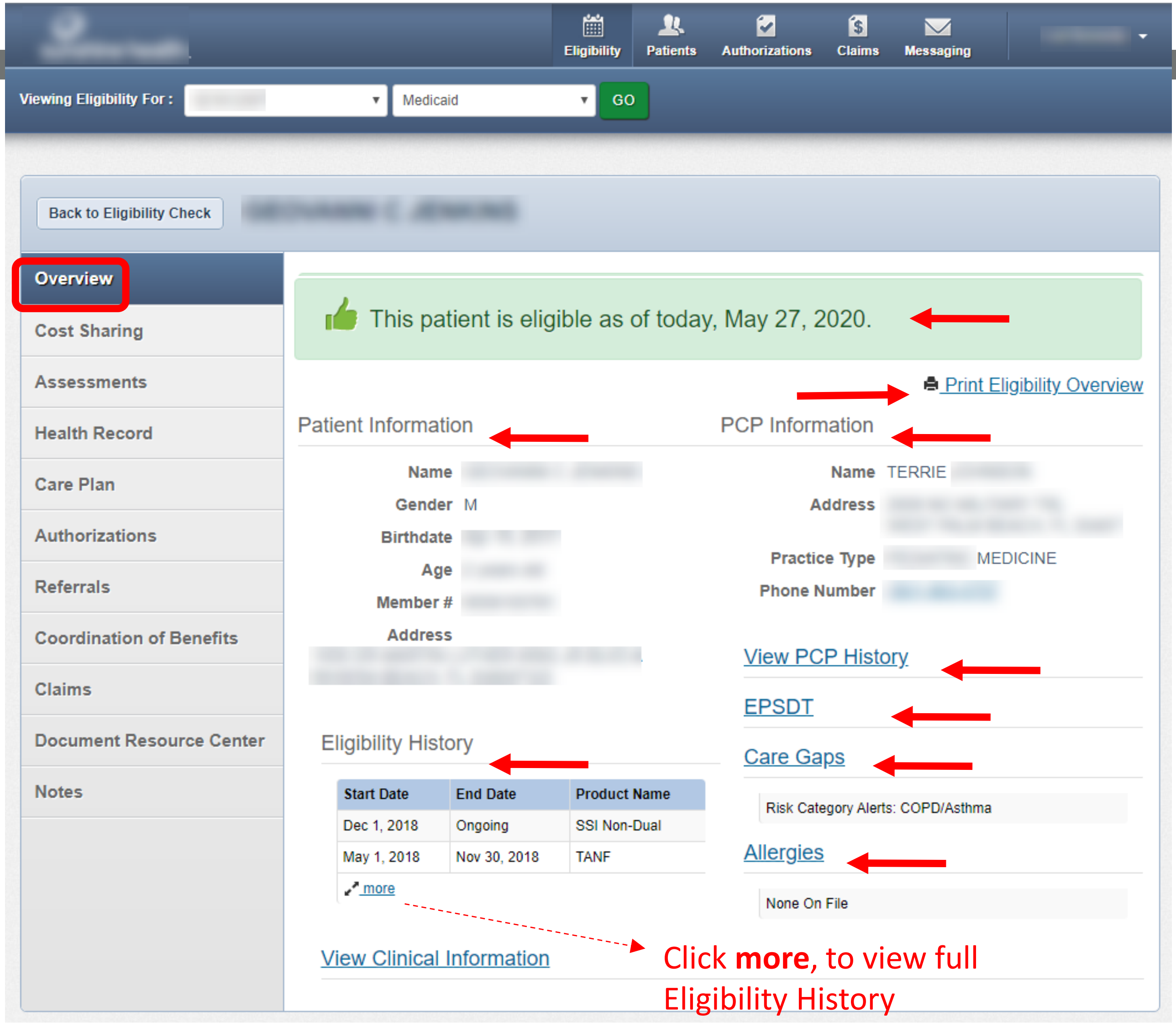
Date of Service: 05/27/2020
Member ID or Last Name: 123456789 or Smith
DOB: mm/dd/yyyy

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	RECENT ADT	CARE GAPS	LOG ER VISIT
👍	05/27/2020	>View details	05/27/2020	NO	Non-compliant for annual well visit.	ER Visit?

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

carolina complete health

Patient Overview


Eligibility
Patients
Authorizations
Claims
Messaging
GO
Back to Eligibility Check
Overview
Cost Sharing
Assessments
Health Record
Care Plan
Authorizations
Referrals
Coordination of Benefits
Claims
Document Resource Center
Notes
Print Eligibility Overview
View PCP History
EPSDT
Care Gaps
Allergies
more
View Clinical Information

Viewing Eligibility For : [redacted] Medicaid

[redacted]

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

Patient Information

Name [redacted]
Gender M
Birthdate [redacted]
Age [redacted]
Member # [redacted]
Address [redacted]

PCP Information

Name TERRIE [redacted]
Address [redacted]
Practice Type [redacted] MEDICINE
Phone Number [redacted]

Eligibility History

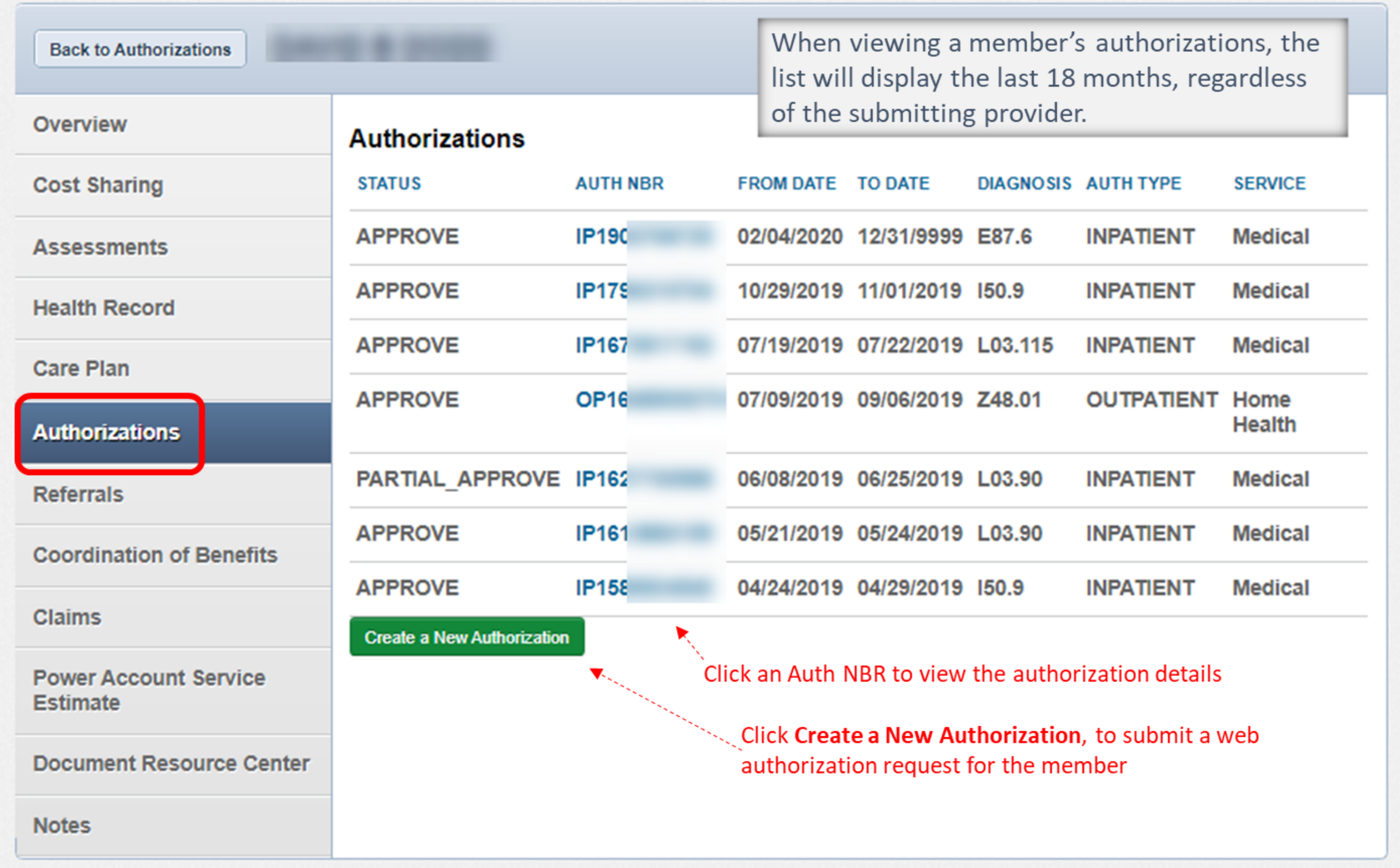
Start Date	End Date	Product Name
Dec 1, 2018	Ongoing	SSI Non-Dual
May 1, 2018	Nov 30, 2018	TANF

Risk Category Alerts: COPD/Asthma

None On File

Click **more**, to view full Eligibility History

Patient Overview – Authorizations


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
Create a New Authorization

[redacted]

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

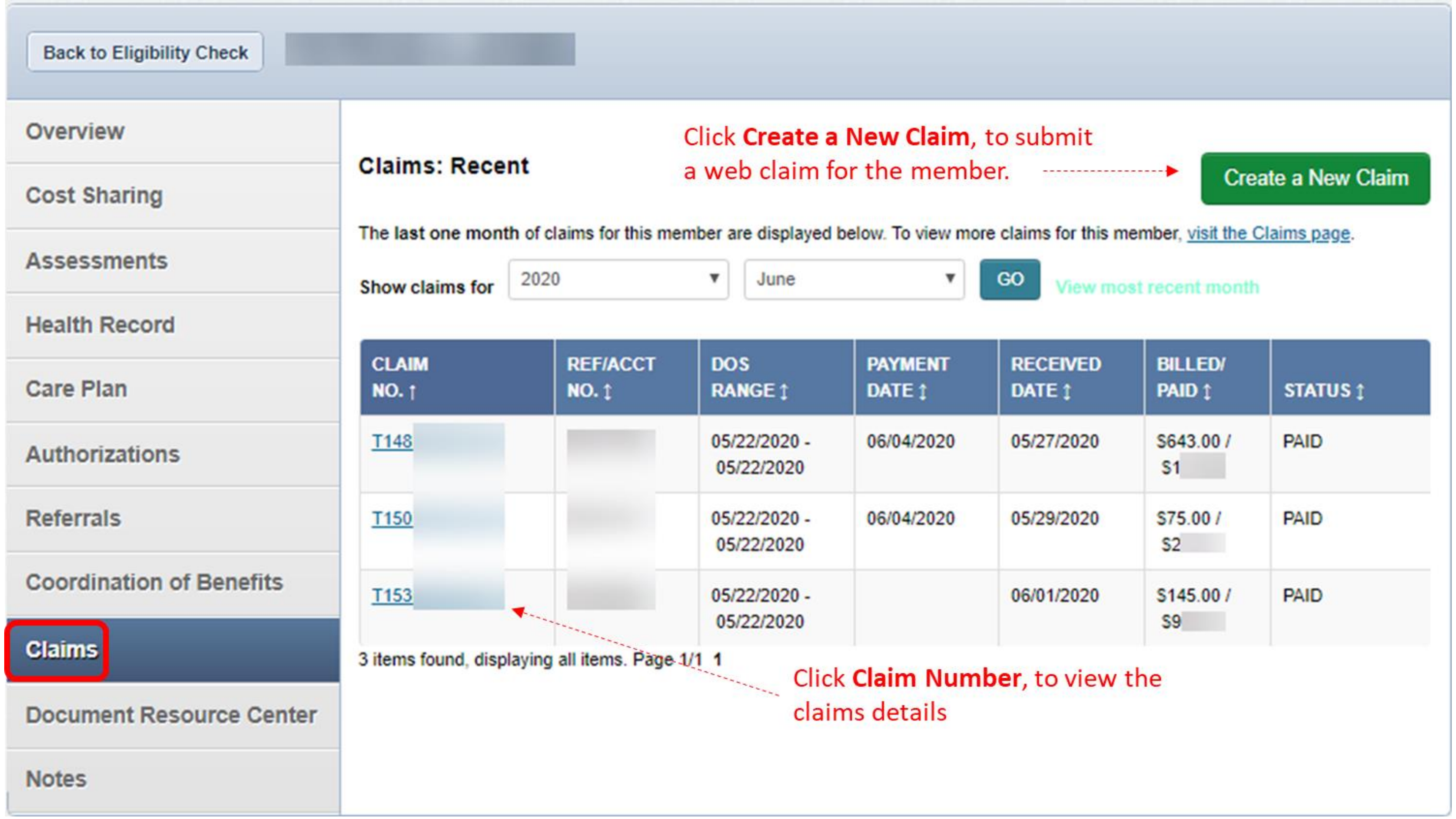
Authorizations

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

Click an Auth NBR to view the authorization details

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

Patient Overview - Claims


Back to Eligibility Check
[redacted]
Overview
Cost Sharing
Assessments
Health Record
Care Plan
Authorizations
Referrals
Coordination of Benefits
Claims
Document Resource Center
Notes
Create a New Claim
GO
View most recent month

Claims: Recent

Click **Create a New Claim**, to submit a web claim for the member.

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 2020 ▾ June ▾

CLAIM NO. ↑	REF/ACCT NO. ↕	DOS RANGE ↕	PAYMENT DATE ↕	RECEIVED DATE ↕	BILLED/ PAID ↕	STATUS ↕
T148[redacted]	[redacted]	05/22/2020 - 05/22/2020	06/04/2020	05/27/2020	$643.00 / $1[redacted]	PAID
T150[redacted]	[redacted]	05/22/2020 - 05/22/2020	06/04/2020	05/29/2020	$75.00 / $2[redacted]	PAID
T153[redacted]	[redacted]	05/22/2020 - 05/22/2020		06/01/2020	$145.00 / $9[redacted]	PAID

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

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

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Portal Functionality: Claims

ACCREDITED
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MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION
FULL

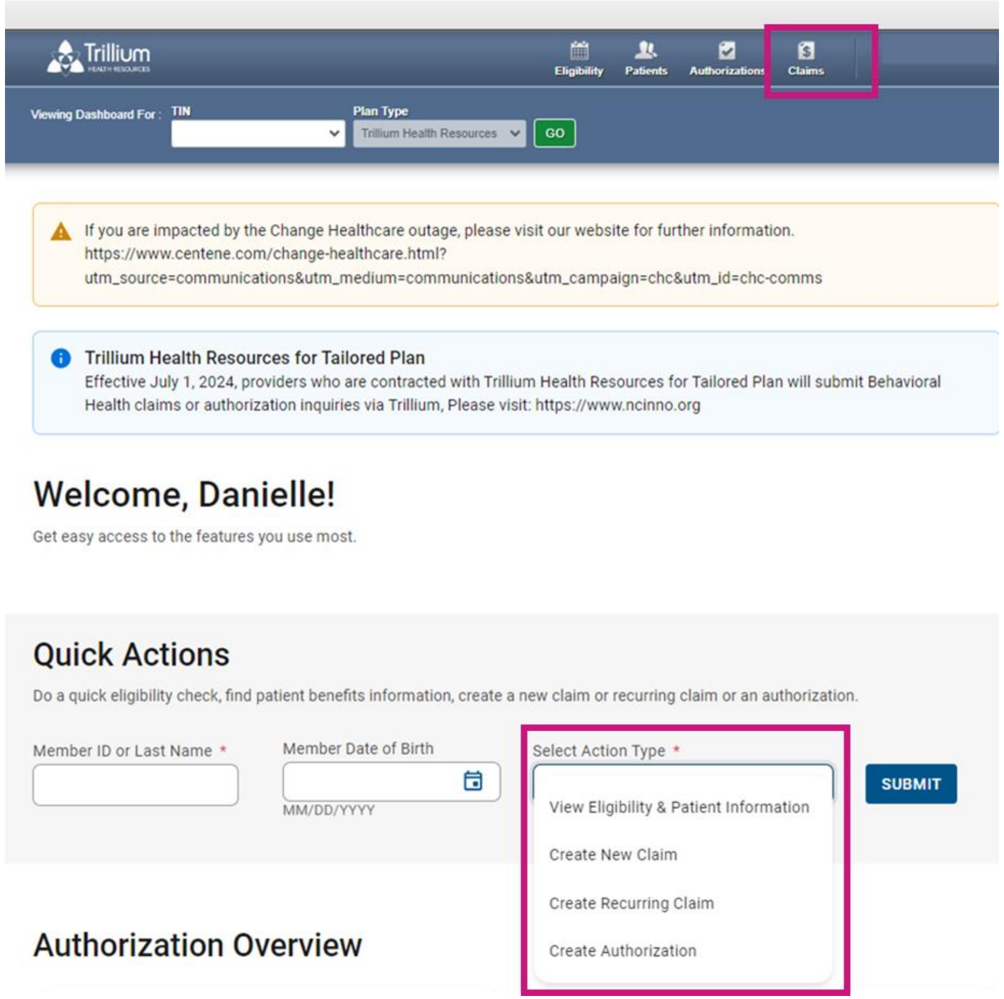
Claims

Providers are able to use the portal to:

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

Claims

The Claims section displays claim-related information and is divided into a series of tabs.


Trillium
Eligibility
Patients
Authorizations
Claims
Viewing Dashboard For :
TIN
Plan Type
Trillium Health Resources
GO

If you are impacted by the Change Healthcare outage, please visit our website for further information. https://www.centene.com/change-healthcare.html?utm_source=communications&utm_medium=communications&utm_campaign=chc&utm_id=chc-comms

Trillium Health Resources for Tailored Plan

Effective July 1, 2024, providers who are contracted with Trillium Health Resources for Tailored Plan will submit Behavioral Health claims or authorization inquiries via Trillium, Please visit: https://www.ncinno.org

Welcome, Danielle!

Get easy access to the features you use most.

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 *
View Eligibility & Patient Information
Create New Claim
Create Recurring Claim
Create Authorization
SUBMIT
Authorization Overview

Claims - Individual

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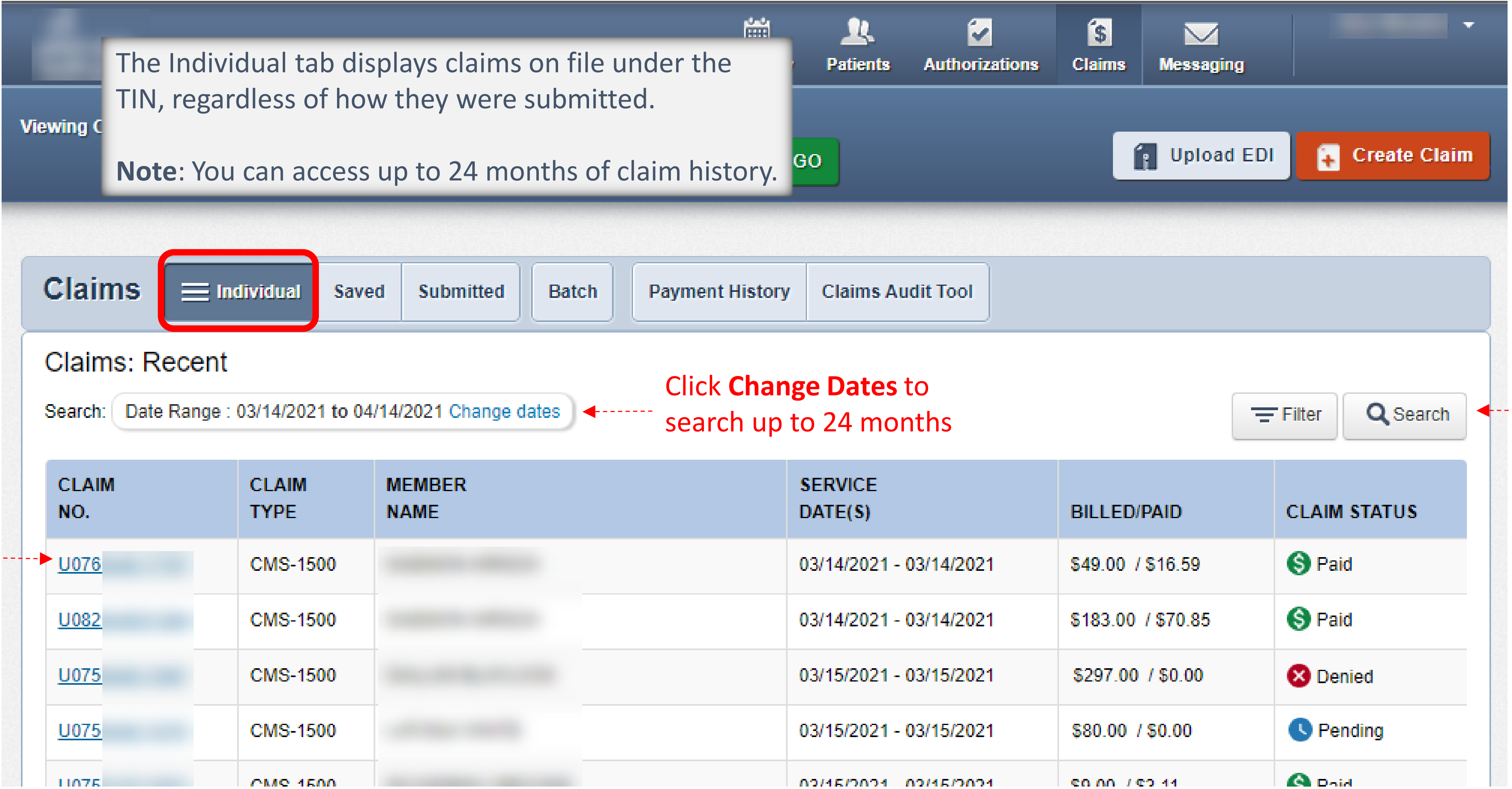
Patients
Authorizations
Claims
Messaging
Viewing C
GO
Upload EDI
Create Claim
Claims
Individual
Saved
Submitted
Batch
Payment History
Claims Audit Tool
Filter
Search

The Individual tab displays claims on file under the TIN, regardless of how they were submitted.

Note: You can access up to 24 months of claim history.

Claims: Recent

Search: Date Range : 03/14/2021 to 04/14/2021 Change dates

Click **Change Dates** to search up to 24 months

CLAIM NO.	CLAIM TYPE	MEMBER NAME	SERVICE DATE(S)	BILLED/PAID	CLAIM STATUS
U076[redacted]	CMS-1500	[redacted]	03/14/2021 - 03/14/2021	$49.00 / $16.59	Paid
U082[redacted]	CMS-1500	[redacted]	03/14/2021 - 03/14/2021	$183.00 / $70.85	Paid
U075[redacted]	CMS-1500	[redacted]	03/15/2021 - 03/15/2021	$297.00 / $0.00	Denied
U075[redacted]	CMS-1500	[redacted]	03/15/2021 - 03/15/2021	$80.00 / $0.00	Pending
U075[redacted]	CMS-1500	[redacted]	03/15/2021 - 03/15/2021	$0.00 / $3.11	Paid

Click Claim Number to view claim details

Click **Filter** and/or **Search** for additional options

Claim Details

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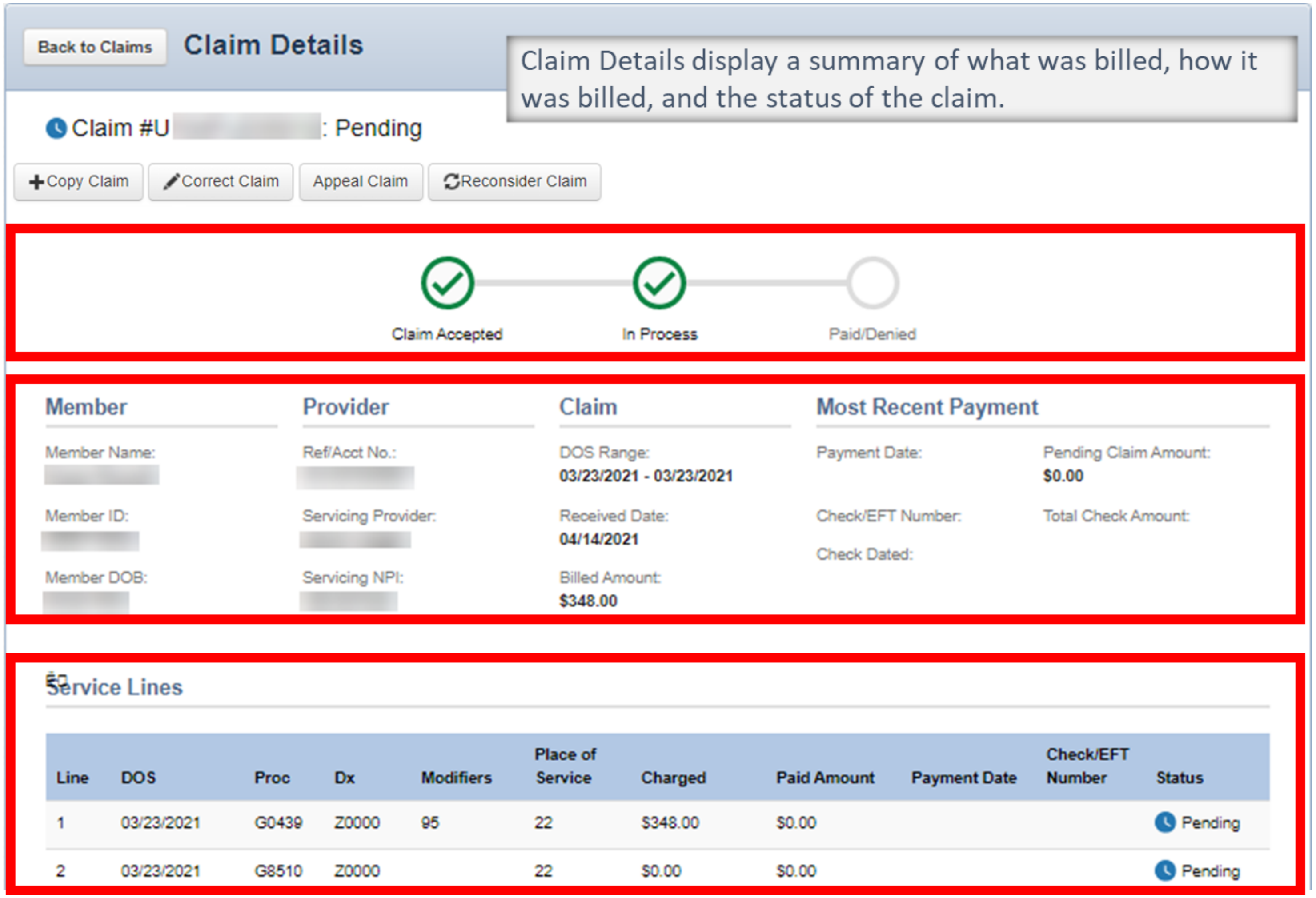
Claim Action Buttons

Claim Status Tracking

Claim Information

Claim Service Line(s)



Claim Details display a summary of what was billed, how it was billed, and the status of the claim.

Back to Claims
Claim Details

Claim #U[redacted]: Pending

Copy Claim
Correct Claim
Appeal Claim
Reconsider Claim
✓ Claim Accepted
✓ In Process
○ Paid/Denied

Member

Member Name: [redacted]

Member ID: [redacted]

Member DOB: [redacted]

Provider

Ref/Acct No.: [redacted]

Servicing Provider: [redacted]

Servicing NPI: [redacted]

Claim

DOS Range: 03/23/2021 - 03/23/2021

Received Date: 04/14/2021

Billed Amount: $348.00

Most Recent Payment

Payment Date:

Pending Claim Amount: $0.00

Check/EFT Number:

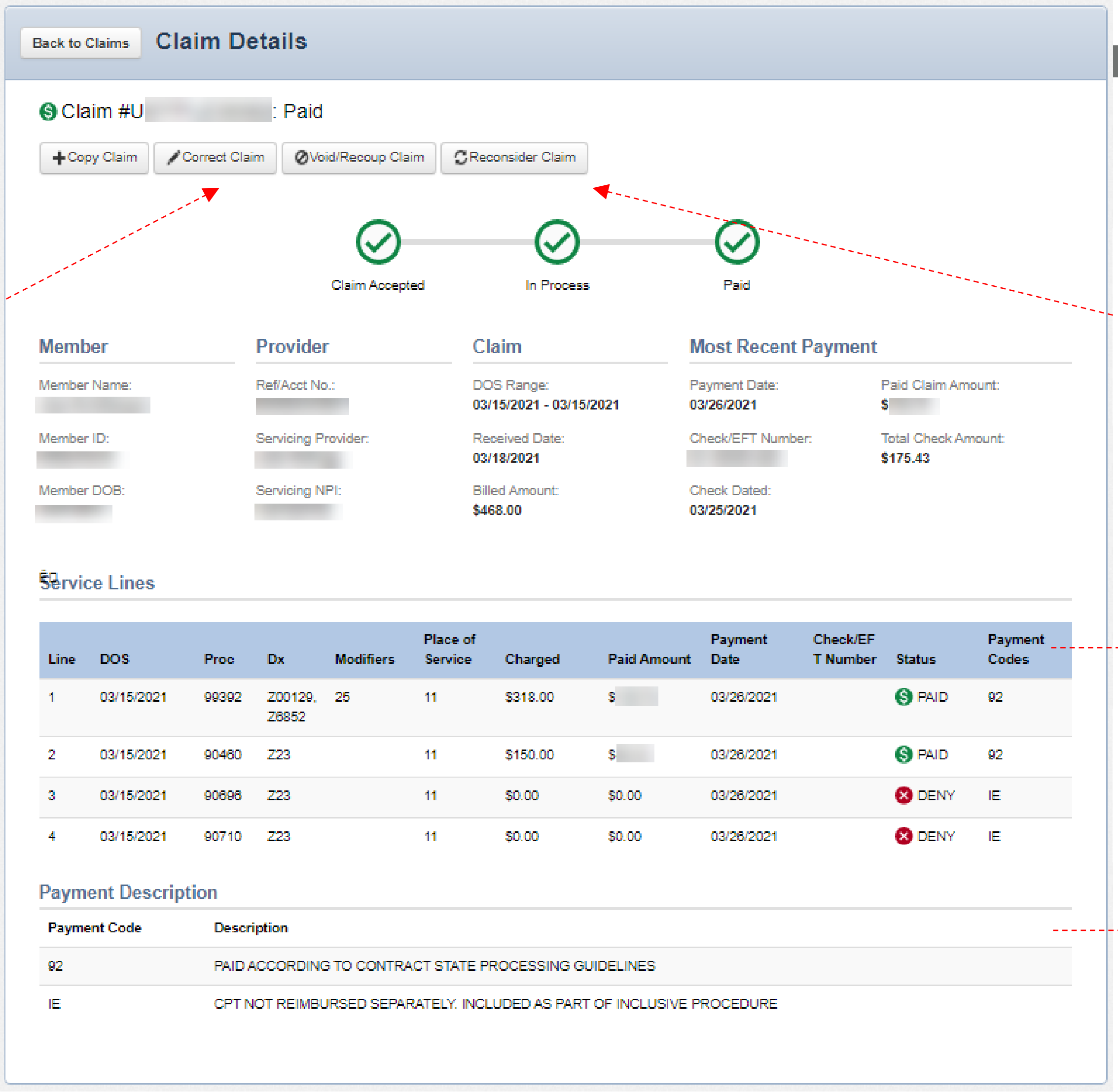
Total Check Amount:

Check Dated:

Service Lines

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Paid Amount	Payment Date	Check/EFT Number	Status
1	03/23/2021	G0439	Z0000	95	22	$348.00	$0.00			Pending
2	03/23/2021	G8510	Z0000		22	$0.00	$0.00			Pending

Claim Details - Finalized



Claim Details

Claim #U[redacted]: Paid

Member

Member Name: [redacted]

Member ID: [redacted]

Member DOB: [redacted]

Provider

Ref/Acct No.: [redacted]

Servicing Provider: [redacted]

Servicing NPI: [redacted]

Claim

DOS Range: 03/15/2021 - 03/15/2021

Received Date: 03/18/2021

Billed Amount: $468.00

Most Recent Payment

Payment Date: 03/26/2021

Paid Claim Amount: $[redacted]

Check/EFT Number: [redacted]

Total Check Amount: $175.43

Check Dated: 03/25/2021

Service Lines

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Paid Amount	Payment Date	Check/EFT Number	Status	Payment Codes
1	03/15/2021	99392	Z00129, Z6852	25	11	$318.00	$[redacted]	03/26/2021		PAID	92
2	03/15/2021	90460	Z23		11	$150.00	$[redacted]	03/26/2021		PAID	92
3	03/15/2021	90696	Z23		11	$0.00	$0.00	03/26/2021		DENY	IE
4	03/15/2021	90710	Z23		11	$0.00	$0.00	03/26/2021		DENY	IE

Payment Description

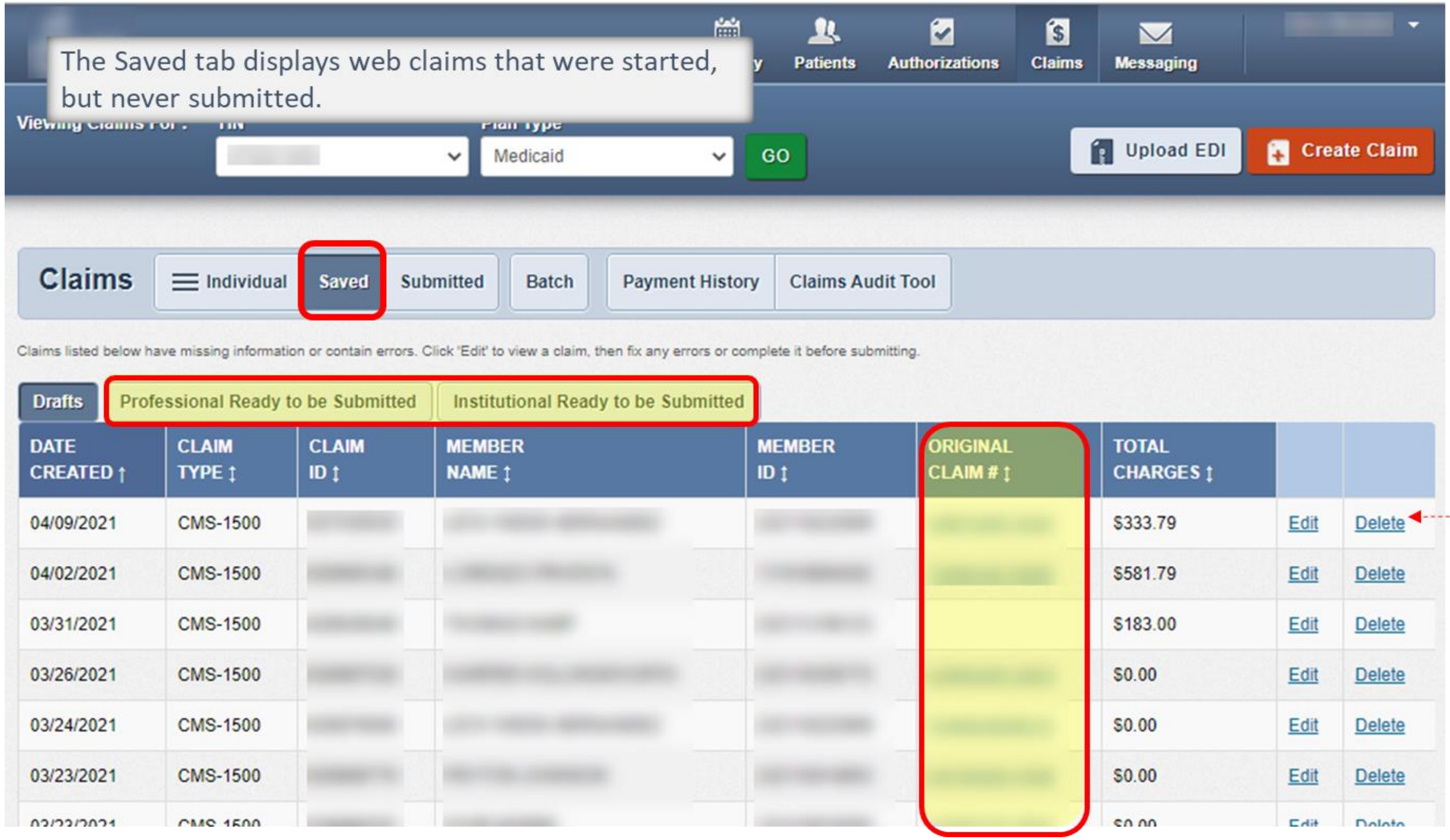
Payment Code	Description
92	PAID ACCORDING TO CONTRACT STATE PROCESSING GUIDELINES
IE	CPT NOT REIMBURSED SEPARATELY. INCLUDED AS PART OF INCLUSIVE PROCEDURE

Click **Correct Claim** to correct a finalized claim

Click **Reconsider Claim** to submit reconsideration request

Payment Codes and **Payment Description** display on finalized claims

Claims - Saved



The Saved tab displays web claims that were started, but never submitted.

Patients
Authorizations
Claims
Messaging
Viewing Claims For :
TIN
Plan Type
Medicaid
GO
Upload EDI
Create Claim
Claims
Individual
Saved
Submitted
Batch
Payment History
Claims Audit Tool
Drafts
Professional Ready to be Submitted
Institutional Ready to be Submitted

Claims listed below have missing information or contain errors. Click 'Edit' to view a claim, then fix any errors or complete it before submitting.

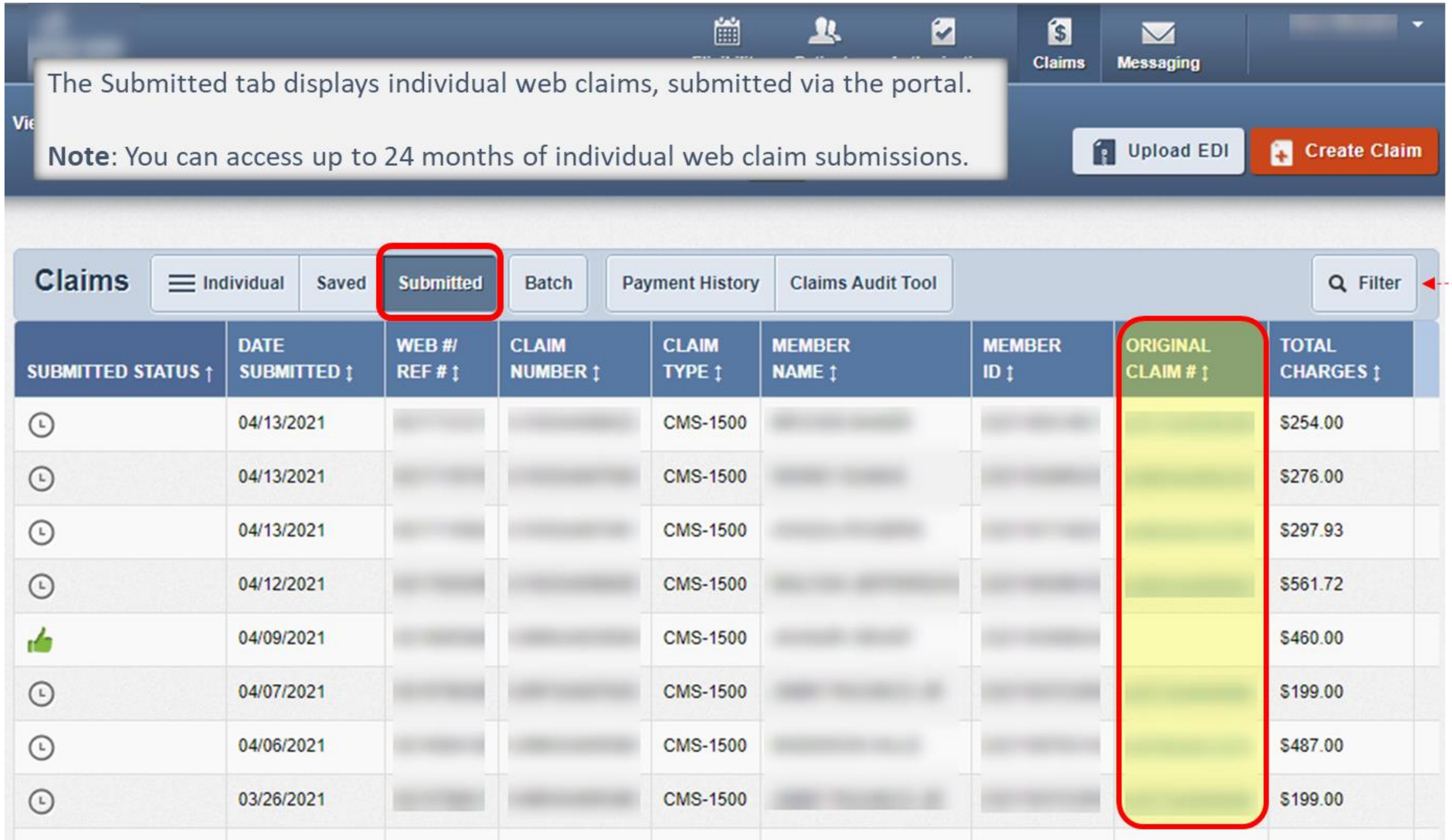
DATE CREATED ↑	CLAIM TYPE ↕	CLAIM ID ↕	MEMBER NAME ↕	MEMBER ID ↕	ORIGINAL CLAIM # ↕	TOTAL CHARGES ↕		
04/09/2021	CMS-1500	[redacted]	[redacted]	[redacted]	[redacted]	$333.79	Edit	Delete
04/02/2021	CMS-1500	[redacted]	[redacted]	[redacted]	[redacted]	$581.79	Edit	Delete
03/31/2021	CMS-1500	[redacted]	[redacted]	[redacted]		$183.00	Edit	Delete
03/26/2021	CMS-1500	[redacted]	[redacted]	[redacted]	[redacted]	$0.00	Edit	Delete
03/24/2021	CMS-1500	[redacted]	[redacted]	[redacted]	[redacted]	$0.00	Edit	Delete
03/23/2021	CMS-1500	[redacted]	[redacted]	[redacted]	[redacted]	$0.00	Edit	Delete
03/23/2021	CMS-1500	[redacted]	[redacted]	[redacted]	[redacted]	$0.00	Edit	Delete

Click **Edit** to resume, complete, and submit web claim

Click **Delete** to delete the web claim draft

Tip: A Claim Number in the **Original Claim #** column, indicates it is a corrected claim draft.

Claims – Submitted


Claims
Messaging
Upload EDI
Create Claim
Claims
Individual
Saved
Submitted
Batch
Payment History
Claims Audit Tool
Filter

The Submitted tab displays individual web claims, submitted via the portal.

Note: You can access up to 24 months of individual web claim submissions.

SUBMITTED STATUS	DATE SUBMITTED	WEB #/ REF #	CLAIM NUMBER	CLAIM TYPE	MEMBER NAME	MEMBER ID	ORIGINAL CLAIM #	TOTAL CHARGES
◷	04/13/2021	[redacted]	[redacted]	CMS-1500	[redacted]	[redacted]	[redacted]	$254.00
◷	04/13/2021	[redacted]	[redacted]	CMS-1500	[redacted]	[redacted]	[redacted]	$276.00
◷	04/13/2021	[redacted]	[redacted]	CMS-1500	[redacted]	[redacted]	[redacted]	$297.93
◷	04/12/2021	[redacted]	[redacted]	CMS-1500	[redacted]	[redacted]	[redacted]	$561.72
👍	04/09/2021	[redacted]	[redacted]	CMS-1500	[redacted]	[redacted]		$460.00
◷	04/07/2021	[redacted]	[redacted]	CMS-1500	[redacted]	[redacted]	[redacted]	$199.00
◷	04/06/2021	[redacted]	[redacted]	CMS-1500	[redacted]	[redacted]	[redacted]	$487.00
◷	03/26/2021	[redacted]	[redacted]	CMS-1500	[redacted]	[redacted]	[redacted]	$199.00

Click **Filter** for additional search options

Tip: A Claim Number in the **Original Claim #** column, indicates it is a corrected claim submission.

Claims - Batch

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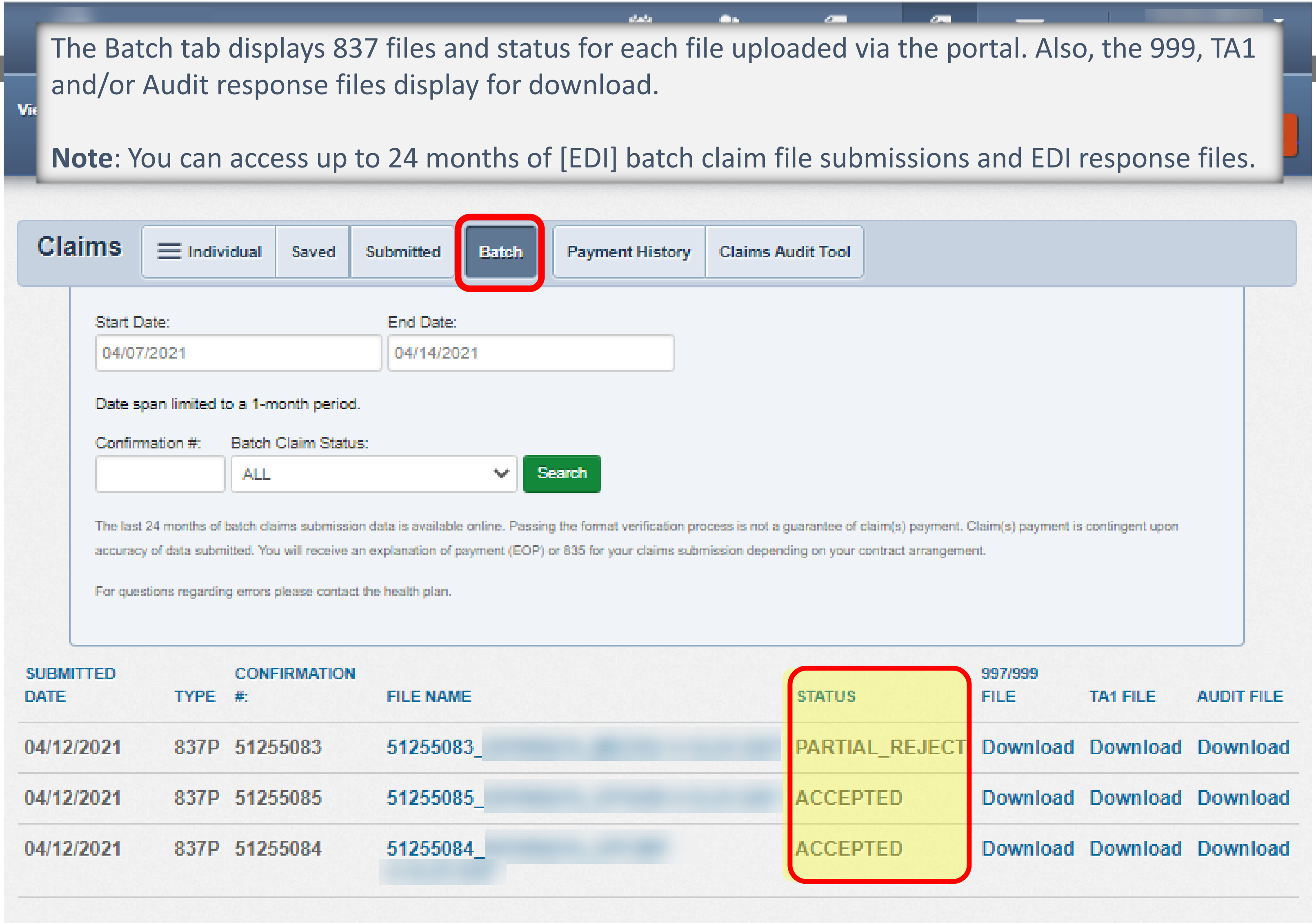
The Batch tab displays 837 files and status for each file uploaded via the portal. Also, the 999, TA1 and/or Audit response files display for download.

Note: You can access up to 24 months of [EDI] batch claim file submissions and EDI response files.



Start Date: 04/07/2021

End Date: 04/14/2021

Date span limited to a 1-month period.

Confirmation #:

Batch Claim Status: ALL

The last 24 months of batch claims submission data is available online. Passing the format verification process is not a guarantee of claim(s) payment. Claim(s) payment is contingent upon accuracy of data submitted. You will receive an explanation of payment (EOP) or 835 for your claims submission depending on your contract arrangement.

For questions regarding errors please contact the health plan.

SUBMITTED DATE	TYPE	CONFIRMATION #:	FILE NAME	STATUS	997/999 FILE	TA1 FILE	AUDIT FILE
04/12/2021	837P	51255083	51255083_[redacted]	PARTIAL_REJECT	Download	Download	Download
04/12/2021	837P	51255085	51255085_[redacted]	ACCEPTED	Download	Download	Download
04/12/2021	837P	51255084	51255084_[redacted]	ACCEPTED	Download	Download	Download

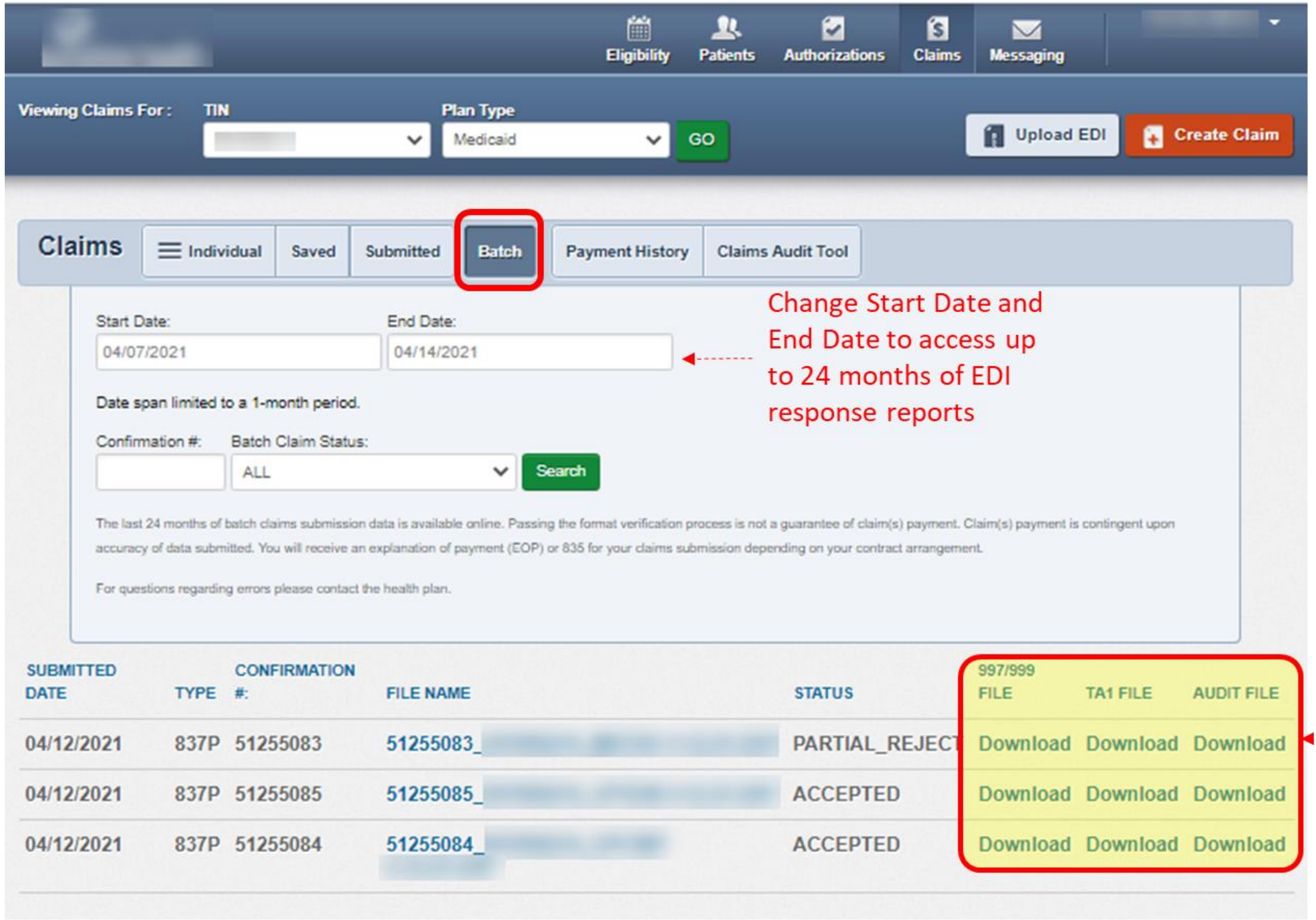
The File status displays in Status. File status Rejected or Partial_Rejected indicates file-level EDI front-end rejections.

Action required to resolve file-level rejections:

- The errors must be corrected in your system
- Re-batch claims
- Resubmit (i.e. upload)

Note: Front-end EDI rejections will not be processed any further, therefore, the claims will never load for adjudication.

Claims – Batch, continued



Eligibility
Patients
Authorizations
Claims
Messaging
Upload EDI
Create Claim
GO
Claims
Individual
Saved
Submitted
Batch
Payment History
Claims Audit Tool
Search

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

Start Date: 04/07/2021

End Date: 04/14/2021

Date span limited to a 1-month period.

Confirmation #:

Batch Claim Status: ALL

The last 24 months of batch claims submission data is available online. Passing the format verification process is not a guarantee of claim(s) payment. Claim(s) payment is contingent upon accuracy of data submitted. You will receive an explanation of payment (EOP) or 835 for your claims submission depending on your contract arrangement.

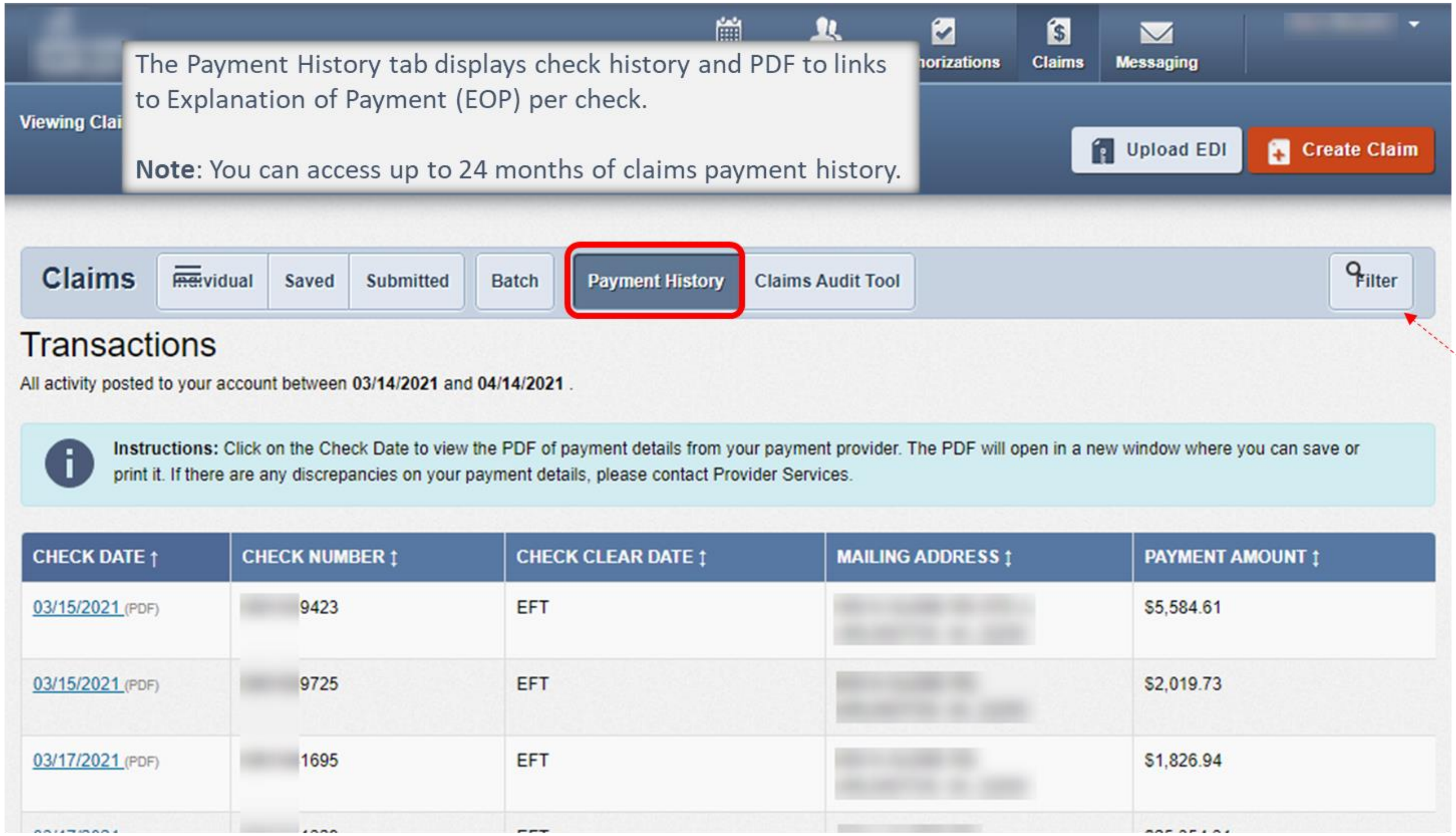
For questions regarding errors please contact the health plan.

SUBMITTED DATE	TYPE	CONFIRMATION #	FILE NAME	STATUS	997/999 FILE	TA1 FILE	AUDIT FILE
04/12/2021	837P	51255083	51255083_[redacted]	PARTIAL_REJECT	Download	Download	Download
04/12/2021	837P	51255085	51255085_[redacted]	ACCEPTED	Download	Download	Download
04/12/2021	837P	51255084	51255084_[redacted]	ACCEPTED	Download	Download	Download

Change Start Date and End Date to access up to 24 months of EDI response reports

Click **Download** to export / view the EDI response reports

Claims – Payment History


horizations
Claims
Messaging
Viewing Clai
Upload EDI
Create Claim
Claims
Individual
Saved
Submitted
Batch
Payment History
Claims Audit Tool
Filter

The Payment History tab displays check history and PDF to links to Explanation of Payment (EOP) per check.

Note: You can access up to 24 months of claims payment history.

Transactions

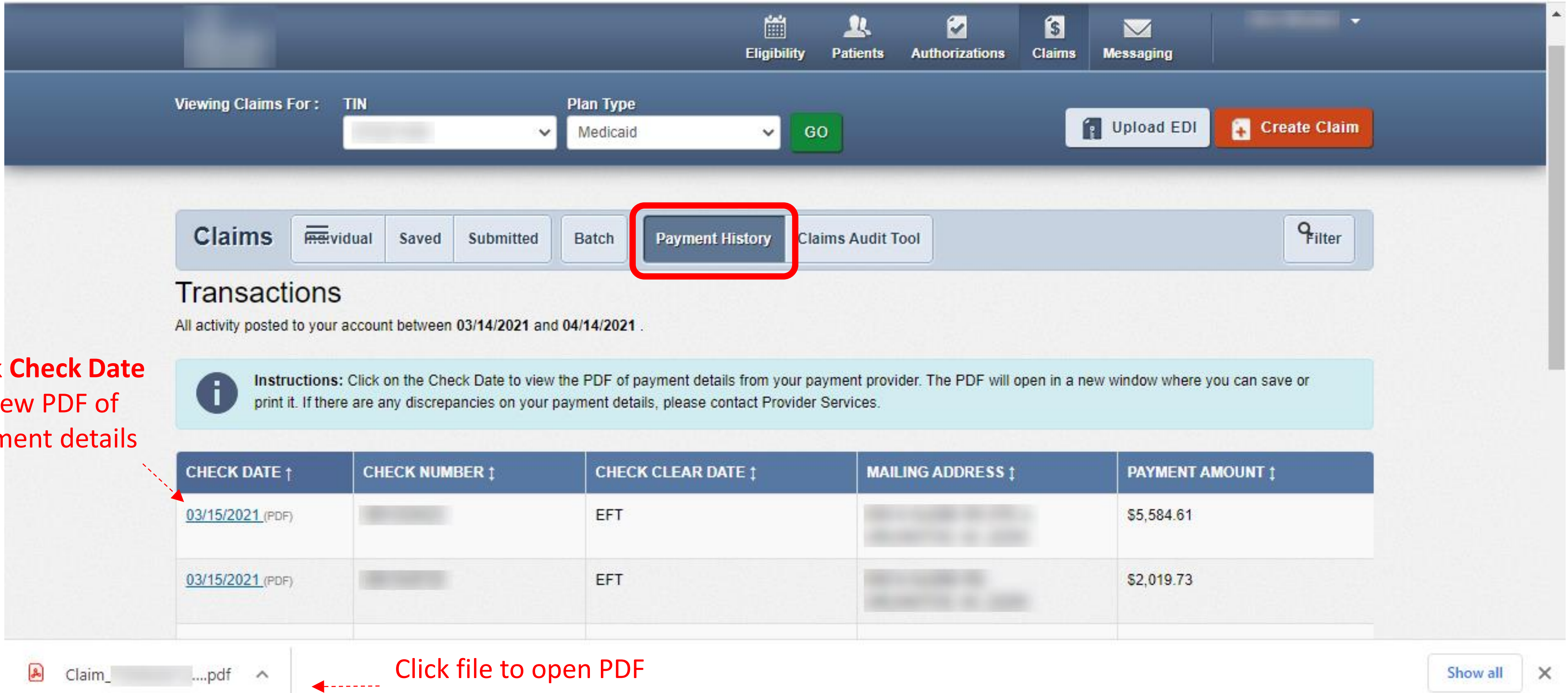
All activity posted to your account between **03/14/2021** and **04/14/2021** .

Instructions: Click on the Check Date to view the PDF of payment details from your payment provider. The PDF will open in a new window where you can save or print it. If there are any discrepancies on your payment details, please contact Provider Services.

CHECK DATE ↑	CHECK NUMBER ↕	CHECK CLEAR DATE ↕	MAILING ADDRESS ↕	PAYMENT AMOUNT ↕
03/15/2021 (PDF)	[redacted]9423	EFT	[redacted]	$5,584.61
03/15/2021 (PDF)	[redacted]9725	EFT	[redacted]	$2,019.73
03/17/2021 (PDF)	[redacted]1695	EFT	[redacted]	$1,826.94

Click **Filter** for additional search options

Claims – Payment History, continued


Eligibility
Patients
Authorizations
Claims
Messaging
Viewing Claims For :
TIN
[redacted]
Plan Type
Medicaid
GO
Upload EDI
Create Claim
Claims
ndividual
Saved
Submitted
Batch
Payment History
Claims Audit Tool
Filter
Claim_[redacted]....pdf
Show all

Transactions

All activity posted to your account between **03/14/2021** and **04/14/2021** .

Instructions: Click on the Check Date to view the PDF of payment details from your payment provider. The PDF will open in a new window where you can save or print it. If there are any discrepancies on your payment details, please contact Provider Services.

CHECK DATE ↑	CHECK NUMBER ↕	CHECK CLEAR DATE ↕	MAILING ADDRESS ↕	PAYMENT AMOUNT ↕
03/15/2021 (PDF)	[redacted]	EFT	[redacted]	$5,584.61
03/15/2021 (PDF)	[redacted]	EFT	[redacted]	$2,019.73

Click **Check Date** to view PDF of payment details

Click file to open PDF of payment details

Claims - Explanation of Payment PDF

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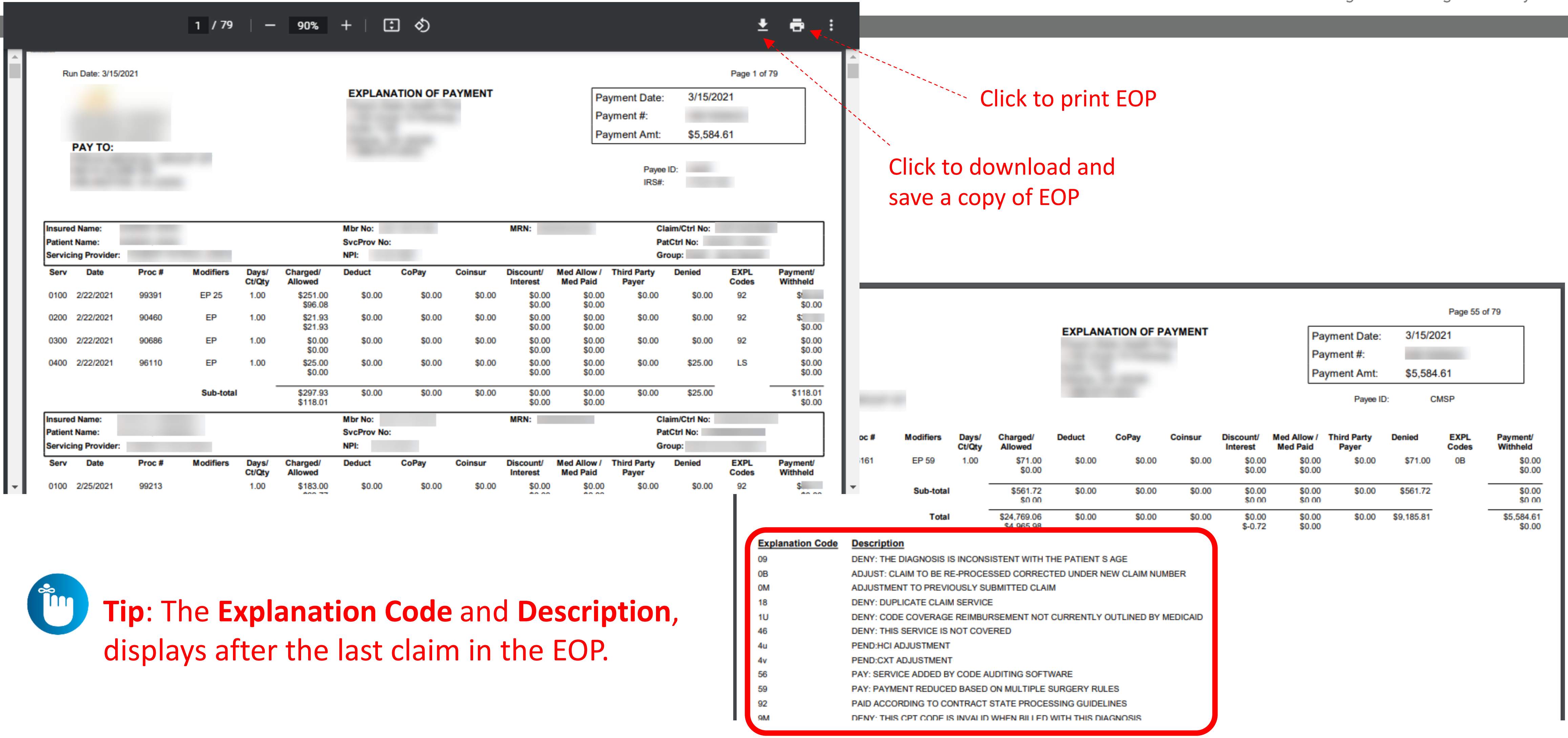

Click to print EOP

Click to download and save a copy of EOP

Run Date: 3/15/2021

Page 1 of 79

[redacted]

EXPLANATION OF PAYMENT

[redacted]

PAY TO:

[redacted]

Payment Date:	3/15/2021
Payment #:	[redacted]
Payment Amt:	$5,584.61

Payee ID: [redacted]
IRS#: [redacted]

Insured Name:	[redacted]	**Mbr No:**	[redacted]	**MRN:** [redacted]	**Claim/Ctrl No:** [redacted]
Patient Name:	[redacted]	**SvcProv No:**			**PatCtrl No:** [redacted]
Servicing Provider:	[redacted]	**NPI:**	[redacted]		**Group:** [redacted]

Serv	Date	Proc #	Modifiers	Days/ Ct/Qty	Charged/ Allowed	Deduct	CoPay	Coinsur	Discount/ Interest	Med Allow / Med Paid	Third Party Payer	Denied	EXPL Codes	Payment/ Withheld
0100	2/22/2021	99391	EP 25	1.00	$251.00 $96.08	$0.00	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$0.00	92	$[redacted] $0.00
0200	2/22/2021	90460	EP	1.00	$21.93 $21.93	$0.00	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$0.00	92	$[redacted] $0.00
0300	2/22/2021	90686	EP	1.00	$0.00 $0.00	$0.00	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$0.00	92	$0.00 $0.00
0400	2/22/2021	96110	EP	1.00	$25.00 $0.00	$0.00	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$25.00	LS	$0.00 $0.00
			Sub-total		$297.93 $118.01	$0.00	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$25.00		$118.01 $0.00

Insured Name:	[redacted]	**Mbr No:**	[redacted]	**MRN:** [redacted]	**Claim/Ctrl No:** [redacted]
Patient Name:	[redacted]	**SvcProv No:**			**PatCtrl No:** [redacted]
Servicing Provider:	[redacted]	**NPI:**	[redacted]		**Group:** [redacted]

Serv	Date	Proc #	Modifiers	Days/ Ct/Qty	Charged/ Allowed	Deduct	CoPay	Coinsur	Discount/ Interest	Med Allow / Med Paid	Third Party Payer	Denied	EXPL Codes	Payment/ Withheld
0100	2/25/2021	99213		1.00	$183.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	92	$[redacted]

Page 55 of 79

EXPLANATION OF PAYMENT

[redacted]

Payment Date:	3/15/2021
Payment #:	[redacted]
Payment Amt:	$5,584.61

Payee ID: CMSP

oc #	Modifiers	Days/ Ct/Qty	Charged/ Allowed	Deduct	CoPay	Coinsur	Discount/ Interest	Med Allow / Med Paid	Third Party Payer	Denied	EXPL Codes	Payment/ Withheld
161	EP 59	1.00	$71.00 $0.00	$0.00	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$71.00	0B	$0.00 $0.00
Sub-total			$561.72 $0.00	$0.00	$0.00	$0.00	$0.00 $0.00	$0.00 $0.00	$0.00	$561.72		$0.00 $0.00
Total			$24,769.06 $4,965.98	$0.00	$0.00	$0.00	$0.00 $-0.72	$0.00 $0.00	$0.00	$9,185.81		$5,584.61 $0.00

Explanation Code	Description
09	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT S AGE
0B	ADJUST: CLAIM TO BE RE-PROCESSED CORRECTED UNDER NEW CLAIM NUMBER
0M	ADJUSTMENT TO PREVIOUSLY SUBMITTED CLAIM
18	DENY: DUPLICATE CLAIM SERVICE
1U	DENY: CODE COVERAGE REIMBURSEMENT NOT CURRENTLY OUTLINED BY MEDICAID
46	DENY: THIS SERVICE IS NOT COVERED
4u	PEND:HCI ADJUSTMENT
4v	PEND:CXT ADJUSTMENT
56	PAY: SERVICE ADDED BY CODE AUDITING SOFTWARE
59	PAY: PAYMENT REDUCED BASED ON MULTIPLE SURGERY RULES
92	PAID ACCORDING TO CONTRACT STATE PROCESSING GUIDELINES
9M	DENY: THIS CPT CODE IS INVALID WHEN BILLED WITH THIS DIAGNOSIS

Tip: The **Explanation Code** and **Description**, displays after the last claim in the EOP.

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HEALTH RESOURCES

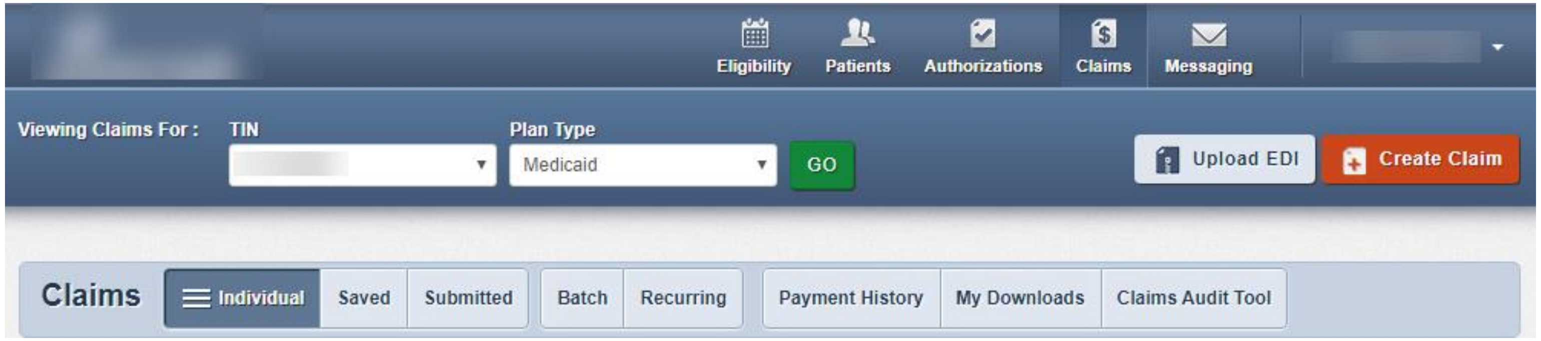
Portal Functionality: Claim Submission

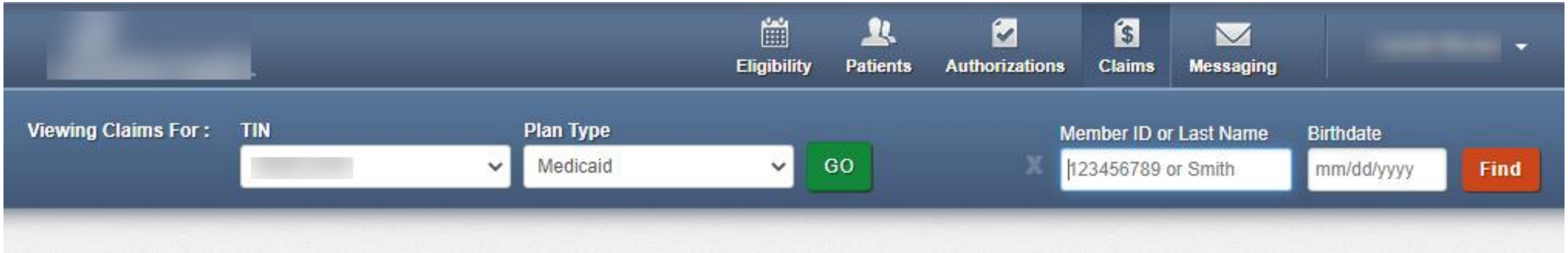
ACCREDITED
NCQA
MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION
FULL

Claim Submission – Create Claim (Individual Web Claim)

To begin an individual web claim:

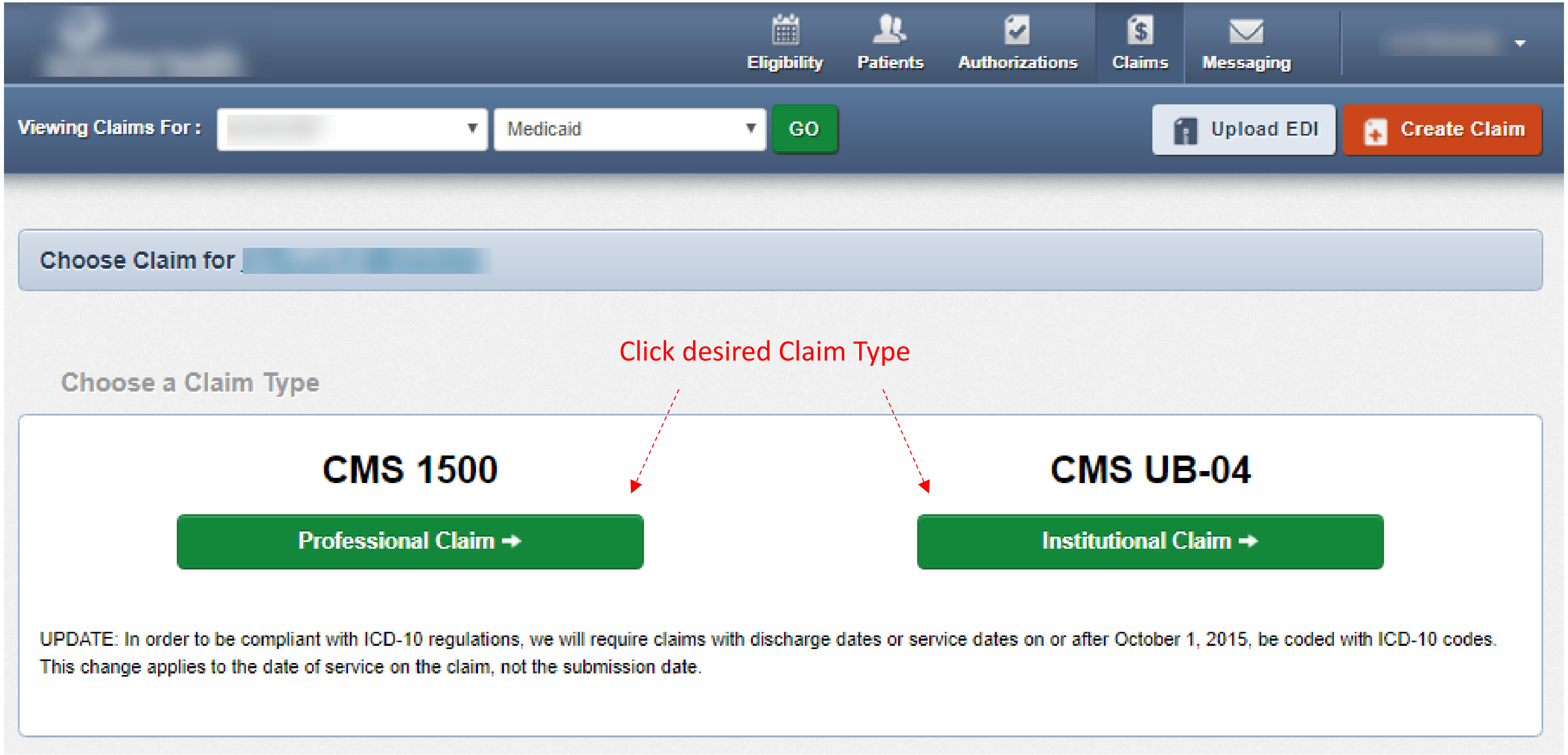
1. Click **Claims**
2. Click **Create Claim**
3. Enter **Member ID or Last Name**
4. Enter Member's **Birthdate**
5. Click **Find**


Eligibility
Patients
Authorizations
Claims
Messaging
Viewing Claims For :
TIN
Plan Type
Medicaid
GO
Upload EDI
Create Claim
Claims
Individual
Saved
Submitted
Batch
Recurring
Payment History
My Downloads
Claims Audit Tool


Eligibility
Patients
Authorizations
Claims
Messaging
Viewing Claims For :
TIN
Plan Type
Medicaid
GO
Member ID or Last Name
123456789 or Smith
Birthdate
mm/dd/yyyy
Find

Create Claim - Claim Type Selection

Transforming Lives. Building Community Well-Being.


Eligibility
Patients
Authorizations
Claims
Messaging
Viewing Claims For :
Medicaid
GO
Upload EDI
Create Claim

Choose Claim for

Click desired Claim Type

Choose a Claim Type

CMS 1500

Professional Claim →

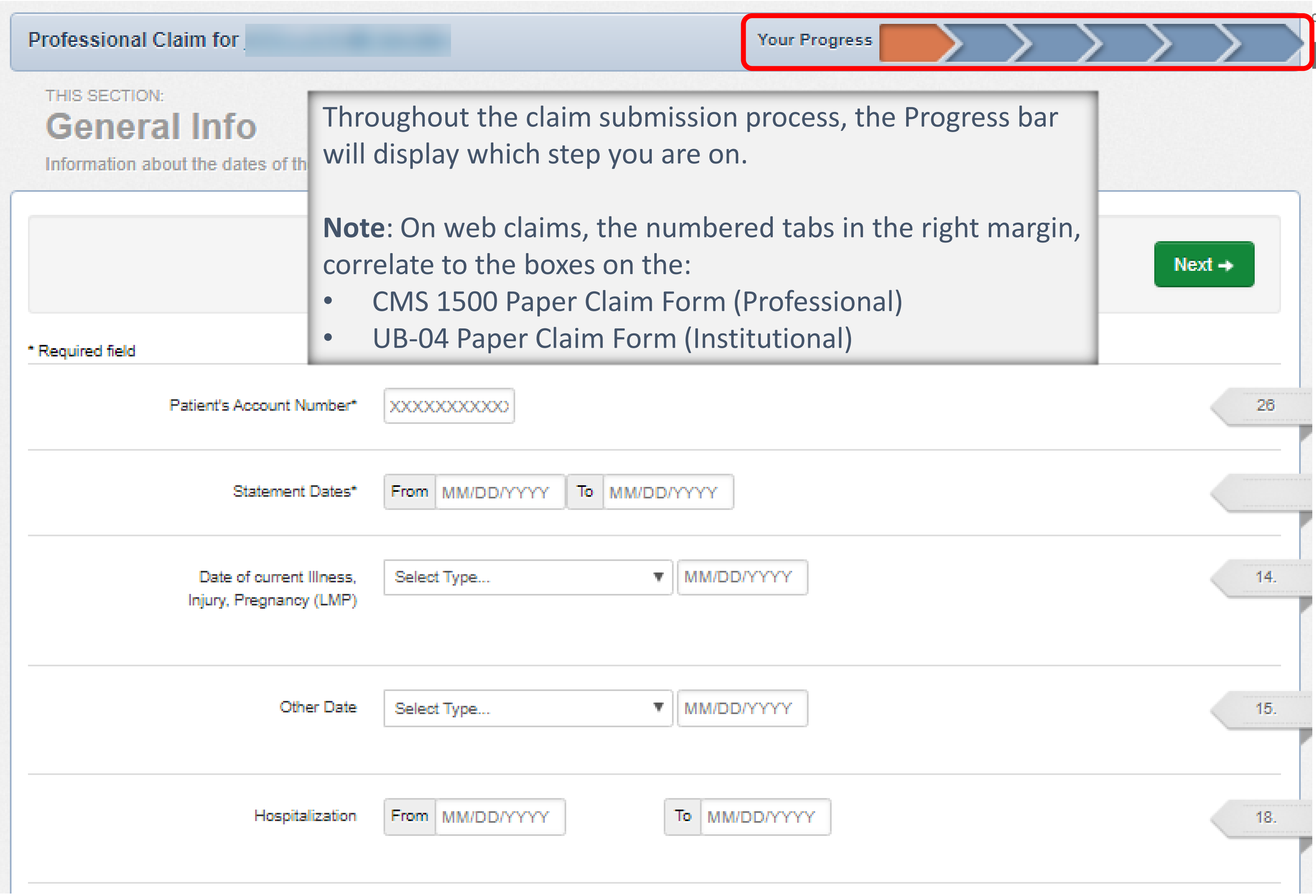
CMS UB-04

Institutional Claim →

UPDATE: In order to be compliant with ICD-10 regulations, we will require claims with discharge dates or service dates on or after October 1, 2015, be coded with ICD-10 codes. This change applies to the date of service on the claim, not the submission date.

Create Claim - General Information

Trillium
HEALTH RESOURCES
orming Lives. Building Community Well-Being.



Professional Claim for [redacted]

THIS SECTION:

General Info

Information about the dates of th

* Required field

Patient's Account Number*: XXXXXXXXXXX

Statement Dates*: From MM/DD/YYYY To MM/DD/YYYY

Date of current Illness, Injury, Pregnancy (LMP): Select Type... MM/DD/YYYY

Other Date: Select Type... MM/DD/YYYY

Hospitalization: From MM/DD/YYYY To MM/DD/YYYY

Throughout the claim submission process, the Progress bar will display which step you are on.

Note: On web claims, the numbered tabs in the right margin, correlate to the boxes on the:

- CMS 1500 Paper Claim Form (Professional)
- UB-04 Paper Claim Form (Institutional)

Hover mouse over tabs for additional information

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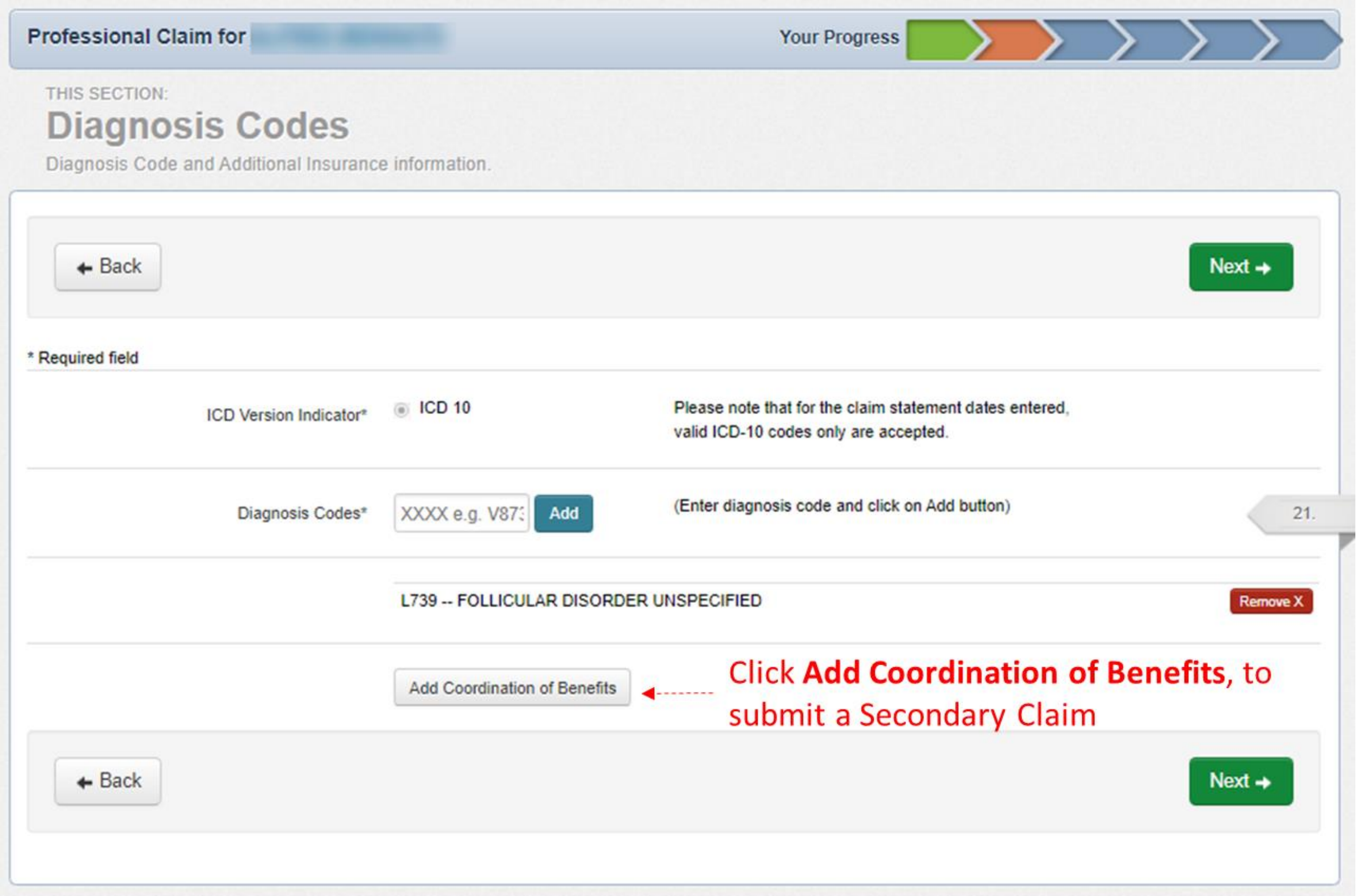
Create Claim – Diagnosis Codes



Your Progress
← Back
Next →
Add
Remove X
Add Coordination of Benefits
21.

Professional Claim for [redacted]

THIS SECTION:

Diagnosis Codes

Diagnosis Code and Additional Insurance information.

* Required field

ICD Version Indicator* ● ICD 10

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

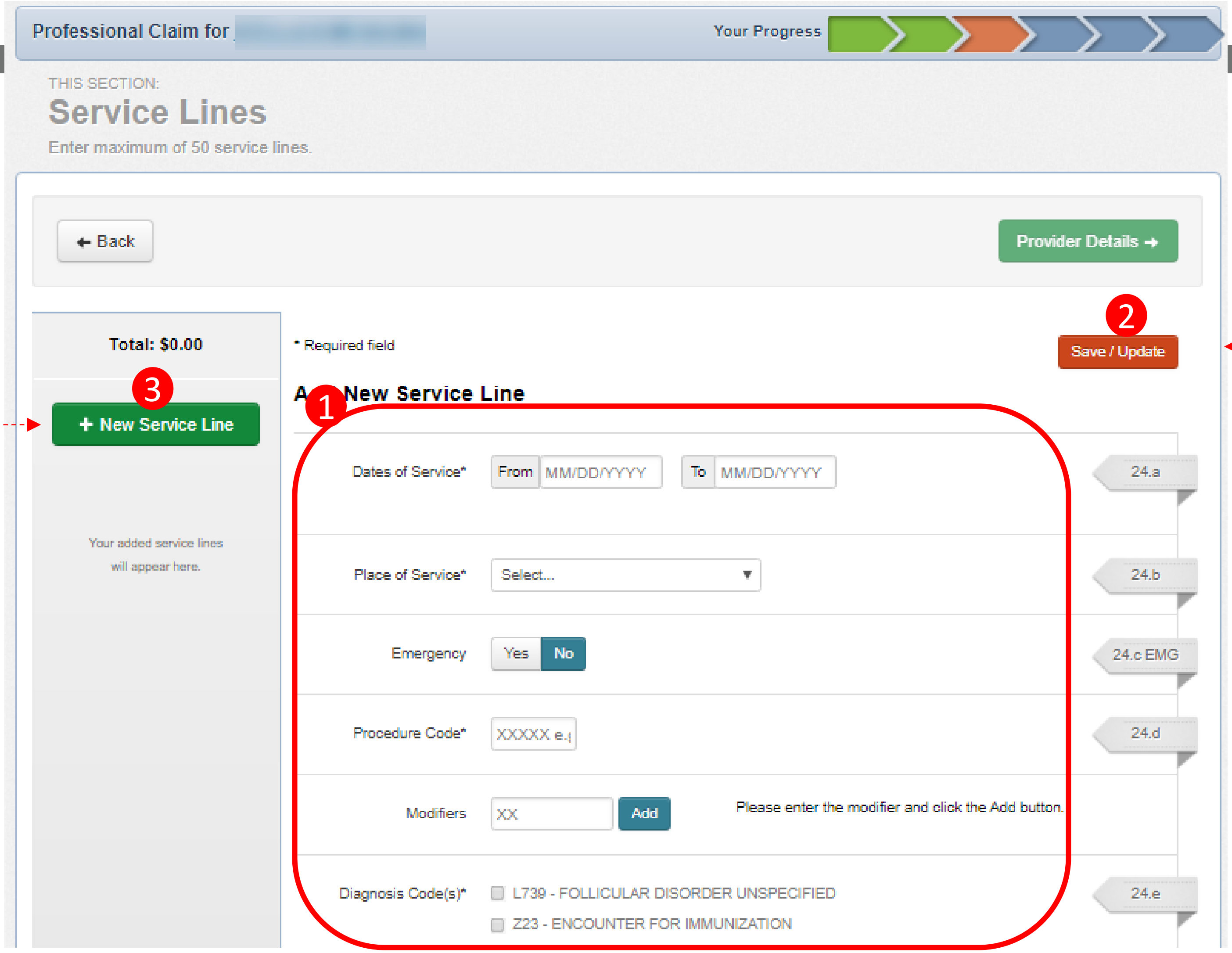
Diagnosis Codes* XXXX e.g. V873

(Enter diagnosis code and click on Add button)

L739 -- FOLLICULAR DISORDER UNSPECIFIED

Click **Add Coordination of Benefits**, to submit a Secondary Claim

Create Claim - Service Lines



Professional Claim for [redacted]

Your Progress

THIS SECTION:

Service Lines

Enter maximum of 50 service lines.

Total: $0.00

Your added service lines will appear here.

* Required field

A New Service Line

Dates of Service* From MM/DD/YYYY To MM/DD/YYYY 24.a

Place of Service* Select... 24.b

Emergency Yes No 24.c EMG

Procedure Code* XXXXX e.| 24.d

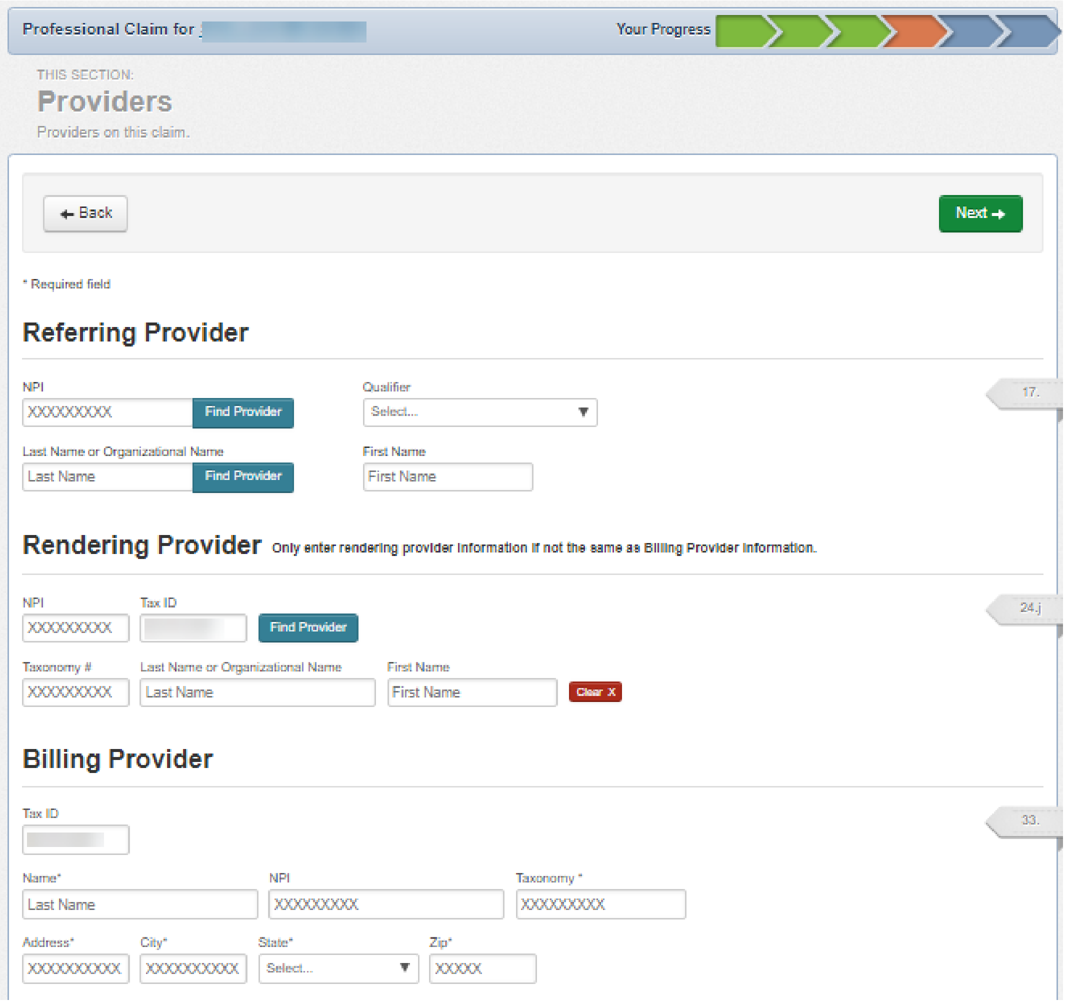
Modifiers XX Add — Please enter the modifier and click the Add button.

Diagnosis Code(s)* 24.e
☐ L739 - FOLLICULAR DISORDER UNSPECIFIED
☐ Z23 - ENCOUNTER FOR IMMUNIZATION

Click **+ New Service Line** to enter additional Service Line(s).

After entering or editing a Service Line, click **Save/Update.**

Create Claim - Providers



Professional Claim for [redacted]

Your Progress

THIS SECTION:

Providers

Providers on this claim.

* Required field

Referring Provider

NPI	XXXXXXXXX	Qualifier: Select...
Last Name or Organizational Name	Last Name	First Name: First Name

Rendering Provider Only enter rendering provider information if not the same as Billing Provider information.

NPI: XXXXXXXXX	Tax ID: [redacted]		
Taxonomy #: XXXXXXXXX	Last Name or Organizational Name: Last Name	First Name: First Name	

Billing Provider

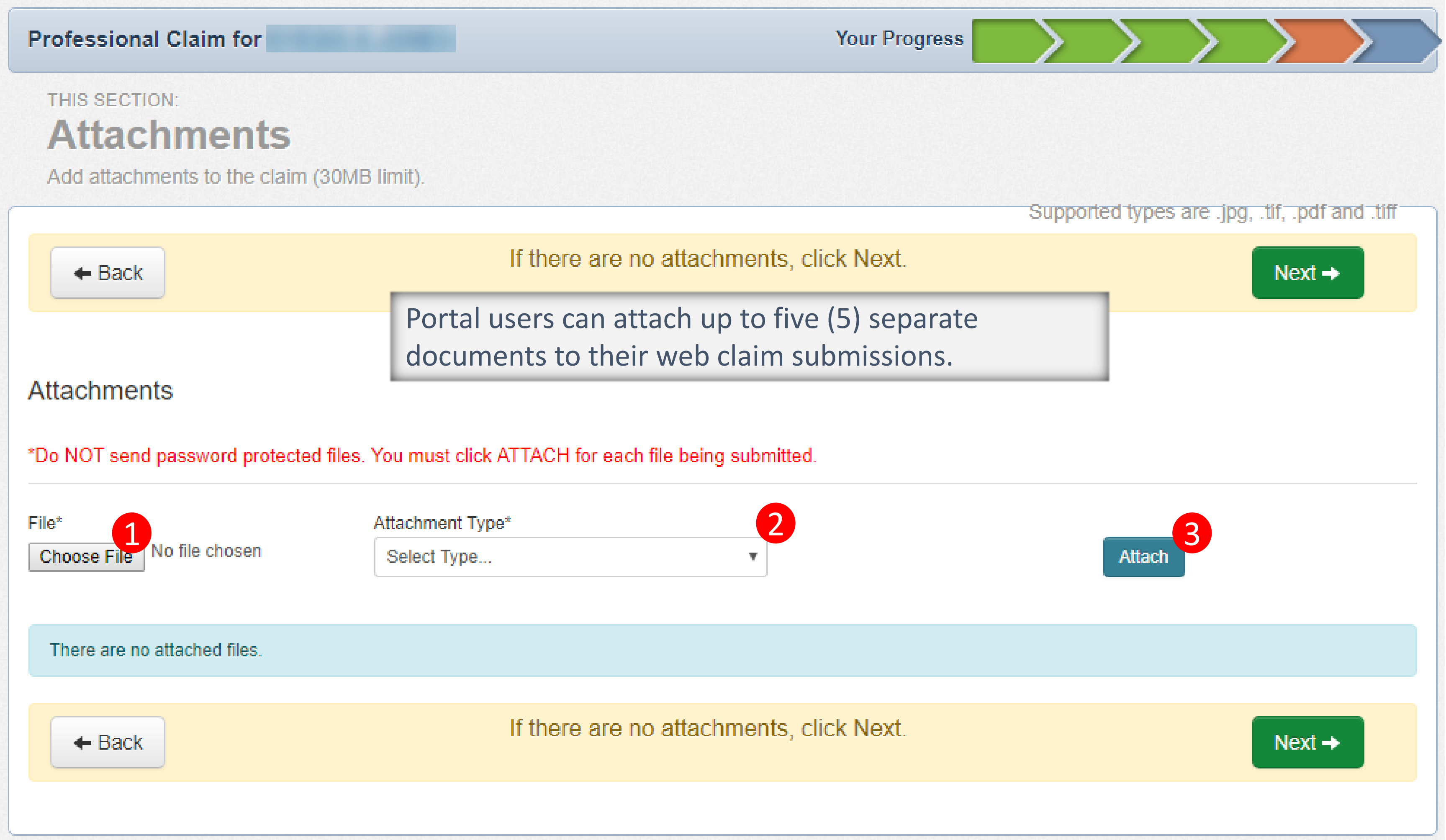
Tax ID: [redacted]

Name*: Last Name	NPI: XXXXXXXXX	Taxonomy *: XXXXXXXXX	
Address*: XXXXXXXXXX	City*: XXXXXXXXXX	State*: Select...	Zip*: XXXXX

Tip: Missing Taxonomy is a common cause of processing delays and denials.

For more information, view our Claims Submission Reminder Guide (PDF)

Create Claim - Attachments



Professional Claim for [redacted]

THIS SECTION:

Attachments

Add attachments to the claim (30MB limit).

Supported types are .jpg, .tif, .pdf and .tiff

If there are no attachments, click Next.

Portal users can attach up to five (5) separate documents to their web claim submissions.

Attachments

*Do NOT send password protected files. You must click ATTACH for each file being submitted.

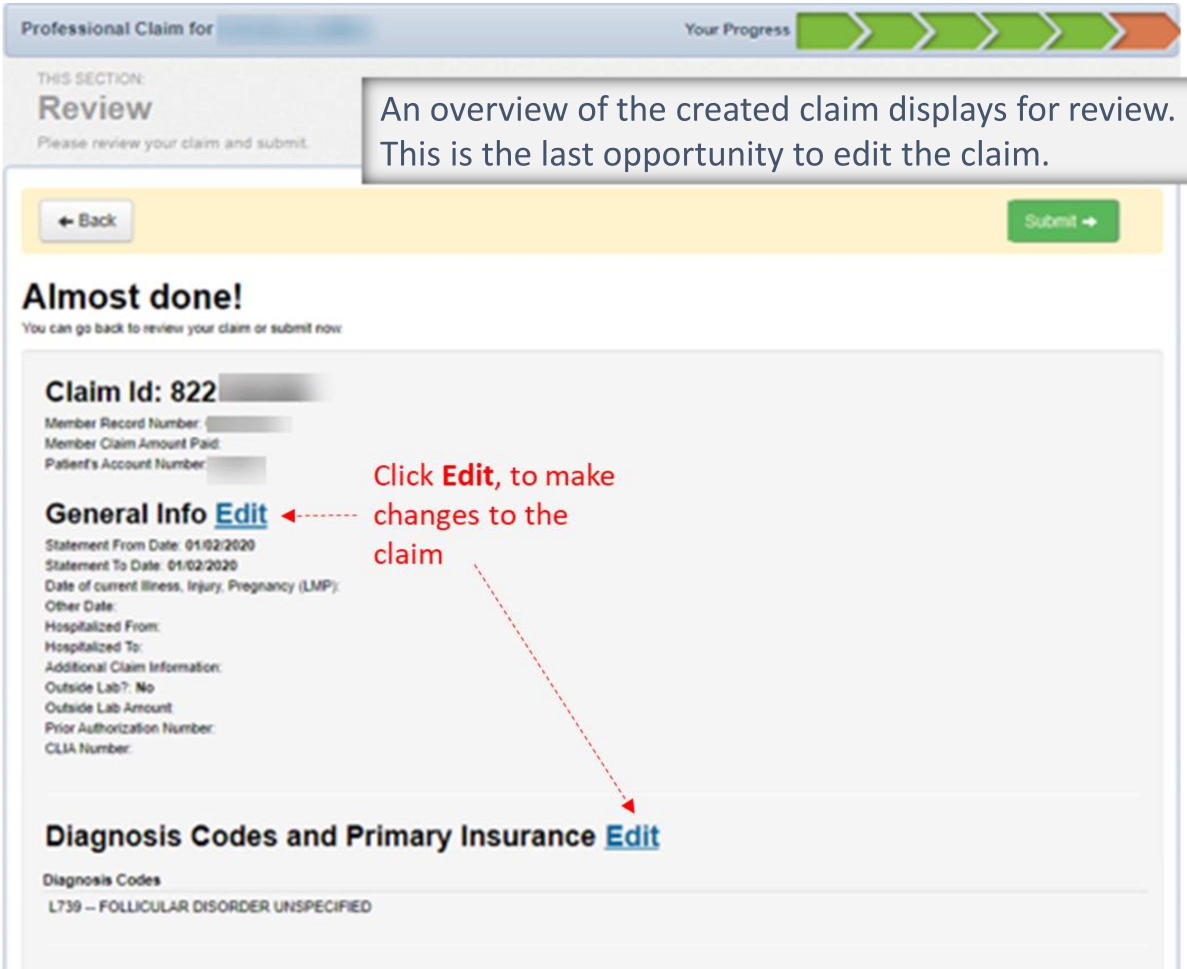
File* No file chosen

Attachment Type*

There are no attached files.

If there are no attachments, click Next.

Create Claim - Review and Submit



Professional Claim for [redacted]

THIS SECTION:

Review

Please review your claim and submit.

Almost done!

You can go back to review your claim or submit now.

Claim Id: 822[redacted]

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

General Info Edit

Statement From Date: 01/02/2020
Statement To Date: 01/02/2020
Date of current Illness, Injury, Pregnancy (LMP):
Other Date:
Hospitalized From:
Hospitalized To:
Additional Claim Information:
Outside Lab?: No
Outside Lab Amount:
Prior Authorization Number:
CLIA Number:

Diagnosis Codes and Primary Insurance Edit

Diagnosis Codes

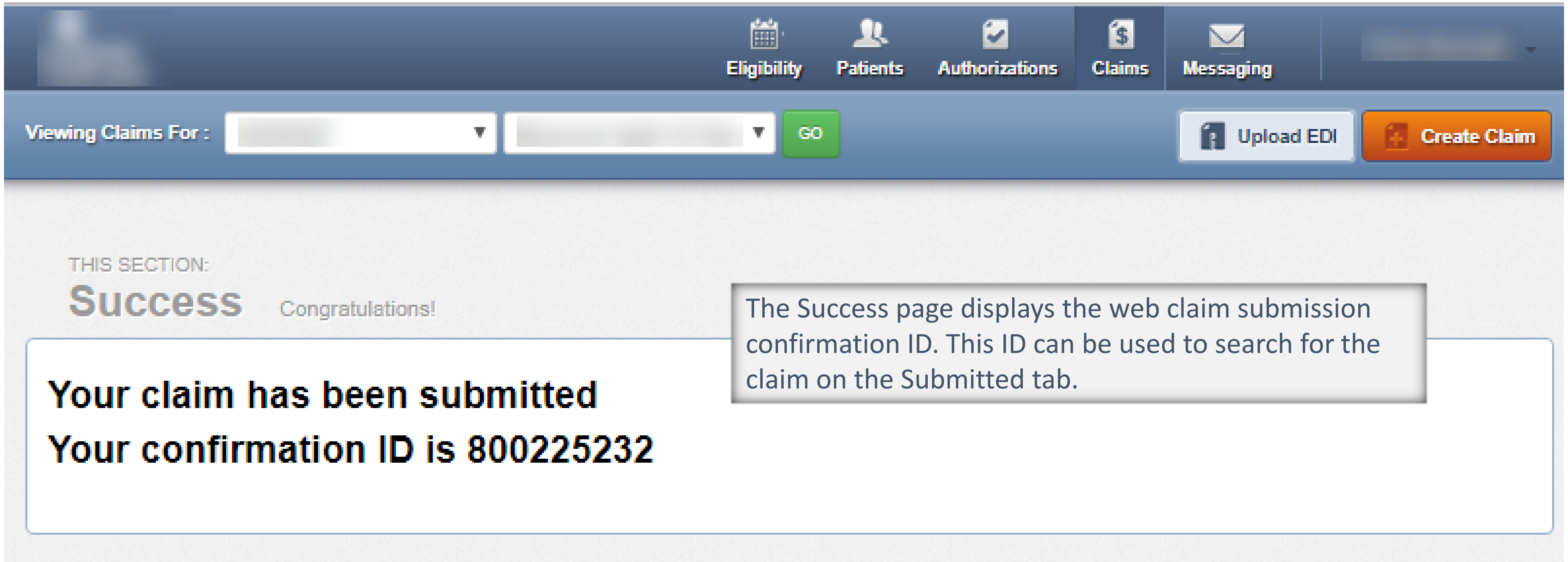
L739 -- FOLLICULAR DISORDER UNSPECIFIED

An overview of the created claim displays for review. This is the last opportunity to edit the claim.

Click **Submit** to complete claim submission

Click **Edit**, to make changes to the claim

Create Claim - Submission Confirmation


Eligibility
Patients
Authorizations
Claims
Messaging
Viewing Claims For :
GO
Upload EDI
Create Claim
THIS SECTION:
Success
Congratulations!

Your claim has been submitted

Your confirmation ID is 800225232

The Success page displays the web claim submission confirmation ID. This ID can be used to search for the claim on the Submitted tab.

Create Claim - Claim Type Selection

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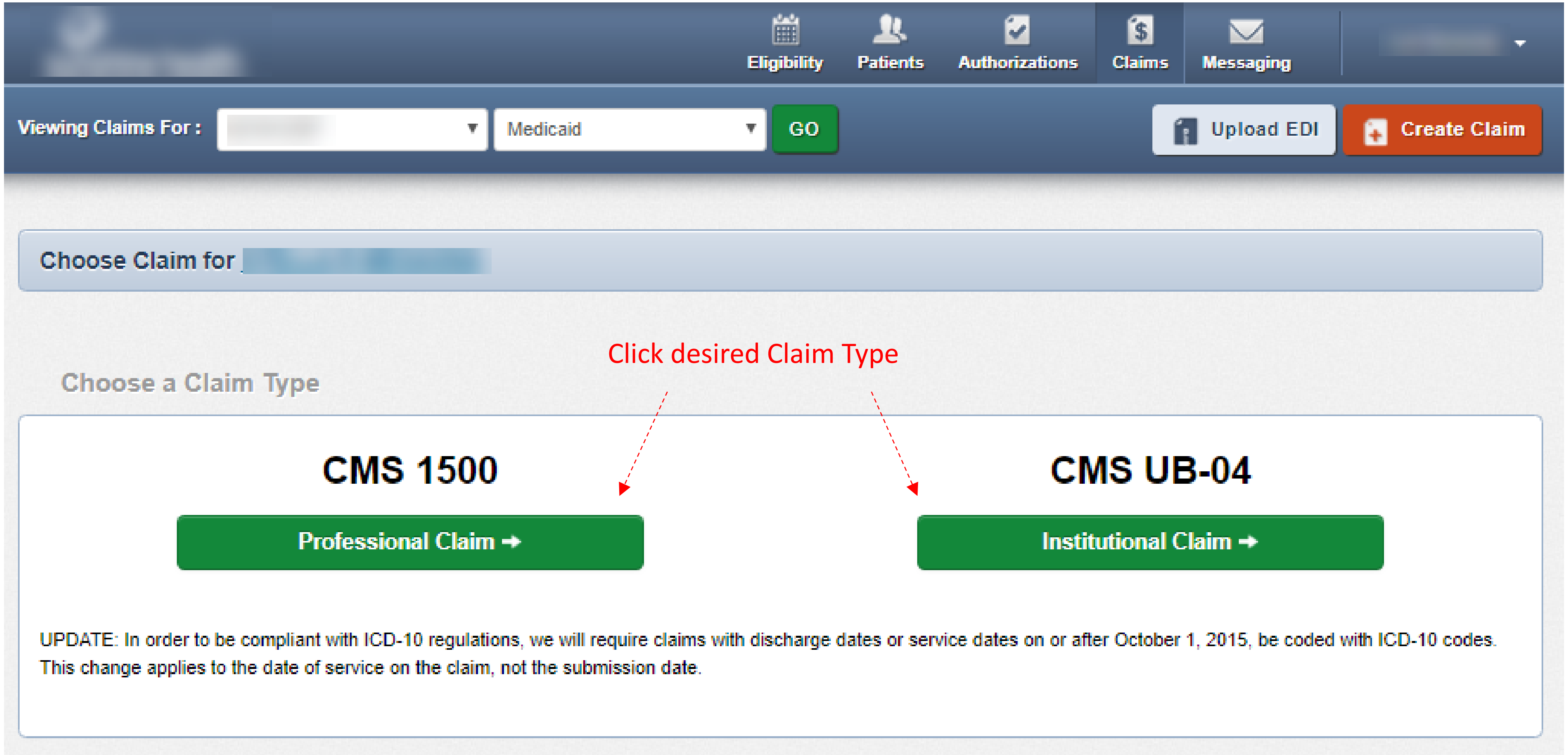
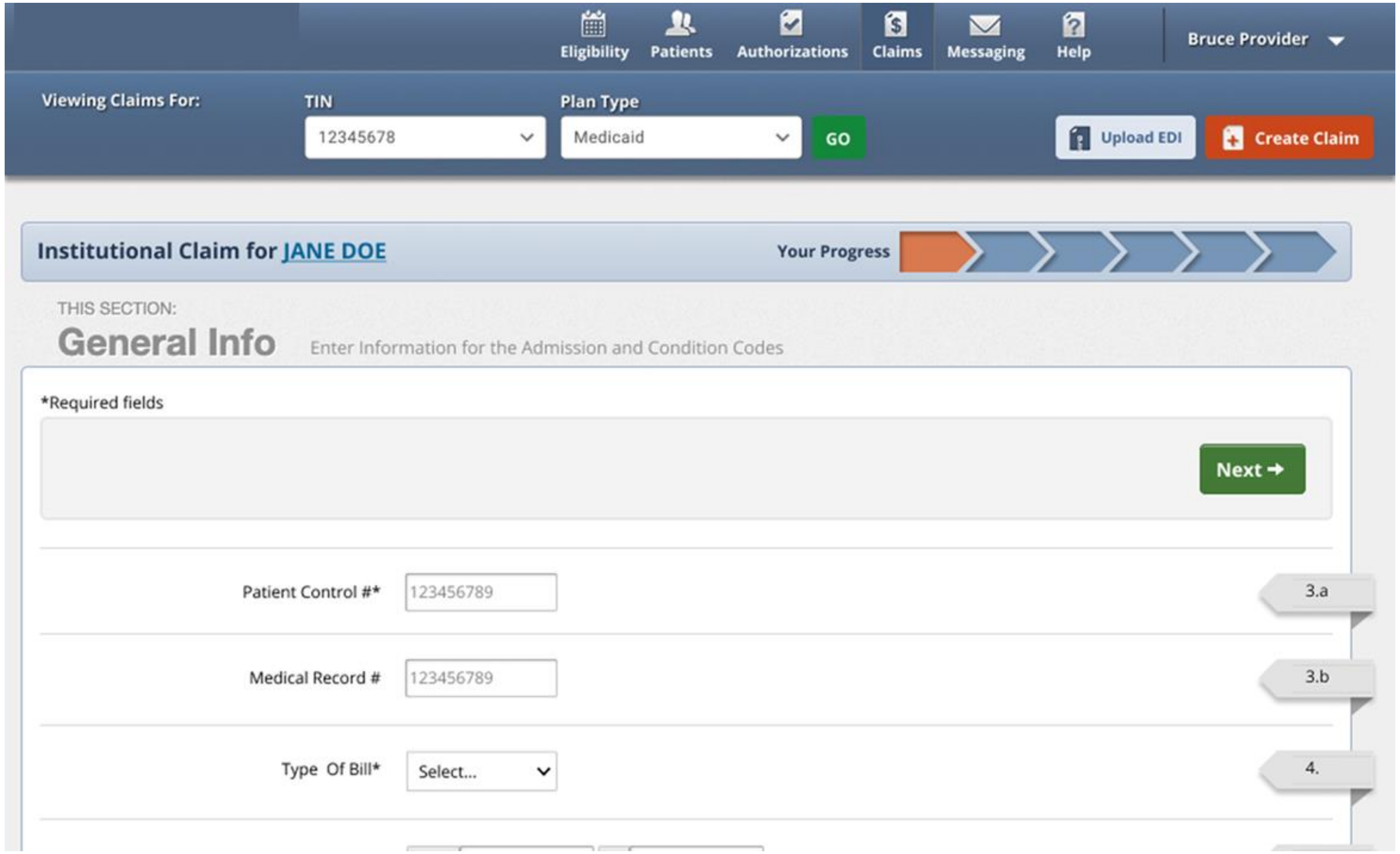

Eligibility
Patients
Authorizations
Claims
Messaging
Viewing Claims For :
Medicaid
GO
Upload EDI
Create Claim
Choose Claim for
Choose a Claim Type
CMS 1500
Professional Claim →
CMS UB-04
Institutional Claim →

Click desired Claim Type

UPDATE: In order to be compliant with ICD-10 regulations, we will require claims with discharge dates or service dates on or after October 1, 2015, be coded with ICD-10 codes. This change applies to the date of service on the claim, not the submission date.

Claims Submission - Institutional

- In the General section, populate the admission and condition code information. The fields displayed here reflect those on a UB-04 form.
- Then click Next, and follow the prompts to reflect the Billing Provider, Pay-to Provider, and Attending Provider, etc, and then click Next.



Eligibility
Patients
Authorizations
Claims
Messaging
Help
Bruce Provider
Viewing Claims For:
GO
Upload EDI
Create Claim
Your Progress
Next ➜
3.a
3.b
4.

TIN: 12345678

Plan Type: Medicaid

Institutional Claim for JANE DOE

THIS SECTION:

General Info

Enter Information for the Admission and Condition Codes

*Required fields

Patient Control #*: 123456789

Medical Record #: 123456789

Type Of Bill*: Select...

Institutional Claim Submission

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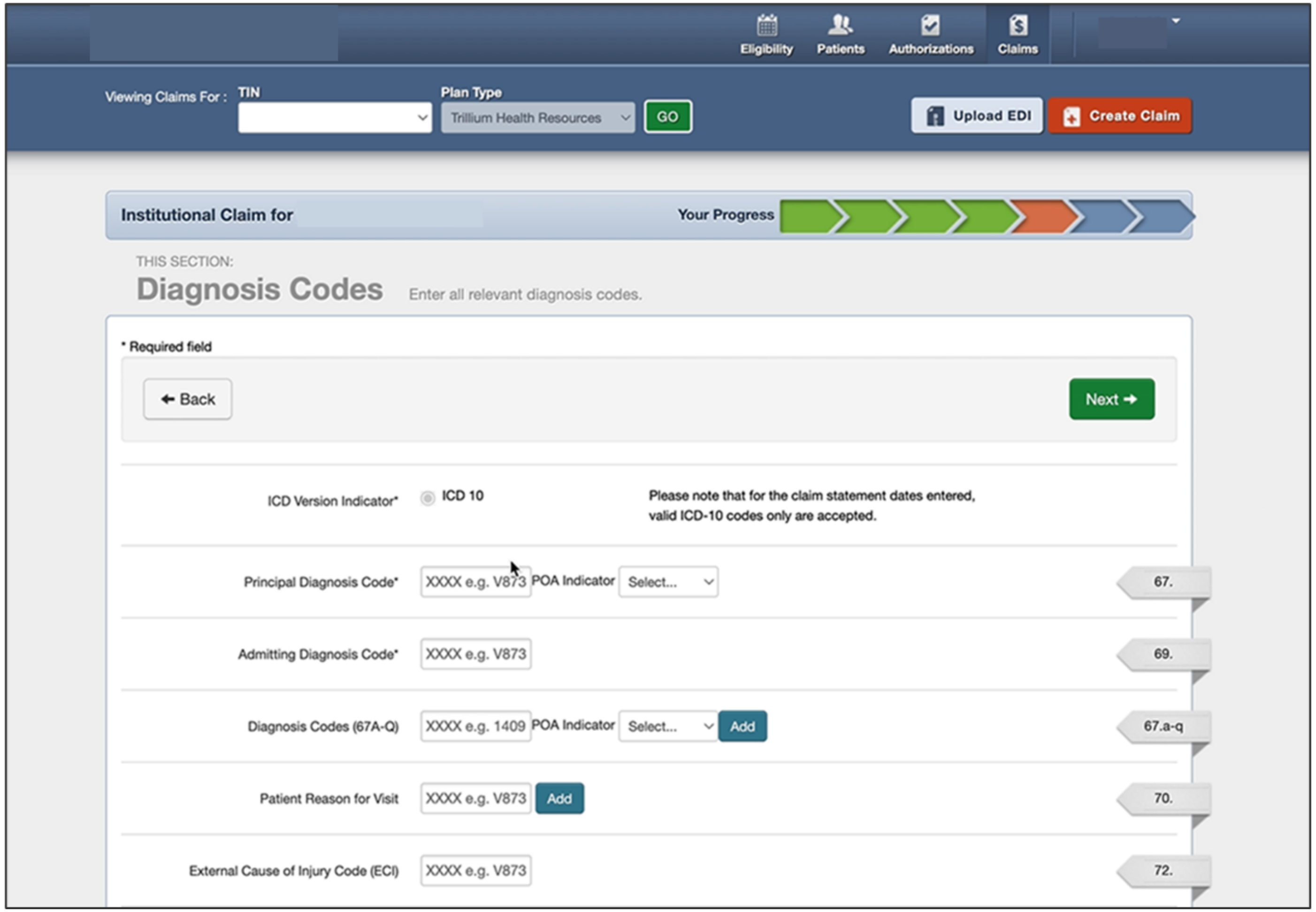


Eligibility
Patients
Authorizations
Claims
Viewing Claims For :
TIN
Plan Type
Trillium Health Resources
GO
Upload EDI
Create Claim
Your Progress
Back
Next
Select...
Add
67.
69.
67.a-q
70.
72.

Institutional Claim for

THIS SECTION:

Diagnosis Codes Enter all relevant diagnosis codes.

* Required field

ICD Version Indicator* ○ ICD 10

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

Principal Diagnosis Code* XXXX e.g. V873 POA Indicator Select...

Admitting Diagnosis Code* XXXX e.g. V873

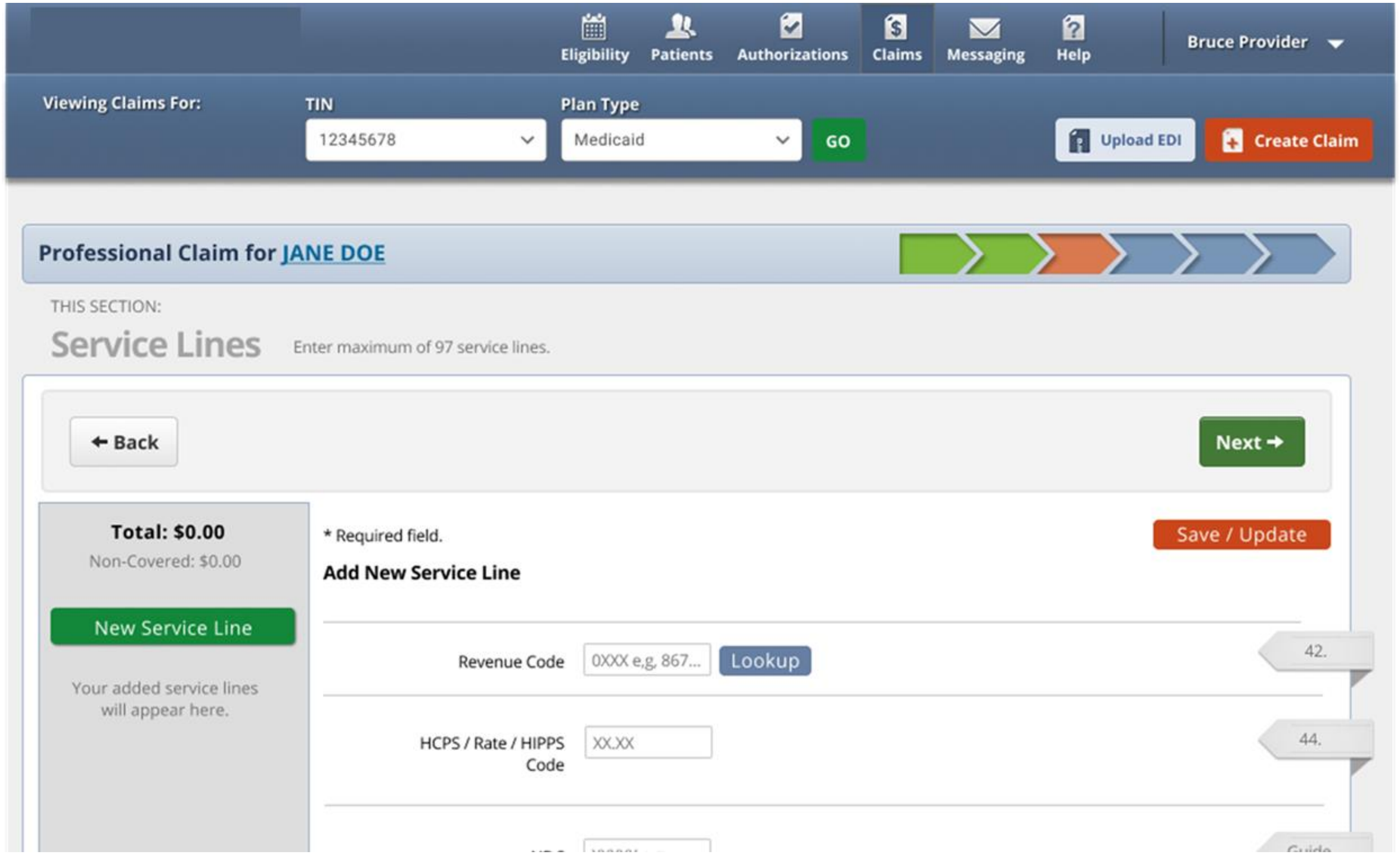
Diagnosis Codes (67A-Q) XXXX e.g. 1409 POA Indicator Select... Add

Patient Reason for Visit XXXX e.g. V873 Add

External Cause of Injury Code (ECI) XXXX e.g. V873

Claims Submission - Institutional

- In the Service Lines section, enter the information about the services provided.
- Click **Save/Update**, and to add a new service line click the **+ New Service Line** button on the left to add additional service lines.
- Click the **Next** button.


Eligibility
Patients
Authorizations
Claims
Messaging
Help
Bruce Provider
GO
Upload EDI
Create Claim
Back
Next
Save / Update
New Service Line
Lookup

Viewing Claims For:
TIN: 12345678
Plan Type: Medicaid

Professional Claim for JANE DOE

THIS SECTION:
Service Lines
Enter maximum of 97 service lines.

Total: $0.00
Non-Covered: $0.00

Your added service lines will appear here.

* Required field.

Add New Service Line

Revenue Code: 0XXX e.g. 867... — 42.

HCPS / Rate / HIPPS Code: XX.XX — 44.

Claims Submission - Institutional

- Your final step is to review the entire claim. Once you have confirmed that everything is correct, click the green Submit button

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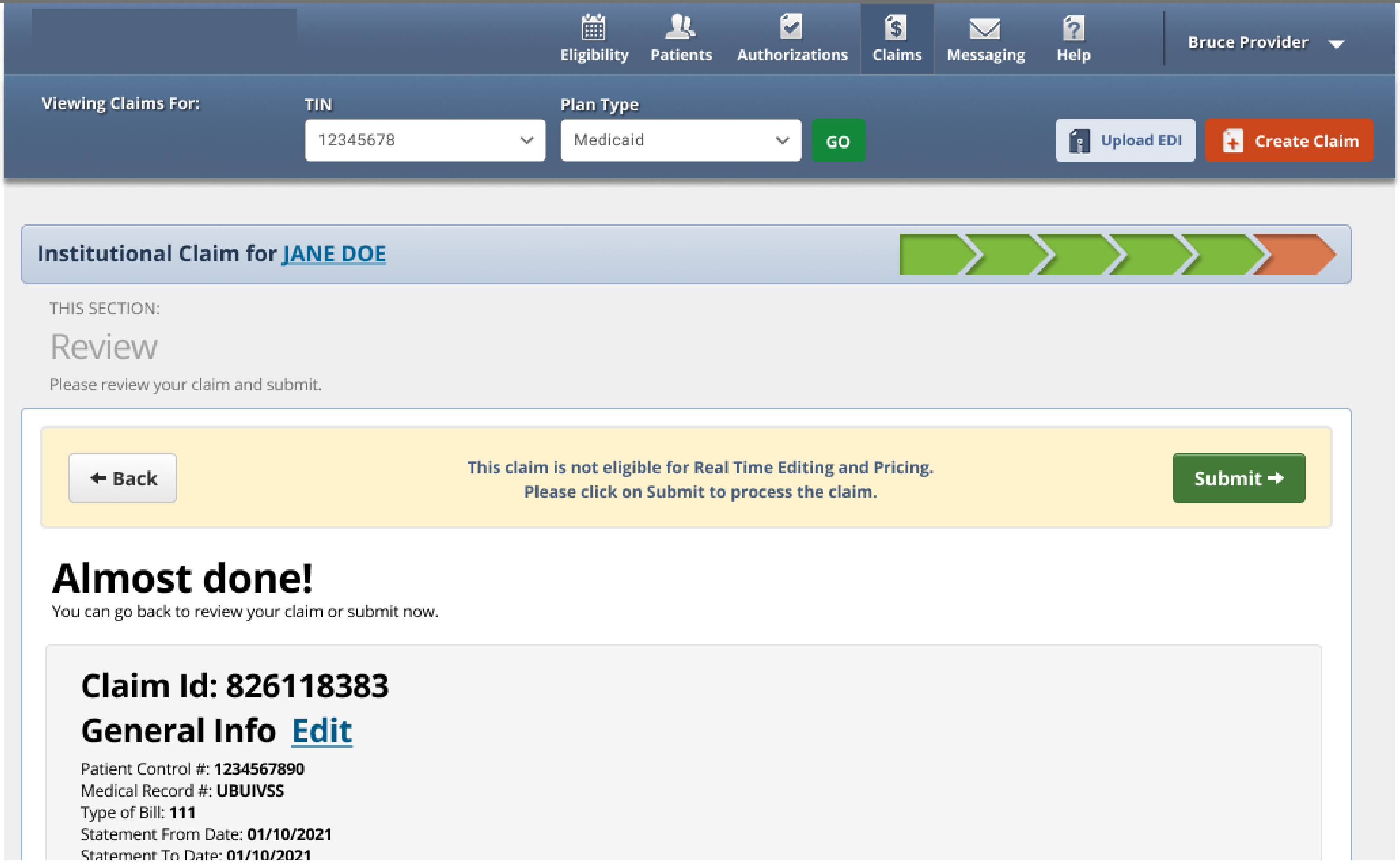
Eligibility
Patients
Authorizations
Claims
Messaging
Help
Bruce Provider
Upload EDI
Create Claim
GO
← Back
Submit →

Viewing Claims For:
TIN: 12345678
Plan Type: Medicaid

Institutional Claim for JANE DOE

THIS SECTION:

Review

Please review your claim and submit.

This claim is not eligible for Real Time Editing and Pricing.
Please click on Submit to process the claim.

Almost done!

You can go back to review your claim or submit now.

Claim Id: 826118383

General Info Edit

Patient Control #: **1234567890**
Medical Record #: **UBUIVSS**
Type of Bill: **111**
Statement From Date: **01/10/2021**
Statement To Date: **01/10/2021**

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Claim Submission - Upload EDI

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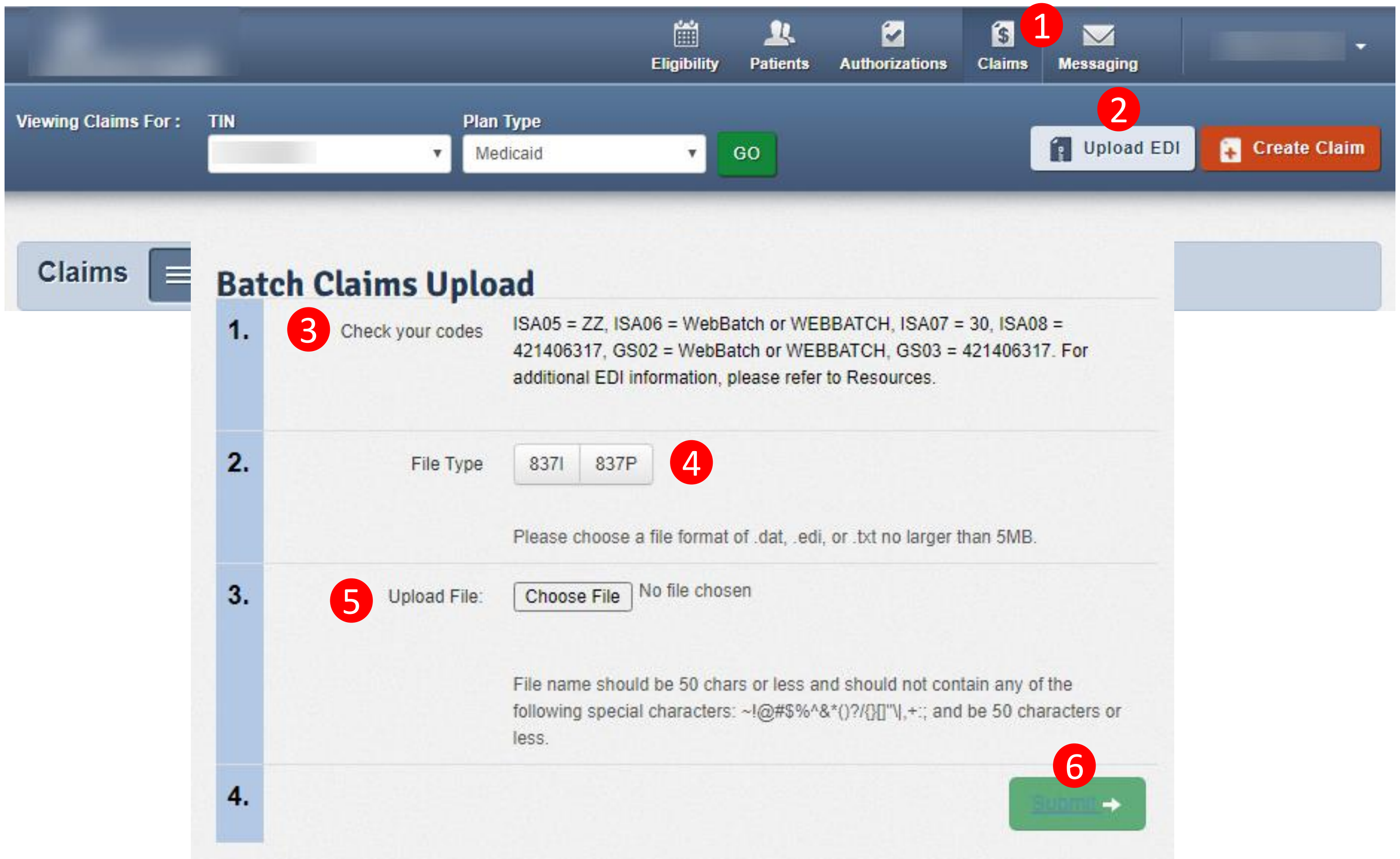
To upload an EDI claim batch (837I / 837P):

1. Click **Claims**.
2. Click **Upload EDI**.
3. Check the codes in your file.
    - Ensure file name is less than 50 characters and does not contain special characters
4. Select **File Type**.
5. Click **Choose File**. A separate window will display, to select file from your computer directory.
6. Click **Submit**.



Eligibility
Patients
Authorizations
Claims
Messaging
1
Viewing Claims For :
TIN
Plan Type
Medicaid
GO
2
Upload EDI
Create Claim
Claims
Batch Claims Upload
1.
3
Check your codes
2.
File Type
837I
837P
4
3.
5
Upload File:
Choose File
No file chosen
4.
6
Submit

ISA05 = ZZ, ISA06 = WebBatch or WEBBATCH, ISA07 = 30, ISA08 = 421406317, GS02 = WebBatch or WEBBATCH, GS03 = 421406317. For additional EDI information, please refer to Resources.

Please choose a file format of .dat, .edi, or .txt no larger than 5MB.

File name should be 50 chars or less and should not contain any of the following special characters: ~!@#$%^&*()?/{}[]"\|,+:; and be 50 characters or less.

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Trillium
HEALTH RESOURCES

Portal Functionality: Authorizations

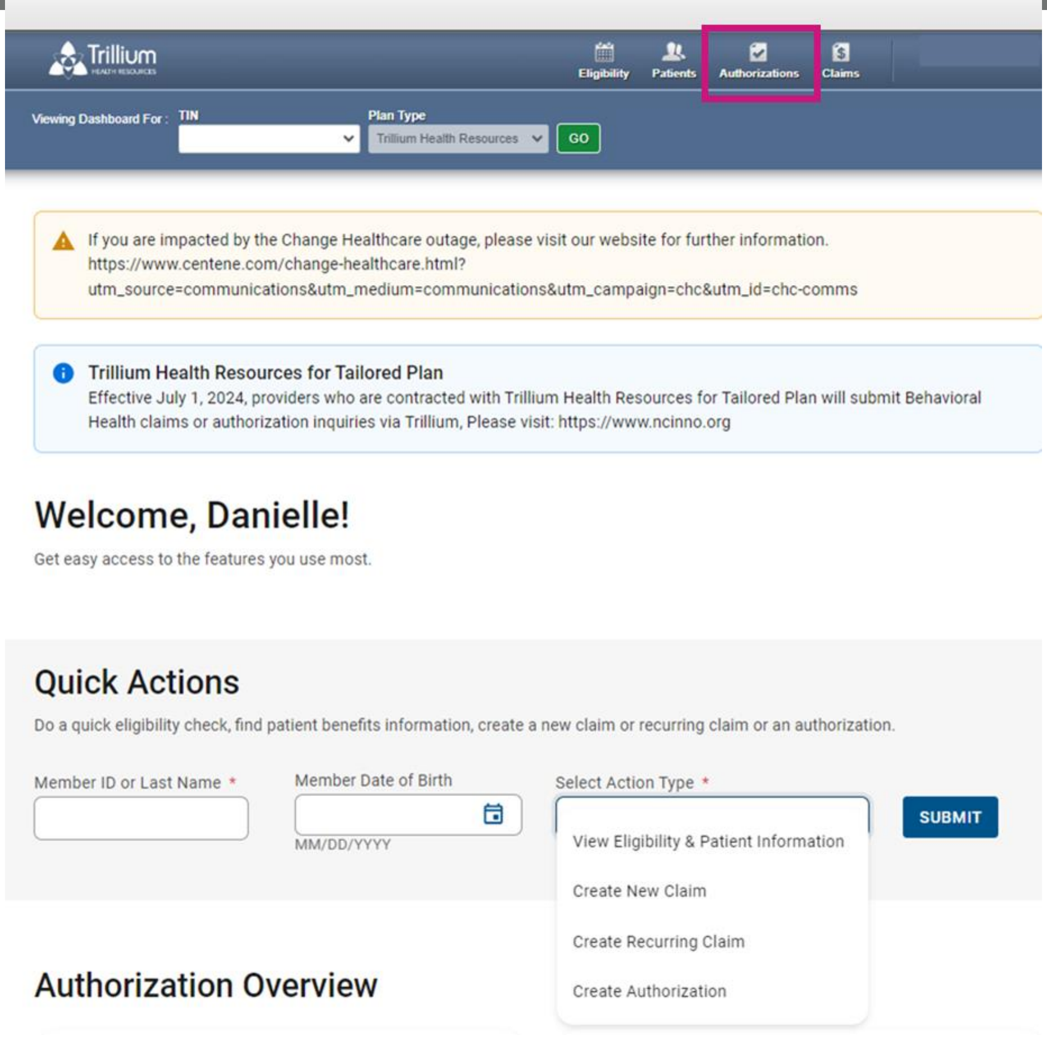
ACCREDITED
NCQA
MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION
FULL

Authorizations

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

Accessing Authorizations

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


Trillium
HEALTH RESOURCES
Eligibility
Patients
Authorizations
Claims
Viewing Dashboard For :
TIN
Plan Type
Trillium Health Resources
GO

If you are impacted by the Change Healthcare outage, please visit our website for further information. https://www.centene.com/change-healthcare.html?utm_source=communications&utm_medium=communications&utm_campaign=chc&utm_id=chc-comms

Trillium Health Resources for Tailored Plan

Effective July 1, 2024, providers who are contracted with Trillium Health Resources for Tailored Plan will submit Behavioral Health claims or authorization inquiries via Trillium, Please visit: https://www.ncinno.org

Welcome, Danielle!

Get easy access to the features you use most.

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 *
View Eligibility & Patient Information
Create New Claim
Create Recurring Claim
Create Authorization
SUBMIT
Authorization Overview

Authorizations Summary

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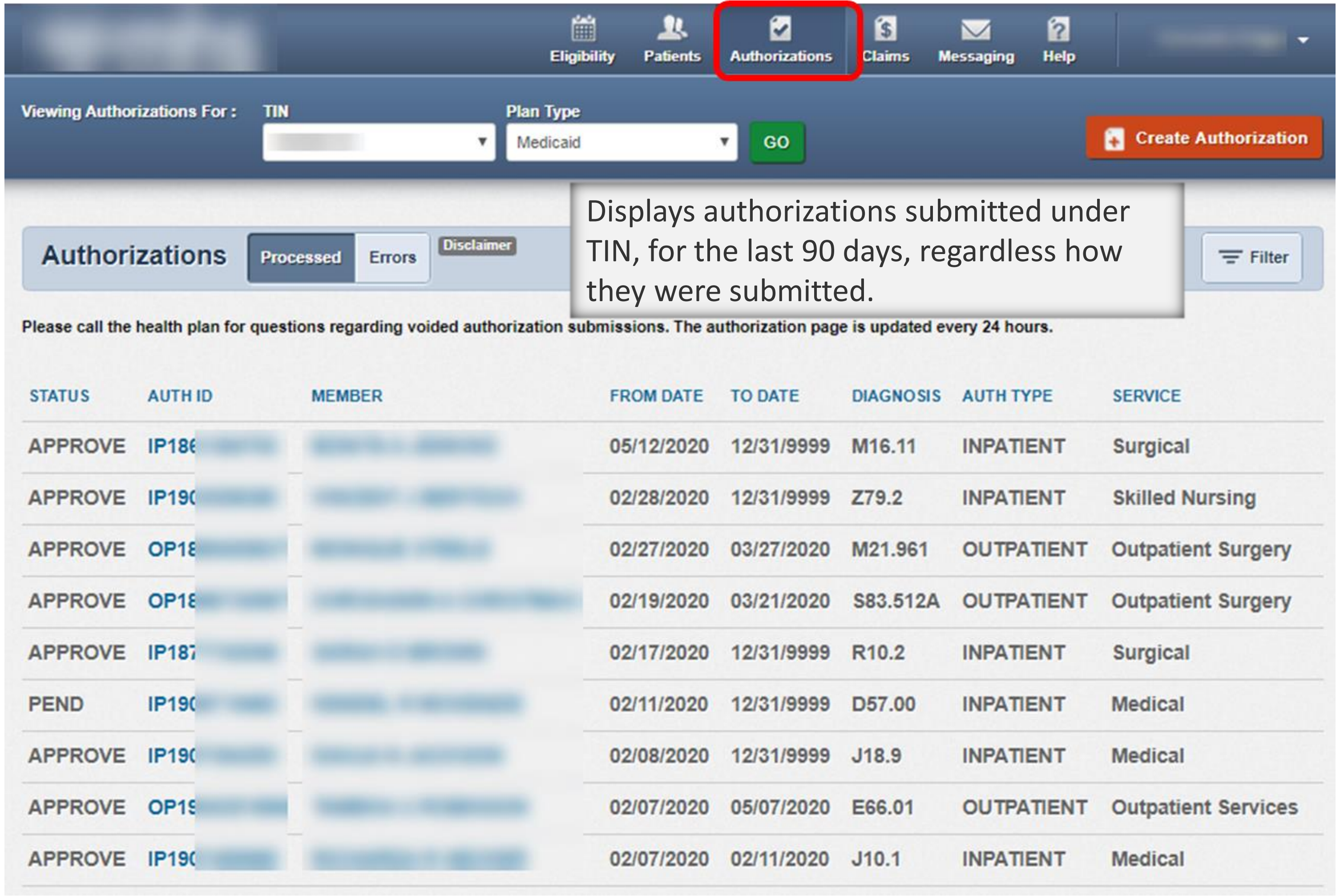
[redacted]
Eligibility
Patients
Authorizations
Claims
Messaging
Help
[redacted]
Viewing Authorizations For :
TIN
[redacted]
Plan Type
Medicaid
GO
Create Authorization
Authorizations
Processed
Errors
Disclaimer
Filter

Displays authorizations submitted under TIN, for the last 90 days, regardless how they were submitted.

Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.

STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	IP186[redacted]	[redacted]	05/12/2020	12/31/9999	M16.11	INPATIENT	Surgical
APPROVE	IP190[redacted]	[redacted]	02/28/2020	12/31/9999	Z79.2	INPATIENT	Skilled Nursing
APPROVE	OP18[redacted]	[redacted]	02/27/2020	03/27/2020	M21.961	OUTPATIENT	Outpatient Surgery
APPROVE	OP18[redacted]	[redacted]	02/19/2020	03/21/2020	S83.512A	OUTPATIENT	Outpatient Surgery
APPROVE	IP187[redacted]	[redacted]	02/17/2020	12/31/9999	R10.2	INPATIENT	Surgical
PEND	IP190[redacted]	[redacted]	02/11/2020	12/31/9999	D57.00	INPATIENT	Medical
APPROVE	IP190[redacted]	[redacted]	02/08/2020	12/31/9999	J18.9	INPATIENT	Medical
APPROVE	OP19[redacted]	[redacted]	02/07/2020	05/07/2020	E66.01	OUTPATIENT	Outpatient Services
APPROVE	IP190[redacted]	[redacted]	02/07/2020	02/11/2020	J10.1	INPATIENT	Medical

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

Click **Filter** to access filter options

Authorization Details

Trillium HEALTH RESOURCES
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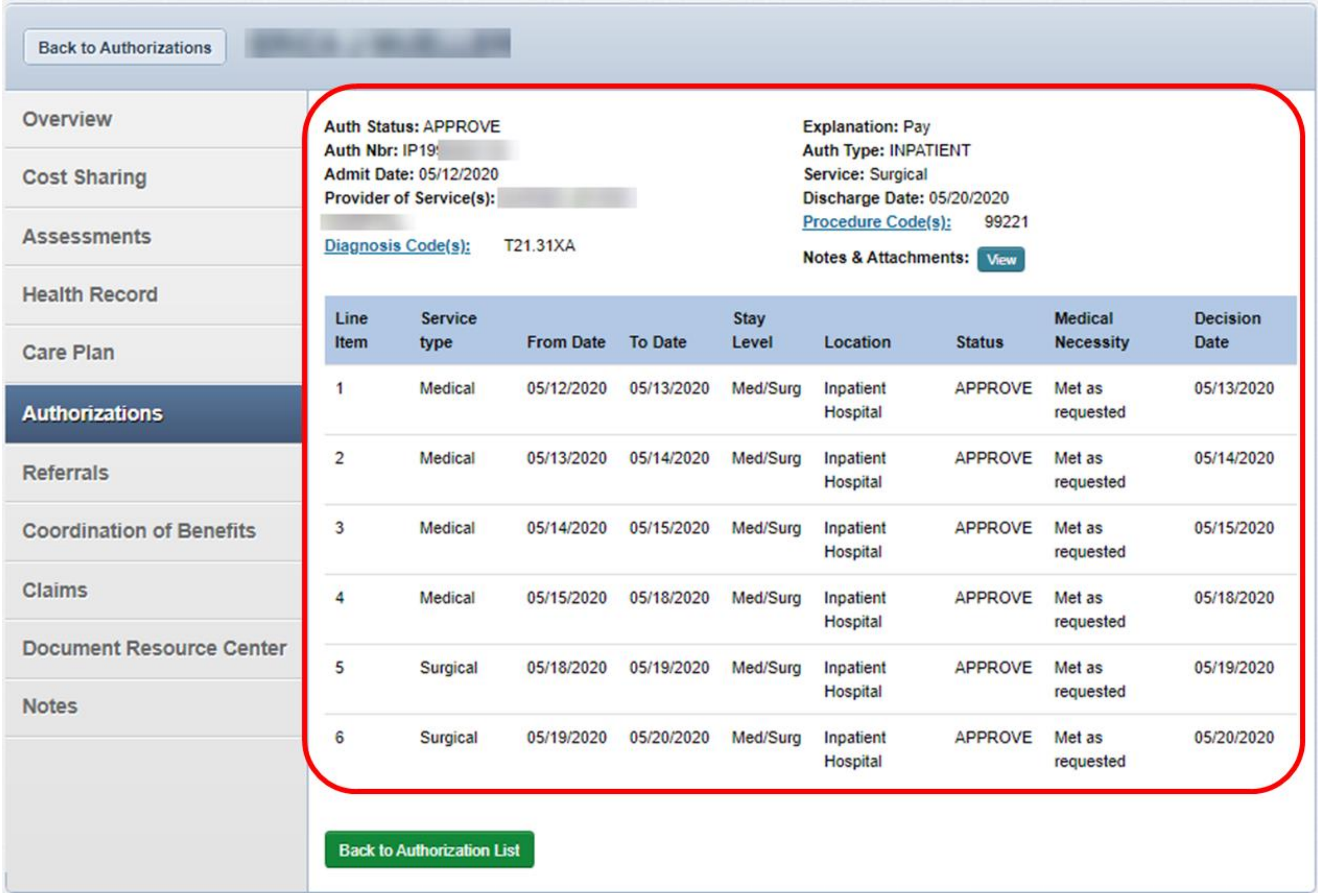
Back to Authorizations
Overview
Cost Sharing
Assessments
Health Record
Care Plan
Authorizations
Referrals
Coordination of Benefits
Claims
Document Resource Center
Notes
Back to Authorization List

[redacted]

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

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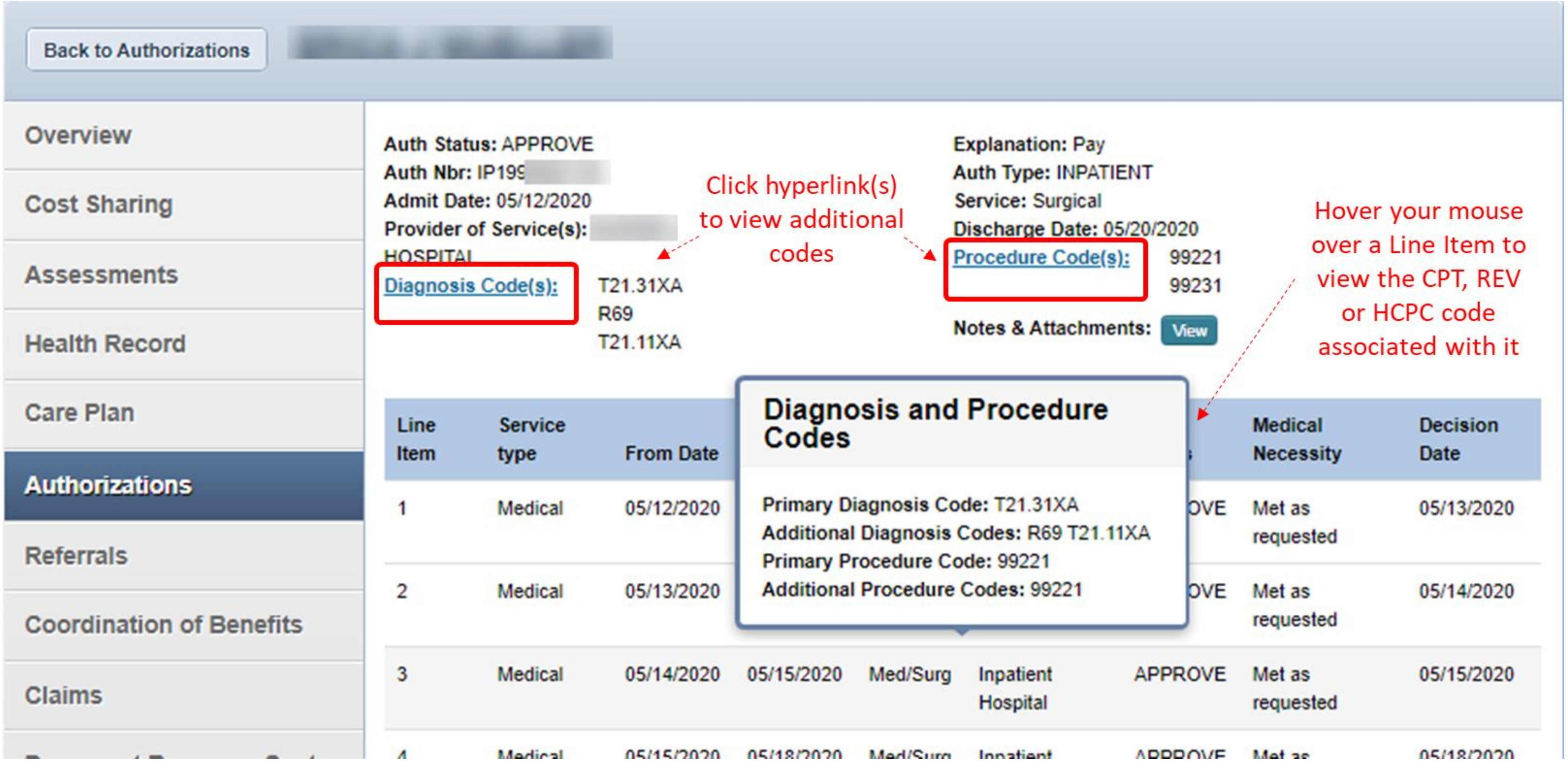
Authorization Details Links and Pop-Up



Back to Authorizations
[redacted]
Overview
Cost Sharing
Assessments
Health Record
Care Plan
Authorizations
Referrals
Coordination of Benefits
Claims

Auth Status: APPROVE
Auth Nbr: IP199[redacted]
Admit Date: 05/12/2020
Provider of Service(s): [redacted] HOSPITAL
Diagnosis Code(s): T21.31XA
R69
T21.11XA

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

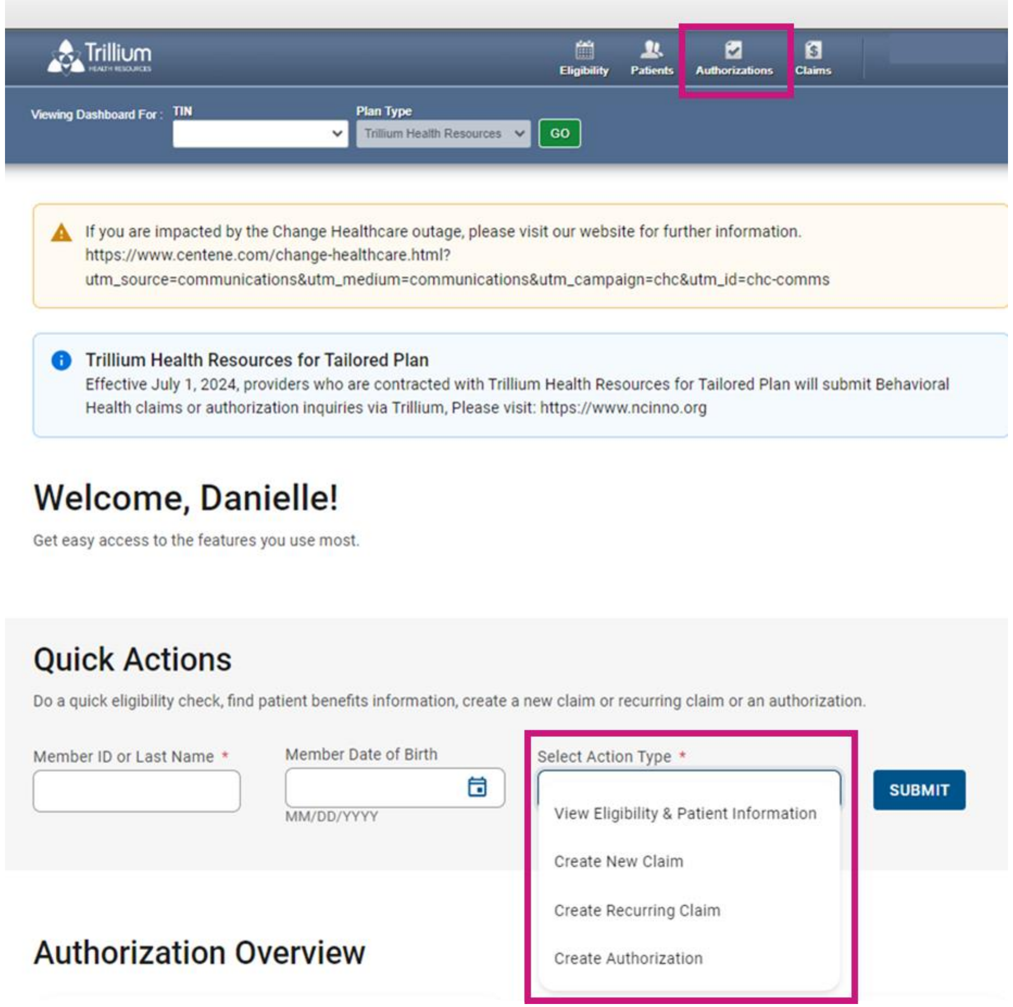
Diagnosis and Procedure Codes

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

Line Item	Service type	From Date					Medical Necessity	Decision Date
1	Medical	05/12/2020				OVE	Met as requested	05/13/2020
2	Medical	05/13/2020				OVE	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	APPROVE	Met as	05/18/2020

Create Authorization

- To create and submit a web authorization request, click **Authorizations** or **use Quick Actions**.


Trillium
Eligibility
Patients
Authorizations
Claims

Viewing Dashboard For : TIN

Plan Type: Trillium Health Resources

GO

If you are impacted by the Change Healthcare outage, please visit our website for further information. https://www.centene.com/change-healthcare.html?utm_source=communications&utm_medium=communications&utm_campaign=chc&utm_id=chc-comms

Trillium Health Resources for Tailored Plan
Effective July 1, 2024, providers who are contracted with Trillium Health Resources for Tailored Plan will submit Behavioral Health claims or authorization inquiries via Trillium, Please visit: https://www.ncinno.org

Welcome, Danielle!
Get easy access to the features you use most.

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 *
View Eligibility & Patient Information
Create New Claim
Create Recurring Claim
Create Authorization
SUBMIT

Authorization Overview

Create Authorization (Web Authorization Request)

Trillium HEALTH RESOURCES

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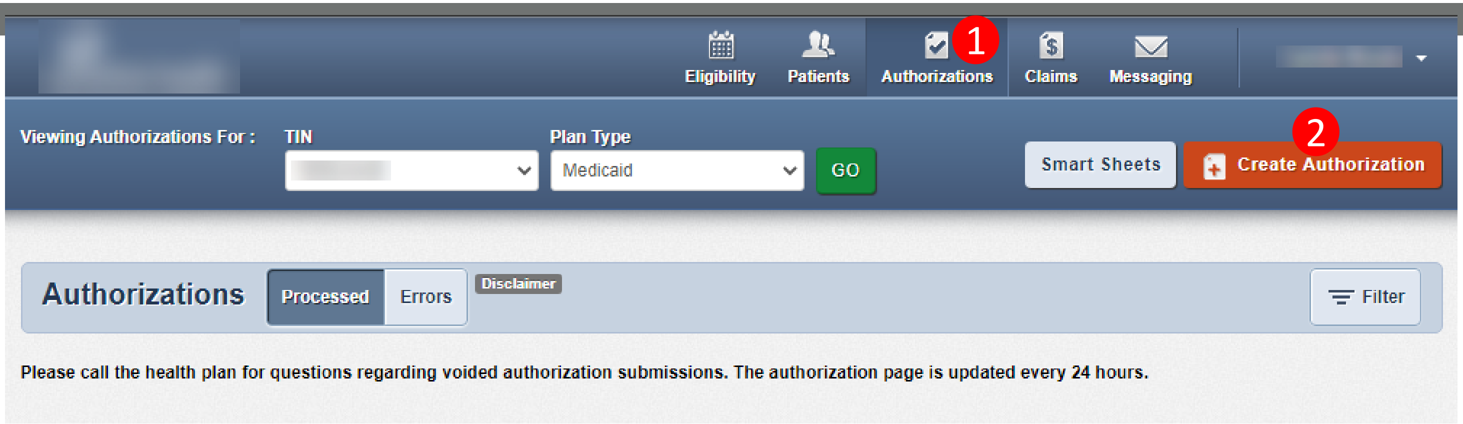
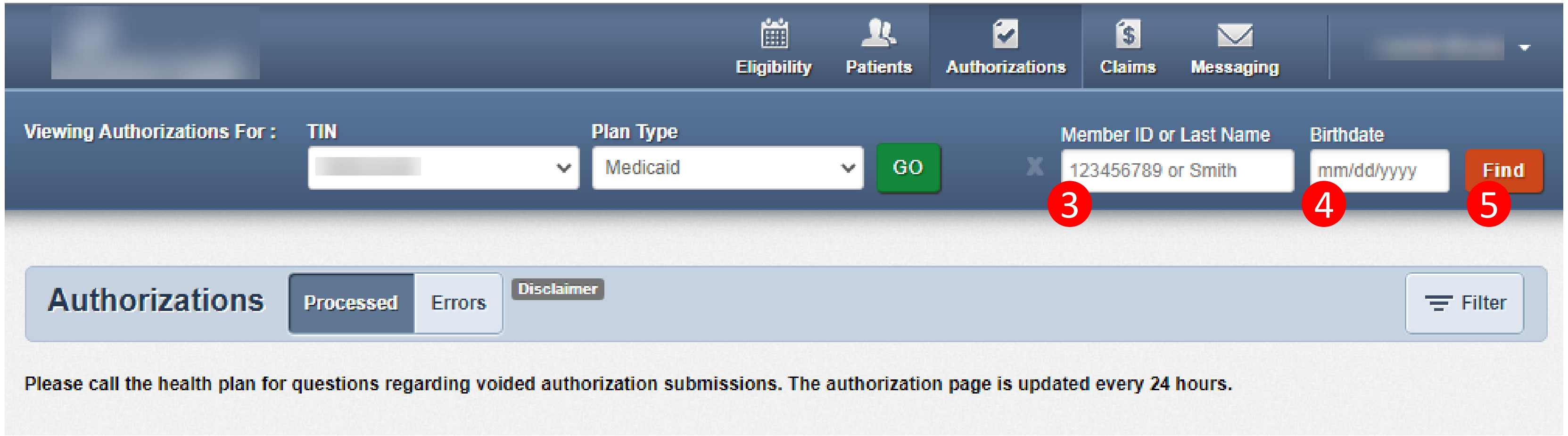
To begin a web authorization request:

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.


Eligibility
Patients
Authorizations
1
Claims
Messaging
Viewing Authorizations For :
TIN
Plan Type
Medicaid
GO
Smart Sheets
2
Create Authorization
Authorizations
Processed
Errors
Disclaimer
Filter

Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.


Eligibility
Patients
Authorizations
Claims
Messaging
Viewing Authorizations For :
TIN
Plan Type
Medicaid
GO
Member ID or Last Name
123456789 or Smith
3
Birthdate
mm/dd/yyyy
4
Find
5
Authorizations
Processed
Errors
Disclaimer
Filter

Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.

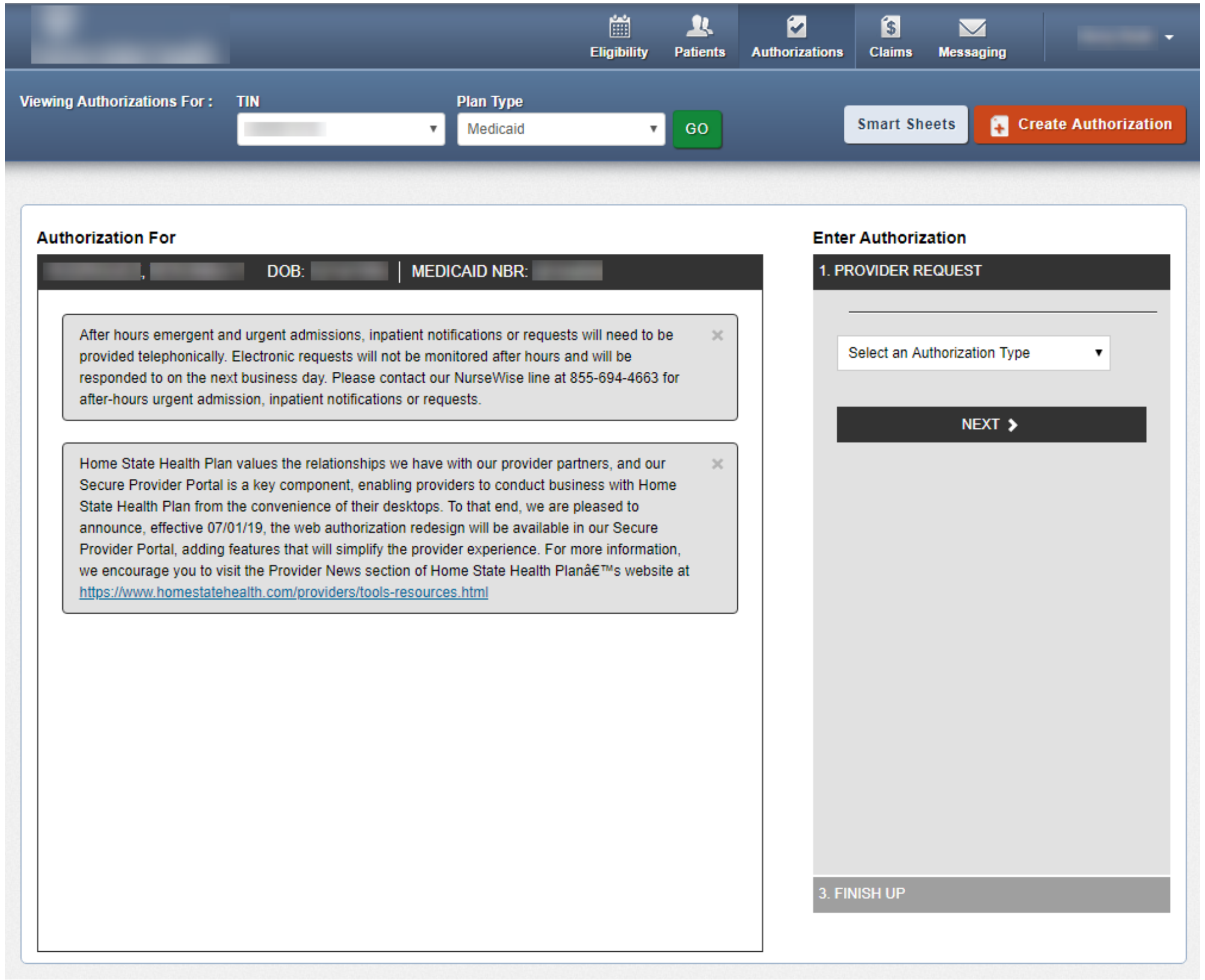
Tip: You cannot create a web authorization on an ineligible member.

Web Authorization Request

Web Authorization request has three sections:

1. Provider Request
2. Service Line
3. Finish Up

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



Viewing Authorizations For : TIN [redacted] Plan Type Medicaid

Authorization For

[redacted], [redacted] DOB: [redacted] | MEDICAID NBR: [redacted]

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 855-694-4663 for after-hours urgent admission, inpatient notifications or requests.

Home State Health Plan values the relationships we have with our provider partners, and our Secure Provider Portal is a key component, enabling providers to conduct business with Home State Health Plan from the convenience of their desktops. To that end, we are pleased to announce, effective 07/01/19, the web authorization redesign will be available in our Secure Provider Portal, adding features that will simplify the provider experience. For more information, we encourage you to visit the Provider News section of Home State Health Planâ€™s website at https://www.homestatehealth.com/providers/tools-resources.html

Enter Authorization

1. PROVIDER REQUEST

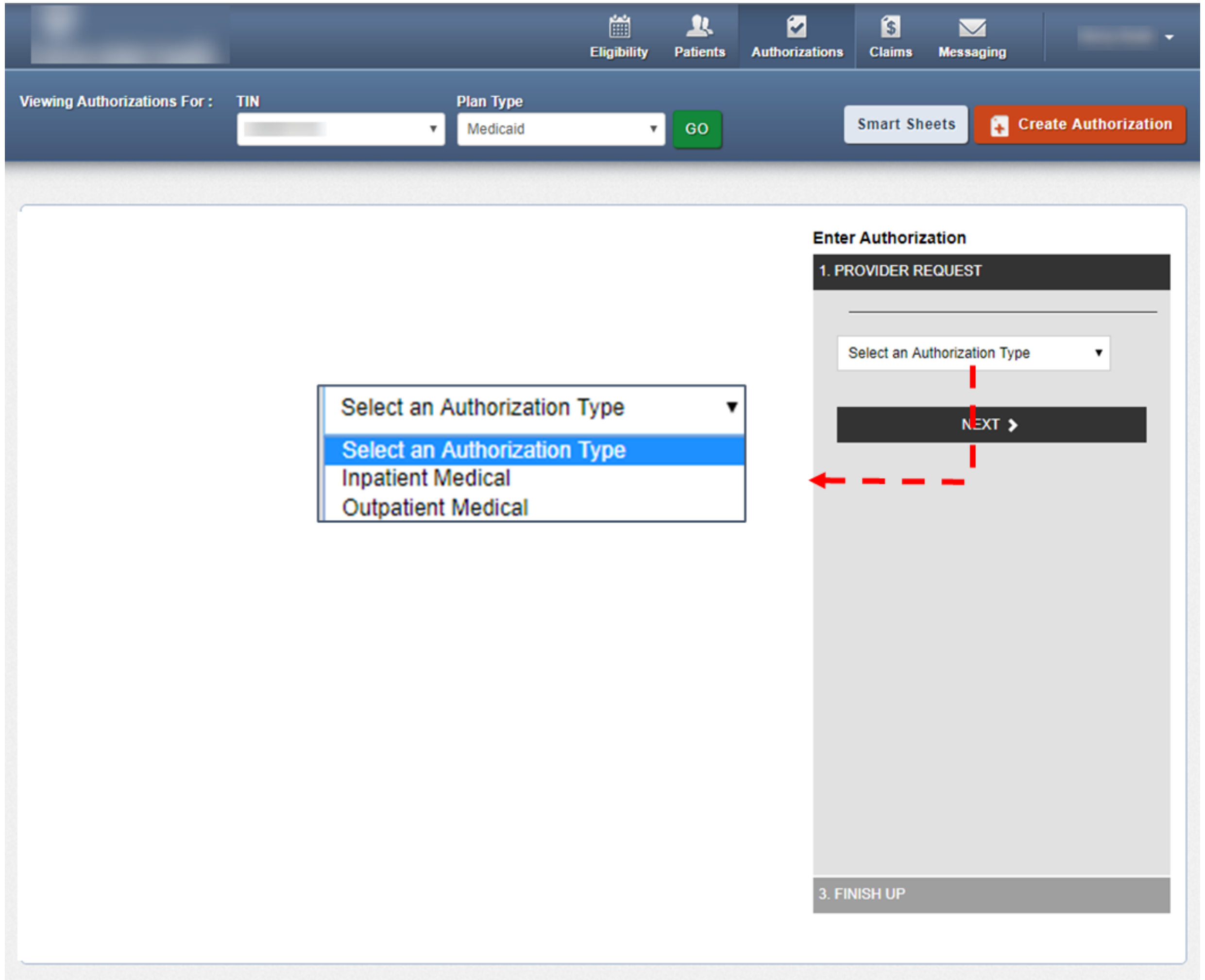
Select an Authorization Type

3. FINISH UP

Web Authorization

Web Authorization

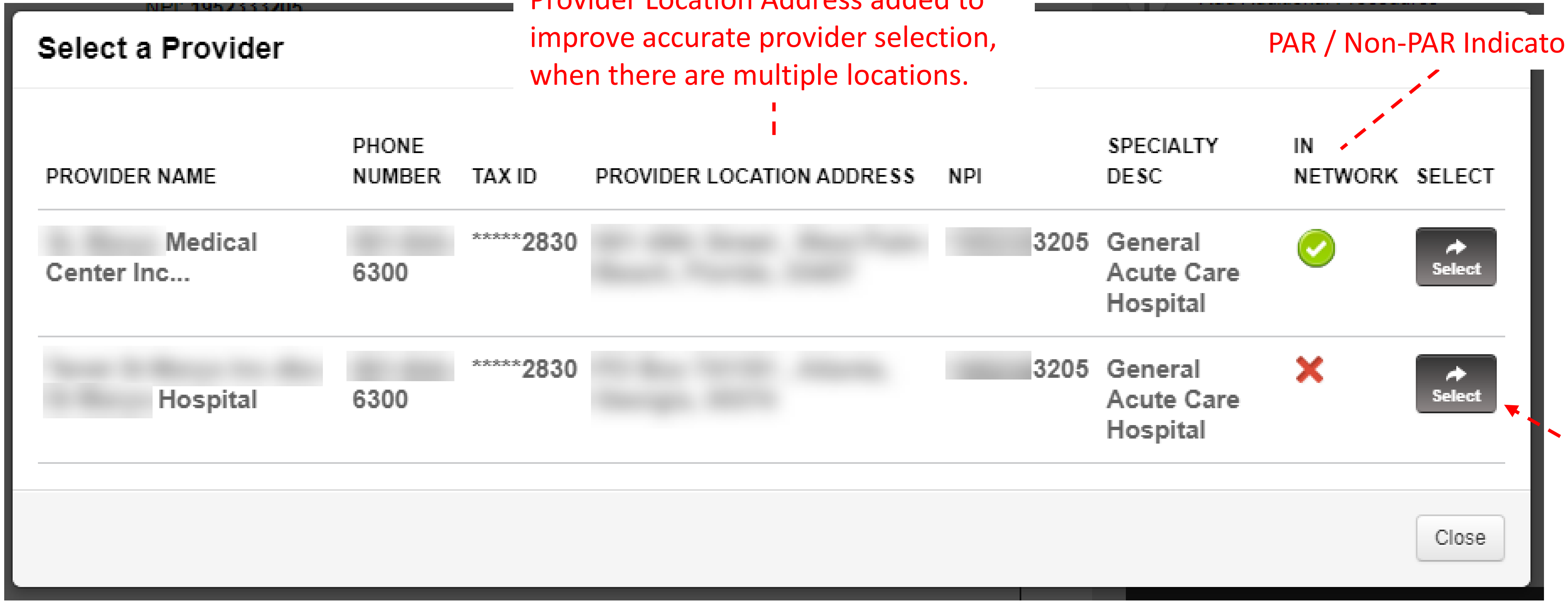
- Authorization Type-driven
- Streamlined


Eligibility
Patients
Authorizations
Claims
Messaging
Viewing Authorizations For :
TIN
Plan Type
Medicaid
GO
Smart Sheets
Create Authorization
Enter Authorization
1. PROVIDER REQUEST
Select an Authorization Type
NEXT
3. FINISH UP
Select an Authorization Type
Select an Authorization Type
Inpatient Medical
Outpatient Medical

Web Authorization - Select a Provider Pop-Up

When Provider information is entered in a web authorization Provider / Facility field, the **Select a Provider** pop-up displays.

NOTE: If the NPI or name is not loaded in our system, the “**No providers found**” pop-up displays.



Provider Location Address added to improve accurate provider selection, when there are multiple locations.

PAR / Non-PAR Indicator

Select a Provider

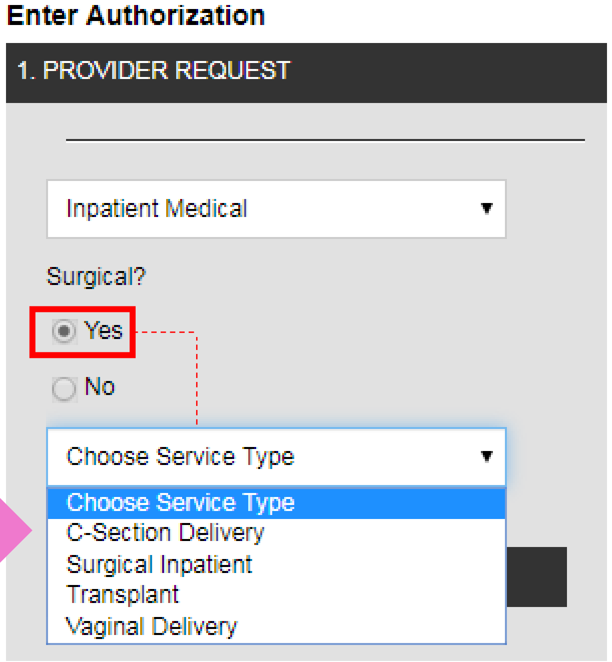
PROVIDER NAME	PHONE NUMBER	TAX ID	PROVIDER LOCATION ADDRESS	NPI	SPECIALTY DESC	IN NETWORK	SELECT
[redacted] Medical Center Inc...	[redacted] 6300	*****2830	[redacted]	[redacted]3205	General Acute Care Hospital	✓	Select
[redacted] Hospital	[redacted] 6300	*****2830	[redacted]	[redacted]3205	General Acute Care Hospital	✗	Select

Click **Select**, to choose Provider / Facility.

Tip: For best results, enter the Provider / Facility NPI, instead of name.

Inpatient Medical - Service Type Options (Surgical)

When **Inpatient Medical → Surgical → Yes** is selected, the age (female only) and gender of the Member drives the options in the Service Type drop-down.



Enter Authorization

1. PROVIDER REQUEST

Inpatient Medical

Surgical?

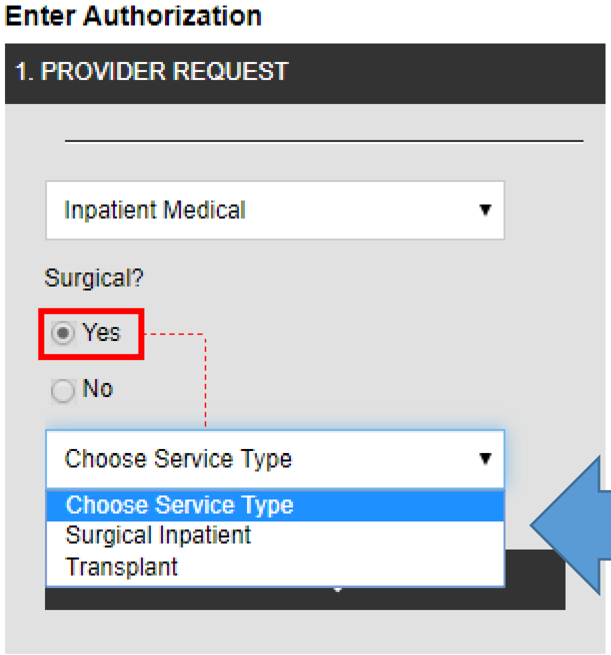
● Yes

○ No

Choose Service Type

- Choose Service Type
- C-Section Delivery
- Surgical Inpatient
- Transplant
- Vaginal Delivery

Female



Enter Authorization

1. PROVIDER REQUEST

Inpatient Medical

Surgical?

● Yes

○ No

Choose Service Type

- Choose Service Type
- Surgical Inpatient
- Transplant

Male

Provider Request - Inpatient Medical (Surgical)

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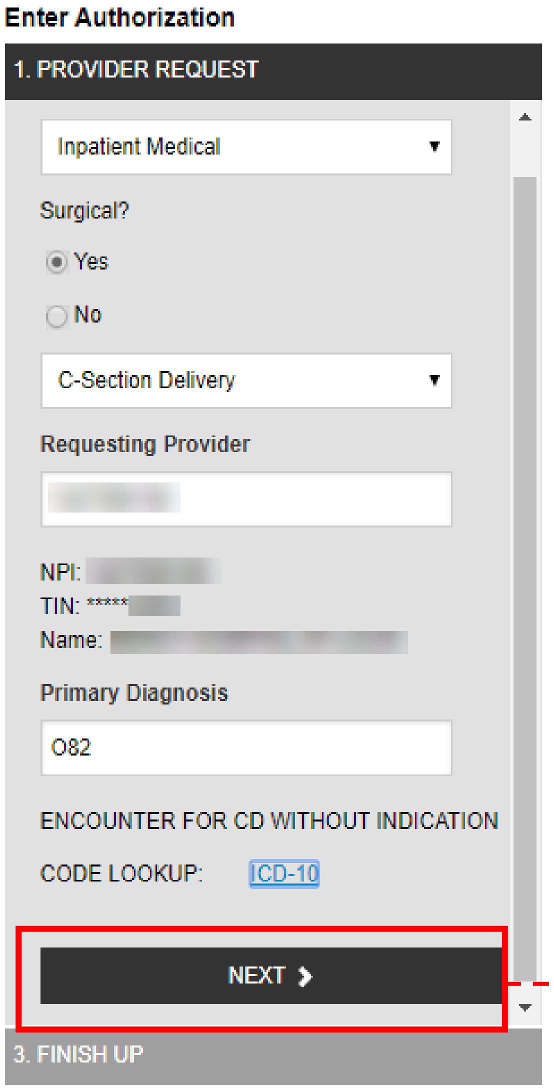
C-Section Delivery, or

Vaginal Delivery



Enter Authorization

1. PROVIDER REQUEST

Inpatient Medical ▾

Surgical?

● Yes

○ No

C-Section Delivery ▾

Requesting Provider

[redacted]

NPI: [redacted]
TIN: *****[redacted]
Name: [redacted]

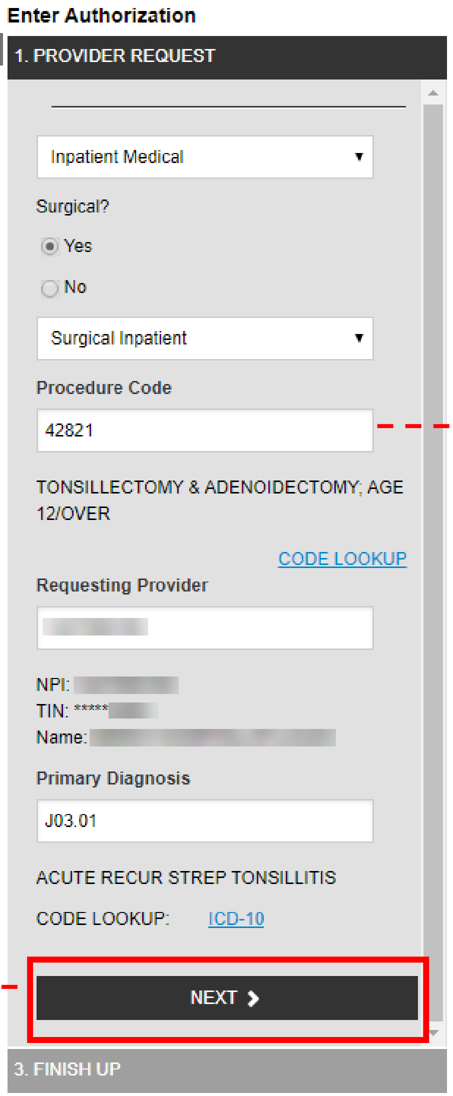
Primary Diagnosis

O82

ENCOUNTER FOR CD WITHOUT INDICATION

CODE LOOKUP: ICD-10

When completed, click **Next**.



Enter Authorization

1. PROVIDER REQUEST

Inpatient Medical ▾

Surgical?

● Yes

○ No

Surgical Inpatient ▾

Procedure Code

42821

TONSILLECTOMY & ADENOIDECTOMY; AGE 12/OVER

CODE LOOKUP

Requesting Provider

[redacted]

NPI: [redacted]
TIN: *****[redacted]
Name: [redacted]

Primary Diagnosis

J03.01

ACUTE RECUR STREP TONSILLITIS

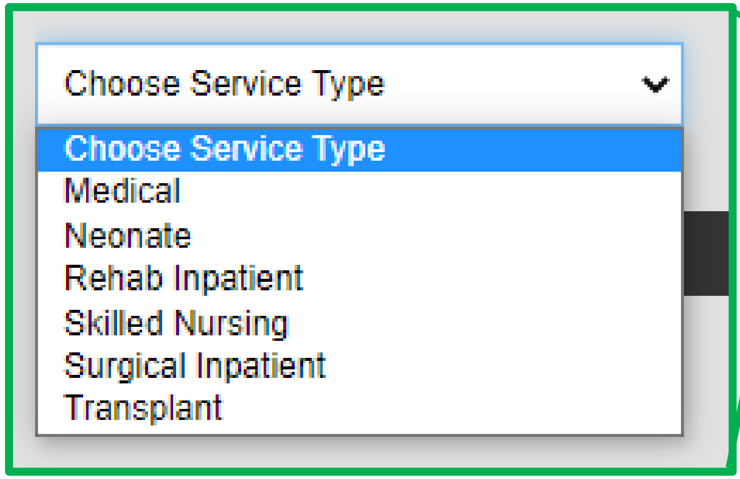
CODE LOOKUP: ICD-10

Surgical Inpatient, or

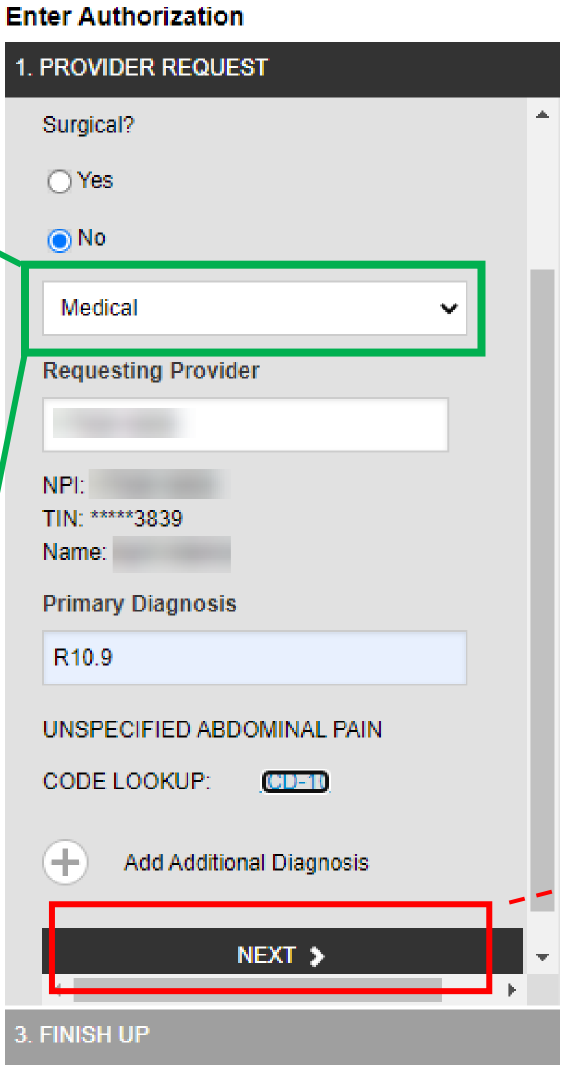
Transplant

A Procedure Code is required on Surgical Inpatient and Transplant requests

Provider Request – Inpatient Medical (Non-Surgical)



Choose Service Type
Choose Service Type
Medical
Neonate
Rehab Inpatient
Skilled Nursing
Surgical Inpatient
Transplant



Enter Authorization

1. PROVIDER REQUEST

Surgical?

○ Yes

● No

Medical

Requesting Provider

[redacted]

NPI: [redacted]
TIN: *****3839
Name: [redacted]

Primary Diagnosis

R10.9

UNSPECIFIED ABDOMINAL PAIN

CODE LOOKUP: ICD-10

Add Additional Diagnosis
NEXT
3. FINISH UP

When completed, click **Next**.

Provider Request – Outpatient Medical

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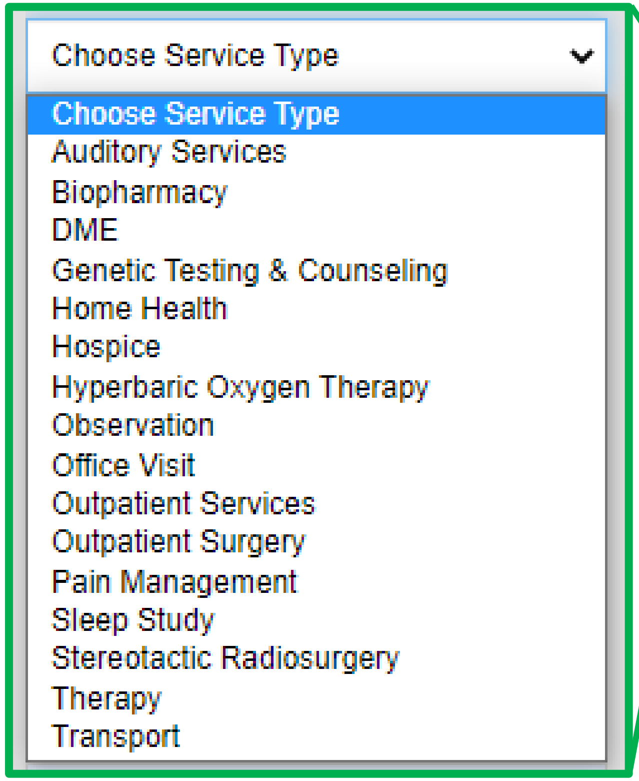
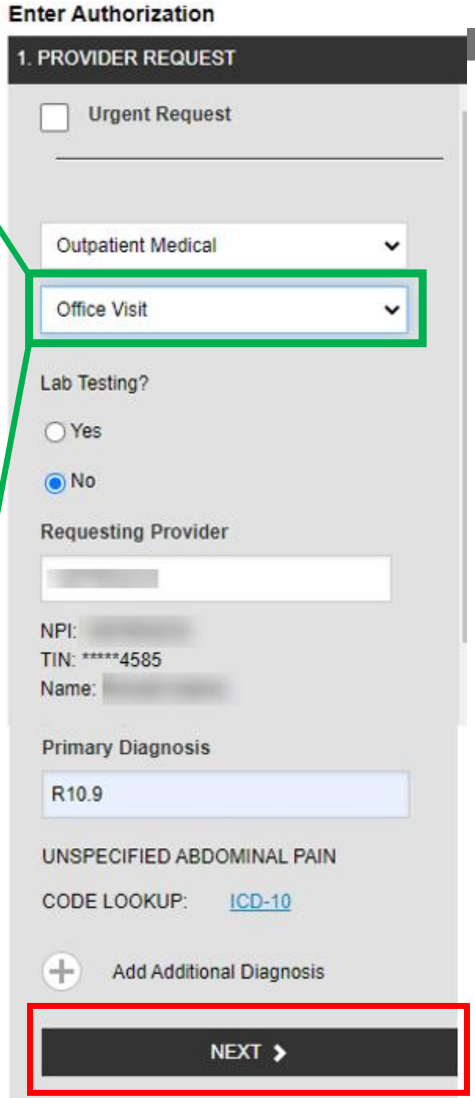


Choose Service Type

- Choose Service Type
- Auditory Services
- Biopharmacy
- DME
- Genetic Testing & Counseling
- Home Health
- Hospice
- Hyperbaric Oxygen Therapy
- Observation
- Office Visit
- Outpatient Services
- Outpatient Surgery
- Pain Management
- Sleep Study
- Stereotactic Radiosurgery
- Therapy
- Transport



Enter Authorization

1. PROVIDER REQUEST

☐ Urgent Request

Outpatient Medical

Office Visit

Lab Testing?

○ Yes

● No

Requesting Provider

[redacted]

NPI: [redacted]

TIN: *****4585

Name: [redacted]

Primary Diagnosis

R10.9

UNSPECIFIED ABDOMINAL PAIN

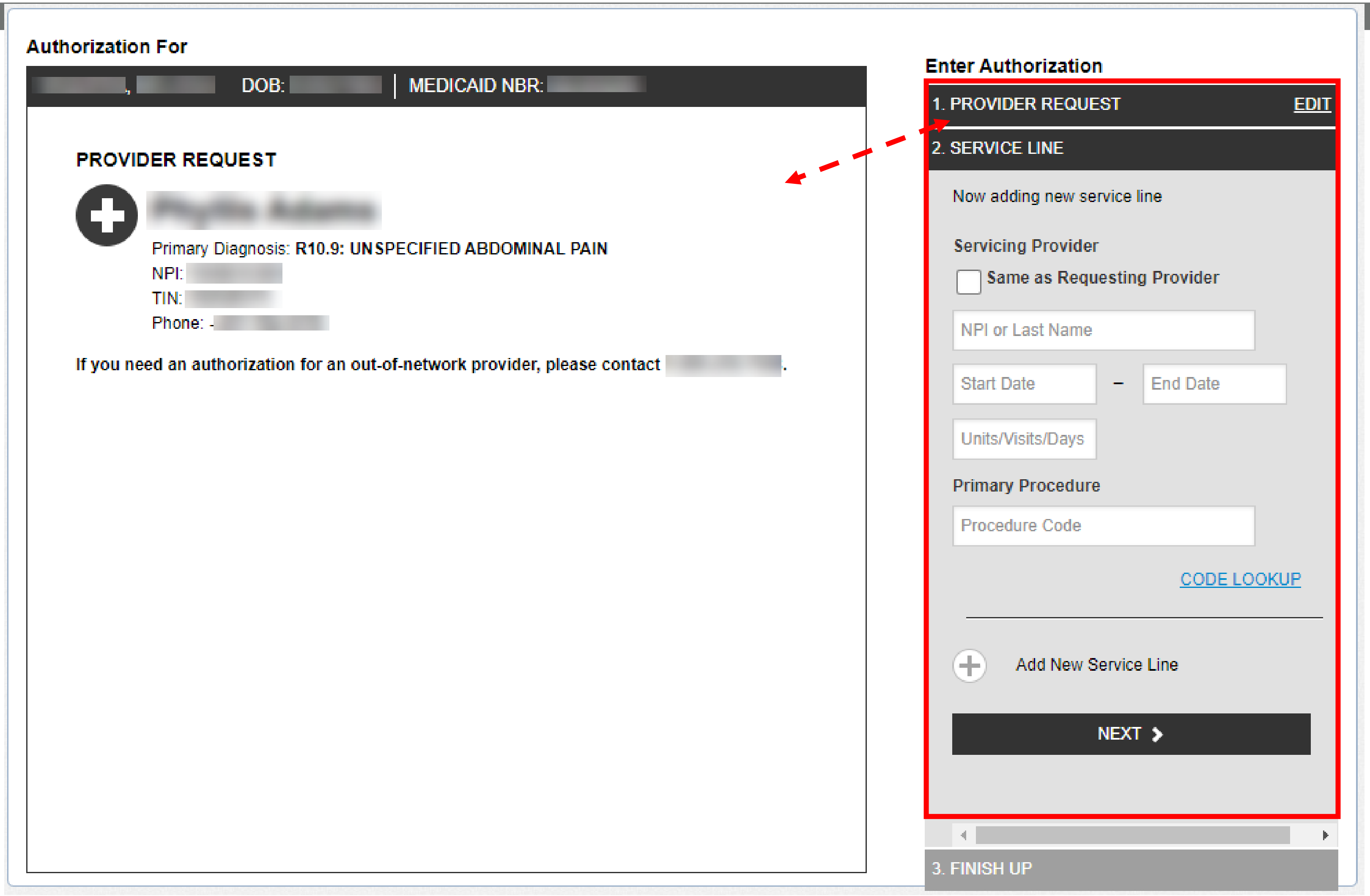
CODE LOOKUP: ICD-10

When completed, click **Next**.

Tip: Service Type options may vary by Health Plan and Plan Type.

Service Line

- The left pane displays the information entered in the Provider Request section, for review.
- Complete the Service Line information in the right pane.



Authorization For

[redacted], [redacted] DOB: [redacted] | MEDICAID NBR: [redacted]

PROVIDER REQUEST

[redacted]

Primary Diagnosis: **R10.9: UNSPECIFIED ABDOMINAL PAIN**

NPI: [redacted]

TIN: [redacted]

Phone: -[redacted]

If you need an authorization for an out-of-network provider, please contact [redacted].

Enter Authorization

1. PROVIDER REQUEST EDIT

2. SERVICE LINE

Now adding new service line

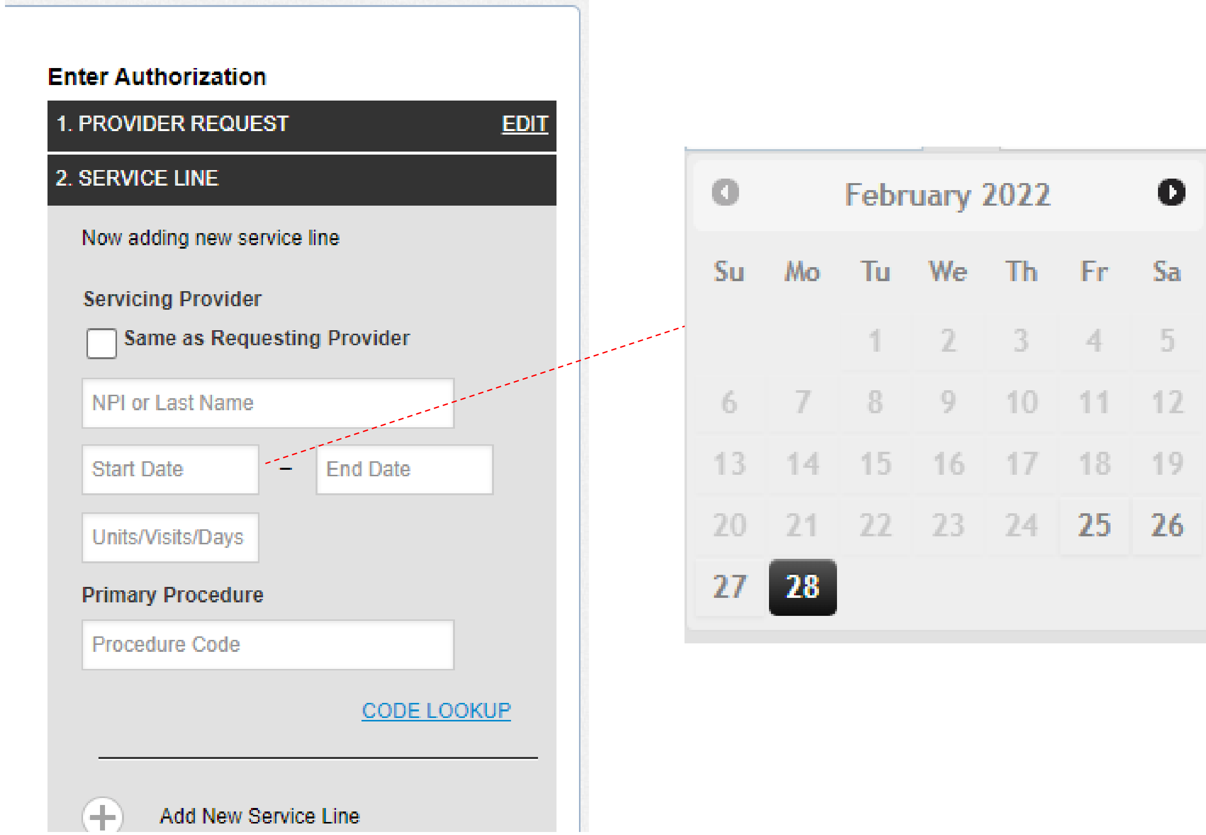
Servicing Provider

☐ Same as Requesting Provider

NPI or Last Name
Start Date
End Date
Units/Visits/Days
Primary Procedure
Procedure Code
CODE LOOKUP
Add New Service Line
NEXT
3. FINISH UP

Service Line - Start Date

Excluding lab testing, for most services, the **Start Date** should be the current calendar date.



Enter Authorization

1. PROVIDER REQUEST EDIT

2. SERVICE LINE

Now adding new service line

Servicing Provider

☐ Same as Requesting Provider

NPI or Last Name
Start Date
–
End Date
Units/Visits/Days

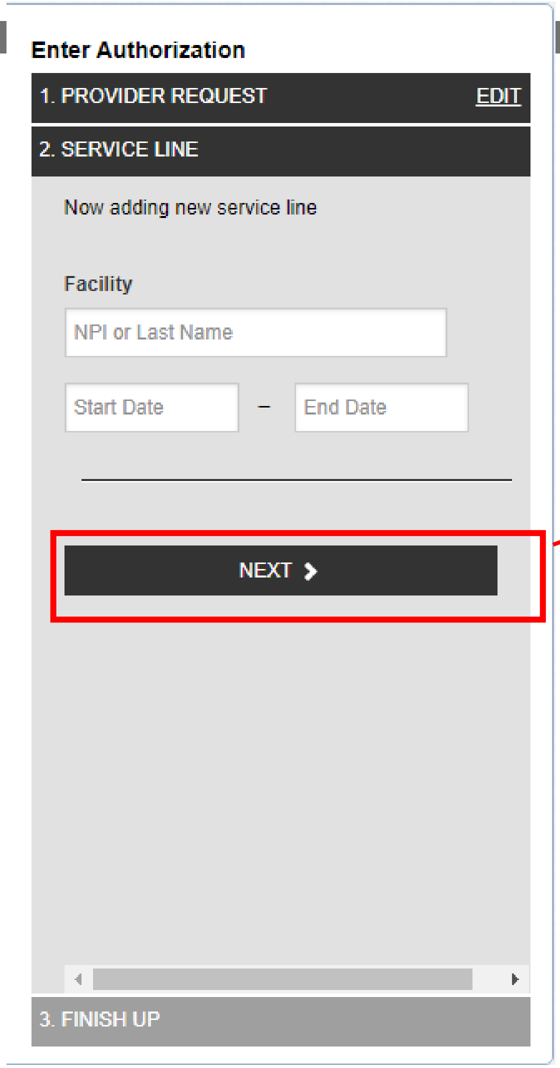
Primary Procedure

Procedure Code
CODE LOOKUP
Add New Service Line

February 2022

Su	Mo	Tu	We	Th	Fr	Sa
		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					

Service Line - Inpatient Medical


Enter Authorization

1. PROVIDER REQUEST EDIT

2. SERVICE LINE

Now adding new service line

Facility

NPI or Last Name

Start Date – End Date

NEXT ›

3. FINISH UP

When completed, click **Next**.

Tip: For best results, enter the Facility NPI

Service Line - Outpatient Medical

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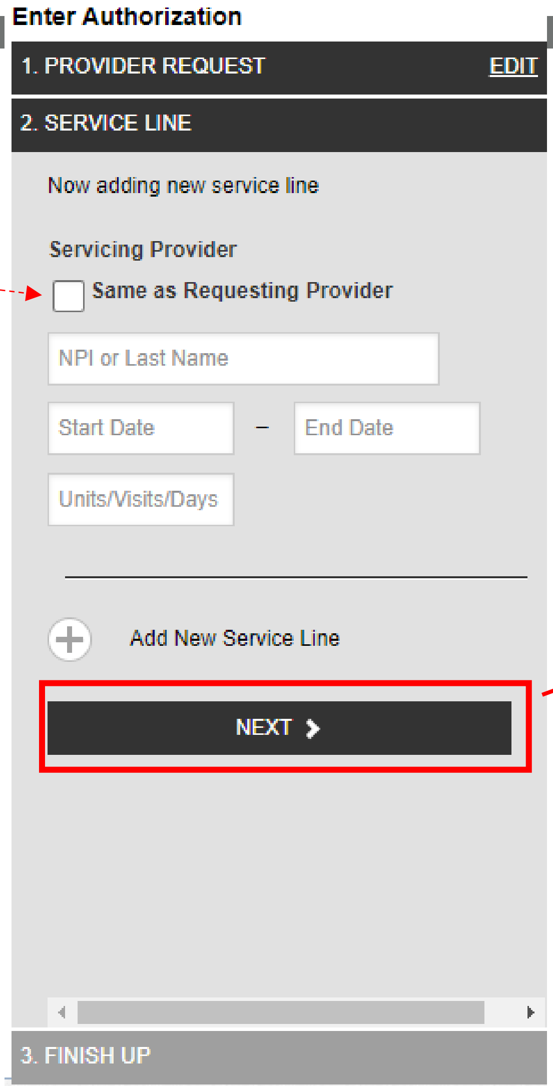


Enter Authorization

1. PROVIDER REQUEST EDIT

2. SERVICE LINE

Now adding new service line

Servicing Provider

☐ Same as Requesting Provider

NPI or Last Name
Start Date
–
End Date
Units/Visits/Days
Add New Service Line
NEXT

3. FINISH UP

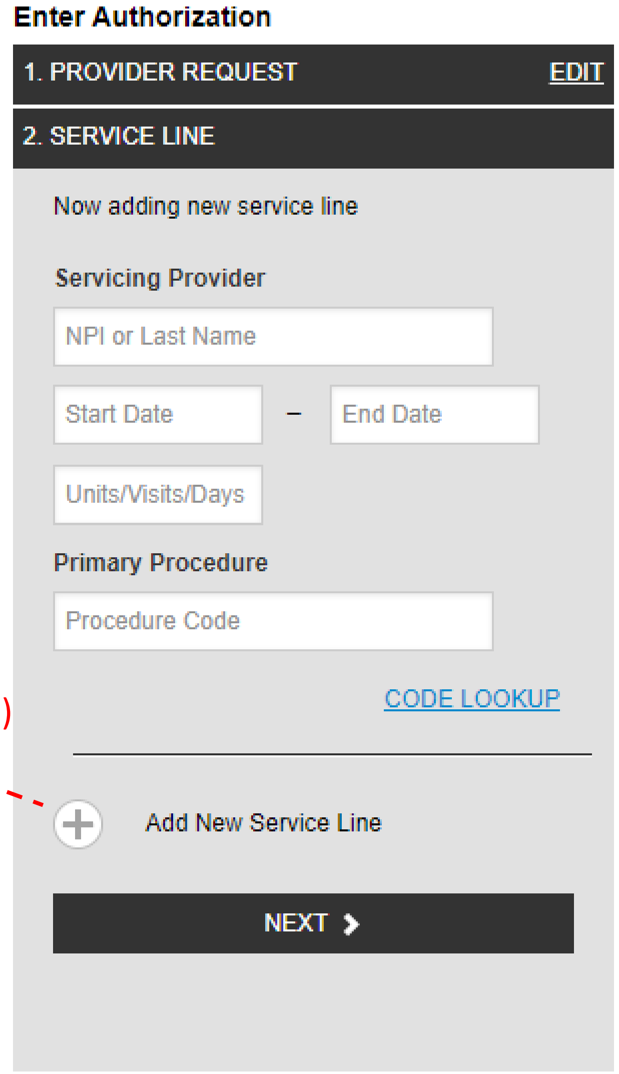
Click the checkbox, if the Requesting and Servicing Provider is the same

When completed, click **Next**.

Tip: For best results, enter the Servicing Provider NPI

Service Line – Outpatient Medical: Add New Service Line

- The **Add New Service Line**, capability enables portal users to submit web authorization requests with multiple procedure codes.
- You must add a new Service Line for each additional procedure code.
- If you add Service Line(s), the addition must align with the options selected in Provider Request:
  - Outpatient Medical / Service Type
  - Lab Testing? Yes or No



Enter Authorization

1. PROVIDER REQUEST EDIT

2. SERVICE LINE

Now adding new service line

Servicing Provider

NPI or Last Name

Start Date – End Date

Units/Visits/Days

Primary Procedure

Procedure Code

CODE LOOKUP

Add New Service Line

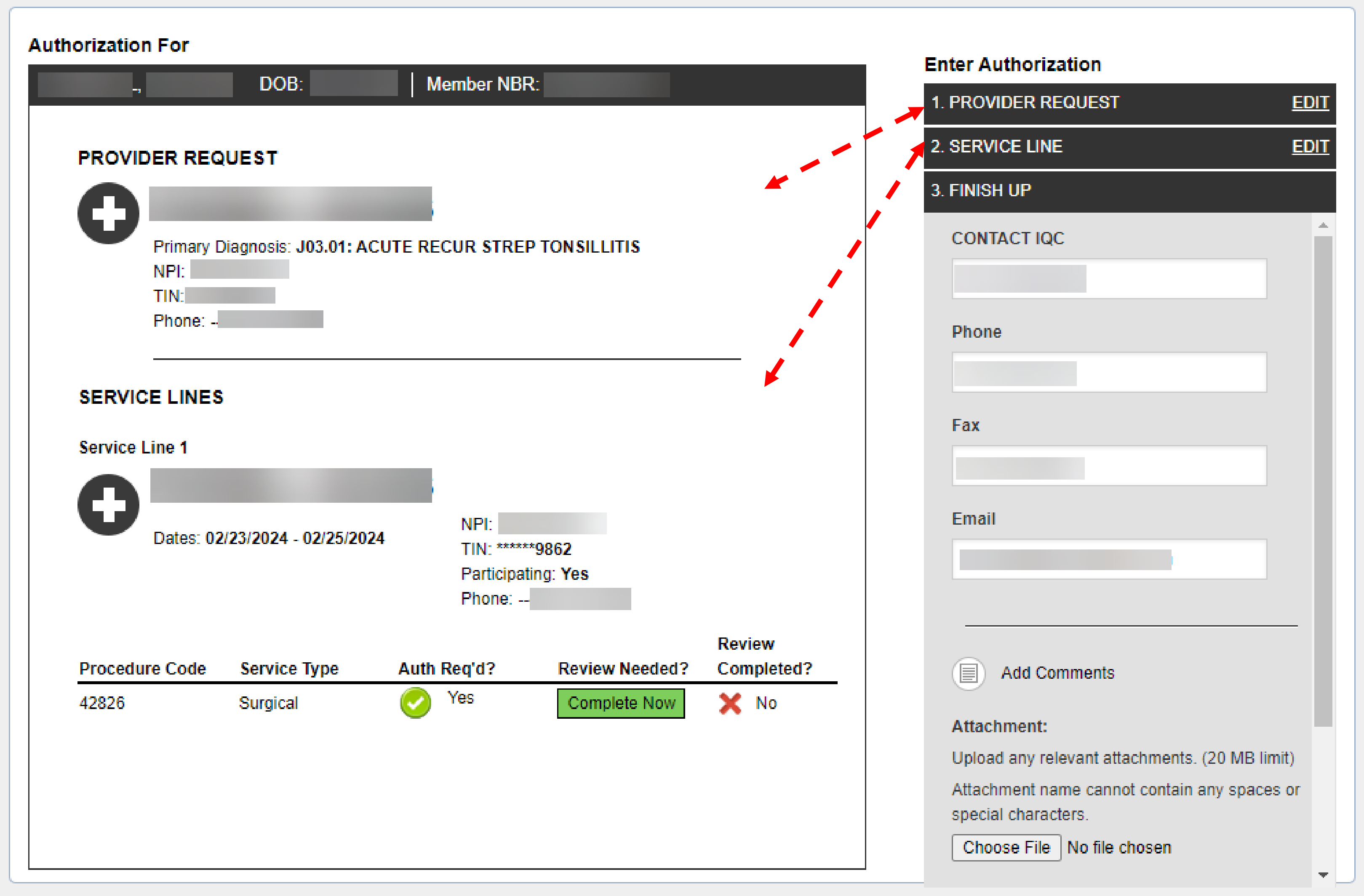
NEXT

Click plus icon to add Service Line(s)

Finish Up

- Completed Provider Request and Service Line(s) displays in the left pane.
- The Contact information will auto-populate the user's information.

Tip: If the user is not the contact for the auth request, enter the contact information for Phone, Fax, and Email, in the applicable fields.



Authorization For

[redacted], [redacted] DOB: [redacted] | Member NBR: [redacted]

PROVIDER REQUEST

[redacted]

Primary Diagnosis: **J03.01: ACUTE RECUR STREP TONSILLITIS**
NPI: [redacted]
TIN: [redacted]
Phone: -[redacted]

SERVICE LINES

Service Line 1

[redacted]

Dates: **02/23/2024 - 02/25/2024**

NPI: [redacted]
TIN: ********9862**
Participating: **Yes**
Phone: --[redacted]

Procedure Code	Service Type	Auth Req'd?	Review Needed?	Review Completed?
42826	Surgical	✓ Yes	Complete Now	✗ No

Enter Authorization

1. PROVIDER REQUEST EDIT
2. SERVICE LINE EDIT
3. FINISH UP

CONTACT IQC
[redacted]

Phone
[redacted]

Fax
[redacted]

Email
[redacted]

Add Comments

Attachment:

Upload any relevant attachments. (20 MB limit)

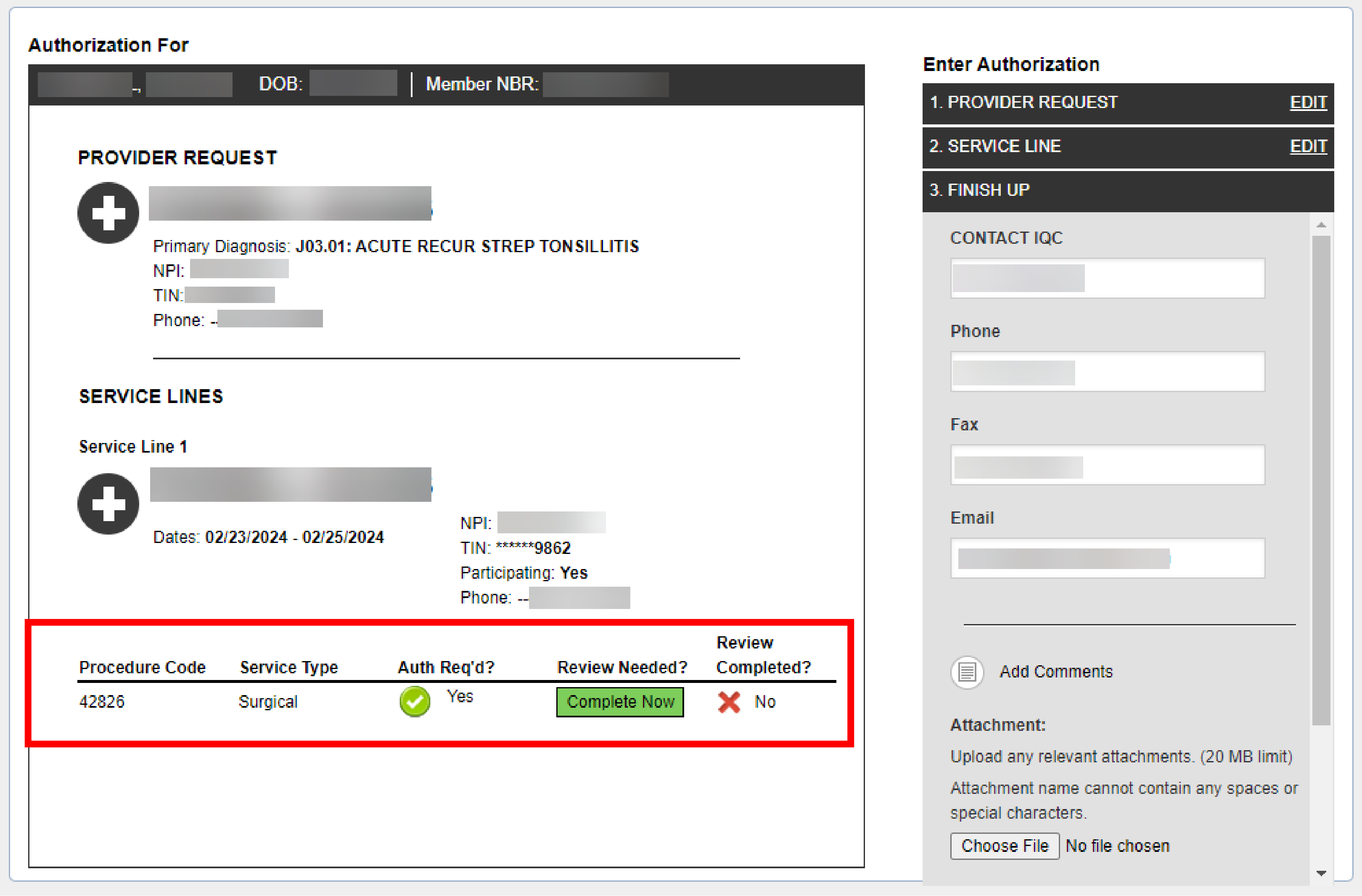
Attachment name cannot contain any spaces or special characters.

Choose File No file chosen

Finish Up - InterQual Connect (IQC)

Completed Service Lines will display:

- **Auth Req'd**
    - Yes
    - Not Covered
    - Not Required, or
    - Vendor
- **Review Needed**
    - No
    - Health Plan Review, or
    - **Complete Now**



Authorization For

[redacted], [redacted] DOB: [redacted] | Member NBR: [redacted]

PROVIDER REQUEST

[redacted]

Primary Diagnosis: **J03.01: ACUTE RECUR STREP TONSILLITIS**
NPI: [redacted]
TIN: [redacted]
Phone: -[redacted]

SERVICE LINES

Service Line 1

[redacted]

Dates: **02/23/2024 - 02/25/2024**

NPI: [redacted]
TIN: ********9862**
Participating: **Yes**
Phone: --[redacted]

Procedure Code	Service Type	Auth Req'd?	Review Needed?	Review Completed?
42826	Surgical	✓ Yes	Complete Now	✗ No

Enter Authorization

1. PROVIDER REQUEST EDIT
2. SERVICE LINE EDIT
3. FINISH UP

CONTACT IQC
[redacted]

Phone
[redacted]

Fax
[redacted]

Email
[redacted]

Add Comments

Attachment:

Upload any relevant attachments. (20 MB limit)

Attachment name cannot contain any spaces or special characters.

Choose File No file chosen

Finish Up - [Service] Not Covered

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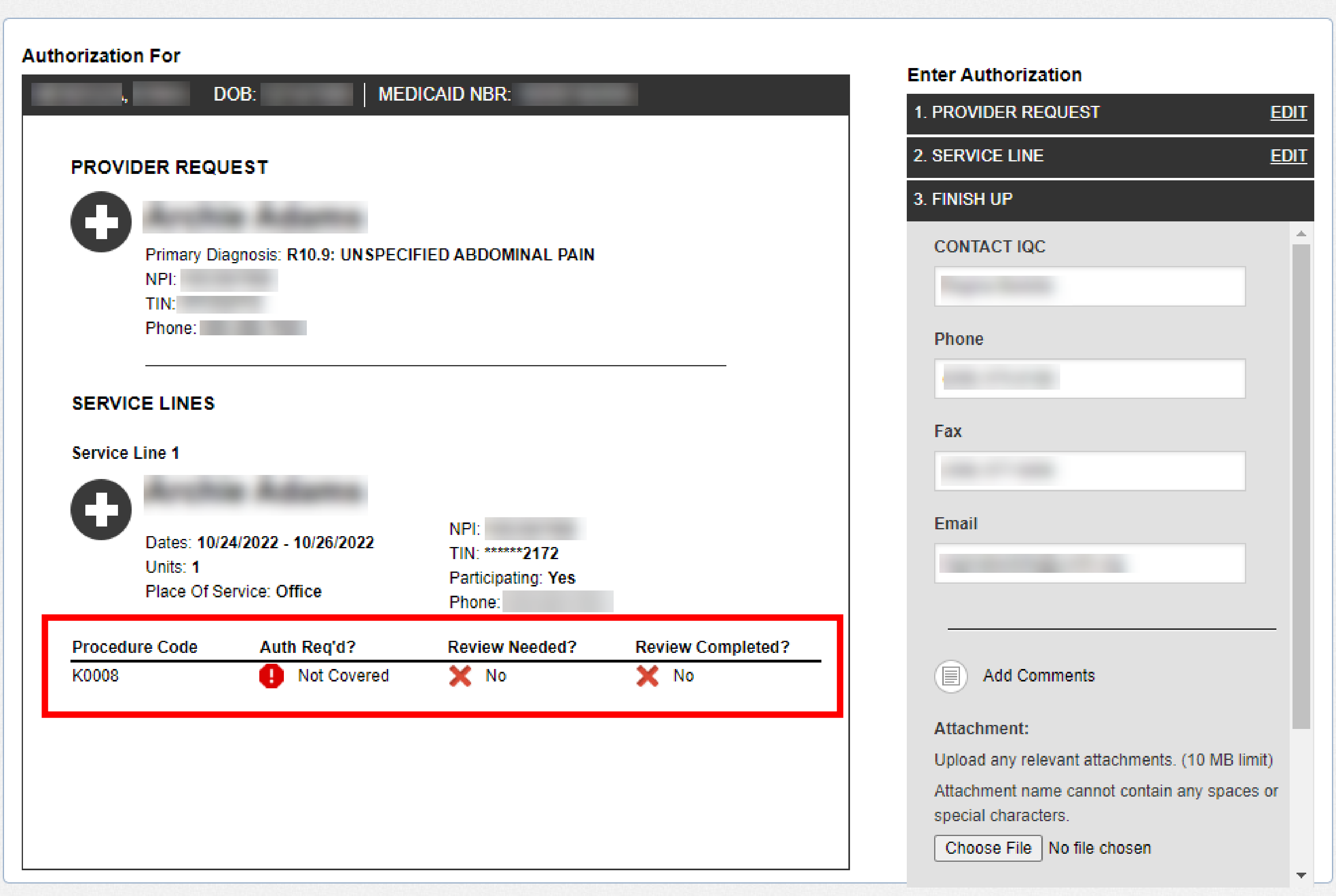

Authorization For

[redacted], [redacted] DOB: [redacted] | MEDICAID NBR: [redacted]

PROVIDER REQUEST

[redacted]

Primary Diagnosis: **R10.9: UNSPECIFIED ABDOMINAL PAIN**
NPI: [redacted]
TIN: [redacted]
Phone: [redacted]

SERVICE LINES

Service Line 1

[redacted]

Dates: **10/24/2022 - 10/26/2022**
Units: **1**
Place Of Service: **Office**

NPI: [redacted]
TIN: ********2172**
Participating: **Yes**
Phone: [redacted]

Procedure Code	Auth Req'd?	Review Needed?	Review Completed?
K0008	❗ Not Covered	✗ No	✗ No

Enter Authorization

1. PROVIDER REQUEST EDIT
2. SERVICE LINE EDIT
3. FINISH UP

CONTACT IQC
[redacted]

Phone
[redacted]

Fax
[redacted]

Email
[redacted]

Add Comments

Attachment:

Upload any relevant attachments. (10 MB limit)

Attachment name cannot contain any spaces or special characters.

Choose File No file chosen

carolina complete health

Finish Up - No Authorization Required

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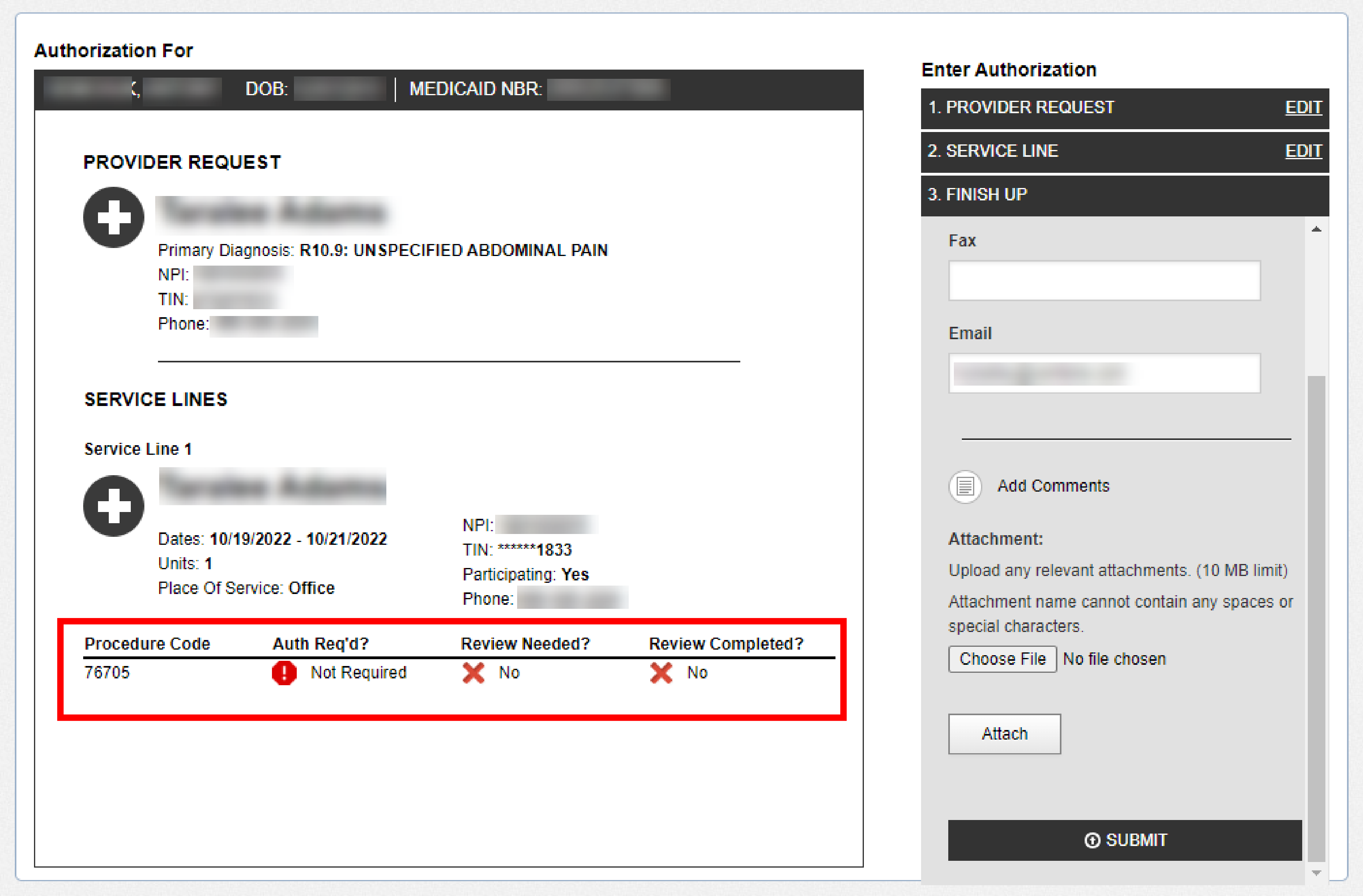

Authorization For

[redacted], [redacted] DOB: [redacted] | MEDICAID NBR: [redacted]

PROVIDER REQUEST

[redacted]

Primary Diagnosis: **R10.9: UNSPECIFIED ABDOMINAL PAIN**

NPI: [redacted]

TIN: [redacted]

Phone: [redacted]

SERVICE LINES

Service Line 1

[redacted]

Dates: **10/19/2022 - 10/21/2022**

Units: **1**

Place Of Service: **Office**

NPI: [redacted]

TIN: ******1833

Participating: **Yes**

Phone: [redacted]

Procedure Code	Auth Req'd?	Review Needed?	Review Completed?
76705	❗ Not Required	✗ No	✗ No

Enter Authorization

1. PROVIDER REQUEST EDIT
2. SERVICE LINE EDIT
3. FINISH UP

Fax

Email

[redacted]

Add Comments

Attachment:

Upload any relevant attachments. (10 MB limit)

Attachment name cannot contain any spaces or special characters.

Choose File No file chosen

Attach

SUBMIT

Finish Up - Vendor

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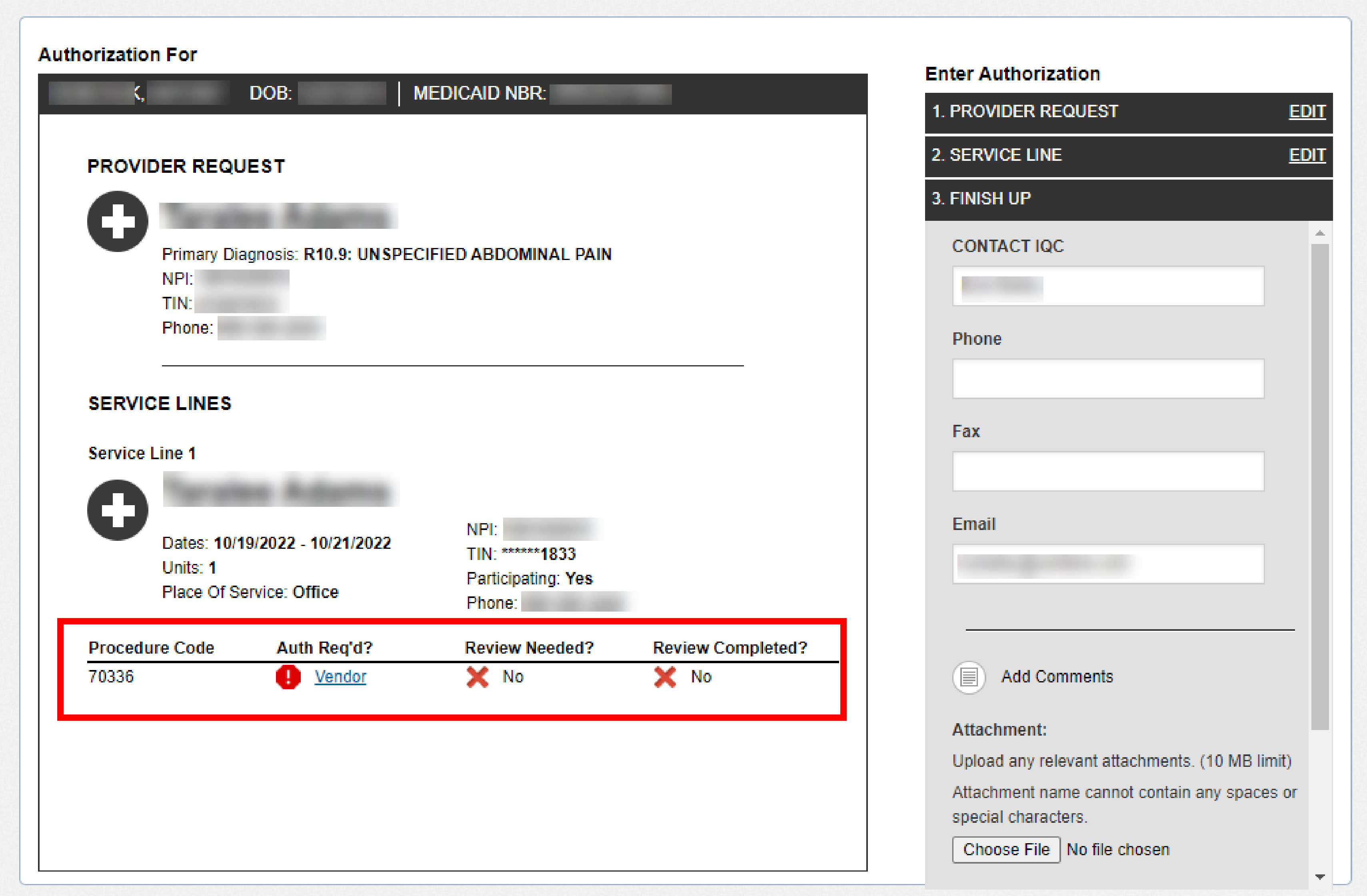

Authorization For

[redacted] DOB: [redacted] | MEDICAID NBR: [redacted]

PROVIDER REQUEST

[redacted]

Primary Diagnosis: **R10.9: UNSPECIFIED ABDOMINAL PAIN**
NPI: [redacted]
TIN: [redacted]
Phone: [redacted]

SERVICE LINES

Service Line 1

[redacted]

Dates: **10/19/2022 - 10/21/2022**
Units: **1**
Place Of Service: **Office**

NPI: [redacted]
TIN: ********1833**
Participating: **Yes**
Phone: [redacted]

Procedure Code	Auth Req'd?	Review Needed?	Review Completed?
70336	❗ Vendor	✗ No	✗ No

Enter Authorization

- 1. PROVIDER REQUEST EDIT
- 2. SERVICE LINE EDIT
- 3. FINISH UP

CONTACT IQC: [redacted]

Phone:

Fax:

Email: [redacted]

Add Comments

Attachment:

Upload any relevant attachments. (10 MB limit)

Attachment name cannot contain any spaces or special characters.

Choose File No file chosen

Finish Up - Authorization Must Be Submitted via Vendor

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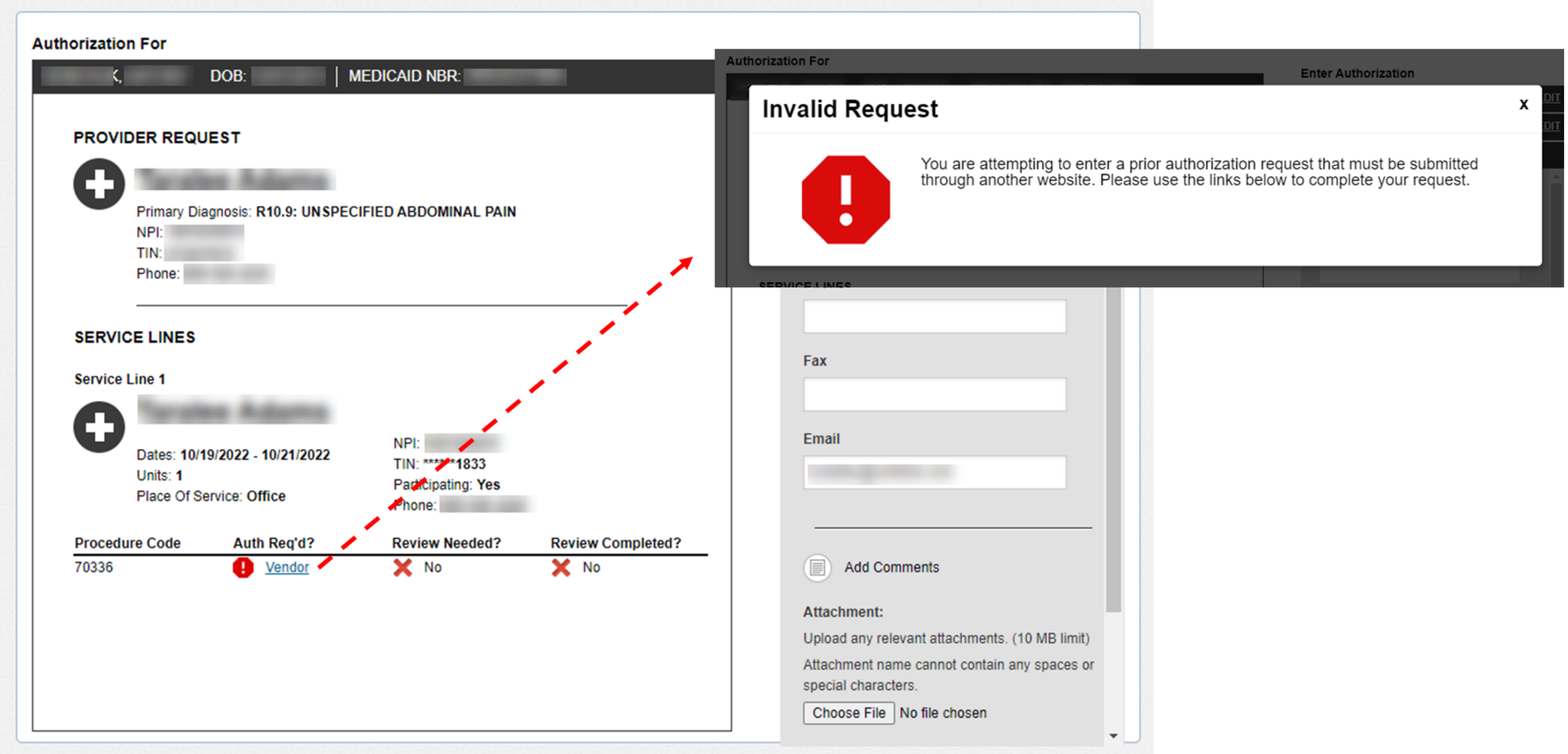


Authorization For

[redacted], [redacted] DOB: [redacted] | MEDICAID NBR: [redacted]

PROVIDER REQUEST

[redacted]

Primary Diagnosis: **R10.9: UNSPECIFIED ABDOMINAL PAIN**
NPI: [redacted]
TIN: [redacted]
Phone: [redacted]

SERVICE LINES

Service Line 1

[redacted]

Dates: **10/19/2022 - 10/21/2022**
Units: **1**
Place Of Service: **Office**

NPI: [redacted]
TIN: *****1833
Participating: **Yes**
Phone: [redacted]

Procedure Code	Auth Req'd?	Review Needed?	Review Completed?
70336	! Vendor	✗ No	✗ No

Fax

Email
[redacted]

Add Comments

Attachment:
Upload any relevant attachments. (10 MB limit)
Attachment name cannot contain any spaces or special characters.

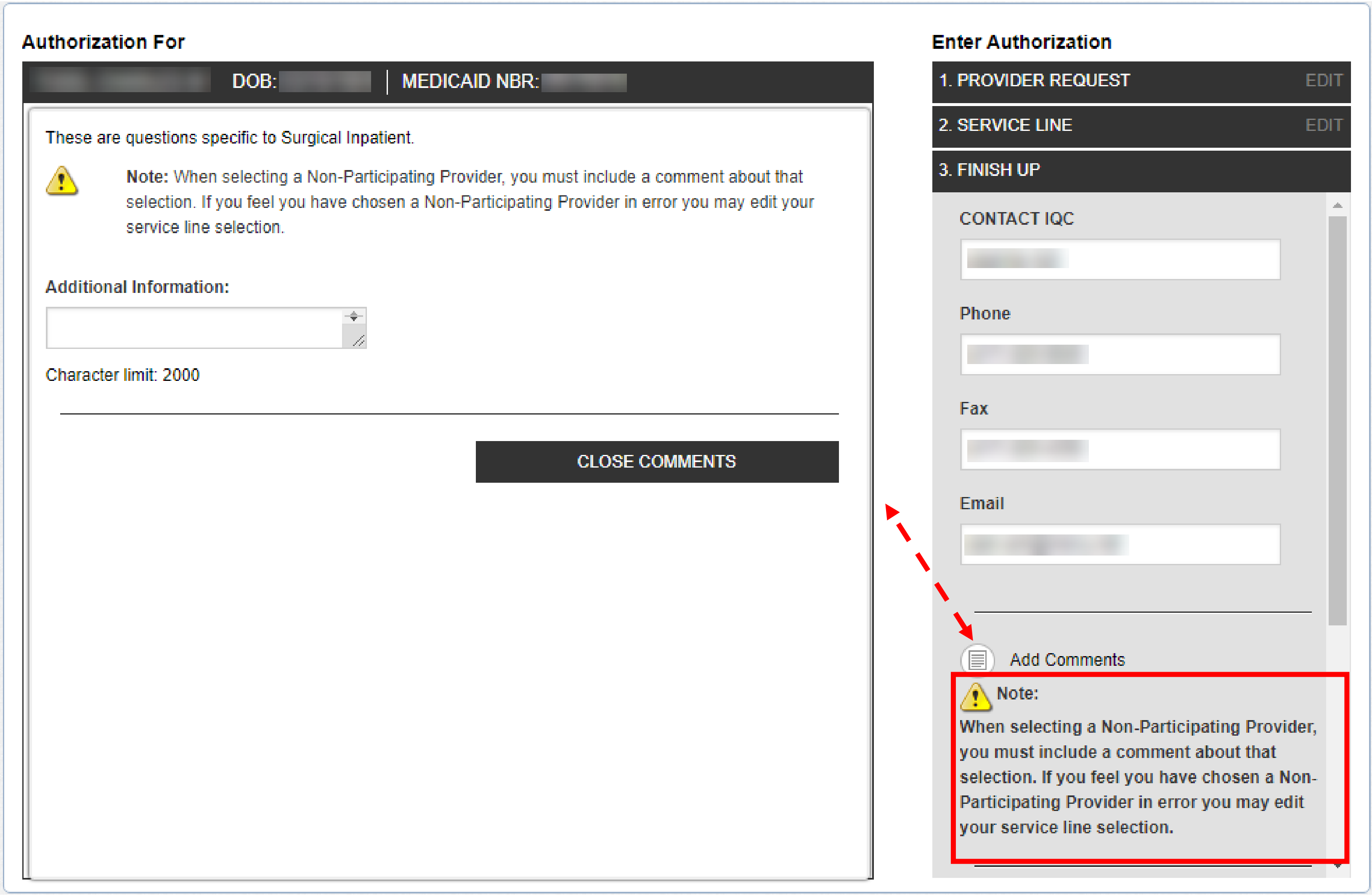
Invalid Request

You are attempting to enter a prior authorization request that must be submitted through another website. Please use the links below to complete your request.

Finish Up - Comments (Medical)

Click **Add Comments** to enter comments.

Click **CLOSE COMMENTS**, to close and save comments.



Authorization For

[redacted] DOB: [redacted] | MEDICAID NBR: [redacted]

These are questions specific to Surgical Inpatient.

⚠ **Note:** When selecting a Non-Participating Provider, you must include a comment about that selection. If you feel you have chosen a Non-Participating Provider in error you may edit your service line selection.

Additional Information:

Character limit: 2000

Enter Authorization

1. PROVIDER REQUEST EDIT
2. SERVICE LINE EDIT
3. FINISH UP

CONTACT IQC: [redacted]

Phone: [redacted]

Fax: [redacted]

Email: [redacted]

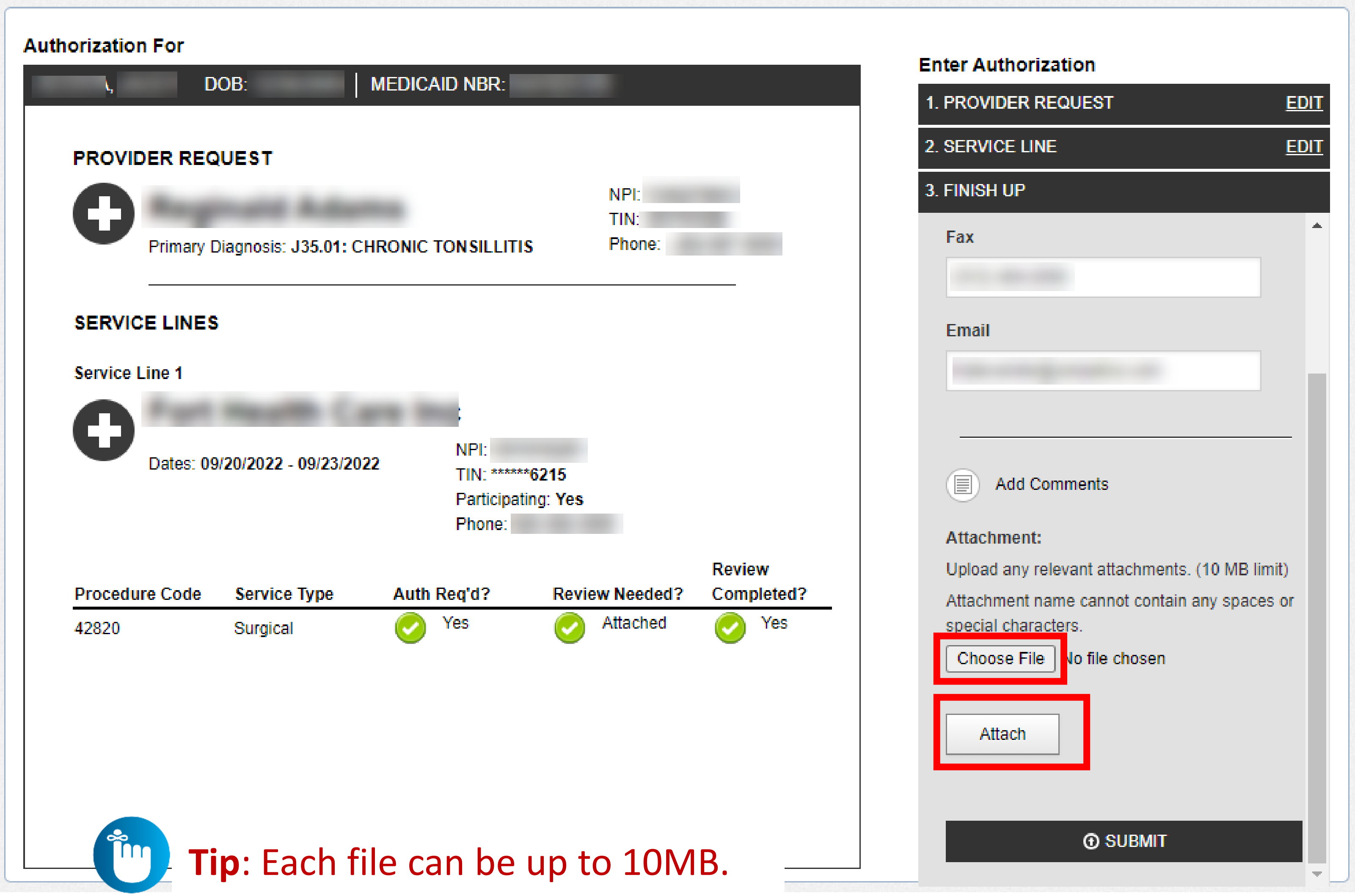
⚠ Note:

When selecting a Non-Participating Provider, you must include a comment about that selection. If you feel you have chosen a Non-Participating Provider in error you may edit your service line selection.

Finish Up – Attachments

You can attach up to five (5) documents on web authorization requests. To attach a document:

1. Click **Choose File**. A separate window will display.
2. Select document from your computer directory.
3. Click **Open**.
4. Click **Attach**.
   - Repeat steps 1 – 4, as needed



Authorization For

[redacted], [redacted] DOB: [redacted] | MEDICAID NBR: [redacted]

PROVIDER REQUEST

[redacted]

Primary Diagnosis: **J35.01: CHRONIC TONSILLITIS**

NPI: [redacted]
TIN: [redacted]
Phone: [redacted]

SERVICE LINES

Service Line 1

[redacted]

Dates: **09/20/2022 - 09/23/2022**

NPI: [redacted]
TIN: ********6215**
Participating: **Yes**
Phone: [redacted]

Procedure Code	Service Type	Auth Req'd?	Review Needed?	Review Completed?
42820	Surgical	✓ Yes	✓ Attached	✓ Yes

Enter Authorization

1. PROVIDER REQUEST EDIT
2. SERVICE LINE EDIT
3. FINISH UP

Fax
[redacted]

Email
[redacted]

Add Comments

Attachment:

Upload any relevant attachments. (10 MB limit)

Attachment name cannot contain any spaces or special characters.

Choose File No file chosen

Attach

SUBMIT

Tip: Each file can be up to 10MB.

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Web Authorization Submission

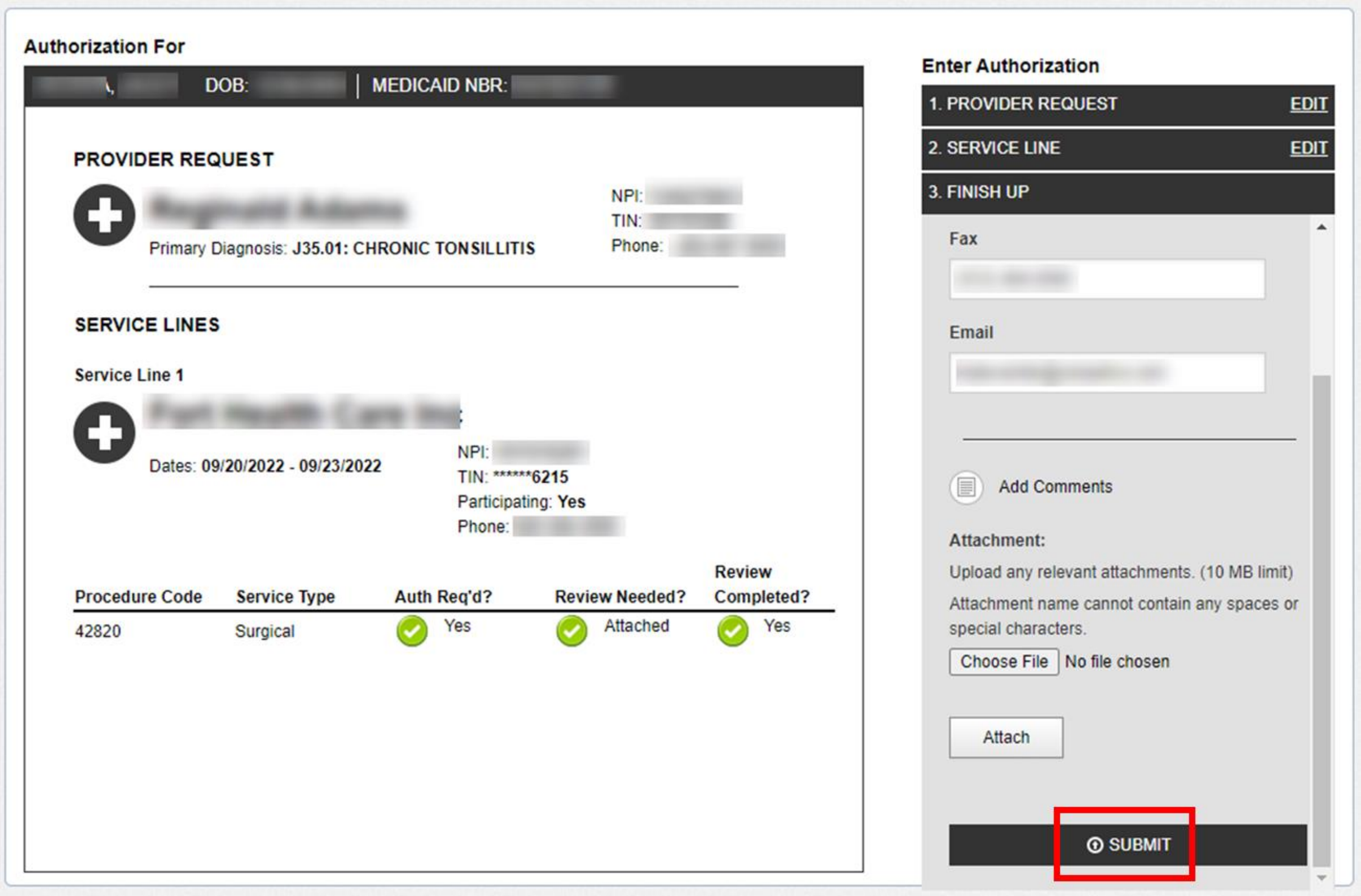
Once you complete:

1. Provider Request
2. Service Line
3. Finish Up
    - ❖ Click **Complete Now**
    - ❖ Complete Medical Review
    - ❖ Return to web authorization

Medical

A. Add Comments
B. Add Attachment(s)

- ❖ Click **Submit**



Authorization For

[redacted], [redacted] DOB: [redacted] | MEDICAID NBR: [redacted]

PROVIDER REQUEST

[redacted]

Primary Diagnosis: **J35.01: CHRONIC TONSILLITIS**

NPI: [redacted]
TIN: [redacted]
Phone: [redacted]

SERVICE LINES

Service Line 1

[redacted]

Dates: **09/20/2022 - 09/23/2022**

NPI: [redacted]
TIN: ********6215**
Participating: **Yes**
Phone: [redacted]

Procedure Code	Service Type	Auth Req'd?	Review Needed?	Review Completed?
42820	Surgical	✓ Yes	✓ Attached	✓ Yes

Enter Authorization

Fax: [redacted]

Email: [redacted]

Attachment:

Upload any relevant attachments. (10 MB limit)

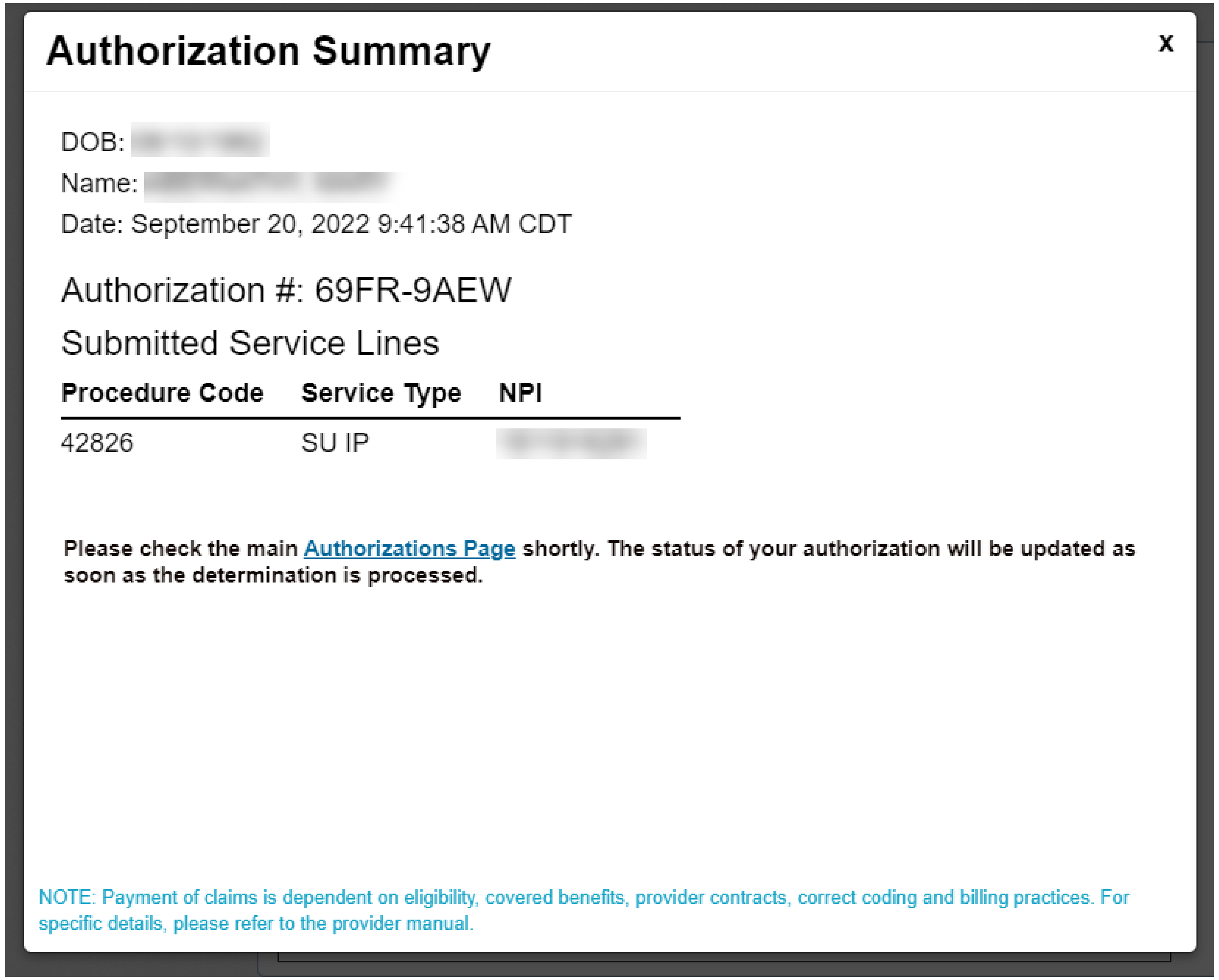
Attachment name cannot contain any spaces or special characters.

Tip: You must click **Submit**, to submit the web authorization request for processing.

Web Authorization Confirmation

The web authorization confirmation will display the Service Lines entered on the request.

This Tracking Number can be used by internal teams to search for the request in our authorization processing system.



Authorization Summary

DOB: [redacted]
Name: [redacted]
Date: September 20, 2022 9:41:38 AM CDT

Authorization #: 69FR-9AEW

Submitted Service Lines

Procedure Code	Service Type	NPI
42826	SU IP	[redacted]

Please check the main Authorizations Page shortly. The status of your authorization will be updated as soon as the determination is processed.

NOTE: Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual.

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