

Job Aid

Professional Crossover Claim with TPL Submission

This job aid provides step by step instructions to submit a Professional Crossover Claim with TPL in the MESA portal. Please read the instructions thoroughly and follow all directions.

Starting December 18, 2023, providers will have access to their portal account for up to 1 year from the date of termination. Claims for services provided before the termination effective date may be submitted for processing as well as adjustments or voids. Claims for services provided on or after the termination date will be denied.

When submitting a crossover claim make sure to follow these tips:

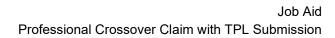
- > Only include the EOMB(s) needed to process the claim.
- > EOMBs must be completely legible.
- > Negative dollar amounts are not accepted and must be entered as zero.
- > All of the data on the EOMB must match the data entered on the portal submitted claim.

Review the Steps to Submit a Professional Crossover Claim with TPL

| Steps | | Description | | | | | | | | | |
|--------|--|--|---|--|--|--|--|--|--|--|--|
| Step 1 | Login to the Portal. The Portal Home screen Displays. | | | | | | | | | | |
| | | Search Medicaid: | | | | | | | | | |
| | Home Eligibility Claims Care Management Patient Health History Files Exchange Resources Contact Us | | | | | | | | | | |
| | Home | | Wednesday 11/30/2022 04:31 PM CST | | | | | | | | |
| | Provider Name Location | Role IDs Taxonomy | | | | | | | | | |
| | User Details Welcome Group Mu Profile Manage Accounts Provider Name Provider ID Location ID Characteristics | Weicher Erschles System Assistance Weicher Heafth Care Professional Ware committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers. | Sign Up to Receive News Secure Correspondence Latest News Late Breaking News Provider Bulletins UM/QIO Report Fraud | | | | | | | | |
| | Provider Se Member Focused Viewing Search Payment History Affiliated Providers 340B Program Information | | | | | | | | | | |



| Steps | Description | | | | | | | | |
|--------|--|--|--|--|--|--|--|--|--|
| Step 2 | The following steps will review how to submit a Professional Crossover Claim in MESA: Hover over the Claims tab on the menu bar. A list of claim types displays below. Select Submit Claim Prof. | | | | | | | | |
| | Home Eligibility Claims Care Management Patient Health History Files Exchange Resources Contact Us Search Claims Submit Claim Dental Submit Claim Inst Submit Claim Prof Submit Claim Pharm Search Payment History | | | | | | | | |
| Step 3 | The Portal displays the "Submit Professional Claim": Step 1 page. Select Claim Type Crossover Professional. | | | | | | | | |
| | Submit Professional Claim: Step 1 * Indicates a required field. Claim Type Crossover Professional | | | | | | | | |
| Step 4 | Complete the Provider Information section. NOTE : There will be information already generated in this section. Complete additional fields if applicable to the claim being submitted. | | | | | | | | |
| | Provider Information | | | | | | | | |
| | Billing Provider ID ID Type NPI Name | | | | | | | | |
| | Taxonomy Performing Provider ID ID Type NPI Name Taxonomy | | | | | | | | |
| | Referring Provider ID Q ID Type NPI Name Taxonomy | | | | | | | | |
| | Taxonomy _ | | | | | | | | |
| Step 5 | Complete the Member Information section. NOTE: Once the Member ID is entered, the system will generate the remaining fields in this section. Verify the fields populate correctly. | | | | | | | | |
| | Member Information *Member ID Last Name Birth Date Address Address Line 2 City State V | | | | | | | | |
| | | | | | | | | | |





| Desc | ription |
|---|--|
| - | |
| Claim Information | |
| Date Type Accident Related Patient Number | Date of Current Admission Date Authorization Number |
| *Transport Certification O Yes No | |
| *Does the provider have a signature on file? | ○ Yes ● No |
| *Does the provider accept assignment for claim processing? | ○Yes No Clinical Lab Services Only |
| *Are benefits assigned to the provider by the patient or their authorized representative? | ○ Yes |
| *Does the provider have a signed statement from the patient releasing their medical information? | ⊖ Yes® No |
| Include Other Insurance 💿 | Total Charged Amount \$0.00 |
| | |
| Review all sections on Submit Professional C correct select Continue to move on to Step 2. | Claim: Step 1 page. If all the information entered is |
| Claim Information | |
| Date Type | Date of Current () () () () () () () () () () () () () |
| *Does the provider have a signature on file? | ● Yes ○ No |
| *Does the provider accept assignment for claim processing? | ● Yes ○ No ○ Clinical Lab Services Only |
| *Are benefits assigned to the provider by the patient or their authorized representative? | ● Yes ○ No ○ N/A |
| *Does the provider have a signed statement from the patient releasing their medical information? | ● Yes ○ No |
| Include Other Insurance | Total Charged Amount \$0.00 |
| | Continue Cancel |
| | |
| | Complete the Claim Information section. NOTE: The "Include Other Insurance" box is grader in the insurance in the provider accept assignment for the provider have a signature on file? * Does the provider accept assignment for claim processing? * Are benefits assigned to the provider by the patient or their authorized representative? * Does the provider have a signed statement from the patient releasing their medical information? Include Other Insurance information Claim Information Claim Information * Review all sections on Submit Professional C correct select Continue to move on to Step 2. Claim Information Date Type information * Transport Certification in the patient or the patient or the patient releasing their medical information? * The transport Certification in the patient or the patient number in the patient number in the patient or the patient or the patient or the patient or the patient or the patient releasing it patient patie |



| Steps | | | Description | | | |
|---------|---|---------------------------------|--|------------------------------|---------------------|-----------|
| Step 8 | The Portal displays the "Sub entered in step 1 will displayReview the previously sup | at the top of the | page in step 2. | The previous inf | ormation tl | hat was |
| | Submit Professional Claim: Step 2 | | | | | 2 |
| | * Indicates a required field. | | | | | <u> </u> |
| | | Claim Type Cross | sover Professional | | | |
| | Provider Information | | | | | |
| | Billing Provider ID | 1 | D Type NPI | Name | | |
| | Taxonomy Patient and Claim Information | | | | | |
| | Member ID | | | | | |
| | Member Birth Date | | Gender | | | |
| | Birtii Date | | Total Charged Amount | | | |
| | | | | | | |
| Step 9 | • Enter the Diagnosis Co Everything with a Red asteri | | • | | - | |
| | Diagnosis Codes | | | | | - |
| | Select the row number to edit the row. Click the Please note that the 1st diagnosis entered is co | | | | | |
| | # Diagnosis Type | | Diagnosis Code | | | Action |
| | 1 | | | | | |
| | 1 *Diagnosis Type ICD-10-CM V | *Diagnosis Co | ode Ə | | | |
| | Add Reset | | | | | |
| | | | | | | |
| | | | | | | |
| Step 10 | Scroll down to the Other Ins | urance Detail p | anel. | | | |
| | NOTE: If there is other insur button under the Action colu | | already populated that | it is out of date, | select the | Remove |
| | Select the plus sign to a | | irance. Steps are show | vn below to add | Medicare | and other |
| | insurance outside of Me | | | | mouldid | |
| | 1 | | | | | |
| | Other Insurance Details | | | | | |
| | Enter the carrier and policy holder information | below. | | | | |
| | Enter other carrier Remittance Advice details h Details section. | nere for the claim or with eacl | n service line. Enter adjusted payment o | details, such as reason code | s, in the Claim Adj | ustment |
| | NOTE: Please click Remove to discard any un | related "Other Insurance", pr | ior to submitting claim. | | | |
| | | | 1 | | Refresh Other I | insurance |
| | # Carrier Name | Carrier Code | Group # | COB Payer Paid Amount | mittance Date | Action |
| | Click to add a new other insurance. | | | | | |
| | | | | | | |



| Steps | | | | Description | | | | | | |
|---------|--|--|------------------|--------------------------------------|--------------------------|-----------------------|-----------|--|--|--|
| Step 11 | To add Medicare Part A, B, or C follow these steps. Using the Claim Filing Indicator dropdown, select 16 (Medicare Part C), MA (Medicare Part A), or MB (Medicare Part B). No additional fields are necessary for these selections. For this example, MB-Medicare Part B was selected from the Claim Filing Indicator dropdown. Click Add Insurance to save the selection. Other Insurance Details displays Medicare Part B on line #1. Other Insurance Details Enter the carrier and policy holder information below. Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section. NOTE: Please click Remove to discard any unrelated "Other Insurance", prior to submitting claim. | | | | | | | | | |
| | | | , | - | | Refresh Other | Insurance | | | |
| | # | Carrier Name | Carrier Code | Group # | COB Payer Paid Amount | Remittance Date | Action | | | |
| | | lick to collapse. | | | | | | | | |
| | | *Claim Filing Indicator MB | -Medicare Part B | ~ | | | | | | |
| | | Add Insurance | cel Insurance | | | | | | | |
| Step 12 | Othe Enter Enter Detai | Select the plus sign r Insurance Details the carrier and policy holder inform other carrier Remittance Advice de Is section. | nation below. | service line. Enter adjusted payment | details, such as reason | codes, in the Claim A | | | | |
| | # | Carrier Name | Carrier Code | Group # | COB Payer Paid | Remittance Date | Action | | | |
| | 1 | Claim Filing Indicator: 'Medicare P | art B' | | Amount | | Remove | | | |
| | | lick to add a new other insurance. | | | | | | | | |
| | | | | | | | | | | |



| | | | Description | | | |
|------------------------|---|--|--|---|---|--------------------|
| • | Medicare A (MA), I | ance that is applicabl Medicare B (MB), or M ne selection is made. that line. | ledicare C (Claim fili | ing indicator = 16 |), then addition | onal field |
| - | Click to collapse. | | | | | |
| | *Claim Filing | Indicator | | | | ~ |
| | | | Non-Federal Program | ms | | |
| | Add Ins | 12-Prefer | red Provider Organiz of Service (POS) | | | |
| Co | ondition Codes | 14-Exclus | sive Provider Organiz nnity Insurance | ation (EPO) | | |
| CI | ick the Remove link | 17-Denta | n Maintenance Organ I Maintenance Organ | | dicare Risk | |
| | # | BL-Blue C | nobile Medical Cross/Blue Shield | | | |
| | 1 | | ercial Insurance Co. | | | |
| 1 | *Conditio | | al Employees Program | | | |
| | | CC LM-Liabili | | nization | | |
| | Add | | care Part A care Part B | | | |
| | 100 | | Federal Program | | | - |
| • | Complete the addi Link to Carrier Coo | | | | | 6 |
| Ot Eni De | Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advic tails section. | <u>des</u> | ch service line. Enter adjusted pay | rment details, such as reason Everything w must b | codes, in the Claim Ac rith a red aster e completed. Refresh Other | isk * |
| Ot Eni De NG | Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advic tails section. DTE: Please click Remove to disco Carrier Name | des nformation below. ce details here for the claim or with ea | ch service line. Enter adjusted pay | rment details, such as reason Everything w | vith a red aster e completed. | isk * |
| Ot Eni De NO | Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advic tails section. DTE: Please click Remove to disco Carrier Name Click to collapse. | hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code | ch service line. Enter adjusted pay prior to submitting claim. Group # | ment details, such as reason Everything w must b COB Pyer Paid | vith a red aster e completed. Refresh Other | isk * Insurance |
| Ott Eni De NO | Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advic tails section. | des nformation below. ce details here for the claim or with ea ard any unrelated "Other Insurance", s | ch service line. Enter adjusted pay prior to submitting claim. Group # | ment details, such as reason Everything w must b COB Pyer Paid | vith a red aster e completed. Refresh Other | isk * Insurance |
| Ott Eni De NO | Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advic tails section. | hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code | ch service line. Enter adjusted pay prior to submitting claim. Group # | ment details, such as reason Everything w must b COB Pyer Paid | vith a red aster e completed. Refresh Other | isk * |
| Ott Eni De NO | Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advic tails section. | hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code | ch service line. Enter adjusted pay prior to submitting claim. Group # | ment details, such as reason Everything w must b COB Pyer Paid | vith a red aster e completed. Refresh Other | isk * |
| Ott Eni De NO | Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advic tails section. | hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code | ch service line. Enter adjusted pay prior to submitting claim. Group # | ment details, such as reason Everything w must b COB Pyer Paid | vith a red aster e completed. Refresh Other | isk * |
| Ott Eni De NO | Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advic tails section. | hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code | ch service line. Enter adjusted pay prior to submitting claim. Group # | ment details, such as reason Everything w must b COB Pyer Paid | vith a red aster e completed. Refresh Other | isk * |
| Ott Eni De NO | Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advice tails section. DTE: Please dick Remove to discu- DTE: Please dick Remove to discu- Carrier Name Click to collapse. *Claim Filing Indicator *Carrier Name *Subscriber Last Name Subscriber Address City Zip Code 0 | hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code | ch service line. Enter adjusted pay prior to submitting claim. Group # Carrier Code [*First Name] | ment details, such as reason Everything w must b COB Pyer Paid | rith a red aster e completed. Refresh Other Remittance Date | isk * |
| Ott Eni De NO | Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advice tails section. DTE: Please dick Remove to disci Carrier Name Click to collapse. *Claim Filing Indicator *Carrier Name *Subscriber Last Name Subscriber Address City Zip Code 0 *Subscriber ID | hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code | ch service line. Enter adjusted pay prior to submitting claim. Group # Carrier Code [*First Name] | ment details, such as reason Everything w must b COB Pyer Paid | rith a red aster e completed. Refresh Other Remittance Date | isk * |
| Ott Eni De NO | Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advice tails section. DTE: Please click Remove to discu- Carrier Name Click to collapse. *Claim Filing Indicator *Carrier Name *Subscriber Last Name Subscriber Address City Zip Code @ *Subscriber ID *Group # | hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code | ch service line. Enter adjusted pay prior to submitting claim. Group # Carrier Code [*First Name] | ment details, such as reason Everything w must b COB Pyer Paid | rith a red aster e completed. Refresh Other Remittance Date | isk * |
| Ott Eni De NO | Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advice tails section. DTE: Please dick Remove to discu- Carrier Name Click to collapse. *Claim Filing Indicator *Carrier Name *Subscriber Last Name Subscriber Address City Zip Code @ *Subscriber ID *Group # Group Name | hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code | ch service line. Enter adjusted pay prior to submitting claim. Group # *Carrier Code [*First Name] State [Country] | ment details, such as reason Everything w must b COB Driver Paid mount | rith a red aster e completed. Refresh Other Remittance Date | isk * |
| Ott Eni De NO | Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advice tails section. TE: Please dick Remove to discu- Carrier Name Click to collapse. *Claim Filing Indicator *Carrier Name *Subscriber Last Name Subscriber Address City Zip Code 0 *Subscriber ID *Group # Group Name *Payer Responsibility | hormation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code BL-Blue Cross/Blue Shield DUID | ch service line. Enter adjusted pay prior to submitting claim. Group # Carrier Code [*First Name] | COB Diver Paid | rith a red aster e completed. Refresh Other Remittance Date | isk * |
| Ott Eni De NO | Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advice tails section. TE: Please dick Remove to discu- Carrier Name Click to collapse. *Claim Filing Indicator *Carrier Name *Subscriber Last Name Subscriber Address City Zip Code 0 *Subscriber ID *Group # Group Name *Payer Responsibility | hformation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code | ch service line. Enter adjusted pay prior to submitting claim. Group # *Carrier Code *First Name State Country | ment details, such as reason Everything w must b COB Driver Paid mount | rith a red aster e completed. Refresh Other Remittance Date | isk * |
| Ott Eni De NO | Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advice tails section. DTE: Please dick Remove to discu- Carrier Name Click to collapse. *Claim Filing Indicator *Carrier Name *Subscriber Last Name Subscriber Address City Zip Code 0 *Subscriber ID *Group # Group Name *Payer Responsibility *COB Payer Paid Amount Remaining Patient Liability | hormation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code BL-Blue Cross/Blue Shield BL-Blue Cross/Blue Shield | ch service line. Enter adjusted pay prior to submitting claim. Group # *Carrier Code *First Name State Country | COB Diver Paid | rith a red aster e completed. Refresh Other Remittance Date | isk * |
| Ott Eni De NO | Link to Carrier Coo her Insurance Details ter the carrier and policy holder in ter other carrier Remittance Advice tails section. TE: Please dick Remove to discu- Carrier Name Click to collapse. Click to collapse. *Claim Filing Indicator *Carrier Name *Subscriber Last Name Subscriber Address City Zip Code 0 *Subscriber ID *Group # Group Name *Payer Responsibility *COB Payer Paid Amount | hormation below. te details here for the claim or with ea ard any unrelated "Other Insurance", ; Carrier Code BL-Blue Cross/Blue Shield DUID | ch service line. Enter adjusted pay prior to submitting claim. Group # *Carrier Code *First Name State Country | COB Diver Paid | rith a red aster e completed. Refresh Other Remittance Date | isk * |



| 52 | MISSISSIPPI DIVISION OF |
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| - | MEDICAID |

| Steps | | | Description |
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| | • | Select the appropriate Pay | or Responsibility. If not known, select Unknown. |
| | | | |
| | | *Payer Responsibility | |
| | | *COB Payer Paid Amount | D Driver |
| | | Remaining Patient Liability | P-Primary S-Secondary |
| | | *Release of Information | T-Tiertiary U-Unknown |
| | | Assignment of Benefits | A-Payer Responsibility Four |
| | | _ | - C-Paver Responsibility Six - |
| | | Outpatient Adjudication Inform | D-Payer Responsibility Seven E-Payer Responsibility Eight |
| | | Reimbursement Rate | F-Payer Responsibility Nine G-Payer Responsibility Ten |
| | | Remark CoMS 1 | H-Payer Responsibility Eleven |
| | | Remark COPIS 1 | |
| | • | Everything with a Red aste | erisk * must be completed if the section is applicable to the claim. |
| | • | | entered select Add Insurance. |
| | | | |
| | Ou | tpatient Adjudication Information | |
| | | Reimbursement Rate | Claim HCPCS Payable |
| | | | Amount |
| | | Remark CoMS 1 Remark Code 2 | |
| | | Remark Code 3 | |
| | | Remark Code 4 | |
| | | Remark Code 5 | Non-payable Professional Component Amount |
| | C | laim ESRD Payment Amount | |
| | | Add Insurance Cancel Insura | ance |
| | | | |
| | • | | |
| | _ | | |
| | Scr | oll down to see all other i | nsurance details panels. |
| | | | |
| | | | |
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| Steps | | | | Description | | | | | | | |
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| Step 14 | i | nsurance just added | | added, select the nun | | | | | | | |
| | | NOTE : Users can only view the Other Insurance Reasons sub-panel if the Claim Filing Indicator is anything other than Medicare A, B, or 16. | | | | | | | | | |
| | *The | *The user MUST click on the other insurance hyperlink after adding insurance to add additional information. | | | | | | | | | |
| | Othe | r Insurance Details | | | | | - | | | | |
| | | the carrier and policy holder inforr | | | | | | | | | |
| | | Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section. | | | | | | | | | |
| | NOT | NOTE: Please click Remove to discard any unrelated "Other Insurance", prior to submitting claim. | | | | | | | | | |
| | | | | | | Refresh Othe | r Insurance | | | | |
| | # | Carrier Name | Carrier Code | Group # | COB Payer Paid Amount | Remittance Date | Action | | | | |
| | 1 | Claim Filing Indicator: 'Medicare F | | | | | <u>Remove</u> | | | | |
| | 2 + C | test lick to add a new other insurance. | test | test | \$0.00 | 11/30/2022 | Remove | | | | |
| 01 15 | | | | | | | | | | | |
| Step 15 | | | Insurance Reason urance Reasons sect | | | | | | | | |
| | | - | | completed if the section | n is applicable | e to the clair | n. | | | | |
| | | | to save the information | on to the reason. | | | | | | | |
| | | er Insurance Reasons can enter up to five unique group | codes. You can repeat six combinati | ions of reason code and adjustment an | ount with each group | code. | _ | | | | |
| | Click | the Remove link to remove the e | ntire row. | | | | | | | | |
| | # | Group Code | | Reason | Amount | Units of Service | Action | | | | |
| | | Click to collapse. | | | | | | | | | |
| | | *Group Code *Reason 9 | | ~ | | | | | | | |
| | | *Amount | 0.00 | Units of Service | | | | | | | |
| | | Add Reason Cance | el Reason | | | | | | | | |
| | | Once the Other Insu | rance Reasons are | added, select Save In | surance to m | ove to the r | next | | | | |
| | | er Insurance Reasons | | | | | | | | | |
| | | | odes. You can repeat six combinatio | ons of reason code and adjustment amo | ount with each group co | de. | | | | | |
| | Click | the Remove link to remove the e | ntire row. | | | | | | | | |
| | # | Group Code | | Reason | Amount | Units of Service | Action | | | | |
| | 1 | PR-Patient Responsibility | 36-Balance does not exceed | co-payment amount. | \$1. | 00 | Remove | | | | |
| | • | Click to add a new claim reason. | | | | | | | | | |
| | | Save Insurance | cel Insurance | | | | | | | | |
| | | | | | | | | | | | |





| Steps | | | | | | Descript | ion | | |
|---------|-------------------------------------|--|--------------------------------|--------------------|--------------------|---------------------|-----------------------------------|--------------------------|----------------------|
| Step 16 | was • | The Portal displays the "Submit Professional Claim": Step 3 page. The previous information that was entered in step 1 and step 2 is displayed at the top of the page on step 3. Scroll down to view the additional sections on this page. NOTE: Select the plus and minus for each section to expand and collapse the section. | | | | | | | |
| | Submit Professional Claim: Step 3 ? | | | | | | | | ? |
| | | | | | Claim Type C | rossover Profession | al | | |
| | Prov | ider Inform | ation | | | | | | |
| | | | illing Provider ID | | | ID Type NPI | Name | | |
| | | | Taxonomy | | | | | | |
| | Patio | ent and Clai | m Information | | | | | | |
| | | | Member ID Member | | | | Gender | | |
| | | | Birth Date | | | Total (| Charged Amount | | |
| | Med | icare Crosso | over Details | | | | | | |
| | | Allowed | Medicare Amount | \$0.00 | | | Co-insurance Amount \$0.00 | | |
| | | | eductible Amount | | | P | sychiatric Services Amount \$0.00 | | |
| | | Medicare | Payment Amount Copay Amount | | | | Medicare Payment Date | | |
| | | | | | | | | Evnan | d All Collapse All |
| | Diag | nosis Codes | ; | | | | | | |
| | Pleas | e note that t | he 1st diagnosis ent | ered is considered | I to be the princi | pal (primary) Diagn | osis Code. | | |
| | | # | |)iagnosis Type | | | Diagnosis Cod | | |
| | | 1 | | ICD-10-CM | | | R071-CHEST PAIN ON B | REATHING | |
| | Othe | er Insurance | e Details | | | | | | |
| | # | | Carrier Name | • | Carri | ier Code | Group # | COB Payer Paid Amount | Remittance Date |
| | 1 | | Indicator: 'Health N | 1aintenance Orga | | 1edicare Risk' | | | |
| | 2 | test | | | test | | test | \$0.00 | 12/09/2022 |
| | | | | | | | | | |



| Steps | | | | Description | | | | | |
|---------|---|---|--|---|---|-------|--------|--|--|
| Step 17 | Fill out the required information for the Service Details section. Complete the Medicare Crossover Details section. Complete the NDCs for Svc. # panel if applicable. Once all information has been completed, select Add. The data entered must match the submitted EOMB or the system could deny. Ex: EOMB shows the member has a copay of \$20. The Copay field must have \$20 entered. If \$ is entered in the Coinsurance field that will cause the claim to deny. Ex: EOMB shows Medicare Payment Date of 10/01/2024 but the date entered was 09/30/2024. Th will cause the claim to deny, | | | | | | | | |
| | Service Details | | w. Click the Remove link to remove th | he entire row. | | | | | |
| | Svc # From Date | To Date | Place of Service | Procedure Code | Charge Amount | Units | Action | | |
| | # 1 *From Date 0 1 *From Date 0 Charge Amount Clia Number Referring Provider ID Performing Provider ID Ordering Provider ID Medicare Crosson Allowed N De | 02/02/2025 99215-OFFICE \$100.00 \$100.0 | To Date 0 02/02/2025 O/P1 Modifiers 0 *Units 60.000 Authorization Number ID Type NPI ID Type NPI | Place of 10-Telehealth Provided in Service Unit Type *Unit Type Minutes EPSDT Taxonomy | Patient's Home *Diagnosis 1 Pointers t \$10.00 t \$0.00 | | | | |
| | Note: Repeat | this step | for each detail on the | claim. | | | | | |



| Step 18 • Click the hyperlink in the Svc # column to view the Other Insurance Details for each detail in the service section. Step 18 • Click the hyperlink in the Svc # column to view the Other Insurance Details for each detail in the service section. Step 18 • Click the hyperlink in the Svc # column to view the Other Insurance Details for each detail in the service section. Step 18 • Clock the hyperlink in the Svc # column to view the Other Insurance Details for each detail in the service section. Step 18 • Total to Date • Preceder Code Step 19 • Total total • Other Insurance Details for each detail in the Svc # column total | Steps | | | | Description | | | | | | | | |
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| Select the row number to edit the row. Click the Remove link to remove the entire row. Svc From Date To Date Place of Service Procedure Code Charge Amount Units Action 1 02/02/2023 02/02/2023 10-Telshealth Provided in Patient's 99213-OFFICE O/P EST HI 40 MIN \$100.00 60.000 Remove 2 | Step 18 | | | | mn to view the Other Insura | ance Details f | or each | detail in | | | | | |
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| 1 02/02/2025 02/02/2025 Home 99215-OFFICE 0/P EST HI 40 MIN \$100.00 Minutes Remove 2 | | From Date | To Date | Place of Service | Procedure Code | Charge Amount | Units | Action | | | | | |
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| Medicare Payment Amount \$0.00 Medicare Payment Date Copay Amount \$0.00 NDCs for Svc. # 2 | | | | | | | | | | | | | |
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| section. Note: If you added any insurance with a Claim Filing Indicator value other than 16, MA, or MB then the Other Insurance Details for Svc # section is displays imust be completed. If the Other Insurance Details for Svc # section is displayed then the Other Carrier dropdo will only display the insurance carrier options with Claim Filing Indicator values other than 16, N or MB. • Select Add Insurance to save the insurance information for that service. Everything with a Red asterisk * must be completed if the section is applicable to the claim. Section 10 Section 10 Sectio | Steps | Description | | | | | | | | | | |
|---|---------|---|--|--|--|--|--|--|--|--|--|--|
| Note: If you added any insurance with a Claim Filing Indicator value other than 16, MA, or MB then the Other Insurance Details for Svc # section displays imust be completed. If the Other Insurance Details for Svc # section is displayed then the Other Carrier dropdd will only display the insurance carrier options with Claim Filing Indicator values other than 16, M or MB. • Select Add Insurance to save the insurance information for that service. Everything with a Red asterisk * must be completed if the section is applicable to the claim. • Select Add Insurance to save the insurance information for that service. Everything with a Red asterisk * must be completed if the section is applicable to the claim. • Select Add Insurance Information for that service the transmit is a the insurance information for that service. • Sector is a set in the transmit is a set in the sector is applicable to the claim. • Sector is a set in the sector in the sector is applicable to the claim. • Sector is a set in the sector is applicable to the claim is a set in the sector is applicable to the claim. • Sector is a set in the sector in the sector is applicable to the claim. • Sector is a set in the sector is applicable to the claim is a set in the sector is a set in the sector is applicable to the sector is a set in the | Step 19 | | | | | | | | | | | |
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| Select the row number to edit the row. Click the Remove link to remove the entire row. Set From Date To Date Place of Service Procedure Code Charge Amount Unit Active 1 02/02/2025 02/02/2025 02/02/2025 10-Telehealth Provided In Patient's 99215-OFFICE 0/P EST H1 40 MIN \$100.00 60.000 Minutes 1 "From Date 0 02/02/2025 To Date 0 02/02/2025 *Place of 10-Telehealth Provided In Patient's Horn V V Pointers 1 "From Date 0 62/02/2025 *Place of 10-Telehealth Provided In Patient's Horn V V Pointers 1 "From Date 0 62/02/2025 *Place of 10-Telehealth Provided In Patient's Horn V V Pointers 1 "From Date 0 62/02/2025 *Unit Yape Minutes V V Pointers 1 "Date 0 *Unit Yape Minutes EPSDT Pointers Pointers 1 Date 0 *Unit Yape Minutes EPSDT Pointers Pointers 1 Date 0 Web/case Cassover Data 0 Date 0 Pointers Pointers Poin | | Everything with a Red asterisk * must be completed if the section is applicable to the claim. | | | | | | | | | | |
| Sec # From Date To Date Place of Service Procedure Code Charge Amount Units Action Action 1 02/02/2025 02/02/2025 10 ⁻ Telebeath Provided in Reserct's 59215-OFFICE O/P ESTHI 40 MIN \$100.00 6 | | | | | | | | | | | | |
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| Deductible Amount \$10.00 Psychiatric Services Amount \$30.00 Medicare Payment Amount \$50.00 Medicare Payment Date 0 04/01/2023 *** NDCs for Svc. # 1 Copay Amount \$50.00 Remaining Patient Bundled Action # Carrier Code Procedure Code Modifiers COB Payer Paid Remaining Patient Bundled Action * Other Carrier V Bundled into Line # 0 ************************************ | | Medicare Crossover Details | | | | | | | | | | |
| NDCs for Svc. # 1 Other Insurance Details for Svc. # 1 Click the row number to edit the row. Click the Remove link to remove the entire row. # Carrier Code Procedure Code Modifiers COB Payer Paid Remaining Patient Bundled Liability Liability Click to collapse. *Other Carrier *Other Carrier Bundled into Line # 0 *Procedure Code a *Procedure Code a Modifiers 0 *Procedure Code a COB Payer Paid Amount \$0.00 *Remittance Date a *Paid Units 0.00 *Paid Units 0.00 Remaining Patient Liability Liability Add Insurance | | Deductible Amount \$10.00 Psychiatric Services Amount Medicare Payment Amount \$50.00 Medicare Payment Date | | | | | | | | | | |
| Click the row number to edit the row. Click the Remove link to remove the entire row. # Carrier Code Procedure Code Modifiers COB Payer Paid Amount Remaining Patient Date Bundled Liability Action Click to collapse. Click to collapse. *Other Carrier *Other Carrier Modifiers @ Modifiers @ COB Payer Paid Amount \$0.00 *Remittance Date @ *Paid Units 0.00 *Paid Units 0.00 *Remittance Date @ *Paid Units 0.00 *Add Insurance Cancel Insurance Cancel Insurance Cancel Insurance Concel In | | | | | | | | | | | | |
| # Carrier Code Procedure Code Modifiers COB Payer Paid Amount Remittance Date Paid Units Remaining Patient Liability Bundled Line Action Click to collapse. *Other Carrier V Bundled into Line # 0 • • *Other Carrier V Bundled into Line # 0 • • • • Modifiers 0 • • • • • • • • COB Payer Paid Amount \$0.00 *Remittance Date 0 *Paid Units 0.00 • • • • Remaining Patient | | Other Insurance Details for Svc. # 1 | | | | | | | | | | |
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| | | Save Reset Cancel | | | | | | | | | | |



| Steps | Description | | | | | | | | |
|-------|--|--|--|--|--|--|--|--|--|
| | Select the Other Carrier from the drop-down list. | | | | | | | | |
| | Other Insurance Details for Svc. # 1 | | | | | | | | |
| | # Carrier Code Procedure Code Modifiers COB Payer Paid Amount Remittance Date Paid Units Remaining Patient Liability Bundled Line Action | | | | | | | | |
| | Click to collapse. | | | | | | | | |
| | *Other Carrier *Procedure Code Modifiers 1000111-First Choice Bundled into Line # 0 | | | | | | | | |
| | COB Payer Paid Amount S0.00 Remntance Date 9 *Paid Units 0.00 | | | | | | | | |
| | Add Insurance Cancel Insurance | | | | | | | | |
| | Add all information about the detail as applicable. Any Red asterisk * fields are required. | | | | | | | | |
| | Click the row number to edit the row. Click the Remove link to remove the entire row. | | | | | | | | |
| | # Carrier Code Procedure Code Modifiers COB Payer Paid Amount Remittance Date Paid Units Remaining Patient Liability Bundled Line Action | | | | | | | | |
| | Click to collapse. | | | | | | | | |
| | *Other Carrier 1000111-First Choice ✓ Bundled into Line # 0 *Procedure Code₀ 99215-OFFICE O/P EST HI 40 MIN Modifiers₀ | | | | | | | | |
| | COB Payer Paid Amount \$50.00 *Remittance Date • 04/01/2025 *Paid Units 60.00 Remaining Patient \$25.00 Liability | | | | | | | | |
| | Add Insurance Cancel Insurance | | | | | | | | |
| | Save Reset Cancel | | | | | | | | |
| | • Once the Add Insurance is clicked, it is added to the detail and will look like the panel below. | | | | | | | | |



| Steps | | | | | | Descr | iption | | | | |
|---------|---------------------------|---------------------------|-------------------------|-------------------|-----------------------|--------------------------|--------------------|------------------|--------------------------------|-------------------|---------------|
| | Ser | vice Details | | | | | | | | | - |
| | Sele | ct the row numb | er to edit the row | . Click the Remo | ve link to rer | move the entire ro | w. | | | | |
| | Svc # | From Date | To Date | Place | of Service | | Procedure | Code | Charge Amount | Units | Action |
| | 1 | 02/02/2025 | 02/02/2025 | 10-Telehealth P | rovided in Pa Iome | tient's 992 | 15-OFFICE O/P E | EST HI 40 MIN | \$100.00 | 60.000 Minutes | Remove |
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| | | Provider ID Performing | | | e NPT | Taxonomy | | | | | |
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| | Me | edicare Crossov | er Details | | | | | | | | |
| | | Allowed M | edicare Amoun | it \$75.00 | | | Co | -insurance Amou | unt \$10.00 | | |
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| | | Medicare P | ayment Amoun | | _ | | Medica | are Payment Dat | ee 04/01/2025 | | |
| | | | Copay Amoun | it \$5.00 | | | | | | | |
| | N | DCs for Svc. # 1 | L | | | | | | | | Đ |
| | | 1 | Details for Svc. | | | | | | | | |
| | | | | | ove link to re | emove the entire ro | Nol. | | | | |
| | | | | | | | | | | | |
| | # | Carrier Cod | e Procedur | e Code Mo | odifiers | COB Payer Paid Amount | Remittance Date | Paid Units | Remaining Patient Liability | Bundled Line | Action |
| | 1 | 1000111 | 99215-OFF EST HI 4 | | | \$50.00 | 04/01/2025 | 60.00 | \$25.00 | 0 | <u>Remove</u> |
| | Ŀ | Click to add a n | ew other insuran | ice. | | | | | | | |
| | | Save | Reset C | ancel | | | | | | | |
| | | | | | | | | | | | |
| Step 20 | Nex | t to add C |)ther Insu | rance Rea | asons c | lick the ro | w number | in front of | the Other Ins | urance | Details |
| 0100 20 | | Svc. #. | | | | | i namber | in none of | | | Details |
| | | | etails for Svc. # | # 1 | | | | | | | = |
| | | | | | ve link to rer | move the entire ro | w. | | | | _ |
| | # | Carrier Code | Procedure | Code Mo | difiers | COB Payer Paid Amount | Remittance Date | Paid Units | Remaining Patient Liability | Bundled Line | Action |
| | 1 | 1000111 | 99215-OFFI EST HI 40 | | | \$50 . 00 | 04/01/2025 | 60.00 | \$25.00 | 0 | Remove |
| | ± (| Click to add a ne | w other insuranc | e. | | | | | | | |
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| Description | | | | | | | | | | | | | |
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| • The panel will expand and show the Other Ins | urance Reasons a | rea. | | | | | | | | | | | |
| Other Insurance Details for Svc. # 1 | | | | | | | | | | | | | |
| Click the row number to edit the row. Click the Remove link to remove the entire row. | | | | | | | | | | | | | |
| Carrier Code Procedure Code Modifiers COB Payer Paid Amount Remittance Date Paid | d Units | ndled Action | | | | | | | | | | | |
| 1000111 99215-OFFICE O/P EST HI 40 MIN \$50.00 04/01/2025 | 60.00 \$25.00 | 0 <u>Remove</u> | | | | | | | | | | | |
| *Other Carrier 1000111-First Choice Bundled into Line # 0 *Procedure Codee 99215-OFFICE O/P EST HI 40 MIN | | | | | | | | | | | | | |
| Modifierse | | | | | | | | | | | | | |
| COB Payer Paid Amount \$50.00 *Remittance Date 0 04/01/2025 | *Paid Units 60.00 | | | | | | | | | | | | |
| Remaining Patient \$25.00 | | | | | | | | | | | | | |
| Liability Other Insurance Reasons | | | | | | | | | | | | | |
| You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustr | nent amount with each group code. | | | | | | | | | | | | |
| Click the Remove link to remove the entire row. | | | | | | | | | | | | | |
| # Group Code Reason | Amount Units Service | Action | | | | | | | | | | | |
| Click to collapse. | | | | | | | | | | | | | |
| *Group Code | | | | | | | | | | | | | |
| *Reason (*Amount \$0.00 Units of Service | | | | | | | | | | | | | |
| Add Reason Cancel Reason | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| Save Insurance Cancel Insurance | | | | | | | | | | | | | |
| Click to add a new other insurance. | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| • Select the Group Code from the dropdown lis | - Select the Crown Code from the drandown list. | | | | | | | | | | | | |
| Select the Group Code from the dropdown list: | | | | | | | | | | | | | |
| *Group Code CO-Contractual O | | | | | | | | | | | | | |
| *Group Code CO-Contractual C *Reason 0 | | | | | | | | | | | | | |
| *Group Code CO-Contractual C *Reason 0 *Amount CO-Contractual C | bligations | | | | | | | | | | | | |
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| | | he amount for | | | | if applica | ble. | | | |
| | Click Add Reason to add it to the service detail. | | | | | | | | | |
| 0 |)ther Insurance Re | asons | | | | | | | | |
| Y | You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code. Click the Remove link to remove the entire row. | | | | | | | | | |
| C | | | | | | | | | | |
| + | # Gro | oup Code | | Reaso | on | | Amount | Units of Service | Actio | |
| E | Click to collapse. Scroup Code CO-Contractual Obligations Reason 1-Deductible Amount | | | | | | | | | |
| | | | | | | | | | | |
| | | *Reason (1-De *Amount \$10. | | | Units of Servio | ce 🗌 | | | | |
| - | Add R | eason Cancel Rea | ason | | | | | | | |
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| | Save In | surance Cancel I | insurance | | | | | | | |
| ÷ | Click to add a new o | ther insurance. | | | | | | | | |
| | Other Insurance De | | | | | led. | | | | |
| C | Other Insurance De | | | remove the entire ro | w. Remittance | led. Paid Units | Remaining Patien | | Action | |
| 4 | Other Insurance De | tails for Svc. # 1 to edit the row. Click th Procedure Code 99215-OFFICE Q/P | e Remove link to | remove the entire ro | w. | | Remaining Patien Liability \$25.0 | Line | Action 0 Removi | |
| 4 | Other Insurance De Click the row number # Carrier Code 1 1000111 | tails for Svc. # 1 to edit the row. Click th Procedure Code 99215-OFFICE O/P EST HI 40 MIN | e Remove link to Modifiers | COB Payer Paid | w. Remittance Date | Paid Units 60.00 | Liability \$25.0 | Line | | |
| 4 | Other Insurance De Click the row number # Carrier Code 1 1000111 | tails for Svc. # 1 to edit the row. Click th Procedure Code 99215-OFFICE O/P EST HI 40 MIN rrier 1000111-First (| e Remove link to Modifiers | COB Payer Paid Amount \$50.00 | w. Remittance Date 04/01/2025 | Paid Units 60.00 | Liability | Line | | |
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| S | Description | | | | | | | | | | | | |
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| | • 0 | nce all cha | anges ha | ive be | en mad | e to the | e service | detail | click Sa | Ve | | | |
| | | Once all changes have been made to the service detail, click Save . | | | | | | | | | | | |
| | | Select the row number to edit the row. Click the Remove link to remove the entire row. | | | | | | | | | | | |
| | | Svc # From Dat | te To Date Place of Service Procedure Code Charge Amount Units Action | | | | | | | | Action | | |
| | | <u>1</u> 02/02/202 | 02/02/2025 02/02/2025 10-Telehealth Provided in Patient's 99215-OFFICE O/P EST HI 40 MIN \$100.00 Minutes | | | | | | | | | Remove | |
| | | 1 *From Date 0 | From Date 02/02/2025 I To Date 02/02/2025 I To Date 02/02/2025 I Service EMG Service | | | | | | | | | | |
| | | Procedure [99215-OFFICE O/P] Modifiers@ Code @ Pointers | | | | | | | | | | | |
| | | Charge Amount Clia Number | | | *Units 60.000 Authorization N | | hit Type Minute | EPSC | т 🗌 | | | | |
| | | Referring Provider ID | | 9 п | D Type NPI | Taxon | iomy " | | | | | | |
| | | Performing Provider ID | | | D Type NPI | | iomy " | | | | | | |
| | | Ordering Provider ID | | <u>с</u> п | D Type NPI | Taxon | iomy " | | | | | | |
| | | Medicare Cross | over Details Medicare Amou | nt \$75.00 | | | | Co-insurance | Amount \$10.0 | 0 | | | |
| | | | Deductible Amou e Payment Amou | | | | | | Amount \$0.00 | | 1 | | |
| | | | Copay Amou | | | | | | | | | | |
| | | NDCs for Svc. | #1 | | | | | | | | | • | |
| | | | ce Details for Svo mber to edit the ro | | Remove link to | remove the ent | tire row. | | | | | | |
| | | # Carrier C | ode Procedu | re Code | Modifiers | COB Payer F | | e Paid Unit | Remaining | | Bundled | Action | |
| | | 1 10001: | 99215-OF | | | Amount | 0.00 04/01/202 | 5 60 | .00 | \$25.00 | Line | Remove | |
| | | - | a new other insura | | | | | | | | _ | | |
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| | | Sa | Reset | Cancel | | | | | | | | | |
| | • Tr | ne service | dotail wi | ll dien | lav | | | | | | | | |
| | | s | ervice Details | | | | | | | | • | | |
| | | s | | To Date | Place of Ser | | Procedure | Code | Charge Amount | Units | Action | | |
| | | - | ¢ | | 0-Telehealth Provide Home | | 99215-OFFICE O/P | | \$100.00 | 60.00 | Remove | | |
| | | | 2 | | _ | | | | | | | | |
| | | 2 | *From Date e | | To Date e | | *Place of Service | | *Diagnosis | | | | |
| | | | Code e | | *Units | | Init Type Unit N | EPSDT | Pointers | | | | |
| | | | Clia Number Referring Provider ID | e | ID Type NP | ion Number | nomy " | | | | | | |
| | | Performing ID Type NPI Taxonomy Provider ID | | | | | | | | | | | |
| | | Ordering ID Type NPI Taxonomy Provider ID Medicare Crossover Details | | | | | | | | | | | |
| | | - | Allowed Medi | care Amount tible Amount | | | | -insurance Amour | | | | | |
| | | | Medicare Payr | nent Amount opay Amount | | | Medic | are Payment Date | θ Ξ | | | | |
| | | | NDCs for Svc. # 2 | | | | | | | | ۰ | | |
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| Steps | | Descripti | on | | | | | | | |
|---------|---|--|------------------------|---------------------|--------|--|--|--|--|--|
| Step 21 | Select the plus sign in the Attachments section to attach a copy of the EOMB. Note: Crossover Claims require the Explanation of Medicare Benefits (EOMB) to be attached. If Other insurance information was added, then the Explanation of Benefits (EOB) for that carrier must be attached as well. Attachments must be in PDF format. | | | | | | | | | |
| | Attachments Click the Remove link to remove the entire row | v. | | | | | | | | |
| | # Transmission Method | File | Control # | Attachment Type | Action | | | | | |
| | Click to add attachment. | | | | | | | | | |
| | Back to Step 1 Back to Step | p 2 | | Submit Cancel | | | | | | |
| | | | | | | | | | | |
| Step 22 | Complete the additional in Everything with a red asteristic everything e | required fields for this sect | | cable to the claim. | | | | | | |
| | Attachments | | 11 | | | | | | | |
| | Click the Remove link to remove the entire rov | v. | | | | | | | | |
| | # Transmission Method Click to collapse. | File | Control # | Attachment Type | Action | | | | | |
| | *Transmission Method FT-File | Transfer | | ✓ | | | | | | |
| | Add | | | | | | | | | |
| | Back to Step 1 Back to Step | 92 | | Submit Cancel | | | | | | |
| | • Select Add to save the a | ttachment to the claim. | | | | | | | | |
| Step 23 | The attachments display in the Review the information | ne Attachments section. on entered for Step 3 and | select Submit . | | | | | | | |



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| | Attack | hments | | | | | | | | |
| | | he Remove link to remove the entire r | ow. | | | | | | | |
| | | | | | | | | | | |
| | # | Transmission Method | File | Control # | Attachment Type | Acti | | | | |
| | 1 FT-File Transfer | | Medicare EOMB.pdf (36K) | 20221202122716197843 | Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor) | Remo | | | | |
| | 2 | FT-File Transfer | Other Carrier EOMB.pdf | 123 | Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor) | Remove | | | | |
| | + Cli | ick to add attachment. | | | | | | | | |
| | | Back to Step 1 Back to St | ep 2 | | Submit Cancel | | | | | |
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| 24 | The P | ortal displays the Con | firm Professional Claim | page. | | | | | | |
| | • | | mation entered for this clai | | is and minus to expan | id and | | | | |
| | • | | on. Expand All and Collap | | | | | | | |
| | NOTE | : At the bottom of the | page, select Back to Step | o 1. 2. or 3 to ao l | back and edit the infor | matic | | | | |
| | | ed for this claim. | p-g-, | , <u>,</u> , ., | | | | | | |
| | 0 | Confirm Professional Claim | | | | | | | | |
| | | | you want to assure you view the claim as you e | ntered it After confirmation Pri | nt Preview may reflect changes as the cl | _ | | | | |
| | | een saved on the payer system. | you mane to assure you then the claim as you e | | ne rreview may relieve endinges as are a | | | | | |
| | | | Claim Type Crossover Profession | ıal | | | | | | |
| | P | rovider Information | | | | | | | | |
| | | Billing Provider ID | ID Type NPI | Name | | | | | | |
| | | Tovenomy | | | | | | | | |
| | | Taxonomy Performing Provider ID | ID Туре | Name | Name _ | | | | | |
| | | Taxonomy _ | | | | | | | | |
| | | Referring Provider ID | ID Type | Name | m | | | | | |
| | | Taxonomy _ | | | | | | | | |
| | | | | | | | | | | |
| | | Supervising Provider ID | ID Туре 🔔 | Name | - | | | | | |
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| | м | Supervising Provider ID | ID Type _ | Name | - | | | | | |
| | м | Supervising Provider ID _ Taxonomy _ | ID Type _ | Name Gender | - | | | | | |
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| | | Supervising Provider ID _ Taxonomy _ tember Information | ID Type _ | Gender | - | | | | | |
| | | Supervising Provider ID _ Taxonomy _ tember Information | ID Type _ | Gender Zip Code | - | | | | | |
| | | Supervising Provider ID Taxonomy = Taxonomy | | Gender Zip Code Date of Current _ | - | | | | | |
| | | Supervising Provider ID Taxonomy = Intember Information Itember In | | Gender Zip Code Date of Current Admission Date _ | - | | | | | |
| | | Supervising Provider DD Taxonomy = Intember Information Interpreter Birth Date Birth Date Birth Date State Address Line 2 City State Interpreter State Inter | Δι | Gender Zip Code Date of Current Admission Date _ | - | | | | | |
| | | Supervising Provider 1D Taxonomy = Internet Information Internet Birth Date Birth Date Birth Date I Address Line 2 City State Internet Information Internet Internet III Address Line 2 City State Internet IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII | | Gender Zip Code Date of Current Admission Date _ | - | | | | | |



| Steps | | | | | | | Descript | ion | | | | | |
|---------|---|--|---|----------------------|----------------|-------------------|----------------------------|-------------------------------------|-----------|--------------|---------------|------------------------|-----------------------------|
| | | Are benefits assigned to the provider by the patient or their authorized No representative? Does the provider have a signed statement from the patient releasing No their medical information? Total Charged Amount \$0.00 | | | | | | | | | | | |
| | Medicare Crossover Details Allowed Medicare Amount \$0.00 Co-insurance Amount \$0.00 Deductible Amount \$0.00 Psychiatric Services Amount \$0.00 Medicare Payment Amount \$0.00 Medicare Payment Date | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| | | Diagn | iosis Codes | | | | | | | | | Expan | d All <u>Collapse All</u> |
| | | | | agnosis entered is | considered | d to be the prin | cipal (primary) Diagn | osis Code. | | | | | |
| | I | | # | Diagnos | sis Type | | | | Dia | agnosis Cod | e | | |
| | I | | 1 | ICD-1 | 0-CM | | | | R071-CHES | T PAIN ON BR | REATHI | NG | |
| | | Other | r Insurance Details | | | | | | | | | | • |
| | | # | Ca | rrier Name | | Car | rrier Code | | Group # | | | B Payer Paid Amount | Remittance Date |
| | | 1 | Claim Filing Indicate | or: 'Health Mainten: | ance Orgai | nization (HMO) | Medicare Risk' | | | | | | |
| | | 2 | test | | | test | | test | | | | \$0.00 | 12/09/2022 |
| | | Servio | ce Details | | | | | | | | | | - |
| | | # | From Date | To Date | Place Servi | EMG | Procedure Code | Mod Diag Code Units EPSDT Charge Am | | | Charge Amount | | |
| | | 1 | 12/07/2022 | 12/08/2022 | 02 | | 01232 | | 1 | 1.000 U | nit | | \$0.00 |
| | | Attac | hments | | | | | | | | | | + |
| | | | Back to Ste | p 1 Back to St | ep 2 E | Back to Step 3 | 3 Print Preview | l | | | Con | nfirm Can | cel |
| | Once reviewing the claims information entered has been completed, select Confirm to confirm the claim submission. | | | | | | | | | | | | <mark>firm</mark> to |
| Step 25 | NC EC | DTE : DMB. | The confirr | mation pag | je disp | plays. A | Professional LL Crossov | | | | | | to verify the |
| | | | Crossover Profess ver Professional Cl | | firmation | | | | | | | | 2 |
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Change History

The following change history log contains a record of changes made to this document:

| Version # | Published/ Revised | Author | Section/Nature of Change |
|-----------|-----------------------|----------|---|
| 1.0 | 12/14/2022 | Gainwell | Initial publication |
| 1.1 | 06/02/2023 | Gainwell | Updated providers display to show CCO information based on CR1925. |
| 1.2 | 12/06/2023 | Gainwell | Updated portal access to inactive providers date of termination based on CR 2278. |
| 1.3 | 4/19/2024 | Gainwell | Updated an image and some verbiage in steps 6, 14, 15 and 16. |
| 1.4 | 07/22/2024 | Gainwell | Updated per CR2113 |
| 1.5 | 8/13/2024 | Gainwell | Updated the Other Insurance information for clearer instructions. |
| 1.6 | 11/13/2024 | Gainwell | Added tips to introduction |
| 1.7 | 06/05/2025 | Gainwell | Updated steps per Claims Resolution feedback |