



Job Aid

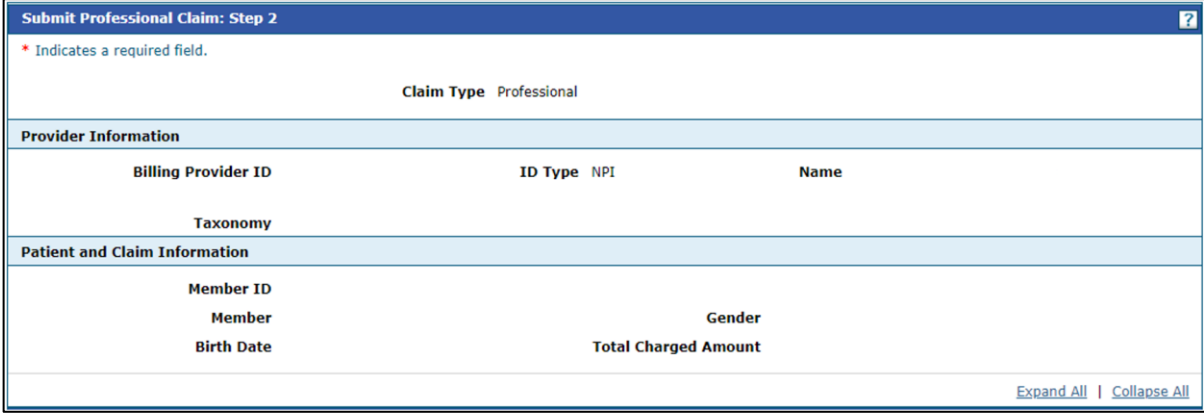
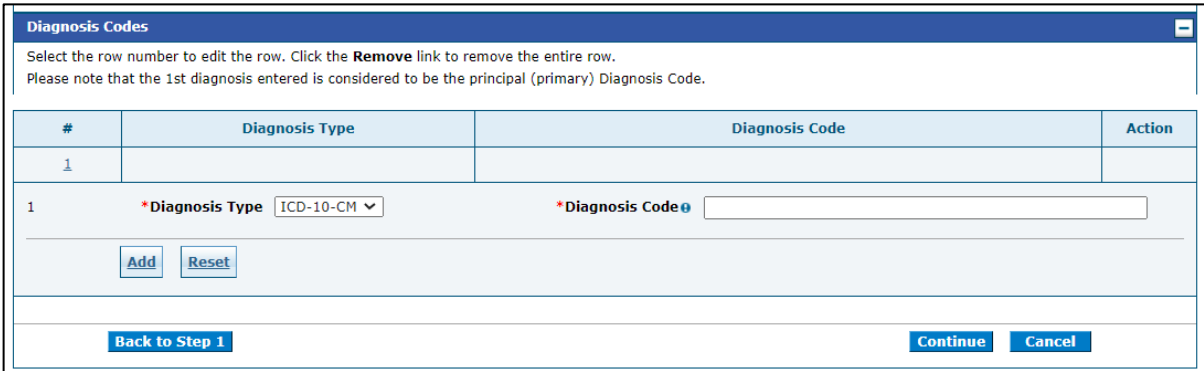
Professional Claim Submission

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

Review the Steps to Submit a Professional Claim

Steps	Description
Step 1	<p>Login to the Portal. The Portal Home screen Displays.</p> 
Step 2	<p>The following steps will review how to submit a Professional Claim in MESA: Hover over the Claims tab on the menu bar. A list of claim types displays below.</p> <ul style="list-style-type: none"> Select Submit Claim Prof. 
Step 3	<p>The Portal displays the “Submit Professional Claim: Step 1” page.</p> <ul style="list-style-type: none"> Select Claim Type Professional.

Steps	Description																																
	<p>Submit Professional Claim: Step 1 ?</p> <p>* Indicates a required field.</p> <div style="border: 1px solid orange; padding: 5px; display: inline-block;"> Claim Type Professional ▼ </div>																																
Step 4	<ul style="list-style-type: none"> Complete the Provider Information section. <p>NOTE: There will be information already generated in this section. Complete additional fields if applicable to the claim being submitted.</p> <div style="border: 1px solid black; padding: 5px;"> <p>Provider Information</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">Billing Provider ID</th> <th style="width: 20%;">ID Type</th> <th style="width: 20%;">NPI</th> <th style="width: 20%;">Name</th> </tr> </thead> <tbody> <tr> <td>Taxonomy _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Performing Provider ID <input type="text"/> </td> <td>ID Type</td> <td>NPI</td> <td>Name _____</td> </tr> <tr> <td>Taxonomy _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Referring Provider ID <input type="text"/> </td> <td>ID Type</td> <td>NPI</td> <td>Name _____</td> </tr> <tr> <td>Taxonomy _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Supervising Provider ID <input type="text"/> </td> <td>ID Type</td> <td>NPI</td> <td>Name _____</td> </tr> <tr> <td>Taxonomy _____</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> </div>	Billing Provider ID	ID Type	NPI	Name	Taxonomy _____				Performing Provider ID <input type="text"/>	ID Type	NPI	Name _____	Taxonomy _____				Referring Provider ID <input type="text"/>	ID Type	NPI	Name _____	Taxonomy _____				Supervising Provider ID <input type="text"/>	ID Type	NPI	Name _____	Taxonomy _____			
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Step 5	<ul style="list-style-type: none"> Complete the Member Information section. <p>NOTE: Once the Member ID is entered, the system will generate the remaining fields in this section. Verify the fields populate correctly.</p> <div style="border: 1px solid black; padding: 5px;"> <p>Member Information</p> <div style="border: 2px solid orange; padding: 2px; display: inline-block;"> *Member ID <input type="text"/> </div> <table style="width: 100%; margin-top: 10px;"> <tr> <td style="width: 50%;">Last Name _____</td> <td style="width: 50%;">First Name _____</td> </tr> <tr> <td>Birth Date _____</td> <td></td> </tr> <tr> <td colspan="2">Address <input type="text"/></td> </tr> <tr> <td colspan="2">Address Line 2 <input type="text"/></td> </tr> <tr> <td colspan="2">City <input type="text"/></td> </tr> <tr> <td>State <input type="text" value="MS"/></td> <td>Zip Code <input type="text"/></td> </tr> </table> </div>	Last Name _____	First Name _____	Birth Date _____		Address <input type="text"/>		Address Line 2 <input type="text"/>		City <input type="text"/>		State <input type="text" value="MS"/>	Zip Code <input type="text"/>																				
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Step 6	<ul style="list-style-type: none"> Complete the Claim Information section. Once complete, review the information entered on this page and select Continue. <p>NOTE: Everything with a red asterisk * must be completed.</p> <div style="border: 1px solid black; padding: 5px;"> <p>Claim Information</p> <table style="width: 100%; margin-top: 10px;"> <tr> <td>Date Type <input type="text" value=""/></td> <td>Date of Current <input type="text"/> </td> </tr> <tr> <td>Accident Related <input type="text" value=""/></td> <td>Admission Date <input type="text"/> </td> </tr> <tr> <td>Patient Number <input type="text"/></td> <td>Authorization Number <input type="text"/></td> </tr> </table> <p>*Transport Certification <input type="radio"/> Yes <input type="radio"/> No</p> <p>*Does the provider have a signature on file? <input type="radio"/> Yes <input type="radio"/> No</p> <p>*Does the provider accept assignment for claim processing? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Clinical Lab Services Only</p> <p>*Are benefits assigned to the provider by the patient or their authorized representative? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A</p> <p>*Does the provider have a signed statement from the patient releasing their medical information? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Include Other Insurance <input type="checkbox"/></p> <p style="text-align: right;">Total Charged Amount \$0.00</p> <div style="text-align: right; margin-top: 10px;"> <div style="border: 2px solid orange; padding: 2px; display: inline-block; margin-right: 10px;">Continue</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">Cancel</div> </div> </div>	Date Type <input type="text" value=""/>	Date of Current <input type="text"/>	Accident Related <input type="text" value=""/>	Admission Date <input type="text"/>	Patient Number <input type="text"/>	Authorization Number <input type="text"/>																										
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Steps	Description
Step 7	<p>The Portal displays the “Submit Professional Claim: Step 2” page. The previous information that was entered in step 1 will display at the top of the page in step 2.</p> <ul style="list-style-type: none"> Review the previously submitted information and scroll down. 
Step 8	<ul style="list-style-type: none"> Enter the Diagnosis Code then select Add. Once complete, review the information entered on this page and select Continue. <p>NOTE: Everything with a red asterisk * must be completed if the section is applicable to the claim.</p> 
Step 9	<p>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.</p> <p>Scroll down to view the additional sections on this page.</p> <p>NOTE: Select the plus and minus for each section to expand and collapse.</p>

Steps	Description																					
	<div data-bbox="277 264 1468 804"> <p>Submit Professional Claim: Step 3 ?</p> <p>* Indicates a required field.</p> <p style="text-align: center;">Claim Type Professional</p> <hr/> <p>Provider Information</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 33%;">Billing Provider ID</td> <td style="width: 33%;">ID Type NPI</td> <td style="width: 33%;">Name</td> </tr> <tr> <td colspan="3" style="text-align: center;">Taxonomy</td> </tr> </table> <hr/> <p>Patient and Claim Information</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 33%;">Member ID</td> <td style="width: 33%;">Gender</td> <td style="width: 33%;"></td> </tr> <tr> <td>Member</td> <td></td> <td></td> </tr> <tr> <td>Birth Date</td> <td>Total Charged Amount</td> <td></td> </tr> </table> <p style="text-align: right;">Expand All Collapse All</p> <hr/> <p>Diagnosis Codes -</p> <p>Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.</p> <table border="1" style="width: 100%;"> <thead> <tr> <th>#</th> <th>Diagnosis Type</th> <th>Diagnosis Code</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>ICD-10-CM</td> <td>R071-CHEST PAIN ON BREATHING</td> </tr> </tbody> </table> </div>	Billing Provider ID	ID Type NPI	Name	Taxonomy			Member ID	Gender		Member			Birth Date	Total Charged Amount		#	Diagnosis Type	Diagnosis Code	1	ICD-10-CM	R071-CHEST PAIN ON BREATHING
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<p>Step 10</p>	<ul style="list-style-type: none"> • Fill out the required information for the Service Details section. <ul style="list-style-type: none"> ○ Complete the NDCs for Svc. #1 panel if applicable. • Once all information has been completed, select Add. <div data-bbox="277 947 1468 1749"> <p>Service Details -</p> <p>Select the row number to edit the row. Click the Remove link to remove the entire row.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Svc #</th> <th>From Date</th> <th>To Date</th> <th>Place of Service</th> <th>Procedure Code</th> <th>Charge Amount</th> <th>Units</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <div style="border: 1px solid #ccc; padding: 5px; margin-top: 5px;"> <p>1 *From Date <input type="text"/> To Date <input type="text"/> *Place of Service <input type="text"/> EMG <input type="text"/></p> <p>*Procedure Code <input type="text"/> Modifiers <input type="text"/> <input type="text"/> <input type="text"/> *Diagnosis Pointers <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Charge Amount <input type="text"/> *Units <input type="text"/> *Unit Type <input type="text"/> EPSDT <input type="checkbox"/></p> <p>Clia Number <input type="text"/> Authorization Number <input type="text"/></p> <p>Referring Provider ID <input type="text"/> ID Type NPI Taxonomy <input type="text"/></p> <p>Performing Provider ID <input type="text"/> ID Type NPI Taxonomy <input type="text"/></p> </div> <hr/> <p>NDCs for Svc. # 1 -</p> <p>If applicable, only one NDC/UPN is allowed per service detail line. When adding an NDC/UPN, the Code Type, Quantity and Unit of Measure fields are required. Additionally, NDC/UPN information is required when adding or saving NDC/UPN with prescription information (Prescription Number, Prescription Type, Prescription Date).</p> <div style="border: 1px solid #ccc; padding: 5px; margin-top: 5px;"> <p>Code Type <input type="text"/></p> <p>NDC/UPN <input type="text"/></p> <p>Quantity <input type="text"/> Unit of Measure <input type="text"/></p> <p>Prescription Number <input type="text"/> Prescription Type <input type="text"/></p> <p>Prescription Date <input type="text"/></p> </div> <p style="text-align: center; margin-top: 10px;"> <input style="border: 2px solid orange;" type="button" value="Add"/> <input type="button" value="Reset"/> </p> </div>	Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action	1												
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<p>Step 11</p>	<ul style="list-style-type: none"> • Select the plus sign in the Attachments section to submit an attachment with the claim. 																					

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	<div data-bbox="272 260 1471 478"> <p>Attachments</p> <p>Click the Remove link to remove the entire row.</p> <table border="1"> <thead> <tr> <th>#</th> <th>Transmission Method</th> <th>File</th> <th>Control #</th> <th>Attachment Type</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="6">Click to add attachment.</td> </tr> </tbody> </table> <p> <input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/> <input type="button" value="Submit"/> <input type="button" value="Cancel"/> </p> </div>	#	Transmission Method	File	Control #	Attachment Type	Action	Click to add attachment.																																															
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<p>Step 12</p>	<ul style="list-style-type: none"> Select FT-File Transfer or NotSpecified-Not Specified from the Transmission Method dropdown. This selection affects the fields that display. Complete the additional required fields for this section and select Add. <p>NOTE: Everything with a red asterisk * must be completed if the section is applicable to the claim.</p> <div data-bbox="272 655 1471 1083"> <p>Attachments</p> <p>Click the Remove link to remove the entire row.</p> <table border="1"> <thead> <tr> <th>#</th> <th>Transmission Method</th> <th>File</th> <th>Control #</th> <th>Attachment Type</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="6">Click to collapse.</td> </tr> <tr> <td colspan="6"> <p>*Transmission Method FT-File Transfer</p> <p>*Upload File Choose File No file chosen</p> <p>*Attachment Type</p> <p>Description</p> <p> <input type="button" value="Add"/> <input type="button" value="Cancel"/> </p> </td> </tr> <tr> <td colspan="6"> <p> <input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/> <input type="button" value="Submit"/> <input type="button" value="Cancel"/> </p> </td> </tr> </tbody> </table> <p>If NotSpecified-Not Specified was selected for the Transmission Method, an Attachment Control Number (ACN) must be added in the Control # field.</p> <p>NOTE: A unique Attachment Control Number (ACN) must be created for each claim if NotSpecified-Not Specified is selected as the Transmission Method. In addition, a Claim Attachment Form must accompany each Explanation of Medicaid Benefits (EOMB) and must identify the Provider's NPI and ACN as it was entered in the Attachments section. The Claim Attachment Form is located at: Forms - Mississippi Division of Medicaid.</p> <div data-bbox="272 1329 1471 1793"> <p>Attachments</p> <p>Click the Remove link to remove the entire row.</p> <table border="1"> <thead> <tr> <th>#</th> <th>Transmission Method</th> <th>File</th> <th>Control #</th> <th>Attachment Type</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>FT-File Transfer</td> <td>Attachment.pdf (1925K)</td> <td>20221221142941170516</td> <td>Admission Summary</td> <td>Remove</td> </tr> <tr> <td colspan="6">Click to collapse.</td> </tr> <tr> <td colspan="6"> <p>*Transmission Method NotSpecified-Not Specified</p> <p>*Control #</p> <p>*Attachment Type</p> <p>Description</p> <p> <input type="button" value="Add"/> <input type="button" value="Cancel"/> </p> </td> </tr> <tr> <td colspan="6"> <p> <input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/> <input type="button" value="Submit"/> <input type="button" value="Cancel"/> </p> </td> </tr> </tbody> </table> </div> </div>	#	Transmission Method	File	Control #	Attachment Type	Action	Click to collapse.						<p>*Transmission Method FT-File Transfer</p> <p>*Upload File Choose File No file chosen</p> <p>*Attachment Type</p> <p>Description</p> <p> <input type="button" value="Add"/> <input type="button" value="Cancel"/> </p>						<p> <input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/> <input type="button" value="Submit"/> <input type="button" value="Cancel"/> </p>						#	Transmission Method	File	Control #	Attachment Type	Action	1	FT-File Transfer	Attachment.pdf (1925K)	20221221142941170516	Admission Summary	Remove	Click to collapse.						<p>*Transmission Method NotSpecified-Not Specified</p> <p>*Control #</p> <p>*Attachment Type</p> <p>Description</p> <p> <input type="button" value="Add"/> <input type="button" value="Cancel"/> </p>						<p> <input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/> <input type="button" value="Submit"/> <input type="button" value="Cancel"/> </p>					
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Step 14	<p>The Portal displays the Confirm Professional Claim page.</p> <p>Review all the information entered for this claim. Select the plus and minus to expand and collapse each section. Expand All and Collapse All to expand and collapse all the sections at once.</p> <p>At the bottom of the page, select Back to Step 1, 2, or 3 to go back and edit the information entered for this claim.</p> <ul style="list-style-type: none"> Once reviewing the claims information entered has been completed, select Confirm to confirm the claim submission. <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Confirm Professional Claim ?</p> <p>Select Print Preview before you Confirm if you want to assure you view the claim as you entered it. After confirmation, Print Preview may reflect changes as the claim has been saved on the payer system.</p> <p style="text-align: center;">Claim Type Crossover Professional</p> <hr/> <p>Provider Information</p> <table style="width: 100%;"> <tr> <td style="width: 33%;">Billing Provider ID</td> <td style="width: 33%;">ID Type NPI</td> <td style="width: 33%;">Name</td> </tr> <tr> <td>Taxonomy</td> <td></td> <td></td> </tr> <tr> <td>Performing Provider ID</td> <td>ID Type</td> <td>Name</td> </tr> <tr> <td>Taxonomy</td> <td></td> <td></td> </tr> <tr> <td>Referring Provider ID</td> <td>ID Type</td> <td>Name</td> </tr> <tr> <td>Taxonomy</td> <td></td> <td></td> </tr> <tr> <td>Supervising Provider ID</td> <td>ID Type</td> <td>Name</td> </tr> <tr> <td>Taxonomy</td> <td></td> <td></td> </tr> </table> <hr/> <p>Member Information</p> <table style="width: 100%;"> <tr> <td style="width: 60%;">Member ID</td> <td style="width: 40%;">Gender</td> </tr> <tr> <td>Member</td> <td></td> </tr> <tr> <td>Birth Date</td> <td></td> </tr> <tr> <td>Address</td> <td></td> </tr> <tr> <td>Address Line 2</td> <td></td> </tr> <tr> <td>City</td> <td></td> </tr> <tr> <td>State</td> <td>Zip Code</td> </tr> </table> <hr/> <p>Claim Information</p> <table style="width: 100%;"> <tr> <td style="width: 50%;">Date Type</td> <td style="width: 50%;">Date of Current</td> </tr> <tr> <td>Accident Related</td> <td>Admission Date</td> </tr> <tr> <td>Patient Number</td> <td>Authorization Number</td> </tr> <tr> <td>Transport Certification No</td> <td></td> </tr> </table> <p style="text-align: center;">Does the provider have a signature on file? No</p> <p style="text-align: center;">Does the provider accept assignment for claim processing? No</p> </div>	Billing Provider ID	ID Type NPI	Name	Taxonomy			Performing Provider ID	ID Type	Name	Taxonomy			Referring Provider ID	ID Type	Name	Taxonomy			Supervising Provider ID	ID Type	Name	Taxonomy			Member ID	Gender	Member		Birth Date		Address		Address Line 2		City		State	Zip Code	Date Type	Date of Current	Accident Related	Admission Date	Patient Number	Authorization Number	Transport Certification No	
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	<p>Are benefits assigned to the provider by the patient or their authorized representative? No</p> <p>Does the provider have a signed statement from the patient releasing their medical information? No</p> <p style="text-align: right;">Total Charged Amount \$0.00</p> <hr/> <p>Medicare Crossover Details</p> <table border="0"> <tr> <td>Allowed Medicare Amount \$0.00</td> <td>Co-insurance Amount \$0.00</td> </tr> <tr> <td>Deductible Amount \$0.00</td> <td>Psychiatric Services Amount \$0.00</td> </tr> <tr> <td>Medicare Payment Amount \$0.00</td> <td>Medicare Payment Date -</td> </tr> <tr> <td>Copay Amount \$0.00</td> <td></td> </tr> </table> <p style="text-align: right;">Expand All Collapse All</p> <p>Diagnosis Codes</p> <p>Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.</p> <table border="1"> <thead> <tr> <th>#</th> <th>Diagnosis Type</th> <th>Diagnosis Code</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>ICD-10-CM</td> <td>R071-CHEST PAIN ON BREATHING</td> </tr> </tbody> </table> <p>Other Insurance Details</p> <table border="1"> <thead> <tr> <th>#</th> <th>Carrier Name</th> <th>Carrier Code</th> <th>Group #</th> <th>COB Payer Paid Amount</th> <th>Remittance Date</th> </tr> </thead> <tbody> <tr> <td>1</td> <td colspan="5">Claim Filing Indicator: 'Health Maintenance Organization (HMO) Medicare Risk'</td> </tr> <tr> <td>2</td> <td>test</td> <td>test</td> <td>test</td> <td>\$0.00</td> <td>12/09/2022</td> </tr> </tbody> </table> <p>Service Details</p> <table border="1"> <thead> <tr> <th>#</th> <th>From Date</th> <th>To Date</th> <th>Place of Service</th> <th>EMG</th> <th>Procedure Code</th> <th>Mod</th> <th>Diag Code Ptrs</th> <th>Units</th> <th>EPSDT</th> <th>Charge Amount</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>12/07/2022</td> <td>12/08/2022</td> <td>02</td> <td></td> <td>01232</td> <td></td> <td>1</td> <td>1.000 Unit</td> <td><input type="checkbox"/></td> <td>\$0.00</td> </tr> </tbody> </table> <p>Attachments</p> <p style="text-align: center;"> Back to Step 1 Back to Step 2 Back to Step 3 Print Preview Confirm Cancel </p>	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 -	Copay Amount \$0.00		#	Diagnosis Type	Diagnosis Code	1	ICD-10-CM	R071-CHEST PAIN ON BREATHING	#	Carrier Name	Carrier Code	Group #	COB Payer Paid Amount	Remittance Date	1	Claim Filing Indicator: 'Health Maintenance Organization (HMO) Medicare Risk'					2	test	test	test	\$0.00	12/09/2022	#	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Charge Amount	1	12/07/2022	12/08/2022	02		01232		1	1.000 Unit	<input type="checkbox"/>	\$0.00
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Step 15	<p>The Portal returns the Submit Professional Claim: Confirmation page.</p> <p>NOTE: The confirmation page displays. ALL Crossover claims go to a PENDING status to verify the EOMB.</p> <p>NOTE: If the claim has an attachment with a not-specified transmission method then the Confirmation page has an Attachments Coversheet(s) button for the cover page.</p> <p>NOTE: It is required to mail the attachment after submitting the claim when a not-specified value is selected for the transmission method.</p> <div data-bbox="272 1444 1469 1829" style="border: 1px solid black; padding: 5px;"> <p>Submit Professional Claim: Confirmation</p> <p>Professional Claim Receipt</p> <p>Your Professional Claim was successfully submitted. The claim status is Finalized Payment.</p> <p>The Claim ID is 2322346000001.</p> <p>Click Attachment Coversheet(s) to view the claim attachments coversheet(s).</p> <p>Click Print Preview to view the claim details as they have been saved on the payer's system.</p> <p>Click Copy to copy member or claim data.</p> <p>Click New to submit a new claim.</p> <p>Click View to view the details of the submitted claim.</p> <p style="text-align: center;"> Attachment Coversheet(s) Print Preview Copy New View </p> </div>																																																						

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	12/30/2022	Gainwell	Initial publication
1.1	6/2/2023	Gainwell	Updated providers display to show CCO information based on CR1925.