

ProviderOne Provider System User Manual



Submitting a Dental Claim

Disclaimer:

A contract, known as the Core Provider Agreement, governs the relationship between the State of Washington and Medical Assistance providers. The Core Provider Agreement's terms and conditions incorporate federal laws, rules and regulations, state laws, rules and regulations, as well as program policies, numbered memoranda, and billing instructions, including the materials located in this presentation.

Providers must submit a claim in accordance with the rules, policies, numbered memoranda, and billing instructions in effect at the time they provided the service. Every effort has been made to ensure the accuracy of this material. However, in the unlikely event of an actual or apparent conflict between this material and a department rule, the department rule controls.

ProviderOne Provider System User Manual

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Submitting a Dental Claim

Using ProviderOne to Submit an On-line Dental Claim Using Direct Data Entry and Batch Upload

The following ProviderOne tasks and topics are covered in this section:

- The ProviderOne On-line Claims Submission Process
- Accessing and Navigating the Dental Claim Form
- Knowing When Data Entry is Required
- Accessing On-line Billing Instructions
- Completing the Basic Claim Info Section
- Saving the Claim and Retrieving a Saved Claim
- Submitting the Claim and Adding Backup Documentation
- Submitting an On-line Dental Batch Claim

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The ProviderOne On-line Claims Submission Process

The following section describes the process of submitting a Dental Claim using ProviderOne Direct Data Entry.

The high-level steps for submitting an on-line Dental Claim using ProviderOne are:

- Using the EXT Provider Claims Submission user profile, access the online claim form.
- Complete the Basic Claim Info section.
- Attach any supporting documentation.
- Submit the Claim.

Each of these steps are covered in detail in the following pages.

Upon successful submission of the claim ProviderOne assigns a Transaction Control Number (TCN) to each claim. The TCN uniquely identifies the claim and is helpful when searching for a claim, and tracking the claim payment.

Submitted Dental Claim Details:

TCN: [REDACTED]
Provider NPI: [REDACTED]
Client ID: [REDACTED]
Date of Service: 9/1/2009 0:0:0-9/1/2009 0:0:0
Total Claim Charge: 135

Please click "Add Attachment" button, to attach the documents.

Attachment List:

| Line No | File Name | Attachment Type | Transmission Code | Attachment Control | File Size | Delete | Uploaded On |
|--------------------|-----------|-----------------|-------------------|--------------------|-----------|--------|-------------|
| No Records Found ! | | | | | | | |

Figure 1 - Submitted Dental Claim Details

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Accessing and Navigating the Dental Claim Form

Accessing the Dental Claim Form



From the Provider Portal, select the On-line Claims Entry link and click the Submit Dental link.



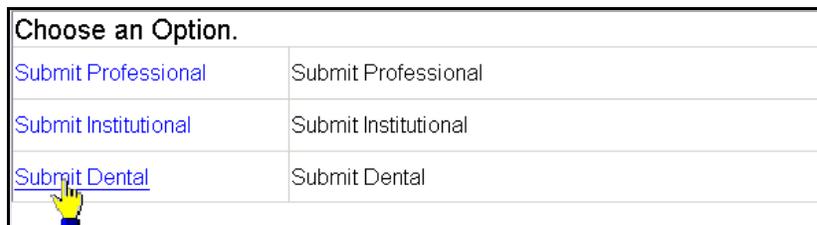
ProviderOne displays the Claim Submission page.



Figure 2 – Claim Submission Page



Select the Submit Dental hyperlink.



ProviderOne displays the Dental Claim form.

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The screenshot displays the 'Dental Claim' data entry form. At the top, a navigation bar shows the user is logged in as 'Brown, Betty' with the profile 'EXT Provider Claims Submitter'. The path is 'Provider Portal/ Claim Submission/ Submit Dental Claim'. Below the navigation bar are buttons for 'Close', 'Save Claim', 'Submit Claim', and 'Reset'. The form is titled 'Dental Claim:' and includes a note: 'Note: asterisks (*) denote required fields.' There are two tabs: 'Basic Claim Info' (selected) and 'Other Claim Info'. A 'Billing Instructions' link is also present. A breadcrumb trail shows 'Billing Provider | Subscriber | Claim | Service'. The 'Submitter ID' is 101195300. The 'PROVIDER INFORMATION' section includes a note to go to 'Other Claim Info' for other providers. The 'BILLING PROVIDER' section has fields for 'Provider NPI' and 'Taxonomy Code', both marked as required. A question asks 'Is the Billing Provider also the Rendering Provider?' with 'Yes' and 'No' radio buttons. The 'SUBSCRIBER/CLIENT INFORMATION' section has a 'Client ID' field and expandable sections for 'Additional Subscriber/Client Information' and 'OTHER INSURANCE INFORMATION'. The 'CLAIM INFORMATION' section has a note to go to 'Other Claim Info' for additional information and a 'CLAIM DATA' section with a 'Patient Account No.' field.

Figure 3 – Dental Claim Direct Data Entry Form

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Navigating the Dental Claim Form



Navigate to major sections within the form by clicking the links located in the form header, clicking the scroll bar, or clicking the Top hyperlinks located throughout the form.

Welcome Brown, Betty . You have logged-in with EXT Provider Claims Submitter profile. Links: --Select--

Path: Provider Portal/ Claim Submission/ Submit Dental Claim

Close Save Claim Submit Claim Reset

Dental Claim:

Note: asterisks (*) denote required fields. Billing Instructions

Basic Claim Info Other Claim Info

Billing Provider | Subscriber | Claim | Service

Submitter ID: 101195300

PROVIDER INFORMATION

Go to Other Claim Info to enter information for providers other than the Referring provider.

BILLING PROVIDER

* Provider NPI: * Taxonomy Code:

? * Is the Billing Provider also the Rendering Provider? Yes No

SUBSCRIBER/CLIENT INFORMATION [Top](#)

Note: For information about the Other Claim Info tab see the appendix.

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Knowing When Data Entry is Required

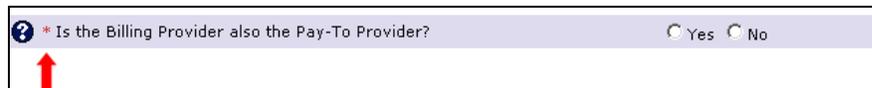
Required Fields

Required fields are marked with an asterisk and must be completed to submit the claim.



A screenshot of a form section titled "BILLING PROVIDER". It contains two input fields: "* Provider NPI:" and "* Taxonomy Code:". Both fields have a red arrow pointing to them from below, indicating they are required.

Questions marked with an asterisk must be answered to submit the claim.



A screenshot of a question: "* Is the Billing Provider also the Pay-To Provider?". The question is marked with an asterisk and a question mark icon. To the right of the question are two radio buttons labeled "Yes" and "No". A red arrow points to the question text from below.

Optional and Situational Data Entry Panels

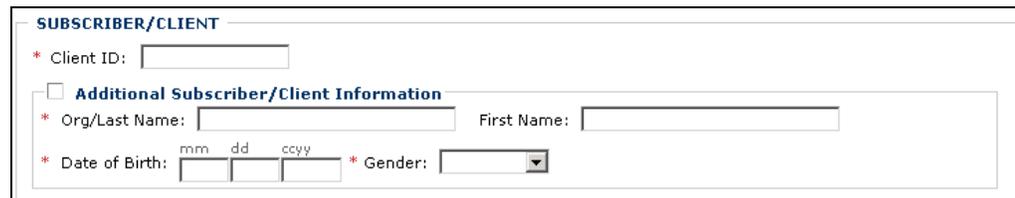
Additional data entry fields are located within expandable  data entry panels.



A screenshot of a form section titled "SUBSCRIBER/CLIENT". It contains one input field: "* Client ID:". Below this field is an expandable panel with a plus icon and the text "Additional Subscriber/Client Information". A red arrow points to the plus icon from below.

These data entry panels may or may not be necessary depending on the claim being submitted.

Clicking on expander buttons  reveal additional data entry options.



A screenshot of the expanded "SUBSCRIBER/CLIENT" section. It shows the "* Client ID:" field. Below it is the expanded "Additional Subscriber/Client Information" panel, which contains three fields: "* Org/Last Name:", "First Name:", and "* Date of Birth:" (with sub-fields for mm, dd, and ccyy). There is also a "* Gender:" dropdown menu. All fields in this panel are marked with an asterisk.

IMPORTANT: Fields located within expanded data entry panels and marked with an asterisk are required "only if the data entry panel is opened".

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Accessing Online Billing Instructions



From the Dental Claim form, click the Billing Instructions link.

The screenshot shows a web form titled "Dental Claim:". Below the title is a note: "Note: asterisks (*) denote required fields." To the right of this note is a red arrow pointing to the text "Billing Instructions". Below the note are two tabs: "Basic Claim Info" (which is selected) and "Other Claim Info". At the bottom of the form, there is a navigation bar with the following links: "Billing Provider", "Subscriber", "Claim", and "Service".



ProviderOne displays the external Billing Instructions web page.

About the Billing Instructions Page

- This page launches in a separate browser window.
- If necessary, keep this window open while completing the Claim Form.

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Completing the Basic Claim Info Section

The Basic Claim Info section of the Dental Claim Form consists of four sub-sections.

PROVIDER INFORMATION

- BILLING PROVIDER
- RENDERING (PERFORMING) PROVIDER

SUBSCRIBER/CLIENT INFORMATION

- SUBSCRIBER/CLIENT
- OTHER INSURANCE INFORMATION

CLAIM INFORMATION

- CLAIM DATA
- PRIOR AUTHORIZATION
- CLAIM NOTE
- Accident Related

BASIC LINE ITEM INFORMATION

- BASIC SERVICE LINE ITEMS
- Prior Authorization

Note: SUBSCRIBER/CLIENT refers to the patient receiving services.

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PROVIDER INFORMATION

PROVIDER INFORMATION
Go to [Other Claim Info](#) to enter information for providers other than the Referring provider.

BILLING PROVIDER

* Provider NPI: * Taxonomy Code:

? * Is the Billing Provider also the Rendering Provider? Yes No

Top

Figure 4 - Dental Claim - PROVIDER INFORMATION



Enter the Billing Provider NPI and the Billing Provider Taxonomy Code.

BILLING PROVIDER

* Provider NPI: * Taxonomy Code:



Answer No and complete this segment if the Rendering Provider is different from the Billing Provider. Otherwise, answer Yes.

? * Is the Billing Provider also the Rendering Provider? Yes No

RENDERING (PERFORMING) PROVIDER

* Provider NPI: * Taxonomy Code:

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SUBSCRIBER/CLIENT INFORMATION



Figure 5 - Dental Claim - SUBSCRIBER/CLIENT INFORMATION

Note: SUBSCRIBER/CLIENT refers to the patient receiving services.



Enter the Client ID.

Click the red expander symbol to open the Additional Subscriber/Client Information segment and enter the Org/Last Name, Date of Birth, and select the Gender.



NOTE: The Org/Last Name, Date of Birth, and Gender fields must be completed before submitting the claim.



If the patient is covered by insurance other than Medicaid open and complete the OTHER PAYER INSURANCE INFORMATION. Use the Add Another link to add information about multiple payers.



The following steps apply only if the patient has insurance coverage other than Medicaid.

OTHER PAYER INSURANCE INFORMATION

1 OTHER PAYER INSURANCE INFORMATION

Other Payer Information

* Payer/Insurance Organization Name:

+ Additional Other Payer Information

COB Monetary Amounts

COB Payer Paid Amount:

+ Additional COB Information

+ OTHER PAYER BILLING PROVIDER

+ OTHER PAYER ASSISTANT SURGEON

+ CLAIM LEVEL ADJUSTMENTS

+ Other Subscriber Information

+ Other Insurance Coverage



Complete the Other Payer Information segment.

Other Payer Information

* Payer/Insurance Organization Name:

+ Additional Other Payer Information



Enter the Payer/Insurance Organization Name.

Open and complete the Additional Other Payer Information segment. If necessary complete the Secondary ID Information segment.

Additional Other Payer Information

* ID: * ID Type:

Claim Check or Remittance Date:

Number Type: PA/Referral No.:

+ Secondary ID Information

Secondary ID Information

1 * ID Type: * ID Number:

2 ID Type: ID Number:



Complete the COB MONETARY AMOUNTS segment.

COB Monetary Amounts

COB Payer Paid Amount:

+ Additional COB Information



Open and complete the Additional COB Information segment.

Additional COB Information

COB Total Non-Covered Amount: \$ Remaining Patient Liability: \$



Complete the OTHER PAYER BILLNG PROVIDER segment.

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OTHER PAYER BILLING PROVIDER
Provider NPI:



Complete the **OTHER PAYER ASSISTANT SURGEON** section.

OTHER PAYER ASSISTANT SURGEON
Provider NPI:



Complete the **CLAIM LEVEL ADJUSTMENTS** segment.

CLAIM LEVEL ADJUSTMENTS

| | | | | | | | | |
|---|----------------|----------------------|-----------------|----------------------|------------|----------------------|------------|----------------------|
| 1 | * Group Code : | <input type="text"/> | * Reason Code : | <input type="text"/> | * Amount : | <input type="text"/> | Quantity : | <input type="text"/> |
| 2 | Group Code : | <input type="text"/> | Reason Code : | <input type="text"/> | Amount : | <input type="text"/> | Quantity : | <input type="text"/> |
| 3 | Group Code : | <input type="text"/> | Reason Code : | <input type="text"/> | Amount : | <input type="text"/> | Quantity : | <input type="text"/> |
| 4 | Group Code : | <input type="text"/> | Reason Code : | <input type="text"/> | Amount : | <input type="text"/> | Quantity : | <input type="text"/> |
| 5 | Group Code : | <input type="text"/> | Reason Code : | <input type="text"/> | Amount : | <input type="text"/> | Quantity : | <input type="text"/> |



Complete the **Other Subscriber Information** segment.

Other Subscriber Information
Subscriber Member ID:
Subscriber Last Name: First Name: MI: Suffix:
Insured's Group or Policy Number: Insured's Group or Plan Name:
 Additional Other Subscriber Information



Complete the **Additional Other Subscriber Information** segment.

Additional Other Subscriber Information

| | | | |
|---|----------------------|-----------------|----------------------|
| Entity Qualifier: | <input type="text"/> | Address Line 2: | <input type="text"/> |
| Address Line 1: | <input type="text"/> | State: | <input type="text"/> |
| City: | <input type="text"/> | Country: | <input type="text"/> |
| Zip Code: | <input type="text"/> | | |
| Relation to Individual: | <input type="text"/> | | |
| Claim Filing Code: | <input type="text"/> | | |
| Insurance Type Code: | <input type="text"/> | | |
| * Payer Responsibility Sequence Number Code | <input type="text"/> | | |



Complete the **Other Insurance Coverage** segment.

Other Insurance Coverage
Benefits Assignment Certification:
Release Of Information Code:
 Secondary ID Information



Complete the **Secondary ID Information** segment.

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| | |
|--|-----------------------------------|
| <input type="checkbox"/> Secondary ID Information | |
| 1 * ID Type: <input type="text"/> | * ID Number: <input type="text"/> |
| 2 ID Type: <input type="text"/> | ID Number: <input type="text"/> |

CLAIM INFORMATION

CLAIM INFORMATION

Go to [Other Claim Info](#) to enter additional claim information not displayed on this page.

- CLAIM DATA

Patient Account No.:

* Service Date:

* Place of Service:

Additional Claim Data

Diagnosis Codes

PRIOR AUTHORIZATION

CLAIM NOTE

* Is this claim accident related? Yes No

Figure 6 - Dental Claim - CLAIM INFORMATION



Complete the CLAIM DATA segment.

- CLAIM DATA

Patient Account No.:

* Service Date:

* Place of Service:

Additional Claim Data

Diagnosis Codes



Complete the Additional Claim Data segment.

Additional Claim Data

Delay Reason Code:

Provider Signature on File: Yes No

Special Program Type Code:

Provider Accept Assignment Code:

Benefits Assignment Certification:

Release Of Information Code:

Service Authorization Exception Code:

Patient Paid Amount:

Appliance Placement Date:



Open the PRIOR AUTHORIZATION segment and enter any Prior Authorization numbers that apply to this claim.

PRIOR AUTHORIZATION

1. * Prior Authorization Number:

2. Prior Authorization Number:

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Open and complete the CLAIM NOTE segment.

The screenshot shows a form segment titled "CLAIM NOTE" with a collapse icon. It contains three fields: a dropdown menu for "Type Code", a large text area for "Note", and a "characters remaining" indicator showing "80".



If this claim is accident related, answer Yes and complete the RELATED CAUSES INFORMATION segment. Otherwise, answer No.

The screenshot shows a form segment titled "RELATED CAUSES INFORMATION" with a collapse icon. At the top, there is a question: "Is this claim accident related?" with radio buttons for "Yes" (selected) and "No". Below the question are two dropdown menus for "Related Causes: 1." and "2.". At the bottom, there are input fields for "Accident State:", "Accident Country:", and "Accident Date:" (with sub-labels "mm", "dd", "ccyy").

BASIC LINE ITEM INFORMATION

BASIC LINE ITEM INFORMATION

Click on the Other Svc. Info link associated with each added Service Line Item to enter line item information other than that displayed on this

BASIC SERVICE LINE ITEMS

* Procedure Code:

* Submitted Charges: \$

Place of Service:

Modifiers: 1: 2: 3: 4:

+ Diagnosis Pointers

+ Tooth Information

* Procedure Count/Units: (Billing for anesthesia? Please indicate minutes here.)

Service Date: (If different from the claim service date)

Appliance Placement Date:

Oral Cavity Designation: 1: 2:

3: 4:

5:

+ Prior Authorization

+ Additional Service Line Information

Figure 7 - Dental Claim - BASIC LINE ITEM INFORMATION



Complete the BASIC SERVICE LINE ITEMS segment.

BASIC SERVICE LINE ITEMS

* Procedure Code:

* Submitted Charges: \$

Place of Service:

Modifiers: 1: 2: 3: 4:

+ Diagnosis Pointers

+ Tooth Information

* Procedure Count/Units: (Billing for anesthesia? Please indicate minutes here.)

Service Date: (If different from the claim service date)

Appliance Placement Date:

Oral Cavity Designation: 1: 2:

3: 4:

5:

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Complete the Tooth Information segment.

Tooth Information

1. * Tooth Code/Number: [Add Another](#)

Tooth Surface: 1: 2: 3: 4: 5:

Note: DO NOT use the Add Another link.



Complete the Prior Authorization segment.

Prior Authorization

1. * Prior Authorization Number:

2. Prior Authorization Number:



Complete the Additional Service Line Information segment (Optional).

Additional Service Line Information

Replacement Date: Prior Placement Date:

Line Item Control Number: Prosthesis, Crown or Inlay Code:

Sales Tax Amount: \$

Adding Service Lines Item to the Claim

All other claim information should be completed before adding the Basic Service Line Item to the claim.



Click the Add Service Line Item button.



ProviderOne adds the line item to the claim and shifts to the top of the claim form.



To view the new line item, click the Service tab.

Dental Claim:

Note: asterisks (*) denote required fields.

Basic Claim Info Other Claim Info

Billing Provider | Subscriber | Claim **Service**

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ProviderOne displays the BASIC LINE ITEM INFORMATION section. All previously entered line item data has been cleared from the form. The service line item has been added to the Previously Entered Line Item Information table.

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$ 60

| Line No | Proc. Code | Submitted Charges | Modifiers | | | | Diagnosis Pntbs | | | | Oral Cavity | | | | | Units | Service Date | Appliance Placement | Tooth/Surface | PA Number | | |
|---------|------------|-------------------|-----------|---|---|---|-----------------|---|---|---|-------------|---|---|---|---|-------|--------------|---------------------|---------------|-----------|--|-----------------|
| | | | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 5 | | | | | | | |
| 1 | D0120 | 60 | | | | | | | | | | | | | | 1 | | | | | | Delete or Other |



Repeat this process until all service line items have been added to the claim.

Updating a Service Line Item



To update a service line item, click the hyperlink in the Line No column for the service line item to be updated.

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$ 60

| Line No | Proc. Code | Submitted Charges | Modifiers | | | | Diagnosis Pntbs | | | | Oral Cavity | | | | | Units | Service Date | Appliance Placement | Tooth/Surface | PA Number | | |
|-------------------|------------|-------------------|-----------|---|---|---|-----------------|---|---|---|-------------|---|---|---|---|-------|--------------|---------------------|---------------|-----------|--|-----------------|
| | | | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 5 | | | | | | | |
| 1 | D120 | 60 | | | | | | | | | | | | | | 1 | | | | | | Delete or Other |



ProviderOne returns to the top of the claim form.



Click the Service Tab to return to the BASIC LINE ITEM INFORMATION section.

Dental Claim:

Note: asterisks (*) denote required fields.

| | | | |
|------------------|------------|------------------|---------|
| Basic Claim Info | | Other Claim Info | |
| Billing Provider | Subscriber | Claim | Service |



ProviderOne shifts to the BASIC LINE ITEM INFORMATION section and populates the fields with data from the selected service line item.



After editing existing data and/or adding additional data, click the Update Service Line Item button.

Deleting a Service Line Item



Click the Delete hyperlink of the Service Line Item to be deleted.

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Saving the Claim and Retrieving a Saved Claim

Requirements for Saving a Dental Claim

The following Dental Claim Form data entry elements must be completed before a claim can be saved:

PROVIDER INFORMATION

- Billing Provider NPI
- Billing Provider Taxonomy
- Is the Billing Provider also the Rendering Provider?

SUBSCRIBER/CLIENT INFORMATION

- Client ID

Entering the Client ID will not automatically populate the first and last name field. If you want to see the client's last name on the saved claim list you will need to expand the Additional Subscriber/Client Information segment and enter the client's name.

CLAIM INFORMATION

- Is this claim accident related?

BASIC SERVICE LINE ITEMS

- Line Items are not required for saving a claim.
- To include line items in a saved claim, the line item must be added to the claim using standard claim data entry steps.

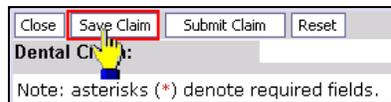
Required data entry fields that appear as a result of answering claim form questions must be completed before the claim can be saved.

Saving the Claim



Complete all required data entry.

Click the Save Claim button.



ProviderOne displays the following confirmation dialog.



Click OK to proceed or Cancel to return to the claim form.

If necessary, correct any missing data or invalid data entry errors identified by ProviderOne.



If no data entry errors or missing data are detected ProviderOne saves the claim and closes the claim form.

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Retrieving a Saved Claim



From the Provider Portal, click the Retrieve Saved Claims hyperlink.



ProviderOne displays the Saved Claims List.

| <input type="checkbox"/> | Link | Billing Provider NPI | Client ID | Client Last Name | User Login ID |
|--------------------------|------|----------------------|------------|------------------|---------------|
| <input type="checkbox"/> | ▶ | [REDACTED] | [REDACTED] | [REDACTED] | BettyB |
| <input type="checkbox"/> | ▶ | [REDACTED] | [REDACTED] | [REDACTED] | BobS |
| <input type="checkbox"/> | ▶ | [REDACTED] | [REDACTED] | [REDACTED] | BobS |
| <input type="checkbox"/> | ▶ | [REDACTED] | [REDACTED] | [REDACTED] | BettyB |
| <input type="checkbox"/> | ▶ | [REDACTED] | [REDACTED] | [REDACTED] | SallyS |
| <input type="checkbox"/> | ▶ | [REDACTED] | [REDACTED] | [REDACTED] | BettyB |
| <input type="checkbox"/> | ▶ | [REDACTED] | [REDACTED] | [REDACTED] | SallyS |
| <input type="checkbox"/> | ▶ | [REDACTED] | [REDACTED] | [REDACTED] | BettyB |
| <input type="checkbox"/> | ▶ | [REDACTED] | [REDACTED] | [REDACTED] | BettyB |
| <input type="checkbox"/> | ▶ | [REDACTED] | [REDACTED] | [REDACTED] | BettyB |

Figure 8 – Saved Claims List



Click the Link icon to retrieve a claim.

| <input type="checkbox"/> | Link | Billing Provider NPI | Client ID | Client Last Name | User Login ID |
|--------------------------|------|----------------------|------------|------------------|---------------|
| <input type="checkbox"/> | ▶ | [REDACTED] | [REDACTED] | [REDACTED] | BettyB |
| <input type="checkbox"/> | ▶ | [REDACTED] | [REDACTED] | [REDACTED] | BobS |



ProviderOne loads the saved claim data into the Dental Claim Form.

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Continue with Dental Claim data entry.

Once a saved claim has been retrieved and submitted it will be removed from the Saved Claims List.

For more information on managing the Saved Claims List, see the Managing Claims Provider System User Manual.

Submitting the Claim and Adding Backup Documentation

Submitting the Claim



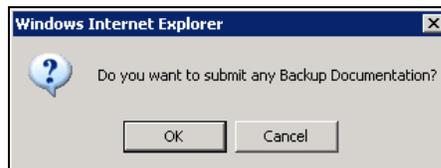
Click the Submit Claim button.



The screenshot shows a web interface with a top navigation bar containing buttons for 'Close', 'Save Claim', 'Submit Claim', and 'Reset'. Below the navigation bar is a section titled 'Dental Claim:' with a red arrow pointing to the 'Submit Claim' button. Underneath, there is a note: 'Note: asterisks (*) denote required fields.' Below the note are two tabs: 'Basic Claim Info' (selected) and 'Other Claim Info'. At the bottom, there are four links: 'Billing Provider', 'Subscriber', 'Claim', and 'Service'.



ProviderOne displays the following prompt.



The screenshot shows a 'Windows Internet Explorer' dialog box with a question mark icon and the text: 'Do you want to submit any Backup Documentation?'. At the bottom of the dialog box are two buttons: 'OK' and 'Cancel'.



Click OK to display the Claim Backup Documentation form.



Click the Cancel button if there is no backup documentation.



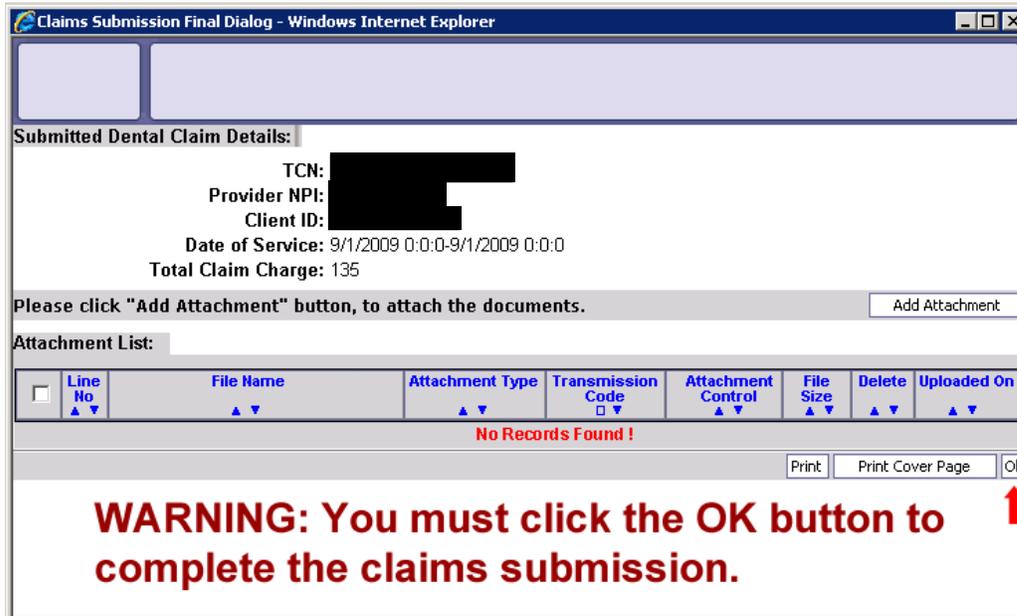
ProviderOne generates a TCN for the new claim and displays the Submitted Dental Claim Details page.



To print this information click Print.



Click OK to finalize this transaction. Failure to click OK will void this transaction.



Submitted Dental Claim Details:

TCN: [REDACTED]
 Provider NPI: [REDACTED]
 Client ID: [REDACTED]
 Date of Service: 9/1/2009 0:0:0-9/1/2009 0:0:0
 Total Claim Charge: 135

Please click "Add Attachment" button, to attach the documents.

Attachment List:

| <input type="checkbox"/> | Line No | File Name | Attachment Type | Transmission Code | Attachment Control | File Size | Delete | Uploaded On |
|--------------------------|---------|-----------|-----------------|-------------------|--------------------|-----------|--------|-------------|
| No Records Found! | | | | | | | | |

WARNING: You must click the OK button to complete the claims submission.

Figure 9 - Submitted Dental Claim Details

CAUTION "READ THIS": If you don't click OK, the claim is not transmitted.

Submitting Claims Backup Documentation

If you responded OK to the Internet Explorer prompt after clicking the Submit Claim button, ProviderOne displays the Claims Backup Documentation form.



To submit additional backup documentation, click the Add Attachment button.

ProviderOne displays the Claims Backup Documentation form.

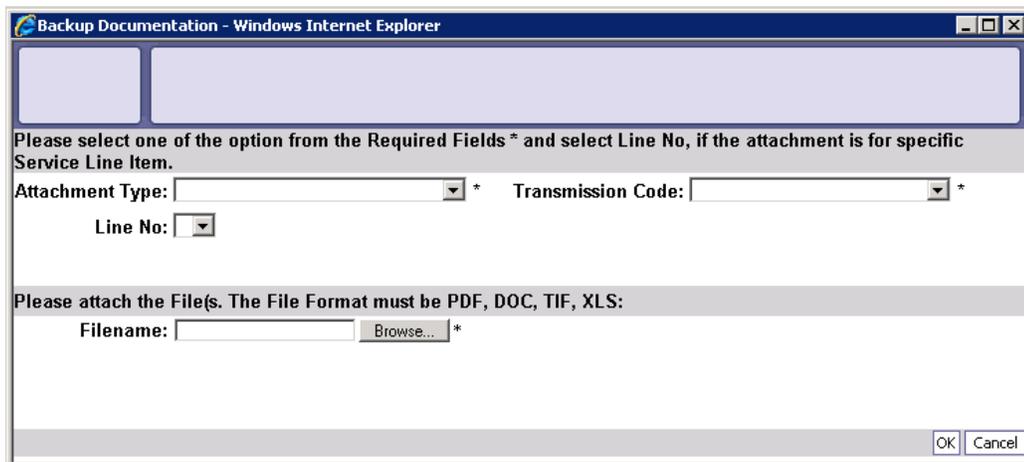


Figure 10 - Claims Backup Documentation



Select the Attachment Type and Transmission Code.

If the Transmission Code is BM: By Mail



If the Transmission Code is BM:By Mail, click the OK button.

If the Transmission Code is FX: By Fax



If the Transmission Code is FX: By Fax, click the OK button.

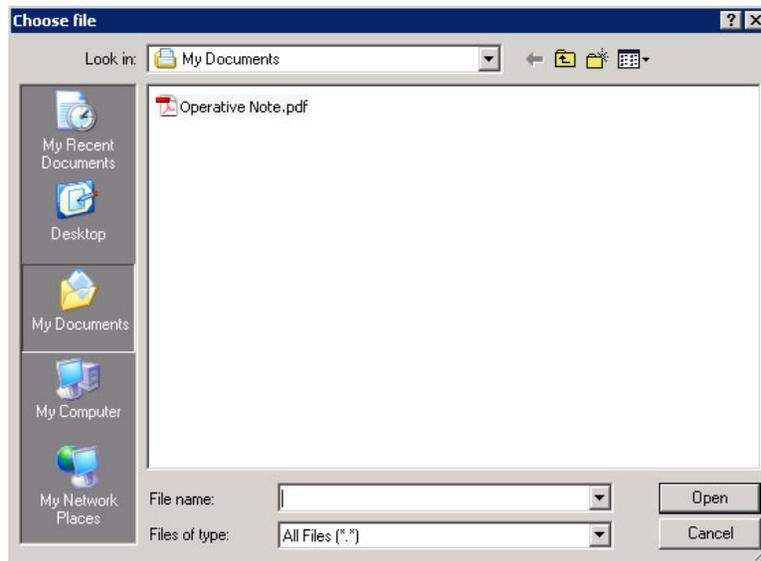
If the Transmission Code is EL: Electronically Only



Click the Browse button.



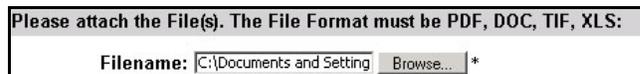
ProviderOne displays a Windows Choose File dialog.



Select the file to attach and click the Open button.



ProviderOne displays the file in the Filename field.



Click the OK button.



ProviderOne generates a TCN and displays the Submitted Dental Claim Details page. The new attachment appears in the attachment list.



To print this information, click Print.



Click OK to finalize this transaction. Failure to click OK will void this transaction.

Claims Submission Final Dialog - Windows Internet Explorer

Submitted Dental Claim Details:

TCN: [REDACTED]
 Provider NPI: [REDACTED]
 Client ID: [REDACTED]
 Date of Service: 9/1/2009 0:0:0-9/1/2009 0:0:0
 Total Claim Charge: 135

Please click "Add Attachment" button, to attach the documents. Add Attachment

Attachment List:

| <input type="checkbox"/> | Line No | File Name | Attachment Type | Transmission Code | Attachment Control | File Size | Delete | Uploaded On |
|--------------------------|---------|---------------------------|--------------------------|-------------------|--------------------|-----------|--------|-------------|
| <input type="checkbox"/> | 1 | ShowAttachmentServlet.xls | application/vnd.ms-excel | EL | | 23kb | X | 09/01/2009 |
| <input type="checkbox"/> | 2 | BM | | BM | | 0kb | X | 09/01/2009 |

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS

Print Print Cover Page **OK**

WARNING: You must click the OK button to complete the claims submission.

Figure 11 - Submitted Dental Claim Details

CAUTION "READ THIS": If you don't click OK, the claim is not transmitted.

The page intentionally blank.

Printing the Attachment Cover Page



Click the Print Cover Page button.



ProviderOne displays a PDF preview of the Cover Page.



Fill in the information required, print this cover page, and include with mailed attachments.

NOTE: After entering data into a field on the form, you must press the tab key or click outside of a data field to update the bar code with the date entered. Updated bar codes will be wider than bar codes that have not been updated.

DO NOT use previously saved cover pages, each page has a bar coding unique to the current claim.

Printing the Claim Details



To print a copy of the claim, click the Print button.



ProviderOne displays a PDF preview of the claim details.



Print or Save this PDF file.

The page is intentionally blank.

Submitting an Online Batch Claim

Before Uploading Your Document

You must be enrolled as a Trading Partner in the ProviderOne system.

You must be authorized (tested and approved by CNSI) to submit HIPAA files over the web to ProviderOne.

The file you are uploading must be less than or equal to 50MB in size.

Accessing the Batch Attachment Response Page



From the Provider Portal, click the On-line Batch Claims Submission (837) link.



ProviderOne displays the Batch Attachment Response page.

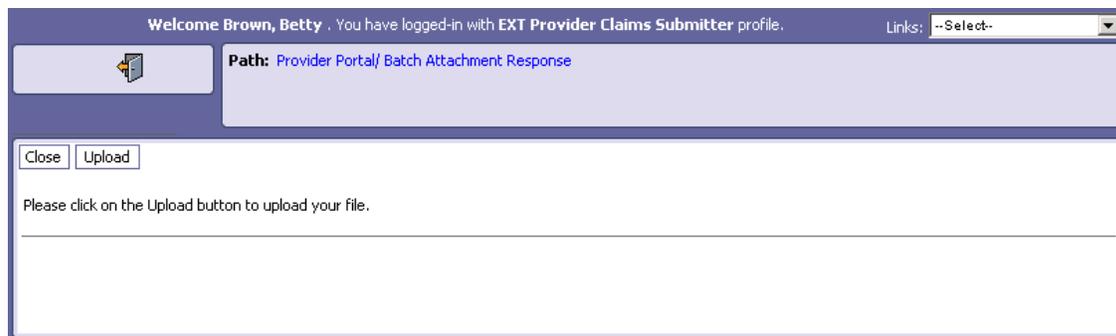


Figure 12 - Batch Attachment Response

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Submitting the Document



Click the Upload button.

ProviderOne displays the Attachment page.

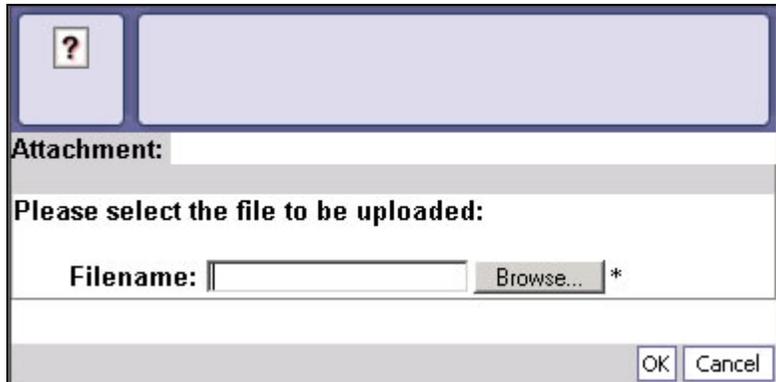


Figure 13 - Attachment



Click the Browse button, select the file to upload, and click the OK button.

If the Upload was successful, ProviderOne displays the Upload File Response.

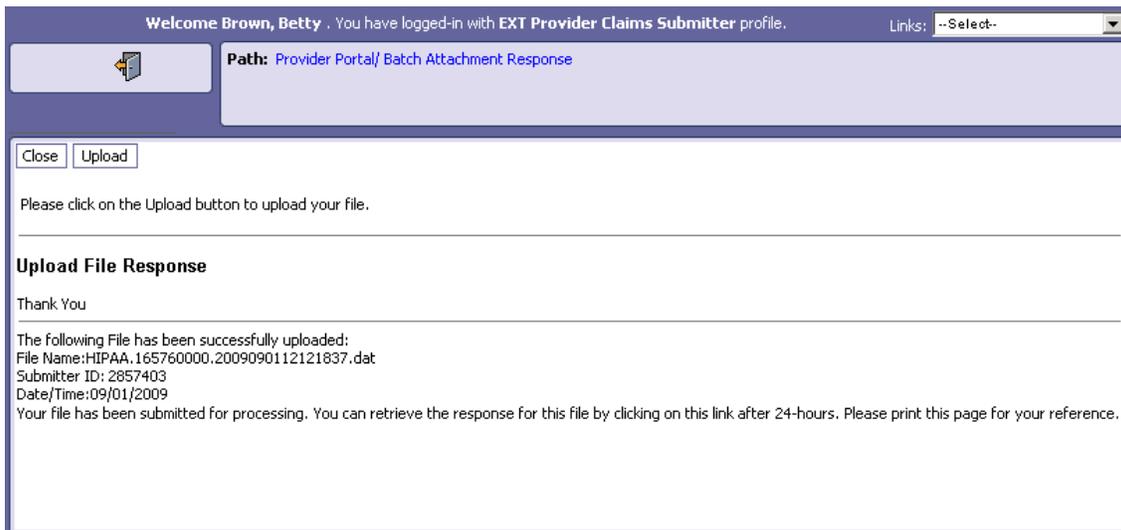


Figure 14 - HIPAA Batch Response – Upload File Response



Click the Close button.

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Appendix

Other Claim Info and Other Service Line Info sections are not required for Direct Data Entry Claims submission using ProviderOne.

This section is for reference only.

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Completing the Other Claim Info Section

The Other Claim Info section has one sub-section.

CLAIM INFORMATION

- REFERRING PROVIDER INFORMATION
- ORTHODONTIC TOTAL MONTHS OF TREATMENT
- TOOTH STATUS
- SERVICE FACILITY
- SUPERVISING PROVIDER

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Accessing Other Claim Info

You must complete the Basic Info form before you can access the Other Claim Info form.



Access the Other Claim Info form by clicking the Other Claim Info tab.



Dental Claim:

Note: asterisks (*) denote required fields.

Basic Claim Info | Other Claim Info

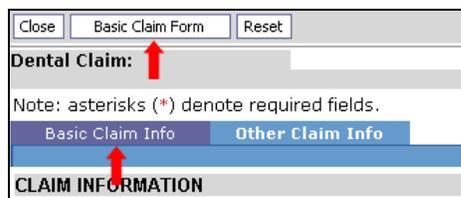
Billing Provider | Subscriber | Claim | **Service**



ProviderOne displays the Other Claim Info form.



After completing the form, return to the Basic Claim Info form by clicking the Basic Claim Info tab or Basic Claim Form button.



Close | Basic Claim Form | Reset

Dental Claim:

Note: asterisks (*) denote required fields.

Basic Claim Info | **Other Claim Info**

CLAIM INFORMATION

This page is intentionally blank.

CLAIM INFORMATION

CLAIM INFORMATION

Go to [Basic Claim Info](#) to enter basic claim information.

- REFERRING PROVIDER INFORMATION**
- ORTHODONTIC TOTAL MONTHS OF TREATMENT**
- TOOTH STATUS**
- SERVICE FACILITY**
- SUPERVISING PROVIDER**

Figure 15 - Dental Claim - Other Claim Info - CLAIM INFORMATION



Complete the REFERRING PROVIDER INFORMATION segment.

REFERRING PROVIDER INFORMATION

* Provider NPI:



Complete ORTHODONTIC TOTAL MONTHS OF TREATMENT segment.

ORTHODONTIC TOTAL MONTHS OF TREATMENT

Orthodontic Total Months of Treatment:

Orthodontic Treatment Months Remaining:



Complete the TOOTH STATUS segment.

TOOTH STATUS

| | | | | |
|---|-----------------------------------|-------------------|----------------------|-----------------------------|
| 1 | Tooth Number <input type="text"/> | Tooth Status Code | <input type="text"/> | Add Another |
|---|-----------------------------------|-------------------|----------------------|-----------------------------|

Use the [Add Another](#) link to enter information on multiple Tooth Numbers.



Complete the SERVICE FACILITY segment.

SERVICE FACILITY

Provider NPI:



Complete the SUPERVISING PROVIDER segment.

SUPERVISING PROVIDER

Provider NPI:



ProviderOne Provider System User Manual

Completing the Other Service Info Section

The Other Service Info section consists of the following sub-sections.

CLAIM INFORMATION

- TREATMENT DATES

SERVICE LINE PROVIDER INFORMATION

- RENDERING PROVIDER INFORMATION
- SERVICE LINE ADJUDICATION INFO



ProviderOne Provider System User Manual

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CLAIM INFORMATION

CLAIM INFORMATION

Go to [Basic Claim Info](#) to enter basic claim information.

TREATMENT DATES

Figure 17 - Dental Claim - Other Claim Info – CLAIM INFORMATION



Complete the TREATMENT DATES segment.

TREATMENT DATES

Treatment Start Date:

Treatment Completion Date:

SERVICE LINE PROVIDER INFORMATION

SERVICE LINE PROVIDER INFORMATION

Go to Basic Claim Info to enter basic service line information.

- RENDERING PROVIDER INFORMATION
- SERVICE LINE ADJUDICATION INFO

Figure 18 - Dental Claim - Other Claim Info – SERVICE LINE PROVIDER INFORMATION



Complete the **RENDERING PROVIDER INFORMATION** segment.

RENDERING PROVIDER INFORMATION

* Provider NPI: Taxonomy Code:



Complete the **SERVICE LINE ADJUDICATION INFO** segment.

SERVICE LINE ADJUDICATION INFO

1 SERVICE LINE ADJUDICATION

[Add Another](#)

1 SERVICE LINE ADJUDICATION

| | |
|--|---|
| *Other Payer Primary ID: <input type="text"/> | *Service Line Paid Amount: \$ <input type="text"/> |
| *Claim Check or Remittance Date: <input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy | *Paid Service Line Unit Count: <input type="text"/> |
| *Procedure Qualifier: <input type="text"/> | *Procedure Code: <input type="text"/> |
| Procedure Code Description: <input type="text"/> | Bundled Line Number: <input type="text"/> |
| Procedure Code Modifiers: 1: <input type="text"/> | 2: <input type="text"/> |
| Remaining Patient Liability Amount: <input type="text"/> | 3: <input type="text"/> 4: <input type="text"/> |

SERVICE ADJUSTMENT



Complete the **SERVICE ADJUSTMENT** segment.

SERVICE ADJUSTMENT

| | | | |
|--------------------------------------|-------------------------------------|--------------------------------|--------------------------------|
| 1 * Group Code: <input type="text"/> | * Reason Code: <input type="text"/> | * Amount: <input type="text"/> | Quantity: <input type="text"/> |
| 2 Group Code: <input type="text"/> | Reason Code: <input type="text"/> | Amount: <input type="text"/> | Quantity: <input type="text"/> |
| 3 Group Code: <input type="text"/> | Reason Code: <input type="text"/> | Amount: <input type="text"/> | Quantity: <input type="text"/> |
| 4 Group Code: <input type="text"/> | Reason Code: <input type="text"/> | Amount: <input type="text"/> | Quantity: <input type="text"/> |
| 5 Group Code: <input type="text"/> | Reason Code: <input type="text"/> | Amount: <input type="text"/> | Quantity: <input type="text"/> |