



PROVIDER PORTAL DOCUMENT

Client name



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INTRODUCTION

The Provider Portal is a robust tool which allows providers to both submit and view data, as well as, communicate directly with the organization. Within the portal, providers can perform key tasks including entering and look up of authorization requests and claims. It also gives you a platform for performing eligibility verification of the patient.

The portal also allows providers to print EOBs on-demand. Each of these functions serve to make the provider staff happier and more efficient. To login to the Portal, go to <https://prosource.quickcap.net> using Mozilla FireFox.

❖ AUTHORIZATION/REFERRAL

From the **Authorization/Referral** module, users are able to submit a new authorization and referral and check the status of an existing authorization.



● SUBMITTING A NEW AUTHORIZATION

Step 1: From the **Authorization/Referral** list, select **New Auth Entry**.

To submit a new authorization, follow the steps below:



Step 2: The screen will display as shown below. On this screen, there are three subsections to add an authorization.

Authorization

Member ID: DOB: Age: Sex:

Name: Address:

HP: Benefit: Eff dt:

PCP Name: Eff dt:

Authorization Date/Details

*Priority: * Requested Dt:

*POS: Service Req Dt:

Medication Other

Requesting Provider Information

Specialty: Contract:

* Prov ID: Req Prov:

Office:

Phone: Fax:

Referring to Provider Information

Same as Requesting Provider?

* Referring To: Contract:

Specialty: Provider:

Fac Prov: Fac-Prov ID:

Diagnosis

* Diag 1: [Diag description] Diag 2: [Diag description] Diag 3: [Diag description] Diag 4: [Diag description]

Service Code Service Package Service Category:

(Press enter to add service details)

Service Code	Service Desc	Diag Ref	Modifier	Qty	Unit Type	Notes
<input type="text"/>	<input type="text"/>	<input type="text"/>	None Selected	<input type="text"/>	None Selected	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	None Selected	<input type="text"/>	None Selected	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	None Selected	<input type="text"/>	None Selected	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	None Selected	<input type="text"/>	None Selected	<input type="text"/>

Clinical Indication For Request

(include pertinent past medical hx, treatment, physical findings, and attach all relevant medical records and test results etc.)

Step 3: The first section is the **Member Section**. Users can enter the member’s information in one of two ways:

- Enter the **Member ID** for the specific member. The system will begin suggesting members once the user has entered part of an ID. Users can then select the correct ID to add the member’s information to the screen.
- Users can click on the **Magnifying Glass** icon to search for the member. The **Member Lookup** screen will open. From this screen, users can search using a combination of **Member ID**, **Health Plan**, **Name**, and **DOB** to find the record. Double click the correct record to add it to the authorization request.

2 | Page

Authorization 

Member ID:  DOB: _____ Phone: _____ Age: _____

Name: 444666- (FINKLE /RAY /MLNA /) _____ Address: _____

Health Plan: _____ Benefit: _____ Efft dt: _____

PCP Name: _____ **Auto-Suggest** Efft dt: _____

Authorization 

Member ID:

Name: _____

Health Plan: _____

PCP Name: _____

Member Lookup

Member ID: Health Plan:

Last Name: First Name:

Member Search Window

Member Lookup

Member ID	Name	Health Plan	Provider Name	DOB
180013332013	BACKER MARK M	HEALTHNET MEDICARE	CHOU J. KRISTIN	09-19-199
0558643712	BORDE CHANDU	HEALTHNET MEDICARE	CHOU J. KRISTIN	04-09-199
9898640104	BRADLEY IRVING J	CITIZENS CHOICE HEAL	CHOU J. KRISTIN	08-25-197

Basic Details | Upload Documents/Additi

Requesting Provider Information

Specialty: _____

*Prov ID: _____

Office:

Step 4: The details for the selected member will be populated on the screen. The system will default the **Requesting Provider** information matching the organization and provider logged in.

- Authorization		- A	
Member ID:	888222	DOB:	04-04-1980
		Phone:	
		Age:	35.4
		Sex:	M
Name:	JONES MIKE		
Address:	8787 ARNOLD COURT, WHEELING, IL, 60090		
Health Plan:	HP2107	Benefit:	BC_2107
		Effdt:	08-20-2015
PCP Name:	MURRAY BILL	Effdt:	06-01-2015

Basic Details	Additional Details
---------------	--------------------

- Requesting Provider Information		MURRAY BILL	
Specialty:	INTERNAL MEDICINE	Contract:	CONTRACT FEE FOR SERVICE
* Prov ID:	777888	Req Prov:	MURRAY BILL
Office:	456 ELMWOOD COURT, ARLINGTON, CALIFORNIA, 98765		
Phone:	8472221006	Fax:	8474442000

- Diagnosis	
-------------	--

Step 5: The user can select the **Priority** and the **Place of Service** for the request.

- Authorization Date/Details			
*Priority:	ROUTINE	* Requested Dt:	07-21-2015
*POS:		Service Req Dt:	07-21-2015
	<ul style="list-style-type: none"> ROUTINE APPEAL URGENT RETRO 		
		<input type="radio"/> Medication <input checked="" type="radio"/> Other	

- Within the **Priority** dropdown menu, two options which will trigger a popup screen to appear or additional options.
 - **Urgent:** If selected, the **Required Information for Urgent Requests** screen will open. Enter the necessary information and click the **Add** button to complete this step.

Required information for urgent requests Close

ABUSE OF URGENT PA STATUS WILL BE MONITORED. Urgent Request MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient in the provider's best professional judgement. Please explain reason for urgency in Clinical Indications for Request section below.

* Person Requesting: * Phone Number: * Fax Number:

Email Address:

Address:

Reason for Request/Comments:

Add

- **Retro:** If the services have already been provided, users should select **Retro**. A new field, **Retro Date**, will appear and require date entry.

Authorization Date/Details

*Priority: * Requested Dt:

*POS: Service Req Dt:

* Retro Dt:

Step 6: The section to the right of the **Member Details** is the **Authorization Date/ Details**. The **Requested Date** is non-editable and will always default to the date of submission.

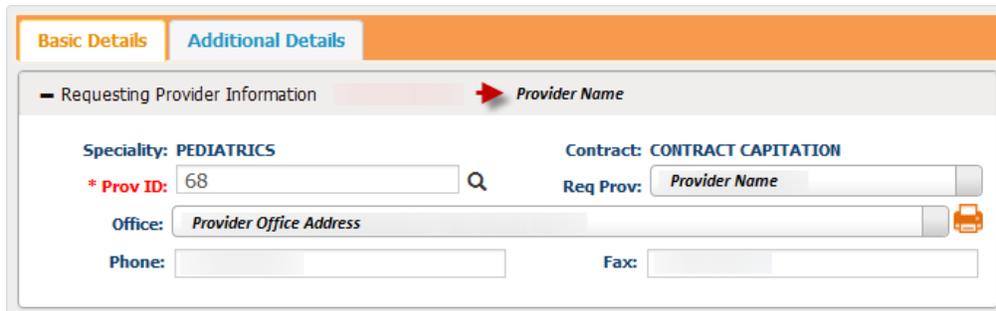
Authorization Date/Details

*Priority: * Requested Dt:

*POS: Service Req Dt:

- The **Service Requested Date**, displayed in the **Service Req. Dt** field should be entered as the date that the service should be performed, scheduled for, or for the authorization to become effective. This date will be reviewed by Nivano Physicians internal staff and is subject to their discretion.

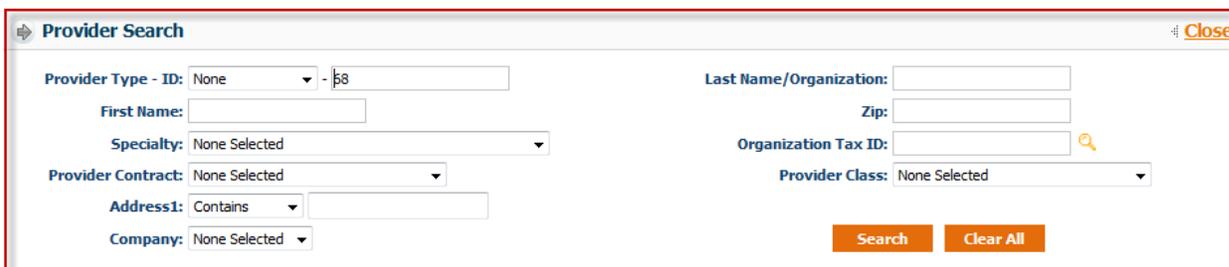
Step 7: The **Basic Details** tab displays the **Requesting Provider Information**. This will default for the provider that is logged into the system. This screen includes **the Specialty, Contract Type, Provider ID, Requesting Provider Name**, and the contact information.



The screenshot shows the 'Basic Details' tab with the following fields:

- Specialty:** PEDIATRICS
- Contract:** CONTRACT CAPITATION
- * Prov ID:** 68 (with a magnifying glass icon)
- Req Prov:** Provider Name
- Office:** Provider Office Address (with a printer icon)
- Phone:** [Empty field]
- Fax:** [Empty field]

- If the requesting provider needs to be changed, users can search for a new provider by clicking the **Magnifying Glass** icon on the right of the **Provider ID** field. The **Provider Search** screen will open as shown below. Search the provider by entering any of the available information.



The screenshot shows the 'Provider Search' screen with the following fields:

- Provider Type - ID:** None - 68
- First Name:** [Empty field]
- Specialty:** None Selected
- Provider Contract:** None Selected
- Address:** Contains [Empty field]
- Company:** None Selected
- Last Name/Organization:** [Empty field]
- Zip:** [Empty field]
- Organization Tax ID:** [Empty field]
- Provider Class:** None Selected
- Buttons:** Search, Clear All

- Click the **Provider ID** indicated in orange to populate the details of the requesting provider on the authorization request.
- If the provider has multiple offices, users can select the correct office from the dropdown menu.

Step 8: The next section, **Referring to Provider Information**, allows users to enter the information for the provider that member is being referred to.

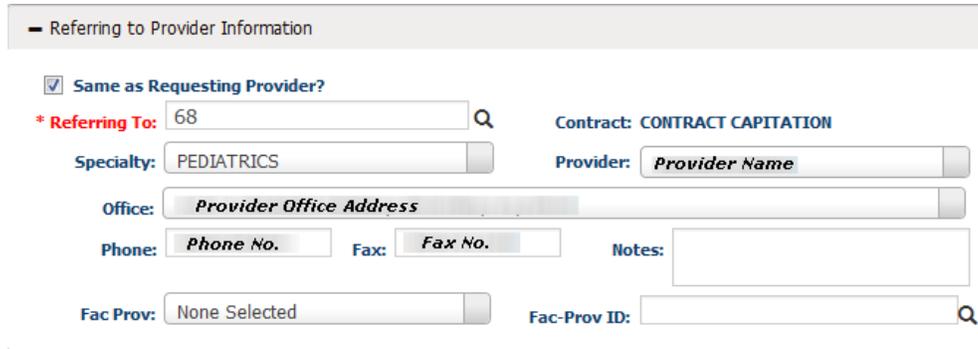


The screenshot shows the 'Referring to Provider Information' section with the following fields:

- Same as Requesting Provider?**
- * Referring To:** [Empty field]
- Specialty:** undefined
- Fac Prov:** None Selected
- Contract:** [Empty field]
- Provider:** undefined
- Fac-Prov ID:** [Empty field]

Red arrows point to the magnifying glass icons on the 'Referring To' and 'Fac-Prov ID' fields.

- For self-referrals, select the “**Same as Requesting Provider**” checkbox. This will auto-populate the information from the **Requesting Provider** screen.
- To search for a **Referring To Provider**, click the **Magnifying Glass** icon beside the **Referring To** field. The **Provider Search** screen will populate as shown in the above section. Users can search for the specific provider.
- Click the correct **Provider ID** to enter the details of the referring provider on the authorization request.



- Then, select the **Referring to Office** from the dropdown menu.

Step 9: This step is optional. Users can enter **Facility Provider Information** for the request, if needed.

Step 10: The next section, **Diagnosis**, is where users will enter all diagnosis details for a request.



- Enter all ICD codes related to the request in the **Diagnosis Code** field.
 - If the user knows the ICD code, they can enter it into the field and press **tab** on their keyboard. The system will populate the description to the right in the **Diag. Description** field. The system will auto suggest codes if they are partially entered.
 - To search for the diagnosis code, click the **Magnifying Glass** icon by the **Diagnosis Code** field. The **Diagnosis Search** screen will populate, as shown below.

Diagnosis Search Close

Diagnosis Code: Diagnosis Code 2: Description:

Version: **Show Mapping**

Diagnosis Code	Diagnosis Code 2	Description	Medium Description	Long Description	Version	Description Details
<input type="checkbox"/> 10	10	CONJUNTIVA OPERATIONS	PRIMARY TB COMPLEX UNS EXAM	PRIMARY TUBERCULOUS COMPLEX UNSPECIFIED EXAMINATION	ICD-9	
<input type="checkbox"/> 10.	10	H	H	H	ICD-9	
<input checked="" type="checkbox"/> 10.0	100	INCISE/REMOV CONJUNCT FB	INCISE/REMOVAL CONJUNCT FB	REMOVAL OF EMBEDDED FOREIGN BODY FROM CONJUNCTIVA BY INCISION	ICD-9	

Diagnosis Code	Diagnosis Code 2	Description	Medium Description	Long Description	Short Disclosure	Version
<input type="checkbox"/> 08CTXZZ	08CTXZZ	EXTIRPAT MATTER LT CONJUNCTIVA	EXTIRPATION MATTER LT CONJUNCTIVA EXTERNAL	Extirpation of Matter from Left Conjunctiva, External Approach		ICD-10
<input type="checkbox"/> 08CSXZZ	08CSXZZ	EXTIRPAT MATTER RT CONJUNCTIVA	EXTIRPATION MATTER RT CONJUNCTIVA EXTERNAL	Extirpation of Matter from Right Conjunctiva, External Approach	Best code alternative based on clinical review of Index/Tabular files and Official Coding Guidelines	ICD-10

- From the **Diagnosis Search** screen:
 - Enter either the diagnosis code or description to search for the code.
 - Select the version of the code. ICD 9 codes will default. However, users can search for ICD 9, ICD 10, or for both codes.
 - Users can view the mapping between versions by selecting the **Show Mapping** checkbox.
 - Click the **Search** button.
 - Click the **+** icon to the left of each code to view the mapping.
 - Select the desired code by clicking on the correct **Diagnosis Code** shown in orange.

Note: Users can add 12 distinct diagnosis codes.

Step 11: The next section is used to enter the CPT/HCPCS codes for the requested services.

CPT/HCPCS Code **Service Package**

CPT/HCPCS Code	Service Desc	Diag Ref	Modifier	Qty	Unit Type	Notes
99201	OFFICE/OUTPATIEI	1	None Selected	1	None Selected	SAMPLE NOTES
		1	None Selected	1	None Selected	
		1	None Selected	1	None Selected	
		1	None Selected	1	None Selected	
		1	None Selected	1	None Selected	

(Press enter to add service details)

Service Code ↕	Service Desc	Diag Ref	Modifier	Qty	Unit Type	Notes
99213	OFFICE/OUTPATIE	1	None Selected	1	None Selected ▾	
			None Selected		None Selected ▾	

(Press enter to add service details)

Service Code ↕	Service Desc	Diag Ref	Modifier	Qty	Unit Type	Notes
99213	OFFICE/OUTPATIENT	1	None Selected	1	None Selected	
			None Selected		None Selected ▾	

- The option for **CPT/HCPCS Code** defaults for entry; users can select **Service Package** if it is enabled. This will be described further below.
- To utilize the **CPT/HCPCS Code** option, users can enter the service code or search for the service code by clicking **F2** on the keyboard.
- If **Service Package** is selected, users can select the package from the dropdown menu. **Service Packages** may consist of multiple codes that are affiliated. This can be used to identify certain services such as Office Visits or Consultation visits.
- After the code is entered, the description will auto populate into the **Service Desc** field.
- Users can enter the **Diagnosis Reference**. The system will default automatically to 1, which indicates that the code is linked to the first ICD code from the **Diagnosis** section. Users can change the digit corresponding to which diagnosis code the service should reference.
- Users can enter a quantity for the service and select the unit type. If none is selected, it will default to **None** and for 1 for the **Quantity**.
- Users can add any modifiers if needed. Modifiers can be selected from the dropdown menu or manually enter the code.
- Press **tab** on the keyboard to go to the next CPT (service) line.

Step 12: The next section is **Clinical Indication for Request**. In this section, users can add the member’s past medical history, physical findings, service notes being requested, or attach all relevant medical records and test results.

– Clinical Indication For Request

(include pertinent past medical hx. treatment, physical findings, and attach all relevant medical records and test results etc.)

Step 13: The second information tab is **Additional Details**. Within this tab, three more sections will appear.

Step 14: The first section is **Documents**. Users can upload and attach documents to the referral request. Users are also able to fax documents to the organization. To upload documentation and submit it electronically with the referral request:

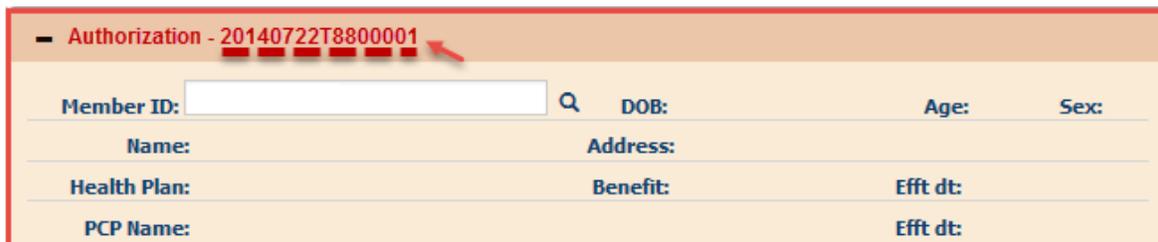
- Select the **Category** and **Priority** of the document.
- Click **Browse** to find the file from the computer directory
- Upload documents in the following formats: .doc, .docx, .xls, .xlsx, .pptx, .xps, .psd, .htm, .pdf, .tiff, .rtf, and text.
- Click the **Add Additional Documents** button to add multiple documents.
- Once users click **Save**, the document will send with the referral automatically.

Step 15: After verifying the data entered, users can save the request.

- To submit the referral request, click **Save**.
- To submit the referral request and add another request for the same member, click **Save and Add for Same Member**.



Note: When an authorization or referral request is submitted, users will receive a notification detailing the authorization request number with the status. Then on the **Authorization** screen, the recently submitted authorization number will be displayed automatically on the header portion.



- Authorization - 20140722T8800001 

Member ID:	<input type="text"/>	DOB:	Age:	Sex:
Name:	Address:			
Health Plan:	Benefit:	Eff dt:		
PCP Name:			Eff dt:	

Step 16: Users have the option to **Print Auth** on the lower section of the screen once it is saved. This feature allows users to print authorization requests. The popup window gives options to print and export the request.

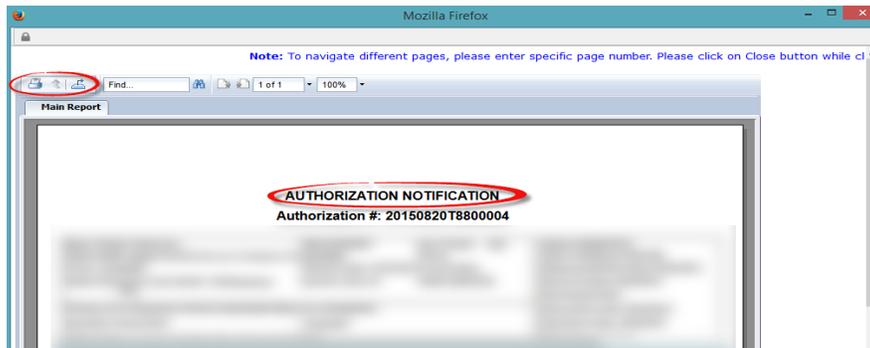
Authorization [Authorization # : 20150820T8800004 Status: REQUESTED] Authorization Date/Details

CPT/HCPCS Code Service Package

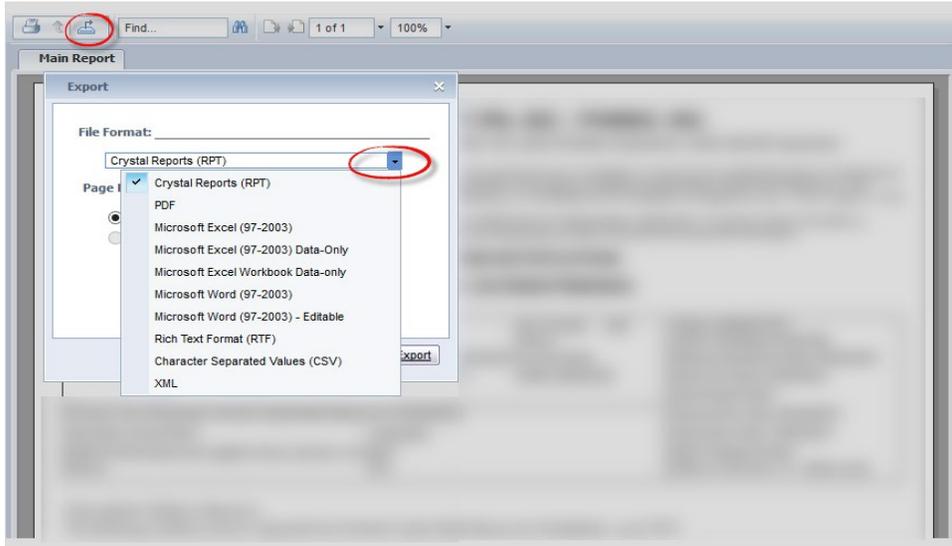
CPT/HCPCS Code	Service Desc	Diag Ref	Modifier	Qty	Unit Type	Notes
99214	OFFICE/OUTPATIENT	1	None Selected	1	None Selected	
		1	None Selected	1	None Selected	
		1	None Selected	1	None Selected	
		1	None Selected	1	None Selected	
		1	None Selected	1	None Selected	

Clinical Indication For Request
(include pertinent past medical hx, treatment, physical findings, and attach all relevant medical records and test results etc.)

Buttons: Save, Save & Add for same Member, **Print Auth**, Go to Search Member Page



- **Export Options:** There are several options that the reports can be exported to:
 - Crystal Reports (RPT)
 - PDF
 - Excel 97 – 2003
 - Excel 97 – 2003 Data Only
 - Excel Workbook Data Only
 - Word 97 – 2003
 - Word 97 – 2003 Editable
 - Rich Text Format (RTF)
 - Character Separated Values (CSV)
 - XML



• CHECKING THE STATUS OF AN AUTHORIZATION

To verify the status of an authorization, follow these steps:

Step 1: From the **Authorization/Referral** list, select **View/Search Authorization**.



Step 2: The **Authorization/Referral Status Search** screen will display as shown below:

Authorization/Referral-Status Search

Member ID: Last Name: First Name:
 Member SSN: DOB: Auth. No:
 Request/Receive Date From: Request/Receive Date To: Health Plan:
 Auth. Date From: Auth. Date To: Place of Service:
 Requesting physician ID: Status: Priority/Services Is:
 Requesting Org ID: Referring To physician ID: Referring To Org ID:
 Company: Created By:

No. of Authorization(s): 7

Authorization No. Status	Member Id Member Name	Sex	DOB	Requesting Physician	Referring To Physician	Health Plan	Place of Service Requested Date	Reason	Company
20150914T800001 REQUESTED	111222 DOE JANE	F	01-01-1981	Smith, John (Medical Organization, Inc.)	112233 Smith, John (Medical Organization, Inc.)	Commercial Health Plan	OFFICE VISIT 09/14/2015		QUICKCAP
Service Code/Package 99215	Service/Package Description OFFICE/OUTPATIENT VISIT EST		Diag Code 339.83	Description COUGH HEADACHE					

Step 3: The first section is where users search for authorizations. Enter search criteria in any of the available fields. The search results will display in the results section below.

Step 4: Click the (+) icon to view the services requested in the authorization. The service information will be visible.

Step 5: The status of the authorization (requested, approved, denied) is displayed in the **Authorization No. Status** column.

Step 6: To view all of the information for a specific authorization, click on the row for the authorization. This will redirect users to the **Authorization/Referral Status Search** screen with all of the authorization details.

Note: This screen is only for viewing purposes. Only a few sections are enabled.

Authorization/Referral-Status Search [Collapse All](#) [Back](#)

To our specialist providers: In compliance with HIPAA regulations, your search function of the member on the web portal will be limited to "active referral" from the primary care provider. Should you not have the patient's referral information, please ask your patient to obtain this from his or her PCP prior to your office appointment.

Authorization Details Request Type: Medication Other

Authorization No: 20150914T800001
 Created By: Deanna McQuillan Created DateTime: 09-14-2015 13:58:46
 Status: REQUESTED
 Modified By: Deanna McQuillan Modified DateTime: 09-14-2015 13:58:46
 Service Is: ROUTINE
 * Requested/Received Date: 09-14-2015 Time: 13:43 (HH:mm)
 * Place of Service: 11 - OFFICE VISIT
 Approved LOS: 0 Actual LOS: 0
 Service Category:
 Payment Status: OPEN
 Admission DRG:
 * Valid From/Action Date: 09-14-2015
 Valid For: 30 Day(s).
 Valid To/Auth Expiration Date: 09-24-2015
 Discharge Date:
 Final Decision Made: NA
 Notification To Member: NA
 Notification To Provider: NA

Member Details Company: QUICKCAP

* HP Member ID: 111222
 Member Name: DOE JANE
 DOB: 01-01-1981 Age: 34.8 Sex: F
 HP Effective Date: 01-01-2015
 PCP Effective Date: 01-01-2015
 Health Plan: Commercial Health Plan
 Guardian Name: Language: Cell/Phone Number:
 Member Address:
 PCP ID: 112233
 PCP Name: Smith, John
 PCP Fax: 8475551234
 PCP Phone: 8475551234
 HR#:
 PCP Approved? Yes No Unknown [View CCD](#)

Step 7: To add additional details to the current authorization request, click the **Additional Details** button. The **Additional Details** screen will populate as shown below.

Additional Details [Close](#)

Additional Details saved successfully.

General Details

* Review Date: User: Priority: Criteria:

* Notes:

Add

Edit	Date	User	Priority	Criteria	Status	Level of Care	Notes	Submitted Date	Delete
	09-14-2015		M		REQUESTED		The member requires additional care.	09-14-2015 14:08:09	

- In the **General Details** section, select the review date, priority of detail and criteria. Enter the information needed in the **Notes** field. Click the **Add** button to save the details.
- If you want to edit already added details, click the **Edit** icon.

Step 8: To view the member’s eligibility details, click the **Member Eligibility** button. The **Member Eligibility** screen will populate as shown below.

Member Eligibility [Close](#)

Auth No.: 20150914T8800001 and Requested Date: 09-14-2015 and Member: DOE JANE (111222) HCL1 - BCL1 - 01-01-1981 (34.8F - Adult)

Member Details **MOOP Details**

Member ID: 111222, Name: DOE JANE, DOB: 01-01-1981, Age: 34.700, Other Member ID: and Status:

Address	Address 2	City	State	Zip	Phone	Work Phone	Extension	Fax	Email	Language

Eligibility Details

Provider	Provider Name	PCP From Date	PCP To Date	Org Name	PCP Phone #	PCP Fax #
112233	Smith John	01-01-2015		Medical Organization, Inc.	8475551234	8475551234

Health Plan Details

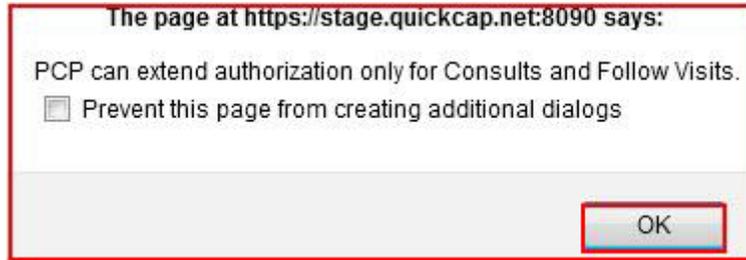
HP Code	Health Plan Name	LOB	Benefit Code	Effective From Date	Effective To Date	Other Coverage?	Resp. Code	Policy #
HCL1	Commercial Health Plan	COMMERCIAL INSURANCE	BCL1	01-01-2015		No		

Benefit Code Details

Benefit Code	Benefit Description	Copay Copy Instance Type	CoInsurance %	CoInsurance Instance Type	From Date	To Date	Benefit Notes
BCL1	Benefit Code Commercial	\$0.00			01-01-2015		

[Detail Option](#)

Step 9: If you want to extend the date of authorization, then click the **Extend Authorization** button. A message will pop up as follows.



- Click the **OK** button. This will redirect the user to the **Auth Expiration Date** field. Users can extend by either entering the new authorization expiration date or by entering the number of days in **Valid For** field.

Step 10: Users can add medication details and edit existing medication details from the **Medication** section.

Step 11: Users can send additional documentation related to the referral by adding the attachments in the **Documents** section.

Step 12: Click the **Save** button to save the updated request.



CLAIMS

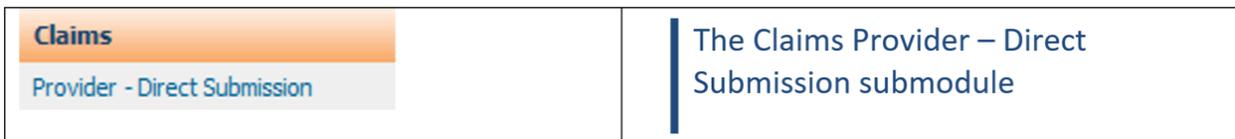
From the **Claims** module, users are able to submit a new claim view and search for previously submitted claims.



• SUBMITTING A NEW CLAIM

To submit a new claim, follow the below:

Step 1: From the **Claims** list, select **Provider – Direct Submission**.



Step 2: The screen will display as shown below. Look up the member for which you want to add claim for, using Member ID or Last Name, DOB and HealthPlan, by adding details in search and clicking on search icon.

Provider - Direct Submission ◀ Back

Member ID/Other ID: 22222 Last Name: First Name:

HP: None Selected DOB: Company: None Selected

Site Number:

Member ID	Name	Sex	Date of Birth(Age)	HP Code/Name	RAF	PCP Name	PCP Effective Date	HP Effective From	HP Effective To	Phone	Member SSN	Subscriber ID	Company	Secondary ID	Other ID/Type	Site Info
2222	MED TEST	M	01-01-1965 (53.749)	2222 TestMed		Med Test	01-01-2017	01-01-2017		8989898989						

Note: The Members in red font are inactive. [Additional Details](#)

Step 3: Once you have the member record in result field, click on Submit claim button at the left-hand corner of the member record.



Step 4: Once the button is clicked, system will re-direct to the screen to add claims. Please refer to the image on next page of how the screen will look now. There is a total of 10 sections to fill the details.

Company ID: _____ Authorization #: _____

Member Information

ID: 2222 Name: MED TEST
 DOB: 01-01-1965 Sex: M Health Plan: TestMed

Provider Information

Provider ID: 1578606132
 Select the Provider: Med Test
 Name: Med Test
 Speciality: DERMATOLOGY
 Organization: 2222 - MEDTEST
 Provider Type: CONTRACT FEE FOR SERVICE

Billing Facility Address **Service Facility Address** **Pay-to Address**

Name: MEDTEST Name: Med Test Same as Billing Address
 Address Line 1: Test Address Line 1: TestMed Address Line 1: Test
 Address Line 2: Med Address Line 2: Address Line 2: Med
 City: TestMed State: RI Zip: 92214 City: MedCity State: CA Zip: 90001 City: TestMed State: RI Zip: 92214
 NPI: 1962403860 Tax ID: 770311552 NPI: 1578606133 Tax ID: _____

Referring Provider Information

Referring Provider ID: _____ Name: _____

Additional Information

Provider Claim / Patient Account #: _____
 Patient Paid Amount: _____ Purchase Service Amount: _____

Claim Details

POS: 11 - Office
 Admission Date: _____ Discharge Date: _____

Diagnosis

* Diagnosis Code: _____ (Only 12 distinct diagnosis codes are allowed.)

Diag. Reference	Diag. Code	Diag. Description
No diagnosis codes added.		

Services Requested Yellow fields mandatorily require input.

Service Date-Time	Service Code	NDC Code - Qty - Unit	Modifier	Diag. Ref.	Qty - Billed	Other Insurance	Notes
From: _____ To: _____	_____	11-digit 5- NDC Code Quantity Unit	Modif. 1 Modif. 2 Modif. 3 Modif. 4	Ref. 1 Ref. 2 Ref. 3 Ref. 4	1 Billed Amount		<input type="button" value="Add"/>

Clinical Indications for request
 (Include pertinent past medical history, treatment, physical findings, and attach all relevant medical records, test results, etc.)

Documents

Attachments: No file selected. X
 (Please upload .doc, .docx, .xls, .xlsx, .ppt, .xps, .psd, .htm, .pdf, .tif, .rtf and text documents only.)
 = Add more documents

(Fields marked with the asterisk * are mandatory.)

Step 5: Below are the steps to add details on the claim:

- Add **Authorization number** on the claim. You can click on the magnifying glass to look up an authorization from the system. Click on the Auth# to select the auth for this claim.

Company ID: Authorization #:

Company ID: CLINICASQA Authorization #:

Member Information

Authorization Search - Mozilla Firefox

https://portal.quickcap.net:8090/CA/searchAuthorization.aspx?enc=0zV4KBT2wt+X3d+s74F6B8TWMxQ7di6Z37UCS7xZevy7

Authorization Search

Member ID: 2222 Last Name: First Name: Auth No:

Member SSN: DOB: Health Plan: None Selected

Request/Receive Date From: Request/Receive Date To: Place of Service: None Selected

Auth. Date From: Auth. Date To: Priority: All

Requesting / Requesting To physician ID: Status: All

CPT Code: Diag Code: Company:

Search Clear All

Authorization Details

Auth. No.	Status/Reason	Request/Receive Date	Authorization Date	Expiration Date	Retro Date	Places Of Service	Member	Provider	Request Provider	Net Amount	Records	CCS	Company
20170508T8800026	APPROVED	05-08-2017	05-08-2017	07-06-2017		11 Office	2222 MED,TEST	1578606132 Med Test	1578606132 Med Test	\$0.00			

- Basic **member information** will automatically populate, based on the member we selected initially before we clicked **Submit Claim**

Member Information

ID: 2222 Name: MED TEST

DOB: 01-01-1965 Sex: M Health Plan: TestMed

- Under **Provider Information** section, you can choose the rendering provider for the claim. Provider can be selected using two options
 - Provider ID** search using magnifying glass, to look up provider using filters. Once you have the provider in result grid, click on the ID to select the provider.

Provider Information

Provider ID: 2000030007

Provider Search - Mozilla Firefox

Provider Search

ID: PROVIDER ID - 2000030007

First Name: Last Name/Organization: City: Zip: Organization Tax ID: Provider Contract: None Selected

Specialty: None Selected

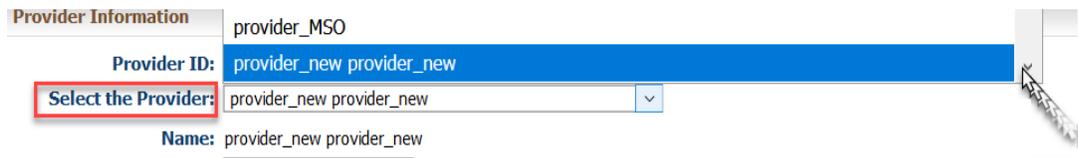
Provider Class: None Selected

Address1: Contains

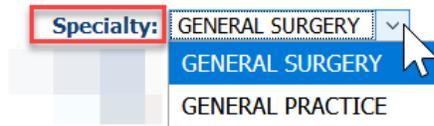
Company: None Selected

Search Clear All

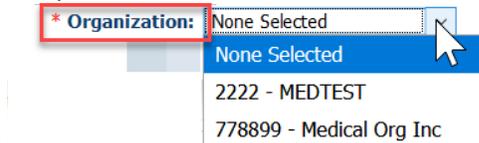
- Select the Provider drop down. which will show you all providers under your organization.



- Once you have selected the provider, all other details will be auto-populated.
- If you wish to change the specialty of the provider (In case the provider is multi-specialty), click on the specialty drop down.



- If you wish to change the organization (Billing entity) you can click on the drop down to choose from different organizations linked to this provider.



- **Addresses – Billing, Service and Pay to**

- These addresses will auto-populate based on the provider and organization selected. However, if you wish to manually override it, you can.



- **Additional Information** section will let you add additional details on this claim like

- **Patient Account #**
- **Patient paid amount**
- **Purchase service amount**

- **Claim Details** will let you enter the **POS** of this claim.

- When the POS added is an inpatient POS, it lets you add the admit and discharge date.

Claim Details

POS: 21 - Inpatient Hospital

* Admission Date:

Discharge Date:

Note: In case of inpatient claim, it is mandatory to add Admit date.

- When the POS is Ambulance, the ambulance icon gives you pop up to add ambulance details. Fill in the details and click on OK to save the ambulance details.

POS: 41 - Ambulance Land

Ambulance Information

Ambulance Transport Information

* Reason Code: Select Weight: 0 * Miles: 0

Round Trip:

Stretcher:

Applicable Certification Condition Codes **Not Applicable Certification Condition Codes**

Sele Sele Sele Sele Sele Sele Sele Sele Sele Sele

Pick-up Location

* Address 1:

Address 2:

* City: * State: * Zip:

Drop-Off Location

Name:

* Address 1:

Address 2:

* City: * State: * Zip:

State of Illinois Requirements

State: Vehicle License Number:

Origin Time: Destination Time:

OK Clear All

- **Diagnosis** field lets you add 12 distinct diagnosis on the claim. You can either type in the diagnosis code (Tab Out) and hit add OR you can look up the diagnosis code using the magnifying glass.

Diagnosis

* Diagnosis Code: Add (Only 12 distinct diagnosis codes are allowed.)

Diag. Reference	Diag. Code	Diag. Description
1	D82.4	HYPERIMMUNOGLOBULIN E SYNDROME

Lets you add the diagnosis on the claim

Diagnosis Search - Mozilla Firefox

Diagnosis Search

Diagnosis Code(with decimal): Description: Contains

Version: ICD-10 Show Mapping Search Clear All

Note: This mapping might not be truly equivalent - it is only an approximation.

Lets you search for the diagnosis

- **Services** lets you add all the details for procedures to be billed on this claim.

Services Requested Yellow fields mandatorily require input.

Service Date-Time	Service Code	NDC Code - Qty - Unit	Modifier	Diag. Ref.	Qty - Billed	Other Insurance	Notes
From: 10-02-2017 14:20 To: 10-02-2017 15:05	01440 ANESTH KNEE AR...	11-digit 5-4-2 08021-0000-18 5 Milliter	Modif. 1 Modif. 2 Modif. 3 Modif. 4	1 Ref. 2 Ref. 3 Ref. 4	300	50	Add
From: 10-01-2017 To: 10-01-2017	99213 - OFFICE/OUTPATIENT VISIT EST	NDC Code: 57520-0547-01 Quantity: 2 Unit Type: ME	25	1	Qty: 1 Billed: \$70.00	20	
Totals:					Qty: 1 Billed: \$70.00		

- Below are the details you can add on the service line
 - **Service From** and **Service To** *date and time*. (Advised to add time for Anesthesia claims)

Service Date-Time

From:

To:

- **Service code/Procedure code**. You can type in or look up from the magnifying glass icon. Click on the code to add on claim.

Service Code

Procedure Search - Mozilla Firefox

Service Search

Service Type: All Service Codes: Description: Contains Search Clear All

- **NCD Code – QTY – Unit. (Mandatory to add for all J codes)**
 - You can add NDC code in different formats. Format can be selected from the drop down.

11-digit 5-4-2

11-digit 5-4-2

10-digit 4-4-2

10-digit 5-3-2

10-digit 5-4-1

- Once you have selected the format, you can add your NDC code or look up using the magnifying glass.

NDC Code - Qty - Unit	Modifier	Diag. Ref.	Qty - Billed	Other Insurance
11-digit 5-4-2	NDC Code	Modif. 1 Modif. 2	Ref. 1 Ref. 2	1

NDC Search - Mozilla Firefox

Code: Description: Search Clear All

11 - Digit Code	Description	Major Ingredient	Start Marketing Date	End Marketing Date
49836002509	Anesthesia S/I-40 (Propofol, Isopropyl Alcohol) KIT 1 KIT in 1 PACKAGE, COMBINATION (49836-025-09) * 20 mL in 1 VIAL * .55 mL in 1 POUCH 20170824 N N		08/24/2017	

- QTY is the space provided to define the number of quantity for the drug specified on NDC code
- Unit, lets you choose the unit for the code

Quantity	Unit	▼
----------	------	---

- **Modifier code** lets you add four modifiers on each service line

Modifier	
Modif. 1	Modif. 2
Modif. 3	Modif. 4

- **Diagnosis code ref**, lets you add the diagnosis code indicator for each service line. Please add numeric value in this to indicate the diagnosis code place value you would like to add.

Diag. Reference	Diag. Code	Diag. Description
1	D82.4	HYPERGAMMAGLOBULIN E SYNDROME
2	D82.6	ANTIBODY DEF NEAR-NORM, QUANT

Services Requested Yellow fields mandatorily require input.

Diag. Ref.	
1	Ref. 2
Ref. 3	Ref. 4

- **QTY** is the quantity for the procedure code you want to bill.
- **Billed** is the billed amount for this procedure code
- **Other Insurance** is the amount received from Primary insurance if this is secondary claim, etc.
- **Notes** lets you add service level note if needed. Any significant detail for this line item can be sent here.

Qty - Billed	Other Insurance	Notes	
1			Add
Billed Amount			

- **ADD** icon adds these details and makes these fields blank again for the next line item
- Once all details are added, you can see the detail lines added and their total below them.

Services Requested Yellow fields mandatorily require input.

Service Date-Time	Service Code	NDC Code - Qty - Unit	Modifier	Diag. Ref.	Qty - Billed	Other Insurance
From: <input type="text"/> <input type="text"/> To: <input type="text"/> <input type="text"/>	<input type="text"/>	11-digit 5-4-2 <input type="text"/> NDC Code <input type="text"/> Quantity <input type="text"/> Unit <input type="text"/>	Modif. 1 <input type="text"/> Modif. 2 <input type="text"/> Modif. 3 <input type="text"/> Modif. 4 <input type="text"/>	1 <input type="text"/> Ref. 2 <input type="text"/> Ref. 3 <input type="text"/> Ref. 4 <input type="text"/>	1 <input type="text"/> Billed Amount <input type="text"/>	<input type="text"/>
From: 10-01-2017 To: 10-01-2017	99213 - OFFICE/OUTPATIENT VISIT EST	NDC Code: 57520-0547-01 Quantity: 2 Unit Type: ME	25	1	Qty: 1 Billed: \$70.00	20
From: 10-02-2017 14:20 To: 10-02-2017 15:05	01440 - ANESTH KNEE ARTERIES SURG	NDC Code: 08021-0000-18 Quantity: 5 Unit Type: ML		1	Qty: 1 Billed: \$300.00	50
Totals:					Qty: 2 Billed: \$370.00	

Note: To delete a line item added in error please click on the Cross icon at the right end of each service line. To merely update the details, click on the edit the icon on extreme left of the service line.

- **Clinical Indication** is a section where you can add additional details to be submitted on the claim. This can contain patient’s history, medical findings or any relevant records.

Clinical indications for request
(include pertinent past medical history, treatment, physical findings, and attach all relevant medical records, test results, etc.)

- **Documents** let you attach any relevant document about the claim being submitted. You can attach files with the type as mentioned on the screen.
 - To add document, click on Browse, to select a file from your machine.
 - To add more than one document click on the link for **+add more document**.
 - To **delete** a document attached before submitting claim, you can hit the cross on the right.

Documents

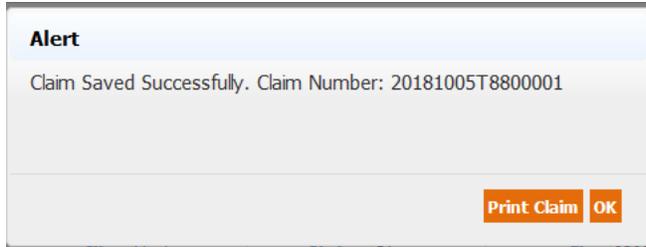
File	Additional Documents
Attachments: <input type="button" value="Browse..."/> No file selected. (Please upload .doc,.docx,.xls,.xlsx,.pptx,.xps,.psd,.htm,.pdf,.tiff,.rtf and text documents only.)	<input type="button" value="X"/>
+ Add more documents	

Step 6: Once all the details are added, click on **Save to submit the claim** for processing. You can also use **Save & add for same member** if you wish to add another claim for the same member.

Save

Save & Add for Same Member

Note: Once the claim is saved it will give you a pop up with claim number, as shown below. You can click on **OK** to go back to the screen. If you wish to print the submitted claim as CMS 1500 click on **PRINT CLAIM**.



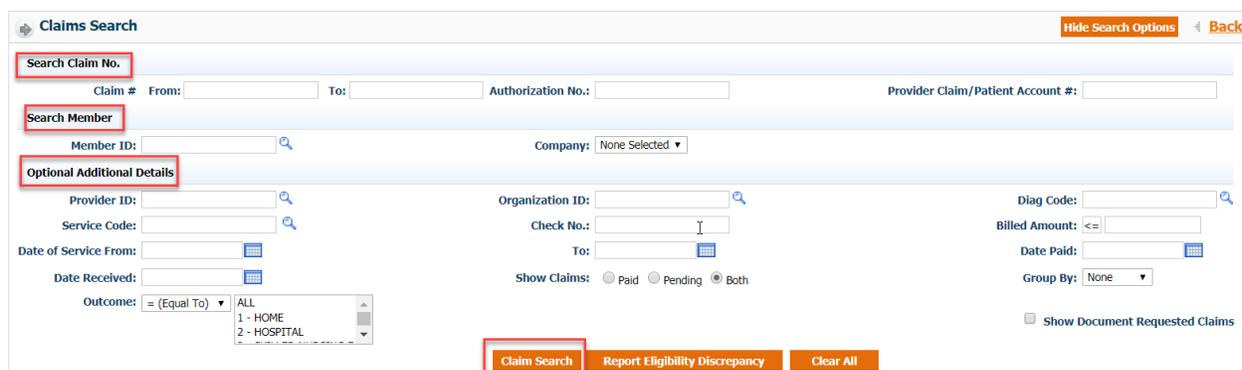
• CHECKING THE STATUS OF A CLAIM

To verify the status of a claim, follow these steps:

Step 1: From the **Claims** list, select **Claims Status/Search**.



Step 2: The screen will display as shown below. On this screen, there are three subsections to search claims by.



Step 3: Based on the criteria users have input, the search results will display in Claim Details section, as shown below.

Claim Details Notes: ** All blue text is clickable, N/A = Not Applicable.

Claim No.	Received Date	Service Date	Auth. No.	Place Of Service	Member	Provider	Organization	Payee	Billed Amount	Contract Amount	Net Amount	Company	Outcome
2018082183700001	07-16-2018	05-15-2018	11	OFFICE	2106201801 KHAN KHAN	2106 DAN SINGH	2106 Test Organization	Organization	\$1,000.00	\$0.00	0.00	PROT	HOME

Service Date	ServiceCode	Modifier(s)	Diag. Code	Financial Resp.	Adjust. Descr.	Paid Date	Check No.	QTY	Billed	Contract	CoPay	Coinsurance	Deductible	Adjust	Net	Admin. Fee/Withhold	Status
05-15-2018	99214 OFFICE/OUTPATIENT VISIT EST		I10	JPA		08-21-2018		1.00	500.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	PAID
05-15-2018	99218 INITIAL OBSERVATION CARE		I10	JPA		08-21-2018		1.00	500.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	PAID

[Show EOB](#)
[Print CMS 1500](#)
[View EDI Claim](#)
[Upload Document](#)

Health Plan Details PCP History

Health Plan	Effective From Date	Effective To Date	Other Coverage?	Resp. Code	Policy #	Provider	Name	Effective From Date	Effective To Date
Test	08-08-2012		No			2106	DAN SINGH	08-08-2012	

- The **Status** can be found on the right side in the last box. The adjustment code and net amount on the claim is not finalized and is subject to change until the **Status** is **Paid**.

Step 4: To view and print the claim in CMS 1500 format, click the **Print CMS 1500** button.

Step 5: If the claim is in a **Paid** status, there will be an additional button for **Show EOB**.



❖ ELIGIBILITY

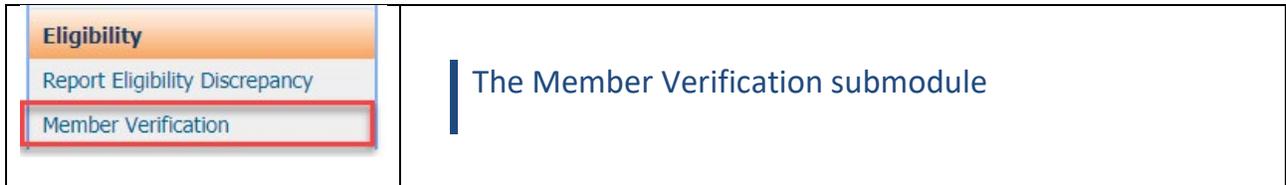
From the **Eligibility** module, users are able to verify a member's eligibility and report any discrepancies.



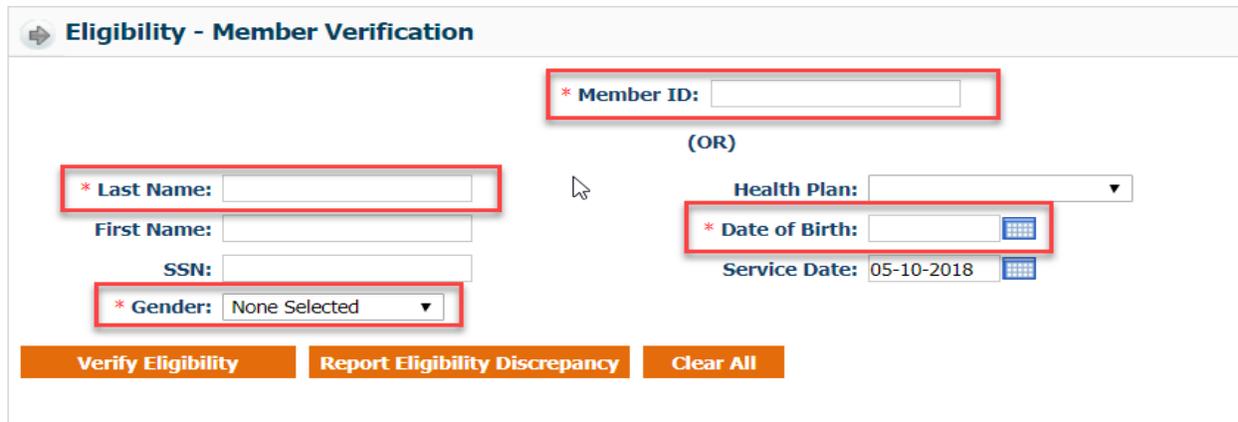
• VERIFYING ELIGIBILITY

To verify Eligibility for a member, follow these steps:

Step 1: From the **Eligibility** list, select **Member Verification**.



Step 2: The screen will display as shown below.



The screenshot shows the 'Eligibility - Member Verification' form. It includes several input fields:

- * Member ID: (text input, highlighted with a red box)
- (OR)
- * Last Name: (text input, highlighted with a red box)
- First Name: (text input)
- SSN: (text input)
- * Gender: (dropdown menu, currently 'None Selected', highlighted with a red box)
- Health Plan: (dropdown menu)
- * Date of Birth: (calendar icon, highlighted with a red box)
- Service Date: (text input, value '05-10-2018', highlighted with a red box)

 At the bottom, there are three buttons: 'Verify Eligibility' (orange), 'Report Eligibility Discrepancy' (orange), and 'Clear All' (orange).

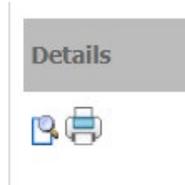
Step 3: Users can search for members in two different ways:

- Search by entering the **Member ID** for the specific person.
- Search by entering the **Last Name**, **Date of Birth**, and **Gender** of the member; all three fields must be completed.
 - Users can add the **Health Plan**, **First Name**, **SSN**, and **Service Date** for a more detailed search.

Step 4: Select **Verify Eligibility**. If the member exists in the system, their details will be displayed as shown below.

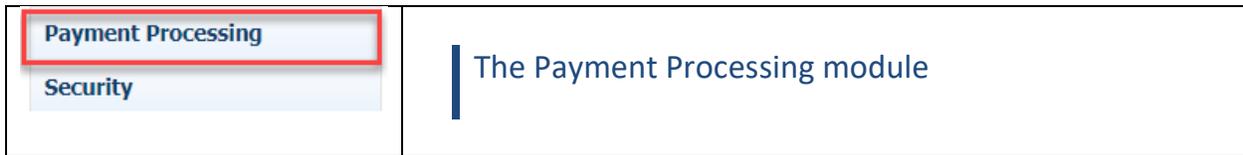
Details	Member ID	Name	Gender	Date of Birth	Member SSN	Health Plan	Provider ID	Name	Other Coverage?	Resp. Code	Policy #	HP Status	PCP Status
			F			BC			No	Unknown		Inactive	Inactive

- To view additional details about the member’s eligibility, click the **magnifying glass** (first icon) under **Details**.
- To print the member’s eligibility, click the **Print** button (second icon) under **Details**.



❖ PAYMENT PROCESSING

From the **Payment Processing** module, users are able to generate Explanation of Benefits (EOBs) for members that claims have been submitted and paid for.



• CLAIMS EOB

To print a claims EOB, follow these steps:

Step 1: From the **Payment Processing** list, select **Claims EOB**.



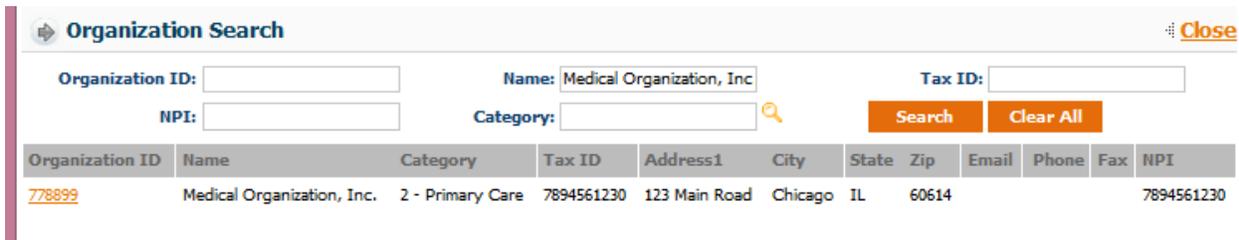
Step 2: The screen will display as shown below.



Step 3: Enter the specific member’s name that you want to generate the EOB for.

- **Note:** Users can skip this search criteria if they want to generate EOBs for multiple members from an organization.

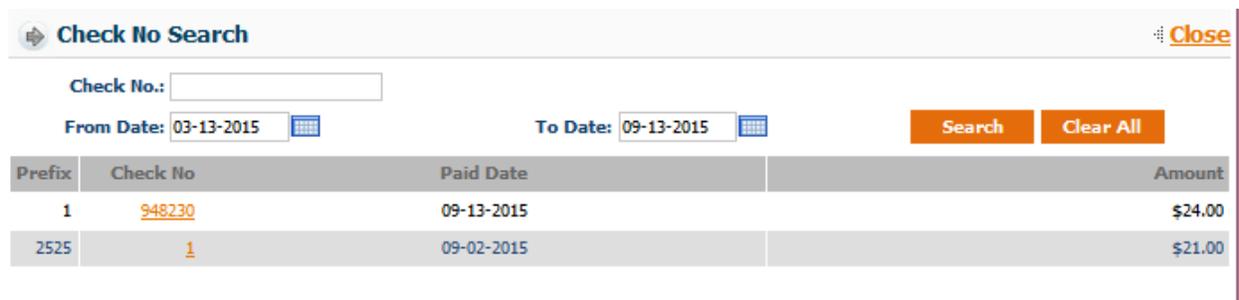
Step 4: Enter the correct organization name or search the organization by clicking the magnifying glass icon. The **Organization Search** screen will be displayed as below. Only organizations that users are affiliated with will show in the search screen.



Organization ID	Name	Category	Tax ID	Address1	City	State	Zip	Email	Phone	Fax	NPI
778899	Medical Organization, Inc.	2 - Primary Care	7894561230	123 Main Road	Chicago	IL	60614				7894561230

- Search the organization by entering any of the available information.
- Select the organization by clicking the **Organization ID**.

Step 5: Enter the check number that the EOB was paid with. If the user does not know the check number, they can search for the check by clicking the **Retrieve Check** button. The **Check No Search** screen will display as shown below.



Prefix	Check No	Paid Date	Amount
1	948230	09-13-2015	\$24.00
2525	1	09-02-2015	\$21.00

- Search the check by entering either the check number or by entering date ranges. To search for all checks ever paid, leave the fields blank and click the **Search** button.
- Select the check by clicking on the **Check No**.

Step 6: By entering the check number, the **Paid Date** field will be populated with the dates automatically. Click the **Display EOB** button and the EOBs will be generated as shown below.

QuickCap
555 WEST CHICAGO AVENUE, CHICAGO, IL
EXPLANATION OF BENEFITS

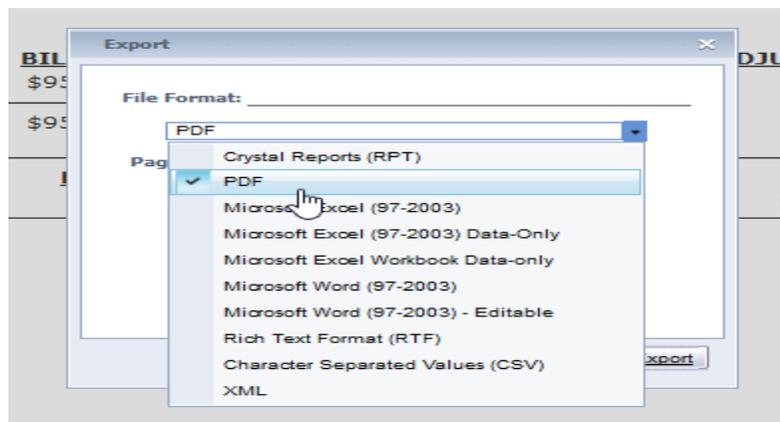
09/13/2015
Page 1 of 2

CHECK NO: 948230
PAID DATE: 09/13/2015

ORGANIZATION: 778899 Medical Organization, Inc.
PROVIDER: 999999 Smith, Micheal
MEMBER: 555444 DOE JANE
CLAIM #: 20150913T8800001

SERVICE CODE & DESCRIPTION	MOD	SVCDATE	BILLED	CNTRCT	COPAY	ADJUST	W/H	INT	NET	ADJUSTMENT CODE & DESCRIPTION
P-99213 - OFFICE/OUTPATIENT...		9/1/2015	\$95.00	\$24.00	\$0.00	\$0.00	\$0.00	\$0.00	\$24.00	
AUTH #:										
PROV ACCT:										
HEALTH PLAN: BLUE CROSS										
CLAIM TOTAL:			\$95.00	\$24.00	\$0.00	\$0.00	\$0.00	\$0.00	\$24.00	
ORGANIZATION TOTAL:			\$95.00	\$24.00	\$0.00	\$0.00	\$0.00	\$0.00	\$24.00	\$24.00

- To print the report, click the **Print** icon.
- To export the report, click the **Export** icon. An **Export** dialogue box will be populated as shown below.



- Select which file format to save the report in.
- Click the **Export** button. The report will be exported in the selected file format.

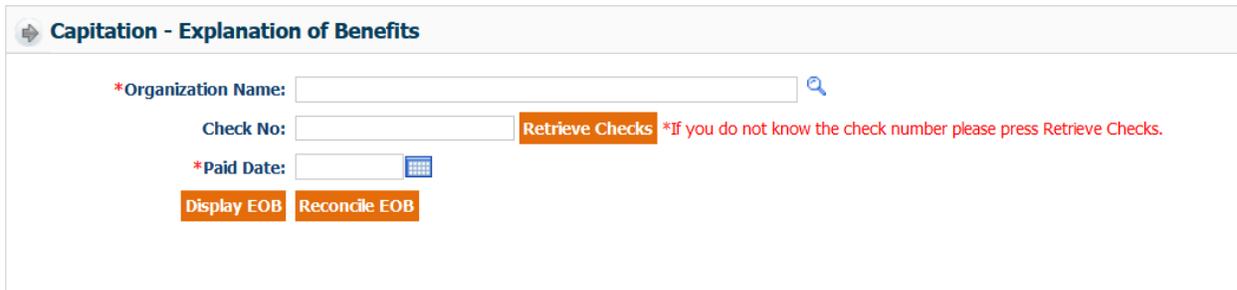
• CAPITATION EOB

To print a capitation EOB, follow these steps:

Step 1: From the **Payment Processing** list, select **Capitation Explanation of Benefits**.



Step 2: The screen will display as shown below.



The screenshot shows a web interface titled "Capitation - Explanation of Benefits". It contains the following fields and buttons:

- *Organization Name:** A text input field with a search icon to its right.
- Check No:** A text input field followed by an orange button labeled "Retrieve Checks".
- *Paid Date:** A date input field with a calendar icon to its right.
- Below the date field are two orange buttons: "Display EOB" and "Reconcile EOB".
- A red asterisked note reads: "*If you do not know the check number please press Retrieve Checks."

Step 3: The name of the **Organization** should populate automatically.

Step 4: Enter the **Check Number**, this is an optional field.

Step 5: Enter the **Paid Date**.

Step 6: Click **Display EOB**.



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