

The “Claim Status Inquiry & View Remittance Advice (RA)” How To provides instructions on how to check the status of a submitted claim and view your Remittance Advance.

- Claim Inquiry2
- View & Download RA9
- Common Adjustment & Denial Codes 19



Social Service Claim Status Inquiry & View Remittance Advice (RA)

CLICK TO BEGIN

Washington State Department of Social & Health Services
ProviderOne

Notes Menu Glossary

Welcome

Hello, and welcome to our class, Social Service Claim Status Inquiry and View Remittance Advice or RA.

At the completion of this course, you will have learned how to check the status of a submitted claim and to view and download your RA within ProviderOne.

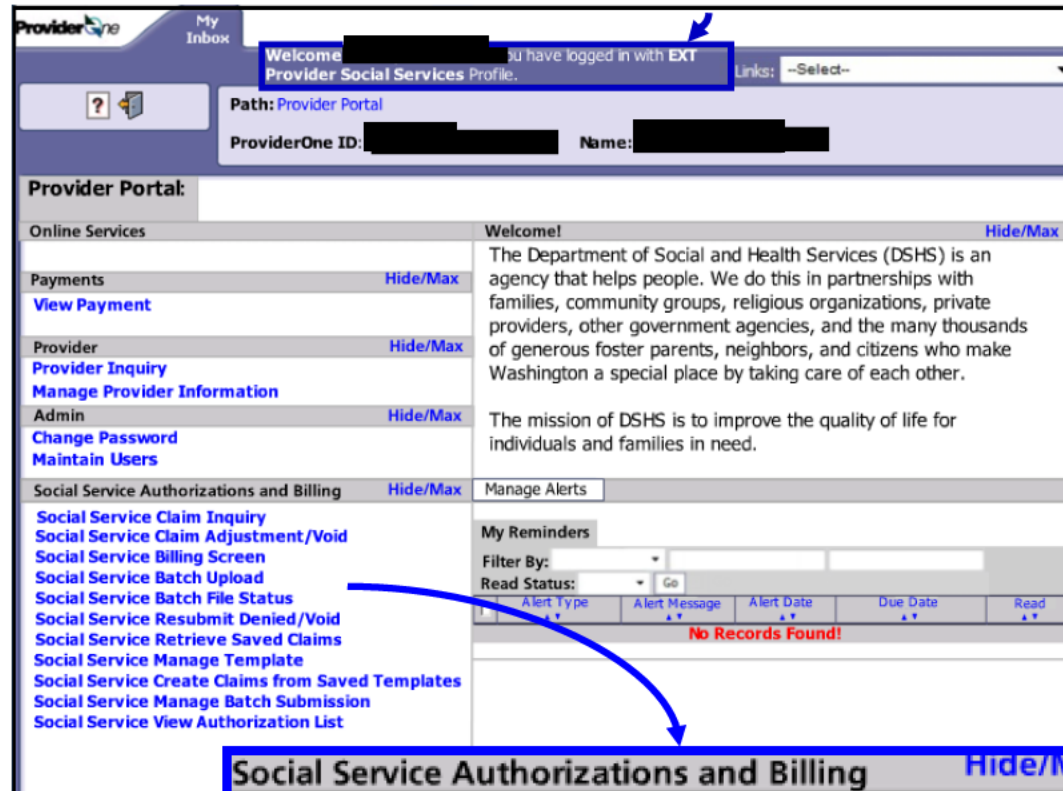
This tutorial will take approximately 10 minutes to complete.

NEXT >

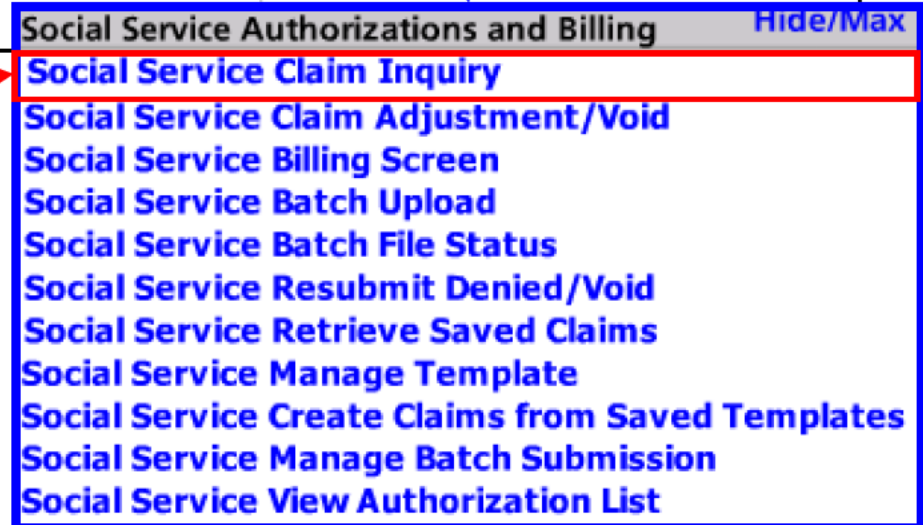
1. From the **Provider Portal**
 - a. Check that you are in the **EXT Provider Social Service** profile
2. **Click on** Social Service Claim Inquiry

1 Provider Portal

1a



2 Click on

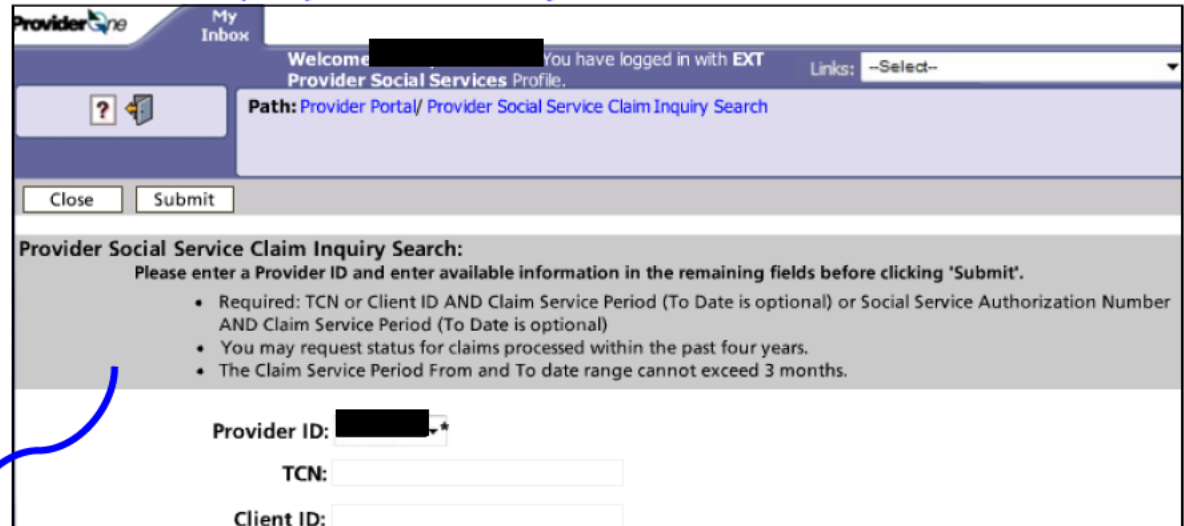


- Social Service Claim Inquiry**
- Social Service Claim Adjustment/Void
- Social Service Billing Screen
- Social Service Batch Upload
- Social Service Batch File Status
- Social Service Resubmit Denied/Void
- Social Service Retrieve Saved Claims
- Social Service Manage Template
- Social Service Create Claims from Saved Templates
- Social Service Manage Batch Submission
- Social Service View Authorization List

3. Claim Inquiry Search page appears

4. Search requirements

3 Claim Inquiry Search Page



ProviderOne My Inbox
Welcome [redacted] You have logged in with EXT
Provider Social Services Profile. Links: --Select--
Path: Provider Portal/ Provider Social Service Claim Inquiry Search
Close Submit
Provider Social Service Claim Inquiry Search:
Please enter a Provider ID and enter available information in the remaining fields before clicking 'Submit'.

- Required: TCN or Client ID AND Claim Service Period (To Date is optional) or Social Service Authorization Number AND Claim Service Period (To Date is optional)
- You may request status for claims processed within the past four years.
- The Claim Service Period From and To date range cannot exceed 3 months.

Provider ID: [redacted]*
TCN:
Client ID:

4

Provider Social Service Claim Inquiry Search:
Please enter a Provider ID and enter available information in the remaining fields before clicking 'Submit'.

- Required: TCN or Client ID AND Claim Service Period (To Date is optional) or Social Service Authorization Number AND Claim Service Period (To Date is optional)
- You may request status for claims processed within the past four years.
- The Claim Service Period From and To date range cannot exceed 3 months.

You can search by:

- Transaction Control Number (TCN) or
- Client ID and Claim Service Period (To Date is optional) or
- Authorization # and Claim Service Period (To Date is optional).

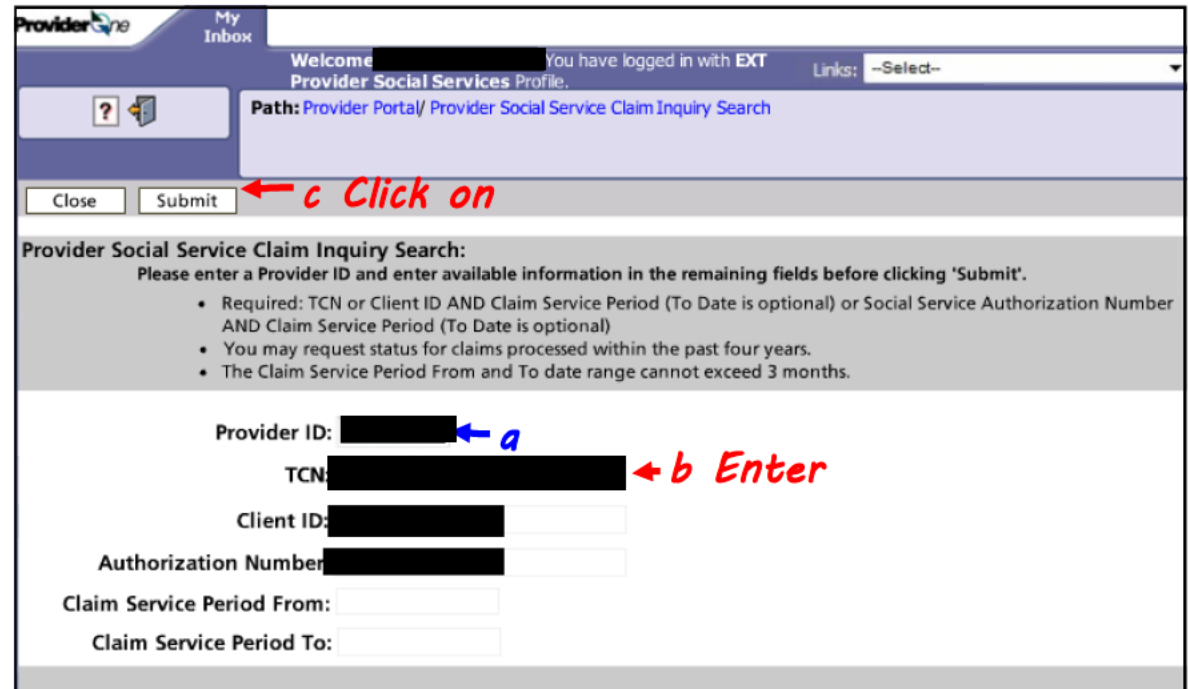
Search requests must be for claims submitted within the past 4 years.

The Claim Service Period (From Date & To Date) cannot exceed 3 months.

Transaction Control Number (TCN) Search

- Verify Provider ID
- Enter Transaction Control Number (TCN)
- Click on Submit

Claim Inquiry Search Page



The screenshot shows the 'Claim Inquiry Search Page' in a web browser. The page header includes the 'ProviderOne' logo, 'My Inbox', and a welcome message: 'Welcome [redacted] You have logged in with EXT Provider Social Services Profile.' A dropdown menu for 'Links' is set to '-Select-'. The breadcrumb path is 'Provider Portal / Provider Social Service Claim Inquiry Search'. Below the path are 'Close' and 'Submit' buttons. A red arrow points to the 'Submit' button with the text 'c Click on'. The main content area is titled 'Provider Social Service Claim Inquiry Search:' and contains instructions: 'Please enter a Provider ID and enter available information in the remaining fields before clicking 'Submit''. A bulleted list of requirements follows: 'Required: TCN or Client ID AND Claim Service Period (To Date is optional) or Social Service Authorization Number AND Claim Service Period (To Date is optional)', 'You may request status for claims processed within the past four years.', and 'The Claim Service Period From and To date range cannot exceed 3 months.' Below the instructions are input fields for 'Provider ID', 'TCN', 'Client ID', 'Authorization Number', 'Claim Service Period From', and 'Claim Service Period To'. Blue and red arrows point to the 'Provider ID' and 'TCN' fields respectively, with the text 'a' and 'b Enter' next to them.

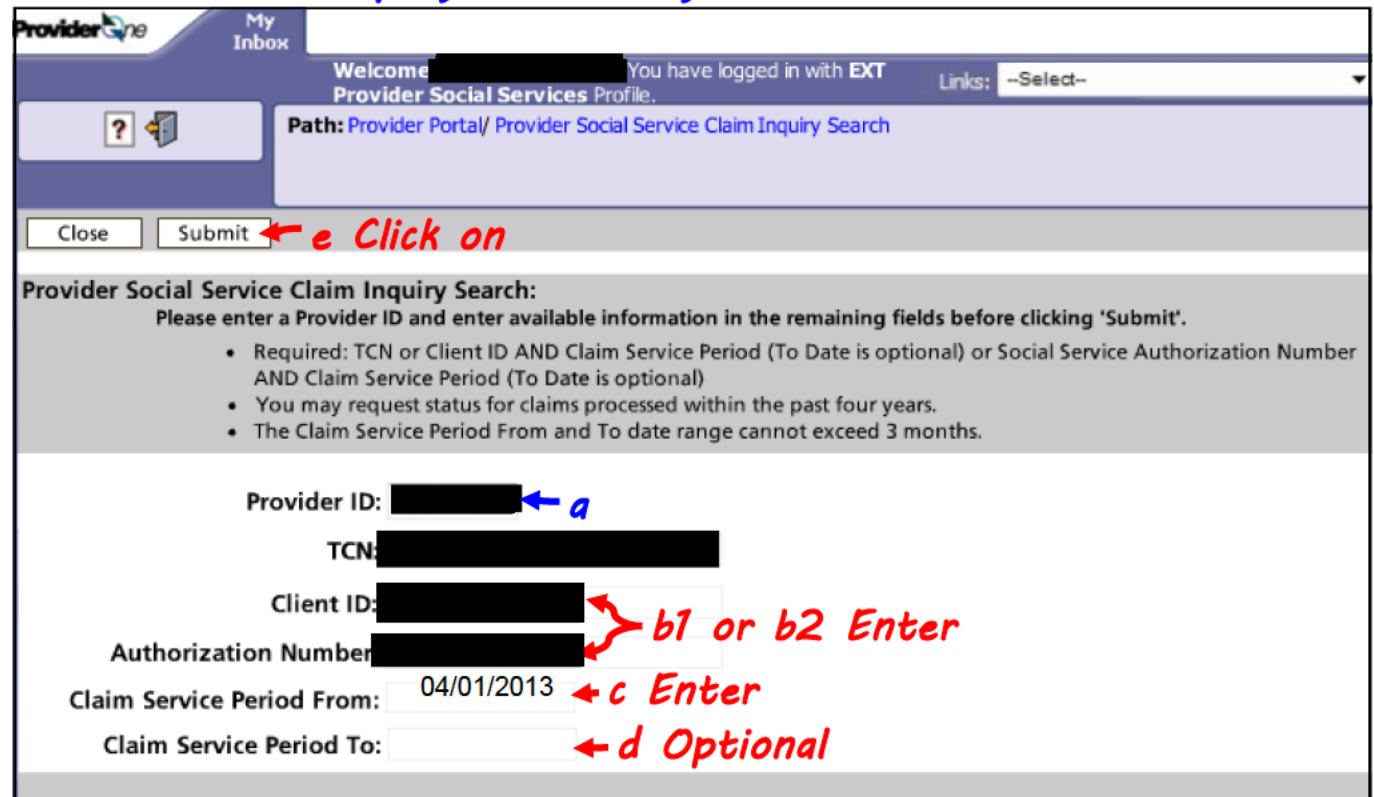
Client ID & Authorization Number Search

- a. **Verify** Provider ID
- b. Search
 1. **Enter** Client ID number

Or

2. **Enter** Authorization number
- c. **Enter** Claim Service Period from date
- d. **Enter** Claim Service Period To date (optional)
- e. **Click on** Submit

Claim Inquiry Search Page



The screenshot shows the 'Claim Inquiry Search Page' in the ProviderOne system. The page header includes 'My Inbox', a welcome message, and a dropdown menu for 'Links'. The breadcrumb path is 'Provider Portal / Provider Social Service Claim Inquiry Search'. Below the path are 'Close' and 'Submit' buttons. A red arrow points to the 'Submit' button with the text 'e Click on'. The main content area is titled 'Provider Social Service Claim Inquiry Search:' and contains instructions: 'Please enter a Provider ID and enter available information in the remaining fields before clicking 'Submit''. A bulleted list of requirements follows: 'Required: TCN or Client ID AND Claim Service Period (To Date is optional) or Social Service Authorization Number AND Claim Service Period (To Date is optional)', 'You may request status for claims processed within the past four years.', and 'The Claim Service Period From and To date range cannot exceed 3 months.' Below the instructions are input fields for 'Provider ID', 'TCN', 'Client ID', 'Authorization Number', 'Claim Service Period From', and 'Claim Service Period To'. Annotations include: a blue arrow 'a' pointing to the 'Provider ID' field; a red arrow 'b1 or b2 Enter' pointing to the 'Client ID' field; a red arrow 'c Enter' pointing to the 'Claim Service Period From' field (which contains '04/01/2013'); and a red arrow 'd Optional' pointing to the 'Claim Service Period To' field.

- Inquire Claims List appears showing search results

6 Inquire Claims List

- View TCN

- View Claim Status

- View Claim Payment Amount

- Click on TCN

10 Click on

- 11. Claims Details appears
- 12. Status Category Code
- 13. Status
- 14. Charge and Payment amounts
- 15. Scroll down

12

Status Category Code: F1:Finalized/Payment-The claim/line has been paid.

13

Status: 1: For more detailed information, see remittance advice.

11 Claims Details

Claim Details:

Status Information Effective Date: 04/03/2013
 Status Category Code: F1:Finalized/Payment-The claim/line has been paid.
 Service Period: 04/01/2013 To 04/01/2013
 Bill Type Identifier:
 Charged Amount: \$575.00
 Payment Amount: \$120.00

Payment method Code: CHK

Medical Record Number:
 Adjudication or Payment Date: 04/01/2013
 Check Issue or EFT Effective Date: 04/01/2013

Check or EFT Trace Number: [REDACTED]

Remit/Remarks Codes

14

**Charged Amount: \$575.00
 Payment Amount: \$120.00**

15 Scroll →

Provider Data:
 ProviderOne ID: [REDACTED]
 Name or Servicing Organization: [REDACTED]

Client Data:
 Name: [REDACTED] Client ID: [REDACTED]
 Date of Birth: [REDACTED] Gender: M

Payer Data:
 Name: WASHINGTON STATE DSHS MAA Identification: 77859

Unit Item Detail Data:

16 Claims Details

16. Claims Details

17. Scroll up

Line item (daily claim) information is found on the Remittance Advice.

If a claim has been denied, you can choose to resubmit the claim.

Payer Data:	
Name: WASHINGTON STATE DSHS MAA	Identification: 77859
Unit Item Detail Data:	
1	<p>Status Effective Date: 04/03/2013 Status Category Code: F1 Status: 1 Prov/Svc Code: SA114 Service Line Date: 04/01/2013 To 04/01/2013 Charged Amount: \$575.00 Payment Amount: \$120.00 Procedure Modifier 1: Procedure Modifier 2:</p>
	<p>Product or Service ID Qualifier: Revenue Code: Units of Service: 10 Procedure Modifier 3: Procedure Modifier 4:</p>
Information Receiver Data:	
Name or Submitting Organization:	Portal ID:

17 Click on

18. Click on Close

18 Click on

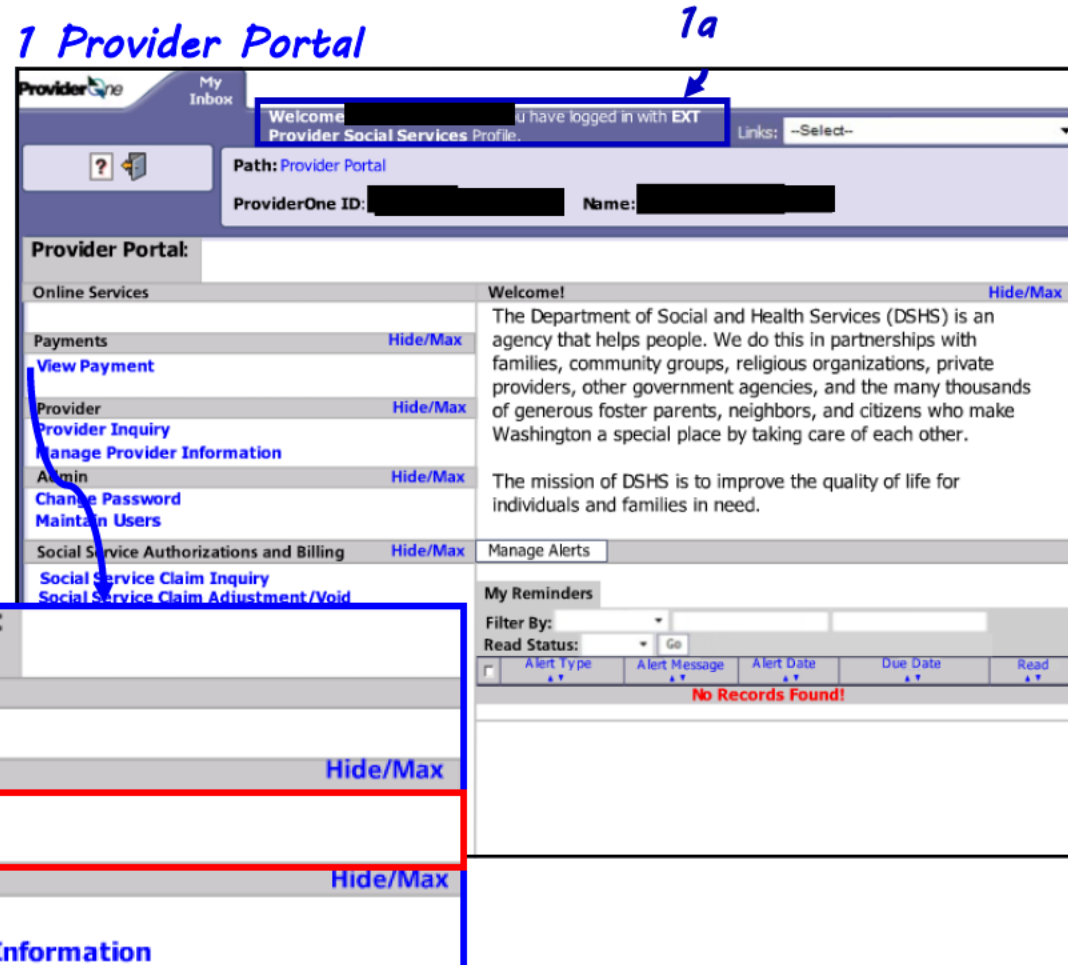
Close	
Claim Details:	
Status Information Effective Date: 04/03/2013	TCN: [REDACTED]
Status Category Code: F1:Finalized/Payment-The claim/line has been paid.	Status: 1: For more detailed information, see remittance advice.
Service Period: 04/01/2013 To 04/01/2013	
Bill Type Identifier:	Medical Record Number:
Charged Amount: \$575.00	Adjudication or Payment Date: 04/01/2013
Payment Amount: \$120.00	Check Issue or EFT Effective Date: 04/01/2013
Payment method Code: CHK	Check or EFT Trace Number: [REDACTED]
Provider Data:	Remit/Remarks Codes

This section covers how to view and download a Remittance Advice (RA).

1. From the **Provider Portal**
 - a. Check that you are in the **EXT Provider Social Service** profile
2. **Click on View Payment**

1 Provider Portal

1a



Provider Portal:

Online Services	Hide/Max
Payments	Hide/Max
View Payment	
Provider	Hide/Max
Provider Inquiry	
Manage Provider Information	
Admin	Hide/Max
Change Password	
Maintain Users	
Social Service Authorizations and Billing	Hide/Max
Social Service Claim Inquiry	
Social Service Claim Adjustment/Void	

Provider Portal:

Online Services	Hide/Max
Payments	Hide/Max
View Payment	
Provider	Hide/Max
Provider Inquiry	
Manage Provider Information	

2 Click on →

3. RA Payment List appears

4. The lists shows the basic information for each RA

Each Remittance Advice (RA) is based on a location.

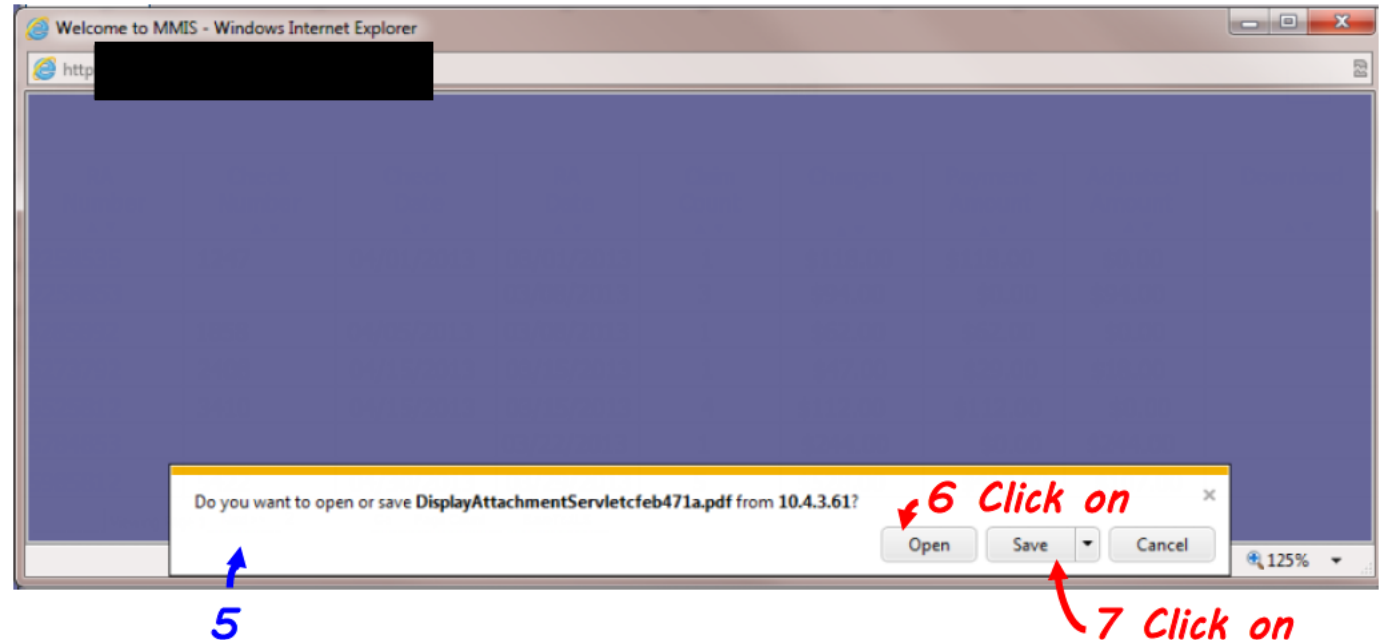
a. Click on RA number

3 RA Payment List

4 →
a Click on →

RA Number	Check Number	Check Date	RA Date	Claim Count	Charges	Payment Amount	Adjusted Amount	Download
[REDACTED]	1247	04/01/2013	03/01/2013	1	\$118.00	\$118.00	\$0.00	
			03/08/2013	3	\$94.00	\$0.00	\$94.00	
	1858	04/05/2013	03/08/2013	1	\$62.00	\$62.00	\$0.00	
	2408	04/15/2013	03/15/2013	1	\$47.00	\$29.00	\$18.00	
	3410	04/15/2013	03/15/2013	4	\$112.00	\$112.00	\$0.00	
			03/22/2013	1	\$244.00	\$0.00	\$244.00	
	5422	04/30/2013	03/29/2013	5	\$528.00	\$412.00	\$107.00	

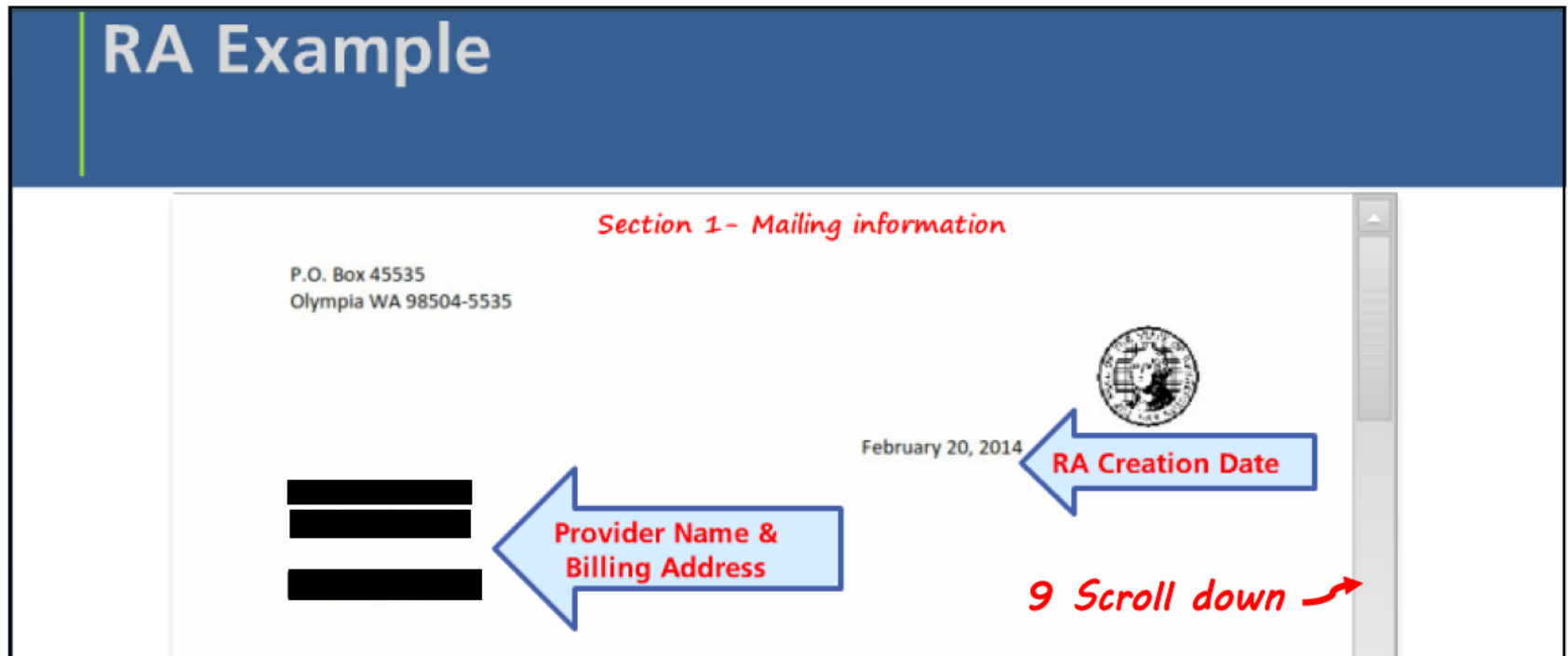
5. Pop-up appears
6. Click on Open PDF
7. To save, click on Save



8. RA appears

9. Scroll down

You can save or print the PDF. Remember, RA can contain multiple page and use a lot of paper and ink to print.



The screenshot shows a document titled "RA Example" with a blue header. The main content area is titled "Section 1- Mailing information" in red. It contains the following text: "P.O. Box 45535", "Olympia WA 98504-5535", and three lines of redacted text. To the right, there is a circular seal and the date "February 20, 2014". A blue arrow points from the date to the text "RA Creation Date". Another blue arrow points from the redacted text to the text "Provider Name & Billing Address". A red arrow points to the bottom right corner of the page with the text "9 Scroll down".

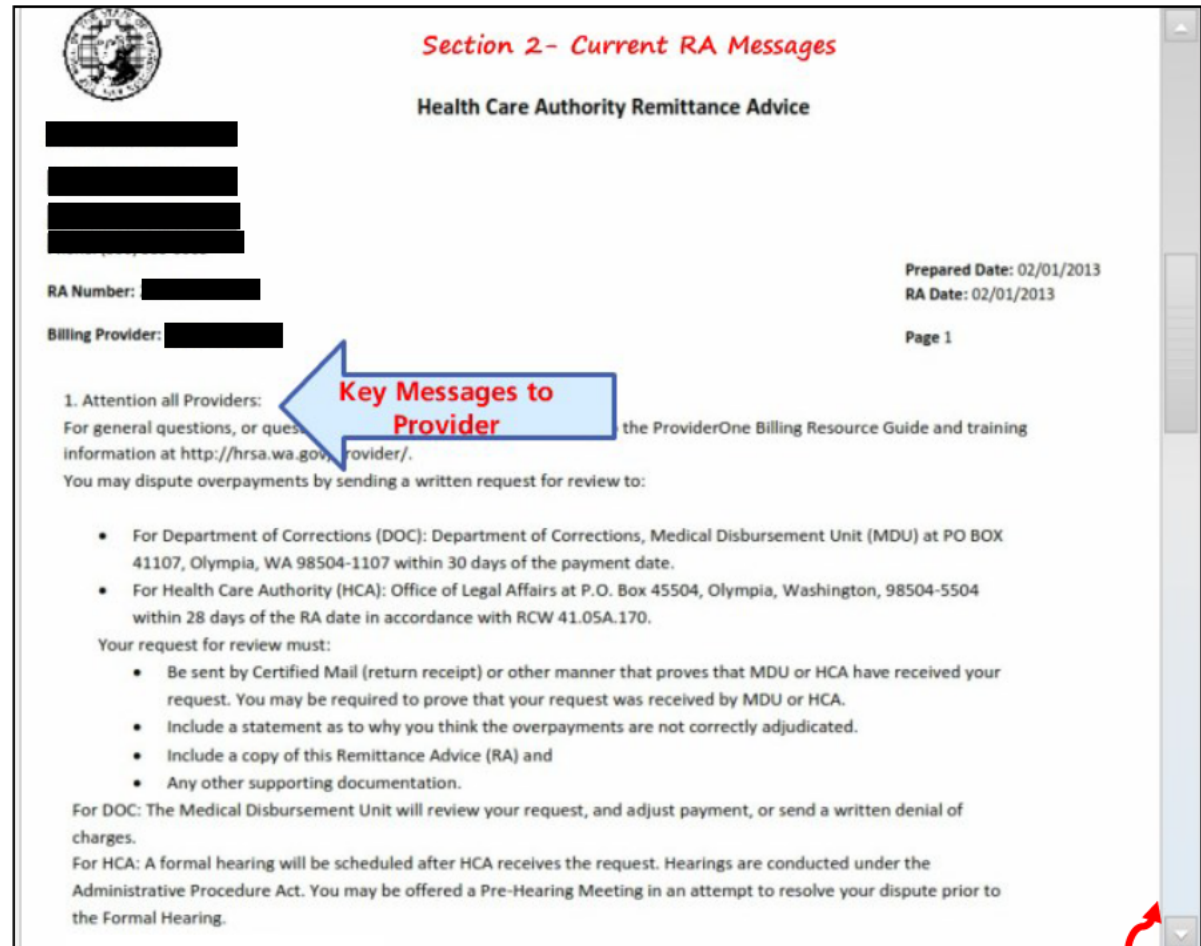
Section 1 Mailing Information

- RA Creation Date
- Provider Name & Billing Address

10. Scroll down

Section 2 Current RA Messages

- Key Messages to Provider from the Health Care Authority about changes and new information.



Section 2- Current RA Messages

Health Care Authority Remittance Advice

Prepared Date: 02/01/2013
RA Date: 02/01/2013
Page 1

RA Number: [REDACTED]
Billing Provider: [REDACTED]

1. Attention all Providers:
For general questions, or questions regarding the ProviderOne Billing Resource Guide and training information at <http://hrsa.wa.gov/provider/>.
You may dispute overpayments by sending a written request for review to:

- For Department of Corrections (DOC): Department of Corrections, Medical Disbursement Unit (MDU) at PO BOX 41107, Olympia, WA 98504-1107 within 30 days of the payment date.
- For Health Care Authority (HCA): Office of Legal Affairs at P.O. Box 45504, Olympia, Washington, 98504-5504 within 28 days of the RA date in accordance with RCW 41.05A.170.

Your request for review must:

- Be sent by Certified Mail (return receipt) or other manner that proves that MDU or HCA have received your request. You may be required to prove that your request was received by MDU or HCA.
- Include a statement as to why you think the overpayments are not correctly adjudicated.
- Include a copy of this Remittance Advice (RA) and
- Any other supporting documentation.

For DOC: The Medical Disbursement Unit will review your request, and adjust payment, or send a written denial of charges.
For HCA: A formal hearing will be scheduled after HCA receives the request. Hearings are conducted under the Administrative Procedure Act. You may be offered a Pre-Hearing Meeting in an attempt to resolve your dispute prior to the Formal Hearing.

10 Scroll down

11. Scroll down

Section 3 - Claims Summary

RA Number: [REDACTED] Warrant/EFT Date: 03/01/2013 Prepared Date: 02/01/2013
Warrant/EFT #: [REDACTED] **Payment Date** RA Date: 02/01/2013

Warrant/EFT Amount: \$118.00 Payment Method: None Page 2

Total Payment

Claims Summary								Provider Adjustments						
Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total TPL Amount	Total Sales Tax	Total Client Resp Amount	Total Paid	Billing Provider	FIN Invoice Number: Parent TCN	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
[REDACTED]	Paid	\$118.00	\$118.00	\$0.00	\$0.00	\$0.00	\$118.00	[REDACTED]	11404911584	System Initiated	NOC Invoice	\$0.00	\$0.00	\$100.00

Total Adjustment Amount \$0.00

Total # of Paid Claims & deductions

11 Scroll down


- Section 3 Payment Summary
- Total Payment
 - Payment Date
 - Total number of claims & deductions

12. Scroll down

Section 4- RA Payment Information

RA Number: [REDACTED] Warrant/EFT #: [REDACTED] Warrant/EFT Date: 03/01/2013 Prepared Date: 02/01/2013 RA Date: 02/01/2013
 Category: Paid Billing Provider: [REDACTED] Page 3

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line/ Rendering # / Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
[REDACTED]	[REDACTED] Social Service	1	01/15/2013 01/15/2013	SA262	1	\$118.00	\$118.00	\$0.00	\$0.00	\$0.00	\$118.00		
Document Total: 01/15/2013-01/15/2013					1	\$118.00	\$118.00	\$0.00	\$0.00	\$0.00	\$118.00		
Category Total:													
Billing Provider Total:					1	\$118.00	\$118.00	\$0.00	\$0.00	\$0.00	\$118.00		



Detailed information about your paid claims

12 Scroll down

Section 4 RA Payment Information

Reading the RA

Third Party Liability:
IE insurance

RA Number: [REDACTED]		Warrant/EFT #: [REDACTED]		Warrant/EFT Date: 01/09/2015		Prepared Date: 01/09/2015		RA Date: 01/09/2015		Page 3				
Category: Paid		Billing Provider: [REDACTED]												
Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	IPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
[REDACTED]	ADSA-D 123456789	1	868	01/01/2015-01/01/2015	T1020 U1	1.0000	\$57.24	\$57.24	\$0.00	\$0.00	\$0.00	\$57.24		
[REDACTED]	ADSA-D 123456789	2	868	01/02/2015-01/02/2015	T1020 U1	1.0000	\$57.24	\$57.24	\$0.00	\$0.00	\$0.00	\$57.24		
[REDACTED]	[REDACTED]			1/03/2015-1/03/2015	T1 U1					\$0.00				
[REDACTED]	[REDACTED]			1/04/2015-1/04/2015	T1 U1					\$0.00				
[REDACTED]	ADSA-D 123456789	5	868	01/05/2015-01/05/2015	T1 U1					\$0.00	\$0.00	\$57.24		
Document Total:				01/01/2015-01/05/2015		5.0000	\$286.20	\$286.20	\$0.00	\$0.00	\$0.00	\$286.2		
[REDACTED]	ADSA-D 654321987	1	868	01/01/2015-01/01/2015	T1020 U1	1.0000	\$61.30	\$61.30	\$0.00	\$0.00	\$61.30	\$0.00		142 = \$61.30
[REDACTED]	ADSA-D 654321987	2	868	01/02/2015-01/02/2015	T1020 U1	1.0000	\$61.30	\$61.30	\$0.00	\$0.00	\$61.30	\$0.00		142 = \$61.30
[REDACTED]	ADSA-D 654321987	3	868	01/03/2015-01/03/2015	T1020 U1	1.0000	\$61.30	\$61.30	\$0.00	\$0.00	\$61.30	\$0.00		142 = \$61.30
[REDACTED]	ADSA-D 654321987	4	868	01/04/2015-01/04/2015	T1020 U1	1.0000	\$61.30	\$61.30	\$0.00	\$0.00	\$61.30	\$0.00		142 = \$61.30
[REDACTED]	ADSA-D 654321987	5	868	01/05/2015-01/05/2015	T1020 U1	1.0000	\$61.30	\$61.30	\$0.00	\$0.00	\$61.30	\$0.00		142 = \$61.30
Document Total:				01/01/2015-01/05/2015		5.0000	\$306.50	\$306.50	\$0.00	\$0.00	\$306.50	\$0.00		

The RA is divided into client sections

Responsibility/participation is applied first. Once responsibility has been met, state payment begins.

Adjustment Code and Remarks Code: See next page.

Each service line of the claim(s) is listed. If you used a date range, the range has been divided into daily lines.

13. Scroll down

Adjustment Reason Codes / NCPDP Rejection Codes
142: Monthly Medicaid patient liability amount.

The Reason Code provides an explanation of why the paid amount was adjusted (why it is less than the billed amount)

Remarks Codes
N54: Claim information is inconsistent with pre-certified/authorized services.

The Remarks Code provides explanation explanations of why the paid amount was adjusted (why it is less than the billed amount)

Examples of Reason Codes

119 : Benefit maximum for this time period or occurrence has been reached.
--

18 : Exact duplicate claim/service

14. To return to the Provider Portal from the [RA Payment List](#)

15. **Click on** Close

14 RA Payment List

15 Click on →

<input type="button" value="Close"/>								
RA Payment List:								
Filter By: <input type="text"/> And <input type="text"/> <input type="button" value="Go"/>								
RA Number ▲▼	Check Number ▲▼	Check Date ▲▼	RA Date ▲▼	Claim Count ▲▼	Charges ▲▼	Payment Amount ▲▼	Adjusted Amount ▲▼	Download ▲▼
[REDACTED]	1247	04/01/2013	03/01/2013	1	\$118.00	\$118.00	\$0.00	
			03/08/2013	3	\$94.00	\$0.00	\$94.00	
	1858	04/05/2013	03/08/2013	1	\$62.00	\$62.00	\$0.00	
	2408	04/15/2013	03/15/2013	1	\$47.00	\$29.00	\$18.00	
	3410	04/15/2013	03/15/2013	4	\$112.00	\$112.00	\$0.00	
				03/22/2013	1	\$244.00	\$0.00	\$244.00
	5422	04/30/2013	03/29/2013	5	\$528.00	\$412.00	\$107.00	
<input type="button" value="Prev"/> Viewing Page 1 <input type="button" value="Next"/> 2 <input type="button" value="Go"/> Page Count <input type="button" value="SaveToXLS"/>								

Below is a short list of common Adjustment Reason and Remarks Codes you may find on your Remittance Advice (RA)

RA adjustment reason/remark code/description	Possible causes	Provider action
142- Monthly Medicaid patient liability amount.	Client responsibility (participation) applied to the claim	You must collect this amount from the client
198- Precertification/authorization exceeded	Social Service Authorization Approved Units have already been claimed	Contact your case worker if you question the number of units authorized
16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication	<ol style="list-style-type: none"> 1. Claimed dates of service are not within the authorization period 2. The authorization line is in error 	<ol style="list-style-type: none"> 1. Contact your case worker if you have questions about the authorization dates 2. Contact your case worker if you have questions about authorization errors
18- Exact duplicate claim/service	<ol style="list-style-type: none"> 1. Claimed the same units on two different lines for the same day, or 2. Claim is an exact duplicate of one already submitted 	<ol style="list-style-type: none"> 1. Adjust the claim and report the number of units on a single claim line 2. No action is needed if duplication was unintended.
177-Patient has not met the required eligibility requirements	The client is not financially eligible	Contact your case worker if you have questions
A1-Claim/Service denied	The authorization is in cancelled status	Contact your case worker if you have questions
B7-This provider was not certified/eligible to be paid for this procedure/service on this date of service	Your contract may be expired.	Contact your contract manager or case worker if you have questions
N54-Claim information is inconsistent with pre-certified/authorized services	Authorization line is in error	Contact your case worker if you have questions
N63-Rebill services on separate claim lines	A separate claim line is required for each date of service for the service/procedure code entered	If you are billing quarter hour units or for each unit types, do not use a date span (example: 1/1/2015 to 1/31/2015) to bill. Adjust the claim to reflect separate claim lines for the date of service for each service provided and resubmit claim
N362 : The number of Days or Units of Service exceeds our acceptable maximum	Too many units claimed. Example: Provider billed two units on monthly units or provider billed two units on daily units with one day date span	Change the number of units to the correct amount and resubmit your claim