



Medicaid Billing Workshop for Medical Providers

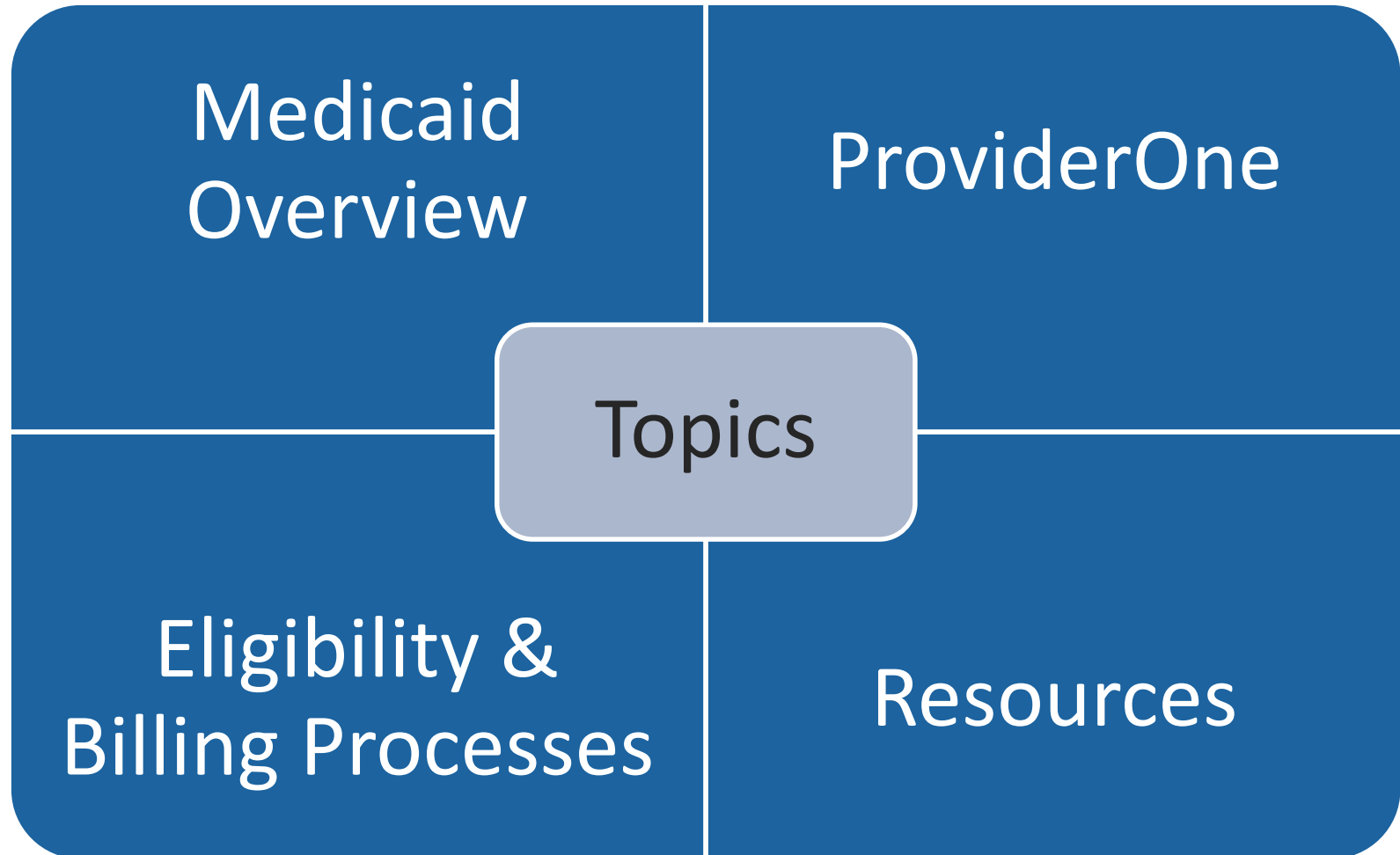
Provider Relations Unit
2017

Who is Provider Relations and what do we do?

Provide outreach and training for Washington Apple Health (Medicaid) providers

Specialize in the use of the ProviderOne portal

Assist with program and policy questions



Medicaid Overview

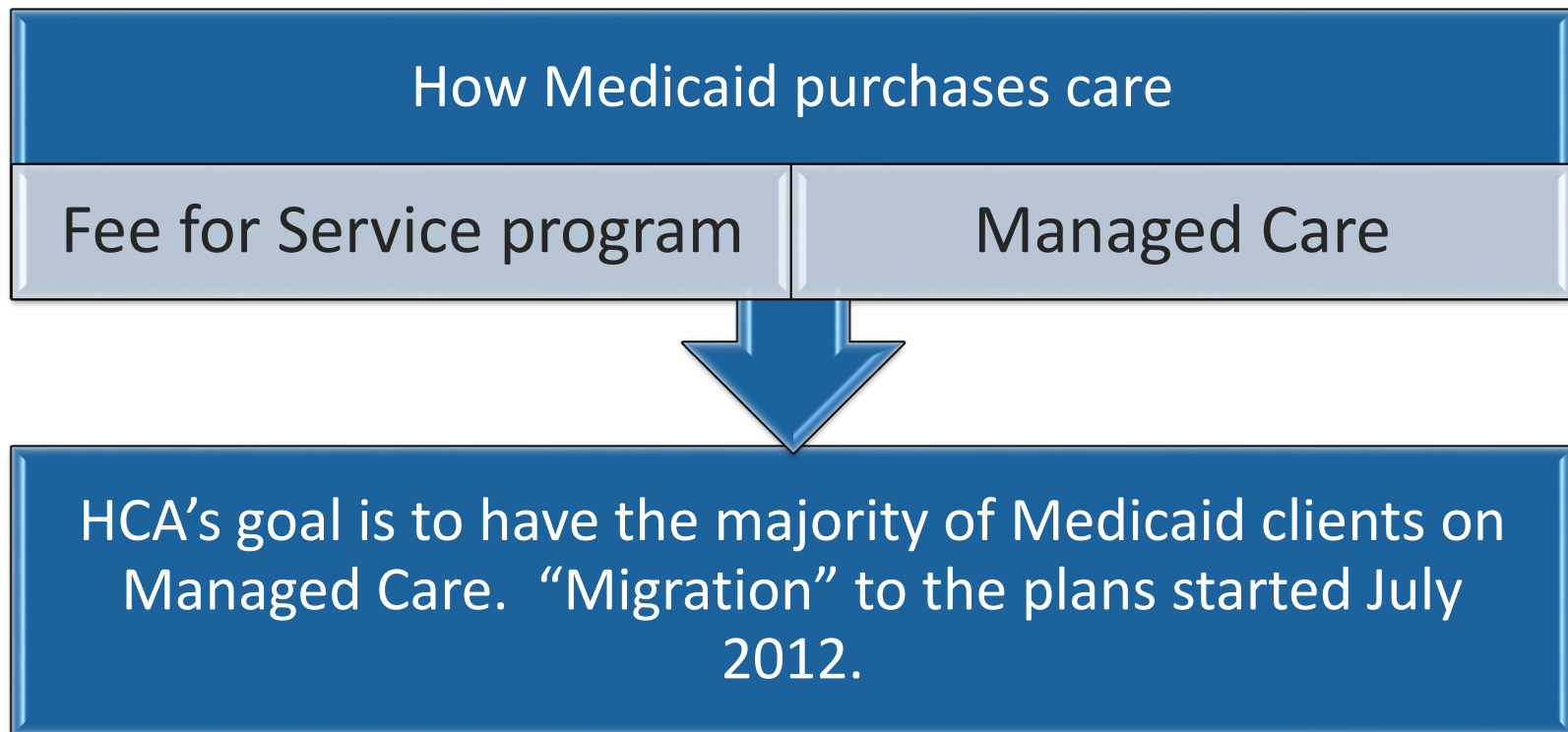
Medicaid Overview

Medicaid is no longer managed by DSHS

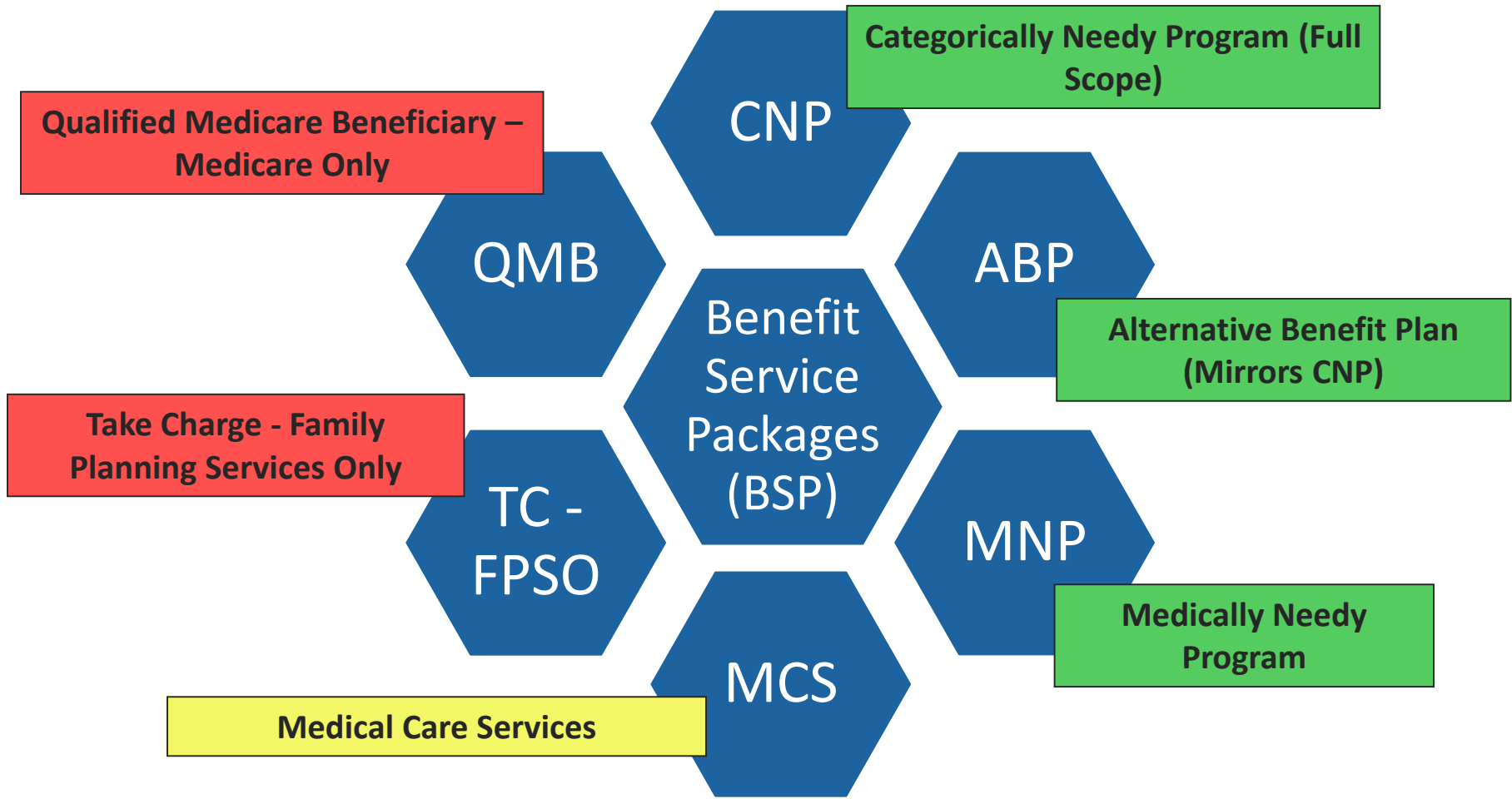
Medicaid is managed by the Health Care Authority

“Apple Health” is the new name for Medicaid

Medicaid Overview



Eligibility Programs



For a complete listing of BSP, visit the [ProviderOne Billing and Resource Guide](#).

Accessing ProviderOne

Accessing ProviderOne

➤ Before logging into ProviderOne:

- Make sure you are using one of the following and your popup blockers are turned **OFF**:

Computer operating systems	Internet browsers
Windows <ul style="list-style-type: none"> • 10 • 8.1 • 8 • 7 	Internet Explorer <ul style="list-style-type: none"> • 11 • 10
Macintosh <ul style="list-style-type: none"> • OS 10.12 Sierra • OS X 10.11 El Capitan • OS X 10.10 Yosemite 	Google Chrome <ul style="list-style-type: none"> • 55.0.2883 • 54.0.2840
	Firefox <ul style="list-style-type: none"> • 50.0.2 • 45.5.1 ESR
	Safari <ul style="list-style-type: none"> • 10.0.1

Accessing ProviderOne

- Use web address:
<https://www.waproviderone.org>
- Ensure that your system “**Pop Up Blockers**” are turned “**OFF**”.
- Login using assigned Domain, Username, and Password.
- Click the “**Login**” button.

ProviderOne

Domain Name

User Name

Password

Login

Note: The Domain, Username and Password fields are case sensitive.

Unlock Account and Reset Password? [Click here](#)

If you are a Client, [Click here](#)

Login Problems? [Click here](#)

ProviderOne Users

HCA establishes System Administrators for your domain/NPI

- A System Administrator can assign profiles to other users as necessary.
- Staff can be assigned one or more security profiles to meet their job duties and provide them the level of access necessary in the system.

Visit the [ProviderOne Security](#) web page.


How to Get Access in ProviderOne

- Review the [ProviderOne Security](#) web page for detailed instructions on setting up users.
- New provider and don't have the form? Email ProviderOne Security at: provideronesecurity@hca.wa.gov (in the subject line enter "Request for ProviderOne User Access Request form").

How to Get Access in ProviderOne

- The ProviderOne User Access Request form is for a newly enrolled Facility, Clinic, Individual Provider, or a new Office Administrator.
- Complete the form and fax to: 360-507-9019.
- If changing System Administrators, a letter on office correspondence must also be completed and faxed with the form.

State of Washington



ProviderOne User Access Request

IMMEDIATE ACTION REQUIRED

ProviderOne Id:

In order to gain access to ProviderOne, you must complete and return this form. This form will be used to establish the System Administrator for your assigned Domain (ProviderOne ID) in the ProviderOne system.

The System Administrator is responsible for maintaining access to ProviderOne for your staff; which includes setting up accounts for additional users, assigning profiles to user accounts, and resetting user passwords.

Once you have completed and returned this form, we will send a username and a temporary password in two separate emails to the email address you provide.

ProviderOne System Administrator Information	
Name of System Administrator (First, Middle Initial, Last) <input type="text"/>	Physical Address Street: <input type="text"/> City: <input type="text"/> , State: <input type="text"/> Zip: <input type="text"/>
System Administrator's Date of Birth mm/dd/yyyy <input type="text"/>	Business Name <input type="text"/>
System Administrator's Individual Email Address (generic email addresses will not be accepted) <input type="text"/>	National Provider Identifier (NPI if applicable) <input type="text"/>
System Administrator's Phone Number <input type="text"/>	Federal Tax ID (FEIN/SSN) <input type="text"/>

Each domain user must have his/her own account:

With the system administrator login information, we will send instructions on how to create additional user accounts for your Domain and how to add profiles to the accounts.

*To better understand the different types of user profiles, look for the **Provider Information** link on our site: <http://www.hca.wa.gov/Medicaid/provider/Pages/index.aspx>*

To review or update provider information:

You may edit information in your provider file at any time by using the EXT Provider Maintenance or EXT Super User profile. Once you receive your login information, please verify the accuracy of all the data in your provider file.

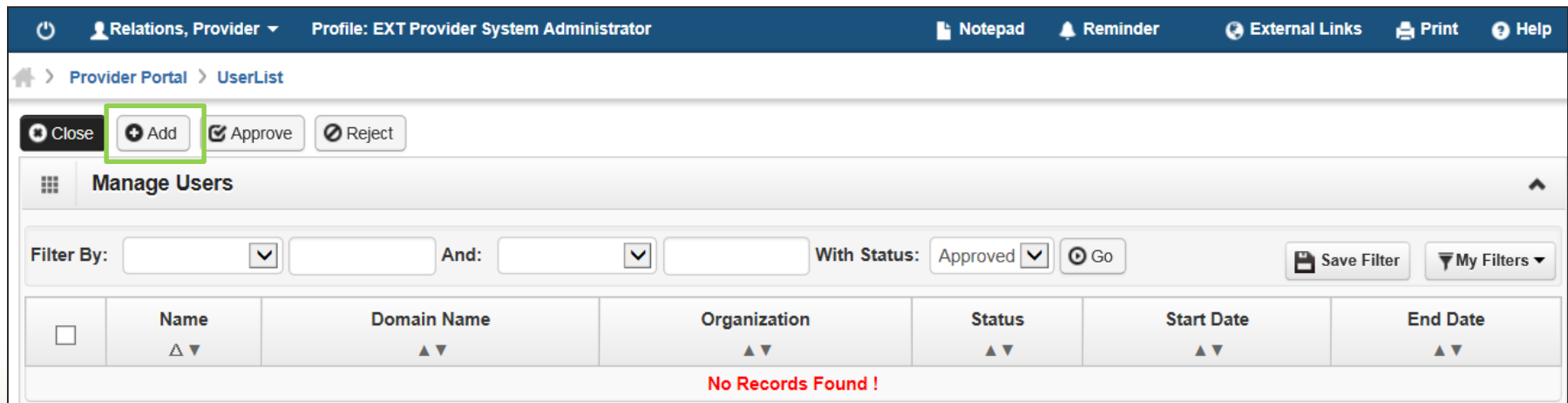
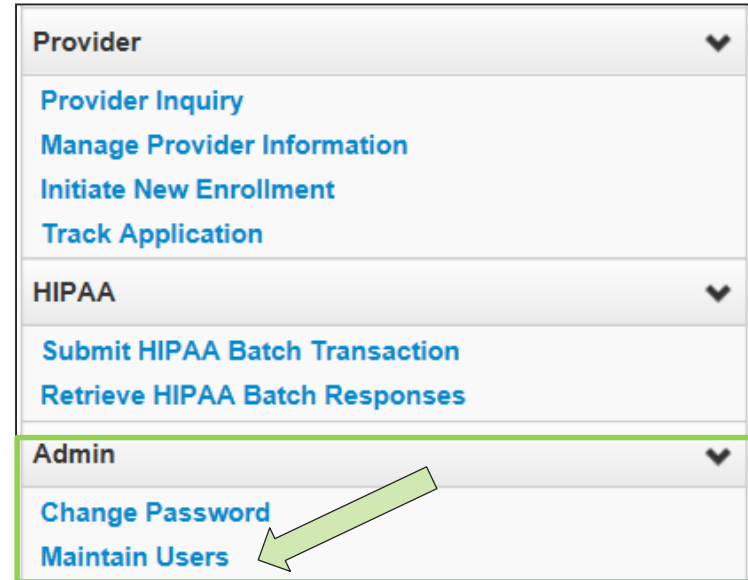
- Address Information
- Payment Detail; and
- Electronic Data Interchange Information if you plan on submitting HIPAA batch files

If updates are made in the Provider File Business Process Wizard, please make sure you go to the last step and *submit* your modification request for review and approval. Include a copy of the bar code coversheet on any documentation you send. http://hrs.a.dshs.wa.gov/download/document_submission_cover_sheets.html

Return this completed form by email: provideronesecurity@hca.wa.gov, or
 Fax to: (360) 507-9019 or
 Mail to: HCA IT Security, PO Box 45512, Olympia, WA 98504-5512

How to Set Up a User

- Log in with the **System Administrator** Profile.
- Click on **Maintain Users**.
- The system now displays the User List screen.
- Click on the **Add** button.



How to Set Up a User

➤ Adding a user:

☰ **Add User** ▲

Please enter the following information:

<p>First Name: <input type="text"/> *</p> <p>Last Name: <input type="text"/> *</p> <p>User Login ID: <input type="text"/> *</p> <p>Date of Birth: <input type="text"/> <input type="button" value="📅"/> *</p> <p>Domain Name: 9999999</p> <p>Start Date: <input type="text" value="01/05/2016"/> <input type="button" value="📅"/> *</p> <p>Status: <input type="text" value="In Review"/> ▼</p> <p>Comments: <input style="width: 100%;" type="text"/></p>	<p>Middle Name: <input type="text"/></p> <p>User Type: <input type="text" value="Batch User"/> ▼ *</p> <p>EID: <input type="text"/> *</p> <p>Expiration Date: <input type="text" value="12/31/2999"/> <input type="button" value="📅"/> *</p>
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➤ Fill in all required boxes that have an asterisk *.

➤ Click the **Next** button.

How to Set Up a User

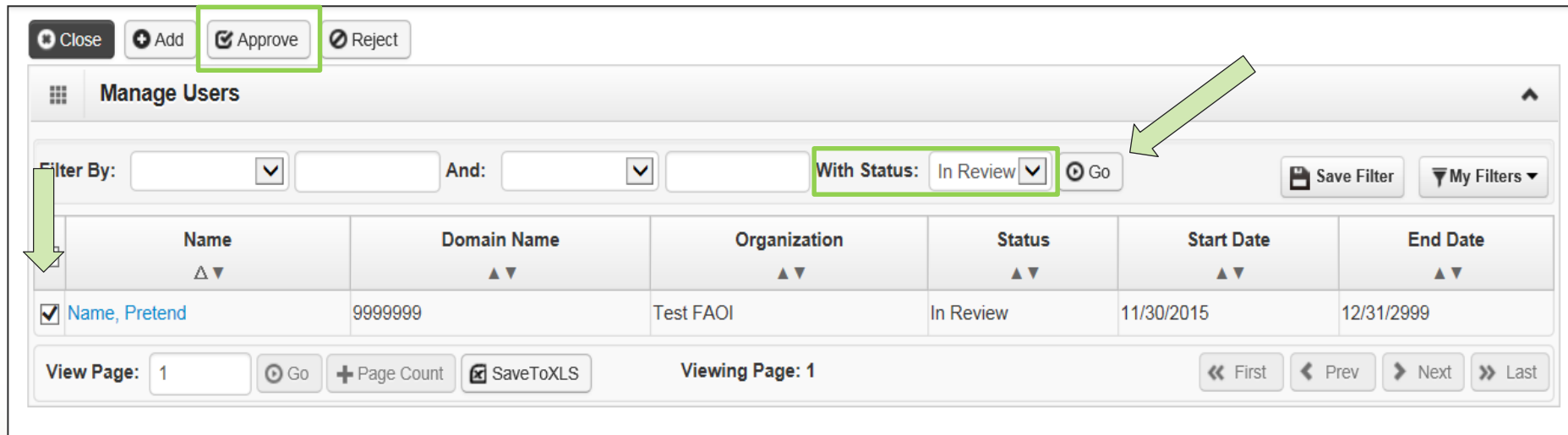
- Complete remaining required fields:

The screenshot shows a web form titled "Add User:". The form contains several input fields for user information, including Password, Confirm Password, Email, Phone Number, Mobile Number, Address Line 1 and 2, Address Line 3, City/Town, State/Province, County, and Zip Code. A blue callout box in the top right corner contains the text: "Note: It is not necessary to complete the address information." At the bottom right of the form, there are three buttons: "Back", "Finish", and "Cancel". The "Finish" button is highlighted with a green box, and a green arrow points to it from the right side of the form.

- Click the **Finish** button.

How to Set Up a User

- To display the new user:
 - In the **With Status** dropdown, select **In Review** and click **Go**.
 - The user's name is displayed with In Review status.
 - Click the box next to the user's name, then click the **Approve** button.

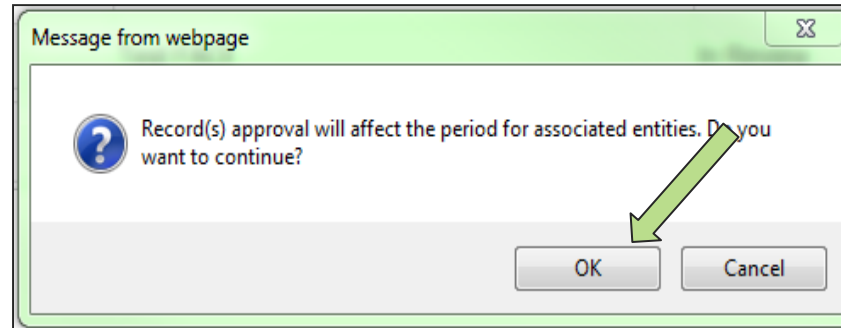


The screenshot shows the 'Manage Users' interface. At the top, there are buttons for 'Close', 'Add', 'Approve', and 'Reject'. Below this is a 'Filter By' section with two dropdown menus and an 'And:' label. The 'With Status' dropdown is set to 'In Review' and is highlighted with a green box. A green arrow points to the 'Go' button next to it. Below the filter section is a table with columns: Name, Domain Name, Organization, Status, Start Date, and End Date. The table contains one row with the following data: Name: Name, Pretend; Domain Name: 9999999; Organization: Test FAOI; Status: In Review; Start Date: 11/30/2015; End Date: 12/31/2999. A green arrow points to the checkbox next to the user's name. At the bottom, there is a 'View Page: 1' section with a 'Go' button, a '+ Page Count' button, and a 'SaveToXLS' button. The 'Viewing Page: 1' section is also present, along with navigation buttons for 'First', 'Prev', 'Next', and 'Last'.

Name	Domain Name	Organization	Status	Start Date	End Date
<input checked="" type="checkbox"/> Name, Pretend	9999999	Test FAOI	In Review	11/30/2015	12/31/2999

How to Set Up a User

- Once approved, a dialogue box will pop up, click **Ok**.



- Once clicked, another window will appear warning you that profiles must be added for this new user. Click **Ok** or **Cancel**.

Print Help

WARNING: Associated profiles must be added and approved before the user is able to access ProviderOne.

Update Status

Status Type: Approved *

Reason Code: None

Remarks:

OK Cancel

How to Set Up a User

- The user is now in **Approved** status.

The screenshot shows a web application interface for managing users. At the top, there are buttons for 'Close', 'Add', 'Approve', and 'Reject'. Below this is a 'Manage Users' header with a grid icon and an upward arrow. A filter section includes 'Filter By:' with two dropdown menus, 'And:' with another dropdown, 'With Status:' set to 'Approved', and a 'Go' button. There are also 'Save Filter' and 'My Filters' options. The main area is a table with columns: Name, Domain Name, Organization, Status, Start Date, End Date, LastName, and FirstName. A single row is visible with the following data: Name: 'Name, Pretend', Domain Name: '9999999', Organization: 'Test FAOI', Status: 'Approved', Start Date: '11/30/2015', End Date: '12/31/2999', LastName: 'Name', and FirstName: 'Pretend'. The 'Status' cell is highlighted with a green box. At the bottom, there are navigation controls including 'View Page: 1', 'Go', '+ Page Count', 'SaveToXLS', 'Viewing Page: 1', and 'First', 'Prev', 'Next', 'Last' buttons.

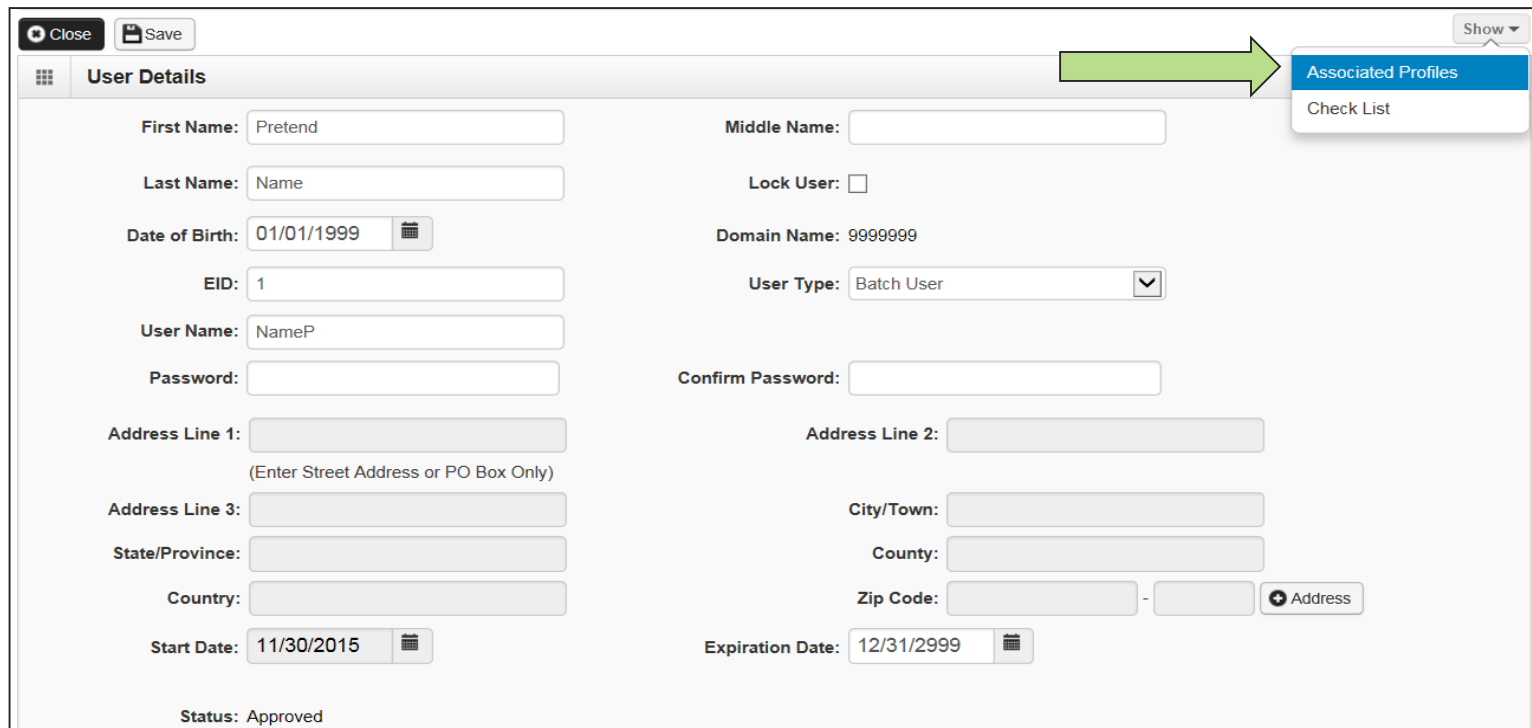
Name	Domain Name	Organization	Status	Start Date	End Date	LastName	FirstName
Name, Pretend	9999999	Test FAOI	Approved	11/30/2015	12/31/2999	Name	Pretend

- Click on the **User Name** to access their user account and tell ProviderOne the functions they will perform in the system.

How to Set Up a User

➤ Adding Profiles:

- Back on the User Details page, click on the **user's name** to access User Details.



The screenshot shows a web form titled "User Details" with various input fields and a "Show" dropdown menu. A green arrow points from the top right of the form to the "Associated Profiles" option in the dropdown menu.

User Details

Close Save

First Name: Pretend Middle Name:

Last Name: Name Lock User:

Date of Birth: 01/01/1999

Domain Name: 9999999

EID: 1 User Type: Batch User

User Name: NameP Confirm Password:

Password:

Address Line 1: Address Line 2:

(Enter Street Address or PO Box Only)

Address Line 3: City/Town:

State/Province: County:

Country: Zip Code: -

Start Date: 11/30/2015 Expiration Date: 12/31/2999

Status: Approved

Show

- Associated Profiles
- Check List

- On the Show menu click on **Associated Profiles**.

How to Set Up a User

➤ Adding Profiles:

- Click on the **Add** button to select profiles.

User Location: NameP Name: Name,Pretend

Close Add Approve Reject Show ▾

Manage User Profiles ▾

Filter By: Filter By ▾ With Status: All ▾ Go

Save this filter My Filters ▾

	Name ▲▼	Description ▲▼	Start Date ▲▼	End Date ▲▼	Status ▲▼
No Records Found !					

How to Set Up a User

➤ Adding Profiles:

The screenshot shows a web application window titled "Add New Profiles to User". At the top, there are "Print" and "Help" icons. Below the title bar, the user name is "Name.Pretend". There are two date pickers: "Start Date: * 12/15/2015" and "End Date: * 12/31/2999".

There are two main sections:

- Available Profiles:** A list of profile names with a scroll bar on the right. The list includes:
 - EXT Provider EHR Administrator
 - EXT Provider Eligibility Checker
 - EXT Provider Eligibility Checker-Claims Submitter
 - EXT Provider File Maintenance
 - EXT Provider File View Only
 - EXT Provider Managed Care Only
 - EXT Provider Social Services Medical
 - EXT Provider Social Services
 - EXT Provider Upload Files
 - EXT Provider Upload and Download Files
- Associated Profiles:** A list of profile names currently associated with the user. It includes:
 - EXT Provider System Administrator
 - EXT Provider Super User

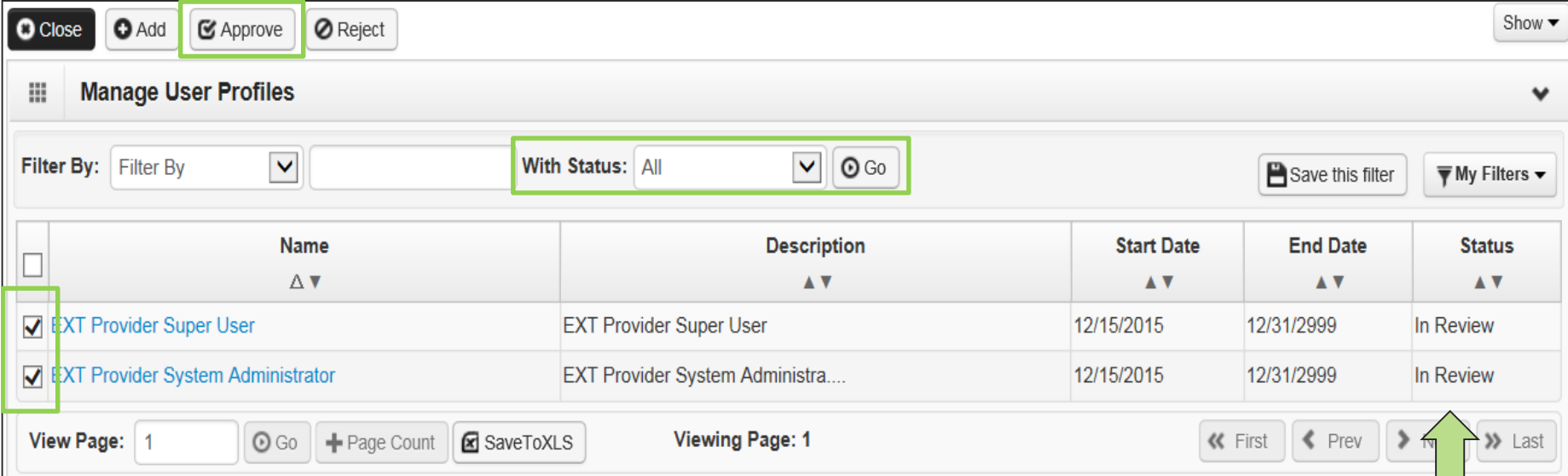
Between the two lists are two arrow buttons: a right-pointing double arrow (highlighted with a green box) and a left-pointing double arrow. A green arrow points from the "Available Profiles" list to the right-pointing double arrow button.

At the bottom right, there are two buttons: "OK" (highlighted with a green box) and "Cancel". A green arrow points from the bottom right towards the "OK" button.

- Highlight Available Profiles desired.
- Click **double arrow button** and move to Associated Profiles box then click the **OK** button.

How to Set Up a User

➤ Adding Profiles:



Close Add Approve Reject Show

Manage User Profiles

Filter By: Filter By With Status: All Go Save this filter My Filters

	Name	Description	Start Date	End Date	Status
<input type="checkbox"/>					
<input checked="" type="checkbox"/>	EXT Provider Super User	EXT Provider Super User	12/15/2015	12/31/2999	In Review
<input checked="" type="checkbox"/>	EXT Provider System Administrator	EXT Provider System Administra...	12/15/2015	12/31/2999	In Review

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

➤ To Display the new profiles:

- The **With Status** dropdown box should state **All**. Click **Go**.
- The profiles are displayed with **In Review** status.
- Click the box next to the profile name, then click the **Approve** button.

How to Set Up a User

- Once approved a dialogue box will pop up, click **Ok**.

Print Help

Update Status

Status Type: Approved *

Reason Code: None

Remarks:

OK Cancel

Page ID: dlgUpdateStatusEntity(Common) Environment: UAT (Beta) ID: app02_01Server Time: 01/11/2016 11:28

How to Set Up a User

- The profile statuses are now **Approved**.

The screenshot shows the 'Manage User Profiles' interface. At the top, there are buttons for 'Close', 'Add', 'Approve', and 'Reject'. Below these is a 'Filter By' section with a dropdown menu, a text input field, and a 'With Status: All' dropdown. There are also 'Save this filter' and 'My Filters' buttons. The main part of the interface is a table with the following columns: Name, Description, Start Date, End Date, and Status. Two rows are visible in the table, both with a status of 'Approved'. A green box highlights the 'Approved' status in the second row. At the bottom, there are navigation controls including 'View Page: 1', 'Go', 'Page Count', 'SaveToXLS', and 'Viewing Page: 1', along with 'First', 'Prev', 'Next', and 'Last' buttons.

	Name	Description	Start Date	End Date	Status
<input type="checkbox"/>	EXT Provider Super User	EXT Provider Super User	12/15/2015	12/31/2999	Approved
<input type="checkbox"/>	EXT Provider System Administrator	EXT Provider System Administra....	12/15/2015	12/31/2999	Approved

- Click **Close** to return to User Details.

How to Set Up a User

➤ Setting up a user's password

- Enter the new temporary password and click **Save** and then **Close**.

Note: Passwords must be changed every 120 days!

User Login Id: NameP Name:

User Details

First Name: Middle Name:
 Last Name: Lock User:
 Date of Birth: Domain Name: 9999999
 EID: User Type:
 User Name:
 Password: Confirm Password:
 Address Line 1: Address Line 2:
(Enter Street Address or PO Box Only)
 Address Line 3: City/Town:
 State/Province: County:
 Country: Zip Code: -
 Start Date: Expiration Date:

Status: Approved

How to Manage a User

➤ How to lock or end date a user:

User Details

Close Save Show

First Name: Pretend Middle Name:

Last Name: Name Lock User:

Date of Birth: 01/01/1999 Domain Name: 9999999

EID: 1 User Type: Batch User

User Name: NameP Confirm Password:

Password:

Address Line 1: Address Line 2:

(Enter Street Address or PO Box Only)

Address Line 3: City/Town:

State/Province: County:

Country: Zip Code: Address

Start Date: 11/30/2015 Expiration Date: 12/31/2999

Status: Approved

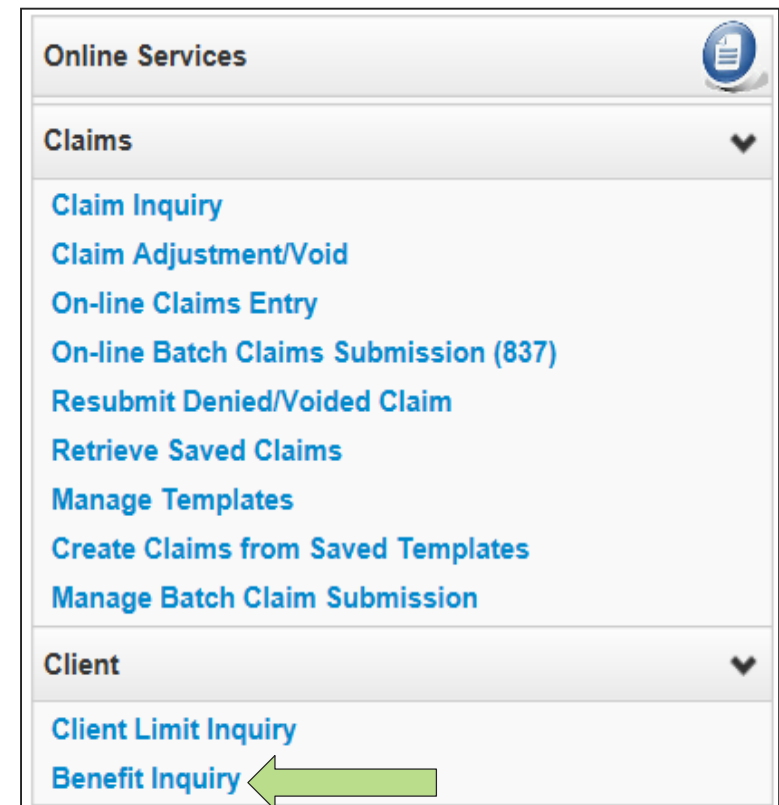
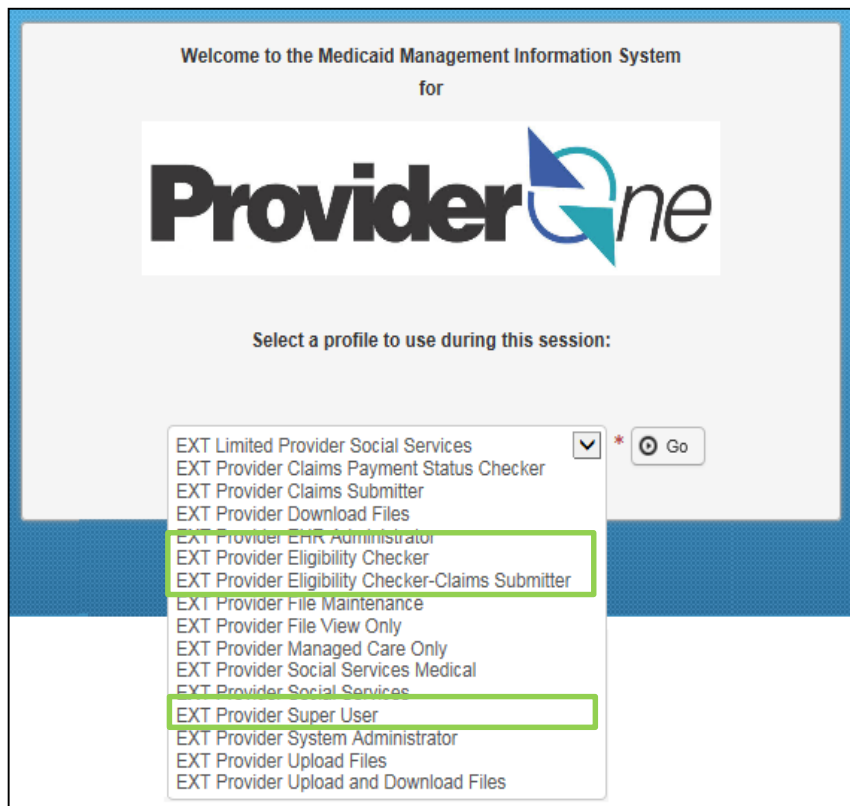
- To lock or unlock a User, click this box.
- Users can also be end dated.

➤ Click **Save** and then **Close**.

Eligibility & Billing Processes

How Do I Obtain Eligibility in ProviderOne

- Select the proper user profile.



- Select Benefit Inquiry under the Client area.

How Do I Obtain Eligibility In ProviderOne

- Use one of the search criteria listed along with the dates of service to verify eligibility.

Submit an Eligibility Inquiry on a specific client, complete one of the following criteria sets and click 'Submit'.

- ProviderOne Client ID(Client Identification Code) or
- Last Name, First Name AND Date of Birth or
- Last Name, First Name AND SSN or
- SSN AND Date of Birth
- ProviderOne Client ID(Client Identification Code), Last Name, First Name AND Date of Birth or
- ProviderOne Client ID(Client Identification Code), Last Name AND Date of Birth or
- ProviderOne Client ID(Client Identification Code) AND Last Name

Please contact Customer Service Center at (800) 562-3022

Client Eligibility Inquiry

ProviderOne Client ID: SSN:

Last Name: First Name:

Date of Birth: Inquiry Start Date: 12/29/2015 Inquiry End Date: 12/29/2015

- An unsuccessful check would look like this:

Selection Criteria Entered

Date of Request: 12/29/2015
Time in Request: 10:27:21 AM PST
Provider ID: 200320900
From Date of Service: 12/29/2015
To Date of Service: 12/29/2015

ProviderOne Client ID: 9999999900
Client Date of Birth:
Client SSN:
Client Last Name:
Client First Name:

Demographic and Response Information

Client Demographic Information:

ProviderOne Client ID:
Client First,Middle,Last Name:
CSO/HCS:
County Code:
CSOR:
Date of Birth:
Gender:
Language:
Placement:
ACES Client ID:
HIC:

System Response Information:

Valid Request Indicator: N
Reject Reason Code: 72 - Invalid/Missing Subscriber/Insured ID
Eligibility or Benefit Information Code:
Follow-Up Action Code: C - Please correct data and resubmit

- Unsuccessful eligibility checks will be returned with an error message
- Check your keying!

Successful Eligibility Check

Client Id: 00000000WA		Name: Doe, Jane	
Printer Friendly Version			
Close		Submit Another Inquiry	
		Exit	
Selection Criteria Entered		Search Criteria Used	
Date of Request: 05/02/2016		ProviderOne Client ID: 00000000WA	
Time in Request: 09:06:50 AM PDT		Client Date of Birth:	
Provider ID: 200320900		Client SSN:	
From Date of Service: 05/02/2016		Client Last Name:	
To Date of Service: 05/02/2016		Client First Name:	
Demographic and Response Information			
Client Demographic Information:		System Response Information:	
ProviderOne Client ID: 00000000WA		Valid Request Indicator: Y	
Client First,Middle,Last Name: Doe, Jane		Reject Reason Code:	
CSO/HCS:		Eligibility or Benefit information Code: 1-Active Coverage	
County Code: 031-Snohomish		Follow-Up Action Code:	
CSOR: 065-SMOKEY POINT CSO			
Date of Birth: 01/30/1999			
Gender: Female			
Language: ENG-English			
Placement:			
ACES Client ID: 000000000			
HIC:			

Basic client detail returned, including ID, gender, and DOB. The eligibility information can be printed out using the **Printer Friendly Version** link in blue.

Successful Eligibility Check

- After scrolling down the page the first entry is the **Client Eligibility Spans** which show:
 - The eligibility program (CNP, MNP, etc.).
 - The date span for coverage.

Client Eligibility Spans								
Insurance Type Code ▲▼	Recipient Aid Category (RAC) ▲▼	Benefit Service Package ▲▼	Eligibility Start Date ▲▼	Eligibility End Date ▲▼	ACES Coverage Group ▲▼	ACES Case Number ▲▼	Retro Eligibility ▲▼	Delayed Certification ▲▼
MC: Medicaid	1203	CNP	02/01/2014	12/31/2999	N11	00000000		

View Page: 1 Viewing Page: 1

Note: Use the benefit service package blue acronym to see the high level coverage for this program.

Successful Eligibility Check

➤ Managed Care Information

- Clients may have more than one of the following managed care programs listed on their eligibility screen. Refer to the [ProviderOne Billing and Resource Guide](#) for detailed information on each program.

Managed Care Information							
Insurance Type Code ▲▼	PCCM Code ▲▼	Plan/PCCM Name ▲▼	Plan/PCCM ID ▲▼	Plan/PCCM Phone Number ▲▼	PCP Clinic Name ▲▼	Start Date ▲▼	End Date ▲▼
HM: Health Maintenance Organization	MC: Capitated	MHC Healthy Options				03/01/2015	12/31/2999

Managed Care Information							
Insurance Type Code ▲▼	PCCM Code ▲▼	Plan/PCCM Name ▲▼	Plan/PCCM ID ▲▼	Plan/PCCM Phone Number ▲▼	PCP Clinic Name ▲▼	Start Date ▲▼	End Date ▲▼
HM: Health Maintenance Organization	MC: Capitated	CHPW Fully Integrated Managed Care				01/01/2016	12/31/2999

Managed Care Information							
Insurance Type Code ▲▼	PCCM Code ▲▼	Plan/PCCM Name ▲▼	Plan/PCCM ID ▲▼	Plan/PCCM Phone Number ▲▼	PCP Clinic Name ▲▼	Start Date ▲▼	End Date ▲▼
HM: Health Maintenance Organization	MC: Capitated	Coordinated Care Healthy Options Foster Care				12/01/2015	12/31/2999

Successful Eligibility Check

➤ Managed Care Information (continued)

Managed Care Information							
Insurance Type Code ▲▼	PCCM Code ▲▼	Plan/PCCM Name ▲▼	Plan/PCCM ID ▲▼	Plan/PCCM Phone Number ▲▼	PCP Clinic Name ▲▼	Start Date ▲▼	End Date ▲▼
HM: Health Maintenance Organization	MC: Capitated	OptumHealth Behavioral Health Organization				09/01/2015	12/31/2999

Managed Care Information							
Insurance Type Code ▲▼	PCCM Code ▲▼	Plan/PCCM Name ▲▼	Plan/PCCM ID ▲▼	Plan/PCCM Phone Number ▲▼	PCP Clinic Name ▲▼	Start Date ▲▼	End Date ▲▼
HM: Health Maintenance Organization	MC: Capitated	MHC Behavioral Health Services Only				03/01/2016	12/31/2999

Note: Effective for claims with dates of service on and after January 1, 2017, clients with other primary health insurance may be enrolled in an Apple Health Managed Care plan as their secondary insurance. Remember to always check for other primary payers when verifying eligibility in ProviderOne. See the Apple Health Medicaid [provider alert](#) and the [ProviderOne Billing and Resource Guide](#) for more detail.

Successful Eligibility Check

➤ Managed Care Information

- Primary Care Case Management (PCCM) and Health Homes provide care management for clients only and are not direct payers.

Managed Care Information							
Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	NATIVE HEALTH OF SPOKANE			NATIVE HEALTH OF SPOKANE	07/01/2012	12/31/2999

Managed Care Information							
Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	SE WA Aging and LTC - Health Home Only				07/01/2016	12/31/2999

Successful Eligibility Checks

➤ Medicare Eligibility Information

- If client has Medicare Part A or Part B this information will be shown with the Medicare eligibility effective dates of service.

Medicare Eligibility Information			
Service Type Code ▲▼	Insurance Type Code ▲▼	Eligibility Start Date ▲▼	Eligibility End Date ▲▼
30: Health Benefit Plan Coverage	MA: Medicare Part A	02/01/1997	12/31/2999
30: Health Benefit Plan Coverage	MB: Medicare Part B	02/01/1997	12/31/2999

- If the client has enrolled in a Medicare Advantage Plan (Part C), if reported it is listed in the **Coordination of Benefits Information** section.

Coordination of Benefits Information									
Service Type Code ▲▼	Insurance Type Code ▲▼	Insurance Co. Name & Contact ▲▼	Carrier Code ▲▼	Policy Holder Name ▲▼	Policy Number ▲▼	Group Number ▲▼	Plan Sponsor ▲▼	Start Date ▲▼	End Date ▲▼
30: Health Benefit Plan Coverage	C1: Commercial	UNITED HEALTHCARE INSURANCE COMPANY	H5008		Med Part D			08/01/2009	12/31/2999
30: Health Benefit Plan Coverage	C1: Commercial	UNITED HEALTHCARE INSURANCE COMPANY	H5008		Med Part C			08/01/2009	12/31/2999

Successful Eligibility Check

➤ Coordination of Benefits Information

- Displays phone numbers and any Policy or Group numbers on file with WA Apple Health for the commercial plans listed.
- For DDE claims the Carrier Code (Insurance ID) is found here.

Coordination of Benefits Information									
Service Type Code	Insurance Type Code	Insurance Co. Name & Contact	Carrier Code	Policy Holder Name	Policy Number	Group Number	Plan Sponsor	Start Date	End Date
30: Health Benefit Plan Coverage	C1: Commercial	CIGNA DENTAL	DN18					01/01/2012	12/31/2999
30: Health Benefit Plan Coverage	C1: Commercial	CIGNA HEALTHCARE	CH55					01/01/2012	12/31/2999

Please Note: If you know an Apple Health client has a commercial insurance and you do not see a Coordination of Benefits Information segment on their eligibility file in ProviderOne, you must complete a [Contact Us](#) email. Choose the option “I am an Apple Health (Medicaid) biller or provider” and then choose the “Medical Provider” button. On the “Select Topic” dropdown, choose “Private Commercial Insurance.” Enter the client’s insurance information in the “Other Comments” section. The agency’s Coordination of Benefits unit will update the client’s file using this information. Check eligibility again in ProviderOne in 3 – 5 business days to verify the update has been made. Only after verification of this information in ProviderOne should you bill the claim to the system.

Successful Eligibility Checks

➤ Restricted Client Information

- Clients may be restricted to specific Hospitals, PCP's, and Pharmacies for care. A referral is required from the PCP for specialized care.

Restricted Client Information				
Assignment Type ▲▼	Provider Name ▲▼	Provider Phone Number ▲▼	Period Start Date ▲▼	Period End Date ▲▼
Pharmacy	SAMUEL EASTERN INC		03/21/2011	12/31/2999
Pharmacy	REIDT PHARMACY CORPORATION		03/04/2011	12/31/2999
Primary Care Physician	MINOR AND JAMES MEDICAL PLLC		02/11/2009	12/31/2999
Primary Care Physician	COMM Health Assoc of Spokane		12/01/2009	12/31/2999
Hospital	PROVIDENCE HOLY FAMILY HOSPITA		08/08/2008	12/31/2999

Successful Eligibility Checks

➤ Children with Special Health Care Needs (CSHCN) Information

- There may be an eligibility segment stating Children with Special Health Care Needs. These clients could also be enrolled into a managed care plan.

Children with Special Health Care Needs Information	
Start Date	End Date
08/05/2015	08/31/2016

Successful Eligibility Checks

➤ Hospice Information

- Client's may be enrolled in a Hospice agency for care:

Hospice Information					
Hospice agency	Hospice Address	Hospice Phone	Hospice Contact	Start date	End date
	PROVIDENCE HOSPICE OF SEAT, 425 PONTIUS AVE N STE 300, SEATTLE, WA 98109-5312			01/04/2016	12/31/2999

Note: If a client is assigned to a Hospice agency, bill the Hospice agency for any care related to the client's terminal illness. WA Medicaid has paid a monthly payment to the agency to cover these services.

Note: If the service is not related to the client's terminal illness, bill these services to WA Medicaid with a note SCI=K.

- The last section of the eligibility check lists the source of the eligibility data.

Successful Eligibility Check

➤ Developmental Disability Information

- It will show the start and end date.
- If current, there will be an open-ended date with 2999 as the year.

Developmental Disability Information	
Start Date	End Date
10/06/1982	12/31/2999

Note: If a client has the DD indicator, they may be eligible for expanded benefits.

Successful Eligibility Check

➤ Foster Care Information

- Client's Medical Records History is available.
- There is an extra button at the top of the eligibility screen.

The screenshot shows a web interface for an eligibility check. At the top, there are four buttons: 'Close', 'Submit Another Inquiry', 'Medical Records' (highlighted with a green box), and 'Exit'. Below the buttons, there are two main sections:

Selection Criteria Entered

Date of Request: 05/02/2016	ProviderOne Client ID: 000000000WA
Time in Request: 09:52:37 AM PDT	Client Date of Birth:
Provider ID: 200320900	Client SSN:
From Date of Service: 05/02/2016	Client Last Name:
To Date of Service: 05/02/2016	Client First Name:

Demographic and Response Information

Client Demographic Information:	System Response Information:
ProviderOne Client ID: 000000000WA	Valid Request Indicator: Y

- Click the **Medical Records** button to see:
 - Pharmacy services claims
 - Medical services claims (**includes dental**)
 - Hospital services claims
- See the [ProviderOne Billing and Resource Guide](#) for complete details. Web address is on the last slide.

Successful Eligibility Check

➤ Foster Care Medical Records History

- Shows claims paid by ProviderOne.
- Sort by using the “diamonds” under each column name.
- Search by using the “Filter by Period” boxes.
- If there are more pages of data use the **Next** or **Previous** buttons.
- If there is no data for the section it will display “no records found.”

Pharmacy								
Filter By Period: All								
Fill Date	Drug Name	Strength	Qty	Days	Refill Sequence	Prescriber Name	Pharmacy Name	Pharmacy Phone #
10/27/2015	GUANFACINE HCL	1 MG	60	30	00	DAVIES,JULIAN	RITE AID PHARMACY # 05228	
10/23/2015	POLYETHYLENE GLYCOL 3350	0	527	30	07	DAVIES,JULIAN	RITE AID PHARMACY # 05228	
04/13/2015	POLYETHYLENE GLYCOL 3350	0	527	30	03	DAVIES,JULIAN	RITE AID PHARMACY # 05228	
04/02/2015	GUANFACINE HCL	1 MG	60	30	00	DAVIES,JULIAN	RITE AID PHARMACY # 05228	
03/17/2015	DESONIDE	.05 %	15	7	00	DAVIES,JULIAN	RITE AID PHARMACY # 05228	
View Page: 2 Page Count SaveToXLS Viewing Page: 1 First Prev Next Last								
Medical Services (primary and specialty care)								
Filter By Period: All								
Start Date	End Date	Primary Code/DX Description	Other Diagnosis Codes	Procedure Code	Servicing Provider Name	Billing Provider Name	Billing Provider Phone #	
06/18/2014	06/18/2014			D0120,D1120,D1208			(206) 782-8223	
06/12/2014	06/12/2014	3129 - Conduct disturbance NOS		90847		King County	(800) 790-8049	
05/29/2014	05/29/2014	3129 - Conduct disturbance NOS		90847		King County	(800) 790-8049	
05/22/2014	05/22/2014	3129 - Conduct disturbance NOS		90847		King County	(800) 790-8049	
05/21/2014	05/21/2014	3129 - Conduct disturbance NOS		90846		King County	(800) 790-8049	
View Page: 11 Page Count SaveToXLS Viewing Page: 10 First Prev Next Last								
Hospital Care								
Filter By Period: All								
Start Date	End Date	Primary Code/DX Description	Other Diagnosis Codes	ER/Outpatient/Inpatient	DRG Description	Attending Provider Name	Billing Provider Name	Billing Provider Phone #
10/21/2015	10/21/2015	M6289 - OTHER SPECIFIED DISORDERS OF MUSCLE	Z4689	Outpatient		MOSCA, VINCENT	Molina Healthcare of Washington Inc	(800) 869-7165

Gender and Date of Birth Updates

- Verified with ProviderOne system staff as of 01/27/14:
 - A large number of claims are denied due to a mismatch between the patient's DOB in the provider's record and the ProviderOne's client eligibility file. Providers can send a secure email to mmishelp@hca.wa.gov with the client's ProviderOne ID, name, and correct DOB. The same is true if providers find a gender mismatch; send the ProviderOne client ID, name, and correct gender to the same email address.

Verifying Eligibility

- Coverage status can change at any time
 - Verify coverage for each visit.
 - Print the Benefit Inquiry result.
 - If eligibility changes after this verification, HCA will honor the printed screen shot
 - **Exception:** Client with commercial insurance carrier that is loaded after you verify eligibility; commercial insurance must be billed first.

Direct Data Entry (DDE) Claims

Fee For Service Claims and
Commercial Insurance Secondary Claims

After this training, you can:

- Submit fee for service DDE claims

- Create and Submit TPL secondary claims DDE
 - With backup
 - Without backup

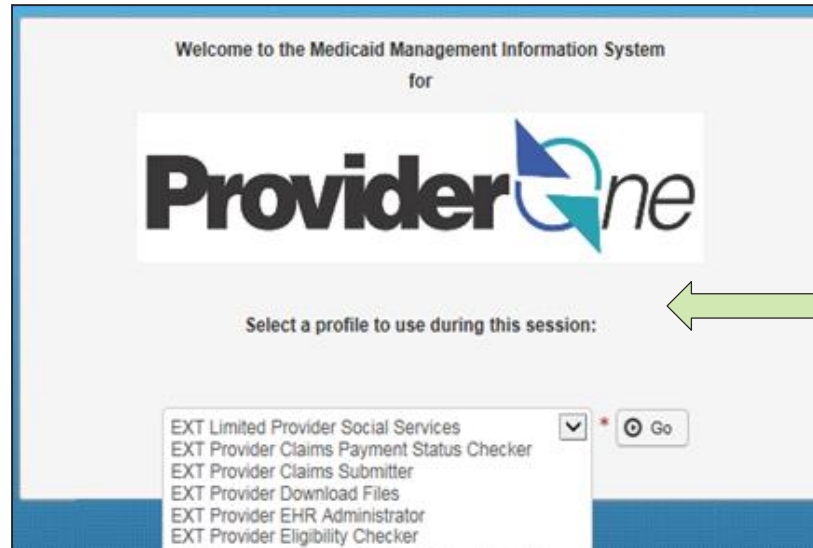
Direct Data Entry (DDE) Claims

- ProviderOne allows providers to enter claims directly into the payment system.
- All claim types can be submitted through the DDE system:
 - Professional (CMS 1500)
 - Institutional (UB-04)
 - Dental (ADA Form)
- Providers can CORRECT and RESUBMIT denied or previously voided claims.
- Providers can ADJUST or VOID previously paid claims.

Determine What Profile to Use

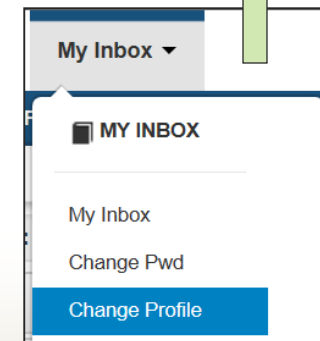
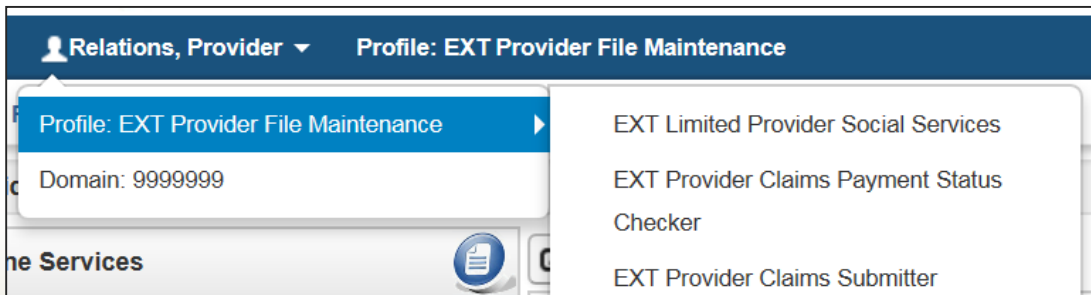
With the upgrade to 3.0, ProviderOne allows you to change your profile in more than one place.

➤ At initial login:



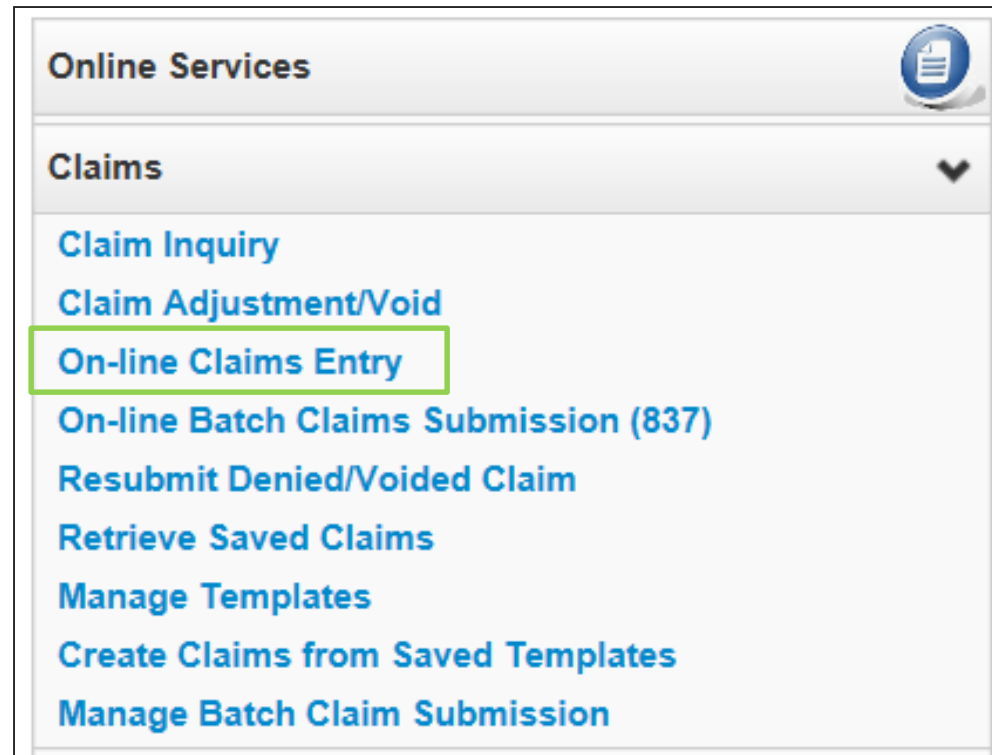
Note: Using **My Inbox** to change profiles, takes you back to the main profile screen.

➤ And in the portal:



Direct Data Entry (DDE) Claims

- From the Provider Portal select the **Online Claims Entry** option located under the Claims heading.



Direct Data Entry (DDE) Claims

➤ Choose the type of claim that you would like to submit with the appropriate claim form:

- Professional – CMS 1500
- Institutional - UB04
- Dental - 2012 ADA

✕ Close

Choose an Option.

Submit Professional	Submit Professional
Submit Institutional	Submit Institutional
Submit Dental	Submit Dental

Direct Data Entry (DDE) Claims

Close Save Claim Submit Claim Reset

Professional Claim

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

Basic Claim Info
Other Claim Info

[Billing Provider](#) | [Rendering Provider](#) | [Subscriber](#) | [Claim](#) | [Service](#)

Submitter ID:

PROVIDER INFORMATION

Go to Other Claim Info to enter information for Referring, Purchasing, Supervising and other providers.

BILLING PROVIDER

* Provider NPI: * Taxonomy Code:

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

? * Is this service the result of a referral? Yes No

[Top](#)

SUBSCRIBER/CLIENT INFORMATION

SUBSCRIBER/CLIENT

* Client ID:

+ **Additional Subscriber/Client Information**

? Is this claim for a Baby on Mom's Client ID? Yes No

? * Is this a Medicare Crossover Claim? Yes No

+ **OTHER INSURANCE INFORMATION**

[Top](#)

CLAIM INFORMATION

Go to Other Claim Info to include the following claim detail information:
Specialized Line Services, Miscellaneous Line Data, Line Level Providers, Miscellaneous Line Dates, Test Results or Form Identification Information.

+ **PRIOR AUTHORIZATION**

+ **CLAIM NOTE**

+ **EPSDT INFORMATION**

+ **CONDITION INFORMATION**

Direct Data Entry (DDE) Claims

? * Is this claim accident related? Yes No

CLAIM DATA

Patient Account No.:

* Place of Service:

+ Additional Claim Data

Diagnosis Codes: * 1: 2: 3: 4: 5: 6:
 7: 8: 9: 10: 11: 12:

BASIC LINE ITEM INFORMATION

Click on Other Svc Info in each line item to include the following additional line item information:
 Attachment, Drug, DMERC Condition, Health Services, Test Results, Home Oxygen Therapy, Service Facility, Miscellaneous Numbers, Indicators, Providers, Dates and Amounts, Medical Equipment, Ambulance Transport, Line Item Note, Other Payer, Spinal Manipulations, Purchased Services and Line Adjudication.

BASIC SERVICE LINE ITEMS

* Service Date From: * Service Date To:

Place of Service:

* Procedure Code: Modifiers: 1: 2: 3: 4:

* Submitted Charges: \$ Diagnosis Pointers: * 1: 2: 3: 4:

* Units:

+ Medicare Crossover Items

National Drug Code:

+ Drug Identification

+ Prior Authorization

+ Additional Service Line Information

Note: Please ensure you have entered any necessary claim information (found in the other sections on this or another page) before adding this service line.

Billing Provider Information

➤ Section 1: Billing Provider Information

PROVIDER INFORMATION	
Go to Other Claim Info to enter information for Referring, Purchasing, Supervising and other providers.	
BILLING PROVIDER	
* Provider NPI: <input type="text"/>	* Taxonomy Code: <input type="text"/>
? * Is the Billing Provider also the Rendering Provider?	<input type="radio"/> Yes <input type="radio"/> No
? * Is this service the result of a referral?	<input type="radio"/> Yes <input type="radio"/> No


Billing Provider Information

- Enter the Billing **Provider NPI** and **Taxonomy Code**.
 - This will likely be the NPI and Taxonomy Code of the clinic/office where the service was performed and where you would like payment to be received.


BILLING PROVIDER	
* Provider NPI:	<input type="text"/>
* Taxonomy Code:	<input type="text"/>

Rendering Provider Information

- If the Rendering Provider is the same as the Billing Provider answer this question **YES** and go on to the next section.

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

- If the Rendering Provider is different than the Billing Provider entered in the previous question, answer **NO** and enter the Rendering (Performing/Serviceing) **Provider NPI** and **Taxonomy Code**.

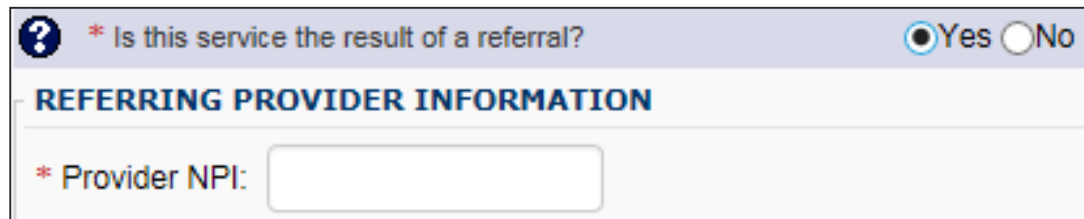
 * Is the Billing Provider also the Rendering Provider? Yes No

RENDERING (PERFORMING) PROVIDER

* Provider NPI: * Taxonomy Code:

Referring Provider Information

- If the service **Is the result of a referral**, answer **Yes** to this question and add the referring **Provider NPI**.



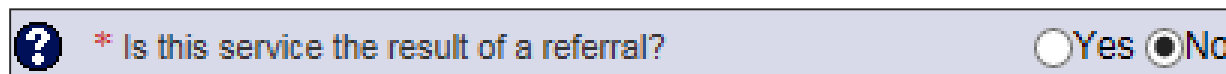
Is this service the result of a referral? Yes No

REFERRING PROVIDER INFORMATION

* Provider NPI:

Note: Only the provider NPI number is required for referring providers.

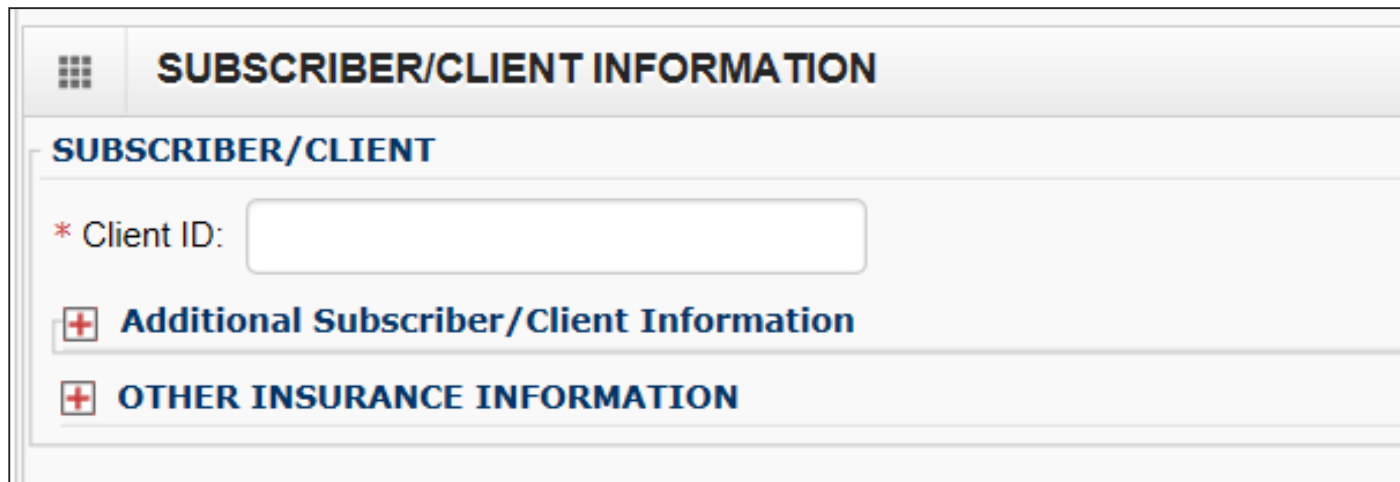
- If the service **Is Not the result of a referral**, answer this question **No** and continue on to next section.



Is this service the result of a referral? Yes No

Subscriber/Client Information

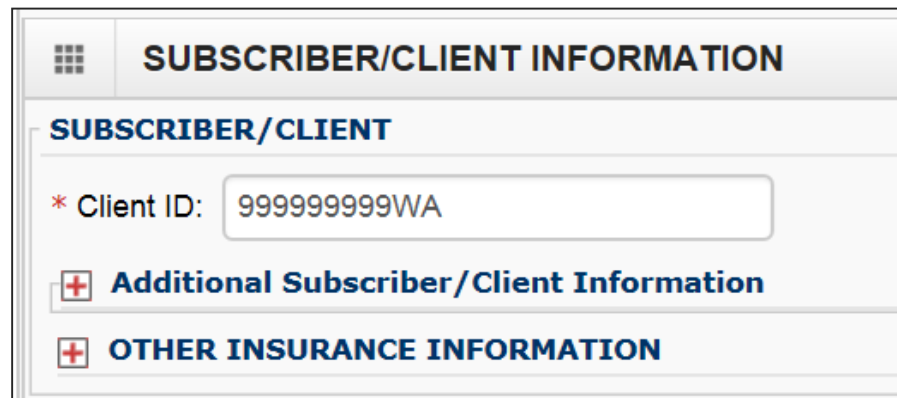
➤ Section 2: Subscriber/Client Information



The screenshot shows a web form with a header bar containing a grid icon and the title "SUBSCRIBER/CLIENT INFORMATION". Below the header, there is a section titled "SUBSCRIBER/CLIENT" with a red asterisk and the label "* Client ID:" followed by an empty text input field. Below the input field, there are two expandable sections, each with a red plus sign icon and a blue title: "Additional Subscriber/Client Information" and "OTHER INSURANCE INFORMATION".

Subscriber/Client Information

- Enter the **Subscriber/Client ID** found on the WA Medicaid services card. This ID is a 9-digit number followed by **WA**.
 - Example: **999999999WA**



The screenshot shows a web form titled "SUBSCRIBER/CLIENT INFORMATION". Under the heading "SUBSCRIBER/CLIENT", there is a field for "Client ID" with the value "999999999WA". Below this field are two expandable sections, each with a red plus sign icon: "Additional Subscriber/Client Information" and "OTHER INSURANCE INFORMATION".

- Click on the red **+** to expand the **Additional Subscriber/Client Information** to enter additional required information.

Subscriber/Client Information

- Once the field is expanded enter the **Patient's Last Name**, **Date of Birth**, and **Gender**.
 - Date of birth must be in the following format:
MM/DD/CCYY.
 - The additional information fields are not needed.

☰ **SUBSCRIBER/CLIENT INFORMATION**

SUBSCRIBER/CLIENT

* Client ID:


- **Additional Subscriber/Client Information**

<p>* Org/Last Name: <input type="text"/></p> <p style="text-align: center; font-size: 0.8em;">mm dd ccyy</p> <p>* Date of Birth: <input type="text"/> <input type="text"/> <input type="text"/></p> <p style="text-align: center; font-size: 0.8em;">mm dd ccyy</p> <p>Date of Death: <input type="text"/> <input type="text"/> <input type="text"/></p>	<p>First Name: <input type="text"/></p> <p>* Gender: <input type="text"/> ▼</p> <p>Patient Weight: <input type="text"/> lbs</p>
--	--

Patient is pregnant: Yes No

Baby on Mom's Client ID


- If claim is for a **baby being billed under the Mom's ID** select **Yes** otherwise choose **No** and continue to next question.

 Is this claim for a Baby on Mom's Client ID? Yes No

Note: If claim is for a baby using the mom's ID, use the baby's last name, the baby's date of birth, and gender when filling out the **Subscriber/Client Information** on the previous slide. Be sure to add the claim note **SCI=B** when billing for a baby using mom's ID.

Medicare Crossover Claim

- If the claim is considered a **Medicare Crossover** answer the question **YES**. This includes Managed Medicare Advantage Plans (Medicare Part C).

 * Is this a Medicare Crossover Claim? Yes No

Medicare Cross Over Items

* Amount Paid by Medicare: \$ * Medicare Deductible: \$ * Medicare Co-payment: \$

* Medicare Co-insurance: \$ * Medicare Allowed Amount: \$

mm dd ccyy

* Medicare Adjudication Date:

Note: WA Medicaid considers a claim as a crossover when Medicare allows the service. If Medicare makes a payment, a co-pay/coinsurance should be indicated or if the charges are applied to a deductible, Medicare may not make any payment.

- If Medicare did not make a payment answer the question **NO**.

Insurance Other than Medicaid

- If the client has other commercial insurance, open the **Other Insurance Information** section by clicking on the red + expander. If there is no insurance, skip over this.

 **OTHER INSURANCE INFORMATION**

- Then open up the **1 Other Payer Insurance Information** section by clicking on the red + expander.

 **OTHER INSURANCE INFORMATION**

 **1 OTHER PAYER INSURANCE INFORMATION**

Note: Bill paid and denied lines on the same claim. This will result in more efficient and quicker processing of your TPL claim.

Insurance Other Than Medicaid

- Enter the **Payer/Insurance Organization Name**.
- Open up the **Additional Other Payer Information** section by clicking on the red (+) expander.

The screenshot shows a web form with the following structure:

- OTHER INSURANCE INFORMATION** (expanded, indicated by a minus sign)
- 1 OTHER PAYER INSURANCE INFORMATION** (expanded, indicated by a minus sign)
- Other Subscriber Information** (collapsed, indicated by a plus sign)
- Secondary ID Information** (collapsed, indicated by a plus sign)
- Other Insurance Coverage** (collapsed, indicated by a plus sign)
- Medicare Outpatient Adjudication Information** (collapsed, indicated by a plus sign)
- Other Payer Information** (expanded section)
 - * Payer/Insurance Organization Name:
 - Additional Other Payer Information** (collapsed, indicated by a plus sign)

Insurance Other Than Medicaid

- In the **Additional Other Payer Information** section fill in the following:

Other Payer Information

* Payer/Insurance Organization Name:

Enter the Insurance Carrier Code number and the ID Type.

- Additional Other Payer Information

Entity Qualifier:

*ID: *ID Type:

mm dd cyyy

Claim Check or Remittance Date:

Number Type: PA/Referral No.:

Payer Claim Adjustment: Yes No

+ Secondary ID Information

Insurance Other Than Medicaid

- Use the Insurance **Carrier Code** found on the client eligibility screen under the Coordination of Benefits section as the ID number for the insurance company.

Coordination of Benefits Information									
Service Type Code ▲▼	Insurance Type Code ▲▼	Insurance Co. Name & Contact ▲▼	Carrier Code ▲▼	Policy Holder Name ▲▼	Policy Number ▲▼	Group Number ▲▼	Plan Sponsor ▲▼	Start Date ▲▼	End Date ▲▼
30: Health Benefit Plan Coverage	C1: Commercial	CIGNA DENTAL	DN18					01/01/2012	12/31/2999
30: Health Benefit Plan Coverage	C1: Commercial	CIGNA HEALTHCARE	CH55					01/01/2012	12/31/2999

Insurance Other Than Medicaid

- Enter the total amount paid by the commercial private insurance in the **COB Payer Paid Amount** field.

Other Payer Information

* Payer/Insurance Organization Name:

- Additional Other Payer Information

Entity Qualifier:

*ID: *ID Type:

mm dd cyy
Claim Check or Remittance Date:

Number Type: PA/Referral No.:

Payer Claim Adjustment: Yes No

+ Secondary ID Information

COB Monetary Amounts

COB Payer Paid Amount:

+ Additional COB Information

Note: If you will be sending in the Insurance EOB via fax/mail, stop here.

- If the claim is for an insurance denial or insurance applied to the deductible, enter a 0 here.

Insurance Other Than Medicaid

- Click on the red + to expand the **Claim Level Adjustments** section.

Other Payer Information

* Payer/Insurance Organization Name:

Additional Other Payer Information

Entity Qualifier:

*ID: *ID Type:

mm dd ccyy

Claim Check or Remittance Date:

Number Type: PA/Referral No.:

Payer Claim Adjustment: Yes No

Secondary ID Information

COB Monetary Amounts

COB Payer Paid Amount:

Additional COB Information

CLAIM LEVEL ADJUSTMENTS

Insurance Other Than Medicaid

- Enter the adjustment **Group Code**, **Reason Code** (Number Only), and **Amount**.

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"/>

Note: The agency only accepts the standardized HIPAA compliant group and reason codes. These can be located at the [Washington Publishing Company's \(WPC\) website](#).

Claim Information

➤ Section 3: Claim Information Section

☰ **CLAIM INFORMATION**

Go to [Other Claim Info](#) to include the following claim detail information:
Specialized Line Services, Miscellaneous Line Data, Line Level Providers, Miscellaneous Line Dates, Test Results or Form Identification Information.

+ **PRIOR AUTHORIZATION**

+ **CLAIM NOTE**

+ **EPSDT INFORMATION**

+ **CONDITION INFORMATION**

? * Is this claim accident related? Yes No

CLAIM DATA

Patient Account No.:

* Place of Service: ▼

+ **Additional Claim Data**

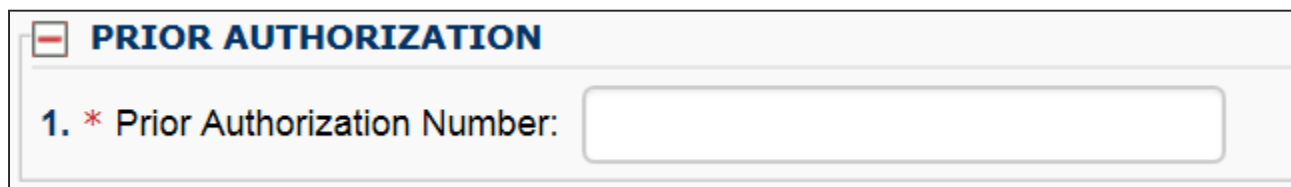
Diagnosis Codes: * 1: 2: 3: 4: 5: 6:
 7: 8: 9: 10: 11: 12:

Prior Authorization

- If a Prior Authorization number needs to be added to the claim, click on the red + to expand the **Prior Authorization** fields.



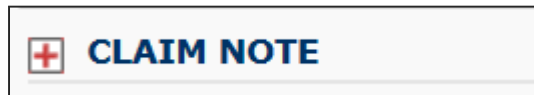
- EPA numbers are considered authorization numbers and should be entered here.

A screenshot of an expanded field in a software interface. At the top, it has a red minus sign icon and the text "PRIOR AUTHORIZATION" in blue. Below this, there is a label "1. * Prior Authorization Number:" followed by a white text input box with a light gray border.

Note: We recommend that providers enter any authorization number in these boxes. Entering the number here will cover the entire claim.

Claim Note

- A note may need to be added to the claim to assist in the processing.



- Click on the red + to expand the **Claim Note** section.


A screenshot of a web form titled "CLAIM NOTE" with a red minus icon on the left. The form contains three main sections: a "Type Code" field with a dropdown arrow, a "Note" field which is a large text area, and a "characters remaining" field showing the number "80".

Note: Recent system changes to ProviderOne have changed how claim notes are read. If a specific program or service requires you to enter a claim note as instructed in a program billing guide, they will still be read by the system. If no claim note is needed, skip this option.

- For commercial insurance, as long as there is an attachment included or the insurance information is completed in the required fields, a claim note is not necessary.

Is the Claim Accident Related?

- This question will always be answered **NO**. Washington Medicaid has a specific Casualty Office that handles claims where another casualty insurance may be primary.
 - The Casualty office can be reached at 800-562-3022 ext. 15462.

 * Is this claim accident related? Yes No

Patient Account Number

- The **Patient Account No.** field allows the provider to enter their internal patient account numbers assigned to the patient by their practice management system.

CLAIM DATA	
Patient Account No:	<input type="text" value="123456"/>

Note: Entering internal patient account numbers may make it easier to reconcile the weekly remittance and status report (RA) as these numbers will be posted on the RA.

Place of Service

- With 5010 implementation, the Place of Service box has been added to the main claim section. Choose the appropriate **Place of Service** from the drop down.

* Place of Service: 11-OFFICE

01-PHARMACY	20-URGENT CARE FACILITY	51-INPATIENT PSYCHIATRIC FACILITY
03-SCHOOL	21-INPATIENT HOSPITAL	52-PSYCHIATRIC FACILITY - PARTIAL HOSPITALIZATION
04-HOMELESS SHELTER	22-OUTPATIENT HOSPITAL	53-COMMUNITY MENTAL HEALTH CENTER
05-INDIAN HLTH SVC FREE-STANDING FACILITY	23-EMERGENCY ROOM - HOSPITAL	54-INTERMEDIATE CARE FACILITY (ICF/MR)
06-INDIAN HLTH SVC PROVIDER-BASED FACILITY	24-AMBULATORY SURGICAL CENTER	55-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
07-TRIBAL 638 FREE-STANDING FACILITY	25-BIRTHING CENTER	56-PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
08-TRIBAL 638 PROVIDER-BASED FACILITY	26-MILITARY TREATMENT FACILITY	57-NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
09-PRISON/CORRECTIONAL FACILITY	31-SKILLED NURSING FACILITY (SNF)	60-MASS IMMUNIZATION CENTER
11-OFFICE	32-NURSING FACILITY	61-COMPREHENSIVE INPATIENT REHAB FACILITY
12-Home	33-CUSTODIAL CARE FACILITY	62-COMPREHENSIVE OUTPATIENT REHAB FACILITY
13-ASSISTED LIVING FACILITY	34-Hospice	65-END-STAGE RENAL DISEASE TREATMENT FACILITY
14-Group Home	41-AMBULANCE - LAND	71-PUBLIC HEALTH CLINIC
15-MOBILE UNIT	42-AMBULANCE - AIR OR WATER	72-RURAL HEALTH CLINIC (RHC)
16-TEMPORARY LODGING	49-INDEPENDENT CLINIC	81-INDEPENDENT LABORATORY
17-WALK-IN RETAIL HEALTH CLINIC	50-FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	99-OTHER PLACE OF SERVICE

Note: The Place of Service is required in this section but can still be added to the line level of the claim. Line level is **NOT** required.

Additional Claim Data

- The **Additional Claim Data** red + expander will allow the provider to enter the patient's spenddown amount.

CLAIM DATA

Patient Account No:

mm dd cyy

* Service Date:

* Place of Service:

+ Additional Claim Data

- If patient has a spenddown click on the red + expander to display the below image. Enter the spenddown amount in the **Patient Paid Amount** box.

- 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:

Patient Signature Source Code:

Patient Paid Amount:

Anesthesia Related Procedure Code 1:

Anesthesia Related Procedure Code 2:

Diagnosis Codes

- Enter the appropriate ICD-10 **Diagnosis Code** or codes.

Diagnosis Codes: * 1:	<input type="text"/>	2:	<input type="text"/>	3:	<input type="text"/>	4:	<input type="text"/>	5:	<input type="text"/>	6:	<input type="text"/>
7:	<input type="text"/>	8:	<input type="text"/>	9:	<input type="text"/>	10:	<input type="text"/>	11:	<input type="text"/>	12:	<input type="text"/>

Note:

- At least 1 diagnosis code is required for all claims.
- ProviderOne will allow up to 12 ICD-10 diagnosis codes.
- Do not enter decimal points in DX codes. ProviderOne will add these in once the claim is submitted.

Basic Service Line Items

➤ Section 4: Basic Line Item Information

BASIC LINE ITEM INFORMATION

Click on Other Svc Info in each line item to include the following additional line item information:
Attachment, Drug, DMERC Condition, Health Services, Test Results, Home Oxygen Therapy, Service Facility, Miscellaneous Numbers, Indicators, Providers, Dates and Amounts, Medical Equipment, Ambulance Transport, Line Item Note, Other Payer, Spinal Manipulations, Purchased Services and Line Adjudication.

BASIC SERVICE LINE ITEMS

* Service Date From: mm dd cyy * Service Date To: mm dd cyy

Place of Service:

* Procedure Code: Modifiers: 1: 2: 3: 4:

* Submitted Charges: \$ Diagnosis Pointers: * 1: 2: 3: 4:

* Units:

+ Medicare Crossover Items

National Drug Code:

+ Drug Identification

+ Prior Authorization

+ Additional Service Line Information

Note: Please ensure you have entered any necessary claim information (found in the other sections on this or another page) before adding this service line.

Previously Entered Line Item Information

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

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	PA Number
	From	To		1	2	3	4	1	2	3	4			

Basic Service Line Items

- Enter the **Service Date From:**

	mm	dd	ccyy
* Service Date From:	<input type="text"/>	<input type="text"/>	<input type="text"/>

- Enter the **Service Date To:**

	mm	dd	ccyy
* Service Date To:	<input type="text"/>	<input type="text"/>	<input type="text"/>

Note: The dates of service must be in the format of a 2 digit month, 2 digit day, and 4 digit year (e.g. 10/03/2016).

Basic Service Line Items

- The **Place of Service Code** is not required here as it is already entered at the Claim Level.

Place of Service: 

01-PHARMACY	20-URGENT CARE FACILITY	51-INPATIENT PSYCHIATRIC FACILITY
03-SCHOOL	21-INPATIENT HOSPITAL	52-PSYCHIATRIC FACILITY - PARTIAL HOSPITALIZATION
04-HOMELESS SHELTER	22-OUTPATIENT HOSPITAL	53-COMMUNITY MENTAL HEALTH CENTER
05-INDIAN HLTH SVC FREE-STANDING FACILITY	23-EMERGENCY ROOM - HOSPITAL	54-INTERMEDIATE CARE FACILITY (ICF/MR)
06-INDIAN HLTH SVC PROVIDER-BASED FACILITY	24-AMBULATORY SURGICAL CENTER	55-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
07-TRIBAL 638 FREE-STANDING FACILITY	25-BIRTHING CENTER	56-PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
08-TRIBAL 638 PROVIDER-BASED FACILITY	26-MILITARY TREATMENT FACILITY	57-NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
09-PRISON/CORRECTIONAL FACILITY	31-SKILLED NURSING FACILITY (SNF)	60-MASS IMMUNIZATION CENTER
11-OFFICE	32-NURSING FACILITY	61-COMPREHENSIVE INPATIENT REHAB FACILITY
12-Home	33-CUSTODIAL CARE FACILITY	62-COMPREHENSIVE OUTPATIENT REHAB FACILITY
13-ASSISTED LIVING FACILITY	34-Hospice	65-END-STAGE RENAL DISEASE TREATMENT FACILITY
14-Group Home	41-AMBULANCE - LAND	71-PUBLIC HEALTH CLINIC
15-MOBILE UNIT	42-AMBULANCE - AIR OR WATER	72-RURAL HEALTH CLINIC (RHC)
16-TEMPORARY LODGING	49-INDEPENDENT CLINIC	81-INDEPENDENT LABORATORY
17-WALK-IN RETAIL HEALTH CLINIC	50-FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	99-OTHER PLACE OF SERVICE

Basic Service Line Items

- Enter the **Procedure Code**:

* Procedure Code:

Note: Use current codes listed in the coding manuals.

- Enter the appropriate procedure **Modifier(s)** if needed.

Modifiers: 1: 2: 3: 4:

Note: ProviderOne allows up to 4 Modifiers to be added to a single procedure code.

Basic Service Line Items

➤ Enter **Submitted Charges**:

* Submitted Charges: \$

Note: If the dollar amount is a whole number, no decimal point is needed.

Note: The agency requests that providers enter their usual and customary charges here. If providers have billed a Commercial Insurance or Medicare as primary, please enter the same charges here as billed to the primary. If a provider is billing for DME supplies that required prior authorization, please enter the same amount here as was on the authorization request because they must match.

Basic Service Line Items

- Enter appropriate **Diagnosis Pointer**:

Diagnosis Pointers: * 1: 2: 3: 4:

1
10
11
12
2
3
4
5
6
7
8
9

Note:

- At least one DX pointer is required.
- Up to 4 DX codes can be added per service line.
- Diagnosis Pointer 1 is the primary DX code.
- Diagnosis Pointer drop down corresponds with DX codes entered previously.

Basic Service Line Items

- Enter procedure **Units**:

* Units:

Note: At least 1 unit is required.

Basic Service Line Items

- If the claim is a Medicare Crossover, complete the following **Medicare Crossover Items:**

Medicare Crossover Items		
* Medicare Deductible: \$	<input type="text"/>	* Medicare Coinsurance: \$ <input type="text"/>
* Medicare Paid: \$	<input type="text"/>	* Medicare Co-payment: \$ <input type="text"/>
	<input type="text"/>	* Medicare Allowed Amount: \$ <input type="text"/>
	mm dd cyy	
* Medicare Paid Date:	<input type="text"/>	<input type="text"/>

Note: Entering the line level Medicare information is required here if the previous question concerning Medicare Crossovers was answered yes. The line level Medicare payment data sum must match the claim level Medicare payment data entered.

Note: For complete instructions on how to submit a Medicare Crossover claim please view the online fact sheet titled [5010 DDE Medicare Crossover Claims](#).

Basic Service Line Items

- Enter **National Drug Code (NDC)** if billing an injectable procedure code.

National Drug Code:

- The **Drug Identification** red (+) expander is not needed when billing for injectable procedure codes.



Drug Identification

Basic Service Line Items

- If a Prior Authorization number needs to be added to a line level procedure code, click on the red + to expand the **Prior Authorization** option.

 **Prior Authorization**

Note: If a Prior Authorization number was entered previously on the claim it is not necessary to enter it again here.

- The **Additional Service Line Information** is not needed for claims submission.

 **Additional Service Line Information**

Add Service Line Items

- Click on the **Add Service Line Item** button to list the procedure line on the claim.

+ Add Service Line Item
✎ Update Service Line Item

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$ 150.00

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Ptrs				Submitted Charges	Units	PA Number	
	From	To		1	2	3	4	1	2	3	4				
1	06/01/2016	06/01/2016	99214					1				150	1		Delete or Other Service Info

Note: Please ensure all necessary claim information has been entered before clicking the **Add Service Line Item** button to add the service line to the claim.

Note: Once the procedure line item is added, ProviderOne will refresh and return to the top of the claim form.

Add Additional Service Line Items

- If additional service lines need to be added, click on the **Service** hyperlink to get quickly back to the **Basic Service Line Items** section.

Close Save Claim Submit Claim Reset

Professional Claim

Note: asterisks (*) denote required fields.

Basic Claim Info Other Claim Info

Billing Provider | Rendering Provider | Subscriber | Claim | Service

- Then follow the same procedure as outlined above for entering data for each line.

Update Service Line Items

- Update a previously added service line item by clicking on the **Line No.** of the line that needs to be updated. This will repopulate the service line item boxes for changes to be made.

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$ 150.00

Line No	Service Date		Proc. Code	Modifiers				Diagnosis Ptrs				Submitted Charges	Units	PA Number	
	From	To		1	2	3	4	1	2	3	4				
1	06/01/2016	06/01/2016	99214					1				150	1		Delete or Other Service Info

Note: Once the line number is chosen, ProviderOne will refresh the screen and return to the top of the claim form. Use the **Service** hyperlink to quickly return to the service line item boxes and make corrections.

Update Service Line Items

- Once the service line is corrected, click on the **Update Service Line Item** button to add corrected information on claim.

+ Add Service Line Item
✎ Update Service Line Item

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$ 175.00

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	PA Number	
	From	To		1	2	3	4	1	2	3	4				
1	06/01/2016	06/01/2016	99214					1				175	1		Delete or Other Service Info

Note: Once the **Update Service Line Item** button is chosen, ProviderOne will refresh screen and return to the top of the claim form. Use the **Service** hyperlink to quickly return to the service line item section to view and verify that changes were completed.

Delete Service Line Items

- A service line can easily be deleted from a claim before submission by clicking on the **Delete** option at the end of the added service line.

+ Add Service Line Item ✎ Update Service Line Item

Previously Entered Line Item Information

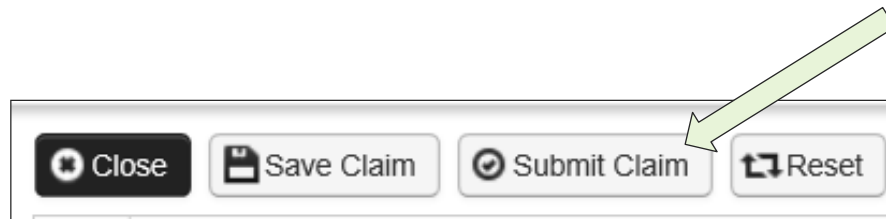
Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$ 175.00

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	PA Number	
	From	To		1	2	3	4	1	2	3	4				
1	06/01/2016	06/01/2016	99214					1				175	1		Delete or Other Service Info

Note: Once the service line item is deleted it will be permanently removed from claim. If the service line was accidentally deleted, the provider will need to re-enter the information following previous instructions.

Submit Claim for Processing

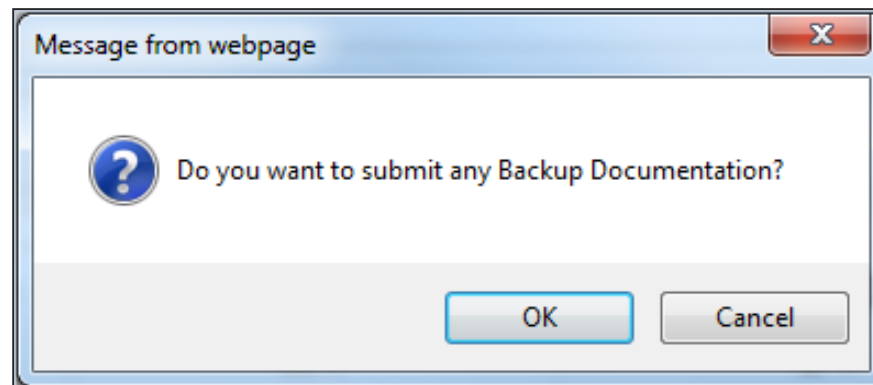
- When the claim is ready for processing, click the **Submit Claim** button at the top of the claim form.



Note: Make sure the browser **Pop Up Blocker** is off or your system will not allow the claim to be submitted.

Submit Claim for Processing

- Click on the Submit Claim button to submit the claim. ProviderOne should then display this prompt:



- Click on the **Cancel** button if no backup is to be sent.
- Click on the **OK** button if backup needs to be attached.

Note: If all insurance information has been entered on the claim, it is not necessary to send the insurance EOB with the claim.

Submit Claim for Processing – No Backup

- ProviderOne now displays the **Submitted Professional Claim Details** screen.
- Click on the **Submit** button to finish submitting the claim.

Submitted Professional Claim Details:

TCN: 201711800093105000
 Provider NPI: 1801231717
 Client ID: 999999998WA
 Date of Service: 06/01/2016-06/01/2016
 Total Claim Charge: \$ 175.00

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

Attachment List

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

Print Print Cover Page Submit

Submit Claim for Processing – With Backup (Electronic File Attached)

- The Claim's Backup Documentation page is displayed.

Print Help

Please select one of the option from the Required Fields * and select Line No, if the attachment is for specific Service Line Item.

Attachment Type: 03-Report Justifying Treatment Bej * Transmission Code: AA-Available on Request at Provid *

Line No: *

Please attach the File(s). The File Format must be PDF, DOC, TIF, XLS-

Filename: Browse... *

OK Cancel

- Enter the **Attachment Type**.
- Pick one of the following Transmission Codes:
 - **EL**- Electronic Only or Electronic file
 - Browse to find the file name
- Click the **OK** button.

Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

- The Claims Backup Documentation page is displayed.

Print Help

Please select one of the option from the Required Fields * and select Line No, if the attachment is for specific Service Line Item.

Attachment Type: 03-Report Justifying Treatment Bey * Transmission Code: AA-Available on Request at Provid *
Line No:

Please attach the File(s). The File Format must be PDF, DOC, TIF, XLS-

Filename: Browse... *

OK Cancel

- Enter the **Attachment Type**.
- Pick one of the following Transmission Codes:
 - **BM** - By Mail; or
 - **FX** - Fax
- Click the **OK** button.

Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

- If sending paper documents with the claim, at the Submitted Professional Claim Details page click on the **Print cover Page** button.

Submitted Professional Claim Details:

TCN: 201711800093204000
 Provider NPI: 1801231717
 Client ID: 99999998WA
 Date of Service: 06/01/2016-06/01/2016
 Total Claim Charge: \$ 175.00

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"/>	0	BM	03	BM		0kb	X	04/28/2017

View Page: Go + Page Count SaveToXLS Viewing Page: 1 « First < Prev Next > » Last

Print Print Cover Page Submit

Submit Claim for Processing – With Backup

- Fill in the boxes with the appropriate information:
 - Tab between fields
 - Expands the bar code
- When completed click on the **Print Cover Sheet** button and mail to:

Electronic Claim Back-up
Documentation
PO BOX 45535
Olympia, WA 98504-5535

OR

Fax: 1-866-668-1214

ProviderOne
ECB Attachment Submission Cover Sheet

Provider Identifier Type
(Select Identifier type)

Provider ID
(Please enter numeric value. Length based on Identifier type.)

TCN
(Please enter 18 or 21 digit numeric value starting with 1,2,3,4 or 9.)

Date of Service
(Please use calendar)

January, 2016						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
27	28	29	30	31	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

 Today: 1/11/2016

ProviderOne Client ID
(Please enter 9 digit numeric value and suffix with WA or wa.)

Please use the Print Cover Sheet Button Above to print ONLY.

FAX to: 1-866-668-1214. THE BAR CODE COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR FAX WITH ALL SUPPORTING DOCUMENTATION BEHIND THE BAR CODE SHEET. 03/12/2012 Ver 3.0

Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

- Push the **Submit** button to submit the claim.

Submitted Professional Claim Details:
▲

TCN: 201711800093204000

Provider NPI: 1801231717

Client ID: 999999998WA

Date of Service: 06/01/2016-06/01/2016

Total Claim Charge: \$ 175.00

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

+ Add Attachment

Attachment List
▲

☐	Line No ▲▼	File Name ▲▼	Attachment Type ▲▼	Transmission Code ▲▼	Attachment Control # ▲▼	File Size ▲▼	Delete ▲▼	Uploaded On ▲▼
☐	0	BM	03	BM		0kb		04/28/2017

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Next ▶
Last ▶▶



Print
Print Cover Page

Submit

Saving and Retrieving a Direct Data Entry Claim

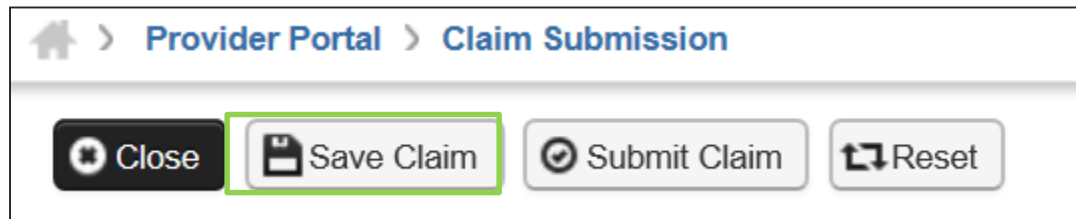
Saving a Direct Data Entry Claim

- ProviderOne allows a provider to save a claim if you are interrupted during the process of entering.
- You can retrieve the saved claim to finish entering the needed information and submit the claim.
- The following data elements are the minimum required to be completed before a claim can be saved:

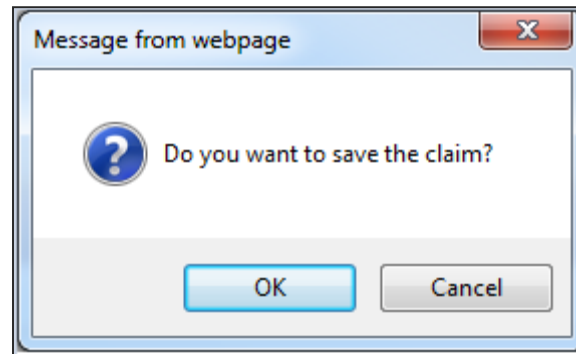
Section 1: Billing Provider Information	Section 2: Subscriber/Client Information	Section 3: Claim Information
Billing Provider NPI	Client ID number	Is this claim accident related? 
Billing Provider Taxonomy		
Is the Billing Provider also the Rendering Provider? 		

Saving a Direct Data Entry Claim

- Save the claim by clicking on the **Save Claim** button.



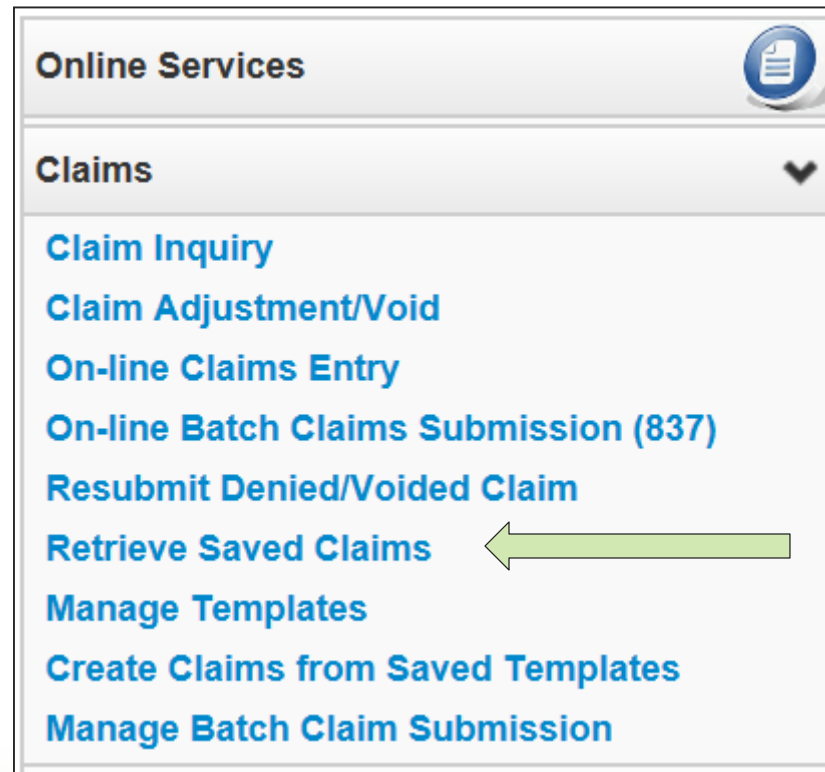
- ProviderOne now displays the following confirmation box:



- Click the **OK** button to proceed or **Cancel** to return to the claim form.
- Once the **OK** button is clicked, ProviderOne checks the claim to make sure the minimum data fields are completed.
- If all data fields are completed, ProviderOne saves the claim and closes the claim form.

Retrieving a Saved Direct Data Entry Claim

- At the Provider Portal, click on the **Retrieve Saved Claims** hyperlink.



Retrieving a Saved Direct Data Entry Claim

- ProviderOne displays the **Saved Claims List**:
 - Click on the Link Icon to retrieve a claim.

Close Delete

Saved Claims List

Filter By: [dropdown] [input] And [dropdown] [input] [input] Go

Save Filter My Filters

Link	Billing Provider NPI	Client ID	Client Last Name	User Login ID
	5100000004	999999998WA	Doe	PRU

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

- The system loads the saved claim in the correct DDE claim form screen.
- Continue to enter data, then submit the claim as normal.
- Once a saved claim has been retrieved and submitted, it will be removed from the Saved Claims List.

Medicare Crossover

Common Terminology

➤ Coinsurance

- An amount a Medicare client may be required to pay as their share of the cost for services.

➤ Deductible

- The amount for which a beneficiary is responsible before Medicare starts paying.

➤ Capitated Copayment

- A predetermined set dollar amount a Medicare client may be required to pay as their share of the cost for services.

➤ Non-Capitated Copayment

- An amount a Medicare client may be required to pay as their share of the cost for services.

Overview – Medicare Crossover

- There are 4 types of Medicare coverage:
 - Medicare **Part A** covers Inpatient hospital services
 - Medicare **Part B** covers professional and vendor services
 - Medicare **Part C** is a managed care version of Medicare, a Medicare Advantage Plan
 - Medicare **Part D** covers prescription drugs

- When is a claim a Medicare crossover claim?
 - If Medicare pays or applies to the deductible, the claim billed to HCA is a crossover.
 - The general rule is to bill the Agency after Medicare on the same claim form billed to Medicare.
 - The Agency is not paying **Part D** co-pays (Part D is not covered in this presentation).

Overview - Medicare Crossovers

- When is a claim **NOT** a crossover claim?
 - Claims (services) denied by Medicare when billed to us are not crossover claims.
 - We still require the Medicare EOB to demonstrate non-payment.

- Sometimes Medicare does **NOT** forward claims automatically to the Agency
 - Can submit Direct Data Entry (DDE) or Electronically without the EOMB (if Medicare denies the service, the EOMB IS required for electronic billing).
 - The Medicare Advantage Plans do not cross claims over directly so they must be billed separately through DDE or Electronically as crossover claims.

Overview - Medicare Crossovers

- If Medicare denies an Apple Health-covered service that requires Prior Authorization, the service still requires authorization:
 - You may request it after the service is provided.
 - The agency waives the “prior” requirement in this circumstance.

Medicare Eligibility

- Eligibility checks may show Medicare as:
 - **QMB** – Medicare Only (Qualified Medicare Beneficiary)
 - This program pays for Medicare premiums and may pay deductibles, coinsurance, and copayments according to Medicaid rules.
 - **CNP-QMB** (Categorically Needy Program – Qualified Medicare Beneficiary)
 - Client has full Medicaid as well as QMB benefits.

Medicare Eligibility

- Programs that HCA would not consider for secondary payment after Medicare:
 - **SLMB** (Special Low Income Medicare Beneficiary)
 - This program only pays for Medicare premiums. Health coverage through Apple Health (Medicaid) is not covered.
 - **QI-1** (Qualified Individual 1)
 - This program only pays for Medicare premiums. Health coverage through Apple Health (Medicaid) is not covered.
 - **QDWI** (Qualified Disabled Working Individual) –
 - This program only pays for Medicare premiums. Health coverage through Apple Health (Medicaid) is not covered.

Medicare Eligibility

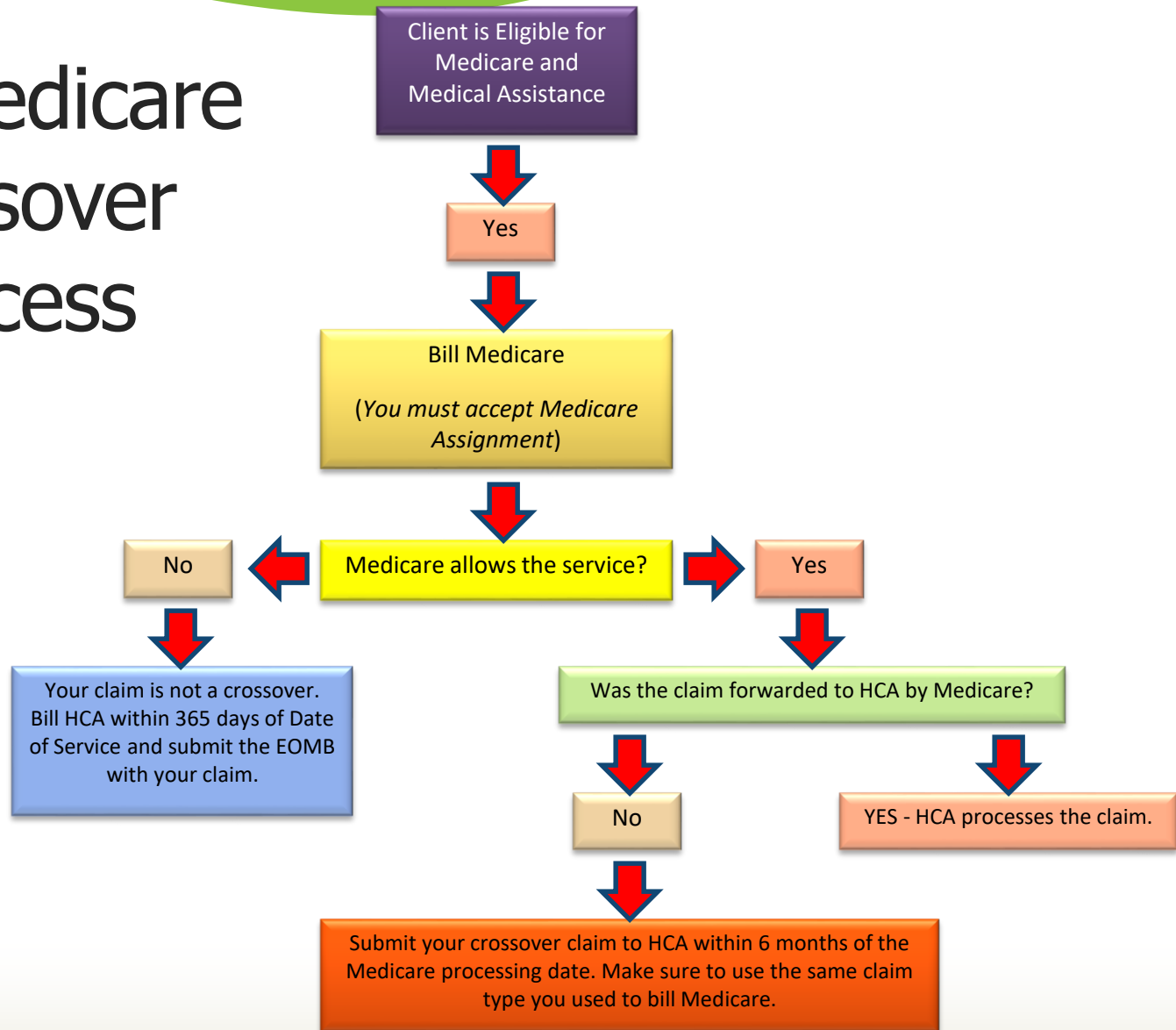
- Determine Medicare eligibility using ProviderOne. Scroll down to the **Medicare Eligibility Information** area.

Medicare Eligibility Information			
Service Type Code ▲▼	Insurance Type Code ▲▼	Eligibility Start Date ▲▼	Eligibility End Date ▲▼
30: Health Benefit Plan Coverage	MA: Medicare Part A	02/01/1997	12/31/2999
30: Health Benefit Plan Coverage	MB: Medicare Part B	02/01/1997	12/31/2999

- The Medicare HIC number is listed under the Client Demographic area.
- Medicare Part C information (if loaded) is located under the **Coordination of Benefits Information** area.

Coordination of Benefits Information									
Service Type Code ▲▼	Insurance Type Code ▲▼	Insurance Co. Name & Contact ▲▼	Carrier Code ▲▼	Policy Holder Name ▲▼	Policy Number ▲▼	Group Number ▲▼	Plan Sponsor ▲▼	Start Date ▲▼	End Date ▲▼
30: Health Benefit Plan Coverage	C1: Commercial	UNITED HEALTHCARE INSURANCE COMPANY	H5008		Med Part D			08/01/2009	12/31/2999
30: Health Benefit Plan Coverage	C1: Commercial	UNITED HEALTHCARE INSURANCE COMPANY	H5008		Med Part C			08/01/2009	12/31/2999

The Medicare Crossover Process



Medicare Billing Part B


Medicare Billing – Part B

➤ DDE Professional, 837P

- If Medicare has paid all lines on your claim and did not forward the claim to Apple Health, submit the crossover claim to the Agency.
- If Medicare has allowed and denied service lines on your claim:
 - You will need to submit **TWO** claims to the Agency;
 - One crossover claim for services Medicare paid; and
 - One professional claim for services Medicare denied.

Medicare Billing – Part B

- Bill the Agency using the same service codes and billed amounts sent to Medicare.
- Medicare and Medicare Advantage Plans are Medicare:
 - HCA does not consider Medicare as insurance.
- When submitting via Direct Data Entry (DDE)
 - Click the Radio button **YES** to indicate this claim is a crossover.

 * Is this a Medicare Crossover Claim? Yes No

- Additional data boxes open to be filled in as required at claim level.

Medicare Cross Over Items

* Amount Paid by Medicare: \$ * Medicare Deductible: \$ * Medicare Co-payment: \$

* Medicare Co-insurance: \$ * Medicare Allowed Amount: \$

mm dd cyy

* Medicare Adjudication Date:

Medicare Billing – Part B

- The rest of the claim information is filled out as normal down to the service line information. Expand the **Medicare Crossover Items** by clicking the red +.

BASIC SERVICE LINE ITEMS

<p>* Service Date From: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/></p> <p>Place of Service: <input type="text" value=""/> <input type="button" value="v"/></p> <p>* Procedure Code: <input type="text" value=""/></p> <p>* Submitted Charges: \$ <input type="text" value=""/></p> <p>* Units: <input type="text" value=""/></p>	<p>* Service Date To: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/></p> <p>Modifiers: 1: <input type="text" value=""/> 2: <input type="text" value=""/> 3: <input type="text" value=""/> 4: <input type="text" value=""/></p> <p>Diagnosis Pointers: * 1: <input type="text" value="v"/> 2: <input type="text" value="v"/> 3: <input type="text" value="v"/> 4: <input type="text" value="v"/></p>
---	--

+ Medicare Crossover Items

- Entering the line level Medicare information is required. The line level Medicare payment amounts must match the claim level Medicare payment total entered.

Medicare Crossover Items

<p>* Medicare Deductible: \$ <input type="text" value=""/></p> <p>* Medicare Paid: \$ <input type="text" value=""/></p>	<p>* Medicare Coinsurance: \$ <input type="text" value=""/></p> <p>* Medicare Allowed Amount: \$ <input type="text" value=""/></p>	<p>* Medicare Co-payment: \$ <input type="text" value=""/></p>
---	--	--

* Medicare Paid Date:

- No EOB is required with the DDE crossover claim.

Tips on Billing Crossovers

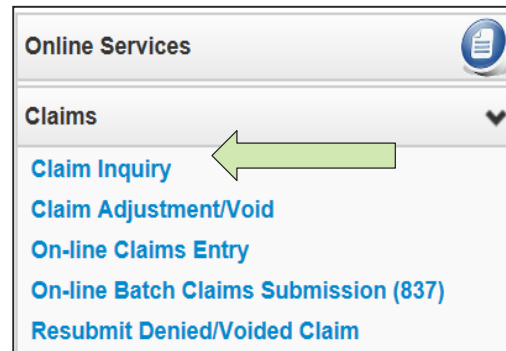
- Bill your taxonomy code(s) to Medicare the same as you bill your taxonomy code(s) to Medicaid.
- If you bill Medicare with an NPI that has not been loaded in ProviderOne, the agency will not be able to identify the provider when these claims are forwarded by Medicare.
- The claim format billed to Medicare must match the claim format billed to ProviderOne.
- The coding and dollar amount billed must match.
- Complete all required fields on the DDE crossover screen.

Claim Inquiry

Claim Inquiry

➤ How do I find claims in ProviderOne?

- **Claim Inquiry**



➤ Enter search data then submit

A screenshot of the 'Provider Claim Inquiry Search' form. The form has a title bar with 'Close' and 'Submit' buttons. A green arrow points to the 'Submit' button. Below the title bar, there is a grid icon and the text 'Provider Claim Inquiry Search'. A message reads: 'Please enter a Provider NPI and enter available information in the remaining fields before clicking 'Submit''. Below this message, there is a green-bordered box containing the following instructions:

- Required: TCN or Client ID 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

The form contains the following fields:

- Provider NPI: 5100000004 (with a dropdown arrow)
- TCN: (empty text box)
- Client ID: (empty text box)
- Claim Service Period From: (empty text box with a calendar icon)
- Claim Service Period To: (empty text box with a calendar icon)

Claim Inquiry

➤ Claim TCN's returned

- Click on TCN number to view the claim data.
 - Denied claims will show the denial codes.
 - Easiest way to find a timely TCN number for re-billing.

Close
Provider NPI: 5100000004

☰ Claim Inquiry Providers List
▲

<input type="checkbox"/>	TCN ▲▼	Date of Service ▲▼	Claim Status ▲▼	Claim Charged Amount ▲▼	Claim Payment Amount ▲▼	Client Name ▲▼	Client ID ▲▼
<input type="checkbox"/>	201600400003942000	01/15/2015	0: Cannot provide further status electronically.	\$60.00	\$0.00	John	999999998WA
<input type="checkbox"/>	201600400003943000	01/15/2015	0: Cannot provide further status electronically.	\$60.00	\$0.00	John	999999998WA
<input type="checkbox"/>	201600400003944000	01/15/2015	0: Cannot provide further status electronically.	\$60.00	\$0.00	John	999999998WA

View Page:

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⏴ Prev
Next ⏵
Last ⏩

Why can't I pull up my claim?

- There are many reasons why you might not be able to retrieve a claim (for any system functions):
 - It has been adjusted, you can't retrieve a claim that has already been adjusted.
 - It has been replaced by another claim.
 - It hasn't finished processing.
 - It was billed under a different domain.
 - You could be using the wrong profile.
 - Trying to do a resubmit on a paid claim or an adjustment on a denied claim.
 - Claims you billed with an NPI not reported in ProviderOne.
 - Claims you billed with an ID only rendering provider NPI number as the pay-to provider.

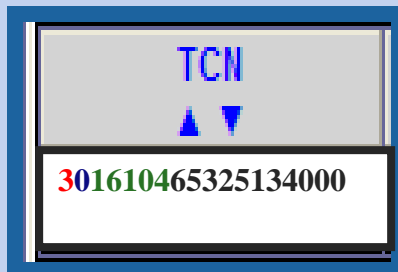
Timely Billing

Timely Billing

- What are the agency's timeliness guidelines?
 - The initial billing must occur within **365** days from the date of service on the claim.
 - Providers are allowed **2** years total to get a claim paid or adjusted.
 - For Delayed Certification client eligibility the agency allows **12** months from the Delayed Cert date to bill.
 - Recoupments from other payer's timeliness starts from the date of the recoupment, not the date of service.
 - The agency uses the Julian calendar on claim numbers for tracking.

What is a TCN?

**TCN=Transaction
Control Number**



**18 digit number that
ProviderOne assigns to
each claim received for
processing. TCN numbers
are never repeated.**

How do I read a TCN?

1st digit-Claim Medium Indicator

- 1-paper
- 2-Direct Data Entry
- 3-electronic, batch submission
- 4-system generated (Credits/Adjustment)

2nd digit-Type of Claim

- 0-Medical/Dental
- 2-Crossover or Medical

3rd thru 7th digits-Date Claim was Received

- 3rd and 4th digits are the year
- 5th, 6th and 7th digits are the day it was received

Example TCN:

301610465325134000

- 3** Electronic submission via batch
- 0** Medical claim
- 16** Year claim was received-2016
- 104** Day claim was received-April 14

How do I prove timeliness?

- HIPAA EDI claims
 - Submit a HIPAA batch transaction using a frequency 7 to adjust/replace the original claim or a frequency 8 to void the original claim.

- Direct Data Entry (DDE) Claims
 - Resubmit Original Denied/Voided Claim; or
 - Enter timely TCN in the Claim Note.

Adjust / Void a Claim

Adjust/Void a Paid Claim

- Select **Claim Adjustment/Void** from the Provider Portal.

A screenshot of a web portal menu. The menu is titled 'Online Services' and has a sub-menu 'Claims' which is expanded. Under 'Claims', there are two options: 'Claim Inquiry' and 'Claim Adjustment/Void'. A green arrow points to the 'Claim Adjustment/Void' option.

- Enter the **TCN** number if known; or
- Enter the **Client ID** and the **From-To date** of service and click the **Submit** button.

Note: Per WAC 182-502-0150 claims can only be adjusted/voided in ProviderOne 24 months from the date of service. Prescription drug claims have only 15 months.

A screenshot of a web form titled 'Provider Claim Adjust Void Search'. The form has a 'Close' button and a 'Submit' button (highlighted with a green box). Below the title, there is a instruction: 'Please enter a Provider NPI and enter available information in the remaining fields before clicking 'Submit''. A green box highlights a list of requirements:

- Required: TCN or Client ID AND Claim Service Period (To date is optional)
- You may Adjust/Void claims processed within the past four years
- The Claim Service Period From and To date range cannot exceed 3 months
- Only paid claims satisfying the selection criterion will be returned

 The form fields include:

- Provider NPI: 510000004 (with a dropdown arrow)
- TCN: [empty text box]
- Client ID: [empty text box]
- Claim Service Period From: [empty date picker]
- Claim Service Period To: [empty date picker]

Adjust/Void a Paid Claim

- The system will display the paid claim(s) based on the search criteria.

Provider NPI: 1447329578

Provider Claims Adjust Void List

	TCN	Date of Service	Claim Status	Claim Charged Amount	Claim Payment Amount	Client Name	Client ID	Child Tcn
<input checked="" type="checkbox"/>	201600700488853000	01/18/2015	1: For more detailed information, see remittance advice.	\$60.00	\$24.84	Client	999999998WA	

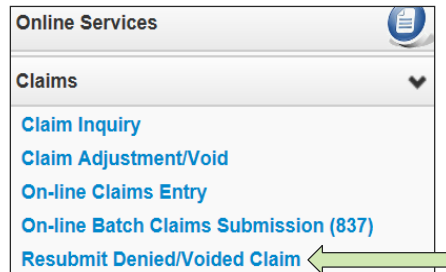
View Page: 1 Go + Page Count SaveToXLS Viewing Page: 1 << First < Prev Next > >> Last

- Check the box of the TCN to adjust/void.
- ProviderOne loads the DDE screen with the claim data.
 - Update the claim information to adjust, then submit.
 - Claim data cannot be changed when doing a void, just submit the void.

Resubmit Denied Claims

Resubmit a Denied Claim

- Select **Resubmit Denied/Voided** Claim from the Provider Portal.



- Enter **TCN**, if known; or
- Enter the **Client ID** and the **From-To date** of service and click the **Submit** button.

Close
Submit

Provider Claim Inquiry Search

Please enter a Provider NPI and enter available information in the remaining fields before clicking 'Submit'.

- Required: TCN or Client ID 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 NPI: ▼

TCN:

Client ID:

Claim Service Period From:

Claim Service Period To:

Resubmit a Denied Claim

- The system will display the claim(s) based on the search criteria.

Close Retrieve ←

Provider NPI: 5100000004

Provider Claims Model List

	TCN ▲▼	Date of Service ▲▼	Claim Status ▲▼	Claim Charged Amount ▲▼	Claim Payment Amount ▲▼	Client Name ▲▼	Client ID ▲▼
<input checked="" type="checkbox"/>	201600400003942000	01/15/2015	1: For more detailed information, see remittance advice.	\$60.00	\$0.00	John	999999998WA

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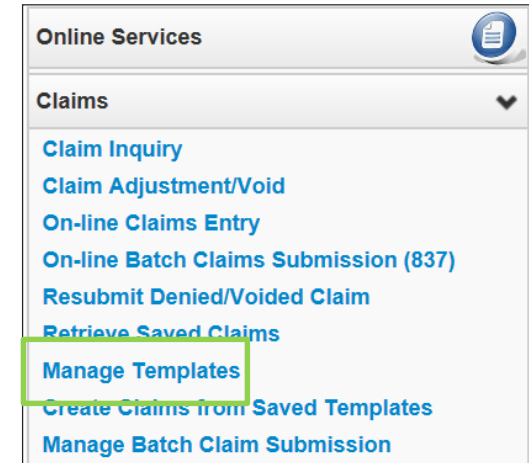
- Check the box of the TCN to resubmit and click **Retrieve**.
- ProviderOne loads the DDE screen with the claim data.
 - Update the claim information that caused the claim to deny, then submit.

Claim Templates

Creating a Claim Template

➤ ProviderOne allows creating and saving templates:

- Log into ProviderOne.
- Click on the **Manage Templates** hyperlink
- At the Create a Claim Template screen, use the dropdown to choose the **Type of Claim**.
- Click the **Add** button.



Close Add

Create a Claim Template

Type Of Claim: Professional

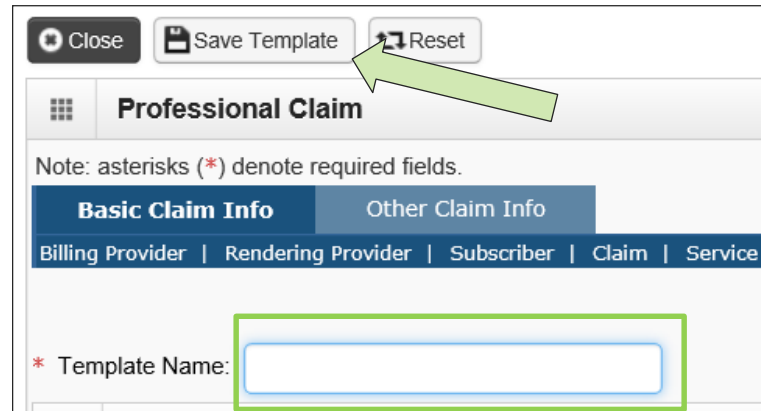
Edit View Delete SaveAs/Copy Create Batch Create Batch All Auto Batch

Claims Template List

Filter By :

Creating a Claim Template

- Once a template type is picked the system opens the DDE screen:



Close Save Template Reset

Professional Claim

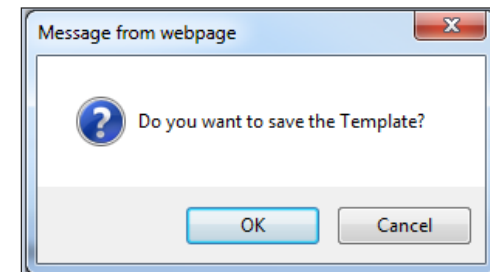
Note: asterisks (*) denote required fields.


Basic Claim Info Other Claim Info

Billing Provider | Rendering Provider | Subscriber | Claim | Service

* Template Name:

- Name the template then fill in as much data as wanted on the template.
- Click on the **Save Template** button and the system verifies you are saving the template.



Note: The minimum information required to save a template is the **Template Name** and answer required questions. 

Creating a Claim Template

- After the template is saved it is listed on the **Claims Template List**.

The screenshot displays a web application interface for managing claim templates. It is divided into two main sections: 'Create a Claim Template' and 'Claims Template List'.

Create a Claim Template Section:

- Buttons: Close, Add
- Title: Create a Claim Template
- Form: Type Of Claim: Professional (dropdown menu)
- Buttons: Edit, View, Delete, SaveAs/Copy, + Create Batch, + Create Batch All, B Auto Batch

Claims Template List Section:

- Filter By: (dropdown menu) And (dropdown menu) Go
- Buttons: Save Filter, My Filters (dropdown menu)
- Table:

<input type="checkbox"/>	Template Name	Type	Last Updated By	Last Updated Date
<input type="checkbox"/>	John Doe	Professional	PRU	05/03/2017

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- Additional templates can be created by:
- Copying a template on the list; or
 - Creating another from scratch.
- Templates can be edited, viewed, and deleted.

Submitting a Template Claim

➤ Claims can be submitted from a template:

- Log into ProviderOne.
- Click on the **Create Claims from Saved Templates**.
- At the **Saved Templates List** find the template to use (sort using the sort tools outlined).

Online Services

Claims

- Claim Inquiry
- Claim Adjustment/Void
- On-line Claims Entry
- On-line Batch Claims Submission (837)
- Resubmit Denied/Voided Claim
- Retrieve Saved Claims
- Manage Templates
- Create Claims from Saved Templates**
- Manage Batch Claim Submission

Close

Create Claim from Saved Templates List

Filter By : [] [] [] And [] [] [] Go

Save Filter My Filters

Template Name	Type	Last Updated By	Last Updated Date
John Doe	Professional	PRU	05/03/2017

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First Prev Next Last

Submitting a Template Claim

- Click on the template name.
- The DDE screen is loaded with the template.

Provider Portal > Create Claims Templates List

Close Save Claim Submit Claim Reset

Professional Claim

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

Basic Claim Info Other Claim Info

Billing Provider | Rendering Provider | Subscriber | Claim | Service

Submitter ID: 200320900

PROVIDER INFORMATION

Go to [Other Claim Info](#) to enter information for Referring, Purchasing, Supervising and other providers.

BILLING PROVIDER

* Provider NPI: 1801231717 * Taxonomy Code: 207Q00000X

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

* Is this service the result of a referral? Yes No

SUBSCRIBER/CLIENT INFORMATION

SUBSCRIBER/CLIENT

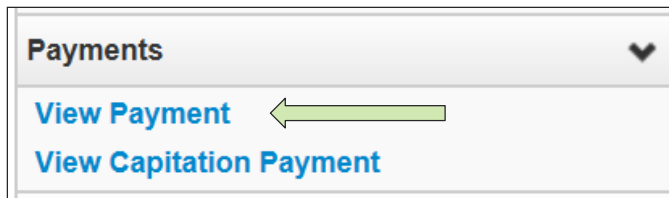
* Client ID: 999999998WA

- Enter or update the data for claim submission then submit as normal.

Reading the Remittance Advice (RA)

Reading the Remittance Advice (RA)

- How do I retrieve the PDF file for the RA?
 - Log into ProviderOne with a **Claims/Payment Status Checker, Claims Submitter, or Super User** profile.



- At the Portal click on the hyperlink **View Payment**.

- The system will open your list of RAs.

RA/ETRR Number ▲▼	Check Number ▲▼	Check/ETRR Date ▲▼	RA Date ▲▼	Claim Count ▲▼	Charges ▲▼	Payment Amount ▲▼	Adjusted Amount ▲▼	Download ▲▼
500649639			08/06/2015	2	\$300.00	\$0.00	\$300.00	
500955089			12/16/2015	1	\$100.00	\$0.00	\$100.00	

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- Click on the **RA number** in the first column to open the whole RA.

Reading the Remittance Advice (RA)

➤ The Summary Page of the RA shows:

- Billed and paid amount for Paid claims
- Billed amount of denied claims
- Total amount of adjusted claims
- Provider adjustment activity

RA Number: 8765432 Warrant/EFT # 852741!								Warrant/EFT Date: 05/29/2014		Prepared Date: 05/30/2014 RA Date: 05/30/2014				
Warrant/EFT Amount: \$9325.93				Payment Method: EFT				Page 2						
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
1122334455	Paid	\$28930.00	\$16114.57	\$0.00	\$0.00	\$0.00	\$9325.93	1122334455	214148190028/ 40140123456789 0000	System Initiated	NOC Invoice	\$0.00	\$0.00	\$3266.00
1122334455	Denied	\$6525.50	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	1122334455	214148190028/ 40149870123456 0000	System Initiated	NOC Referred to CARS	\$3266.00	\$3266.00	\$0.00
1122334455	Adjustments	-\$2981.00	-\$3371.87	\$0.00	\$0.00	\$0.00	-\$3266.00							
1122334455	In Process	\$5946.50	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00							
Total Adjustment Amount												\$3266.00		

Reading the Remittance Advice (RA)

➤ Adjustments:

- P1Off (offset) adjustments: These adjustment amounts can carry over on each week's RA until the amount is paid off or reduced by the amount paid out for claims adjudicated that week.
 - Claims that caused these carry over adjustment amounts can be on previous RAs.
 - Updates to the RA format now provide the parent TCN under the FIN Invoice Number for reference.
- NOC (non-offset) Referred to CARS: System-generated recoveries or adjustments that are referred to OFR for collection.
 - Updates to the RA format now provide the parent TCN under the FIN Invoice Number for reference.

➤ Retention Policy:

- Providers must keep RA's on file for 7 years per Washington Administrative Code (WAC).

Reading the Remittance Advice (RA)

➤ The RA is sorted into different Categories as follows (screen shown is sample of Denials):

- Paid
- Denied
- Adjustments
- In Process

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
Client, Pseudo 999999998WA		201534801403737000 Professional Claim	1		12/01/2015- 12/01/2015	96152	3.0000	\$100.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	N255 N290 N95	170 = \$100.00
Document Total:					12/01/2015-12/01/2015		3.0000	\$100.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	N255,N29 0	16,B7
Category Total:							3.0000	\$100.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		
Billing Provider Total:							3.0000	\$100.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		

Reading the Remittance Advice (RA)

- EOB Codes
 - Adjustment Reason Codes and Remark Codes for denied claims & payment adjustments are located on the last page of the RA

Adjustment Reason Codes / NCPDP Rejection Codes

119 : Benefit maximum for this time period or occurrence has been reached.
 15 : The authorization number is missing, invalid, or does not apply to the billed services or provider.
 16 : Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
 18 : Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
 35 : Lifetime benefit maximum has been reached.
 96 : Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Remark Codes

N20 : Service not payable with other service rendered on the same date.
 N329 : Missing/incomplete/invalid patient birth date.
 N37 : Missing/incomplete/invalid tooth number/letter.
 N39 : Procedure code is not compatible with tooth number/letter.

- The complete list of Federal codes can be located at the [Washington Publishing Company's \(WPC\) website](#).

Authorization

Authorization

1

Complete Authorization Form
13-835

2

Submit Authorization Request to the
Agency with Required Backup

3

Check the Status of a Request

4

Send in Additional Documentation if
Requested by the Agency

Authorization

1. Example of a completed Authorization Form **13-835**:
 - a) Fill (type) in all required fields as indicated on the directions page.
 - b) Use the codes listed in the directions for the required fields.
 - c) Add as much other detail as necessary that may help in approval.
 - d) The data on this form is scanned directly into ProviderOne.
 - e) Processing begins as soon as a correctly filled out form is received.

Step by step instructions:

[ProviderOne Billing and Resource Guide](#)

General Information for Authorization

Org	1. 502			Service Type	2. HB	
Client Information						
Name	3. Doe, John			Client ID	4. 99999998WA	
Living Arrangements	5. Home			Reference Auth #	6.	
Provider Information						
Requesting NPI #	7. 1234567890			Requesting Fax #	8. 111-222-3333	
Billing NPI #	9. 1234567890			Name	10. The Hospital	
Referring NPI #	11. 1234567890			Referring Fax #	12.	
Service Start Date:	13.					
Service Request Information						
Description of service being requested:				16.		17.
15. Safety Enclosure for hospital bed						
18. Serial/NEA or MEA #						
20. Code Qualifier	21. National Code	22. Mod	23. # Units/Days Requested	24. Req	25. Part # (DME Only)	26. Tooth or Quad #
P	E0316		1		6145-001	
Medical Information						
Diagnosis Code	27. R54		Diagnosis name	28. AGE-RELATED PHYSICAL DEBILITY		
Place of Service Code	29. 21					
30. Comments: Client is extremely fragile.						

Sample form only

Please fax this form and any supporting documents to 1-866-668-1214.

The material in this facsimile transmission is intended only for the use of the individual to whom it is addressed and may contain information that is confidential, privileged, and exempt from disclosure under applicable law. **HIPAA Compliance:** Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to seek insurance payment, or to perform other specific health care operations.

Directions for Authorization form 13-835

Instructions to fill out the General Information for Authorization form, HCA 13-835

FIELD	NAME	ACTION																																																												
		ALL FIELDS MUST BE TYPED.																																																												
1	Org (Required)	<p>Enter the Number that Matches the Program/Unit for the Request</p> <p>501 – Dental 502 – Durable Medical Equipment (DME) 504 – Home Health 505 – Hospice 506 – Inpatient Hospital 508 – Medical 509 – Medical Nutrition 511 – Outpt Proc/Diag 513 – Physical Medicine & Rehabilitation (PM & R) 514 – Aging and Long-Term Support Administration (ALTSA) 518 – LTAC 519 – Respiratory 521 – Maternity Support/Infant Case Management 524 – Concurrent Care 525 – ABA Services 526 – Complex Rehabilitation Technology (CRT) 527 – Chemical-Using Pregnant (CUP) Women Program</p>																																																												
2	Service Type (Required)	<p>Enter the letter(s) in all CAPS that represent the service type you are requesting. If you selected "501 – Dental" for field #1, please select one of the following codes for this field:</p> <table border="0"> <tr> <td>ASC for ASC</td> <td>IP for In-Patient</td> </tr> <tr> <td>CWN for Crowns</td> <td>ODC for Orthodontic</td> </tr> <tr> <td>DEN for Dentures</td> <td>OUTP for Out-Patient</td> </tr> <tr> <td>DP for Denture/Partial</td> <td>PSM for Perio-Scaling/Maintenance</td> </tr> <tr> <td>EXT for Extractions</td> <td>PTL for Partial</td> </tr> <tr> <td>EXTD for Extractions w/Dentures</td> <td>RBS for Rebases</td> </tr> <tr> <td>GA for General Anesthesia</td> <td>RLNS for Relines</td> </tr> <tr> <td>GAE for General Anesthesia w/extractions</td> <td>TC for Transfer Case</td> </tr> <tr> <td></td> <td>MISC for Miscellaneous</td> </tr> </table> <p>If you selected "502 – Durable Medical Equipment (DME)" for field #1, please select one of the following codes for this field:</p> <table border="0"> <tr> <td>AA for Ambulatory Aids</td> <td>OS for Orthopedic Shoes</td> </tr> <tr> <td>BB for Bath Bench</td> <td>OTC for Orthotics</td> </tr> <tr> <td>BEM for Bath Equipment (misc.)</td> <td>OP for Ostomy Products</td> </tr> <tr> <td>BGS for Bone Growth Stimulator</td> <td>ODME for Other DME</td> </tr> <tr> <td>BP for Breast Pump</td> <td>OTRR for Other Repairs</td> </tr> <tr> <td>C for Commode</td> <td>PL for Patient Lifts</td> </tr> <tr> <td>CG for Compression Garments</td> <td>PWH for Power Wheelchair - Home</td> </tr> <tr> <td>CSC for Commode/Shower Chair</td> <td>PWNF for Power Wheelchair – NF</td> </tr> <tr> <td>DTS for Diabetic Testing Supplies (See Pharmacy Billing Instructions for POS Billing)</td> <td>PWR for Power Wheelchair Repair</td> </tr> <tr> <td>ERSO for ERSO-PA</td> <td>PRS for Prone Stenders</td> </tr> <tr> <td>FSFS for Floor Sitter/Feeder Seat</td> <td>PROS for Prosthetics</td> </tr> <tr> <td>GL for Gloves</td> <td>RE for Room Equipment</td> </tr> <tr> <td>HB for Hospital Beds</td> <td>SC for Shower Chairs</td> </tr> <tr> <td>HC for Hospital Cribs</td> <td>SBS for Specialty Beds/Surfaces</td> </tr> <tr> <td>IS for Incontinent Supplies</td> <td>SGD for Speech Generating Devices</td> </tr> <tr> <td>MWH for Manual Wheelchair - Home</td> <td>SF for Standing Frames</td> </tr> <tr> <td>MWNF for Manual Wheelchair – NF</td> <td>STND for Stenders</td> </tr> <tr> <td>MWR for Manual Wheelchair Repair</td> <td>TU for TENS Units</td> </tr> <tr> <td></td> <td>US for Urinary Supplies</td> </tr> <tr> <td></td> <td>WDCS for VAC/Wound - decubiti supplies</td> </tr> <tr> <td></td> <td>MISC for Miscellaneous</td> </tr> </table>	ASC for ASC	IP for In-Patient	CWN for Crowns	ODC for Orthodontic	DEN for Dentures	OUTP for Out-Patient	DP for Denture/Partial	PSM for Perio-Scaling/Maintenance	EXT for Extractions	PTL for Partial	EXTD for Extractions w/Dentures	RBS for Rebases	GA for General Anesthesia	RLNS for Relines	GAE for General Anesthesia w/extractions	TC for Transfer Case		MISC for Miscellaneous	AA for Ambulatory Aids	OS for Orthopedic Shoes	BB for Bath Bench	OTC for Orthotics	BEM for Bath Equipment (misc.)	OP for Ostomy Products	BGS for Bone Growth Stimulator	ODME for Other DME	BP for Breast Pump	OTRR for Other Repairs	C for Commode	PL for Patient Lifts	CG for Compression Garments	PWH for Power Wheelchair - Home	CSC for Commode/Shower Chair	PWNF for Power Wheelchair – NF	DTS for Diabetic Testing Supplies (See Pharmacy Billing Instructions for POS Billing)	PWR for Power Wheelchair Repair	ERSO for ERSO-PA	PRS for Prone Stenders	FSFS for Floor Sitter/Feeder Seat	PROS for Prosthetics	GL for Gloves	RE for Room Equipment	HB for Hospital Beds	SC for Shower Chairs	HC for Hospital Cribs	SBS for Specialty Beds/Surfaces	IS for Incontinent Supplies	SGD for Speech Generating Devices	MWH for Manual Wheelchair - Home	SF for Standing Frames	MWNF for Manual Wheelchair – NF	STND for Stenders	MWR for Manual Wheelchair Repair	TU for TENS Units		US for Urinary Supplies		WDCS for VAC/Wound - decubiti supplies		MISC for Miscellaneous
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GA for General Anesthesia	RLNS for Relines																																																													
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AA for Ambulatory Aids	OS for Orthopedic Shoes																																																													
BB for Bath Bench	OTC for Orthotics																																																													
BEM for Bath Equipment (misc.)	OP for Ostomy Products																																																													
BGS for Bone Growth Stimulator	ODME for Other DME																																																													
BP for Breast Pump	OTRR for Other Repairs																																																													
C for Commode	PL for Patient Lifts																																																													
CG for Compression Garments	PWH for Power Wheelchair - Home																																																													
CSC for Commode/Shower Chair	PWNF for Power Wheelchair – NF																																																													
DTS for Diabetic Testing Supplies (See Pharmacy Billing Instructions for POS Billing)	PWR for Power Wheelchair Repair																																																													
ERSO for ERSO-PA	PRS for Prone Stenders																																																													
FSFS for Floor Sitter/Feeder Seat	PROS for Prosthetics																																																													
GL for Gloves	RE for Room Equipment																																																													
HB for Hospital Beds	SC for Shower Chairs																																																													
HC for Hospital Cribs	SBS for Specialty Beds/Surfaces																																																													
IS for Incontinent Supplies	SGD for Speech Generating Devices																																																													
MWH for Manual Wheelchair - Home	SF for Standing Frames																																																													
MWNF for Manual Wheelchair – NF	STND for Stenders																																																													
MWR for Manual Wheelchair Repair	TU for TENS Units																																																													
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	WDCS for VAC/Wound - decubiti supplies																																																													
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HCA 13-835 (5/15)

Instructions to fill out the General Information for Authorization form, HCA 13-835

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2	Service Type (Required) (Continued)	<p>If you selected "504 – Home Health" for field #1, please select one of the following codes for this field:</p> <table border="0"> <tr> <td>ERSO for ERSO-PA</td> <td>MISC for Miscellaneous</td> </tr> <tr> <td>HH for Home Health</td> <td>T for Therapies (PT / OT / ST)</td> </tr> </table> <p>If you selected "505 – Hospice" for field #1, please select one of the following codes for this field:</p> <table border="0"> <tr> <td>ERSO for ERSO-PA</td> <td></td> </tr> <tr> <td>HSPC for Hospice</td> <td></td> </tr> <tr> <td>MISC for Miscellaneous</td> <td></td> </tr> </table> <p>If you selected "506 – Inpatient Hospital" for field #1, please select one of the following codes for this field:</p> <table border="0"> <tr> <td>BS for Bariatric Surgery</td> <td>RM for Readmission</td> </tr> <tr> <td>ERSO for ERSO-PA</td> <td>S for Surgery</td> </tr> <tr> <td>OOS for Out of State</td> <td>TNP for Transplants</td> </tr> <tr> <td>O for Other</td> <td>VNSS for Vagus Nerve Stimulator</td> </tr> <tr> <td>PAS for PAS</td> <td>MISC for Miscellaneous</td> </tr> </table> <p>If you selected "508 – Medical" for field #1, please select one of the following codes for this field:</p> <table border="0"> <tr> <td>BSS2 for Bariatric Surgery Stage 2</td> <td>NP for Neuro-Psych</td> </tr> <tr> <td>BTX for Botox</td> <td>OOS for Out of State</td> </tr> <tr> <td>CIERP for Cochlear Implant</td> <td>PSY for Psychotherapy</td> </tr> <tr> <td></td> <td>SYN for Synagis</td> </tr> <tr> <td>CR for Cardiac Rehab</td> <td>T for Therapies (PT/OT/ST)</td> </tr> <tr> <td>ERSO for ERSO-PA</td> <td>TX for Transportation</td> </tr> <tr> <td>HEA for Hearing Aids</td> <td>V for Vision</td> </tr> <tr> <td>I for Infusion / Parental Therapy</td> <td>VST for Vest</td> </tr> <tr> <td>MC for Medications</td> <td>VT for Vision Therapy</td> </tr> <tr> <td></td> <td>MISC for Miscellaneous</td> </tr> </table> <p>If you selected "509 – Medical Nutrition" for field #1, please select one of the following codes for this field:</p> <table border="0"> <tr> <td>EN for Enteral Nutrition</td> <td></td> </tr> <tr> <td>MN for Medical Nutrition</td> <td></td> </tr> <tr> <td>MISC for Miscellaneous</td> <td></td> </tr> </table> <p>If you selected "511 – Output Proc/Diag" for field #1, please select one of the following codes for this field:</p> <table border="0"> <tr> <td>CCTA for Coronary CT Angiogram</td> <td>OOS for Out of State</td> </tr> <tr> <td>CI for Cochlear Implants</td> <td>OTRS for Other Surgery</td> </tr> <tr> <td>ERSO for ERSO-PA</td> <td>PSCN for PET Scan</td> </tr> <tr> <td>GCK for Gamma/Cyber Knife</td> <td>O for Other</td> </tr> <tr> <td>GT for Genetic Testing</td> <td>S for Surgery</td> </tr> <tr> <td>HO for Hyperbaric Oxygen</td> <td>SCAN for Radiology</td> </tr> <tr> <td>HY for Hysterectomy</td> <td>MISC for Miscellaneous</td> </tr> <tr> <td>MRI for MRI</td> <td></td> </tr> </table> <p>If you selected "513 – Physical Medicine & Rehabilitation (PM & R)" for field #1, please select one of the following codes for this field:</p> <table border="0"> <tr> <td>ERSO for ERSO-PA</td> <td></td> </tr> <tr> <td>PMR for PM and R</td> <td></td> </tr> <tr> <td>MISC for Miscellaneous</td> <td></td> </tr> </table>	ERSO for ERSO-PA	MISC for Miscellaneous	HH for Home Health	T for Therapies (PT / OT / ST)	ERSO for ERSO-PA		HSPC for Hospice		MISC for Miscellaneous		BS for Bariatric Surgery	RM for Readmission	ERSO for ERSO-PA	S for Surgery	OOS for Out of State	TNP for Transplants	O for Other	VNSS for Vagus Nerve Stimulator	PAS for PAS	MISC for Miscellaneous	BSS2 for Bariatric Surgery Stage 2	NP for Neuro-Psych	BTX for Botox	OOS for Out of State	CIERP for Cochlear Implant	PSY for Psychotherapy		SYN for Synagis	CR for Cardiac Rehab	T for Therapies (PT/OT/ST)	ERSO for ERSO-PA	TX for Transportation	HEA for Hearing Aids	V for Vision	I for Infusion / Parental Therapy	VST for Vest	MC for Medications	VT for Vision Therapy		MISC for Miscellaneous	EN for Enteral Nutrition		MN for Medical Nutrition		MISC for Miscellaneous		CCTA for Coronary CT Angiogram	OOS for Out of State	CI for Cochlear Implants	OTRS for Other Surgery	ERSO for ERSO-PA	PSCN for PET Scan	GCK for Gamma/Cyber Knife	O for Other	GT for Genetic Testing	S for Surgery	HO for Hyperbaric Oxygen	SCAN for Radiology	HY for Hysterectomy	MISC for Miscellaneous	MRI for MRI		ERSO for ERSO-PA		PMR for PM and R		MISC for Miscellaneous	
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HCA 13-835 (5/15)

Directions for Authorization form 13-835

Instructions to fill out the General Information for Authorization form, HCA 13-835

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
2	Service Type (Required) (Continued)	<p>If you selected "514 – Aging and Long-Term Support Administration (ALTA) for field #1, please select one of the following codes for this field: PDN for Private Duty Nursing MISC for Miscellaneous</p> <p>If you selected "518 – LTAC" for field #1, please select one of the following codes for this field: ERSO for ERSO-PA LTAC for LTAC O for Other</p> <p>If you selected "519 – Respiratory" for field #1, please select one of the following codes for this field: CPAP for CPAP/BiPAP OXY for Oxygen ERSO for ERSO-PA SUP for Supplies NEB for Nebulizer VENT for Vent OXM for Oximeter O for Other</p> <p>If you selected "521 – Maternity Support/Infant Case Management (MSS)" for field #1, please select one of the following codes for this field: ICM for Infant Case Management PO for Post Pregnancy Only PPP for Prenatal/Post Pregnancy O for Other</p> <p>If you selected "524 – Concurrent Care" (for children on Hospice) for field #1, please select one of the following codes for this field: CC for Concurrent Care Services</p> <p>Enter the letter(s) in all CAPS that represent the service type you are requesting. If you selected "525 – ABA Services" for field #1, please select one of the following codes for this field: IH for In Home/Community/Office DAYP for Day Program</p> <p>If you selected "526 – Complex Rehabilitation Technology" (CRT) for field #1, please select one of the following codes for this field: ERSO for ERSO-PA PWH for Power Wheelchair - Home MWH for Manual Wheelchair - Home PWNF for Power Wheelchair – NF MWNF for Manual Wheelchair - NF PWR for Power Wheelchair Repairs MWR for Manual Wheelchair Repairs PWS for Power Wheelchair Supplies MWS for Manual Wheelchair Supplies</p> <p>If you selected "527 – Chemical-Using Pregnant (CUP) Women Program" for field #1, please select one of the following codes for this field: DX for Detox DM for Detox/Medical Stabilization MS for Medical Stabilization</p>

Instructions to fill out the General Information for Authorization form, HCA 13-835

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
3	Name: (Required)	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
4	Client ID: (Required)	<p>Enter the client ID - 9 numbers followed by WA. For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending):</p> <ul style="list-style-type: none"> You will need to contact HCA at 1-800-562-3022 and the appropriate extension of the Authorization Unit. A reference PA will be built with a placeholder client ID. If the PA is approved – once the client ID is known – you will need to contact HCA either by fax or phone with the Client ID. <p>The PA will be updated and you will be able to bill the services approved.</p>
5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: (Required)	The 10 digit number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Billing NPI #: (Required)	The 10 digit number that has been assigned to the billing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: (Required).	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA or MEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA/MEA# to access the x-rays/pictures for this request.
20	Code Qualifier: (Required).	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S - ICD-9/10 Diagnosis Code
21	National Code: (Required).	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: (Units or \$ required).	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific Medicaid Provider Guide for the appropriate unit/day designation for the service code entered).
24	\$ Amount Requested: (Units or \$ required).	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Medicaid Provider Guide and fee schedules for assistance) Must be entered in dollars & cents with a decimal (e.g. \$400 should be entered as 400.00).
25	Part # (DME only): (Required for all requested codes).	Enter the manufacturer part # of the item requested.

Directions for Authorization form 13-835

Instructions to fill out the General Information for Authorization form, HCA 13-835

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26	Tooth or Quad#: (Required for dental requests).	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-32, A-T, AS-TS, and 51-82																																																																
27	Diagnosis Code	Enter appropriate diagnosis code for condition.																																																																
28	Diagnosis name	Short description of the diagnosis.																																																																
29	Place of Service	Enter the appropriate two digit place of service code. <table border="1"> <thead> <tr> <th>Place of Service Code(s)</th> <th>Place of Service Name</th> </tr> </thead> <tbody> <tr><td>1</td><td>Pharmacy</td></tr> <tr><td>3</td><td>School</td></tr> <tr><td>4</td><td>Homeless Shelter</td></tr> <tr><td>5</td><td>Indian Health Service Free-standing Facility</td></tr> <tr><td>6</td><td>Indian Health Service Provider-based Facility</td></tr> <tr><td>7</td><td>Tribal 638 Free-standing Facility</td></tr> <tr><td>8</td><td>Tribal 638 Provider-based Facility</td></tr> <tr><td>9</td><td>Prison-Correctional Facility</td></tr> <tr><td>11</td><td>Office</td></tr> <tr><td>12</td><td>Home</td></tr> <tr><td>13</td><td>Assisted Living Facility</td></tr> <tr><td>14</td><td>Group Home</td></tr> <tr><td>15</td><td>Mobile Unit</td></tr> <tr><td>16</td><td>Temporary Lodging</td></tr> <tr><td>17</td><td>Walk in Retail Health Clinic</td></tr> <tr><td>20</td><td>Urgent Care Facility</td></tr> <tr><td>21</td><td>Inpatient Hospital</td></tr> <tr><td>22</td><td>Outpatient Hospital</td></tr> <tr><td>23</td><td>Emergency Room – Hospital</td></tr> <tr><td>24</td><td>Ambulatory Surgical Center</td></tr> <tr><td>25</td><td>Birthing Center</td></tr> <tr><td>26</td><td>Military Treatment Facility</td></tr> <tr><td>31</td><td>Skilled Nursing Facility</td></tr> <tr><td>32</td><td>Nursing Facility</td></tr> <tr><td>33</td><td>Custodial Care Facility</td></tr> <tr><td>34</td><td>Hospice</td></tr> <tr><td>41</td><td>Ambulance - Land</td></tr> <tr><td>42</td><td>Ambulance – Air or Water</td></tr> <tr><td>49</td><td>Independent Clinic</td></tr> <tr><td>50</td><td>Federally Qualified Health Center</td></tr> <tr><td>51</td><td>Inpatient Psychiatric Facility</td></tr> </tbody> </table>	Place of Service Code(s)	Place of Service Name	1	Pharmacy	3	School	4	Homeless Shelter	5	Indian Health Service Free-standing Facility	6	Indian Health Service Provider-based Facility	7	Tribal 638 Free-standing Facility	8	Tribal 638 Provider-based Facility	9	Prison-Correctional Facility	11	Office	12	Home	13	Assisted Living Facility	14	Group Home	15	Mobile Unit	16	Temporary Lodging	17	Walk in Retail Health Clinic	20	Urgent Care Facility	21	Inpatient Hospital	22	Outpatient Hospital	23	Emergency Room – Hospital	24	Ambulatory Surgical Center	25	Birthing Center	26	Military Treatment Facility	31	Skilled Nursing Facility	32	Nursing Facility	33	Custodial Care Facility	34	Hospice	41	Ambulance - Land	42	Ambulance – Air or Water	49	Independent Clinic	50	Federally Qualified Health Center	51	Inpatient Psychiatric Facility
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HCA 13-835 (5/15)

Instructions to fill out the General Information for Authorization form, HCA 13-835

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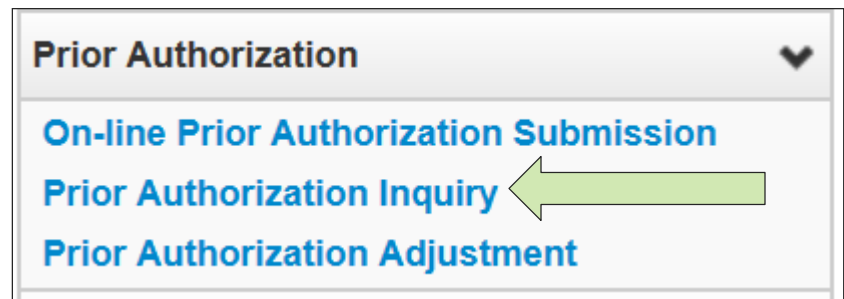
Check the Status of an Authorization Request

➤ Necessary Profiles for checking

Authorization Status:

- EXT Provider Claims Submitter
- EXT Provider Eligibility Checker
- EXT Provider Eligibility Checker-Claims Submitter
- EXT Provider Super User

➤ Select the **Provider Authorization Inquiry**



Check the Status of an Authorization Request

➤ Search using one of the following options:

- Prior Authorization number; or
- Provider NPI and Client ID; or
- Provider NPI, Client Last & First Name, and the client birth date.

Close
Submit

☰ **PA Inquire**

To submit a Prior Authorization Inquiry, complete one of the following criteria sets and click 'Submit'.

- Prior Authorization Number; or
- Provider NPI AND Client ID; or
- Provider NPI, Client Last Name, Client First Name, AND Client Date of Birth

For additional information, please contact our Customer Service Center (WA State DSHS Provider Relations) (800) 562-3022

Prior Authorization Number:

Provider NPI:

Client ID:

Client Last Name:

Client First Name:

Client Date of Birth:

Check the Status of an Authorization Request

- The **Auth Search List** screen returns the information requested from the search criteria used:
 - Click on the **Auth #** hyperlink to access the PA Utilization screen.
 - Do not submit multiple requests for the same client/service.
 - Check online after 48 hours to verify the authorization request was received before resubmitting.
 - The status of these requests are explained in more detail on the following slides.

Auth #	Client ID	Status	Org	Requestor ID	Last Updated	Request Date	Service Type
		Rejected	PA - DENTAL		01/05/2016	01/05/2016	Dentures
1000000000	999999998WA	Approved	PA - DENTAL	1122334455	01/05/2016	01/05/2016	Dentures

Check the Status of an Authorization Request

- The system returns the following information, with the status of the request noted in the upper right side of the **PA Utilization** screen:

Close

Authorization Status: Approved

PA Utilization

Authorization #:

Client ID:

Service: Dentures

Request Date: 2016-01-05

Service Start Date: 2016-01-05

Requestor ID:

Client Name:

Organization: PA - DENTAL

Last Updated Date: 2016-01-05

Service End Date: 2016-04-06

Requestor Name:

Service List

Line #	Modified Date	Servicing Provider ID	Code	Claim Type	Modifier1	ToothNum	ToothSurf	Quad	From Date	To Date	Request Amount	Request Units	Auth Amount	Auth Units	Used Amount	Used Units	Status
1	01/05/2016	0000000000	D5110	0-All					01/05/2016	04/06/2016	0	1	0	1	0		Approved

View Page: Go Page Count SaveToXLS

Viewing Page: 1

First
Prev
Next
Last

Authorization Status

- The following list shows the different statuses you may see on the PA Utilization screen with definitions:

Requested	This means the authorization has been requested and received.
In Review	This means your authorization is currently being reviewed.
Cancelled	This means the authorization request has been cancelled.
Pended	This means we have requested additional information in order to make a decision on the request.
Referred	This means the request has been forwarded to a second level reviewer.
Approved/Hold	This means the request has been approved, but additional information is necessary before the authorization will be released for billing.
Approved/Denied	This means the request has been partially approved and some services have been denied.
Rejected	This means the request was returned to you as incomplete.
Approved	This means the Department has approved your request.
Denied	This means the Department has denied your request.

Submit the Prior Authorization Request

ProviderOne
PA Pend Forms Submission Cover Sheet

Authorization Reference #
(Please enter 9 digit numeric value.)





Instructions will not appear on the printed coversheet

INSTRUCTIONS:
Click ENTER on your keyboard after typing the number in above.
Please use the **Print Cover Sheet** Button Above to print ONLY.
Use Only ADOBE Reader to generate this coversheet. Other readers will not generate the barcode correctly.

DO NOT USE FOR PHARMACY RELATED AUTHORIZATION REQUESTS!

Privacy Statement:
This material in this facsimile is intended only for the use of the individual who it is addressed and may contain information that is confidential, privileged and exempt from disclosure under applicable law.

HIPAA Compliance:
Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment to see insurance payment or to perform other specific health care operations.

FAX to : 1-866-668-1214.

THE BAR CODE COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR FAX WITH ALL SUPPORTING DOCUMENTATION BEHIND THE BAR CODE SHEET.



For more information, visit the [document submission cover sheets](#) web page.

Spenddown

What is a Spenddown?

- An expense or portion of an expense which has been determined by the agency to be a client liability.
- Expenses which have been assigned to meet a client liability are not reimbursed by the agency.
- Spenddown liability is deducted from any payment due the provider.
- Call the customer service line at 1-877-501-2233.

How does a Provider know if a client has a Spenddown Liability?

- The client benefit inquiry indicating **Pending Spenddown – No Medical** looks like this:

Client Eligibility Spans								
Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1113	QMB	06/01/2014	12/31/2999	S03	000000000		
MC: Medicaid	1126	Pending Spenddown - No Medical	01/01/2015	05/31/2015	S99	000000000		

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- No longer pending – has MNP coverage:

MC: Medicaid	1124	LCP-MNP	11/01/2014	01/31/2015	S99
--------------	------	---------	------------	------------	-----

What is the Spenddown amount?

- The same eligibility check indicates the spenddown amount:

Spenddown Information
RAC Code - 1126 **Base Period - Start: 12/01/2014 End: 05/31/2015**

Total Spenddown ▲▼	Spenddown Liability ▲▼	Remaining Spenddown ▲▼	EMER Liability ▲▼	Remaining EMER ▲▼	Spenddown Status ▲▼	Update Date ▲▼	Spenddown Start Date ▲▼
144.00	144.00	144.00	0.00	0.00	Pending	10/27/2014	12/01/2014

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- The clients “award” letter indicates who the client pays.
- Call the spenddown call center at Call 1-800-394-4571.
- See the [Provider Spenddown Step-by-Step](#) fact sheet for more detail and information about where to bill the spenddown amount on claims.

Billing a Client

Background

Washington Administrative Code (WAC) 182-502-0160, Billing a Client, allows providers, in limited circumstances, to bill fee-for-service or managed care clients for covered healthcare services. It also allows fee-for-service or managed care clients the option to self-pay for covered healthcare services.

Note: The full text of WAC 182-502-0160 can be found on the [Apple Health \(Medicaid\) manual WAC index](#) page.

Billing a Client

Healthcare Service Categories

The groupings of healthcare services listed in the table in WAC 182-501-0060. Healthcare service categories are included or excluded depending on the client's **Benefit Service Package (BSP)**.

Excluded Services

A set of services that we do not include in the client's BSP. There is no Exception To Rule (ETR) process available for these services (e.g. Family Planning Only).

Covered service

A healthcare service contained within a "service category" that is included in a medical assistance BSP as described in WAC 182-501-0060.

Non-covered service

A specific healthcare service (e.g., crowns for 21 and older) contained within a service category that is included in a medical assistance BSP, for which the Agency does not pay without an approved exception to rule (ETR) (see WAC 182-501-0160). **A non-covered service is not an excluded service** (see WAC 182-501-0060). Non-covered services are identified in WAC 182-501-0070 and in specific health-care program rules.



Agreement to Pay for Healthcare Services
WAC 182-502-0160 ("Billing a Client")

Form 13-879

This is an agreement between a "client" and a "provider," as defined below. The client agrees to pay the provider for healthcare service(s) that the Health Care Authority (HCA) will not pay. Both parties must sign this Agreement. For the purposes of this Agreement, "services" include but are not limited to healthcare treatment, equipment, supplies, and medications.

Client - A recipient of Medicaid or other healthcare benefits through the HCA or a managed care organization (MCO) that contracts with the HCA.

Provider - An institution, agency, business, or person that provides healthcare services to HCA clients and has a signed agreement with the HCA or authorization from an MCO.

This Agreement and WAC 182-502-0160 apply to billing a client for covered and noncovered services as described in WAC 182-501-0050 through WAC 182-501-0070. Providers may not bill any HCA client (including those enrolled with an MCO that contracts with the HCA) for services which the HCA or an MCO that contracts with the HCA may have paid until the provider has completed all requirements for obtaining authorization.

CLIENT'S PRINTED NAME	CLIENT'S ID NUMBER
PROVIDER'S PRINTED NAME	PROVIDER NUMBER

Directions:

- Both the provider and the client must fully complete this form **before** an HCA client receives any service for which this Agreement is required.
- You must complete this form no more than 90 calendar days before the date of the service. If the service is not provided within 90 calendar days, the provider and client must complete and sign a new form.
- The provider and the client must complete this form **only after** they exhaust all applicable HCA or HCA-contracted MCO processes which are necessary to obtain authorization for the requested service(s). These may include the exception to rule (ETR) process for noncovered services as described in WAC 182-501-0160 or the administrative hearing process, if the client chooses to pursue these processes.
- Limited English proficient (LEP) clients must be able to understand this form in their primary language. This may include a translated form or interpretation of the form. If the form is interpreted for the client, the interpreter must also sign and date the form. Both the client and the provider must sign a translated form.

Fully complete the table on back of this form. If needed, attach another sheet for additional services. The client, provider, and interpreter (if applicable) must sign and date each additional page.

Important Note from HCA:

- This agreement is void and unenforceable if the provider fails to comply with the requirements of this form and WAC 182-502-0160 or does not satisfy HCA conditions of payment as described in applicable Washington Administrative Code (WAC) and Billing Instructions. The provider must reimburse the client for the full amount paid by the client.
- See WAC 182-502-0160(9) for a list of services that cannot be billed to a client, regardless of a written agreement.
- Keep the original agreement in the client's medical record for 6 years from the date this agreement is signed. Give a copy of this completed, signed agreement to the client.
- Providers are responsible for ensuring that translation or interpretation of this form and its content is provided to LEP clients. Translated forms are available at <http://hrsa.dshs.wa.gov/mpforms.shtml>.

SPECIFIC SERVICE(S) OR ITEM(S) TO BE PROVIDED AND ANTICIPATED DATE OF SERVICE	CPT/CDT/ HCPC CODE (BILLING CODE)	AMOUNT TO BE PAID BY CLIENT	REASON WHY THE CLIENT IS AGREEING TO BE BILLED (CHECK THE ONE THAT APPLIES FOR EACH SERVICE)	COVERED TREATMENT ALTERNATIVES OFFERED BUT NOT CHOSEN BY CLIENT	DATE(S) ETR/NFJ REQUESTED/DENIED OR WAIVED, OR PRIOR AUTHORIZATION (PA) REQUESTED/DENIED, IF APPLICABLE	
			<input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Non-formulary drug, NFJ waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for <input type="checkbox"/> Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED	ETR DENIAL (ATTACH HCA NOTICE)
			<input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Non-formulary drug, NFJ waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for <input type="checkbox"/> Order, prescribed, or referred by non-enrolled licensed health care professional		PA REQUEST	PA DENIAL (ATTACH HCA NOTICE)
			<input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Non-formulary drug, NFJ waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for <input type="checkbox"/> Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED	ETR DENIAL (ATTACH HCA NOTICE)
			<input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Non-formulary drug, NFJ waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for <input type="checkbox"/> Order, prescribed, or referred by non-enrolled licensed health care professional		PA REQUEST	PA DENIAL (ATTACH HCA NOTICE)
<ul style="list-style-type: none"> I understand that HCA or an MCO that contracts with HCA will not pay for the specific service(s) being requested for one of the following reasons, as indicated in the above table: 1) HCA does not cover the service(s); 2) the service(s) was denied as not medically necessary for me, or 3) the service(s) is covered but the type I requested is not. I understand that I can, but may choose not to: 1) ask for an Exception to Rule (ETR) after an HCA or HCA-contracted MCO denial of a request for a noncovered service; 2) submit a Non-Formulary Justification (NFJ) with the help of my prescriber for a non-formulary medication; or 3) ask for a hearing to appeal an HCA or HCA-contracted MCO denial of a requested service. I have been fully informed by this provider of all available medically appropriate treatment, including services that may be paid for by the HCA or an HCA-contracted MCO, and I still choose to get the specified service(s) above. I understand that HCA does not cover services ordered by, prescribed by, or are a result of a referral from a healthcare provider who is not contracted with HCA as described in Chapter 182-502 WAC. <i>I agree to pay the provider directly for the specific service(s) listed above.</i> I understand the purpose of this form is to allow me to pay for and receive service(s) for which HCA or an HCA-contracted MCO will not pay. This provider answered all my questions to my satisfaction and has given me a completed copy of this form. I understand that I can call HCA at 1-800-562-3022 to receive additional information about my rights or services covered by HCA under fee-for-service or managed care. 						
I AFFIRM: I understand and agree with this form's content, including the bullet points above.			CLIENT'S OR CLIENT'S LEGAL REPRESENTATIVE'S SIGNATURE		DATE	
I AFFIRM: I have complied with all responsibilities and requirements as specified in WAC 182-502-0160.			PROVIDER OF SERVICE(S) SIGNATURE		DATE	
I AFFIRM: I have accurately interpreted this form to the best of my ability for the client signing above.			INTERPRETER'S PRINTED NAME AND SIGNATURE		DATE	

The bill counts toward the financial obligation of the client or applicant (such as spenddown liability, client participation as described in WAC 388-513-1380, emergency medical expense requirement, deductible, or copayment required by the agency.)

Printed or copied records requested by the client. Department of Health has established a policy noted at WAC 246-08-400.

**WHEN CAN A PROVIDER BILL A CLIENT WITHOUT
FORM 13-879**

The client represented himself/herself as a private pay client and not receiving medical assistance when the client was already eligible for and receiving benefits under a Washington Apple Health.

The client refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill a third party insurance carrier for a service.

The client chose to receive services from a provider who is not contracted with Washington Apple Health.

The service is covered by the agency with prior authorization, all the requirements for obtaining authorization are completed and was denied, the client completes the administrative hearings process or chooses to forego it or any part of it, and the service remains denied by the agency as not medically necessary.

The service is covered by the agency and does not require authorization, but the service is a specific type of treatment, supply, or equipment based on the client's personal preference that the agency does not pay for. The client completes the administrative hearings process or chooses to forego it or any part of it.

**WHEN CAN A PROVIDER BILL A CLIENT WITH
FORM 13-879?**

If the service is not covered, the provider must inform the client of his or her right to have the provider request an ETR, and the client chooses not to have the provider request an ETR .

The service is not covered by the agency, the provider requests an ETR and the ETR process is exhausted, and the service is denied.

Services for which the provider did not correctly bill the agency.

If the agency returns or denies a claim for correction and resubmission, the client cannot be billed.

WHEN CAN A PROVIDER NOT BILL A CLIENT?

Services for which the agency denied the authorization because the process was placed on hold pending receipt of requested information but the requested information was not received by the agency. (WAC 182-501-0165(7)(c)(i)). This includes rejected authorizations, when the authorization request is returned due to missing required information.

The cost difference between an authorized service or item and an "upgraded" service or item preferred by the client (e.g., precious metal crown vs. stainless steel).

Providers are not allowed to:

- “Balance bill” a client
- Bill a client for missed, cancelled, or late appointments
- Bill a client for a “rescheduling fee”

"Boutique," "concierge," or enhanced service packages (e.g., newsletters, 24/7 access to provider, health seminars) as a condition for access to care.

WHEN CAN A PROVIDER **NOT** BILL A CLIENT?

Services for which the provider has not received payment from the agency or the client's MCO because the provider did not complete all requirements necessary to obtain payment (example: billing using a diagnosis code which is not a primary diagnosis code per ICD10).

Copying, printing, or otherwise transferring healthcare information, as the term healthcare information is defined in chapter 70.02 RCW, to another healthcare provider, which includes, but is not limited to:

- Medical/dental charts,
- Radiological or imaging films
- Laboratory or other diagnostic test results
- Postage or shipping charges related to the transfer

Provider File Maintenance

Provider File Maintenance

➤ Modifying Provider File Information

- Log into ProviderOne with the **Provider File Maintenance** or **Super User** profile.
- Click on the **Manage Provider Information** hyperlink

The screenshot shows the ProviderOne portal interface. On the left, there is a navigation menu with categories like Claims, Client, Payments, Managed Care, Prior Authorization, and Provider. The 'Provider' category is highlighted with a green box, and a green arrow points to the 'Manage Provider Information' link. The main content area shows 'My Reminders' (No Records Found), 'Your Recent Online Activities', and a 'Calendar' for December 2015. A blue box on the right lists provider types.

Provider Types include:

- Individual
- Group
- Tribal
- Facilities (FAOI)
- Servicing

Go to the [ProviderOne user manuals web page](#) for more information on provider file updates for the different provider types.

Provider File Maintenance

➤ Modifying Provider File Information

- The **Business Process Wizard** contains the steps for modification. Click on the step title to modify.

View/Update Provider Data - Group Practice							
Business Process Wizard - Provider Data Modification (Group Practice). In order to finalize submission of your requested changes, you must complete the Step - Submit Modification Request for Review.							
<input type="checkbox"/>	Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
<input type="checkbox"/>	Step 1: Basic Information	Required	09/08/2009	09/30/2009	Complete		
<input type="checkbox"/>	Step 2: Locations	Required	09/03/2009	09/30/2009	Complete		
<input type="checkbox"/>	Step 3: Specializations	Required	07/01/2008	07/01/2008	Complete		
<input type="checkbox"/>	Step 4: Ownership & Managing/Controlling Interest details	Required	09/08/2009	09/30/2009	Complete		
<input type="checkbox"/>	Step 5: Licenses and Certifications	Required	09/14/2009	09/30/2009	Complete		
<input type="checkbox"/>	Step 6: Training and Education	Optional	07/01/2008	07/01/2008	Complete		
<input type="checkbox"/>	Step 7: Identifiers	Optional	07/01/2008	07/01/2008	Complete		
<input type="checkbox"/>	Step 8: Contract Details	Optional	07/01/2008	07/01/2008	Complete		
<input type="checkbox"/>	Step 9: Federal Tax Details	Required	09/08/2009	09/30/2009	Complete		
<input type="checkbox"/>	Step 10: EDI Submission Method	Optional	07/01/2008	07/01/2008	Complete		
<input type="checkbox"/>	Step 11: EDI Billing Software Details	Optional	07/01/2008	07/01/2008	Complete		
<input type="checkbox"/>	Step 12: EDI Submitter Details	Optional	07/01/2008	07/01/2008	Complete		
<input type="checkbox"/>	Step 13: EDI Contact Information	Optional	07/01/2008	07/01/2008	Complete		
<input type="checkbox"/>	Step 14: Servicing Provider Information	Required	09/14/2009	07/01/2008	Complete		
<input type="checkbox"/>	Step 15: Payment and Remittance Details	Required	07/01/2008	07/01/2008	Complete		
<input type="checkbox"/>	Step 16: Submit Modification for Review	Required	07/01/2008	07/01/2008	Complete		

Provider File Maintenance

➤ Step 3: Specializations (Taxonomy Codes)

Close Add Update Note: Provider Type and Specialty/Subspecialty are your Taxonomy Codes.

Specialty/Subspecialty List

Filter By : And And Operational Status: Active Go Save Filter My Filters

Contract Number	Provider Type	Specialty/Subspecialty	Administration	Start Date	End Date	Operational Status	Status	Inactivation Date	End Reason	Location Code	Location Name
	12-Dental Providers	23-Dentist/G0001-General Practice	HRSA	01/01/1998	12/31/2999	Active	Approved			00	
	12-Dental Providers	23-Dentist/00000-Dentist	HRSA	01/01/1998	12/31/2999	Active	Approved			00	

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- The taxonomy code shown here is separated by type and subspecialty. Add an “X” to the end of each taxonomy code you bill with (e.g. 122300000X).
- Be aware of the taxonomy code start date (should be the same as provider start date).
- Additional taxonomy codes may be added (based on the provider credentialing).

Provider File Maintenance

➤ Step 10: EDI Submission Method - How are you going to bill?

You may check multiple Modes of Submission. NPI is required for all selections.

EDI Submission Details

If Web Batch and/or FTP Secured Batch are selected, you must complete and mail a new ProviderOne Trading Partner Agreement.

Mode of Submission: Billing Agent/Clearinghouse FTP Secured Batch Web Batch Web Interactive

Status: In Review

Method	When to Use
Web Batch	For upload/download of files in ProviderOne
Billing Agent/Clearinghouse	For providers who use a 3rd party to bill
FTP Batch	For submitting files via an SFTP site
Web Interactive	For entering (keying) claims directly in ProviderOne

- Your EDI submission method is "Web Batch" if you currently upload and download batch files using WaMedWeb. This method is often used by providers who submit their own HIPAA batch transactions. It allows a maximum file size of 50 MB.
- Your EDI submission method is "FTP Secured Batch" if you submit and retrieve batches at a secure web folder assigned to you by DSHS. This method was designed with clearinghouses and billing agents in mind. It allows a maximum file size of 100 MB.

OK Cancel

Provider File Maintenance

➤ Step 10: EDI Submission Method - Updates

- For adding or changing submission method, such as Billing Agent/Clearinghouse.
- To see your addition, filter by **Status**.
- Enter % and click **Go**.
- Your request appears with **In Review** status.

The screenshot shows the 'EDI Submission Method' interface. At the top, there are 'Close' and 'Add' buttons. Below is a filter section with 'Filter By: Status' dropdown and a text input containing '%'. To the right, there are 'And' and 'And Operational Status' dropdowns, with 'Operational Status' set to 'Active' and a 'Go' button. Further right are 'Save Filter' and 'My Filters' buttons. Below the filter is a table with columns: 'EDI Submission Method', 'Start Date', 'End Date', 'Status', 'Operational Status', and 'Inactivation Date'. The table contains one row: 'Billing Agent/Clearinghouse, Web Interactive' with 'Start Date' 01/06/2016, 'End Date' 12/31/2999, and 'Status' IN REVIEW. At the bottom, there are 'View Page: 1', 'Go', 'Page Count', 'SaveToXLS', 'Viewing Page: 1', and navigation buttons for 'First', 'Prev', 'Next', and 'Last'.

EDI Submission Method	Start Date	End Date	Status	Operational Status	Inactivation Date
Billing Agent/Clearinghouse, Web Interactive	01/06/2016	12/31/2999	IN REVIEW	Active	

Provider File Maintenance

- Step 12: EDI Submitter Details – Billing Agent/Clearinghouse
 - Add the Billing Agent/Clearinghouse ProviderOne ID;
 - Add the start date with your organization;
 - Select authorized HIPAA transactions and click **Ok**.

Associate Billing Agent/Clearinghouse

Billing Agent/Clearinghouse ProviderOne Id: *

Start Date: *

End Date:

Status: In Review

Note: In the "Authorized Transaction Responses" section, please select 'yes' for any outbound HIPAA transactions that your clearinghouse acquires on your behalf.

Authorized Transaction Responses

Transaction Response	Authorized	Start Date	End Date
271-Eligibility Response	No <input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
277-Claim Status Response	No <input type="checkbox"/> <input type="checkbox"/>		
277U-Unsolicited Claims Status Response	No <input type="checkbox"/> <input type="checkbox"/>		
278-Prior Authorization Response	No <input type="checkbox"/> <input type="checkbox"/>		
820-Premium Payment	No <input type="checkbox"/> <input type="checkbox"/>		
834-Benefit Enrollment	No <input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>

Note: Get the ID number from the Billing Agent/Clearinghouse, or you can review the [published list](#).

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Provider File Maintenance

- Step 14: Servicing Provider Information
 - View the list of providers that work at the clinic.

Close
Add

☰ Servicing Provider List
▲

Filter By : And And Operational Status: Active

☐	ProviderOne ID ▲▼	Servicing Provider Name ▲▼	Servicing Provider NPI ▲▼	Start Date ▲▼	End Date ▲▼	Status ▲▼	Operational Status ▲▼	Inactivation Date ▲▼
<input type="checkbox"/>	0000001	DOE, JOHN		01/01/2008	12/31/2999	Approved	Active	
<input type="checkbox"/>	0000002	DOE, JANE		01/01/1998	12/31/2999	Approved	Active	

View Page:
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Provider File Maintenance

- Step 14: Servicing Provider Information – Ending a provider association:
 - Click on the **ProviderOne ID** on the provider list.

ProviderOne ID	Servicing Provider Name	Servicing Provider NPI	Start Date	End Date	Status	Operational Status	Inactivation Date
0000001	DOE, JOHN		01/01/2008	12/31/2999	Approved	Active	
0000002	DOE, JANE		01/01/1998	12/31/2999	Approved	Active	

- Enter an end date and click the **Save** button.

ProviderOne ID / NPI: 0000001

Provider Name: DOE, JOHN

Status: Approved

Start Date: 01/01/2008

End Date: 12/31/2999

Provider File Maintenance

➤ Step 14: Servicing Provider Information

- Viewing a Servicing Provider's taxonomy codes:

ProviderOne ID	Servicing Provider Name
0000001	DOE, JOHN
0000002	DOE, JANE

- At the provider list page, click on the **provider's name**.
- ProviderOne opens the individual provider's **Business Process Wizard (BPW)**.

- Click on **Step 3: Specializations** to see the taxonomy code list for your provider.

Step	Required	Last Modification Date	Last Review Date	Status
Step 1: Basic Information	Required	09/08/2009	07/01/2008	Complete
Step 2: Locations	Not Required	07/01/2008	07/01/2008	Incomplete
Step 3: Specializations	Required	07/01/2008	07/01/2008	Complete

Provider File Maintenance

➤ Step 15: Payment Details

- Current payment information is displayed.
- To modify click on the **00** hyperlink.

Close Add

Payment Details

Filter By : [] [] And [] [] And Operational Status: Active [Go] [Save Filter] [My Filters]

	Location Code	Location Name	Payment Method	Start Date	End Date	Status	Operational Status	Inactivation Date
<input type="checkbox"/>	00	JOHN AND JANE DOE DENTAL	Paper Check	01/01/1998	12/31/2999	APPROVED	Active	

View Page: 1 [Go] [Page Count] [SaveToXLS] Viewing Page: 1 [First] [Prev] [Next] [Last]

Provider File Maintenance

➤ Step 15: Payment Details

- Switching to Electronic Funds Transfer (preferred):

☰ **Payment Details** ▲

Identify Payment Details

Location: 00-JOHN AND JANE DOE DENTAL State Wide Vendor Number: P1V

Payment Method: Electronic Funds Transfer(Direct Deposit) Paper Check

Requested EFT Start Date: *

End Date:

Status: Approved

☰ **Financial Institution Information** ▲

Financial Institution Name: * Financial Institution Routing Number: *

Providers Account Number with Financial Institution: * Type of Account at Financial Institution: ▼ *

Payment Notification Preference: ▼ * EFT Test Status: ▼

Account Number Linkage to Provider Identifier: *

- Enter your banking information under the Financial Institution Information fields and click **OK**.

Provider File Maintenance

➤ Step 15: Payment Details

- Complete the Authorization Agreement for Electronic Funds Transfer form:
 - Use Form 12-002 for new EFT set up.
 - Check the box for change of EFT account number.
- Have the form signed.
- Fax in to 360-725-2144; or
- Mail to address on the form.
- Find the form at the [Forms](#) web page.

Provider File Maintenance

➤ Step 16: Submit Modification for Review

Close Submit Provider Modification

Final Submission

ProviderOne ID: Enrollment Type: Group Practice

The requested modifications submitted shall be verified and reviewed by the DSHS.
During this time, you may not make additional changes.

By clicking on the button "Submit Provider Modification", you are agreeing that the information submitted for modification is correct (Privacy and Confidentiality).

Please use your NPI in all the documentation sent to DSHS. If you do not use an NPI please use your ProviderOne ID.

Instructions for submitting documentation:

1. Please click on [this link](#) to display the documentation cover sheet.
2. Print the cover sheet.
3. Write the the NPI number or ProviderOne ID number in the Provider ID field on the cover sheet.
4. Include the cover sheet, with the NPI number or ProviderOne ID number, when mailing or faxing documentation to the DSHS.

Application Document Checklist

Forms/Documents ▲▼	Special Instructions ▲▼	Source ▲▼	Required ▲▼
Training and Education	Please provide a copy of all required Training and Documentation.		NO
Tax Documents	Please provide a copy of all required Tax Documents.	http://www.irs.gov/	YES
Licenses and Certifications	Please provide a copy of all required Licenses and Certifications.	http://www.doh.wa.gov	YES
EDI Required Documentations	Please provide a copy of all required Trading Partner documents.		NO
Contracts and Agreements	Please provide a copy of all required Contracts and Agreements. Include a copy of the current Core Provider Agreement.		YES
Business License	Please provide a copy of business license.	http://www.dor.wa.gov	YES

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Provider File Maintenance

- More information on provider file maintenance, visit the [ProviderOne user manuals](#) web page.
- Find your manual to review.

Enroll an Existing Rendering Provider

Enroll an Existing Rendering Provider

- Log into ProviderOne using the **File Maintenance or Super User profile**:

Provider ▼

- Provider Inquiry
- Manage Provider Information ←
- Initiate New Enrollment
- Track Application

- Under Provider click on the hyperlink **Manage Provider Information**.
- At the Business Process Wizard click on **Step 14: Servicing Provider Information**.

<input type="checkbox"/>	Step 13: EDI Contact Information	Optional	07/01/2008
<input type="checkbox"/>	Step 14: Servicing Provider Information	Required	09/14/2009
<input type="checkbox"/>	Step 15: Payment and Remittance Details	Required	07/01/2008

Enroll an Existing Rendering Provider

- When the Servicing Provider List opens, click on the **Add** button.

The screenshot shows a web application window titled "Servicing Provider List". At the top left, there are two buttons: "Close" and "Add". A green arrow points to the "Add" button. Below the title bar, there is a filter section with "Filter By:" followed by two dropdown menus, an "And" connector, another two dropdown menus, and "And Operational Status:" with a dropdown menu set to "Active" and a "Go" button. There are also "Save Filter" and "My Filters" buttons. The main area contains a table with the following data:

<input type="checkbox"/>	ProviderOne ID ▲▼	Servicing Provider Name ▲▼	Servicing Provider NPI ▲▼	Start Date ▲▼	End Date ▲▼	Status ▲▼	Operational Status ▲▼	Inactivation Date ▲▼
<input type="checkbox"/>	0000001	DOE, JOHN		01/01/2008	12/31/2999	Approved	Active	
<input type="checkbox"/>	0000002	DOE, JANE		01/01/1998	12/31/2999	Approved	Active	

At the bottom of the window, there is a "View Page: 1" field, a "Go" button, a "+ Page Count" button, a "SaveToXLS" button, and a "Viewing Page: 1" label. On the right side, there are navigation buttons: "First", "Prev", "Next", and "Last".

Enroll an Existing Rendering Provider

- At the **Add Servicing Provider** screen:
 - Enter the provider's NPI;
 - Enter their start date at your clinic;
 - Click on the **Confirm Provider** button.

The screenshot shows a web form titled "Add Servicing Provider" with a sub-header "Provide Servicing Provider ID Details." The form contains the following elements:

- A text input field labeled "ProviderOne ID / NPI:" with a red asterisk, highlighted with a red box.
- A text input field labeled "Provider Name:".
- A date input field labeled "Start Date:" with a calendar icon and a red asterisk, highlighted with a red box.
- A date input field labeled "End Date:" with a calendar icon.
- A green arrow pointing downwards from the "End Date:" field towards the "Confirm Provider" button.
- Three buttons at the bottom right: "Confirm Provider", "OK", and "Cancel".

Enroll an Existing Rendering Provider

- If the provider is already entered in ProviderOne - their name will be confirmed.

Add Servicing Provider

Provide Servicing Provider ID Details.

ProviderOne ID / NPI: 0000000001 *

Provider Name: BETTY DOE

Start Date: 05/16/2013 *

End Date:

Confirm Provider OK Cancel

- Click the **OK** button to add the provider to your list.
- Remember to click **Step 16: Submit Modification for Review.**
- Your modification request will be reviewed and worked in chronological order.

Enroll a New Rendering Provider

Enrolling a New Rendering Provider

- On the Provider Portal, select the **Initiate New Enrollment** hyperlink.

Provider ▾

- Provider Inquiry
- Manage Provider Information
- Initiate New Enrollment ←
- Track Application

Enrollment Type

If you have a National Provider Identifier (NPI) please continue.
If you are not required to have an NPI please contact DSHS.

Select the Enrollment Applicable Form

Individual

Group Practice

Billing Agent/Clearinghouse

Fac/Agency/Orgn/Inst

Tribal Health Services

Close Submit ←

- Click on **Individual** to start a new enrollment for the rendering or servicing provider and click **Submit**.

Enrolling a New Rendering Provider

- At the **Basic Information** page for the rendering provider enrollment:

Basic Information

If you don't have NPI and

* Tax Identifier Type: FEIN SSN

Provider Name(Organization Name): (as shown on income tax return)

Organization Business Name:

Federal Employer Identification Number(FEIN):

Provider Name: (First Name)

Suffix: ▼

SSN:

Date of Birth: 📅

(Middle Name) (Last Name)

Gender: ▼

Title: ▼

Servicing Type: ▼

National Provider Identifier(NPI):

W-9 Entity Type: ▼ *

Other Organizational Information: ▼ *

Enrollment Effective Date: 📅

Receive Invoice for Medical Services?: ▼ *

UBI:

W-9 Entity Type (If Other):

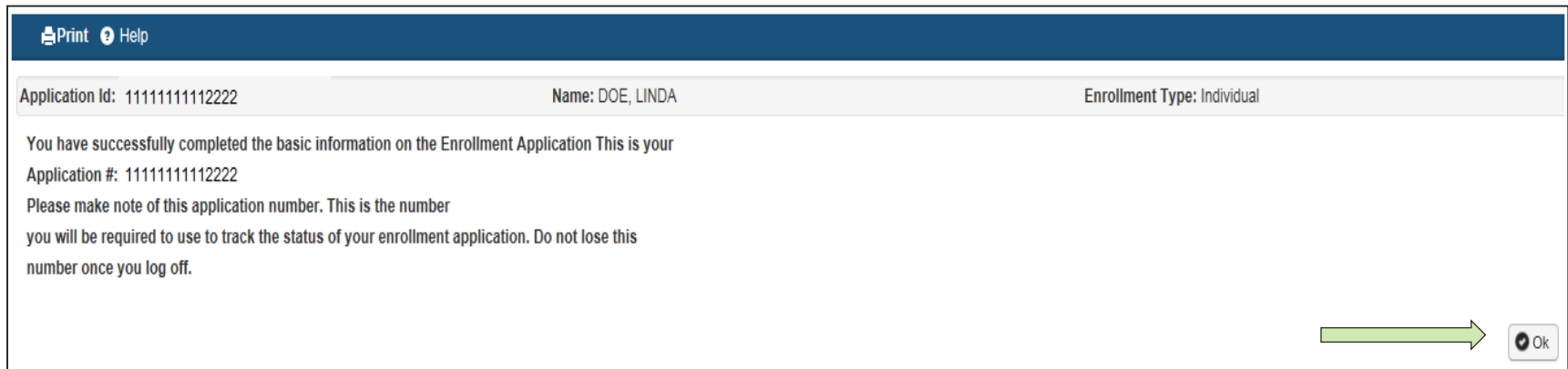
Email Address:

- Click the **SSN** radio button.
- Complete the rest of the data fields.
- Select **Servicing Only** as the Servicing Type.
- For the **W-9 Entity Type**, choose **Other**.
- In the **W-9 Entity Type (If Other)** box enter **Servicing Only**.
- Once complete, click **Finish**.

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Enrolling a New Rendering Provider

- Once the fields are completed on the Basic Information screen, the enrollment application is submitted into ProviderOne which generates an application number.



The screenshot shows a confirmation message in a web browser window. At the top left, there are 'Print' and 'Help' icons. Below that, a header bar contains three fields: 'Application Id: 1111111112222', 'Name: DOE, LINDA', and 'Enrollment Type: Individual'. The main body of the message reads: 'You have successfully completed the basic information on the Enrollment Application This is your Application #: 1111111112222. Please make note of this application number. This is the number you will be required to use to track the status of your enrollment application. Do not lose this number once you log off.' At the bottom right, there is a green arrow pointing to an 'Ok' button.

- Be sure to record this application number for use in tracking the status of the enrollment application.
- Click **OK**.

Enrolling a New Rendering Provider

➤ The Business Process Wizard - Step 1 shows complete:

Close Required Credentials Purge

Enroll Provider -Individual

Business Process Wizard-Provider Enrollment (Individual). Click on the Step # under the Step Column

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	01/06/2016	01/06/2016	Complete	
Step 2: Add Locations	Not Required			Incomplete	
Step 3: Add Specializations	Required			Incomplete	
Step 4: Ownership & Managing/Controlling Interest details	Not Required			Incomplete	
Step 5: Add Licenses and Certifications	Optional			Incomplete	
Step 6: Add Training and Education	Optional			Incomplete	
Step 7: Add Identifiers	Optional			Incomplete	
Step 8: Add Contract Details	Not Required			Incomplete	
Step 9: Add Federal Tax Details	Optional			Incomplete	
Step 10: Add EDI Submission Method	Not Required			Incomplete	
Step 11: Add EDI Billing Software Details	Not Required			Incomplete	
Step 12: Add EDI Submitter Details	Not Required			Incomplete	
Step 13: Add EDI Contact Information	Not Required			Incomplete	
Step 14: Add Billing Provider Details	Optional			Incomplete	
Step 15: Add Payment and Remittance Details	Not Required			Incomplete	
Step 16: Complete Enrollment Checklist	Required			Incomplete	
Step 17: Submit Enrollment Application for Review	Required			Incomplete	

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➤ The steps indicated as **Required** are a reflection of the W-9 Entity Type selected on the Basic Information screen.

Enrolling a New Rendering Provider

- The required steps for Servicing Only are shown here. See next slide for description:

Close Required Credentials Purge

Enroll Provider -Individual

Business Process Wizard-Provider Enrollment (Individual). Click on the Step # under the Step Column

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	01/06/2016	01/06/2016	Complete	
Step 2: Add Locations	Not Required			Incomplete	
Step 3: Add Specializations	Required	01/06/2016	01/06/2016	Complete	
Step 4: Ownership & Managing/Controlling Interest details	Not Required			Incomplete	
Step 5: Add Licenses and Certifications	Required	01/06/2016	01/06/2016	Complete	
Step 6: Add Training and Education	Optional			Incomplete	
Step 7: Add Identifiers	Optional				
Step 8: Add Contract Details	Not Required				
Step 9: Add Federal Tax Details	Optional				
Step 10: Add EDI Submission Method	Not Required				
Step 11: Add EDI Billing Software Details	Not Required				
Step 12: Add EDI Submitter Details	Not Required			Incomplete	
Step 13: Add EDI Contact Information	Not Required			Incomplete	
Step 14: Add Billing Provider Details	Optional	01/06/2016	01/06/2016	Complete	
Step 15: Add Payment and Remittance Details	Not Required			Incomplete	
Step 16: Complete Enrollment Checklist	Required	01/06/2016	01/06/2016	Complete	
Step 17: Submit Enrollment Application for Review	Required			Incomplete	

Optional steps will change to "Required" depending on your entry.

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 << First < Prev > Next >> Last

Enrolling a New Rendering Provider

- Step 3: Specializations
 - Add Taxonomy here.
- Step 5: Licenses and Certifications
 - Enter license/certification issued by the Department of Health.
- Step 7: Identifiers
 - Add DEA number (if applicable).
- Step 14: Billing Provider Details
 - Add the NPI and Name of clinic that will bill for this rendering provider's services.
- Step 16: Complete Enrollment Checklist
 - Answer questions displayed; and
 - Click **Save** and then **Close**.

Enrolling a New Rendering Provider

➤ Step 17: Submit Modification for Review

- Click this step to initiate sending the enrollment; and
- Click the **Submit Enrollment** button.

Final Submission

Application #: 1111111112222 Enrollment Type: Individual

The information submitted for enrollment shall be verified and reviewed by the DSHS. During this time, any changes to the information shall not be accepted.

I agree that the information submitted as a part of the application is correct (Privacy and Confidentiality).

Please use the Application # in all the documentation sent to the DSHS.

Instructions for submitting documentation:

1. Please click on [this link](#) to display the documentation cover sheet.
2. Print the cover sheet.
3. Write the Application number in the 'Application #' field of the cover sheet.
4. Include the cover sheet, with the Application number, when mailing or faxing documentation to the DSHS.

Application Document Checklist

Forms/Documents	Special Instructions	Source	Required
Training and Education	Please provide a copy of all required Training and Documentation.		NO
Tax Documents	Please provide a copy of all required Tax Documents.	http://www.irs.gov/	YES
Licenses and Certifications	Please provide a copy of all required Licenses and Certifications.	http://www.doh.wa.gov	YES
EDI Required Documentations	Please provide a copy of all required Trading Partner documents.		NO
Contracts and Agreements	Please provide a copy of all required Contracts and Agreements. Include a copy of the current Core Provider Agreement.		YES
Business License	Please provide a copy of business license.	http://www.dor.wa.gov	YES

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- Send in all required supporting documentation (CPA, Certifications, etc.).

Online Resources

Online Resources

- [Medicaid Providers' Home](http://www.hca.wa.gov/billers-providers) (www.hca.wa.gov/billers-providers).

Washington State Health Care Authority

Search Home About HCA Contact HCA

Home > Billers & providers

Billers and Providers

ProviderOne

Forms & publications News Electronic Health Records (EHR) Contact Us

- > [New Apple Health provider?](#)
- > [Dental program changes](#)
- > [New rates start July 1](#)

Claims and billing

- Getting started
- Provider resources (billing guides/fee schedules)
- HIPAA Electronic Data Interchange (EDI)

ProviderOne resources

- ProviderOne Billing and Resource Guide
- ProviderOne user manuals
- ProviderOne Security
- ProviderOne for social services

Programs and services

- Program benefit packages and scope of services
- Autism (Applied Behavior Analysis)
- Dental
- Durable medical equipment and

Online Resources

➤ [ProviderOne Billing and Resource Guide](#) webpage

Home > Billers and providers > ProviderOne resources > ProviderOne Billing and Resource Guide

Billers and providers ProviderOne

Forms & publications News Contact Us

ProviderOne resources

- ProviderOne Billing and Resource Guide**
- ProviderOne user manuals
- ProviderOne for social services
- ProviderOne Security
- Fact sheets
- Webinars
- ProviderOne maintenance
- ProviderOne Discovery Log

ProviderOne Billing and Resource Guide

A complete guide for using ProviderOne.

Important! On January 1, 2017, the Health Care Authority (HCA) changed the process for managing Apple Health (Medicaid) benefits for clients with other primary health insurance. [Learn about these changes](#).

On this page

- [Paperless billing has arrived!](#)
- [Guide updated to reflect paperless billing](#)
- [Appendixes](#)
- [Provider billing guides and fee schedules](#)

The ProviderOne Billing and Resource Guide gives step-by-step instruction to help provider billing staff:

- Find client eligibility for services.
- Bill in a timely fashion.
- Receive accurate payments for covered services.

Stay informed!

[Sign up for Provider Alerts](#)

The guide is intended to:

- Strengthen the current instructions that apply to nearly all types of providers.
- Respond to provider requests for more step-by-step reference materials for ProviderOne.

Washington State
Health Care Authority

Washington Apple Health (Medicaid)

ProviderOne Billing and Resource Guide


January 1, 2017

Contact Us

ContactUs!

Select one to request more information about Washington Apple Health (Medicaid):

If you are looking for more information about eligibility, health plans, services cards or finding a provider click here:	<input type="button" value="Client"/>
If you are a provider with questions about enrollment, billing policy, a claim inquiry or service limitations click here:	<input type="button" value="Medical Provider"/>
If you are a social services provider with questions about ProviderOne billing, claims, login, provider information, security, etc. click here:	<input type="button" value="Social Service Provider"/>



Use the Apple Health [web form!](https://fortress.wa.gov/dshs/p1contactus/)

<https://fortress.wa.gov/dshs/p1contactus/>


Contact Us

- Using the drop down Select Topic, gives the following options to choose from:

ContactUs!

Information Request Form for Providers

Your Email Address:	<input type="text"/>
NPI:	<input type="text"/>
FirstName:	<input type="text"/>
Business or Last Name:	<input type="text"/>
Select Topic:	<--Select-->



<-- Select -->

- Authorization
- Billing/Policy
- Claim Inquiry
- Client Eligibility Clarification
- Create Template/Batch
- Ordering-Referring-Prescribing
- Overpayment Dispute
- Private Commercial Insurance
- Provider Enrollment
- Service Limits
- Mental Incapacity Evaluation
- Other
- SUD AI/AN FFS Program – Client Update
- Log In/Security

Other Comments:

- 48 hour turnaround for **Service Limit** checks:
 - Be sure to include the Date of Service (DOS)
 - Procedure Code and the date range for search
 - ProviderOne Domain number

Contact Us

ContactUs!

Information Request Form for Providers

Your Email Address:	<input type="text" value="email@email.com"/>		
NPI:	<input type="text" value="0000000000"/>		
FirstName:	<input type="text" value="Provider"/>		
Business or Last Name:	<input type="text" value="Vision Clinic"/>		
Select Topic:	<input type="text" value="Service Limits"/>		
Client ID	<input type="text" value="999999998WA"/>	AND: Date of Service (mm/dd/yyyy)	<input type="text" value="6/1/2017"/>
Procedure Code:	<input type="text" value="92012"/>	Type of service:	<input type="text"/>
Other Comments:	<input type="text" value="Please check last eye exam."/>		



Submit Request

Cancel

**All responses to this box will be via email*

Online Resources

- Programs and Services information:
 - Program billing guides and fee schedules: <https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides>
 - Hospital Rates: <https://www.hca.wa.gov/billers-providers/claims-and-billing/hospital-rates-and-billing-guides>
- Provider Enrollment webpage and email:
 - providerenrollment@hca.wa.gov
 - Webpage: <https://www.hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-provider>
- Provider Relations webpage and email:
 - providerrelations@hca.wa.gov
 - <https://www.hca.wa.gov/billers-providers/providerone-resources>
- HCA Forms webpage: <http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx>
- Washington Administrative Code webpage – Administration of Medical Programs: <https://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/apple-health-medicaid-manual-wac-index>

