Washington State Health Care Authority
Medicaid

Operational instructional series:

Direct Data Entry of a Secondary Dental Claim

- A copy of this presentation located at http://hrsa.dshs.wa.gov/provider/webinar.shtml
- Links to all resources located throughout the presentation

After this Webinar, you can:

- **Step by step create and submit TPL secondary claims DDE in ProviderOne**
  - **Without backup**
  - **With backup**
- **Submit TPL secondary batch claims electronically**
  - **Without backup**

Note: If the commercial/private insurance partially paid the services, please separate the paid and denied services and send on separate claims.

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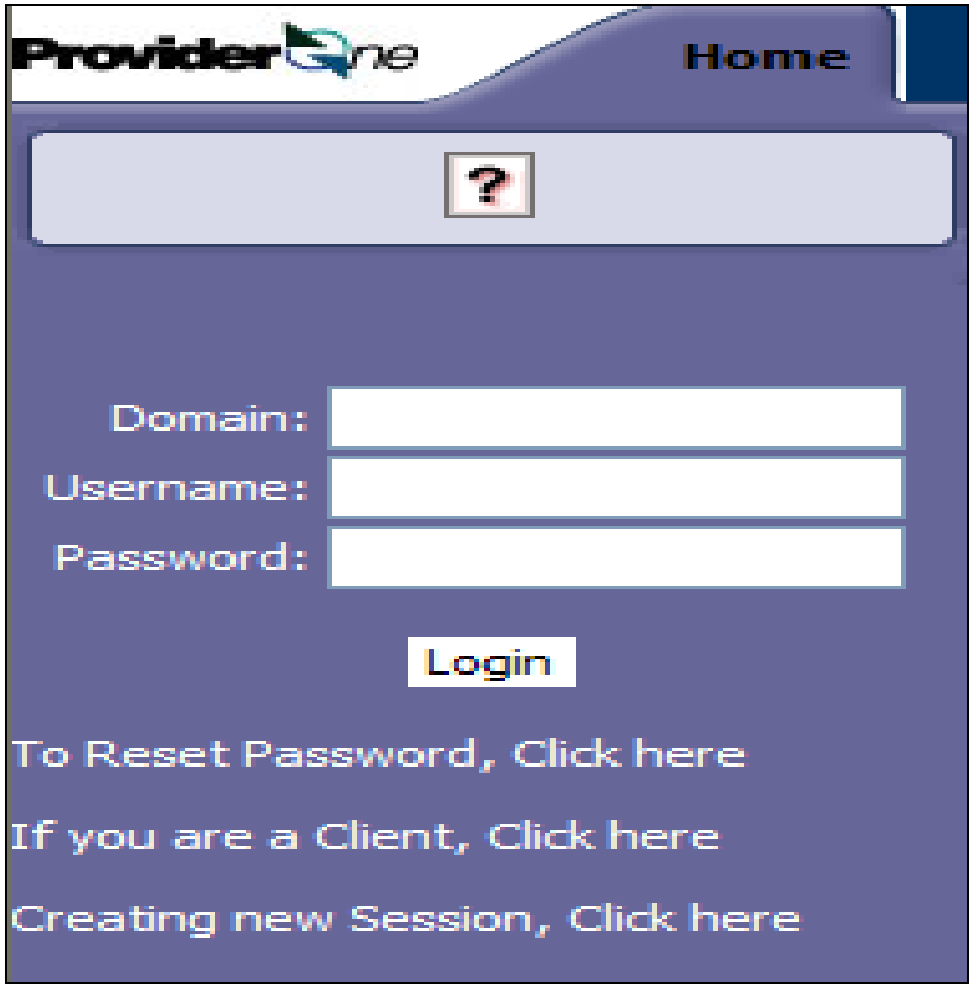
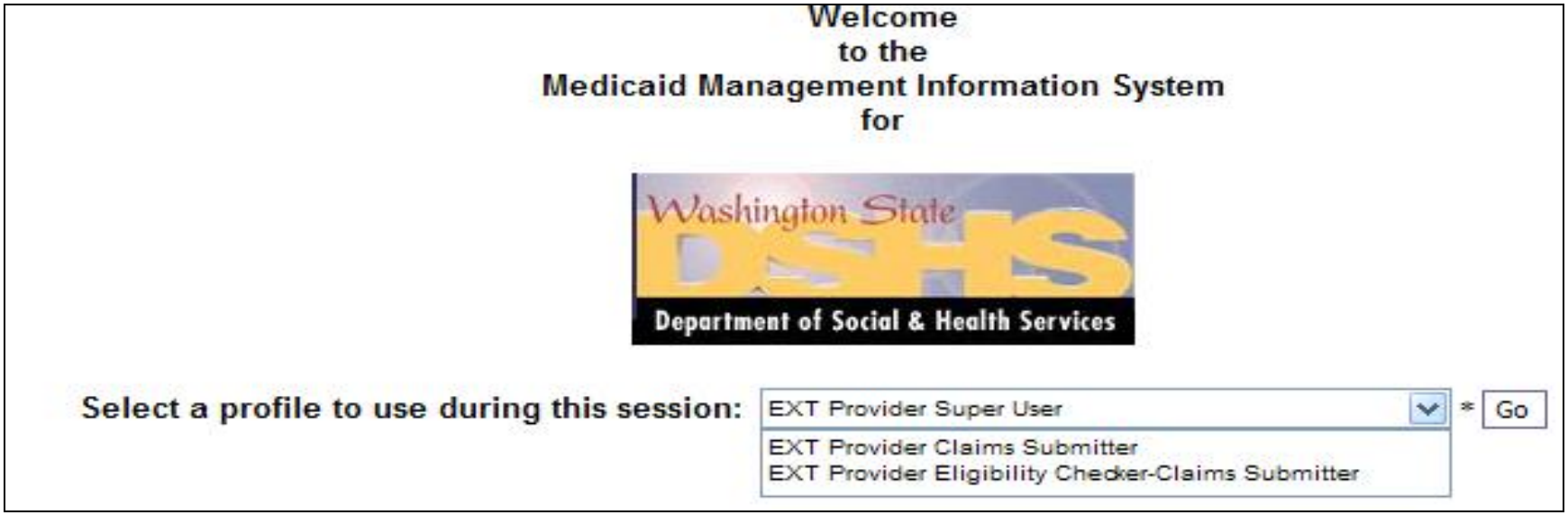
Accessing ProviderOne

- Use web address https://www.waproviderone.org
- Ensure that your system "Pop Up Blocker" is turned "OFF"
- Login using assigned Domain, Username, and Password
- Click on the "Login" button



Determine what profile to use



For claims submission choose one of the following profiles

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

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Provider Portal

- From the Provider Portal select the "Online Claims Entry" option located under the "Claims" Heading

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Provider Portal

- **Choose the type of claim that you would like to submit.**
  - **Professional is the HCFA 1500**
  - **Institutional is the UB04**
  - **Dental is the 2006 ADA form**

Billing Provider Information

- **Section 1: Billing Provider Information of the DDE Dental claim form**

Dental Claim:

Note: asterisks (*) denote required fields.

Basic Claim Info | Other Claim Info

Billing Provider | Subscriber | Claim | Service

PROVIDER INFORMATION

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

BILLING PROVIDER

* Provider NPI: [ ] * Taxonomy Code: [ ]

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

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Billing Provider Information

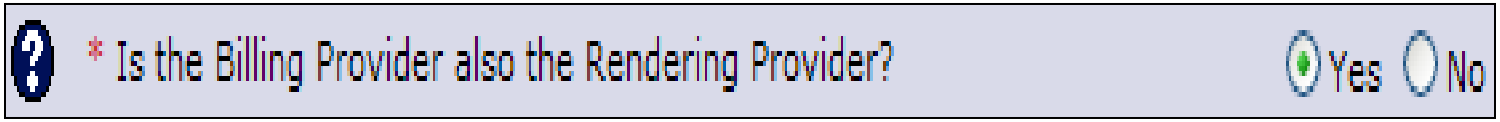
- **Enter the billing provider NPI and taxonomy code**
  - **This will likely be the NPI and Taxonomy Code of the clinic/office where the service was performed and where you would like payment to be received.**

BILLING PROVIDER

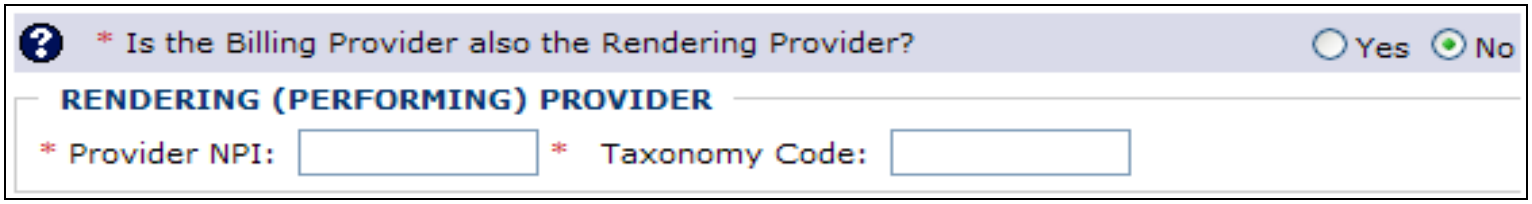
* Provider NPI: * Taxonomy Code:

Rendering Provider Information

- If the "Rendering Provider" is the same as the "Billing Provider" just entered answer the question "YES" and go on to the next question.



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



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Subscriber/Client Information

- **Section 2: Subscriber/Client Information**

SUBSCRIBER/CLIENT INFORMATION

SUBSCRIBER/CLIENT

* Client ID:

Additional Subscriber/Client Information

OTHER INSURANCE INFORMATION

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Subscriber/Client Information

- Enter the Subscriber/Client ID number found on the WA Medicaid medical card. This ID is a 9 digit number followed by a "WA"
  - Example: 123456789WA

- Click on the red "+" to expand the "Additional Subscriber/Client Information" to enter the 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**
  - **Additional shown information is not needed.**

SUBSCRIBER/CLIENT INFORMATION

SUBSCRIBER/CLIENT

* Client ID:

Additional Subscriber/Client Information

* Org/Last Name: First Name:

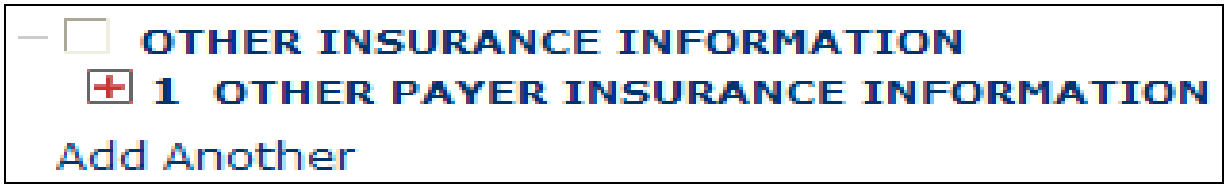
* Date of Birth: mm dd ccyy * Gender:

Note: Client first name is optional. If entered this will be returned on the providers weekly remittance and status report (RA)

Insurance Other Than Medicaid

- If the client ONLY has Medicaid for dental coverage continue to next section.
- If the client DOES have insurance other than Medicaid, click on the red "+" to expand the "Other Insurance Information" section.

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



Insurance Other Than Medicaid

- Enter the "Payer/Insurance Organization Name"

OTHER INSURANCE INFORMATION

1 OTHER PAYER INSURANCE INFORMATION

Other Payer Information

* Payer/Insurance Organization Name: WDS

Additional Other Payer Information

COB Monetary Amounts

COB Payer Paid Amount:

Additional COB Information

OTHER PAYER BILLING PROVIDER

OTHER PAYER ASSISTANT SURGEON

CLAIM LEVEL ADJUSTMENTS

Other Subscriber Information

Other Insurance Coverage

Add Another

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Insurance Other Than Medicaid

- Click on the red "+" to expand the "Additional Other Payer Information" section.
- Then fill in the following:

OTHER INSURANCE INFORMATION
1 OTHER PAYER INSURANCE INFORMATION
Other Payer Information
* Payer/Insurance Organization Name: WDS
Additional Other Payer Information
* ID: WD01 * ID Type: PI-Payor Identification
Claim Check or Remittance Date: mm 12 dd 15 ccyy 2011
Number Type: PA/Referral No.:
Secondary ID Information
COB Monetary Amounts
COB Payer Paid Amount:
Additional COB Information
OTHER PAYER BILLING PROVIDER
OTHER PAYER ASSISTANT SURGEON
CLAIM LEVEL ADJUSTMENTS
Other Subscriber Information
Other Insurance Coverage
Add Another

Enter the Insurance ID number, ID Type, and processing date of the insurance EOB

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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, or

- Use the assigned insurance company ID provided on the insurance EOB

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	WASHINGTON DENTAL SERVICE	WD01	SUPER MAN	100883158			03/01/2007	12/31/2999

Insurance Other Than Medicaid

- **Enter the total amount paid by the commercial private insurance.**

COB Monetary Amounts

COB Payer Paid Amount:

Additional COB Information

Note: If the insurance applied to the deductible enter a $0 here.

Note: If the claim is for an insurance denial enter a $0 here.

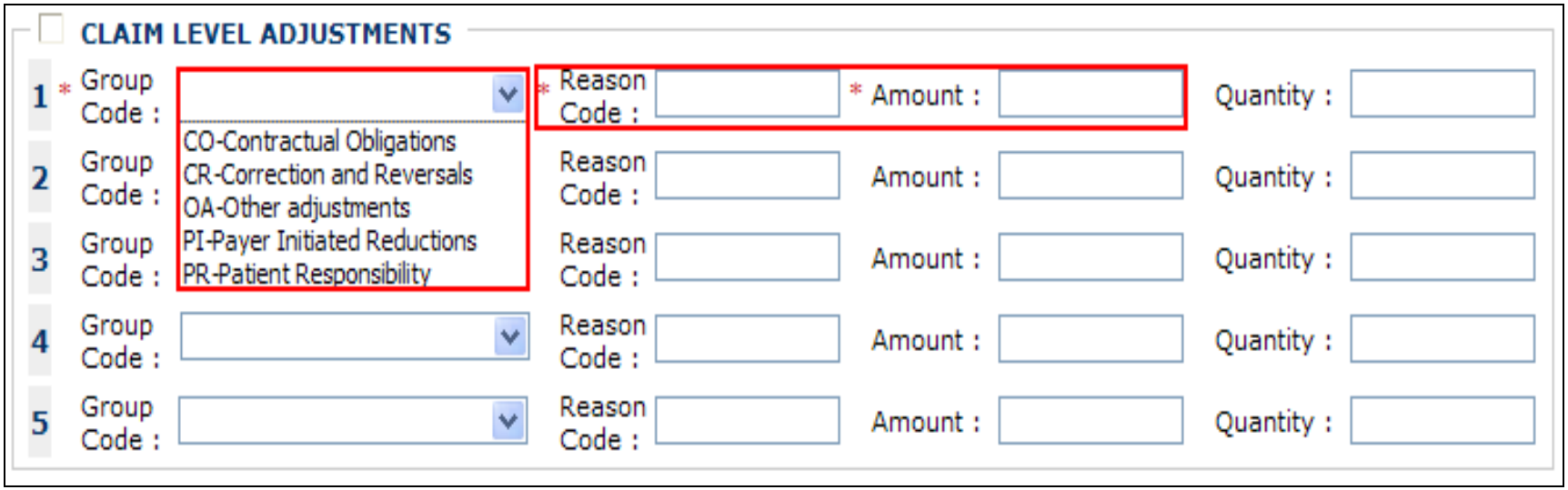
Insurance Other Than Medicaid

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

OTHER INSURANCE INFORMATION
1 OTHER PAYER INSURANCE INFORMATION
Other Payer Information
* Payer/Insurance Organization Name:
Additional Other Payer Information
* ID: * ID Type:
Claim Check or Remittance Date: mm dd ccyy
Number Type: PA/Referral No.:
Secondary ID Information
COB Monetary Amounts
COB Payer Paid Amount:
Additional COB Information
OTHER PAYER BILLING PROVIDER
OTHER PAYER ASSISTANT SURGEON
CLAIM LEVEL ADJUSTMENTS
Other Subscriber Information
Other Insurance Coverage
Add Another

Insurance Other Than Medicaid

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



Note: The Agency only accepts the standardized HIPAA compliant group and reason codes. These can be located at the following website: **http://www.wpc-edi.com/reference/**

Claim Information

- **Section 3: Claim Information Section**

CLAIM INFORMATION

Go to Other Claim Info to enter additional claim information not displayed on this page.

CLAIM DATA

Patient Account No.:

* Service Date: mm dd ccyy

* Place of Service:

Additional Claim Data

Diagnosis Codes

PRIOR AUTHORIZATION

CLAIM NOTE

* 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.**

Patient Account No.:

➢ **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.

Service Date

- **Enter the main Date of Service that is on the claim.**

* Service Date:	mm	dd	ccyy

➢ **Note:** If there is ONE date of service on the claim, it only needs to be entered in this location.

➢ **Note:** The date of service must be in the format of 2 digit month, 2 digit day, and 4 digit year, for example 10/03/2011

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Place of Service Code

- **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:

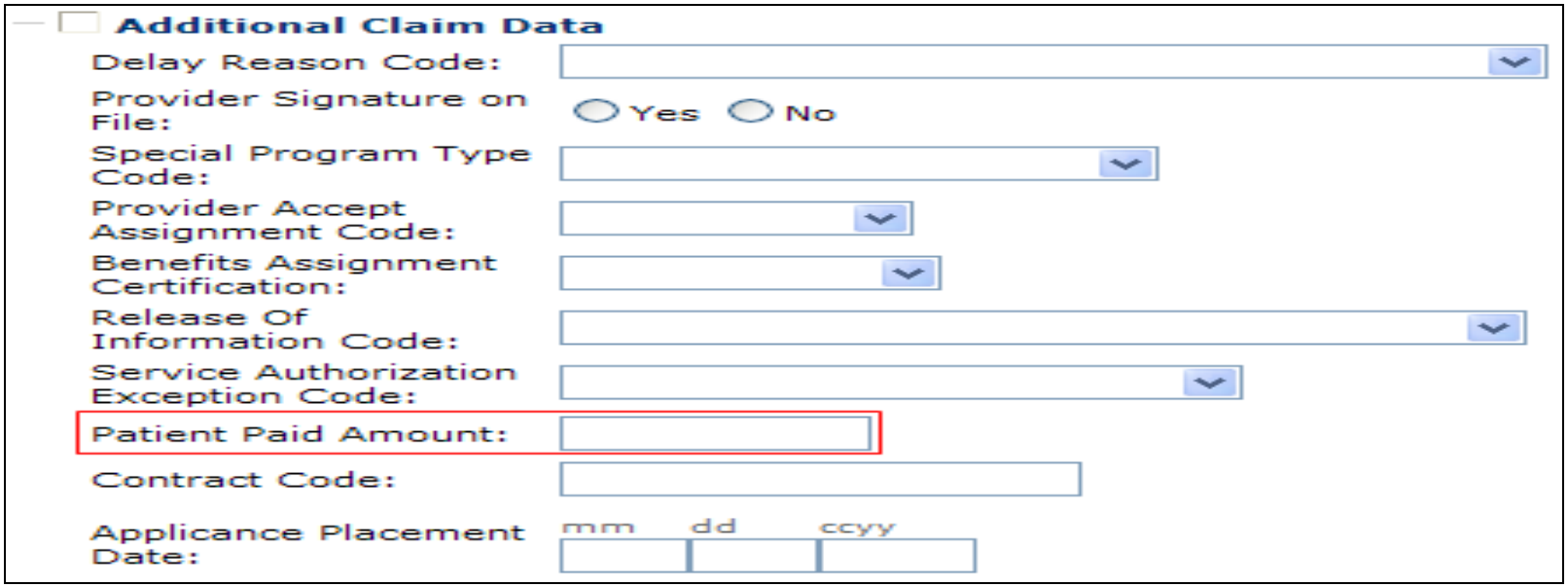
01-PHARMACY	20-URGENT CARE FACILITY	51-INPATIENT PSYCHIATRIC FACILITY
03-SCHOOL	21-INPATIENT HOSPITAL	52-PSYCHIATRIC FACILITY - PARTIAL HOSPITALIZATION
04-HOMELESS SHELTER	22-OUTPATIENT HOSPITAL	53-COMMUNITY MENTAL HEALTH CENTER
05-INDIAN HLTH SVC FREE-STANDING FACILITY	23-EMERGENCY ROOM - HOSPITAL	54-INTERMEDIATE 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 <u>not</u> required.

Additional Claim Data

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

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



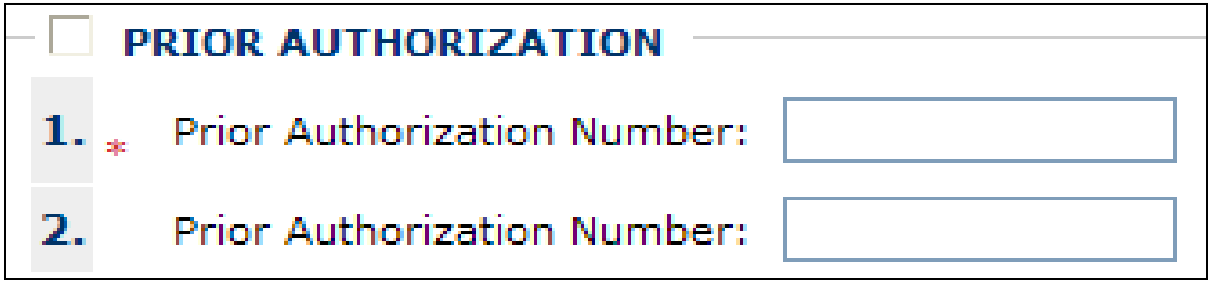
Diagnosis Codes

- **The "Diagnosis Codes" option is currently NOT needed for submission of a dental claim through ProviderOne.**

➢ **Note:** Although a diagnosis is not required for submission of a dental claim, it is shown as an option due to HIPAA.

Prior Authorization

- **If a "Prior Authorization" number needs to be added to the claim, click on the red "+" to expand the "Prior Authorization" fields.**
- **Expedited Prior Authorization (EPA) numbers are considered authorization numbers.**

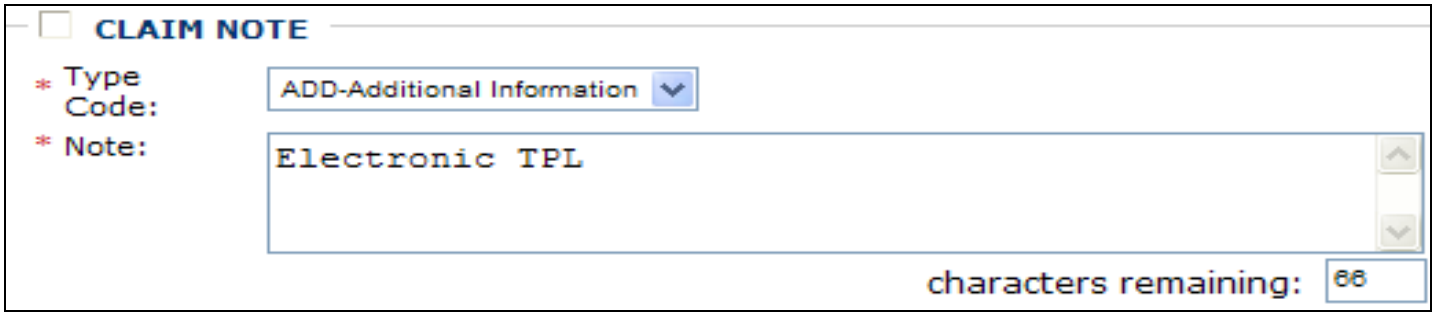


➢ **Note:** We recommend that providers enter any authorization number in these boxes. Entering the number here will cover the entire claim.

Claim Note

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

- Click on the red "+" to expand the "Claim Note" section.
  - Enter the Type Code
  - The NOTE must say "Electronic TPL" if no EOB is sent.
  - The note could say "Sending ins. EOB" if the EOB is sent.
  - ProviderOne allows up to 80 characters in the note.



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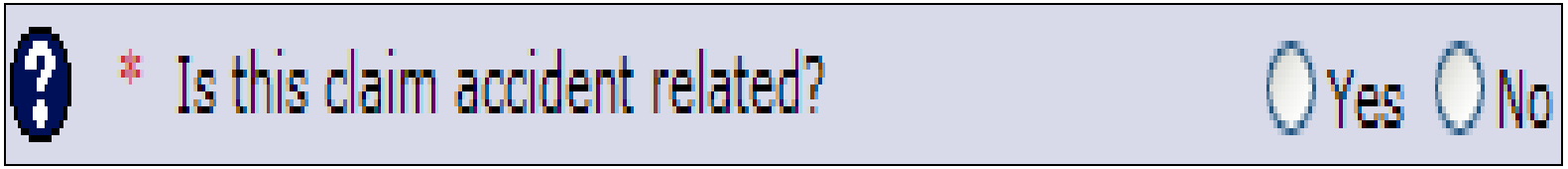
Is the Claim Accident Related?

- **This question will almost always be answered "NO" as Washington Medicaid has a specific casualty office that handles claims where another insurance may be primary.**

  - **The Casualty office can be reached at 800-562-3022 ext 15462**



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Basic Line Item Information

Section 4: Service Line Information

BASIC LINE ITEM INFORMATION

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

BASIC SERVICE LINE ITEMS

* Procedure Code:

* Submitted Charges: $

Place of Service:

Modifiers: 1: 2: 3: 4:

Diagnosis Pointers

Tooth Information

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

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

Appliance Placement Date: mm dd ccyy

Oral Cavity Designation: 1: 2: 3: 4: 5:

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.

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: $ 0

Line No	Proc. Code	Submitted Charges	Modifiers				Diagnosis Pntrs				Oral Cavity					Units	Service Date	Appliance Placement	Tooth/Surface	PA Number
			1	2	3	4	1	2	3	4	1	2	3	4	5					

Basic Service Line Items

- **Enter the "ADA Procedure Code"**

* Procedure Code:

➢ **Note:** Use current codes listed in the CDT coding manual.

➢ **Note:** For dental claims to process in ProviderOne the preceding "**D**" in the procedure code will need to be entered. Example D0120

Basic Service Line Items

- **Enter "Submitted Charges"**

* Submitted Charges: $

➢ **Note:** If dollar amount is a whole number no decimal point is needed.

➢ **Notes:** The Agency request providers to enter their usual and accustom charges here. If you have billed a Commercial Insurance primary please enter the same charges here as billed to the primary.

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Basic Service Line Items

- **Optional "Place of Service Code" (Not required here as already entered)"**

Place of Service:

➢ **Note:** Use the "Blue Arrow" drop down to display all POS codes loaded in ProviderOne.

- **POS codes available:**

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 appropriate procedure "Modifier/s" if needed.**

Modifiers:	1:	2:	3:	4:

➢ **Note**: Although a modifier is not required for submission of a dental claim, it is shown as an option due to HIPAA requirements.

Basic Service Line Items

- **The use of the "Diagnosis Pointer" option is NOT needed for submission of a dental claim in ProviderOne.**

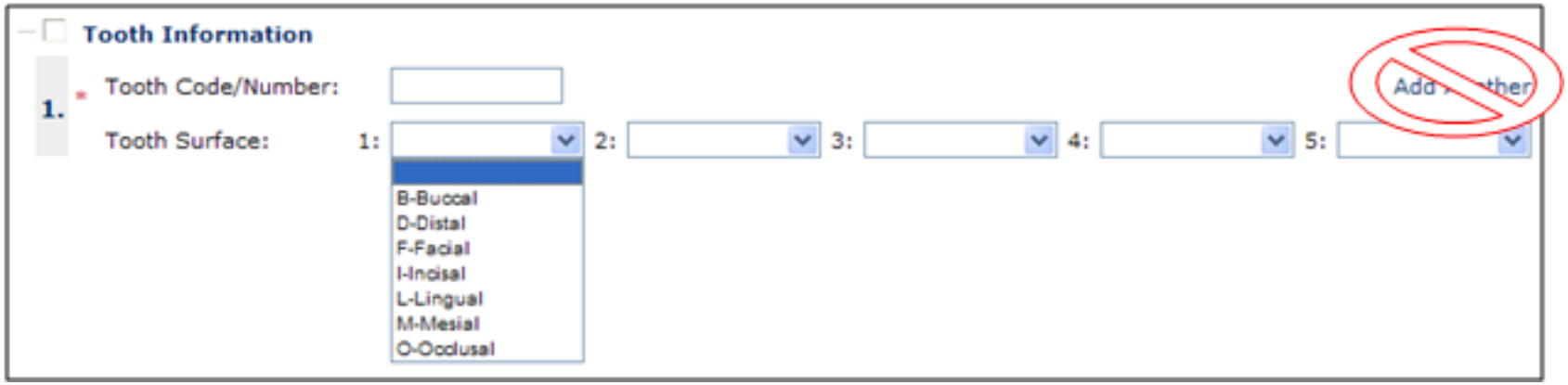
➢ **Note:** Although a diagnosis pointer is not required for submission of a dental claim, it is shown as an option due to HIPAA requirements.

Basic Service Line Items

- If the procedure being billed requires a tooth number and surface this information can be entered by clicking on the "Tooth Information" red (+) expander.

Basic Service Line Items

- **Once the expander is opened, enter the Tooth Code/Number and the Tooth Surface (if required). The tooth surfaces can be found by clicking the drop down arrow.**



➢ **Note:** Enter only one surface per dropdown. ProviderOne will allow up to 5 surfaces per Tooth Code/Number.

➢ **Note:** Do not use the "Add Another" option that is shown. Any additional teeth using the same code should be entered separately on the claim.

Basic Service Line Items

- **Enter "Procedure Count/Units"**

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

➢ **Note:** At least 1 unit is required**.**

➢ **Note:** For anesthesia billing please refer to the Dental billing instructions at **http://hrsa.dshs.wa.gov/Download/BI.html** **.** DO NOT add anesthesia minutes here!

Basic Service Line Items

- **The system allows entry of any additional dates of service for a service line if different than original entered date above.**

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

➢ **Note:** Only enter a date of service here if it is different than what was entered in previous section above.

➢ **Note:** The date of service must be in the format of 2 digit month, 2 digit day, and 4 digit year, for example 10/03/2011.

Basic Service Line Items

Orthodontist Only

- **Enter the date of the appliance placement (banding). If no appliance was placed skip and proceed to the next question.**

Appliance Placement Date:	mm	dd	ccyy

➢ **Note:** The date of service must be in the format of 2 digit month, 2 digit day, and 4 digit year, for example 10/03/2011.

Basic Service Line Items

- **If the procedure being billed requires an "Oral Cavity Designation" when billed choose this from the drop downs provided.**

Oral Cavity Designation: 1: 2: 3: 4: 5:

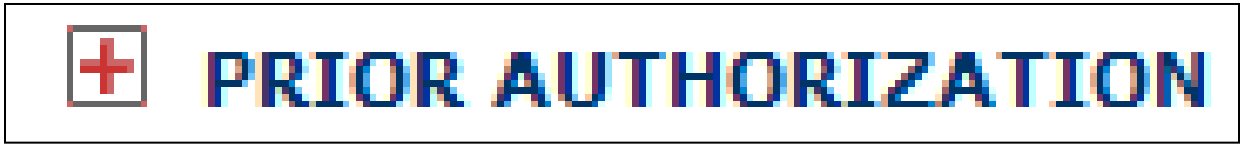
- **Below is the list of "Oral Cavity Designations" available from the drop downs**

00-Entire Oral Cavity	20-Upper Left Quadrant
01-Maxillary Area	30-Lower Left Quadrant
02-Mandibular Area	40-Lower Right Quadrant
09-Other Area Of Oral Cavity	L-Left
10-Upper Right Quadrant	R-Right

➢ **Note:** Although ProviderOne allows the entry of up to 5 oral cavity designations, only enter one per service line. Use the drop down option to choose the correct selection.

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" field.**



➢ **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.**

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: $ 30.00

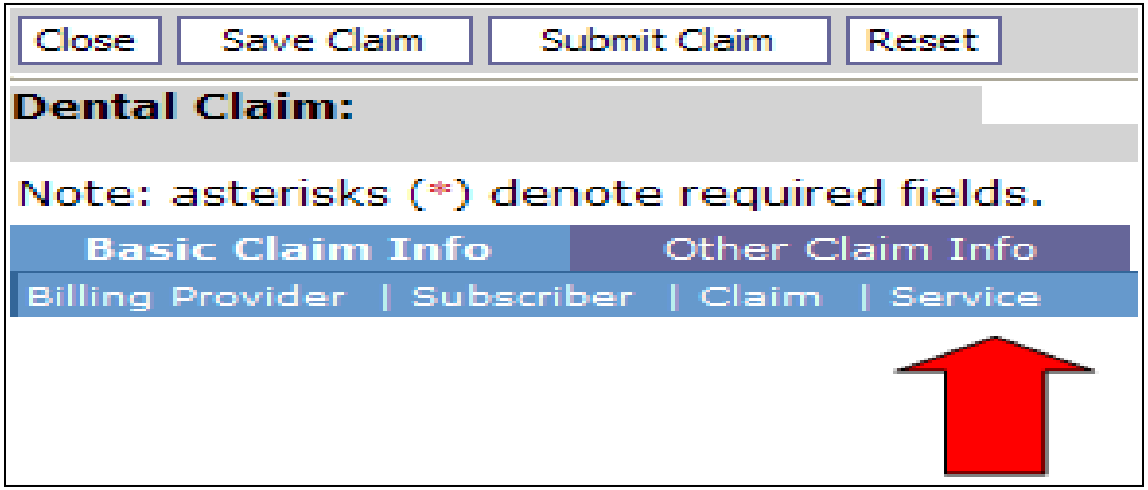
Line No	Proc. Code	Submitted Charges	Modifiers				Oral Cavity					Units	Service Date	Appliance Placement	Tooth/Surface	PA Number	
			1	2	3	4	1	2	3	4	5						
1	D0120	30.00										1					Delete or Other Service Info

➢ **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.



- 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 number of 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: $ 30.00

Line No	Proc. Code	Submitted Charges	Modifiers				Oral Cavity					Units	Service Date	Appliance Placement	Tooth/Surface	PA Number	
			1	2	3	4	1	2	3	4	5						
1	D0120	30.00										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 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: $ 80.00

Line No	Proc. Code	Submitted Charges	Modifiers				Oral Cavity					Units	Service Date	Appliance Placement	Tooth/Surface	PA Number	
			1	2	3	4	1	2	3	4	5						
1	D0120	80.00										1					Delete or Other Service Info

➢ **Note:** Once "**Update Service Line Item**" 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 section to view and verify that changes were completed.

Delete Service Line Items

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

Previously Entered Line Item Information

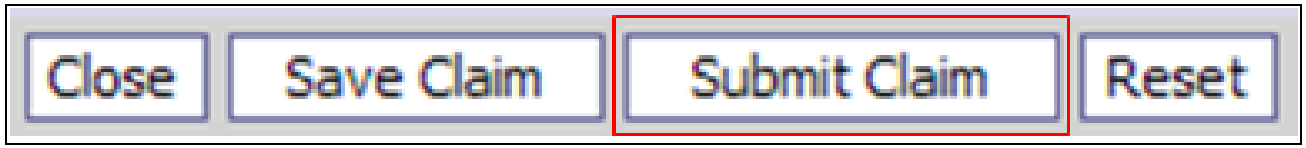
Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: $ 80.00

Line No	Proc. Code	Submitted Charges	Modifiers				Oral Cavity					Units	Service Date	Appliance Placement	Tooth/Surface	PA Number	
			1	2	3	4	1	2	3	4	5						
1	D0120	80.00										1					Delete or Other Service Info

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

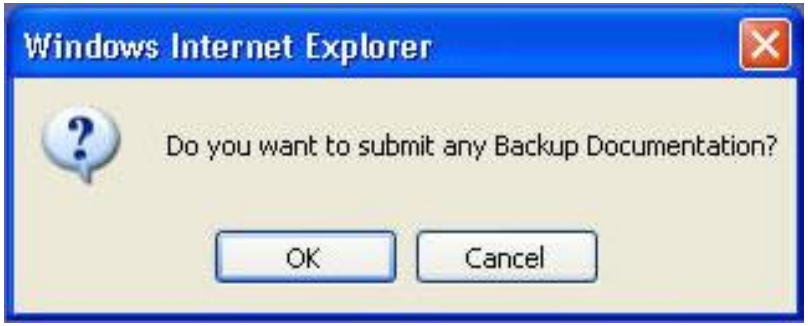
Submit Claim for Processing

- When ready to submit the claim for processing, click the "Submit Claim" button at the top of the claim form.



Submit Claim for Processing

- After clicking on the "Submit Claim" button ProviderOne should display this prompt:



- Click on the "Cancel" button if no backup is to be submitted.
- Click "OK" if backup is to be sent.

Submit Claim for Processing – No Backup

- ProviderOne now displays the "Submitted Dental Claim Detail" screen
- Click on the "OK" button to finish submitting the claim

http://test.providerone.wa.gov/ - Claims Submission Final Dialog - Windows Internet Explorer

Submitted Dental Claim Details:

TCN: 201102000000002000
Provider NPI: 2549198465
Client ID: 200084441WA
Date of Service: 12/10/2010
Total Claim Charge: 190.00

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

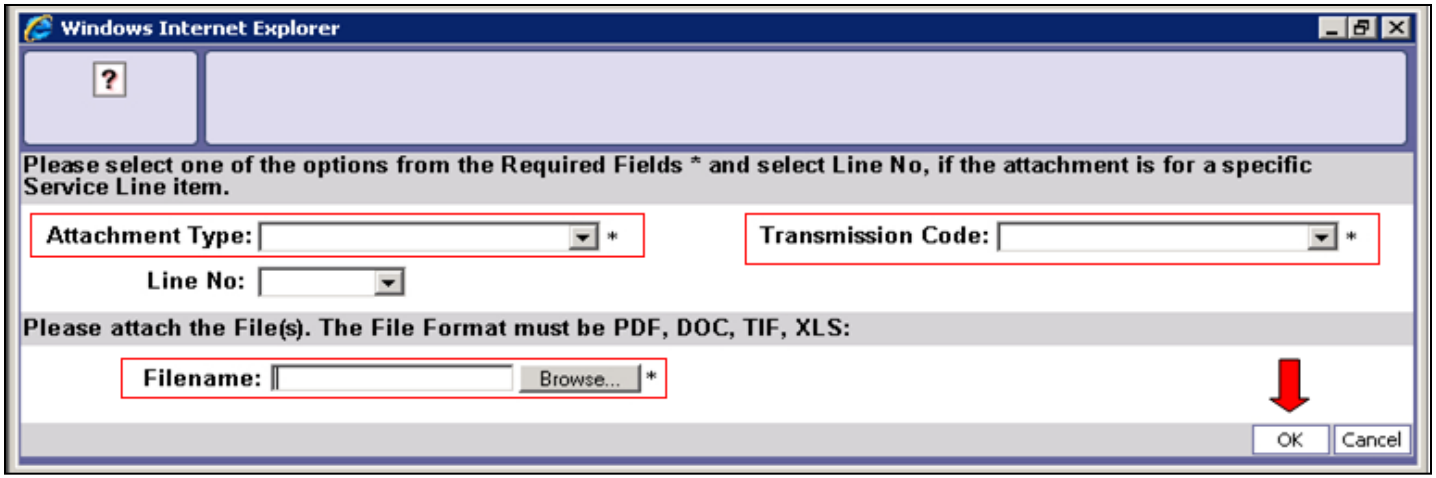
No Records Found !

Print | Print Cover Page | Ok

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

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

- The "Claims Backup Documentation" page is displayed



- Enter the Attachment Type
- Pick one of the following Transmission Codes:
  - EL-Electronic Only or Electronic file,
  - Then browse to find the file name
- Click the "OK" button

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

- The "Submitted Dental Claim Details" page is then displayed

Submitted Dental Claim Details:

TCN: 201201100000004000
Provider NPI: 1760562995
Client ID: 100666385WA
Date of Service: 01/01/2012-01/01/2012
Total Claim Charge: 120

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	10-86.pdf	EB	EL		266kb	X	01/11/2012

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

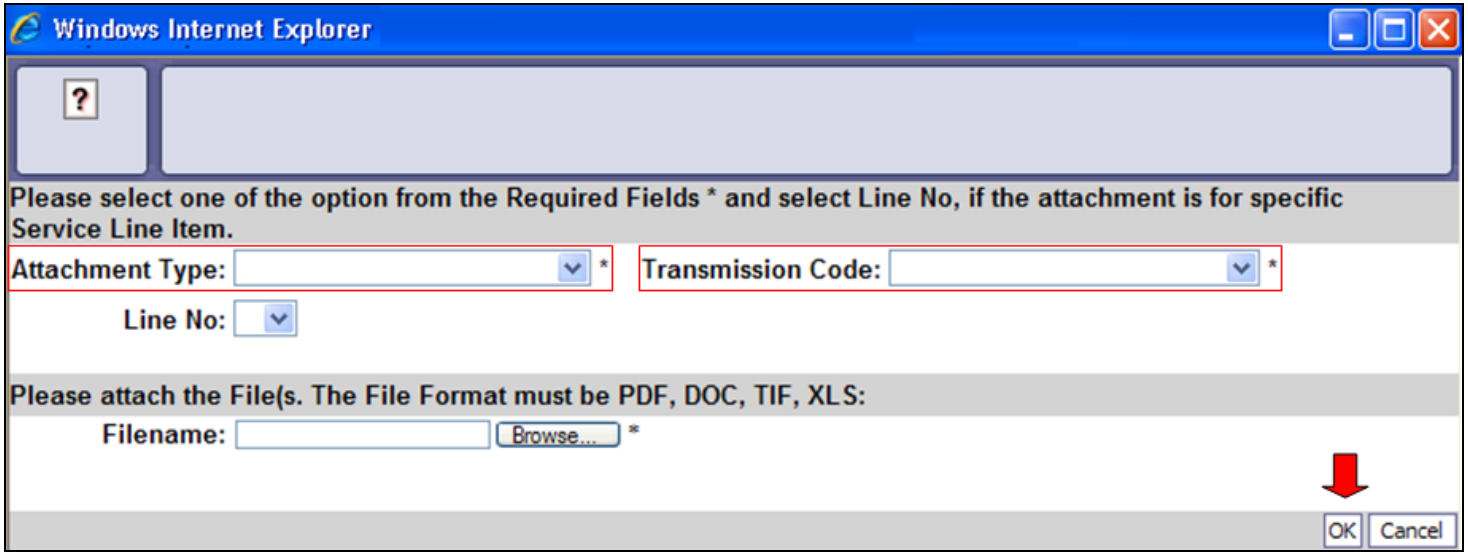
Print Print Cover Page Ok

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

- Now push the "OK" button to submit the claim.

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

- The "Claims Backup Documentation" page is displayed



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

Washington State Health Care Authority
Medicaid

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

- If sending paper documents with the claim, at the "Submitted Dental Claim Details" page click on the "Print Cover Page" button.

Submitted Dental Claim Details:

TCN: 201127300000014000
Provider NPI: 1342222999
Client ID: 300655596WA
Date of Service: 10/20/2010-10/20/2010
Total Claim Charge: 75

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	EB	BM		0kb	X	09/30/2011

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

Print | Print Cover Page | Ok

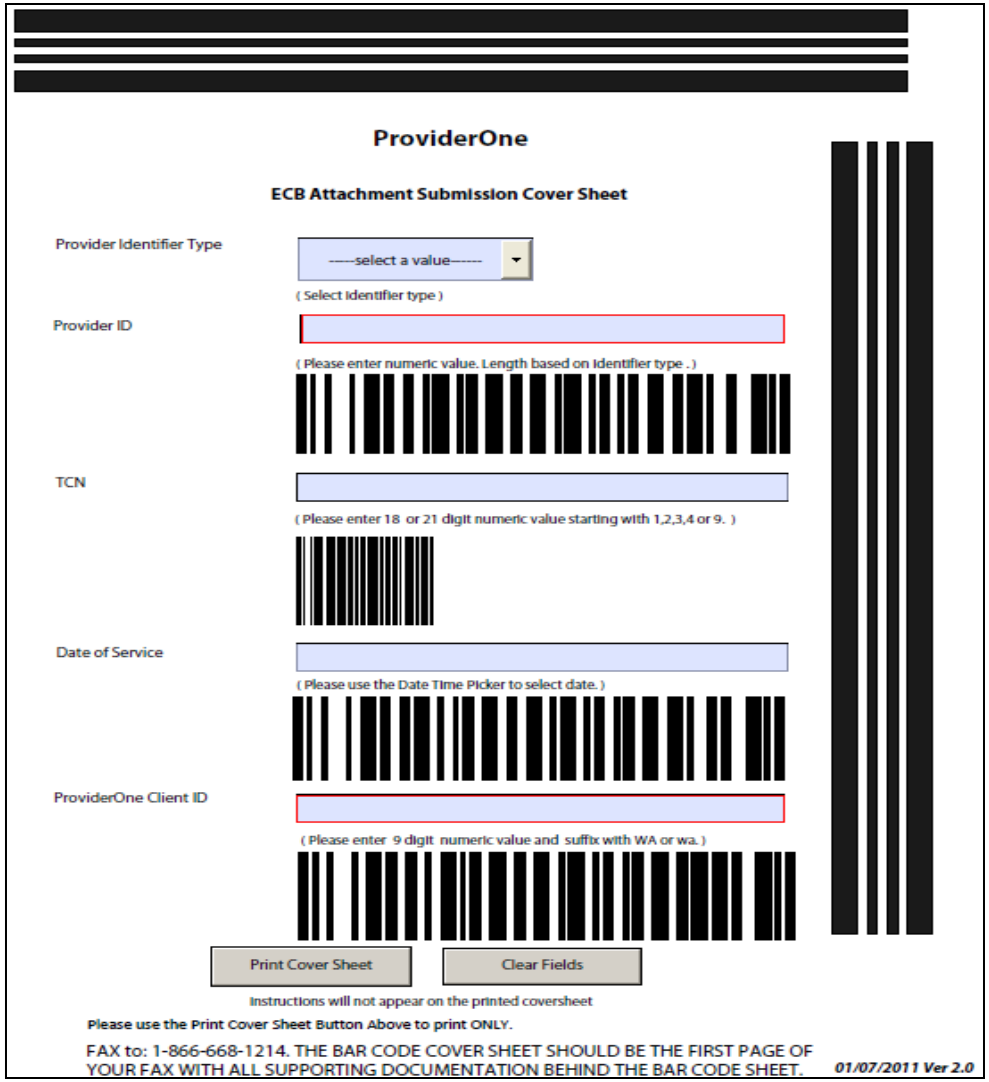
Washington State Health Care Authority
Medicaid

Submit Claim for Processing with Backup

- Fill in the boxes with the appropriate information. When completed click on the "Print Cover Sheet" 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 a value------
(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 the Date Time Picker to select date.)

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

Print Cover Sheet | Clear Fields

Instructions will not appear on the printed coversheet

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.

01/07/2011 Ver 2.0

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

- Now push the "OK button to submit the claim

Submitted Dental Claim Details:

TCN: 201127300000014000
Provider NPI: 1342222999
Client ID: 300655596WA
Date of Service: 10/20/2010-10/20/2010
Total Claim Charge: 75

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	EB	BM		0kb	X	09/30/2011

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

Print | Print Cover Page | Ok

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

Batch Secondary Electronic Billing

- The Agency is accepting secondary electronic claim billing through a clearinghouse batch or a self submitted HIPAA claim batch.
- Follow the HIPAA companion guides to submit primary payer insurance information:
  - Find at http://hrsa.dshs.wa.gov/dshshipaa/
  - 837 Professional (Pages 40-45; 52-53)
  - 837 Institutional (Pages 80-84; 90-91)
  - 837 Dental (Pages 112-116; 122-123)
- Add the required comment "Electronic TPL" in Loop 2300 NTE Segment.
- Add the required Adjustment Reason Code information (Loop information located on the above pages in the companion guides).

Reference Information

General Information about Medicaid:

- **Summarized in the new ProviderOne Billing and Resource Guide http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html**
- **See the new Provider Training web site for links to recorded Webinars, E-Learning, and Manuals http://www.dshs.wa.gov/provider/training.shtml**