

ProviderOne Provider System User Manual



Submitting a Professional Claim

Disclaimer:

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

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

ProviderOne Provider System User Manual

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Submitting a Professional Claim

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

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

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

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The ProviderOne On-line Claims Submission Process

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

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

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

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

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

Line No	File Name	Attachment Type	Transmission Code	Attachment Control	File Size	Delete	Uploaded On
1	ShowAttachmentServelt.xls	application/vnd.ms-excel	EL		23kb	X	09/01/2009
2	BM		BM		0kb	X	09/01/2009

Figure 1 – Submitted Professional Claim Details

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Accessing and Navigating the Professional Claim Form

Accessing the Professional Claim Form



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



ProviderOne displays the Claim Submission page.

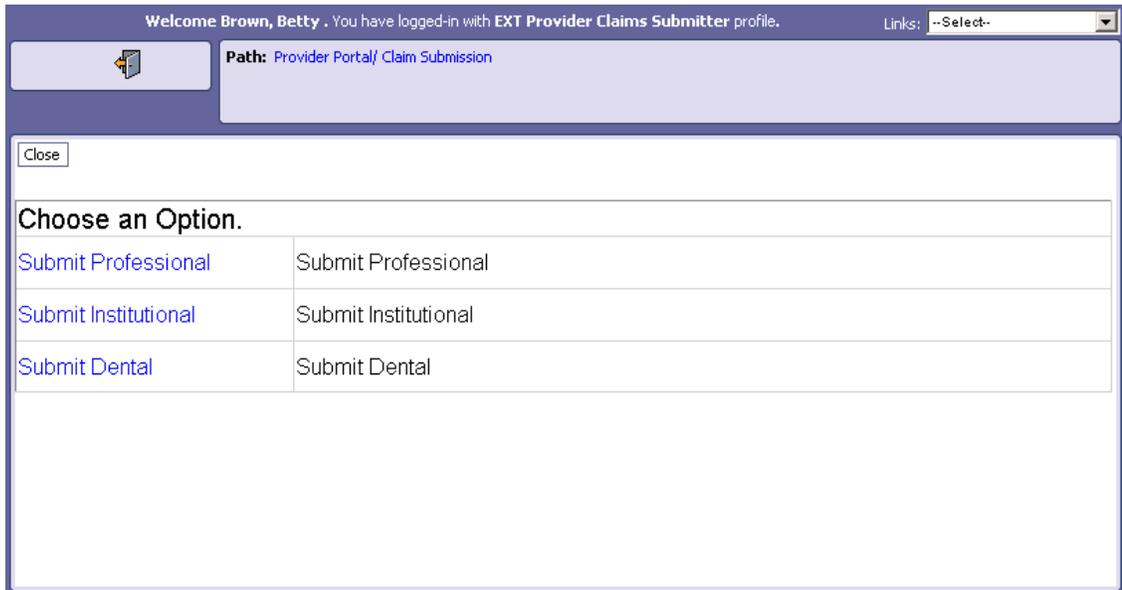


Figure 2 – Claim Submission Page



Select the Submit Professional hyperlink.



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ProviderOne displays the Professional Claim form.

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

Path: [Provider Portal/ Claim Submission/ Submit Professional Claim](#)

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

Figure 1 - Professional Claim Direct Data Entry Form

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Navigating the Professional Claim Form



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

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: [Redacted]

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

Note: [Redacted] information about the Other Claim Info tab see the appendix.

Knowing When Data Entry is Required

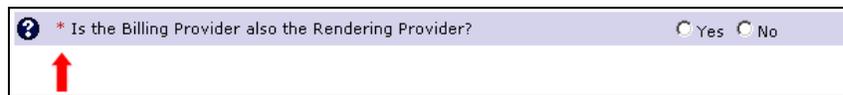
Required Fields

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



BILLING PROVIDER
* Provider NPI: * Taxonomy Code:
↑ ↑

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



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

Optional and Situational Data Entry Panels

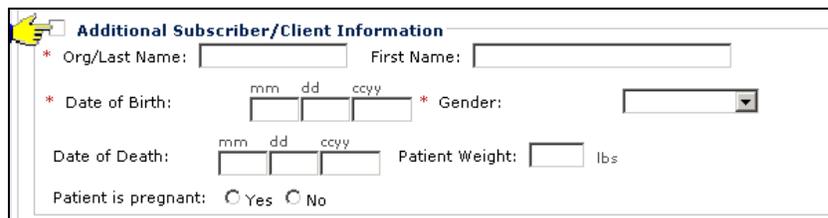
Additional data entry fields are located within expandable  data entry panels.



 **OTHER INSURANCE INFORMATION**
↑

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

Clicking on expander buttons  reveal additional data entry options.



  **Additional Subscriber/Client Information**
* Org/Last Name: First Name:
* Date of Birth: mm dd ccyy * Gender:
Date of Death: mm dd ccyy Patient Weight: lbs
Patient is pregnant: Yes No

NOTE: As a general rule, as long as an expander is closed and no data has been entered in the expanded data segment, ProviderOne will not generate an error message when the submit claim button is clicked. However, if any data fields located in an expanded data segment are filled in, then all required fields in that segment must be completed before clicking the submit button or an error message will be generated.

Accessing Online Billing Instructions



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

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



ProviderOne displays the external Billing Instructions web page.

About the Billing Instructions Page

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

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About Medicare Crossover Claims

Identify the Medicare Crossover Claim

If this is a Medicare Crossover Claim answer the following question with a Yes. This question exists in the SUBSCRIBER/CLIENT section.

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

SUBSCRIBER/CLIENT INFORMATION: Medicare Crossover Items

Answering Yes causes ProviderOne to expand the Medicare Crossover Items segment where Medicare data is entered.

? * Is this a Medicare Crossover Claim? Yes No
Medicare Cross Over Items
* Amount Paid by Medicare: \$ * Medicare Deductible: \$
* Medicare Co-insurance: \$ * Medicare Allowed Amount: \$
* Medicare Adjudication Date: mm dd ccyy

BASIC LINE ITEMS: Medicare Crossover Items

Medicare Crossover pertaining to Line Items are entered in the BASIC LINE ITEMS section of the claim form.

Medicare Crossover Items
* Medicare Deductible: \$ * Medicare Coinsurance: \$
* Medicare Paid: \$ * Medicare Allowed Amount: \$
* Medicare Paid Date: mm dd ccyy

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Completing the Basic Claim Info Section

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

PROVIDER INFORMATION

- BILLING PROVIDER
- RENDERING (PERFORMING) PROVIDER
- REFERRING PROVIDER

SUBSCRIBER/CLIENT INFORMATION

- SUBSCRIBER/CLIENT
- Claim is for Baby on Mom's Client Id
- Medicare Crossover Claim
- OTHER INSURANCE INFORMATION

CLAIM INFORMATION

- PRIOR AUTHORIZATION
- CLAIM NOTE
- EPSDT INFORMATION
- CONTITION INFORMATION
- Accident Related
- CLAIM DATA

BASIC LINE ITEM INFORMATION

- BASIC SERVICE LINE ITEMS

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

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
Top	

Figure 4 - Professional Claim - PROVIDER INFORMATION



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

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



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

? * Is the Billing Provider also the Rendering Provider?	<input checked="" type="radio"/> No
RENDERING (PERFORMING) PROVIDER	
* Provider NPI: <input type="text"/>	* Taxonomy Code: <input type="text"/>



Answer Yes and complete this segment if this service is the result of a referral. Otherwise, answer No.

? * Is this service the result of a referral?	<input checked="" type="radio"/> Yes <input type="radio"/> No
REFERRING PROVIDER INFORMATION	
* Provider NPI: <input type="text"/>	

SUBSCRIBER/CLIENT INFORMATION

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

Figure 5 - Professional Claim – SUBSCRIBER/CLIENT INFORMATION

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



Enter the Client ID.

SUBSCRIBER/CLIENT

* Client ID:

+ Additional Subscriber/Client Information



Click the red expander symbol to open the Additional Subscriber/Client Information segment.



Enter the Org/Last Name, Date of Birth, and select the Gender. Complete other fields as necessary.

+ Additional Subscriber/Client Information

* Org/Last Name: First Name:

* Date of Birth: * Gender:

Date of Death: Patient Weight: lbs

Patient is pregnant: Yes No

- If this claim is for a baby on the Mother's ID, the Date of Birth and Gender should be the baby's.

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



If this claim is for a Baby on the Mom's Client ID, answer Yes. Otherwise, answer No.

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

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If this is a Medicare Crossover claim, click Yes and complete the Medicare Crossover Items segment, otherwise click No.

* Is this a Medicare Crossover Claim? Yes No

Medicare Cross Over Items

* Amount Paid by Medicare: \$ * Medicare Deductible: \$

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

* Medicare Adjudication Date: mm dd cyy

The following steps apply only if the patient has insurance coverage other than Medicaid or answered the question above with YES.

OTHER INSURANCE INFORMATION



If the patient has insurance other than Medicaid expand the OTHER INSURANCE INFORMATION segment.

+ OTHER INSURANCE INFORMATION



Use the Add Another hyperlink to add information on more than one payer.

- OTHER INSURANCE INFORMATION

+ 1 OTHER PAYER INSURANCE INFORMATION

Add Another



To add information on a payer, click the OTHER INFORMATION INSURANCE INFORMATION expander.



ProviderOne expands the OTHER INSURANCE INFORMATION segment.

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OTHER INSURANCE INFORMATION

- 1 OTHER PAYER INSURANCE INFORMATION
 - Other Subscriber Information
 - Secondary ID Information
 - Other Insurance Coverage
 - Medicare Outpatient Adjudication Information
- Other Payer Information

* Payer/Insurance Organization Name:
- Additional Other Payer Information
- COB Monetary Amounts

COB Payer Paid Amount:
- Additional COB Information
- CLAIM LEVEL ADJUSTMENTS
- OTHER PAYER REFERRING PROVIDER INFORMATION
- OTHER PAYER RENDERING PROVIDER INFORMATION
- OTHER PAYER BILLING PROVIDER INFORMATION
- OTHER PAYER SUPERVISING PROVIDER - SECONDARY ID INFORMATION
- OTHER PAYER SERVICE FACILITY LOCATION INFORMATION

Add Another



Expand and complete the Other Subscriber Information section.

Other Subscriber Information

Other Subscriber Information

Subscriber Member ID:

Subscriber Last Name: First Name: MI: Suffix:

Insured's Group or Policy Number: Insured's Group or Plan Name:

 Additional Other Subscriber Information

NOTE: Provide as much information as possible about the other insurance coverage. Subscriber Member ID refers to the other insurance.



If necessary, open and complete the Additional Other Subscriber Information segment.

Additional Other Subscriber Information

Entity Qualifier:

Address Line 1: Address Line 2:

City: State:

Zip Code: Country:

Relation to Individual:

Claim Filing Code:

Insurance Type Code:

* Payer Responsibility Sequence Number Code:

NOTE: If the Additional Other Subscriber Information segment is open, the Payer Responsibility Sequence Number Code must be selected.



Expand and complete The Secondary ID Information segment.

Secondary ID Information

1	* ID Type: <input type="text"/>	* ID Number: <input type="text"/>
2	ID Type: <input type="text"/>	ID Number: <input type="text"/>



Expand and complete the Other Insurance Coverage segment.

Other Insurance Coverage
 Benefits Assignment Certification:
 Release Of Information Code:
 Patient Signature Source Code:



If this is a Medicare Crossover claim, expand and complete the Medicare Outpatient Adjudication Information segment.

Medicare Outpatient Adjudication Information

Reimbursement Rate: <input type="text"/> %	HCPCS Payable Amount: \$ <input type="text"/>
Remark Code 1: <input type="text"/>	Remark Code 2: <input type="text"/>
Remark Code 3: <input type="text"/>	Remark Code 4: <input type="text"/>
Remark Code 5: <input type="text"/>	
ESRD Paid Amount: \$ <input type="text"/>	Professional Component: \$ <input type="text"/>



Complete the Other Payer Information segment.



Enter the Payer/Insurance Organization Name.

Other Payer Information
 * Payer/Insurance Organization Name:
 Additional Other Payer Information



Open the Additional Other Payer Information segment, enter the ID and select the ID Type. Complete other data entry fields as necessary.

Additional Other Payer Information
 Entity Qualifier:
 * ID: * ID Type:
 Claim Check or Remittance Date: mm dd ccyy
 Number Type: PA/Referral No.:
 Payer Claim Adjustment: Yes No
 Secondary ID Information



If necessary, open the Secondary ID Information segment and provide additional ID information.

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Secondary ID Information

1	*	ID Type: <input type="text"/>	*	ID Number: <input type="text"/>
2		ID Type: <input type="text"/>		ID Number: <input type="text"/>



Complete the COB Monetary Amounts segment.

Enter the COB Payer Paid Amount.

COB Monetary Amounts
 COB Payer Paid Amount:

Additional COB Information



If necessary, complete the Additional COB Information segment.

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



Complete the Claim Level Adjustments segment.

CLAIM LEVEL ADJUSTMENTS

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



Complete the Other Referring, Rendering, and Billing Provider Information segments.

OTHER PAYER REFERRING PROVIDER INFORMATION
 * Provider NPI:

 OTHER PAYER RENDERING PROVIDER INFORMATION
 * Provider NPI:

 OTHER PAYER BILLING PROVIDER INFORMATION
 * Provider NPI:



Complete the Other Payer Supervising Provider – Secondary ID Information segment.

OTHER PAYER SUPERVISING PROVIDER - SECONDARY ID INFORMATION

1	*	ID Type: <input type="text"/>	*	ID Number: <input type="text"/>
2		ID Type: <input type="text"/>		ID Number: <input type="text"/>
3		ID Type: <input type="text"/>		ID Number: <input type="text"/>



Complete the Other Payer Service Facility Location Information segment.

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OTHER PAYER SERVICE FACILITY LOCATION INFORMATION
Entity Type:
 Secondary ID Information



Optionally, enter Secondary ID Information.

Secondary ID Information

1	* ID Type:	<input type="text"/>	* ID Number:	<input type="text"/>
2	ID Type:	<input type="text"/>	ID Number:	<input type="text"/>
3	ID Type:	<input type="text"/>	ID Number:	<input type="text"/>

CLAIM INFORMATION

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

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:

Top

Figure 6 - Professional Claim - CLAIM INFORMATION



If applicable, open the PRIOR AUTHORIZATION segment and enter claim Prior Authorization numbers.

PRIOR AUTHORIZATION

1. * Prior Authorization Number:

2. Prior Authorization Number:



If applicable, open the CLAIM NOTE segment, select the Type Code from the dropdown and enter the Note.

CLAIM NOTE

* Type Code:

* Note:

characters remaining: 80



If applicable, open the EPSDT INFORMATION segment and enter EPSDT information.

EPSDT INFORMATION

* Certification Condition Indicator: Yes No

* Condition 1:

Condition 2:

Condition 3:



Enter a Condition Code. Click the Add Another link to add multiple Condition Codes.

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, IR Amounts, Medical Equipment, Ambulance Transport, Line Item Note, Other Payer, Spinal Manipulations, Purchased Services and Line Act

BASIC SERVICE LINE ITEMS

Service mm dd ccyy * Service mm dd ccyy
 * Date From: [] [] [] * 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 (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: \$

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

Figure 7 - Professional Claim - BASIC LINE ITEM INFORMATION

Complete the BASIC LINE ITEM INFORMATION Section



Complete the data entry for the service line item.

BASIC SERVICE LINE ITEMS

Service mm dd ccyy * Service mm dd ccyy
 * Date From: [] [] [] * Date To: [] [] []
 Place of Service: []
 * Procedure Code: [] Modifiers: 1: [] 2: [] 3: [] 4: []
 * Submitted Charges: \$ [] Diagnosis Pointers: *1: [] 2: [] 3: [] 4: []
 * Units: []



If this claim is a Medicare Crossover claim, complete the data entry for the Medicare Crossover Items.

Medicare Crossover Items

* Medicare Deductible: \$ [] * Medicare Coinsurance: \$ []
 * Medicare Paid: \$ [] * Medicare Allowed Amount: \$ []
 * Medicare Paid Date: mm dd ccyy [] [] []

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If applicable, enter the National Drug Code and fill in Drug Identification Information.

National Drug Code:	<input type="text"/>
<input type="checkbox"/> Drug Identification	
* Unit Code:	<input type="text"/>
* National Drug Unit Count:	<input type="text"/>
Prescription or Compound Drug Association Number:	<input type="text"/>
Prescription Date:	mm dd cyy



If this service line item required Prior Authorization, open the Prior Authorization segment and enter the Prior Authorization.

<input type="checkbox"/> Prior Authorization	
1. * Prior Authorization Number:	<input type="text"/>
2. Prior Authorization Number:	<input type="text"/>



Open the Additional Service Line Information and, if applicable, complete any date entry.

<input type="checkbox"/> Additional Service Line Information			
EPSDT Indicator:	<input type="radio"/> Yes <input type="radio"/> No	Family Planning Indicator:	<input type="radio"/> Yes <input type="radio"/> No
Emergency Indicator:	<input type="radio"/> Yes <input type="radio"/> No	Co-Pay Waiver:	<input type="radio"/> Yes <input type="radio"/> No

Adding Service Lines Item to the Claim

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



Click the Add Service Line Item button.

<input type="button" value="Add Service Line Item"/>	<input type="button" value="Update Service Line Item"/>
------------------------------------------------------	---------------------------------------------------------



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



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

Professional Claim:				
Note: asterisks (*) denote required fields.				
Basic Claim Info		Other Claim Info		
Billing Provider	Rendering Provider	Subscriber	Claim	Service

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

Previously Entered Line Item Information															
Click a Line No. below to view/update that Line Item Information.													Total Submitted Charges: \$ 239		
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	09/09/2009	09/09/2009	2610	50				1				239	1		Delete or Other Service Info



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

Updating a Service Line Item



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

Previously Entered Line Item Information																
Click a Line No. below to view/update that Line Item Information.											Total Submitted Charges: \$ 239					
Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntns				Submitted Charges	Units	PA Number		
	From	To		1	2	3	4	1	2	3	4					
1	09/09/2009	09/09/2009	2610	50					1				239	1		Delete or Other Service Info



ProviderOne returns to the top of the claim form.



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

Professional Claim:

Note: asterisks (*) denote required fields.

Basic Claim Info
Other Claim Info

Billing Provider |
 Rendering Provider |
 Subscriber |
 Claim |
 Service



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



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

Add Service Line Item
Update Service Line Item

Deleting a Service Line Item



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

Previously Entered Line Item Information																
Click a Line No. below to view/update that Line Item Information.											Total Submitted Charges: \$ 1373					
Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntns				Submitted Charges	Units	PA Number		
	From	To		1	2	3	4	1	2	3	4					
1	09/09/2009	09/09/2009	2610	50					1				279	1		Delete or Other Service Info

Saving the Claim and Retrieving a Saved Claim

Requirements for Saving a Professional Claim

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

PROVIDER INFORMATION

- Billing Provider NPI
- Billing Provider Taxonomy
- Is the Billing Provider also the Rendering Provider?
- Is this service the result of a referral?

SUBSCRIBER/CLIENT INFORMATION

- Client ID
- Is this a Medicare Crossover Claim?

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

CLAIM INFORMATION

- Is this claim accident related?

BASIC SERVICE LINE ITEMS

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

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

Saving the Claim



Complete all required data entry.

Click the Save Claim button.



ProviderOne displays the following confirmation dialog.



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

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



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

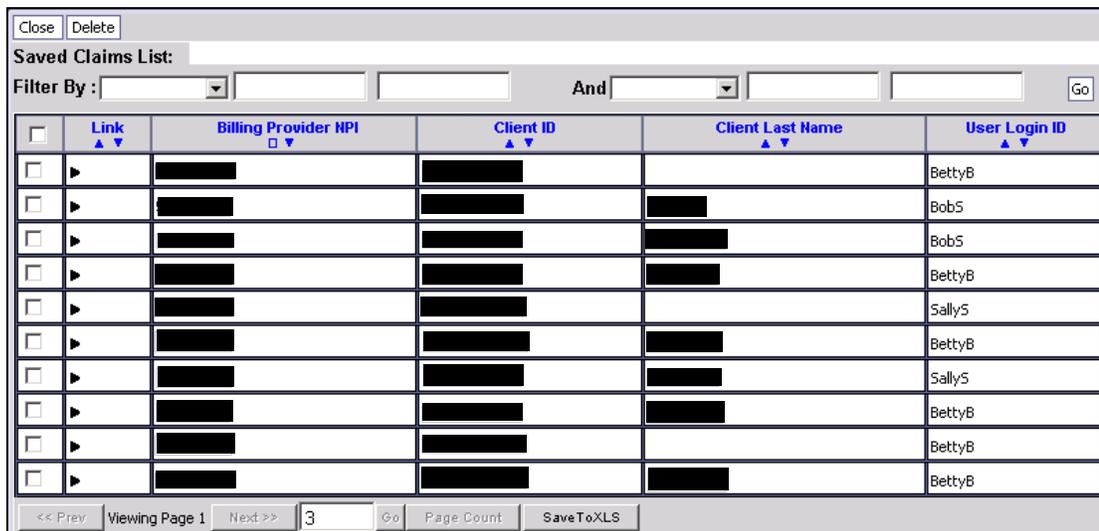
Retrieving a Saved Claim



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



ProviderOne displays the Saved Claims List.



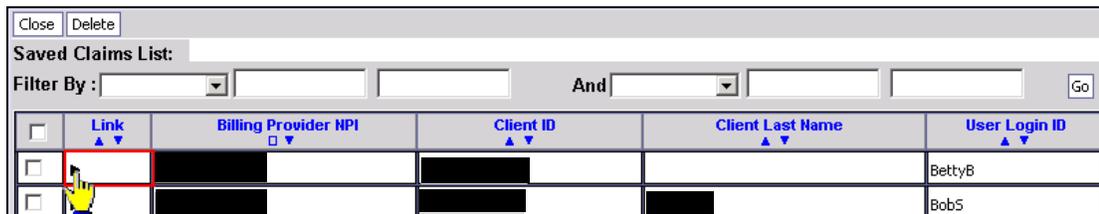
<input type="checkbox"/>	Link	Billing Provider NPI	Client ID	Client Last Name	User Login ID
<input type="checkbox"/>	▶	██████████	██████████		BettyB
<input type="checkbox"/>	▶	██████████	██████████	██████████	BobS
<input type="checkbox"/>	▶	██████████	██████████	██████████	BobS
<input type="checkbox"/>	▶	██████████	██████████	██████████	BettyB
<input type="checkbox"/>	▶	██████████	██████████	██████████	SallyS
<input type="checkbox"/>	▶	██████████	██████████	██████████	BettyB
<input type="checkbox"/>	▶	██████████	██████████	██████████	SallyS
<input type="checkbox"/>	▶	██████████	██████████	██████████	BettyB
<input type="checkbox"/>	▶	██████████	██████████	██████████	BettyB
<input type="checkbox"/>	▶	██████████	██████████	██████████	BettyB

Viewing Page 1 of 3

Figure 8 – Saved Claims List



Click the Link icon to retrieve a claim.



<input type="checkbox"/>	Link	Billing Provider NPI	Client ID	Client Last Name	User Login ID
<input type="checkbox"/>	▶	██████████	██████████		BettyB
<input type="checkbox"/>	▶	██████████	██████████	██████████	BobS



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



Continue with Professional Claim data entry.

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

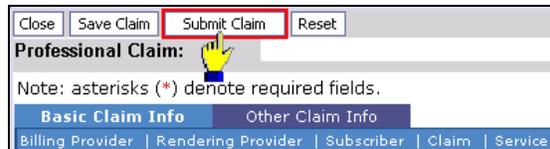
For more information on managing the Saved Claims List, see the Managing Claims Provider System User Manual.

Submitting the Claim and Adding Backup Documentation

Submitting the Claim



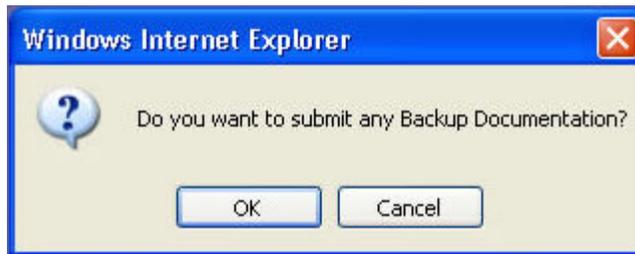
Click the Submit Claim button.



The screenshot shows a web form with buttons for 'Close', 'Save Claim', 'Submit Claim', and 'Reset'. The 'Submit Claim' button is highlighted with a red box and a yellow hand cursor. Below the buttons, the text reads 'Professional Claim:' followed by a text input field. A note below the field states: 'Note: asterisks (*) denote required fields.' At the bottom, there are tabs for 'Basic Claim Info' and 'Other Claim Info', and a breadcrumb trail: 'Billing Provider | Rendering Provider | Subscriber | Claim | Service'.



ProviderOne displays the following prompt.



Click OK to display the Claim Backup Documentation form.



Click the Cancel button if there is no backup documentation.



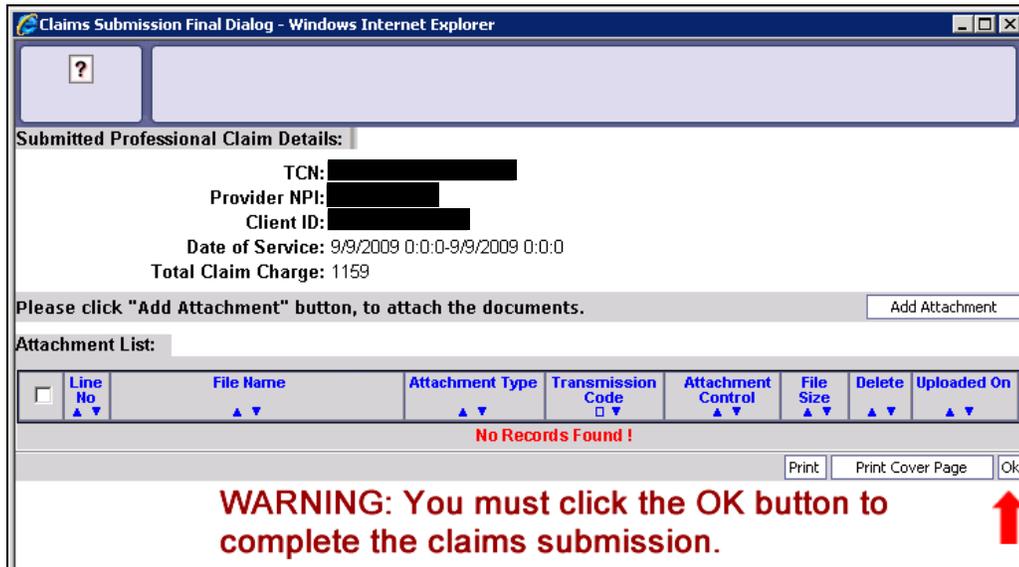
ProviderOne generates a TCN for the new claim and displays the Submitted Professional Claim Details page.



To print this information click Print.



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



Submitted Professional Claim Details:

TCN: [REDACTED]
 Provider NPI: [REDACTED]
 Client ID: [REDACTED]
 Date of Service: 9/9/2009 0:0:0-9/9/2009 0:0:0
 Total Claim Charge: 1159

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

Attachment List:

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

Print

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

Figure 9 - Submitted Professional Claim Details

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

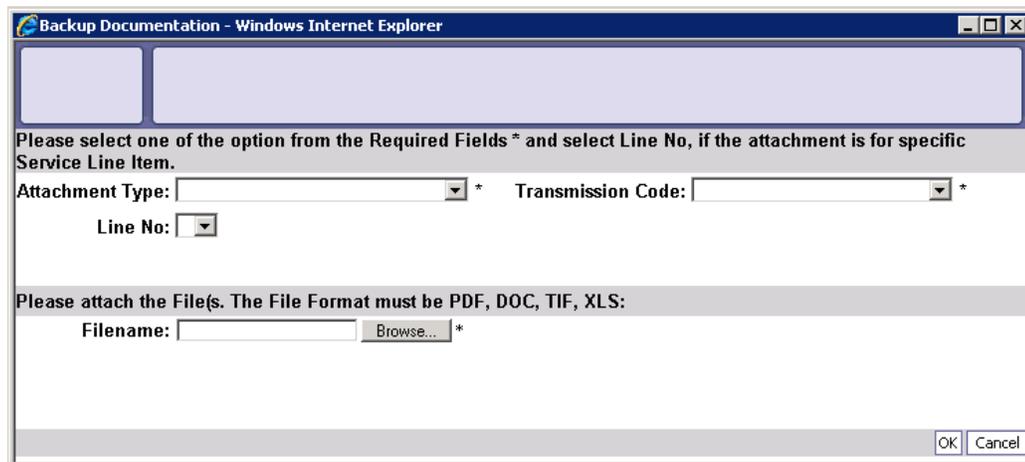
Submitting Claims Backup Documentation

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



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

ProviderOne displays the Claims Backup Documentation form.



The screenshot shows a web browser window titled "Backup Documentation - Windows Internet Explorer". The page content includes the following text and form elements:

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: * Transmission Code: *

Line No:

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

Filename: *

At the bottom right of the form are buttons for "OK" and "Cancel".

Figure 9 - Claims Backup Documentation

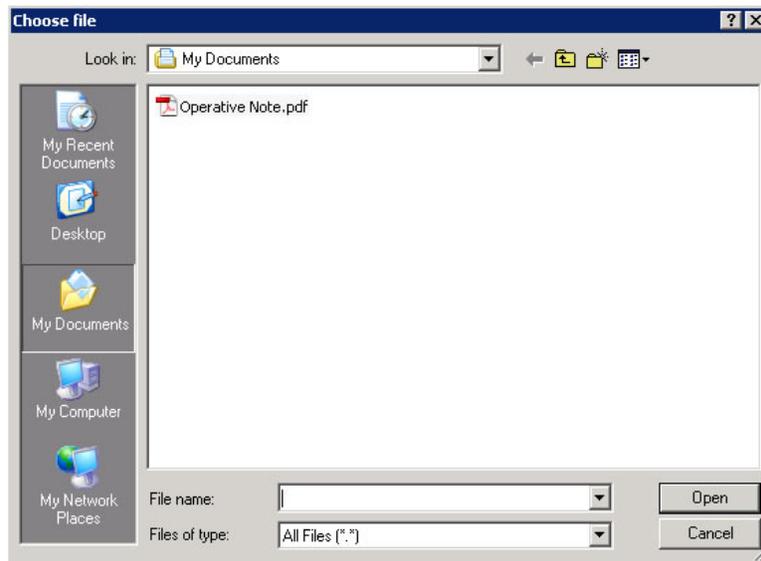


Select the Attachment Type and Transmission Code. If the Transmission Code is EL, click the Browse button and select the file to upload.

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



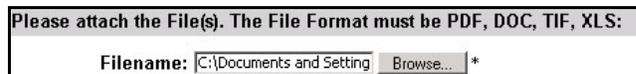
ProviderOne displays a Windows Choose File dialog.



Select the file to attach and click the Open button.



ProviderOne displays the file in the Filename field.



Click the OK button.



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



To print this information click Print.



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

Claims Submission Final Dialog - Windows Internet Explorer

Submitted Professional Claim Details:

TCN: [REDACTED]
 Provider NPI: [REDACTED]
 Client ID: [REDACTED]
 Date of Service: 9/9/2009 0:0:0-9/9/2009 0:0:0
 Total Claim Charge: 1159

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

Attachment List:

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

<< Prev Viewing Page 1 Next >> 1 Go Page Count Save To XLS

Print Print Cover Page **Ok**

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



Figure 10 - Submitted Professional Claim Details

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

Printing the Attachment Cover Page



Click the Print Cover Page button.



ProviderOne displays a PDF preview of the Cover Page.



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

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

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

Printing the Claim Details



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



ProviderOne displays a PDF preview of the claim details.



Print or Save this PDF file.

This page is intentionally blank.

Submitting an Online Batch Claim

Before Uploading Your Document

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

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

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

Accessing the Batch Attachment Response Page



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



ProviderOne displays the Batch Attachment Response page.

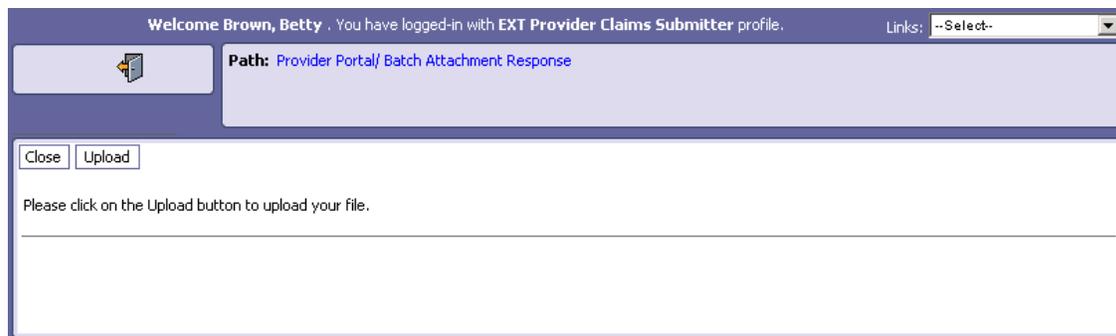


Figure 11 - Batch Attachment Response

This page is intentionally blank.

Submitting the Document



Click the Upload button.

ProviderOne displays the Attachment page.

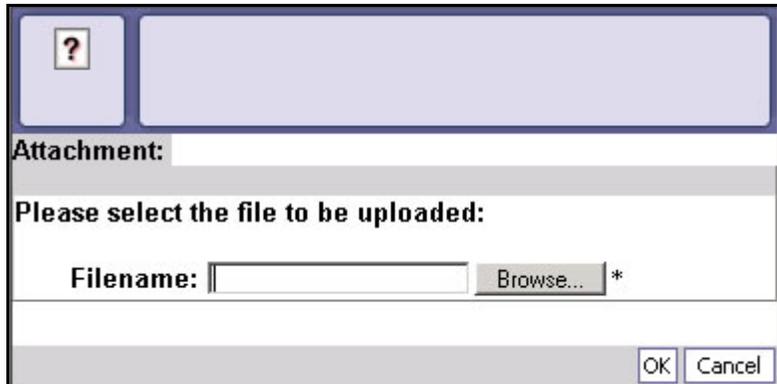


Figure 12 - Attachment



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

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

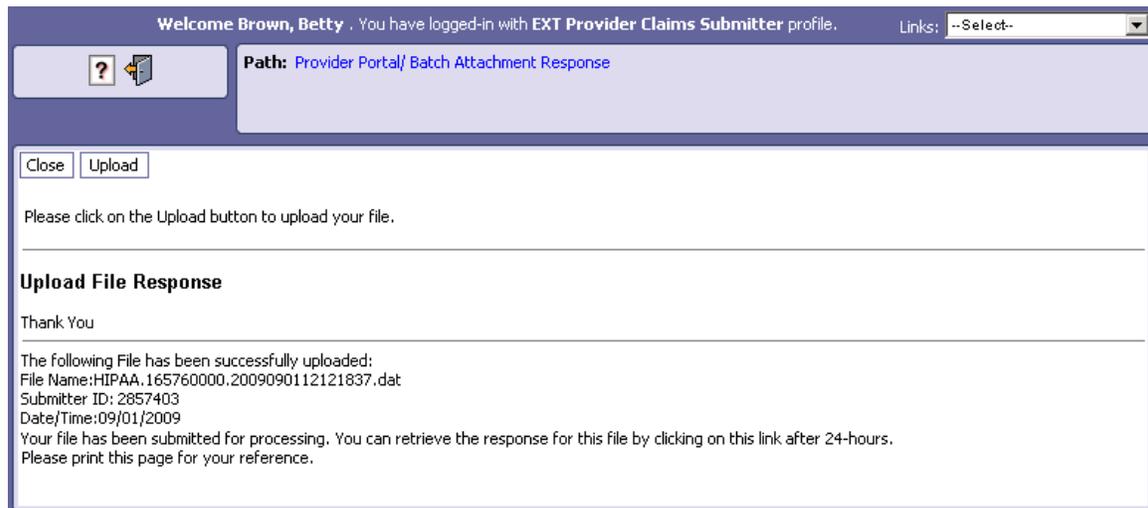


Figure 13 - HIPAA Batch Response – Upload File Response



Click the Close button.

This page is intentionally blank.

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Appendix

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

This section is for reference only.

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Completing the Other Claim Info Section

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

CLAIM INFORMATION

- RELEVANT DATES
- MISCELLANEOUS CLAIM
- SERVICE FACILITY

SPECIALIZED SERVICES INFORMATION

- ABMULANCE
- PATIENT CONDITION - VISION

CLAIM PROVIDER INFORMATION

- SUPERVISING PROVIDER

This page is intentionally blank.

Accessing Other Claim Info

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



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



Professional Claim:

Note: asterisks (*) denote required fields.

Basic Claim Info | Other Claim Info

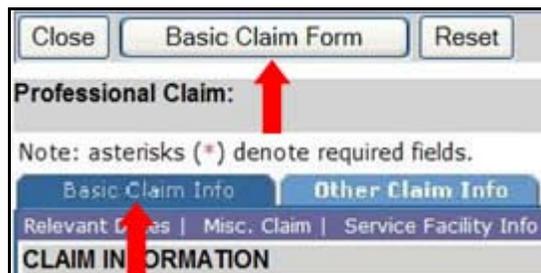
Billing Provider | Subscriber | Claim | Service

A red arrow points to the 'Other Claim Info' tab.



ProviderOne displays the Other Claim Info form.

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



Close | Basic Claim Form | Reset

Professional Claim:

Note: asterisks (*) denote required fields.

Basic Claim Info | Other Claim Info

Relevant Cases | Misc. Claim | Service Facility Info

CLAIM INFORMATION

Red arrows point to the 'Basic Claim Form' button and the 'Basic Claim Info' tab.

This page is intentionally blank.

CLAIM INFORMATION

CLAIM INFORMATION

Go to Basic Claim Info to enter basic claim information.

- RELEVANT DATES**
- MISCELLANEOUS CLAIM**
- SERVICE FACILITY**

Enter RELEVANT DATES

RELEVANT DATES

Date Last Seen: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>	
Admission Date: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>	Discharge Date: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>
Assumed Care Date: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>	Relinquished Care Date: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>
Last Menstrual Date: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>	Onset of Current Illness: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>
Disability Begin Date: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>	Disability End Date: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>
Last Worked Date: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>	Authorized Return to work Date: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>
Hearing & Vision Prescription Date: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>	Acute Manifestation Date: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>
Last X-ray Date: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>	Initial Treatment Date: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>
Property and Casualty Date of First Contact: <input type="text" value="mm"/> <input type="text" value="dd"/> <input type="text" value="ccyy"/>	

Enter MISCELLANEOUS CLAIM

MISCELLANEOUS CLAIM

CLIA Number: <input type="text"/>	Medical Record Number: <input type="text"/>
Investigational Device Exemption ID: <input type="text"/>	Demonstration Project ID: <input type="text"/>
Mammography Certification Number: <input type="text"/>	
Homebound Certification Indicator: <input type="radio"/> Yes <input type="radio"/> No	
Service Authorization Exception Code: <input type="text"/>	
File Information: <input type="text"/>	

Enter SERVICE FACILITY

SERVICE FACILITY

Provider NPI:

SPECIALIZED SERVICES INFORMATION

SPECIALIZED SERVICES INFORMATION

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

AMBULANCE

PATIENT CONDITION - VISION

Top

Enter AMBULANCE

AMBULANCE

* Ambulance Transport Reason Code:

* Transport Distance: Miles Patient Weight: lbs.

Round Trip Purpose Description:

Stretcher Purpose Description:

If the patient was admitted to the hospital, please enter the admission date in the [Other General Claim Information](#) section.

CERTIFICATION CONDITIONS

* Certification Condition Indicator: Yes No

* Condition 1.

Condition 2.

Condition 3.

Condition 4.

Condition 5.

PICK-UP LOCATION

DROP-OFF LOCATION

PICK-UP LOCATION

Address Line 1: Address Line 2:

City: State:

Zip Code: Country:

DROP-OFF LOCATION

Org/Last Name:

Address Line 1: Address Line 2:

City: State:

Zip Code: Country:

Enter PATIENT CONDITION - VISION

PATIENT CONDITION - VISION

* Certification Condition Indicator: Yes No

* Code Category:

* Condition 1.

Condition 2.

Condition 3.

Condition 4.

Condition 5.

CLAIM PROVIDER INFORMATION

CLAIM PROVIDER INFORMATION
Go to Basic Claim Info to enter information about the Billing, Referring and Rendering providers.
<input type="checkbox"/> SUPERVISING PROVIDER

Enter SUPERVISING PROVIDER

<input type="checkbox"/> SUPERVISING PROVIDER
Provider NPI: <input type="text"/>



ProviderOne Provider System User Manual

Completing the Other Service Info Section

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

OTHER SERVICE LINE INFORMATION

- RELEVANT DATES

SERVICE LINE PROVIDER INFORMATION

- RENDERING PROVIDER INFORMATION
- REFERRING PROVIDER INFORMATION
- PURCHASED SERVICE PROVIDER INFORMATION
- ORDERING PROVIDER INFORMATION
- SUPERVISING PROVIDER INFORMATION

SERVICE LINE CLAIM INFORMATION

- SERVICE FACILITY INFORMATION

OTHER LINE ITEM INFORMATION

- DME SERVICE
- DMERC
- AMBULANCE
- SERVICE NOTES
- FILE INFO
- PURCHASED SERVICE
- SERVICE LINE ADJUDICATION INFO

CLAIMS MANAGEMENT SYSTEM (CMS) INFORMATION

- MISCELLANEOUS LINE INFORMATION
- TEST RESULT INFORMATION
- FORM IDENTIFICATION INFORMATION

Accessing Other Service Info

Other Service Info is applied to individual Service Lines.



To open the Other Service Info form for an individual Service Line, click the Other Service Info hyperlink for the 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 Ptrs			Submitted Charges	Units	PA Number	
	From	To		1	2	3	4	1	2				3
1	09/09/2007	09/09/2007	20610	50				1			239	1	Delete or Other Service Info



ProviderOne displays the Other Service Info form.

OTHER SERVICE LINE INFORMATION

OTHER SERVICE LINE INFORMATION
Go to Basic Claim Info to enter basic service line information.
 RELEVANT DATES

Enter RELEVANT DATES

- <input type="checkbox"/> RELEVANT DATES	
Date Last Seen: <input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy	Date Shipped: <input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy
Last Certification: <input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy	Certification Revision: <input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy
Begin Therapy: <input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy	Last X-ray Date: <input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy
	Initial Treatment Date: <input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy
Test Date	
Test Qualifier: <input type="text"/> ▼	Test Date: <input type="text"/> mm <input type="text"/> dd <input type="text"/> ccyy

This page is intentionally blank.

SERVICE LINE PROVIDER INFORMATION

SERVICE LINE PROVIDER INFORMATION

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

- RENDERING PROVIDER INFORMATION**
- REFERRING PROVIDER INFORMATION**
- PURCHASED SERVICE PROVIDER INFORMATION**
- ORDERING PROVIDER INFORMATION**
- SUPERVISING PROVIDER INFORMATION**

[Top](#)

Enter RENDERING PROVIDER INFORMATION

RENDERING PROVIDER INFORMATION

* Provider NPI: Taxonomy Code:

Enter REFERRING PROVIDER INFORMATION

REFERRING PROVIDER INFORMATION

* Provider NPI:

Enter PURCHASED SERVICE PROVIDER INFORMATION

PURCHASED SERVICE PROVIDER INFORMATION

Provider NPI:

Enter ORDERING PROVIDER INFORMATION

ORDERING PROVIDER INFORMATION

Provider NPI:

Enter SUPERVISING PROVIDER INFORMATION

SUPERVISING PROVIDER INFORMATION

Provider NPI:

SERVICE LINE CLAIM INFORMATION

SERVICE LINE CLAIM INFORMATION
Go to Basic Claim Info to enter basic service line information.
<input type="checkbox"/> SERVICE FACILITY INFORMATION
Top

Enter **SERVICE FACILITY INFORMATION**

<input type="checkbox"/> SERVICE FACILITY INFORMATION
Provider NPI: <input type="text"/>

This page is intentionally blank.

OTHER LINE ITEM INFORMATION

OTHER LINE ITEM INFORMATION

Go to [Basic Claim Info](#) to enter basic service line item data.

- DME SERVICE**
- DMERC**
- AMBULANCE**
- SERVICE NOTES**
- FILE INFO**
- PURCHASED SERVICE**
- SERVICE LINE ADJUDICATION INFO**

Top

Enter DME SERVICE

DME SERVICE

* Procedure Code:

Frequency: * Length of Medical Necessity: Days

DME Rental Price: \$ DME Purchase Price: \$

Enter DMERC Information

DMERC

Attachment Transmission Code:

* Certification Type Code: * Number of Months Needed:

* Certification Condition Indicator: Yes No

* Code Category:

* Condition 1:

Condition 2:

Enter AMBULANCE

AMBULANCE

* Transport Reason:

* Transport Distance: Miles Patient Weight: lbs.

Round Trip Purpose Description:

Stretcher Purpose Description:

If the patient was admitted to the hospital, please enter the admission date in the Relevant Dates section.

- CERTIFICATION CONDITIONS**
- PICK-UP LOCATION**
- DROP-OFF LOCATION**

CERTIFICATION CONDITIONS

* Certification Condition Indicator: Yes No

* Condition 1:

Condition 2:

Condition 3:

Condition 4:

Condition 5:

PICK-UP LOCATION

Address Line 1: Address Line 2:

City: State:

Zip Code: Country:

DROP-OFF LOCATION

Org/Last Name:

Address Line 1: Address Line 2:

City: State:

Zip Code: Country:

Enter SERVICE NOTES

SERVICE NOTES

* Type Code:

* Note:

characters remaining:

Enter FILE INFO

FILE INFO

File Information:

Enter PURCHASED SERVICE Information

PURCHASED SERVICE

Purchased Service Provider ID: Purchased Service Charge Amount: \$

Enter SERVICE LINE ADJUDICATION

SERVICE LINE ADJUDICATION INFO

1 SERVICE LINE ADJUDICATION

Add Another

1 SERVICE LINE ADJUDICATION

*Other Payer Primary ID: *Service Line Paid Amount: \$

*Claim Check or Remittance Date: mm dd ccyy *Paid Service Line Unit Count:

*Procedure Qualifier: *Procedure Code:

Procedure Code Description: Bundled Line Number:

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

Remaining Patient Liability Amount:

SERVICE ADJUSTMENT

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

CLAIMS MANAGEMENT SYSTEM (CMS) INFORMATION

CLAIMS MANAGEMENT SYSTEM (CMS) INFORMATION

Go to [Basic Claim Info](#) to enter basic service line item data.

- MISCELLANEOUS LINE INFORMATION
- TEST RESULT INFORMATION
- FORM IDENTIFICATION INFORMATION

Enter MISCELLANEOUS LINE INFORMATION

MISCELLANEOUS LINE INFORMATION

Immunization Batch Number: Postage Claimed Amount:

Sales Tax Amount:

CLIA Number: Referring CLIA Number:

Line Item Control Number: Mammography Certification Number:

Hospice Employer Provider Indicator: Yes No

Enter TEST RESULT INFORMATION

TEST RESULT INFORMATION

Current Line Number:

* Test Measurement ID:

* Test Measurement Qualifier:

* Test Results:

Previously Entered Test Result(s)

Click a Measurement ID below to view/edit that Test Result Information.

Test Measurement ID	Test Measurement Qualifier	Test Result

Enter FORM IDENTIFICATION INFORMATION

FORM IDENTIFICATION INFORMATION

* Form Type: * Form ID:

SUPPORTING DOCUMENTATION INFORMATION

* Question Number or Letter:

Possible Responses to Question Referenced Above:

Question Response: Yes No N/A

Reference ID Response:

Percent Response: %

Date Response: mm dd ccyy