Submitting an Institutional 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.
Every effort has been made to ensure this Guide’s accuracy. However, in the unlikely event of an actual or apparent conflict between this document and a department rule, the department rule controls.
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Submitting an Institutional Claim

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

The following section describes the process of submitting an Institutional Claim using ProviderOne Direct Data Entry.

The high-level steps for submitting an on-line Institutional 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 are 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.
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Accessing and Navigating the Institutional Claim Form

Accessing the Institutional 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.

Select the Submit Institutional hyperlink.

Figure 1 – Claim Submission Page
Choose an Option.

- Submit Professional
- Submit Institutional
- Submit Dental

ProviderOne displays the Institutional Claim form.

![Institutional Claim Direct Data Entry Form](image)

Figure 2 – Institutional Claim Direct Data Entry Form
Navigating the Institutional 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.

Note: For 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]

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

![Is this a Medicare Crossover Claim?]

Optional and Situational Data Entry Panels

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

![Subscriber/Client]

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.

![Subscriber/Client]

IMPORTANT: Fields located within expanded data entry panels and marked with an asterisk are required “only if the data entry panel is opened”.
This page is intentionally blank.
Accessing Online Billing Instructions

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

<table>
<thead>
<tr>
<th>Institutional Claim:</th>
<th>Billing Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: asterisks (*) denote required fields.</td>
<td>Billing Instructions</td>
</tr>
</tbody>
</table>

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.
This page is intentionally blank.
About Medicare Crossover Claims

If you are submitting a Medicare Crossover Claim you must answer the following question with a Yes and input the Medicare Claim specific information.

![Question: Is this a Medicare Crossover Claim? Yes No]

This question appears on the Basic Claim Info form, in the CLAIM INFORMATION, CLAIM DATA section. Answering Yes causes ProviderOne to expand the Medicare Crossover Items area in the CLAIM DATA section (see graphic below).

The following form entry blocks also pertain to Medicare and appear in the OTHER INSURANCE INFORMATION section of CLAIM DATA.
Every effort has been made to ensure this Guide’s accuracy. However, in the unlikely event of an actual or apparent conflict between this document and a department rule, the department rule controls.
Completing the Basic Claim Info Section

The Basic Claim Info section of the Institutional Claim Form consists of four subsections.

**PROVIDER INFORMATION**
- BILLING PROVIDER

**SUBSCRIBER/CLIENT INFORMATION**
- SUBSCRIBER/CLIENT

**CLAIM INFORMATION**
- CLAIM DATA
- Is this a Medicare Crossover Claim?
- EPSDT INFORMATION
- CONDITION INFORMATION
- OCCURRENCE INFORMATION
- OCCURRENCE SPAN INFORMATION
- VALUE INFORMATION
- OTHER INSURANCE INFORMATION
- PRIOR AUTHORIZATION
- DIAGNOSIS INFORMATION
- PROCEDURE INFORMATION
- ATTENDING PHYSICIAN INFORMATION
- OTHER PHYSICIAN INFORMATION
- BILLING NOTE

**SERVICE LINE ITEM INFORMATION**
- SERVICE LINE ITEMS

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

![SUBSCRIBER/CLIENT INFORMATION](image)

**Figure 4 - Institutional Claim - SUBSCRIBER/CLIENT INFORMATION**

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

Enter the Client ID.

![SUBSCRIBER/CLIENT](image)

Click the red expander symbol to open the Additional Subscriber/Client Information segment and enter the Org/Last Name, Date of Birth, and select the Gender.

![Additional Subscriber/Client Information](image)

NOTE: The Org/Last Name, Date of Birth, and Gender fields must be completed before submitting the claim.
This page is intentionally blank.
Every effort has been made to ensure this Guide’s accuracy. However, in the unlikely event of an actual or apparent conflict between this document and a department rule, the department rule controls.
Complete the CLAIM DATA section.

<table>
<thead>
<tr>
<th>CLAIM DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Account No.:</strong></td>
</tr>
<tr>
<td><strong>Medical Record Number:</strong></td>
</tr>
<tr>
<td><strong>Type Of Facility:</strong></td>
</tr>
<tr>
<td><strong>Bill Classification:</strong></td>
</tr>
<tr>
<td><strong>Statement Dates:</strong></td>
</tr>
<tr>
<td>From: mm dd ccyy</td>
</tr>
<tr>
<td>To: mm dd ccyy</td>
</tr>
<tr>
<td><strong>Admission Date/Time:</strong></td>
</tr>
<tr>
<td>mm dd ccyy ih:mm:ss</td>
</tr>
<tr>
<td><strong>Priority(Type) Admission/Visit:</strong></td>
</tr>
<tr>
<td><strong>Point Of Origin Admission/Visit:</strong></td>
</tr>
<tr>
<td><strong>Discharge Hour:</strong></td>
</tr>
<tr>
<td>hh:mm</td>
</tr>
<tr>
<td><strong>Discharge Status:</strong></td>
</tr>
<tr>
<td><strong>Total Claim Charge:</strong></td>
</tr>
<tr>
<td>$</td>
</tr>
<tr>
<td><strong>Patient Est. Amount Due:</strong></td>
</tr>
<tr>
<td>$</td>
</tr>
<tr>
<td><strong>DRG Code:</strong></td>
</tr>
</tbody>
</table>

If this is a Medicare Crossover Claim, answer the question with Yes and complete the Medicare Cross Over Items segment. Otherwise, answer No.

<table>
<thead>
<tr>
<th>Medicare Cross Over Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Days Covered:</td>
</tr>
<tr>
<td><strong>Amount Paid by Medicare:</strong> $</td>
</tr>
<tr>
<td><strong>Medicare Co-Insurance:</strong> $</td>
</tr>
<tr>
<td><strong>Medicare Inpatient Deductible:</strong> $</td>
</tr>
<tr>
<td><strong>Medicare Allowed Amount:</strong> $</td>
</tr>
<tr>
<td><strong>Medicare Adjudication Date:</strong> mm dd ccyy</td>
</tr>
</tbody>
</table>

If necessary, expand and complete the Additional Claim Data.

<table>
<thead>
<tr>
<th>Additional Claim Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delay Reason Code:</strong></td>
</tr>
<tr>
<td><strong>Provider Accept:</strong></td>
</tr>
<tr>
<td><strong>Assignment Code:</strong></td>
</tr>
<tr>
<td><strong>Benefits Assignment:</strong></td>
</tr>
<tr>
<td><strong>Certification:</strong></td>
</tr>
<tr>
<td><strong>Release Of Information Code:</strong></td>
</tr>
<tr>
<td><strong>Auto Accident Code:</strong></td>
</tr>
</tbody>
</table>

Expand and complete the EPSDT INFORMATION segment.

<table>
<thead>
<tr>
<th>EPSDT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Certification Condition Indicators:</strong> C Yes C No</td>
</tr>
<tr>
<td><strong>Condition 1:</strong></td>
</tr>
<tr>
<td><strong>Condition 2:</strong></td>
</tr>
<tr>
<td><strong>Condition 3:</strong></td>
</tr>
</tbody>
</table>
Open and complete the CONDITION INFORMATION segment. If more than one Condition Code needs to be entered, click the Add Another hyperlink.

Open and complete the OCCURRENCE INFORMATION segment. If more than one Occurrence Code is needed, click the Add Another hyperlink.

Open and complete the OCCURRENCE SPAN INFORMATION segment. If more than one Occurrence Code Span is needed, click the Add Another hyperlink.

Open and complete the VALUE INFORMATION segment. Click the Add Another hyperlink to add multiple Value Codes.

Open the OTHER INSURANCE INFORMATION segment. To enter payer information, click the OTHER PAYER INSURANCE INFORMATION hyperlink. Click the Add Another hyperlink to add information about additional payers.

Complete this segment if the client has additional insurance coverage other than Medicare or Medicare Advantage plans.

Open the OTHER PAYER INSURANCE INFORMATION segment.
Every effort has been made to ensure this Guide’s accuracy. However, in the unlikely event of an actual or apparent conflict between this document and a department rule, the department rule controls.
Open and complete the Other Subscriber Information segment.

Open and complete the Additional Other Subscriber Information segment.

NOTE: Other subscriber information is useful if Medicaid is unaware of the private insurance, otherwise it is not necessary to complete.

Open and complete the Other Insurance Coverage segment.

Open and complete the Medicare Adjudication Information segment.

Every effort has been made to ensure this Guide’s accuracy. However, in the unlikely event of an actual or apparent conflict between this document and a department rule, the department rule controls.
Open and complete the Medicare Inpatient Adjudication Information segment.

Open and enter Secondary ID Information.

Open and complete the CLAIM LEVEL ADJUSTMENTS segment.

Enter Other Provider Information.

Every effort has been made to ensure this Guide’s accuracy. However, in the unlikely event of an actual or apparent conflict between this document and a department rule, the department rule controls.
Open and complete the PRIOR AUTHORIZATION segment.

Open and complete the DIAGNOSIS INFORMATION segment. Use the Add Another hyperlink to add multiple E-Codes.

NOTE: Do not use decimals or spaces when entering Diagnosis Codes.

Open and complete the Other Diagnosis Information segment.

Open and complete the PROCEDURE INFORMATION segment.

If additional Procedure Codes must be entered, open and complete the Other Procedure Information segment. Use the Add Another hyperlink to add multiple codes.

Every effort has been made to ensure this Guide’s accuracy. However, in the unlikely event of an actual or apparent conflict between this document and a department rule, the department rule controls.
Open and complete the ATTENDING PHYSICIAN INFORMATION segment.

- ATTENDING PHYSICIAN INFORMATION
  - Provider NPI: 
  - Taxonomy Code: 

Open and complete the OTHER PHYSICIAN INFORMATION segment.

- OTHER PHYSICIAN INFORMATION
  - Provider NPI: 

Open and complete the BILLING NOTE segment.

- BILLING NOTE
  - Type
  - Code:
  - Note:

characters remaining: 0
Service Line Item Information

Click on the Other Site Info link associated with each added Service Line Item to enter line item information other than that displayed in the table.

Service Line Items
* Revenue Code:
Procedure Code:  
Modifiers: 1: 2: 3: 4:  
Service Date/First Data of Service:  
Last Date of Service:  
* Service Units:  
* Total Line Charges: $  
Line Item Control Number:  
Medicare Crossover Items
National Drug Code:  

Figure 6 - Institutional Claim - SERVICE LINE ITEM INFORMATION

Complete the Service Line Items section.

If this is a Medicare Crossover Claim Line Item, open and complete the Medicare Crossover Items segment.

If necessary, enter a National Drug Code. Open and complete the Drug Identification segment.
Open and complete the Additional Service Line Information segment.

Adding the Service Line Item to the Claim

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

Click the Add Service Line Item button.

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.

ProviderOne displays the SERVICE 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.

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.

ProviderOne returns to the top of the claim form.

Click the Service tab to return to the SERVICE LINE ITEM INFORMATION section.

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

Deleting a Service Line Item

Click the Delete hyperlink of the Service Line Item you want to delete.
Saving the Claim and Retrieving a Saved Claim

Requirements for Saving an Institutional Claim

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

PROVIDER INFORMATION
- Billing Provider NPI
- Billing Provider Taxonomy

SUBSCRIBER/CLIENT
- Client ID

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 a Medicare Crossover Claim?

SERVICE LINE ITEM INFORMATION
- 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.

Click the Link icon to retrieve a claim.

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

Continue with Institutional Claim data entry.

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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.

ProviderOne displays the following prompt.

![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 Institutional Claim Details page.
Every effort has been made to ensure this Guide’s accuracy. However, in the unlikely event of an actual or apparent conflict between this document and a department rule, the department rule controls.
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.

![Backup Documentation Form](image)

Figure 9 - Claims Backup Documentation

Select the Attachment Type and Transmission Code.

**If the Transmission Code is BM: By Mail**

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

**If the Transmission Code is EL: Electronically Only**

Click the Browse 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 Institutional 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.
Every effort has been made to ensure this Guide’s accuracy. However, in the unlikely event of an actual or apparent conflict between this document and a department rule, the department rule controls.
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.
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.

![Attachment Page]

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.

![Upload File Response]

Click the Close button.

Every effort has been made to ensure this Guide’s accuracy. However, in the unlikely event of an actual or apparent conflict between this document and a department rule, the department rule controls.
Table of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Claim Submission Page</td>
<td>9</td>
</tr>
<tr>
<td>2</td>
<td>Institutional Claim Direct Data Entry Form</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>Institutional Claim - PROVIDER INFORMATION</td>
<td>21</td>
</tr>
<tr>
<td>4</td>
<td>Institutional Claim - SUBSCRIBER/CLIENT INFORMATION</td>
<td>23</td>
</tr>
<tr>
<td>5</td>
<td>Institutional Claim - CLAIM INFORMATION</td>
<td>25</td>
</tr>
<tr>
<td>6</td>
<td>Institutional Claim - SERVICE LINE ITEM INFORMATION</td>
<td>33</td>
</tr>
<tr>
<td>7</td>
<td>Saved Claims List</td>
<td>39</td>
</tr>
<tr>
<td>8</td>
<td>Submitted Institutional Claim Details</td>
<td>42</td>
</tr>
<tr>
<td>9</td>
<td>Claims Backup Documentation</td>
<td>43</td>
</tr>
<tr>
<td>10</td>
<td>Submitted Institutional Claim Details</td>
<td>45</td>
</tr>
<tr>
<td>11</td>
<td>Batch Attachment Response</td>
<td>47</td>
</tr>
<tr>
<td>12</td>
<td>Attachment</td>
<td>49</td>
</tr>
<tr>
<td>13</td>
<td>HIPAA Batch Response – Upload File Response</td>
<td>49</td>
</tr>
<tr>
<td>14</td>
<td>Institutional Claim - CLAIM INFORMATION</td>
<td>59</td>
</tr>
<tr>
<td>15</td>
<td>Institutional Claim - Other Claim Info - SPECIALIZED SERVICES INFORMATION</td>
<td>60</td>
</tr>
<tr>
<td>16</td>
<td>Institutional Claim - Other Claim Info – COORDINATION OF BENEFITS</td>
<td>66</td>
</tr>
<tr>
<td>17</td>
<td>Institutional Claim - OTHER SERVICE LINE INFORMATION</td>
<td></td>
</tr>
</tbody>
</table>

Every effort has been made to ensure this Guide’s accuracy. However, in the unlikely event of an actual or apparent conflict between this document and a department rule, the department rule controls.
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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.
Completing the Other Claim Info Section

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

**CLAIM INFORMATION**
- MISCELLANEOUS CLAIM

**SPECIALIZED SERVICES INFORMATION**
- CLAIM NOTE
- TREATMENT CODE INFORMATION
- OPERATING PHYSICIAN
- RENDERING PHYSICIAN
- REFERRING PHYSICIAN
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.

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.
Every effort has been made to ensure this Guide’s accuracy. However, in the unlikely event of an actual or apparent conflict between this document and a department rule, the department rule controls.
SPECIALIZED SERVICES INFORMATION

Figure 15 - Institutional Claim - Other Claim Info - SPECIALIZED SERVICES INFORMATION

Enter CLAIM NOTE

Enter TREATMENT CODE INFORMATION

Enter OPERATING PHYSICIAN
Enter RENDERING PHYSICIAN

[ ] RENDERING PHYSICIAN

Provider NPI:

Enter REFERRING PHYSICIAN

[ ] REFERRING PHYSICIAN

Provider NPI:
Completing the Other Service Info Section

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

SERVICE LINE PROVIDER INFORMATION

- OPERATING PHYSICIAN INFORMATION
- OTHER OPERATING PHYSICIAN INFORMATION
- RENDERING PROVIDER INFORMATION
- REFERRING PROVIDER INFORMATION
- SERVICE LINE ADJUDICATION INFO
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.

ProviderOne displays the Other Service Info form.
This page is intentionally blank.

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OTHER SERVICE LINE INFORMATION

Enter Physician and Provider Information

- OPERATING PHYSICIAN INFORMATION
  Provider NPI:

- OTHER OPERATING PHYSICIAN INFORMATION
  Provider NPI:

- RENDERING PROVIDER INFORMATION
  Provider NPI:

- REFERRING PROVIDER INFORMATION
  Provider NPI:

Enter SERVICE LINE ADJUDICATION INFO

- SERVICE LINE ADJUDICATION INFO
  1. SERVICE LINE ADJUDICATION
     Add Another

- SERVICE LINE ADJUDICATION INFO
  1. SERVICE LINE ADJUSTMENT
     Other Payer Primary ID:
     Claim Check or Remittance Date:
     Procedure Qualifiers:
     Procedure Code Description:
     Procedure Code Modifiers:
     Revenue Code:
     Remaining Patient Liability Amount:
     SERVICE ADJUSTMENT

Every effort has been made to ensure this Guide’s accuracy. However, in the unlikely event of an actual or apparent conflict between this document and a department rule, the department rule controls.