

ProviderOne for Social Services: Viewing Claim Status and Payments Guide

Updated January 2026



Introduction

This publication takes effect January 2026 and supersedes earlier billing guides for Social Services Providers.

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and a Health Care Authority (HCA) or Department of Social & Health Services (DSHS) rule arises, the rule applies.

The purpose of this guide is to serve as a resource for Social Services Providers and billing staff and provides directions on:

- **ProviderOne pay periods and claim submission deadlines**
 - Provides information on ProviderOne pay dates and claim submission deadlines
- **Looking up claims in ProviderOne**
 - Explains how to view claims in ProviderOne to confirm claim was submitted successfully and how to view the status of a claim
- **Viewing and understanding the remittance advice (RA)**
 - The remittance advice (RA) provides a detailed breakdown of paid, denied, adjusted, and in process claims. RAs are available in ProviderOne each Friday. This section provides a detailed breakdown of each section of the RA and explains what providers should look for in the RA.
- **Understanding overpayments**
 - Explains what causes overpayments, the difference between offset and non-offset adjustments, and how to identify an overpayment on the RA.



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Acronyms & Definitions

- **AAA** - Area Agency on Aging
- **CARS** - Collections and Accounts Receivable System. The system DSHS's Office of Financial Recovery uses to manage providers' debt (overpayments).
- **COFF** - CARS Offset
- **DDCS** - Developmental Disabilities Community Services. DSHS's DDCCS provides services and support for individuals (children and adults) with developmental disabilities. Prior to May 1, 2025, DDCCS was known as the Developmental Disabilities Administration (DDA).
- **Domain** - Also known as your ProviderOne ID or ProviderOne account. ProviderOne ID, Domain, and ProviderOne account are used interchangeably.
- **DOS** - Date of Service
- **DSHS** - Department of Social and Health Services. State agency in charge of delivering a variety of social services, employment supports, safety programs, and court-ordered behavioral health care.
- **EFT** - Electronic Funds Transfer. This is when funds are deposited directly into a banking account for claims payments.
- **HCA** - Health Care Authority. HCA is WA State's Medicaid agency. HCA oversees managing the ProviderOne system.
- **HCLA** - Home and Community Living Administration. HCLA is a DSHS administration that was formed May 1, 2025. HCLA focuses on coordinating home and community-based services to support clients in their own environments. It was formed by merging key functions from the Developmental Disabilities Administration (DDA) and the Aging and Long-Term Support Administration (AL TSA).
- **HCS** - Home & Community Services. DSHS's HCS provides services for seniors and people with disabilities to promote independence and safety. Prior to May 1, 2025, HCS was known as AL TSA.
- **MOS** - Month of Service
- **NOC** - Non-Offset to CARS
- **NPI** - National Provider Identifier. Most Social Services Providers are not required to have one.
- **OFIN** - Oracle Financial System
- **OFR** - Office of Financial Recovery. OFR recovers debts due to DSHS from vendors/providers who provide services to the Department or DSHS clients. These debts include vendor overpayments, nursing home cost settlements, civil fines, and certification fees. Overpayments are discovered through program or performance audits, computer records (Payment Reliability Program), program staff reviews, and vendors. OFR recovery actions may include recoupment from future claim payments, negotiating repayment agreements, legal actions, demands against security posted by vendors, or filing liens.
- **P1OFF** - ProviderOne Offset
- **ProviderOne or P1** - ProviderOne is the Medicaid management information system (MMIS) utilized by WA State.
- **ProviderOne ID**. A 7-digit ID assigned to each provider's ProviderOne account. Also known as the Provider Domain ID or Domain Name. Your ProviderOne ID + your 2-digit Location Code will be listed on your RAs.
- **RA** - Remittance Advice. RAs provides details about paid, denied, adjusted and in-process claims submitted in ProviderOne.
- **TCN** - Transaction Control Number. A unique tracking number assigned to each claim (also known as the claim number).
- **Warrant** – A paper check issued for claim payments



Contact Information

Note: View the 'For social services providers' [contact list](#) for a full list of contacts.

I need help with ...	Contact ...
<ul style="list-style-type: none"> • There is no active authorization • The authorization is in Error or Canceled status • The dates, units, or rates on the authorization are wrong 	<p>The client’s authorizing case manager</p>
<ul style="list-style-type: none"> • Signing up to receive electronic payments (EFT) • Updating information in ProviderOne (location addresses, email addresses, communication preferences) • Social Service Medical providers only: <ul style="list-style-type: none"> ○ Updating business license, taxonomy, NPI, or Dept. of Health license in ProviderOne 	<p>Health Care Authority--Provider Enrollment Phone: 1-800-562-3022 ext. 16137 Phones are open: Tuesdays and Thursdays from 7:30 a.m. to 4:30 p.m. (Closed from noon to 1 p.m.) Online: HCA Support Portal (see directions below)</p> <ul style="list-style-type: none"> • From HCA Support Portal, choose 'Public Inquiry' • Enter Secure Access Washington (SAW) login credentials <ul style="list-style-type: none"> ○ For assistance with logging in to SAW, click the green 'Get Help' button at the top of the login screen. • Once logged in, click 'My Requests' to view previous requests you've submitted to Provider Enrollment or click 'Make a Request' to enter a new request and then choose the 'Provider Enrollment' category. <ul style="list-style-type: none"> • Keep track of the assigned Incident # in case you need to escalate your issue to DSHS.
<ul style="list-style-type: none"> • Accessing ProviderOne • Login issues (i.e., password reset, locked out) • Setting up additional users, profiles, or system administrators 	<p>Health Care Authority--ProviderOne Security Email: ProviderOneSecurity@hca.wa.gov Online: HCA Secure form</p>



I need help with ...

Contact ...

- Looking up claims in ProviderOne
- How to view RAs
- How to adjust, void, or resubmit a claim

Health Care Authority--Medical Assistance Customer Service Center (MACSC)

Phone: 1-800-562-3022, choose language, then press '4' for 'healthcare or social services provider', then press '1' for 'social services'

Online: [HCA Secure form](#)

- Paying an overpayment
- Disputing an overpayment

DSHS--Office of Financial Recovery (OFR)

Phone: 360-664-5700, option 3, 1-800-562-6114, or TTY WA 1-800-833-6388

Email: OFRMMISVendor@dshs.wa.gov

Note: OFR can only make payment arrangements, respond to questions about your overpayment balance, answer questions about collection activity, and provide information on how to request an administrative hearing. OFR DOES NOT have specific details about the cause of the overpayment. For questions regarding why an overpayment occurred, contact the name listed on the Vendor Overpayment Notice or your client's authorizing case manager.

Urgent payment issues

Note: You should only contact the DSHS ProviderOne payment teams after you have tried resolving your issue through the appropriate channels (i.e., case manager, contract specialist, or HCA) AND client services are impacted, **DSHS--HCS or DDCS**

ProviderOne payment teams

DSHS--HCS or DDCS ProviderOne payment teams

DSHS HCS providers/clients

Email: P1_escalation@dshs.wa.gov

DSHS DDCS providers/clients

Contact the DDCS resource developer or contractor who will escalate to the regional payment specialist as needed.

When emailing DSHS, please include your:

- Name (first and last)
- Name of your organization
- ProviderOne ID (also known as your Domain)
- The date(s) you contacted HCA and the corresponding HCA Incident #
- A brief description of your issue, who you've tried to contact, and how the issue impacts client services and/or your ability to receive payment

Claims & payment overview

- ProviderOne processes payments once a week on Fridays.
- Providers and billers can view claim payments, claim denials, and claim adjustments on the weekly remittance advice (RA). RAs are available in ProviderOne each Friday.
- Providers should review each RA as soon as they are available to ensure claims paid correctly & to make any claim adjustments as needed.
- Providers can also view the status of a claim in ProviderOne using the Claim Inquiry Search feature.
- This guide explains how to look up and view claims in ProviderOne using the Claims Inquiry Search and provides an overview of how to view and download the RAs to see a detailed breakdown of claims.

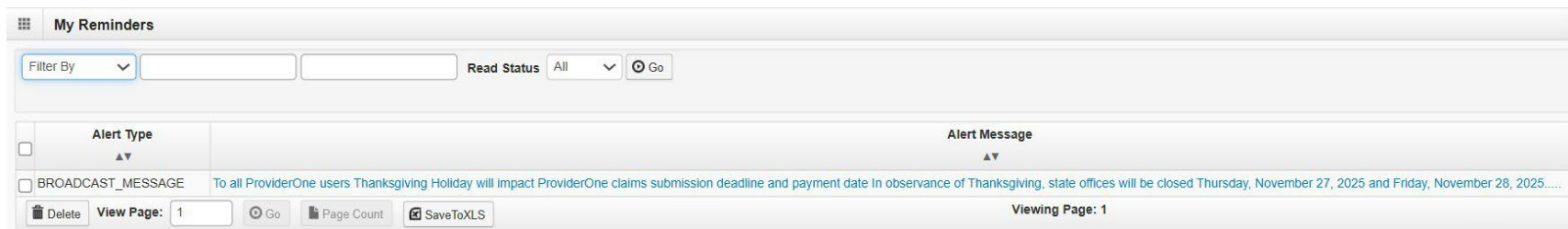


Claim submission deadlines and pay dates

- ProviderOne makes weekly payments.
- Claims submitted by 5 pm. Pacific time on Tuesdays should pay as follows:
 - If you are signed up for EFT (Electronic Funds Transfer/Direct Deposit) your payment transfer should be initiated on Friday of the same week.
 - If you are paid by warrant (check), the check should be put in the mail on Friday of the same week.
 - Holidays & ProviderOne maintenance may impact the claim submission deadline and pay date.
- Claims submitted after the weekly Tuesday 5 pm. deadline should pay on Friday of the following week.
- Holidays may impact claim submission deadlines and pay dates.
 - If the claim submission deadline or pay date is changed due to a holiday, you will see a message in ProviderOne in the Provider Portal:

June 2025						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	Claim for Client A submitted at 4 pm Claim for Client B submitted at 6 pm	17	18	19	Possible pay day for Client A
22	Possible pay day for Client A	23	24	25	26	Possible pay day for Client B
29	Possible pay day for Client B	30				

Example: Claims submitted by 5pm on Tues, 6/17 should pay on Friday, 6/20 or Monday, 6/23. Claims submitted after 5pm on Tues, 6/17 will pay the following Friday, 6/27 or Monday, 6/30.



- DSHS and HCA also notify providers via email if the claim submission deadline or pay date is changed due to a holiday or ProviderOne maintenance. Providers are encouraged to sign up for [DSHS notifications](#) and [HCA notifications](#) so they are alerted of ProviderOne updates and changes.
- Per [WAC 388-05-0010](#), Social Services Providers must submit claims in ProviderOne and have a TCN assigned within 12 months from the date of service.

Look up claims in ProviderOne

Providers may need to look up a claim in ProviderOne to confirm if a claim was submitted correctly or to check on the status of a claim (i.e., to see if the claim has been paid or to see why a claim denied).

To look up claims in ProviderOne:

- For Social Services (Non-Medical) Claims:
 - Log in to ProviderOne using the 'EXT Provider Social Services' profile.
 - From the **Provider Portal**, click **Social Service Claim Inquiry** (under the Social Services Authorization and Billing section).

- For Social Services (Medical) Claims:
 - Log in to ProviderOne using the 'EXT Provider Social Services Medical' profile.
 - From the **Provider Portal**, click **Claim Inquiry** (under the Claims section).



Social Services (Non-Medical) Claims:

- Your 7-digit ProviderOne ID (domain) will auto-populate in the Provider ID field.
- Enter your search criteria to search for a claim. Social Services (Non-Medical) Providers can search for a claim by entering the:
 - TCN (claim number), or
 - Client ProviderOne ID and Claim Dates, or
 - Authorization Number and Claim Dates
- After entering your search criteria, click **Submit**.

Provider Portal > Provider Social Service Claim Inquiry Search

Close Submit

Provider Social Service Claim Inquiry Search

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

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

Provider ID: *

TCN:

Client ID:

Authorization Number:

Claim Service Period From:

Claim Service Period To:

Social Services (Medical) Claims:

- Your 9-digit NPI will auto-populate in the Provider NPI field.
- Enter your search criteria to search for a claim. Social Services (Medical) Providers can search for a claim by entering the:
 - TCN (claim number), or
 - Client ProviderOne ID and Claim Dates
- After entering your search criteria, click **Submit**.

Provider Portal > Provider Claim Inquiry Search

Close Submit

Provider Claim Inquiry Search

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

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

Provider NPI: *

TCN:

Client ID:

Claim Service Period From:

Claim Service Period To:

Note: If searching by Claim Service Period From/To, the dates you enter must match the claim dates. *Example: You submitted a direct data entry claim with dates of service 05/01/2025-05/31/2025. You want to view the claim to confirm the # of units you claimed for dates of service 05/05/2025-05/10/2025 is correct. You must enter 05/01/2025 as the 'Claim Service Period From' date and 05/31/2025 as the 'Claim Service Period To' date. If you enter 05/05/2025-05/10/2025 for your search criteria, you will receive a message that the claim can't be found.*

- If your search is successful, the **Inquire Claims List** appears showing the claim status.
- On this screen, you will see the:
 - **TCN** (Transaction Claim Number) also known as the claim number.
 - **Authorization Number** entered on the claim.
 - **Claim From Date & To Date.**
 - **Claim Status.** Read the Claim Status message to determine the status of the claim. In the example below, the Claim Status message is **F1: Finalized/Payment-The claim/line has been paid** which means the claim is in **Paid** status.
 - **RA Date & RA Number.** You can find more information about the claim on the remittance advice (RA) listed. See pages 13-25 for directions on how to view your RAs.
 - **Claim Charged Amount.** Billed amount submitted on the claim.
 - **Claim Payment Amount.** Amount DSHS paid.

- Click on the blue hyperlinked TCN to view more information.

The screenshot displays the 'Inquire Social Service Claims List' interface. At the top, there is a navigation bar with 'Profile: EXT Limited Provider Social Services' and various utility icons. Below this, the breadcrumb trail reads 'Provider Portal > Provider Social Service Claim Inquiry Search > Claim Inquiry Providers List'. A 'Close' button is visible on the left. The main content area shows 'Provider ID: 1 1' and a table titled 'Inquire Social Service Claims List'. The table has columns for TCN, Authorization Number, From Date, To Date, Claim Status, RA Date, RA Number, Claim Charged Amount, Claim Payment Amount, Client Name, and Client ID. A single row of data is shown with TCN 652-000, Authorization Number 13, From Date 08/01/2020, To Date 08/02/2020, Claim Status 'F1: Finalized/Payment-The claim/line has been paid', RA Date 08/06/2020, RA Number 58, Claim Charged Amount \$175.78, Claim Payment Amount \$0.00, Client Name 1, and Client ID WA. Below the table, there are controls for 'View Page: 1', 'Go', '+ Page Count', and 'SaveToXLS'. Three pop-up boxes are overlaid on the table: one for 'TCN' showing '652 000', one for 'Claim Status' showing 'F1: Finalized/Payment-The claim/line has been paid.', and one for 'Claim Payment Amount' showing '\$0.00'. A large blue arrow points from the left towards the TCN field in the table.



- After clicking on the TCN, additional details about the claim appears.
- We can see this claim contains two dates of service (08/01/2020 & 08/02/2020).

- As you scroll down, you can see claim service line data.

- In the screenshot to the right, we see:
 - 1 unit of code T1020, modifier U3 was claimed for date of service 08/01/2020 (claim line #1) and
 - 1 unit of code T1020, modifier U3 was claimed for date of service 08/02/2020 (claim line #2).

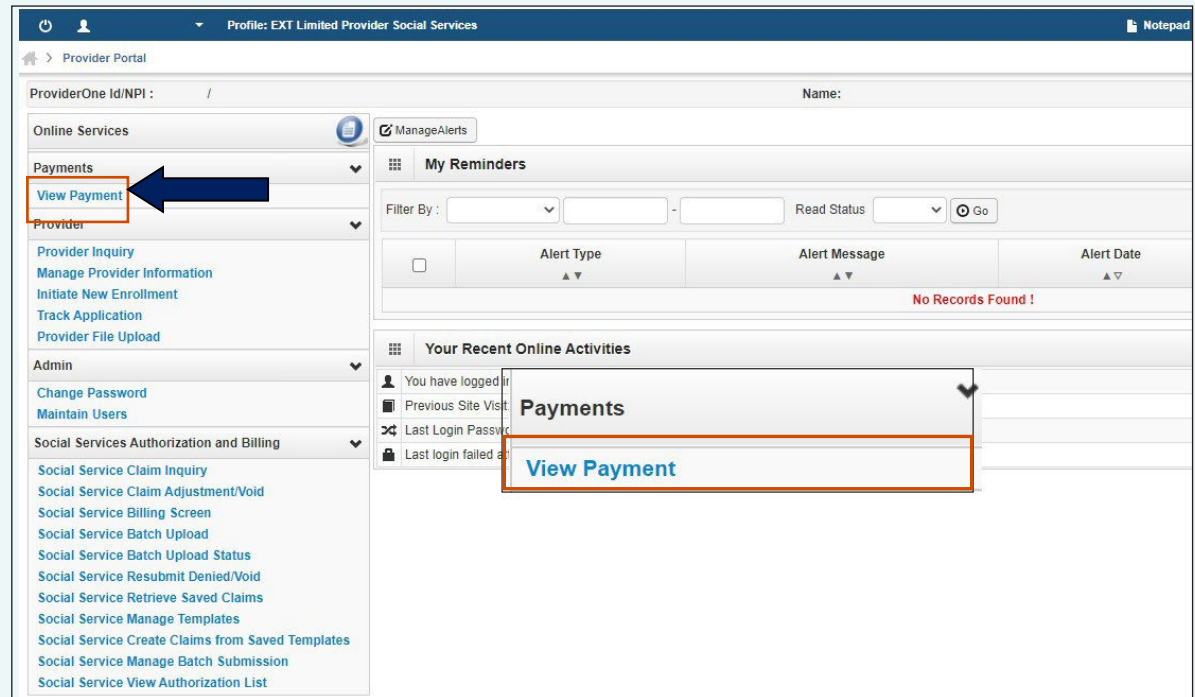
- If the claim is in 'Paid' Status and you need to adjust the claim (i.e., change # of units claimed, add or remove dates, void the claim, etc.), click **Close** to return to the **Provider Portal** and then follow directions in the [Submitting and Adjusting Social Services Claims Guide](#) or the [Submitting and Adjusting Social Services Medical Claims Guide](#).
 - **Note:** If a claim shows as 'In Process', you cannot make any changes to the claim until it shows as 'Finalized/Payment-The claim/line has paid'.

View the Remittance Advice (RA)

- This section provides a brief overview of how to view and download the remittance advice (RA).
- RAs are available in ProviderOne each Friday and include claim details for claims entered during the previous week prior to the Tuesday, 5 pm deadline.
- The RA provides a list of paid, denied, adjusted, and in-process claims.

To view your RAs:

- Login to ProviderOne using the 'EXT Provider Social Services' or 'EXT Provider Social Services Medical' profile.
- From the **Provider Portal**, click on **View Payment**.



Note: RAs are retrievable in ProviderOne for up to 4 years. Providers are required to retain records for up to 6 years and are responsible for retaining copies of the RAs for this purpose.

- After clicking on **View Payment**, the **RA/ETRR Payment List** appears.
- Here, you will see a list of your 10 most recent RAs. To view more RAs, click the **Next** button or the **Last** button at the bottom of the screen to see more RAs.
- The **RA/ETRR Payment List** shows basic information for each RA (claim count, charges, payment amount, etc.), but **this screen should not be used to reconcile your payments.**
- To reconcile and review all payments, adjustments, and denials, click on the RA you want to review.

RA/ETRR Payment List

Billing ProviderOne ID: 207

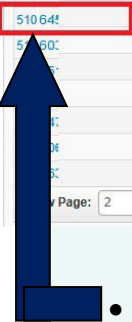
Filter By: [] Go

Save Filter My Filters

RA/ETRR Number	Check Number	Check/ETRR Date	RA Date	Claim Count	Charges	Payment Amount	Adjusted Amount	Download	Billing ProviderOne ID
51078	3807671	11/20/2025	11/21/2025	67	\$12,049.82	\$11,149.62	\$900.20		
51073	3645061	11/13/2025	11/14/2025	73	\$13,940.24	\$11,368.24	\$1,105.96		
51069	3464051	11/06/2025	11/07/2025	65	\$11,625.44	\$10,390.88	\$1,234.56		
51064	3277501	10/30/2025	10/31/2025	67	\$12,757.12	\$10,956.72	\$1,414.60		
51060	3110591	10/23/2025	10/24/2025	72	\$14,506.08	\$13,451.56	\$1,054.52		
51056	2922001	10/16/2025	10/17/2025	77	\$14,879.02	\$13,567.30	\$1,311.72		
51052	2733231	10/09/2025	10/10/2025	52	\$10,699.52	\$9,130.60	\$1,144.54		
51048	2559481	10/02/2025	10/03/2025	66	\$12,667.10	\$6,777.22	\$5,169.72		
51044	2362061	09/25/2025	09/26/2025	66	\$12,872.16	\$7,393.80	\$4,706.76		
51040	2184241	09/18/2025	09/19/2025	78	\$13,695.90	\$13,181.50	\$514.40		

Page: 2 Go Page Count SaveToXLS Viewing Page: 1

First Prev Next Last



- To view an RA, click on the blue hyperlinked RA/ETRR Number.

Note: If you have more than one location, each location will have its own RA for each claim period.

- After clicking on a blue hyperlinked **RA Number**, the RA opens in PDF format.
- Click on the arrow in the top right corner to download and save the PDF to your computer:



Understanding each section of the RA

The RA is broken into four main sections:

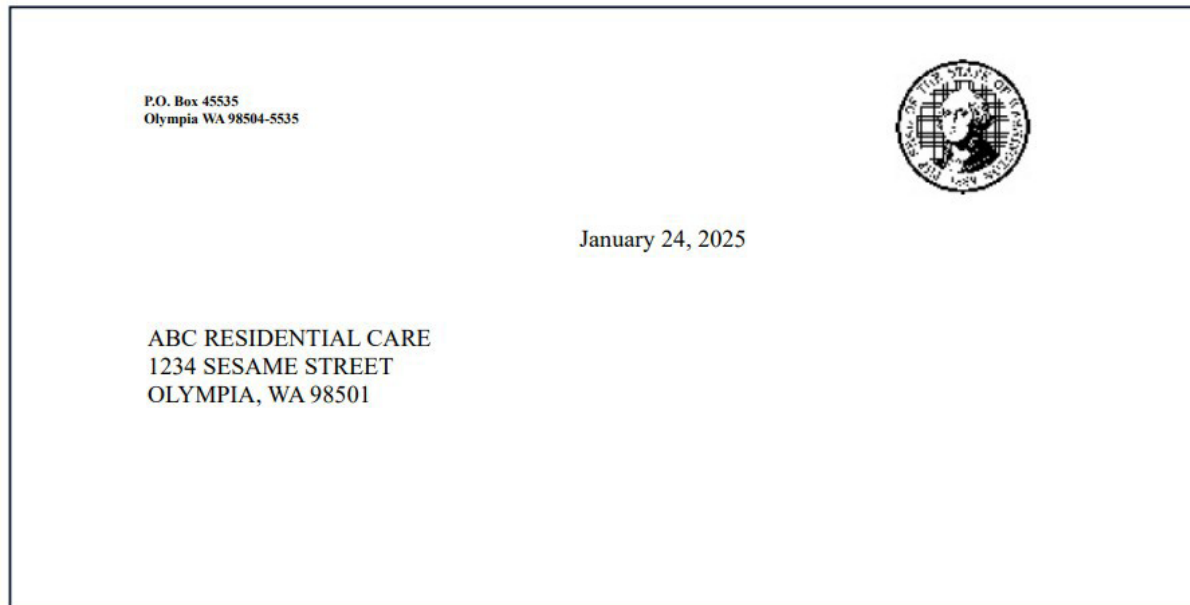
- Section 1: Mailing Information (Cover Page)
- Section 2: Current RA Messages (Page 1)
- Section 3: Payment Summary (Starts on Page 2). Summary of payments and adjustments for claims submitted during the weekly claim cycle.
- Section 4: Payment Information. Detailed breakdown of each claim submitted during the weekly claim cycle broken down by claim category and client.

The following pages provide a detailed explanation of each section of the RA.



Section 1: Mailing Information

The cover page of the RA contains the RA creation date, the provider's name, and the provider's mailing address.




Note: If your mailing address has changed, you must update this information on your ProviderOne account. See the [Getting Started and Billing Essentials Guide](#) for directions on how to update your mailing address.



Section 2: Current RA Messages

On Page 1 of the RA, you will see the:

- A. RA Number
- B. **Billing Provider.** Your 7-digit ProviderOne ID (also known as your ProviderOne domain) + your 2-digit Location Code. If you are a provider with multiple locations, you will receive an RA for each of your locations.
- C. **Prepared Date.** Date the RA was prepared. **RA Date.** Date the payment was released.
- D. **Key messages:** These are alerts from HCA or DSHS about changes to ProviderOne functions or claims deadlines.



ABC RESIDENTIAL CARE

1234 SESAME STREET
OLYMPIA, WA 98501

Health Care Authority Remittance Advice

RA Number: 123456789

Billing Provider: 200000001

A

B

C

Prepared Date: 01/24/2025
RA Date: 01/24/2025

Page 1

If you have questions and need clarification about the Remittance Advice (RA), in the ProviderOne Billing and Resource Guide at <https://www.hca.wa.gov/billing-resource-guide> open section "The remittance advice".

For DSHS Social Service Providers: If you have questions about this document, call 1-800-562-3022, select Provider Services, then select Social Services.

For claims disputes other than overpayments, call 1-800-562-3022 or submit a contact us request here: <http://fortress.wa.gov/hca/pl/contactus/>.

For claims disputes for DOC, email: dochqmedicalpay@doc.wa.gov.

D

You may dispute overpayments **ONLY** by sending a written request for review to:

- For Health Care Authority medical providers: Office of Legal Affairs, PO Box 45504, Olympia WA 98504-5504. Submit documentation within 28 days of the RA date, in accordance with RCW 41.05A.170. A formal hearing will be scheduled after HCA receives the request. Hearings are conducted under the Administrative Procedure Act. You may be offered a pre-hearing in an attempt to resolve your dispute prior to the formal hearing.
- For Department of Corrections: DOC, Medical Disbursement Unit, PO Box 41107, Olympia WA 98504-1107 within 30 days of the payment date. The Medical Disbursement Unit will review your request and adjust payment, or respond with a written denial of charges.

Your request for review must be in writing and:

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



Section 3: Payment Summary

Starting on Page 2 of the RA, the **Payment Summary** provides an overview of payments and adjustments for claims submitted in the most recent claim cycle. On the Payment Summary you will find the:

- A. RANumber, Warrant/EFT#** (check or EFT #), the **Warrant/EFTDate** (date of payment), and **PaymentMethod** (electronic funds transfer-EFT or warrant)
- B. Warrant/EFT Amount.** Total amount paid to the provider.
- C. ClaimsSummary.** Provides a summary (gross sum) of all the claim categories on the RA for claims submitted in the most recent weekly claim cycle.
 - **Category.** Paid (original claims in paid status), Denied (claims in denied status), Adjustments (claims that resulted from an adjustment), In Process (claims that were submitted by the deadline but there was a delay in processing payment).
 - **Total Billed Amount.** Dollar amount of all submitted claims.
 - **Total Allowed Amount.** The amount DSHS is allowed to pay.
 - **Total Client Resp. Amount.** Amount of client responsibility (CR) that will be deducted from the paid claim. The provider collects CR from the client.
 - **Total Paid:** This is the total amount paid by DSHS (Allowed Amount minus Client Responsibility).
- D. Provider Adjustments.** Provides a summary of claim adjustments initiated during the previous week that resulted in an overpayment. Claims can be adjusted by the provider or DSHS. Next to each adjusted amount, the **Adjustment Type (E)** is listed. The Adjustment Type indicates whether the claim was adjusted as Offset or Non-Offset. See [pages 23-29](#) for more information on adjusted claims including explanations of the most common Social Services Adjustment Reason Codes, Adjustment Types, the difference between Offset and Non-Offset, and an overview of overpayments.

RA Number: 123456789 Warrant/EFT # 555556!							A ↔		Warrant/EFT Date: 1/23/2025 Payment Method: EFT			Prepared Date: 1/24/2025 RA Date: 1/24/2025		
Warrant/EFT Amount: \$14,501.85							B							
Claims Summary							Provider Adjustments							
C							D							
Page 2														
Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total Sales Tax	Total Client Resp Amount	Total Paid	Billing Provider	FIN Invoice Number/ Parent TCN	Source	Adjustment Type E	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount	
200000001	Paid	\$43629.14	\$43629.14	\$0.00	\$29127.29	\$14501.85	200000001	217235190028xx x/ 5517192000 44318000	System Initiated	NOC Invoice	\$0.00	\$0.00	\$799.04	
200000001	Denied	\$81.00	\$0.00	\$0.00	\$0.00	\$0.00	200000001	217235190028xx x/ 5517192000 44318000	System Initiated	NOC Referred CARS	\$799.04	\$799.04	\$0.00	
200000001	Adjustments	\$0.00	\$0.00	\$0.00	\$0.00	-\$799.04								
Total Adjustment Amount: \$799.04														



Section 4: Payment Information

The **Payment Information** section provides a detailed breakdown of the information found in [Section 3: Payment Summary](#). Depending on how many claims were submitted during the claim cycle, the Payment Information section may be multiple pages long. The Payment Information section is divided into claim categories. Within each category, you will find the following information:

- A. Category.** The name of the claim category (i.e., Paid, Denied, Adjustments, or In Process) is listed at the top of each page.
- B. Client Name/Client ID.** The client’s name & ProviderOneID.
- C. TCN/Claim Type/Auth #.** Claim number (also known as the TCN), the type of claim (ADSA-H=HCS or ADSA-D=DDCS), and authorization number.
- D. Line #.** The claim line number is listed here and is for each line or date of service on the claim.
 - If the Service Code Unit Type is ‘Day’ and you entered a date range when submitting your claim, the range is divided into daily service lines.
 - If the Service Code Unit Type is ‘Monthly’, you will see the date range that was entered on the claim.
- E. Rendering Provider/RX#/Auth office #.** Listed here is the DSHS office (reporting unit) that authorized the service.
- F. Service Date(s).** This is the service date the provider or biller entered on the claim in ProviderOne.
- G. Svc Code/Mod & Total Units.** The service code, modifier, and # of units billed for each date of service. In the example below, one unit of service was billed each day for a total of 2 units for the week.
- H. Billed Amount & Allowed Amount.** The amount that was billed on the claim and the amount DSHS is allowed to pay.
- I. TPL Amount & Client Responsible Amount.** If the client has private insurance (TPL) or client participation, these amounts will be listed here.
- J. Paid Amount.** This is the amount DSHS paid towards the claim.
- K. Remark Codes & Adjustment Reason Codes.** A code will be listed here when client participation is deducted or if a claim is denied or adjusted.

RA Number: 123456789		Warrant/EFT #: 555556!		Warrant/EFT Date: 1/23/2025		Prepared Date: 1/24/2025		RA Date: 1/24/2025		Page 3				
A Category: Paid		Billing Provider: 20000001												
Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/ B	TCN / Claim Type / RX Claim # / Inv # / Auth # C	Line # D	Rendering Provider / RX # / Auth office # E	Service Date(s) F	Svc Code or NDC / Mod / Rev & Class Code G	Total Units or D/S G	Billed Amount H	Allowed Amount H	Sales Tax I	TPL Amount I	Client Responsible Amount I	Paid Amount J	Remark Codes K	Adjustment Reason Codes / NCPDP Rejection Codes K
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	1	172	1/16/2025 - 1/16/2025	T1020 U1	1.0000	\$70.85	\$70.85	\$0.00		\$0.00	\$70.85		
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	2	172	1/17/2025 - 1/17/2025	T1020 U1	1.0000	\$70.85	\$70.85	\$0.00		\$0.00	\$70.85		
Document Total: 1/16/2025-1/17/2025						2.0000	\$141.70	\$141.70			\$0.00	\$141.70		

On the next few pages, we take a closer look at each claim category within the Payment Information section. A common mistake made by providers & billers is resubmitting claims that have already paid, or resubmitting denied claims without correcting the claim (which will result in another denial). This can happen when each claim category is not thoroughly reviewed.

RA claim category: Paid

The **Paid** claim category shows claims that paid during the previous week. Depending on how many claims were submitted, the Paid claim category may be multiple pages long and may contain multiple clients and multiple dates of service. **Note:** Some paid claims may also contain denied service lines. These denied lines will be displayed in the Paid claim category section. When reviewing the Paid claim category, confirm the following information is correct for each client:

- A. Service Date(s).** The dates submitted by the provider/biller on the claim. These dates should fall within the client’s authorized date range.
- B. Svc Code or NDC/Mod/Rev & Class Code.** The service code and modifier the provider/biller entered on the claim. This should match the client’s authorization.
- C. Total Units or D/S.** The # of units entered on the claim.
- D. Billed Amount & Allowed Amount.** The amount that was billed on the claim and the amount DSHS is allowed to pay.
- E. Client Responsible Amount.** Client responsibility (participation/room & board) amount. The provider must collect this amount from the client. In the example below, we see the client’s participation is \$125.
- F. Paid amount.** The amount DSHS paid. In the example below, we see the total claim amount for 2/1/25-2/2/25 was \$250. Provider must collect \$125 from the client & DSHS pays the remaining \$125.
- G. Remark Codes, Adjustment Reason Codes/NCPDP Rejection Codes.** If a claim line denies, an Adjustment Reason Code will be listed. A Remark Code may also be listed. You will also see an adjustment code listed if the client has client participation (as we can see below). A description of any Adjustment/Remark Codes can be found on the last page of the RA.

RA Number: 123456789		Warrant/EFT #: 555556!		Warrant/EFT Date: 2/13/2025		Prepared Date: 2/14/2025			RA Date: 2/14/2025					
Category: Paid		Billing Provider: 20000001												
Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
				A		C	D	D			E	F	G	G
BEASLEY, PAM 2000000000WA	5524213003513XX000 ADSA-H 1020000000	1	172	2/1/2025-2/1/2025	T1019	1.0000	\$125.00	\$125.00	\$0.00		\$125.00	\$0.00		142 45 94 = \$125.00
BEASLEY, PAM 2000000000WA	5524213003513XX000 ADSA-H 1020000000	2	172	2/2/2025-2/2/2025	T1019	1.0000	\$125.00	\$125.00	\$0.00		\$0.00	\$125.00	-	-
Document Total: 2/1/2025-2/2/2025						2.0000	\$250.00	\$250.00			\$125.00	\$125.00		

Total amount of this claim

Amount provider must collect from client

Amount DSHS paid



RA claim category: Denied

The **Denied** claim category shows claims that denied during the last payment cycle.

Category: Denied

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	1	172	2/10/2025- 2/10/2025	T1019	1.0000	\$125.00	\$125.00	\$0.00		\$0.00	\$0.00		B13=\$125.00
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	2	172	2/11/2025- 2/11/2025	T1019	1.0000	\$125.00	\$125.00	\$0.00		\$0.00	\$0.00		B13=\$125.00
Document Total: 2/10/2025-2/11/2025						2.0000	\$250.00	\$250.00	\$0.00		\$0.00	\$0.00		

When reviewing denied claims:

- Look for the **Adjustment Reason Codes** and **Remark Codes** in the last two columns. Every denied claim will have an **Adjustment Reason Code/NCPDP Rejection Code**. Some will also have a **Remark Code** for further information.
- A description of the Adjustment Reason Code/Remark Code will be listed on the last page of the RA. Review the description of the codes to determine why the claim(s) denied.
- After reviewing the Adjustment Reason Codes and Remark Codes, determine the denial reason and if the claim can be corrected & resubmitted for processing. See the [Submitting and Adjusting Social Services Claims Guide](#) & [Submitting and Adjusting Social Services Medical Claims Guide](#) for directions on how to fix and resubmit denied claims.
- If you are unable to determine why a claim denied after reviewing the Adjustment/Remark Codes, you may contact HCA's Medical Assistance Customer Service Center (MACSC) at 1-800-562-3022 or [submit an online form](#).





RA claim category: In process

- **In Process** claims are claims that are currently in process (i.e., claims haven't paid yet). **In Process** claims are claims that were submitted by the Tuesday, 5 p.m. deadline but are pending review by HCA claims processing staff and will show up on a future RA as a paid or denied claim.
- Claims submitted after the Tuesday, 5 p.m. deadline will not show on this week's RA but will show up on a future RA as a paid or denied claim.

Category: In process

Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	3	172	2/20/2025- 2/20/2025	T1019	1.0000	\$125.00	\$125.00	\$0.00		\$0.00	\$125.00		
BEASLEY, PAM 200000000WA	5524213003513XX000 ADSA-H 1020000000	4	172	2/21/2025- 2/21/2025	T1019	1.0000	\$125.00	\$125.00	\$0.00		\$0.00	\$125.00		
Document Total: 2/20/2025-2/21/2025						2.0000	\$250.00	\$250.00	\$0.00		\$0.00	\$0.00		

RA claim category: Adjustments

The **Adjustments** category shows previously paid claims that have since been adjusted (claims may be adjusted for a variety of reasons including, but not limited to, the rate or units on an authorization changed after the provider received payment, the provider received payment when they shouldn't have, etc. When adjusting a claim, an overpayment may be generated if the new paid claim amount is less than the original paid claim amount. An overpayment means the provider owes the difference between the paid amounts back to the state.

Category: Adjustments													Every adjusted claim will have an Adjustment Reason Code and possibly a Remark Code listed. Descriptions of the Adjustment Reason Codes/Remark Codes can be found on the last page of the RA. If you are unable to determine why a claim was adjusted after reading the description, contact HCA MACSC .	
Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax				Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
BEASLEY, PAM 2000000000WA	5524213003513XX000 ADSA-H 1020000000	1	172	2/5/2025-2/5/2025	T1019	1.0000	-\$125.00	-\$125.00	\$0.00			\$0.00	-\$125.00	119 = \$0.00
BEASLEY, PAM 2000000000WA	5524213003513XX000 ADSA-H 1020000000	2	172	2/6/2025-2/6/2025	T1019	1.0000	-\$125.00	-\$125.00	\$0.00			\$0.00	-\$125.00	119 = \$0.00
Document Total: 2/5/2025-2/6/2025						2.0000	-\$250.00	-\$250.00				-\$250.00		
													Credit →	
Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
BEASLEY, PAM 2000000000WA	5524213003513XX000 ADSA-H 1020000000	1	172	2/5/2025-2/5/2025	T1019	1.0000	\$125.00	\$125.00	\$0.00		\$0.00	\$0.00		16 = \$0.00
BEASLEY, PAM 2000000000WA	5524213003513XX000 ADSA-H 1020000000	2	172	2/6/2025-2/6/2025	T1019	1.0000	\$125.00	\$125.00	\$0.00		\$0.00	\$0.00		16 = \$0.00
Document Total: 2/5/2025-2/6/2025						2.0000	\$250.00	\$250.00				\$0.00		
													Debit →	

Adjustments utilize basic accounting principles and have two transactions displayed on the RA:

- The **Credit** transaction is a copy of the original claim with the dollar amounts originally paid listed as a negative.
- The **Debit** transaction displays the new billed and allowed amounts as a result of the adjustment, and the associated new paid claim dollar amounts.
- **Although a Credit & Debit transaction are displayed, this does not mean the previously paid amount was taken back by DSHS.** In the example above, we see the provider was originally paid \$250 for dates of service 2/5/25-2/6/25. The provider adjusted their paid claim and removed 2/5/25-2/6/25 after discovering the client was out of the facility and services were not provided on those dates. The new paid amount is \$0. Since the provider did not provide services and should never have received payment for 2/5/25-2/6/25, the provider must pay back the \$250. This means the provider has a \$250 “overpayment”. See [pages 26-29](#) for more information about overpayments.



Adjustment reason codes/NCPDP rejection codes and remark codes

On the last page of your RA, you will see a description of any **Adjustment Reason Codes/NCPDP Rejection Codes** and/or **Remark Codes** listed on the RA:

Adjustment Reason Codes / NCPDP Rejection Codes
16 : Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
18 : Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
284 : Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.
B13 : Previously paid. Payment for this claim/service may have been provided in a previous payment.

Remark Codes
M79 : Missing/incomplete/invalid charge.

Most common adjustment reason codes/remark codes

Below is a list of the most common adjustment reason codes/remark codes you may see on your RA and steps you can take if you see these codes on your RA:

Adjustment Reason Code/Remark Code	Possible Causes	Provider Action
4: The procedure code is inconsistent with the modifier used	Incorrect modifier or no modifier was entered on the claim	Check the client's authorization. If the code is authorized with a modifier, fix the claim to add, correct, or remove the modifier as needed and resubmit the denied claim.
16: Claim/service lacks information or has submissions/billing error(s)	Claimed dates of services are not within the authorized period or authorization line is in error	If you claimed the wrong dates, correct the claim and resubmit. If you think the authorization dates are wrong or if you have questions about the authorization dates, contact the client's case manager. If the auth line is in Error or Canceled status, contact the client's case manager.
18: Exact duplicate claim/service	Claimed the same code, same units, for same client on two different lines for the same day or the claim is an exact duplicate of one already submitted	Adjust the paid claim to report the correct # of units on a single claim line. If billing for T1005 or T1019 and the services were provided by two caregivers, add the SSSOP IDs to each claim line as needed. No action is needed if duplication was unintended and no second payment was received.
129: Prior processing information appears incorrect	This typically posts when a claim has been adjusted	No action needed if you meant to adjust your claim. If you did not mean to adjust your claim or if you have questions on why the claim was adjusted, please contact HCA at 1-800-562-3022.
142: Monthly Medicaid patient liability amount (may be listed as "142 45 94" on RA)	Client responsibility (participation)	You must collect this amount from the client
177: Patient has not met the required eligibility requirements	The client is not financially eligible	Contact the client's case manager



Most common adjustment reason codes/remark codes, *continued*

198: Precertification/authorization exceeded	Authorized units have already been claimed	<ul style="list-style-type: none"> Review past RAs to see if you have already received payment for this client, date of service, & code. You can also look up the claim in ProviderOne to see when you received payment. If you have questions, contact HCA at 1-800-562-3022, or If you think the authorized units are incorrect, contact the client's case manager.
A1: Claim/service denied	The authorization is in Canceled or Error status	Contact the client's case manager
B7: This provider was not certified/eligible to be paid for this procedure/service on this date of service	Your DSHS/AAA contract may be expired	Contact your DSHS/AAA contract specialist
B13: Previously paid. Payment for this claim/service may have been provided in a previous payment.	<ul style="list-style-type: none"> You have already claimed and received payment for this date of service, or For providers with EVV claims: ProviderOne cannot yet distinguish between shifts on the same date of service that are provided by the same caregiver. The claim line(s) denied because the same date of service, same client, same Provider ID, and same SSSOP ID were claimed. 	<ul style="list-style-type: none"> Review past RAs to see when you received payment for this client, date of service & code. You can also look up the claim in ProviderOne to see when you received payment. If you have questions, contact HCA at 1-800-562-3022. For providers with EVV claims: Same day shifts should be combined on one line submission when one caregiver works multiple shifts for a single date of service. Providers may need to adjust a paid claim or modify a denied claim to combine shifts worked by same provider on same day onto one line.
N54: Claim information is inconsistent with pre-certified/authorized services	Authorization line is in error	Contact the client's case manager
N63: Rebill services on separate claim lines	A separate claim line is required for each date of service for the service/procedure code billed.	If you are billing for a code that has a Unit Type '1/4 hour' or 'Each', do not use a date span when entering the claim (Example--From date: 1/1/2025, To date: 1/31/2025). Modify/adjust the claim and enter separate claim lines for each date of service and resubmit the claim. For assistance, contact HCA at 1-800-562-3022.
N345: Date range not valid with units submitted	Dates entered on claim do not match dates that are authorized.	Confirm you billed for dates within the authorization period and correct/resubmit as needed. Contact the client's case manager if you have questions about the authorized dates.
N362: The number of days or units of service exceeds our acceptable maximum	Too many units claimed (Example: Provider claimed 2 units when only authorized for 1 unit).	Modify the claim to change the # of units to the correct amount and resubmit the claim.



Overpayments Overview

Overpayments can occur when a paid claim is voided or adjusted.

Overpayments resulting from voided claims:

- When a claim is voided, it will always generate an overpayment because DSHS has paid out money for a claim that is no longer in paid status.
- You should only void a claim if you shouldn't have received payment. This applies specifically to situations where the entire claim was submitted in error and needs to be completely canceled/voided. If a claim has multiple lines and some of the lines are correct and some are incorrect (i.e., incorrect date billed), instead of voiding the entire claim, you should adjust the claim to remove the incorrect lines.
- When a claim is voided, DSHS does not automatically take the payment back. If you void a claim, you are responsible for reimbursing DSHS (OFR) via a check or via future claims payments in ProviderOne.

Overpayments resulting from adjusted claims:

- When a claim is adjusted, an overpayment may be generated if the new paid amount is less than the original paid amount.
- When a claim is adjusted and an overpayment is generated, DSHS does not automatically take the payment back.
- If you receive an overpayment as a result of an adjustment, you are responsible for reimbursing DSHS (OFR) via a check or via future claims payments in ProviderOne.

Adjustments are processed as either **Non-Offset** or **Offset**, which is explained on the following pages.



Non-Offset adjustments

- This is the default adjustment type for Social Services claims. When a claim is adjusted as **Non-Offset** and the new paid amount is less than the original paid amount, this results in an overpayment. The debt (overpayment) is referred to the Office of Financial Recovery (OFR) for collection. If the provider does not pay the overpayment or does not set up a payment plan in a timely manner, the debt will be referred to HCA/ProviderOne and future claim payments will be used to satisfy the debt.
- When an overpayment is referred to OFR, the provider receives a Vendor Overpayment Notice via U.S. mail which provides the overpayment amount, payment instructions, as well as information on how to request an administrative hearing if the provider disagrees with the overpayment.
 - The notice will list the TCN (claim #) that was adjusted/voided and there will be a reason code on the notice along with a brief description as to why the claim was adjusted or voided.
 - Providers should also review their remittance advice (RA) associated with the adjustment to see the specific day(s) or service line(s) that were adjusted. The RA will be generated and available in ProviderOne on the Friday before the week the overpayment notice is generated.
- When a claim is adjusted as non-offset and if it results in an overpayment, providers will see **NOC Referred to CARS** and **NOC Invoice** on the Provider Adjustments section (page 2) of the RA.
- In the example below, we see **NOC Invoice & NOC Referred to CARS** in the amount of \$799.04. This means you were overpaid \$799.04 and the overpayment has been referred to OFR:

RA Number: 123456789		Warrant/EFT # 555556!		Warrant/EFT Date: 1/23/2025		Prepared Date: 1/24/2025							
				Payment Method: EFT		RA Date: 1/24/2025							
Warrant/EFT Amount:													
\$14,501.85													
Claims Summary							Page 2						
Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total Sales Tax	Total Client Resp Amount	Total Paid	Billing Provider	FIN Invoice Number/ Parent TCN	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
200000001	Paid	\$43629.14	\$43629.14	\$0.00	\$29127.29	\$14501.85	200000001	217235190028xx x/ 5517192000 44318000	System Initiated	NOC Invoice	\$0.00	\$0.00	\$799.04
200000001	Denied	\$81.00	\$0.00	\$0.00	\$0.00	\$0.00	200000001	217235190028xx x/ 5517192000 44318000	System Initiated	NOC Referred CARS	\$799.04	\$799.04	\$0.00
200000001	Adjustments	\$0.00	\$0.00	\$0.00	\$0.00	-\$799.04							
							Total Adjustment Amount: \$799.04						

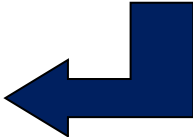
Note: If a claim was adjusted as non-offset and referred to OFR but you want to pay the debt using future claim payments, you can contact OFR to request that offset be turned on for the invoice. When contacting OFR, you will need to provide them with your name, 9-digit ProviderOne ID (7-digit Domain # + 2-digit Location Code), and the Invoice # which can be found on the OFR Vendor Overpayment Notice.

Offset adjustments

- When a claim is adjusted as **Offset** and it results in an overpayment, the overpayment is not referred to OFR, providers will not receive a Vendor Overpayment Notice and will not have administrative hearing rights to dispute the overpayment.
- With this adjustment type, the overpayment amount is deducted from future claim payments in ProviderOne within a 6-month window. After 6 months, if the debt is not satisfied, any remaining balance will be sent to OFR for collection.
- To adjust a claim as offset, providers must contact HCA at 1-800-562-3022 or [online](#) prior to adjusting the claim. Providers must include the claim # (TCN) that needs to be adjusted. HCA will adjust the claim as offset as long as the dates of service on the claim are within the current biennium.
- When a claim is adjusted as offset and it results in an overpayment, providers will see this as a **P1OFF Invoice** on the **Provider Adjustments** section (Page 2) of the RA.
- In the example below, we see claims in the amount of \$24,757.80 were adjusted as offset (as indicated by **P1OFF Invoice**):

Page 2

Provider Adjustments							
Total Paid	Billing Provider	FIN Invoice Number/ Parent TCN	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
		3/0019	System Initiated	P1OFF Invoice	\$3648.27	\$0.00	\$3648.27
		3/0033	System Initiated	P1OFF Invoice	\$3620.47	\$0.00	\$3620.47
		3/0010	System Initiated	P1OFF Invoice	\$3648.27	\$0.00	\$3648.27
		5/0023	System Initiated	P1OFF Invoice	\$3088.04	\$0.00	\$3088.04
		5/0033	System Initiated	P1OFF Invoice	\$3648.27	\$0.00	\$3648.27
		4/0017	System Initiated	P1OFF Invoice	\$3456.30	\$0.00	\$3456.30
		3/0393	System Initiated	P1OFF Invoice	\$3648.27	\$0.00	\$3648.27
Total Adjustment Amount: \$24,757.80							



- Providers can track offset claim payments on the **Provider Adjustment** section (page 2) of the RA. Payments applied to the overpayment will show as **P1OFF Recoupment**. In the example to the right, we can see that claim payments in the amount of \$5036.56 (\$1856.01 + 1459.49 + \$1721.06) went towards the overpayment.

Billing Provider	FIN Invoice Number/ Parent TCN	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
		System Initiated	P1OFF Recoupment	\$1856.01	\$1856.01	\$0.00
		System Initiated	P1OFF Recoupment	\$1459.49	\$1459.49	\$0.00
		System Initiated	P1OFF Recoupment	\$1721.06	\$1721.06	\$0.00



Most common adjustment types on the RA

The most common adjustment types seen on Social Services RAs are listed below. A list of all claim adjustment types and additional information about adjustments and RAs can be found in [HCA's ProviderOne Billing & Resource Guide](#).

Adjustment Type	Definition
NOC Referred to CARS	This occurs when a voided claim or an adjusted claim resulted in a non-offset overpayment and the overpayment has been referred to the Office of Financial Recovery's (OFR) Collection and Accounts Receivable System (CARS) for recovery. An overpayment means you were paid too much and you now owe this money back to the state (DSHS).
NOC Invoice	This posts together with a "NOC Referred to CARS" line. This means that the overpayment was referred to OFR and an invoice was created. OFR mails the invoice to you informing you how much you owe.
P1OFF Invoice	This occurs when you owe DSHS due to adjustments exceeding payments. In these cases, DSHS creates an account receivable which is satisfied by either: <ul style="list-style-type: none"> • Taking payment from a future paid claim, or • Through a receivable sent to OFR to initiate the recovery. <p>The latter only happens if the P1OFF is not satisfied after six months.</p>
P1OFF Recoupment	This identifies the payments used to satisfy the P1OFF receivable. This typically posts immediately following a P1OFF Invoice line.
COFF Invoice	OFR creates a CARS Offset Invoice in OFIN for each request sent to ProviderOne from CARS. Direct all questions about COFF offsets to OFR at 1-800-562-6114.
COFF Recoupment	OFR accepts a receivable to collect, and OFR sends back a request to take other payments for paid claims from you to satisfy the receivable. There should be other paid claims on the RA, and some of those payments go to OFR to help satisfy the debt.
COFF Referred to CARS	ProviderOne tried to recover a dollar amount you owed DSHS but did not have a sufficient total of claim payments post in the last six months to satisfy the debt. The balance owed is sent to OFR for collection.

Additional Resources

Visit the [ProviderOne for Social Services webpage](#) for more resources including:

- Additional ProviderOne for Social Services Billing Guides:
 - [Getting Started and Billing Essentials](#) (ProviderOne basics & viewing the Authorization List)
 - [Submitting and Adjusting Social Services Claims](#)
 - [Submitting and Adjusting Social Services Medical Claims](#)
- [ProviderOne Basics webinar](#)
- [Updates and newsletters](#)
- [Contact information](#)
- [FAQ: ProviderOne Setup and Payment Information for New Providers](#)
- [FAQ: ProviderOne for Social Services Providers](#) (general questions for all providers)
- [How to turn off pop-up blockers](#) (to access ProviderOne)
- [Sign up](#) for ProviderOne for Social Services Newsletters & Bulletins



Revision History

Date	Change(s)	Reason for Change(s)	Provider Communication
6/11/2025	Replaced <i>Claim Status Inquiry & View RA Guide</i> with <i>Viewing Claim Status and Payments Guide</i> .	To replace outdated information & screenshots	<ul style="list-style-type: none"> 4/2025: ProviderOne for Social Services Monthly Newsletter 5/2025: Monthly Newsletter 6/11/2025: GovDelivery Notification 6/2025: Monthly Newsletter
7/17/2025	Added hyperlinks to table of contents & throughout the guide.	Accessibility & to improve usability	7/2025: Monthly Newsletter
1/1/2026	Updated page numbers, Table of Contents, headers/footers, font and hyperlinks throughout guide. Added DSHS & HCA logo to cover page.	Accessibility, readability, and to ensure consistency throughout guide	1/2026: Monthly Newsletter
	Updated Contact Information : Removed ProviderEnrollment@hca.wa.gov email & replaced with link to HCA Support Portal.	ProviderEnrollment@hca.wa.gov inbox no longer active effective 1/1/2026.	
	<ul style="list-style-type: none"> Removed 'Pay Periods' page from <i>Getting Started & Billing Essentials Guide</i> & added to <i>Viewing Claim Status and Payments Guide</i> (renamed to 'Claim submission deadlines and pay dates'). Clarified that providers must submit claims in ProviderOne within 12 months from date of service. 	<ul style="list-style-type: none"> Information is more relevant for <i>Viewing Claim Status and Payments Guide</i> Clarification 	
	Renamed and reorganized sections within the guide and clarified language on how to view, download, and understand each section of the RA .	Accessibility & to improve usability	