

User Guide

ForwardHealth Provider Portal Institutional Claims

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WISCONSIN DEPARTMENT
of HEALTH SERVICES

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1 Introduction

Providers may submit institutional claims directly to ForwardHealth using Direct Data Entry, an online application, available through their secure provider account on the ForwardHealth Portal (the Portal). Using the institutional claim form, providers may submit several types of claims, including inpatient, outpatient, home health, hospice, and long-term care. This user guide provides general instructions for completing an institutional claim through the Portal. For detailed instructions, refer to the UB-04 Claim Form completion instructions in the applicable service area of the [ForwardHealth Online Handbook](#).

2 Access the Claims Page

1. Access the Portal at forwardhealth.wi.gov/.

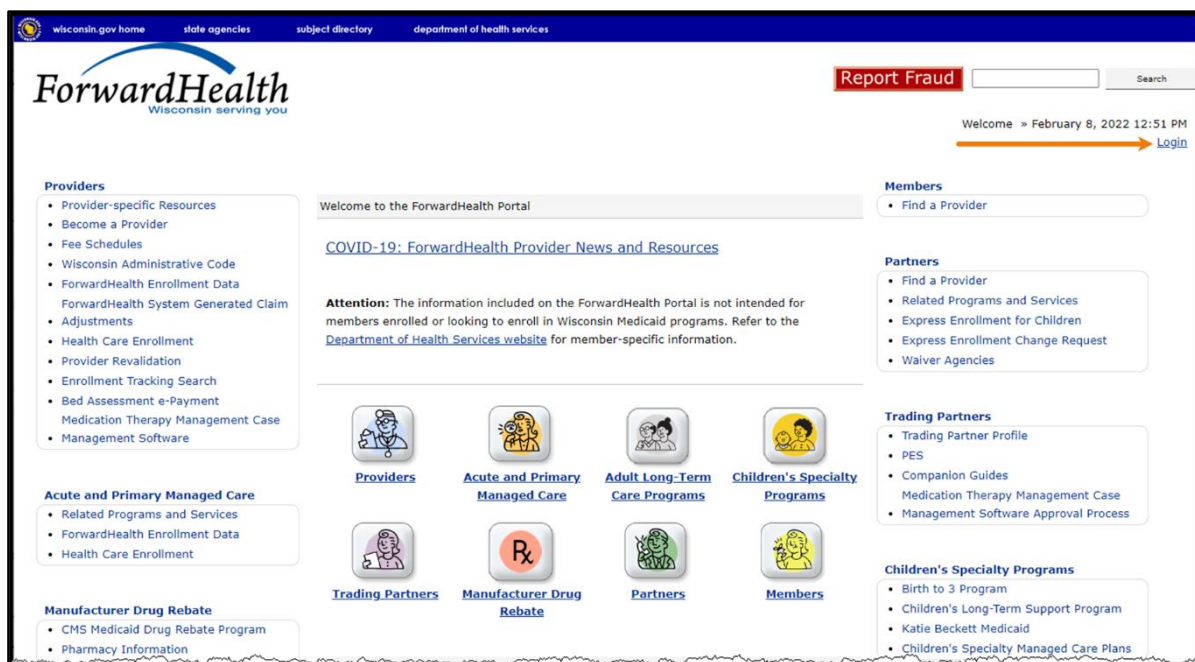
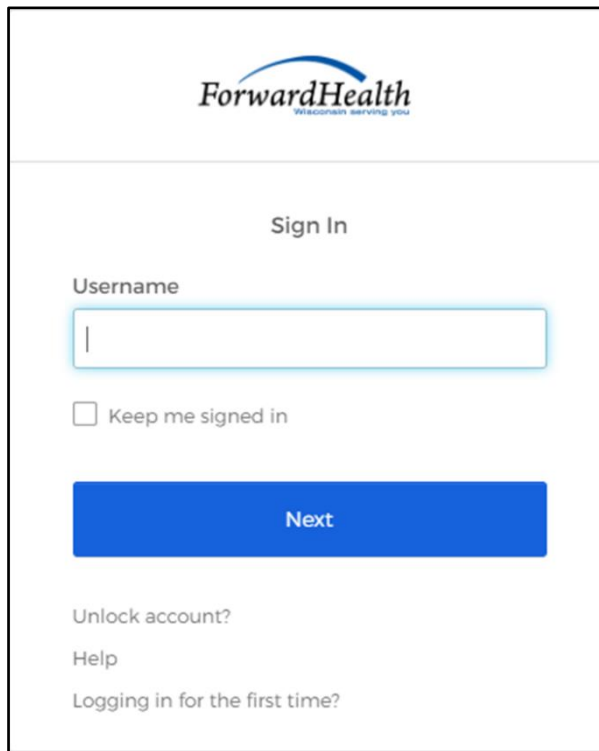


Figure 1 ForwardHealth Portal Homepage

2. Click **Login**. A Sign In box will be displayed.

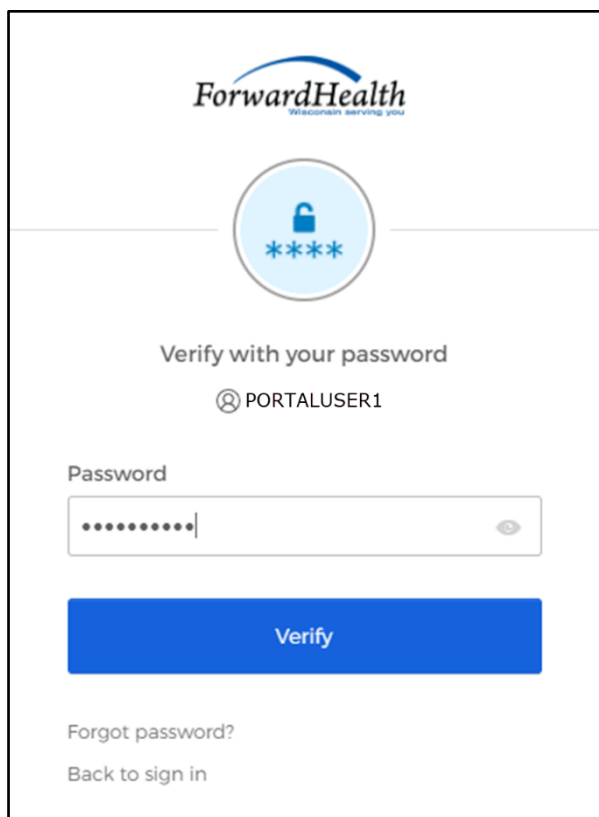


The image shows a 'Sign In' box for ForwardHealth. At the top is the ForwardHealth logo with the tagline 'Wisconsin serving you'. Below the logo is the title 'Sign In'. Underneath is a 'Username' label followed by a text input field. Below the input field is a checkbox labeled 'Keep me signed in'. A large blue button labeled 'Next' is positioned below the checkbox. At the bottom of the box are three links: 'Unlock account?', 'Help', and 'Logging in for the first time?'.

Figure 2 Sign In Box

3. Enter the user's username.

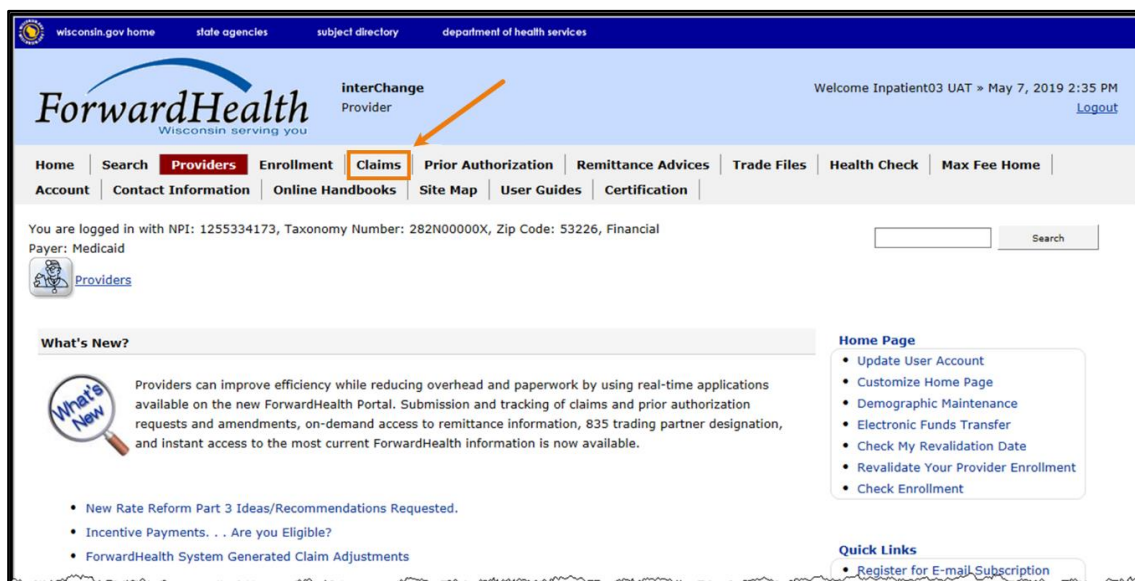
- Click **Next**. A Verify with your password box will be displayed.



The screenshot shows the ForwardHealth login verification page. At the top is the ForwardHealth logo with the tagline 'Wisconsin serving you'. Below the logo is a circular icon containing a blue padlock and four asterisks. The text 'Verify with your password' is centered, followed by the username 'PORTALUSER1' with a user icon. There is a 'Password' label above a text input field that contains eight dots. To the right of the input field is an eye icon for toggling visibility. Below the input field is a large blue button labeled 'Verify'. At the bottom left, there are two links: 'Forgot password?' and 'Back to sign in'.

Figure 3 Verify With Your Password Box

- Enter the user's password.
- Click **Verify**. The secure Provider page will be displayed.



The screenshot shows the ForwardHealth Secure Provider Page. The top navigation bar includes links for 'wisconsin.gov home', 'state agencies', 'subject directory', and 'department of health services'. The ForwardHealth logo is on the left, and the text 'interChange Provider' is on the right. A welcome message 'Welcome Inpatient03 UAT » May 7, 2019 2:35 PM' and a 'Logout' link are in the top right. A main navigation menu includes 'Home', 'Search', 'Providers', 'Enrollment', 'Claims' (highlighted with an orange box and an arrow), 'Prior Authorization', 'Remittance Advices', 'Trade Files', 'Health Check', and 'Max Fee Home'. Below this is a secondary menu with 'Account', 'Contact Information', 'Online Handbooks', 'Site Map', 'User Guides', and 'Certification'. A login status message reads: 'You are logged in with NPI: 1255334173, Taxonomy Number: 282N00000X, Zip Code: 53226, Financial Payer: Medicaid'. There is a 'Providers' link with a user icon and a search bar. The 'What's New?' section features a 'What's New' icon and text about real-time applications. The 'Home Page' section lists links: 'Update User Account', 'Customize Home Page', 'Demographic Maintenance', 'Electronic Funds Transfer', 'Check My Revalidation Date', 'Revalidate Your Provider Enrollment', and 'Check Enrollment'. The 'Quick Links' section includes 'Register for E-mail Subscription'.

Figure 4 Secure Provider Page

- Click **Claims** on the main menu at the top of the page. The Claims page will be displayed.

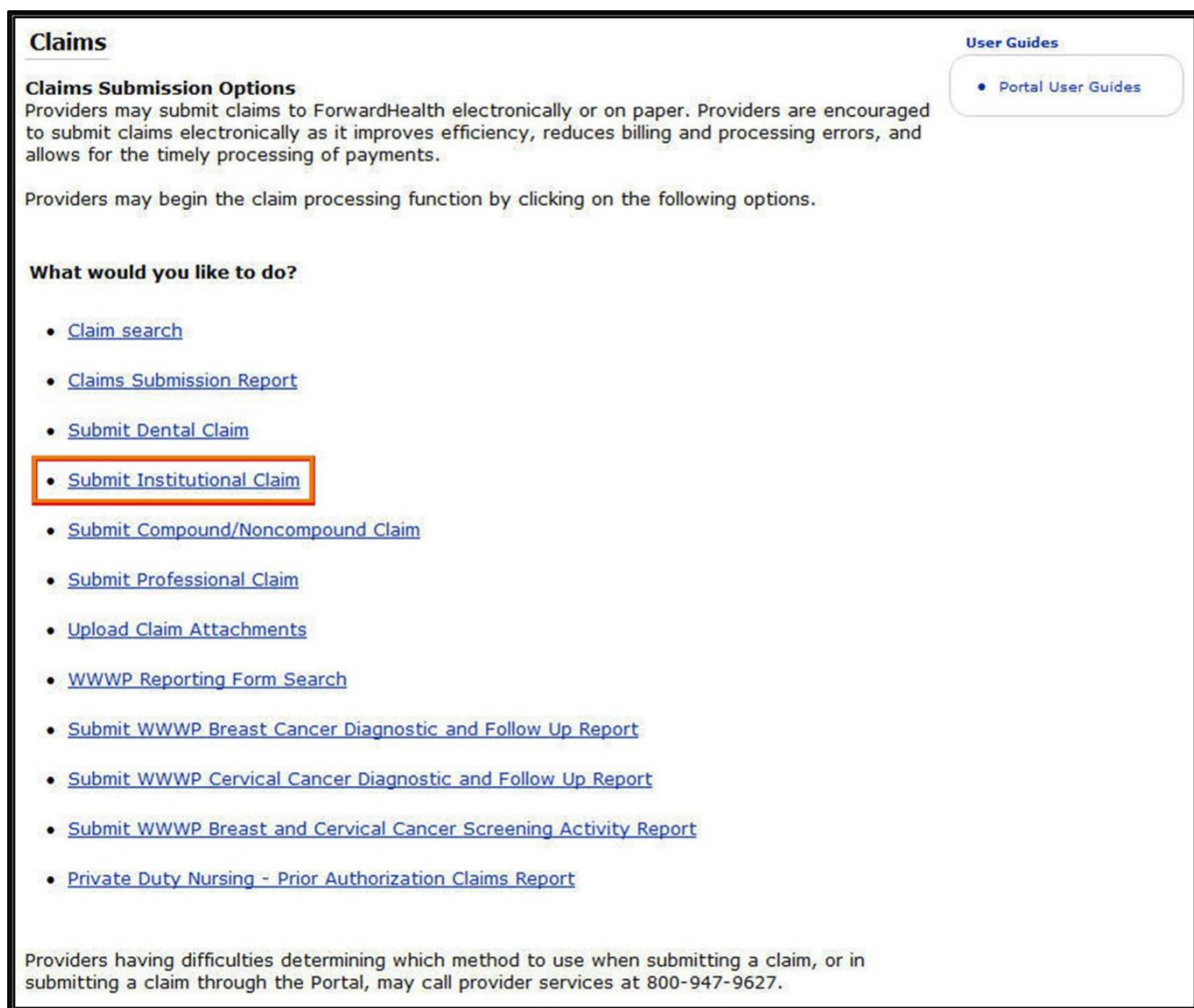


Figure 5 Claims Page

All claim type submission options are available from this page.

Children's Long-Term Support Program (CLTS) providers will see the following options on their Claims page.

- Claim search
- Claims Submission Report
- Submit Institutional Claim
- Submit Professional Claim
- Upload Claim Attachments
- Create a Claim From Prior Authorization (PA)

3 Submit an Institutional Claim

1. Click **Submit Institutional Claim** in the “What would you like do?” section on the Claims page. The Institutional Claim form will be displayed.

Next Search By: ICN

Message Description
ICN not found.

Institutional Claim

Required fields are indicated with an asterisk (*).

ICN

Provider ID 1234567890 NPI

Member ID*

Last Name

First Name, MI

Date of Birth

Patient Account #

Medical Record #

Attending Provider*

Rendering Provider [Search]

Referring Provider [Search]

Other Provider

Notes

Type Of Bill* [Search]

From Date of Service*

To Date of Service*

Patient Status* [Search]

Point of Origin* [Search]

Admission Date

Priority* [Search]

Admission Diagnosis Code [Search]

Covered Days 0

Non Covered Days 0

Medicare Disclaimer no disclaimer

Other Insurance Indicator

Referral Number

Total Charge* \$0.00

Net Difference

PA Number*

[Diagnosis](#) [Condition](#) [Medicare](#) [Payer](#) [Procedure](#) [Occurrence/Scan](#) [Value](#) [Patient Reason for Visit](#) [External Cause of Morbidity](#) [Other Insurance](#)

Detail

Line Number	Revenue Code	HIPPS Code	Rendering Provider	Referring Provider	Procedure Code	Units	Charge	Status	Allowed Amount
A 1						0	\$0.00		\$0.00

Type data below for new record.

Line Number 1

Revenue Code [Search]

From Date of Service*

HIPPS Code [Search]

To Date of Service*

Rendering Provider [Search]

Procedure Code [Search]

Referring Provider [Search]

Modifiers [Search]

Units* 0

Charge \$0.00

Status

Allowed Amount \$0.00

Professional Service Description

[NDCs for JCode](#)

Medicare Information(Detail)

Line Number 1

Deductible Amount \$0.00 +

Medicare Paid Date

Coinurance Amount \$0.00 +

Medicare Paid Amount \$0.00

Blood Deductible Amount \$0.00 +

Medicare Non Covered Charged \$0.00

Copayment Amount \$0.00 +

Remaining Patient Liability \$0.00 =

Attachments

*** No rows found ***

Select row above to update -or- click Add button below.

Attachment Control Number

Description

Claim Status Information

Claim Status Not submitted yet

Figure 6 Institutional Claim Form

3.1 Institutional Claim Panel

Users may enter a claim's header information on the Institutional Claim panel.

Note: Fields marked with an asterisk (*) are required fields. Certain fields may not apply to the user's claim type or program. CLTS providers can contact the CLTS operations team at 844-942-5870 for any questions about their program requirements.

Institutional Claim

Required fields are indicated with an asterisk (*).

ICN <input type="text"/>	Type Of Bill* <input type="text"/> [Search]
Provider ID <input type="text"/> 1234567890 NPI	From Date of Service* <input type="text"/>
Member ID* <input type="text"/>	To Date of Service* <input type="text"/>
Last Name <input type="text"/>	Patient Status* <input type="text"/> [Search]
First Name, MI <input type="text"/>	Point of Origin* <input type="text"/> [Search]
Date of Birth <input type="text"/>	Admission Date <input type="text"/>
Patient Account # <input type="text"/>	Priority* <input type="text"/> [Search]
Medical Record # <input type="text"/>	Admission Diagnosis Code <input type="text"/> [Search]
Attending Provider* <input type="text"/>	Covered Days <input type="text"/> 0
Rendering Provider <input type="text"/> [Search]	Non Covered Days <input type="text"/> 0
Referring Provider <input type="text"/> [Search]	Medicare Disclaimer <input type="text"/> no disclaimer ▼
Other Provider <input type="text"/>	Other Insurance Indicator <input type="text"/>
Notes <input type="text"/>	Referral Number <input type="text"/>
	Total Charge* <input type="text"/> \$0.00
	Net Difference <input type="text"/>
	PA Number* <input type="text"/>

[Diagnosis](#) [Condition](#) [Medicare](#) [Payer](#) [Procedure](#) [Occurrence/Span](#) [Value](#) [Patient Reason for Visit](#) [External Cause of Morbidity](#) [Other Insurance](#)

Figure 7 Institutional Claim Panel

Information cannot be entered in the ICN field. ForwardHealth will automatically assign an internal control number (ICN) when the claim is submitted.

The National Provider Identifier (NPI) under which the user is logged in will populate the Provider ID field for all providers except hospitals and non-healthcare providers. For non-healthcare providers, the Provider ID field will be populated with their Medicaid ID.

For users logged in with a hospital account, this field will have a drop-down menu containing the hospital's main NPI and any sub-part NPIs assigned to that hospital.

From the Provider ID drop-down menu, select the NPI to be indicated on the claim being submitted.

Institutional Claim

Required fields are indicated with an asterisk (*).

ICN

Provider ID 1234567890 NPI

Member ID* 1234567890 NPI

Last Name 0987654321 SUB

First Name, MI

Date of Birth

Type Of Bill*

From Date of Service*

To Date of Service*

Patient Status*

Point of Origin*

Click arrow to select sub-part NPI

Figure 8 Provider ID Drop-Down Menu for Hospital Accounts

1. Enter the member ID number in the Member ID field.

Note: After entering the member ID, click anywhere on the gray area of the form. The Last Name, First Name, MI, and Date of Birth fields will populate with the member's information.

2. Enter the provider's internal number assigned to the patient's account in the Patient Account # field.
3. Enter the provider-assigned medical record number for the service(s) being processed in this claim in the Medical Record # field.
4. Enter the NPI or Medicaid ID of the attending provider in the Attending Provider field. Personal care providers should enter the Medicaid ID of the personal care agency.
5. Enter the NPI or Medicaid ID of any provider who performed services in the Rendering Provider field.
6. Enter the NPI or Medicaid ID of the provider, or providers, who referred the member for services in the Referring Provider field if applicable. Users may enter an NPI or Medicaid ID in the field, or search for the NPI or Medicaid ID using the adjoining Search link.
7. Enter the NPI or Medicaid ID of any other provider who was in attendance during a service that was performed or provided prior to the member being admitted to the institution in the Other Provider field.

Note: If a field exists at both the header and detail level, enter the information in one or the other but not necessarily both. The header will apply automatically to all details. Enter information at the detail only if different than the header value for these details.

8. Enter a brief description in the Notes field if additional information is needed to substantiate the medical treatment indicated if the information is not supported elsewhere on the claim form.
9. Enter the three-digit type of bill code, without the leading zero, in the Type of Bill field or search for the code.

- a. Click **Search** to the right of the Type of Bill field. The Type of Bill search panel will be displayed.

Type Of Bill [Close]

Search ?

Type of Bill Description

search clear

Search Results

*** No rows found ***

Figure 9 Type of Bill Search Panel

- b. Enter a description of the type of bill code:
- If the entire description is unknown, enter a key word or partial description.
 - When entering a partial description, use the percent symbol (%) as a wildcard search character on either side of a word or group of words to display all codes containing that word.
- c. Click **Search**. The “Search Results” section of the panel will be displayed.

Note: If a “No rows found” message is displayed, the user may need to correct inaccurate information and search again.

Type Of Bill [Close]

Search ?

Type of Bill Description

search clear

Search Results

Type of Bill ▲	Description
110	Hospital
111	Hospital
112	Hospital
113	Hospital
114	Hospital
115	Hospital
116	Hospital
117	Hospital
118	Hospital
119	Hospital

1 2 3 4 5 6 7 8 9 10 ... Next >

Figure 10 Type of Bill Search Results Panel

- d. Click the applicable code. The Type of Bill search panel will close, and the selected code will populate the Type of Bill field on the Institutional Claim form.

Note: The same procedure can be used with other search links on the claim form.

10. Enter the date when services began in the From Date of Service field.

11. Enter the date when services ended or will end in the To Date of Service field.
12. Enter the patient status in the Patient Status field or search for a status using the Search link to the right of the field.
13. Enter a code indicating the source of the admission in the Point of Origin field or search for a code using the Search link to the right of the field.
14. Enter the date the member was admitted to a facility for treatment in the Admission Date field.
15. Enter a code indicating the priority of the admission for inpatient or outpatient care in the Priority field or search for a code using the Search link to the right of the field.
16. Enter a valid admission diagnosis code from the International Classification of Diseases (ICD) coding structure in the Admission Diagnosis Code field or search for a code using the Search link to the right of the field.

Note: The Admission Diagnosis Code field should only be used for claims in which the member was admitted to a facility. For specific requirements based on the provider type, refer to the [Online Handbook](#). For a member in a non-admission situation, enter a primary diagnosis code on the [Diagnosis Panel](#).

17. Enter the number of treatment days covered by the primary payer for the dates of service (DOS) indicated on the claim in the Covered Days field.
18. Enter the number of treatment days not covered by the primary payer for the DOS indicated on the claim in the Non Covered Days field.
19. Select a Medicare disclaimer status from the Medicare Disclaimer drop-down menu for traditional Medicare Part A, traditional Medicare Part B, or Medicare Advantage payers. The only valid options include the following:
 - **No Disclaimer**—No disclaimer exists.
 - **7 Mcare disallowed/denied pymt**—Medicare has disallowed or denied the payment according to Medicare rules. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted.
 - **8 Noncovered Mcare srv**—The service provided to the member was not billed to Medicare because the service is not covered under certain circumstances.

Note: The Medicare Disclaimer field should be used to indicate a claim by a Medicare provider for a member with Medicare coverage that the provider wishes to have processed as if it were a primary claim by ForwardHealth, that is, not secondary to Medicare. If a Medicare disclaimer is used, no information should be entered in the Medicare Information (Header) or the Medicare Information (Detail) panels.

20. The Other Insurance Indicator drop-down menu is no longer used on claims submitted on and after June 14, 2014, but remains on this panel for viewing claims submitted before June

14, 2014. Providers are required to use the Other Insurance Header, Detail, and EOB Information panels to report other insurance (OI) information.

21. Enter the referral number in the Referral Number field. The referral number is a unique identifier that can be used to locate the records of a submitted claim.
22. Enter the total charge for the service(s) being provided to the member in the Total Charge field.
23. The Net Difference is the paid amount differences between the original ICN and adjustment ICN. This amount is displayed after an adjustment is processed to completion (paid/deny) for an ICN.
24. Enter the PA number in the PA Number field.

Note: The PA Number field will only be displayed for CLTS providers.

3.1.1 Diagnosis Panel

1. Click **Diagnosis** at the bottom of the Institutional Claim panel.

The screenshot displays the 'Professional Claim' form. At the top, it states 'Required fields are indicated with an asterisk (*)'. The form is divided into two columns of input fields. The left column includes fields for ICN, Provider ID (with the value '1234567890 NPI'), Member ID*, Last Name, First Name, MI, Date of Birth, Patient Account #, Medical Record Number, and SOI Date. The right column includes fields for Rendering Provider, Referring Provider 1, Referring Provider 2, Medicare Disclaimer (set to 'no disclaimer'), Other Insurance Indicator, Referral Number, Total Charge* (set to '\$0.00'), Other Insurance Amount (set to '\$0.00'), Total Amount Paid (set to '\$0.00'), Net Difference, and PA Number*. At the bottom of the form, there is a navigation bar with five links: 'Diagnosis', 'Condition', 'Medicare', 'Anesthesia', and 'Other Insurance'. A red arrow points to the 'Diagnosis' link, which is highlighted with a red box.

Figure 11 Diagnosis Link

The Diagnosis panel will be displayed.

Figure 12 Diagnosis Panel

If a code is entered in the Admission Diagnosis Code field on the Institutional Claim panel, the Admit Diagnosis field will be populated with that code.

2. Enter a diagnosis code from the ICD coding structure in the Diagnosis 1 field or search for a code using the Search link to the right of the field.

Note: Do not use a decimal point when entering a diagnosis code. For example, for ICD diagnosis code 041.00, enter 04100.

For more information about covered services and reimbursement, refer to the Covered and Noncovered Services section of the [Online Handbook](#).

To search for a diagnosis code, complete the following steps:

- a. Click **Search** to the right of the applicable Diagnosis field. The Diagnosis search panel will be displayed.

Figure 13 Diagnosis Search Panel

- b. Enter a description of the code:
 - If the entire description is unknown, enter a key word or partial description.
 - When entering a partial description, use the percent symbol (%) as a wildcard search character on either side of a word to display all codes containing that word.

- c. Click **Search**. Any diagnosis codes matching the query will be displayed in the “Search Results” section of the panel.

Diagnosis	ICD Version	Description
7806	ICD-9	FEVER
78060	ICD-9	FEVER UNSPECIFIED
78061	ICD-9	FEVER IN OTHER CONDITION
R50	ICD-10	FEVER OF OTHER AND UNKNOWN ORIGIN
R5081	ICD-10	FEVER PRESENTING WITH CONDITIONS CLASSIFIED ELSEWHERE
R509	ICD-10	FEVER, UNSPECIFIED

Figure 14 Diagnosis Search Results Panel

- d. Click the applicable diagnosis code. The Diagnosis search panel will close, and the selected code will populate the Diagnosis field.

Figure 15 Diagnosis Code Added to the Claim Form

3. Add additional diagnosis codes to the claim, if necessary. To delete a diagnosis code, erase the entry.
4. A POA indicator is required for inpatient claims when the provider or diagnosis code is not exempt from collection of present on admission (POA) information. Select one of the following POA indicators from the drop-down menu:

Figure 16 POA Code Indicator

- **Y—Yes/Present**—Indicates the diagnosis was present at the time of inpatient admission.
- **N—No**—Indicates the diagnosis was not present at the time of inpatient admission.
- **W—Not Applicable**—Indicates the provider is unable to clinically determine whether the condition was present at the time of inpatient admission.

- **U—Unknown**—Indicates the documentation is insufficient to determine if the condition was present at the time of inpatient admission.

3.1.2 Condition Panel

Through the Condition panel, users can enter a code(s) identifying a condition related to this claim, if applicable. For more information, refer to the UB-04 Billing Manual available through the National Uniform Billing Committee website at www.nubc.org/.

1. Click **Condition** at the bottom of the Institutional Claim panel. The Condition panel will be displayed.

Figure 17 Condition Panel

2. Click **Add**. A row will be added to the Condition panel, and the Condition Code field will activate.

Figure 18 Condition Panel With Added Row

ForwardHealth will assign a sequence number (in numerical order) to the row. Clicking the added row will activate the Sequence field; however, the sequence number must be in numerical order (that is, 1 for the first added row, 2 for the second added row).

3. Enter the code that identifies conditions relating to the claim that may affect processing in the Condition field.

To search for a code, complete the following steps:

- a. Click **Search** to the right of the field. The Condition Code search panel will be displayed.

Figure 19 Condition Code Search Panel

- b. Enter a description of the code:

- If the entire description is unknown, enter a key word or partial description.
 - When entering a partial description, use the percent symbol (%) as a wildcard search character on either side of a word or group of words to display all codes containing that word.
- c. Click **Search**. Any codes matching the query will be displayed in the “Search Results” section of the panel.

Condition	Description
03	Patient Covered by Insurance Not Reflected Here
06	ESRD Patient in First 30 months of Entitlement Covered by Employer Group Health Insurance
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage

Figure 20 Condition Code Search Results Panel

- d. Click the applicable code. The Condition Code search panel will close, and the selected code will populate the Condition field. The code information will also populate the added row.

Sequence	ConditionCode	Description
A 1	03	Patient Covered by Insurance Not Reflected Here

Type data below for new record.

Sequence ConditionCode [Search]

Delete Add

Figure 21 Conditions Panel With Added Information

To add additional condition codes to the claim, click **Add** and either enter the code in the Condition Code field or search for a code using the Search link to the right of the field.

To remove a row, select the desired row and click **Delete**. A dialog panel will be displayed. Click **OK** to delete the specified row.

3.1.3 Medicare Information (Header) Panel

On the Medicare Information panels (Header and Detail), users can report Medicare (or Medicare Advantage Plan) payment and adjustment information, which allows ForwardHealth to process a Medicare secondary claim.

Note: If Medicare does not cover the entire claim, do not use the Medicare Information (Header) and/or Medicare Information (Detail) panels. Return to [Step 19 of 3.1 Institutional Claim Panel](#) to select the appropriate Medicare disclaimer code.

1. Click **Medicare** at the bottom of the Institutional Claim panel. The Medicare Information (Header) panel will be displayed.

Medicare Information(Header)			
Medicare Paid Date	<input type="text"/>	Deductible Amount	<input type="text" value="\$0.00"/> +
Medicare Paid Amount	<input type="text" value="\$0.00"/>	Coinsurance Amount	<input type="text" value="\$0.00"/> +
Medicare Non Covered Charged	<input type="text" value="\$0.00"/>	Blood Deductible Amount	<input type="text" value="\$0.00"/> +
		Copayment Amount	<input type="text" value="\$0.00"/> +
		Remaining Patient Liability	<input type="text" value="\$0.00"/> =

Figure 22 Medicare Information (Header) Panel

2. Enter the date that Medicare paid the claim in the Medicare Paid Date field.
 3. Enter the amount Medicare paid for the claim in the Medicare Paid Amount field.
- Note: The Medicare paid amount on the Medicare Information (Header) panel should be a sum of the paid amounts on the Medicare Information (Detail) panel. The paid amounts must be entered on both panels or the claim will not pay correctly.
4. Enter the amount of the claim not allowed by Medicare in the Medicare Non Covered Charge field. (The noncovered amount on the Medicare Information [Header] panel is the difference between the claim's total charge amount on the Institutional Claim panel and the Medicare paid amount on the Medicare Information [Header] panel.)
 5. Enter the amount that the member is required to pay before Medicare begins to pay in the Deductible Amount field.
 6. Enter the coinsurance amount (percentage of the Medicare payment) that the member is required to pay after payment of the deductible in the Coinsurance Amount field.
 7. Enter the dollar amount that Medicare has determined that a member is required to pay for blood work in the Blood Deductible Amount field.
 8. Enter the copayment amount (percentage of the Medicare payment) that the member is required to pay after payment of the deductible in the Copayment Amount field.
 9. Enter the remaining patient liability amount in the Remaining Patient Liability field. Remaining patient liability must equal the sum of the deductible amount, coinsurance amount, blood deductible amount, and copayment amount.

3.1.4 Payer Panel

Only other commercial health insurance information should be entered on the Payer panel.

1. Click **Payer** at the bottom of the Institutional Claim panel. The Payer panel will be displayed.

Payer

*** No rows found ***

Select row above to update -or- click Add button below.

Sequence

Prior Payment Payer

Figure 23 Payer Panel

2. Click **Add**. A row will be added to the Payer panel, and the fields will activate.

Payer

Sequence	Payer	Prior Payment
A	0	\$0.00

Type data below for new record.

Sequence*

Prior Payment Payer*

Figure 24 Payer Panel With Added Row

3. The Sequence field gives numerical order to the OI information. Enter a **1** for the first added row. If multiple commercial insurance companies paid on the claim, enter numbers in numerical order for each row added.
4. Enter the amount received from the payer prior to this billing in the Prior Payment field.
5. Select **Other** from the Payer drop-down menu.
6. To add additional payers to the claim, click **Add** and enter applicable information.
7. To remove a payer, select the desired row and click **Delete**. A dialog box will be displayed. Click **OK** to delete the specified row.

3.1.5 Procedure Panel

On the Procedure panel, users can report ICD procedure codes.

Note: To add a Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) procedure code, use the Procedure Code field on the [Detail Panel](#).

1. Click **Procedure** at the bottom of the Institutional Claim panel. The Procedure panel will be displayed.

The screenshot shows a web interface titled "Procedure". Below the title, it says "*** No rows found ***". Underneath, there is a message: "Select row above to update -or- click Add button below." There are three input fields: "Sequence" with a dropdown arrow, "Procedure" with a text box and a "[Search]" link to its right, and "Procedure Date" with a date picker. At the bottom right, there are two buttons: "Delete" and "Add".

Figure 25 Procedure Panel

2. Click **Add**. A row will be added to the panel, and the Procedure and Procedure Date fields will activate.

The screenshot shows the "Procedure" panel after a row has been added. At the top, there are four links: "Sequence", "Procedure", "Description", and "Procedure Date". Below these links is a table with one row highlighted in yellow. The row has two columns: "A" and "1". Below the table, there is a message: "Type data below for new record." There are three input fields: "Sequence" with a dropdown arrow showing "1", "Procedure" with a text box and a "[Search]" link to its right, and "Procedure Date" with a date picker. At the bottom right, there are two buttons: "Delete" and "Add".

Figure 26 Procedure Panel With Added Row

3. The Sequence field provides numerical order for the procedure code. A sequence number will automatically be generated when a new row is added.
4. Enter an ICD procedure code that identifies the procedure performed in the in the Procedure field or search for a code using the Search link to the right of the field.
5. Enter the date that the procedure was completed in the Procedure Date field.
6. To add additional procedure codes to the claim, click **Add** and either enter the code in the Procedure field or search for a code using the Search link to the right of the field.
7. To remove a row, select the desired row and click **Delete**. A dialog box will be displayed. Click **OK** to delete the specified row.

3.1.6 Occurrence/Span Panel

1. Click **Occurrence/Span** at the bottom of the Institutional Claim panel. The Occurrence/Span panel will be displayed.

The screenshot shows the 'Occurrence/Span' panel with a grey header. Below the header, it says '*** No rows found ***'. A message reads 'Select row above to update -or- click Add button below.' There are four input fields: 'Sequence' (empty), 'Occurrence Code' (empty), 'From Date' (empty), and 'To Date' (empty). A '[Search]' link is positioned between the Occurrence Code and To Date fields. At the bottom right, there are 'Delete' and 'Add' buttons.

Figure 27 Occurrence/Span Panel

2. Click **Add**. A row will be added to the panel, and the fields will activate.

The screenshot shows the 'Occurrence/Span' panel with a table header: 'Sequence', 'Occurrence Code', 'Description', 'From Date', and 'To Date'. A single row is added with 'A' in the Sequence field and '0' in the Occurrence Code field. Below the table, a message reads 'Type data below for new record.' The 'Sequence' field is now active and contains the number '1'. The 'Occurrence Code' field is empty. The 'From Date*' and 'To Date' fields are also empty. The '[Search]' link is still present. At the bottom right, there are 'Delete' and 'Add' buttons.

Figure 28 Occurrence/Span Panel With Added Row

ForwardHealth will assign a sequence number (in numerical order) to the row. Clicking the added row will activate the Sequence field; however, the sequence number must be in numerical order (that is, 1 for the first added row, 2 for the second added row).

3. Enter the code defining a significant event relating to this claim that may affect payer processing in the Occurrence Code field or search for a code using the Search link to the right of the field.
4. Enter the date that the service began in the From Date field.
5. Enter the date that the service was completed in the To Date field, if applicable.
6. To add additional occurrence codes to the claim, click **Add** and either enter the code in the Occurrence Code field or search for a code using the Search link to the right of the field.
7. To remove a row, select the desired row and click **Delete**. A dialog box will be displayed. Click **OK** to delete the specified row.

3.1.7 Value Panel

1. Click **Value** at the bottom of the Institutional Claim panel. The Value panel will be displayed.

The screenshot shows a panel titled "Value". At the top, it says "*** No rows found ***". Below this, it instructs the user to "Select row above to update -or- click Add button below." There are three input fields: "Sequence" (empty), "Value" (empty), and "Amount" (empty). To the right of the "Value" field is a "[Search]" button. At the bottom right, there are two buttons: "Delete" and "Add".

Figure 29 Value Panel

2. Click **Add**. A row will be added to the panel and the fields will activate.

The screenshot shows the "Value" panel with one row added. The row has the following values: Sequence: A, Value: 0, Description: (empty), Amount: 0. Below the row, it says "Type data below for new record." There are three input fields: "Sequence" (containing "1"), "Value" (empty), and "Amount*" (containing "0"). To the right of the "Value" field is a "[Search]" button. At the bottom right, there are two buttons: "Delete" and "Add".

Figure 30 Value Panel With Added Row

ForwardHealth will assign a sequence number (in numerical order) to the row. Clicking the added row will activate the Sequence field; however, the sequence number must be in numerical order (that is, 1 for the first added row, 2 for the second added row).

3. Enter the code that relates values used to identify data elements necessary to process the claim in the Value field or search for a code using the Search link to the right of the field.
4. Enter the amount of the value code used to identify the data elements necessary to process the claim in the Amount field.
5. To add additional value codes to the claim, click **Add** and either enter the code in the Value field or search for a code using the Search link to the right of the field.
6. To remove a row, select the desired row and click **Delete**. A dialog box will be displayed. Click **OK** to delete the specified row.

3.1.8 Patient Reason for Visit Panel

1. Click **Patient Reason for Visit** at the bottom of the Institutional Claim panel. The Patient Reason for Visit panel will be displayed.

The screenshot shows a panel titled "Patient Reason for Visit". It contains three rows of input fields: "Reason Code 1", "Reason Code 2", and "Reason Code 3". Each field has a "[Search]" button to its right.

Figure 31 Patient Reason for Visit Panel

2. Enter the ICD diagnosis code identifying the medical condition that caused the member to seek care in the Reason Code 1 field or search for a code using the Search link to the right of the field.
3. If necessary, enter additional codes identifying the medical condition that caused the member to seek care.

3.1.9 External Cause of Morbidity Panel

1. Click **External Cause of Morbidity** at the bottom of the Institutional Claim panel. The External Cause of Morbidity panel will be displayed.

External Cause of Morbidity		
External Cause 1	[Search]	
External Cause 2	[Search]	
External Cause 3	[Search]	
External Cause 4	[Search]	
External Cause 5	[Search]	
External Cause 6	[Search]	
External Cause 7	[Search]	
External Cause 8	[Search]	
External Cause 9	[Search]	
External Cause 10	[Search]	
External Cause 11	[Search]	
External Cause 12	[Search]	

Figure 32 External Cause of Morbidity Panel

2. Enter the ICD diagnosis code that indicates the cause of injury if the injury was from an external source (for example, an accident as opposed to a disease or illness) in the External Cause 1 field or search for a code using the Search link to the right of the field.
3. A POA indicator is required for inpatient claims when the provider or diagnosis code is not exempt from collection of POA information. Select a POA indicator from the drop-down menu. Valid indicators include the following:
 - **Y—Yes/Present**—Indicates the diagnosis was present at the time of inpatient admission.
 - **N—Not Present**—Indicates the diagnosis was not present at the time of inpatient admission.
 - **W—Not Applicable**—Indicates the provider is unable to clinically determine whether the condition was present at the time of inpatient admission.
 - **U—Unknown**—Indicates the documentation is insufficient to determine if the condition was present at the time of inpatient admission.
4. If necessary, enter additional codes.

3.1.10 Other Insurance Header Information Panel

The Other Insurance Header Information panel is used to enter header level information for each OI carrier.

1. Click **Other Insurance** at the bottom of the Institutional Claim panel.

The screenshot shows the bottom of the Institutional Claim panel. It includes a 'Notes' text area, an 'Other Insurance Indicator' dropdown, and input fields for 'Referral Number', 'Total Charge*' (displaying \$0.00), 'Net Difference', and 'PA Number*'. At the bottom, a series of tabs are visible: 'Diagnosis', 'Condition', 'Medicare', 'Payer', 'Procedure', 'Occurrence/Spoin', 'Value', 'Patient Reason for Visit', 'External Cause of Morbidity', and 'Other Insurance'. The 'Other Insurance' tab is highlighted with an orange box, and an orange arrow points to it from the 'Total Charge*' field.

Figure 33 Other Insurance Link

The Other Insurance Header Information panel will be displayed. The [Other Insurance Detail Information](#) and [Other Insurance EOB Information](#) panels will also be displayed further down the form.

The screenshot shows the 'Other Insurance Header Information' panel. It displays a message '*** No rows found ***'. Below this are search fields for 'Carrier Number' (with a '[Search]' link), 'Carrier Name', and a 'Claim Filing' dropdown. To the right are fields for 'Payment Date', 'Payment Amount', and 'OI Circumstance' (a dropdown). At the bottom right are 'Delete' and 'Add' buttons.

Figure 34 Other Insurance Header Information Panel

2. Click **Add**. The page will refresh, a yellow row will be added to the top of the panel, and the fields will become active to allow for information to be entered.

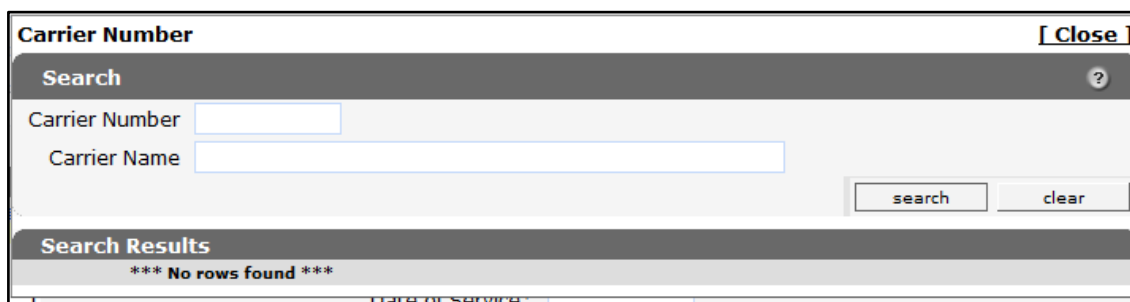
The screenshot shows the 'Other Insurance Header Information' panel after clicking 'Add'. A new row is added at the top, highlighted with a yellow background. This row contains the following fields: 'Carrier Number*' (with a '[Search]' link), 'Carrier Name*', 'Claim Filing*' (a dropdown), 'Payment Date', 'Payment Amount' (displaying \$0.00), and 'OI Circumstance' (a dropdown). The 'Delete' and 'Add' buttons remain at the bottom right.

Figure 35 Add Other Insurance

3. Enter a carrier number and name, or search for a carrier using the Search link next to the Carrier Number field.

To search for a Carrier, complete the following steps:

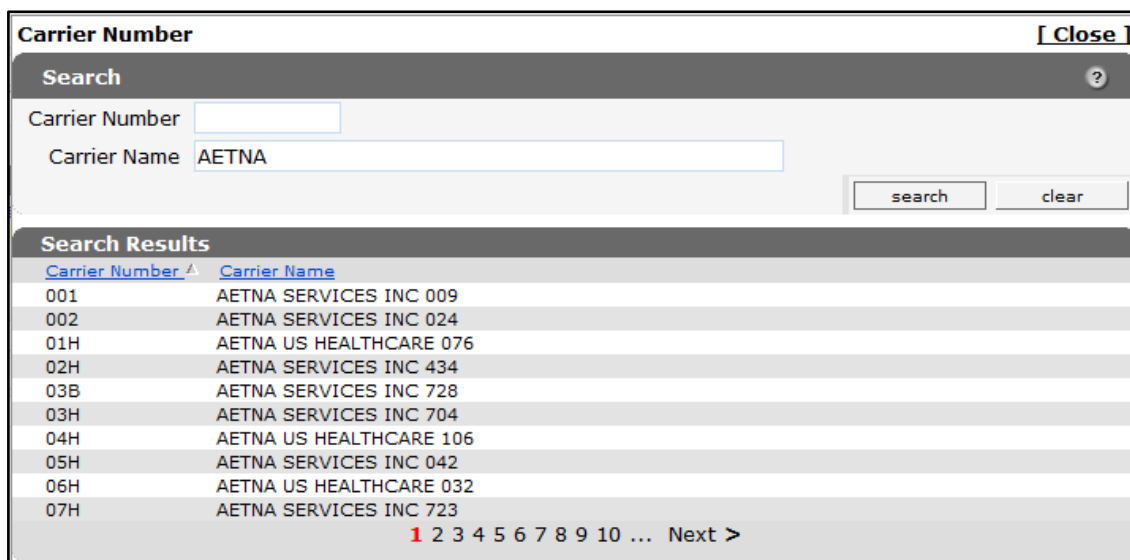
- a. Click **Search** to the right of the Carrier Number field. The Carrier Number search panel will be displayed.



The Carrier Number Search Panel is a modal window with a title bar containing a "Close" button. It has a "Search" section with two input fields: "Carrier Number" and "Carrier Name". Below these fields are "search" and "clear" buttons. The "Search Results" section displays the message "*** No rows found ***".

Figure 36 Carrier Number Search Panel

- b. Enter a full or partial name for the carrier. The user may search using the carrier number, if known.
- c. Click **Search**. Any carrier number matching the query will be displayed in the "Search Results" section of the panel.



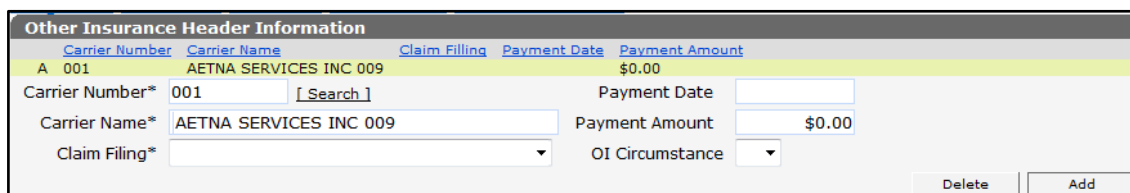
The Carrier Number Search Results Panel is a modal window with a title bar containing a "Close" button. It has a "Search" section with two input fields: "Carrier Number" and "Carrier Name" (containing the text "AETNA"). Below these fields are "search" and "clear" buttons. The "Search Results" section displays a table of results:

Carrier Number	Carrier Name
001	AETNA SERVICES INC 009
002	AETNA SERVICES INC 024
01H	AETNA US HEALTHCARE 076
02H	AETNA SERVICES INC 434
03B	AETNA SERVICES INC 728
03H	AETNA SERVICES INC 704
04H	AETNA US HEALTHCARE 106
05H	AETNA SERVICES INC 042
06H	AETNA US HEALTHCARE 032
07H	AETNA SERVICES INC 723

At the bottom of the results section, there is a pagination control: "1 2 3 4 5 6 7 8 9 10 ... Next >".

Figure 37 Carrier Number Search Results Panel

- d. Click the applicable carrier. The Carrier Number search panel will close, and the selected carrier's number and name will populate the carrier fields.



The Institutional Claim Form shows the "Other Insurance Header Information" section. It contains a table with the following data:

Carrier Number	Carrier Name	Claim Filing	Payment Date	Payment Amount
A 001	AETNA SERVICES INC 009			\$0.00

Below the table, there are input fields for "Carrier Number*" (001), "Carrier Name*" (AETNA SERVICES INC 009), "Claim Filing*" (a dropdown menu), "Payment Date" (a date input field), "Payment Amount" (\$0.00), and "OI Circumstance" (a dropdown menu). There are "Delete" and "Add" buttons at the bottom right.

Figure 38 Carrier Number and Name Added to Institutional Claim Form

Note: The above procedure can be used for other search links on the Institutional Claim Form.

4. Add additional carriers to the claim if necessary. To delete a carrier, select the applicable row and click **Delete**.
5. Select the Claim Filing from the drop-down menu.

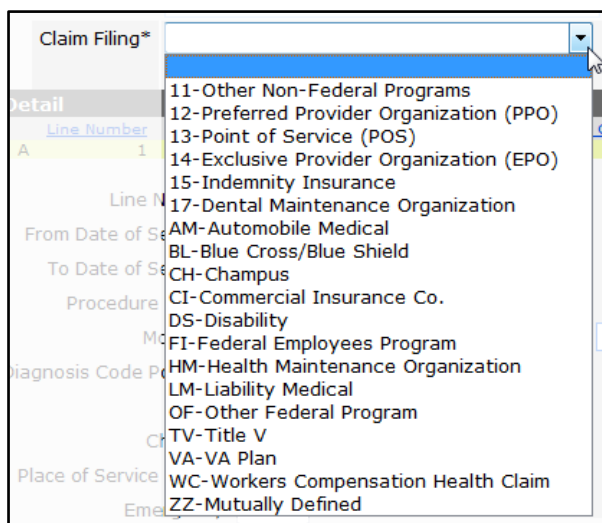


Figure 39 Claim Filing Drop-Down Menu

The claim filing indicates the type of OI billed prior to Medicaid claims submission.

6. Enter the Payment Date.
7. Enter the Payment Amount.

Note: The Payment Date and Payment Amount will not be active if **Y** is selected in the OI Circumstance drop-down menu. If the user inadvertently enters information in these fields and then selects **Y**, the information will be deleted, and the fields will be blank.

8. Use the OI Circumstance drop-down menu to select **Y** for any of the reasons listed below.

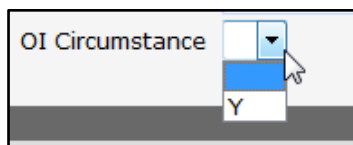


Figure 40 OI Circumstance Drop-Down Menu

A **Y** indicates the member has commercial health insurance or commercial HMO coverage, but the commercial plan was not billed for reasons including the following:

- The member denied coverage or will not cooperate.
- The provider knows the service in question is not covered by the carrier.

- The member's commercial health insurance failed to respond to initial and follow-up claims.
- Benefits are not assignable or cannot get assignment.
- Benefits are exhausted.

For any carrier where OI Circumstance is set to Y, the user is not allowed to enter a paid amount, paid date, or detail or EOB information.

9. Click **Add** to add any other carriers.

Carrier Number	Carrier Name	Claim Filing	Payment Date	Payment Amount
A 107	DELTA DENTAL PLAN OF WISCONSIN	11		\$0.00
A 001	AETNA SERVICES INC 009	11	01/20/2014	\$50.00

Carrier Number* [Search] Payment Date

Carrier Name* Payment Amount

Claim Filing* OI Circumstance

Figure 41 Noncovered Carrier Added to Claim

When finished adding carriers, the information for the last carrier entered will be added to the top row when proceeding to another panel or clicking the Submit button.

3.2 Detail Panel

Line Number	Revenue Code	HIPPS Code	Rendering Provider	Referring Provider	Procedure Code	Units	Charge	Status	Allowed Amount
A 1						0	\$0.00		\$0.00

Type data below for new record.

Line Number Revenue Code [Search]

From Date of Service* HIPPS Code [Search]

To Date of Service* Rendering Provider [Search]

Procedure Code [Search] Referring Provider [Search]

Modifiers [Search] [Search] [Search] [Search]

Units* Charge

Status Allowed Amount

Professional Service Description

[NDCs for JCode](#)

Figure 42 Detail Section

The From Date of Service field is populated with the date entered in the From Date of Service field on the Institutional Claim panel (the header).

The To Date of Service field is populated with the date entered in the To Date of Service field on the Institutional Claim panel (the header).

1. Enter the HCPCS or CPT procedure code that identifies the service performed or provided in the Procedure Code field or search for a code using the Search link to the right of the field.

2. Enter a modifier that provides additional information about the service provided in the first Modifiers field or search for a modifier using the Search link to the right of the field, if applicable. Enter all modifiers that apply to the service provided.
3. If the user indicated a non-specific procedure code, enter a description of the code in the Professional Service Description field.
4. Enter the revenue code that identifies a specific accommodation, ancillary service, or billing calculation in the Revenue Code field or search for a code using the Search link to the right of the field.
5. Enter the Health Insurance Prospective Payment System (HIPPS) code that is used for pricing nursing home (long-term care) claims or search for a code using the Search link to the right of the field. A HIPPS code consists of a series of codes representing a nursing home resident Patient Driven Payment Model classification and the Assessment Indicator.
6. Enter the NPI or Medicaid ID of the provider performing the services if the rendering provider ID is different from the ID with which the user is logged in and the provider ID was not entered at the header level. Generally, only enter a number if there are two or more rendering providers on the claim and it is necessary to distinguish between the providers at the detail level.
7. Enter the NPI or Medicaid ID of any provider who referred the member to another provider for services in the Referring Provider field if the provider ID was not entered at the header level.
8. Enter the number of covered accommodation days or ancillary units of service in the Units field.
9. Enter the amount charged for the service provided in the Charge field.

Information cannot be entered in the Status and Allowed Amount fields. The Status and Allowed Amount fields will be populated when the claim is submitted. The Status field will display the current status of the detail, and the Allowed Amount field will display the amount Wisconsin Medicaid has allowed for the detail.

10. Click **Add** to add more details to the claim. Enter the necessary information for each detail added. Providers may enter up to 999 detail lines per claim.
11. Select the desired row and click **Delete** to remove a detail line. A dialog box will be displayed. Click **OK** to delete the specified row.

3.2.1 NDC Panel

ForwardHealth requires that National Drug Codes (NDCs) be indicated on claims for all provider-administered drugs to identify the drugs and invoice a manufacturer for rebates, track utilization, and receive federal funds. A provider-administered drug is either an oral, injectable, intravenous, or inhaled drug administered by a physician or a designee of the physician (for example, nurse, nurse practitioner, physician assistant) or incidental to a physician service.

1. Click **NDC for JCode** at the bottom of the Detail panel. The NDC panel will be displayed.

NDC (Detail Item 1)
 *** No rows found ***
 Select row above to update -or- click Add button below.

RX Number Unit of Measure

NDC Code Drug Unit Price

Quantity Unit Prescription Date

Figure 43 NDC Panel

Note: A corresponding detail line must be added before any information can be entered on the NDC panel.

2. Click **Add**. A row will be added to the NDC panel, and the fields will activate.

NDC (Detail Item 1)

RX Number	NDC Code	Quantity Unit	Unit of Measure	Drug Unit Price	Prescription Date
A		0		\$0.00	

Type data below for new record.

RX Number Unit of Measure*

NDC Code* Drug Unit Price

Quantity Unit* Prescription Date

Figure 44 NDC Panel With Added Row

3. If the user added multiple line items to the Detail panel, click the applicable line item from the Detail panel. The NDC panel title will reflect the detail line item selected.
4. Enter the prescription number of the NDC in the RX Number field. If more than three numbers are entered, the up and down arrows will become active, allowing the user to scroll through the information entered.
5. Enter the NDC that supplements the procedure code entered on the detail line item in the NDC Code field.
6. Enter the number of units that are being requested for this claim in the Quantity Unit field.
7. Select one of the applicable Unit of Measure from the drop-down menu:
 - F2—International Unit
 - GR—Gram
 - ME—Milligram
 - ML—Milliliter
 - UN—Unit
8. Enter the price per unit in the Drug Unit Price field.
9. Enter the date of the prescription in the Prescription Date field.

3.3 Other Insurance Detail Information Panel

The Other Insurance Detail Information panel is used to enter OI-related information for the claim details.

If any information is entered in the Other Insurance Detail Information panel, all information must be supplied, even if it seems similar to information entered in the Other Insurance Header Information panel.

Other Insurance Detail Information
 *** No rows found ***
 Detail: 1
 Carrier Number:
 Carrier Name:
 Payment Date:
 Payment Amount:
 Delete Add

Figure 45 Other Insurance Detail Information Panel

Note: Other Insurance information should be added to the header or both the header and detail depending on how the individual carrier adjudicated the claim:

- If the other payer's EOB to the provider contains detail-specific information, the information should be added to both the header and detail.
- If the other payer adjudicated the claim only at the header (no detail-specific information), the provider can only enter header information.
- If there is more than one other payer involved, it is possible for one payer to be entered only in the header and the other in both the header and detail depending on how the individual carriers adjudicated the claim.

To enter an Other Insurance detail:

1. If there is more than one carrier in the Other Insurance Header Information panel, scroll up to that panel and click the appropriate carrier to add the detail information for that carrier to those fields. The page will refresh, and the carrier will be highlighted.

Other Insurance Header Information

Carrier Number	Carrier Name	Claim Filing	Payment Date	Payment Amount
A 107	DELTA DENTAL PLAN OF WISCONSIN	11	01/20/2014	\$50.00
A 001	AETNA SERVICES INC 009	11	01/20/2014	\$50.00

Carrier Number*: 001 [Search]
 Carrier Name*: AETNA SERVICES INC 009
 Claim Filing*: 11-Other Non-Federal Programs
 Payment Date*: 01/20/2014
 Payment Amount*: \$50.00
 OI Circumstance:
 Delete Add

Figure 46 Select Carrier in Header

If there is only one carrier listed in the Other Insurance Header panel, step 1 may be skipped.

- Return to the Other Insurance Detail Information panel and click **Add**.

Figure 47 Other Insurance Detail Panel

Note: If **Y** is selected for a carrier in the OI Circumstance field in the header, the user will be unable to add information for that carrier in the Other Insurance Detail Information panel.

The page will refresh, and a yellow row will be added to the top of the panel with the carrier's name and number. The fields will also become active to allow for further information to be entered. The Detail number will display as 1 but can be changed when adding additional information.

Figure 48 Carrier Added to Other Insurance Detail Information Panel

- Select the detail number for which the OI information applies from the drop-down menu, if applicable. The default setting is the number of the detail selected on the Other Insurance Detail Information panel. A header value of 0 (zero) is not allowed on this panel.
- Enter the date the other insurance paid the claim in the Payment Date field.
- Enter the total amount of dollars the OI carrier paid on the detail in the Payment Amount field.
- To add another carrier, scroll up to the Other Insurance Header Information panel and click the carrier to add the detail information for that carrier.

Figure 49 Select Additional Carrier in Header

When returning to the Other Insurance Detail Information panel, the previous carrier's information will be removed, and the fields will be grayed out.

Figure 50 Blank Other Insurance Detail Information Panel

- Click **Add**. The page will refresh, and a yellow row will be added to the top of the panel with the carrier's name and number. The fields will also become active to allow for further information to be entered.

Figure 51 Additional Carrier Added

- When finished adding carriers, the information for the last carrier entered will be added to the top row when going to another panel or clicking the **Submit** button.

3.4 Other Insurance EOB Information Panel

The Other Insurance EOB Information panel is used to enter the adjustment codes that explain why a carrier did not pay the billed amount.

Figure 52 Other Insurance EOB Information Panel

Note: If **Y** is selected for a carrier in the OI Circumstance field in the header, information cannot be added for that carrier in the Other Insurance EOB Information panel.

To enter an OI EOB code:

- Click **Add**. A yellow row will be added to the top of the panel and the fields will become active to allow further information to be entered.

2. Select the Detail Number from the drop-down menu, if applicable. Leave at 0 (zero) if the OI paid at the header. Detail 0 indicates that the other insurance paid the claim at the header.
3. Use the drop-down menu in the Carrier Number field to select the Carrier Number from the carriers already entered on the claim.

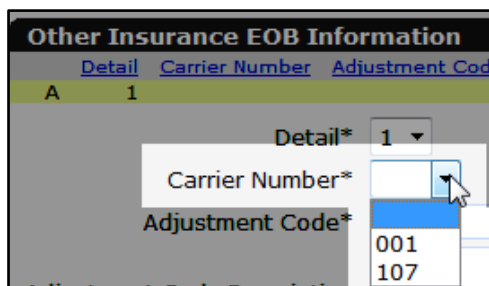


Figure 53 Select Carrier Number

4. In the Adjustment Code field, enter the EOB adjustment code from the carrier's EOB. The EOB description will be entered automatically.

If an adjustment code is not available, search for one:

- a. Click **Search** to the right of the Adjustment Code field.

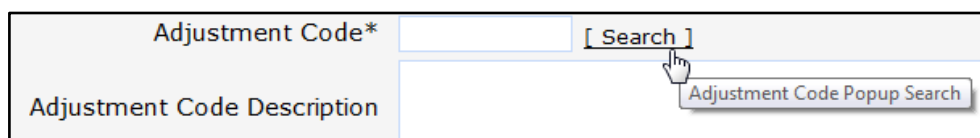


Figure 54 Adjustment Code Search Link

The Adjustment Code search panel will be displayed.



Figure 55 Adjustment Code Search Panel

- b. Enter the adjustment code description.

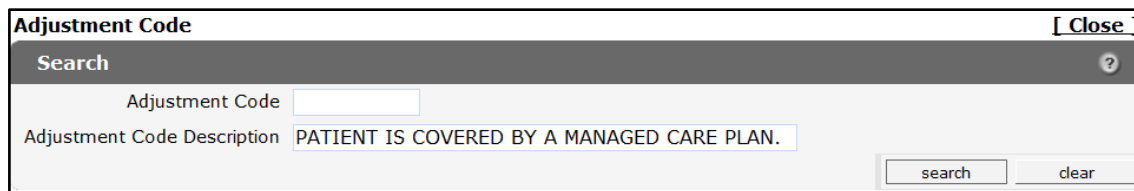


Figure 56 Exact Description

If the exact description is unknown, use the percent (%) symbol as a wildcard to search for any word or group of words in the description.

Adjustment Code [Close]

Search ?

Adjustment Code

Adjustment Code Description

search clear

Figure 57 Wild Card Search

- c. Click **Search**. The codes matching the query will be displayed in the “Search Results” section of the panel.

Adjustment Code [Close]

Search ?

Adjustment Code

Adjustment Code Description

search clear

Search Results

Adjustment Code	Adjustment Code Description
120	Patient is covered by a managed care plan.

Figure 58 Exact Description Search Results

Adjustment Code [Close]

Search ?

Adjustment Code

Adjustment Code Description

search clear

Search Results

Adjustment Code	Adjustment Code Description
104	Managed care withholding.
120	Patient is covered by a managed care plan.
24	Charges are covered under a capitation agreement/managed car
256	Service not payable per managed care contract.

Figure 59 Wild Card Search Results

- d. Click the applicable code. The Adjustment Code search panel will close, and the selected adjustment code and description will populate the fields on the Other Insurance EOB Information Panel.

Adjustment Code* [Search] Group Code*

Adjustment Code Description

Figure 60 Adjustment Code and Description Added to the Panel

The following list includes some common American National Standards Institute (ANSI) codes that are used by ForwardHealth to process claims. Refer to www.wpc-

edi.com/reference/ online for the most current and complete listing of all valid ANSI codes.

Code	Description
1	Deductible Amount.
2	Coinsurance Amount.
3	Co-payment Amount.
23	The impact of prior payer(s) adjudication including payments and/or adjustments.
24	Charges are covered under a capitation agreement/managed care plan.
35	Lifetime benefit maximum has been reached.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
66	Blood Deductible.
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or National Council for Prescription Drug Programs Reject Reason Code.)
119	Benefit maximum for this time period or occurrence has been reached.
122	Psychiatric reduction.
149	Lifetime benefit maximum has been reached for this service/benefit category.

5. Enter the Adjustment Amount.
6. Select the Group Code from the drop-down menu.

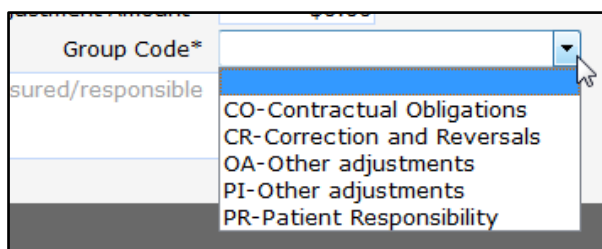


Figure 61 Select Group Code

- Click **Add** to add additional adjustment codes.

Figure 62 EOB Added

When finished adding EOBs, the last EOB entered will be added to the top row when going on to another panel or clicking the **Submit** button.

3.5 Medicare Information (Detail) Panel

- Click **Medicare** at the bottom of the Institutional Claim panel. The Medicare Information (Detail) panel will be displayed.

Figure 63 Medicare Information (Detail) Panel

Important: Under the Enhanced Ambulatory Patient Groups reimbursement methodology, providers adjusting or resubmitting outpatient hospital claims for crossover are required to indicate Medicare adjudication amounts (for example, Medicare allowed, paid, coinsurance, copayment, and deductible amounts) on the Detail panel.

Medicare adjudication amounts for inpatient hospital and nursing home must be entered on the [Medicare Information \(Header\) panel](#).

- Enter the date that Medicare paid the detail line in the Medicare Paid Date field.
- Enter the amount Medicare paid for the detail line in the Medicare Paid Amount field.
- Enter the amount of the detail line not allowed by Medicare in the Medicare Non Covered Charged field.

Note: If Medicare does not cover the entire claim, do not use the Medicare Information (Header) and/or Medicare Information (Detail) panels. Return to [Step 19 of 3.1 Institutional Claim Panel](#) to select the appropriate Medicare disclaimer code.

- Enter the deductible amount (the amount the member is required to pay before Medicare begins to pay) that Medicare applied to the detail line in the Deductible Amount field.

6. Enter the coinsurance amount (percentage of the Medicare payment) indicated by Medicare for the detail line in the Coinsurance Amount field.
7. Enter the dollar amount that Medicare has determined that a member is required to pay for blood work in the Blood Deductible Amount field for that detail line.
8. Enter the copayment amount (percentage of the Medicare payment) indicated by Medicare for the detail line in the Copayment Amount field.
9. Enter the remaining patient liability amount for that detail in the Remaining Patient Liability field. The remaining patient liability must equal the sum of the deductible amount, coinsurance amount, blood deductible amount, and copayment amount.

3.6 Attachments Panel

The screenshot shows a panel titled "Attachments". At the top, it says "*** No rows found ***". Below this, there is a instruction: "Select row above to update -or- click Add button below." There are two input fields: "Attachment Control Number" and "Description". At the bottom right, there are two buttons: "Delete" and "Add".

Figure 64 Attachments Panel

1. Click **Add** if any attachments need to be included with the claim. A row will be added to the Attachments panel, and the Description field will activate.

The Attachment Control Number field is read-only. ForwardHealth will assign a number after the claim is submitted.

2. Enter a description of the attachment being submitted.

The screenshot shows the "Attachments" panel with a new row added. The row is highlighted in yellow and has a label "A" on the left. The "Attachment Control Number" field is now populated with "A". The "Description" field is active and contains the text "Example". The instruction "Type data below for new record." is displayed above the input fields. The "Delete" and "Add" buttons are still present at the bottom right.

Figure 65 Attachments Panel With Added Row

Note: If it is indicated that an attachment will be included with the claim, the claim will suspend for seven days pending the receipt of the indicated attachment. Users may upload attachments electronically through the Portal or submit the attachment by mail or fax using the [Claim Form Attachment Cover Page](#), F-13470, available on the ForwardHealth Forms page of the Portal.

3.7 Submit the Claim

The Claim Status Information panel at the bottom of the Institutional Claim form will indicate that the claim has not yet been submitted.

A screenshot of the 'Claim Status Information' panel. It has a dark header with the title 'Claim Status Information'. Below the header, the text 'Claim Status Not submitted yet' is displayed. At the bottom right, there are two buttons: 'Submit' and 'Cancel'.

Figure 66 Claim Status Information Panel

1. Ensure that information has been entered in all the required fields on the Institutional Claim form.

Note: Since there is no Save feature for the Institutional Claim form, if the claim is not submitted successfully and assigned an ICN, all information will be lost.

2. Click **Submit**.
 - a. If there is a problem and the claim does not process, an ICN will not be assigned, and an error message that indicates what needs to be corrected will be displayed at the top of the page.

Note: If information on the Institutional Claim panel (the header) is missing or needs correction, the fields missing the information or needing correction will be yellow; however, fields missing information or needing correction on the rest of the form will remain white.

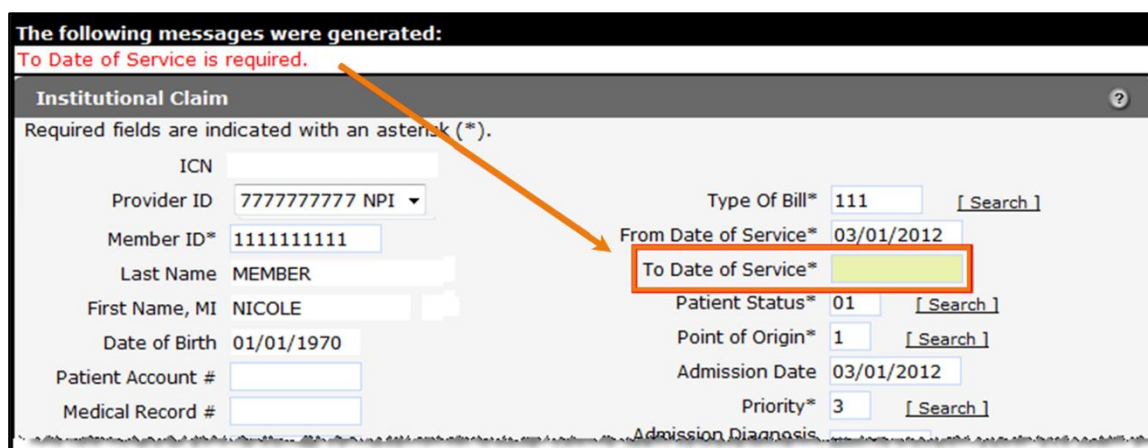
A screenshot of the 'Institutional Claim' form. At the top, a message box says 'The following messages were generated: To Date of Service is required.' An orange arrow points from this message to the 'To Date of Service*' field, which is highlighted in yellow. The form contains various fields: ICN (empty), Provider ID (777777777 NPI), Member ID* (111111111), Last Name (MEMBER), First Name, MI (NICOLE), Date of Birth (01/01/1970), Patient Account # (empty), Medical Record # (empty), Type Of Bill* (111), From Date of Service* (03/01/2012), To Date of Service* (yellow), Patient Status* (01), Point of Origin* (1), Admission Date (03/01/2012), Priority* (3), and Admission Diagnosis (empty). Search buttons are next to several fields.

Figure 67 Error Message

- b. If an attachment was indicated to be submitted with the claim, the claim will suspend, an attachment control number will be added to the Attachments panel, and the Upload Claim Attachments button will be displayed at the bottom of the page:

The screenshot shows the 'Claim Status Information' panel. The 'Claim Status' is 'SUSPEND', 'Claim ICN' is '2311266001001', and 'Paid Amount' is '\$0.00'. Below this is the 'EOB Information' panel with a table showing a detail number 0, code 2222, and description 'Policy not currently enforced.' At the bottom right, there is an 'Upload Claim Attachments' button, which is highlighted with an orange box and an orange arrow pointing to it from the left.

Claim Status Information		
Claim Status	SUSPEND	
Claim ICN	2311266001001	
Paid Amount	\$0.00	

EOB Information		
Detail Number	Code	Description
0	2222	Policy not currently enforced.

Upload Claim Attachments

Figure 68 Submitted Claim With Attachments

- If not ready to upload a file, exit from this page or go to another area of the Portal.
- If ready to upload an attachment, click **Upload Claim Attachments**.

The Upload Claim Attachment File panel will be displayed. For information about uploading attachments, refer to the [ForwardHealth Portal Uploading Claim Attachments Instruction Sheet](#), which is located on the User Guides page of the Portal.

3. If the claim is successfully submitted without an attachment, the Claim Status Information panel will display the ForwardHealth-assigned ICN and the claim's status. In addition, if the claim was priced using a diagnosis-related grouping system, the DRG Results panel will be displayed. The EOB Information panel will also be displayed, indicating how the claim was processed by ForwardHealth.

The screenshot shows three panels: 'Claim Status Information', 'DRG Results', and 'EOB Information'. The 'Claim Status Information' panel shows 'Claim Status' as 'PAY', 'Claim ICN' as '00000000000000', 'Paid Date' as '09/21/2016', and 'Paid Amount' as '\$12,177.66'. The 'DRG Results' panel shows 'DRG Code' as '975', 'DRG Version' as '33', and 'SOI' as '0'. The 'EOB Information' panel shows a table with four rows of pricing adjustments. At the bottom, there are buttons for 'Cancel', 'Adjust', 'Void', and 'Copy claim'.

Claim Status Information		
Claim Status	PAY	
Claim ICN	00000000000000	
Paid Date	09/21/2016	
Paid Amount	\$12,177.66	

DRG Results		
DRG Code	975	
DRG Version	33	
SOI	0	

EOB Information		
Detail Number	Code	Description
0	9816	Pricing Adjustment - Payment amount increased based on hospital access payment
0	9008	Pricing Adjustment - Payment amount decreased based on Pay for Performance poli
0	9932	Pricing Adjustment - DRG pricing applied.
1	9932	Pricing Adjustment - DRG pricing applied.

Cancel Adjust Void Copy claim

Figure 69 Claim Status Information, DRG Results, and EOB Information Panels

If diagnosis-related grouping was used to price the claim, the DRG Results panel will show the DRG code, DRG version, and severity of illness (SOI) indicator.

If the claim is denied or adjusted, an EOB code or codes will be displayed indicating the reason for the denial or adjustment.

4 Create a Claim From Prior Authorization

CLTS providers can search for a PA and create a claim from an existing PA via the Create a Claim From PA link on the Claims page.

1. Click **Claims** on the main menu at the top of the page. The Claims page will be displayed.

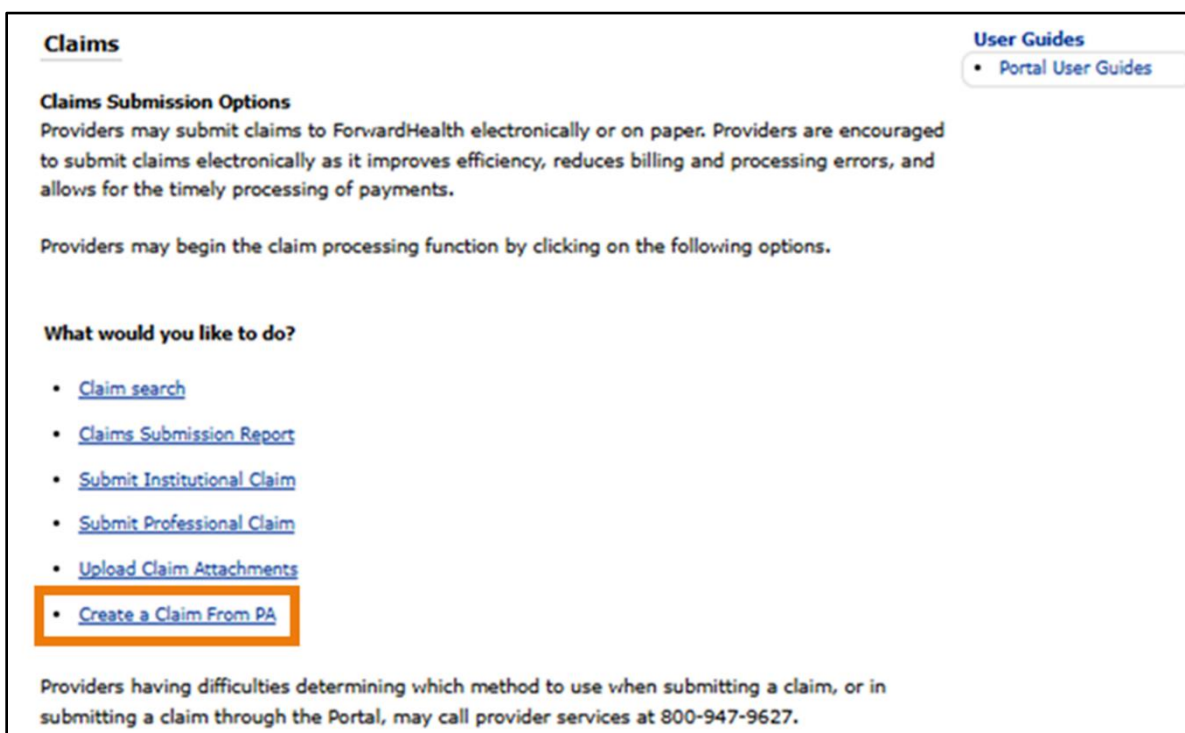
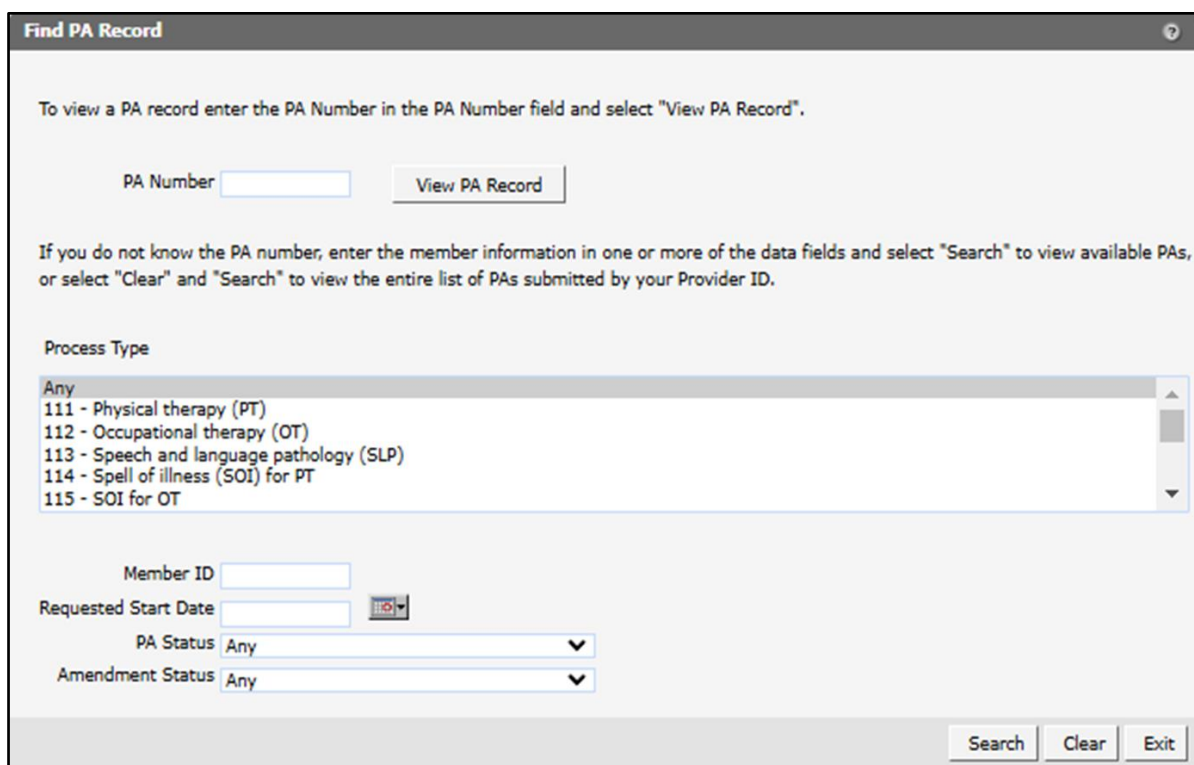


Figure 70 Claims Page

2. Click **Create a Claim From PA** on the claims page. The Find PA Record panel will be displayed.



The Find PA Record panel is a web-based interface for searching prior authorization records. It features a title bar with a question mark icon. Below the title bar, there is a text instruction: "To view a PA record enter the PA Number in the PA Number field and select 'View PA Record'". This is followed by a text input field labeled "PA Number" and a button labeled "View PA Record".

Below this, another instruction reads: "If you do not know the PA number, enter the member information in one or more of the data fields and select 'Search' to view available PAs, or select 'Clear' and 'Search' to view the entire list of PAs submitted by your Provider ID.".

The panel includes a section for "Process Type" with a scrollable list box containing the following options: "Any", "111 - Physical therapy (PT)", "112 - Occupational therapy (OT)", "113 - Speech and language pathology (SLP)", "114 - Spell of illness (SOI) for PT", and "115 - SOI for OT".

Below the list box, there are several input fields: "Member ID", "Requested Start Date" (with a calendar icon), "PA Status" (a dropdown menu currently showing "Any"), and "Amendment Status" (a dropdown menu currently showing "Any").

At the bottom right of the panel, there are three buttons: "Search", "Clear", and "Exit".

Figure 71 Find PA Record Panel

The provider can find a PA by either entering a PA number or entering information in one or more of the data fields.

4.1 Search by Prior Authorization Number

1. Enter the PA number in the PA number field.
2. Click **View PA Record**. If no results match the search, an error message will be displayed at the top of the page.

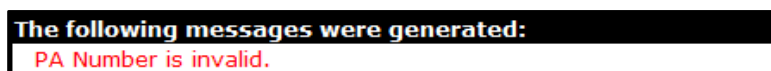


Figure 72 Example Error Message

If the entered PA number is valid, the PA Record page will be displayed with information that was previously submitted.

PA Record

- The PA record below is in "APPROVED" status.
- To view the decision on this approved PA select "View PA Decision Notice" located in the PA Information section. If you wish to submit an amendment request for this PA, select "Amend this PA" located at the bottom of the page.

PA Message

- ***There are No PA Messages***

PA Information

PA Number: 555555554 Media Type: WEB
 First Name: SOPHIA Member ID: 0987654321
 Last Name: CLTS Date of Birth: 07/14/2015
 PA Status: APPROVED [View PA Decision Notice](#)
 Amendment Status:
 Process Type: 147 - Childrens Long-Term Support
 Program: Medicaid
 HealthCheck Other Service: No Start Date - SOI:
 Requested Start Date: 01/01/2024 First Date of Treatment - SOI:
 Primary Diagnosis Code: Z418 Description: ENCNT FOR OTH PROC FOR PURPOSE OTH THAN REMEDY HEALTH STATI
 Secondary Diagnosis Code: Description:
 National Provider Identifier- Prescribing/Referring/Ordering Provider: Name - Prescribing/Referring/Ordering Provider:
[Create a Claim From PA](#)

Line Item Information

Line Item	Status	Service Code	Units Requested	Dollars Requested	Units Authorized	Dollars Authorized	Grant Date	Expiration Date
01	APPROVED	0663	1.000	\$500.00	1.000	\$500.00	01/01/2024	12/30/2024

Select row above to display a different line item's data below.

Line Item: 01
 Status: APPROVED
 Rendering Provider ID: 1234567890 NPI
 Prescribing Provider ID:
 Service Code Type: Revenue Code
 Service Code: 0663
 Service Code Description:
 Tooth: Area of the Oral Cavity:
 Modifiers:
 Place of Service: 99
 Units Requested: 1.000 Dollars Requested: \$500.00
 Units Authorized: 1.000 Dollars Authorized: \$500.00
 Units Remaining: 1.000 Dollars Remaining: \$500.00
 Grant Date: 01/01/2024
 Expiration Date: 12/30/2024

[Previous](#) [Exit](#)

Figure 73 PA Record Panel

3. Click Exit to return to the Prior Authorization page.

4.2 Search by Other Criteria

If the PA number is unknown, the provider can search for the PA using any of the remaining fields on the page. To refine a search, enter information in more than one field.

1. Enter or select information for any of the following fields:

- Process Type

- Member ID
- Requested Start Date
- PA Status
- Amendment Status

To view all previously submitted PAs, leave all the fields blank.

If you do not know the PA number, enter the member information in one or more of the data fields and select "Search" to view available PAs, or select "Clear" and "Search" to view the entire list of PAs submitted by your Provider ID.

Process Type

Any
111 - Physical therapy (PT)
112 - Occupational therapy (OT)
113 - Speech and language pathology (SLP)
114 - Spell of illness (SOI) for PT
115 - SOI for OT

Member ID 0987654321

Requested Start Date

PA Status Any

Amendment Status Any

Search Clear Exit

Figure 74 Search by Other Criteria

2. Click **Search**.

If no results match the criteria entered, an error message will be displayed at the top of the page. Revise the search criteria. Click **Search** again.

The following messages were generated:
No PA records can be found in the system matching the criteria entered.

Figure 75 Example Error Message

If the entered information is valid, the Choose PA Record page will be displayed.

Choose PA Record

From the list below select the PA record you wish to view and press enter. If the PA is not listed, select "Previous", refine your search criteria and search again, or [contact](#) provider services for assistance at 1-800-947-9627.

PA Number	Member Id	Last Name	First Name	Process Type	PA Status	Amendment Status	Requested Start Date	Grant Date	Expiration Date	PA Notice
555555551	0987654321	CLTS	SOPHIA	147 - Childrens Long-Term Support	APPROVED		08/01/2024	08/01/2024	07/30/2025	Decision Notice
555555552	0987654321	CLTS	SOPHIA	147 - Childrens Long-Term Support	APPROVED		08/01/2024	08/01/2024	07/30/2025	Decision Notice
555555553	0987654321	CLTS	SOPHIA	147 - Childrens Long-Term Support	APPROVED		01/01/2024	01/01/2024	12/30/2024	Decision Notice
555555554	0987654321	CLTS	SOPHIA	147 - Childrens Long-Term Support	APPROVED		01/01/2024	01/01/2024	12/30/2024	Decision Notice

Previous Exit

Figure 76 Choose PA Record Page

Note: To sort the results by category, click a column heading once to sort the results in ascending order. Click the heading twice to sort the results in descending order.

3. Select the PA the user wishes to view. The PA Record page will be displayed.

PA Record

- The PA record below is in "APPROVED" status.
- To view the decision on this approved PA select "View PA Decision Notice" located in the PA Information section. If you wish to submit an amendment request for this PA, select "Amend this PA" located at the bottom of the page.

PA Message

- ***There are No PA Messages***

PA Information

PA Number: 555555554 Media Type: WEB
 First Name: SOPHIA Member ID: 0987654321
 Last Name: CLTS Date of Birth: 07/14/2015
 PA Status: APPROVED [View PA Decision Notice](#)
 Amendment Status:
 Process Type: 147 - Childrens Long-Term Support
 Program: Medicaid
 HealthCheck Other Service: No Start Date - SOI:
 Requested Start Date: 01/01/2024 First Date of Treatment - SOI:
 Primary Diagnosis Code: Z418 Description: ENCINTR FOR OTH PROC FOR PURPOSE OTH THAN REMEDY HEALTH STATI
 Secondary Diagnosis Code:
 Description:
 National Provider Identifier- Prescribing/Referring/Ordering Provider:
 Name - Prescribing/Referring/Ordering Provider:
[Create a Claim From PA](#)

Line Item Information

Line Item	Status	Service Code	Units Requested	Dollars Requested	Units Authorized	Dollars Authorized	Grant Date	Expiration Date
01	APPROVED	0663	1.000	\$500.00	1.000	\$500.00	01/01/2024	12/30/2024

Select row above to display a different line item's data below.

Line Item: 01
 Status: APPROVED
 Rendering Provider ID: 1234567890 NPI
 Prescribing Provider ID:
 Service Code Type: Revenue Code
 Service Code: 0663
 Service Code Description:
 Tooth:
 Area of the Oral Cavity:
 Modifiers:
 Place of Service: 99
 Units Requested: 1.000 Dollars Requested: \$500.00
 Units Authorized: 1.000 Dollars Authorized: \$500.00
 Units Remaining: 1.000 Dollars Remaining: \$500.00
 Grant Date: 01/01/2024
 Expiration Date: 12/30/2024

[Previous](#) [Exit](#)

Figure 77 PA Record Page

4. Click **Exit** to return to the Prior Authorization page.

4.3 Create a Claim From Prior Authorization

1. Click **Create a Claim From PA** on the PA Record panel. The Institutional Claim panel will be displayed.

Next Search By: ICN

Institutional Claim

Required fields are indicated with an asterisk (*).

ICN <input type="text"/>	Type Of Bill* <input type="text"/> [Search]
Provider ID <input type="text"/> 1234567890 NPI	From Date of Service* <input type="text"/>
Member ID* <input type="text"/> 0987654321	To Date of Service* <input type="text"/>
Last Name <input type="text"/> CLTS	Patient Status* <input type="text"/> [Search]
First Name, MI <input type="text"/> SOPHIA	Point of Origin* <input type="text"/> [Search]
Date of Birth <input type="text"/> 07/14/2015	Admission Date <input type="text"/>
Patient Account # <input type="text"/>	Priority* <input type="text"/> [Search]
Medical Record # <input type="text"/>	Admission Diagnosis Code <input type="text"/> [Search]
Attending Provider* <input type="text"/>	Covered Days <input type="text"/> 0
Rendering Provider <input type="text"/> [Search]	Non Covered Days <input type="text"/> 0
Referring Provider <input type="text"/> [Search]	Medicare Disclaimer <input type="text"/> no disclaimer
Other Provider <input type="text"/>	Other Insurance Indicator <input type="text"/>
Notes <input type="text"/>	Referral Number <input type="text"/>
	Total Charge* <input type="text"/> \$500.00
	Net Difference <input type="text"/>
	PA Number* <input type="text"/> 555555554

[Diagnosis](#)
[Condition](#)
[Medicare](#)
[Payer](#)
[Procedure](#)
[Occurrence/Seam](#)
[Value](#)
[Patient Reason for Visit](#)
[External Cause of Morbidity](#)
[Other Insurance](#)

Detail

Line Number	Revenue Code	HIPPS Code	Rendering Provider	Referring Provider	Procedure Code	Units	Charge	Status	Allowed Amount
A	0 663		1234567890			1.00	\$500.00		\$0.00

Select row above to update -or- click Add button below.

Line Number <input type="text"/>	Revenue Code <input type="text"/> [Search]
From Date of Service <input type="text"/>	HIPPS Code <input type="text"/> [Search]
To Date of Service <input type="text"/>	Rendering Provider <input type="text"/> [Search]
Procedure Code <input type="text"/> [Search]	Referring Provider <input type="text"/> [Search]
Modifiers <input type="text"/> [Search]	Charge <input type="text"/> [Search]
Units <input type="text"/>	Allowed Amount <input type="text"/>
Status <input type="text"/>	

Professional Service Description

[NDCs for ICD](#)

Medicare Information(Detail)

Line Number <input type="text"/> 1	Deductible Amount <input type="text"/> \$0.00 +
Medicare Paid Date <input type="text"/>	Coinsurance Amount <input type="text"/> \$0.00 +
Medicare Paid Amount <input type="text"/> \$0.00	Blood Deductible Amount <input type="text"/> \$0.00 +
Medicare Non Covered Charged <input type="text"/> \$0.00	Copayment Amount <input type="text"/> \$0.00 +

Remaining Patient Liability =

Attachments

*** No rows found ***

Select row above to update -or- click Add button below.

Attachment Control Number <input type="text"/>
Description <input type="text"/>

Claim Status Information

Claim Status Not submitted yet

Figure 78 Institutional Claim Panel

Information from the PA will be displayed such as the procedure code, units, and charge.

- The user can edit fields in the “Detail” section by clicking the desired row.

Next Search By: ICN

Institutional Claim

Required fields are indicated with an asterisk (*).

ICN <input type="text"/>	Type Of Bill* <input type="text"/> [Search]
Provider ID <input type="text"/> 1234567890 NPI	From Date of Service* <input type="text"/>
Member ID* <input type="text"/> 0987654321	To Date of Service* <input type="text"/>
Last Name <input type="text"/> CLTS	Patient Status* <input type="text"/> [Search]
First Name, MI <input type="text"/> SOPHIA	Point of Origin* <input type="text"/> [Search]
Date of Birth <input type="text"/> 07/14/2015	Admission Date <input type="text"/>
Patient Account # <input type="text"/>	Priority* <input type="text"/> [Search]
Medical Record # <input type="text"/>	Admission Diagnosis Code <input type="text"/> [Search]
Attending Provider* <input type="text"/>	Covered Days <input type="text"/> 0
Rendering Provider <input type="text"/> [Search]	Non Covered Days <input type="text"/> 0
Referring Provider <input type="text"/> [Search]	Medicare Disclaimer <input type="text"/> no disclaimer
Other Provider <input type="text"/>	Other Insurance Indicator <input type="text"/>
Notes <input type="text"/>	Referral Number <input type="text"/>
	Total Charge* <input type="text"/> \$500.00
	Net Difference <input type="text"/>
	PA Number* <input type="text"/> 555555554

[Diagnosis](#) [Condition](#) [Medicare](#) [Payer](#) [Procedure](#) [Occurrence/Span](#) [Value](#) [Patient Reason for Visit](#) [External Cause of Morbidity](#) [Other Insurance](#)

Detail

Line Number	Revenue Code	HIPPS Code	Rendering Provider	Referring Provider	Procedure Code	Units	Charge	Status	Allowed Amount
A	0	663	1234567890			1.00	\$500.00		\$0.00

Type data below for new record.

Line Number <input type="text"/> 0	Revenue Code <input type="text"/> 663 [Search]
From Date of Service* <input type="text"/>	HIPPS Code <input type="text"/> [Search]
To Date of Service* <input type="text"/>	Rendering Provider <input type="text"/> 1234567890 NPI [Search]
Procedure Code <input type="text"/> [Search]	Referring Provider <input type="text"/> [Search]
Modifiers <input type="text"/> [Search]	<input type="text"/> [Search]
Units* <input type="text"/> 1.00	Charge <input type="text"/> \$500.00
Status <input type="text"/>	Allowed Amount <input type="text"/> \$0.00
Professional Service Description <input type="text"/>	

Figure 79 Institutional Claim Panel—Detail Section

3. Once changes are made, click the desired row and updates will be displayed.

Next Search By: ICN

Institutional Claim

Required fields are indicated with an asterisk (*).

ICN

Provider ID 1234567890 NPI

Member ID* 0987654321

Last Name CLTS

First Name, MI SOPHIA

Date of Birth 07/14/2015

Patient Account #

Medical Record #

Attending Provider*

Rendering Provider [Search]

Referring Provider [Search]

Other Provider

Notes

Type Of Bill* [Search]

From Date of Service*

To Date of Service*

Patient Status* [Search]

Point of Origin* [Search]

Admission Date

Priority* [Search]

Admission Diagnosis Code [Search]

Covered Days 0

Non Covered Days 0

Medicare Disclaimer no disclaimer

Other Insurance Indicator

Referral Number

Total Charge* \$500.00

Net Difference

PA Number* 555555554

[Diagnosis](#) [Condition](#) [Medicare](#) [Payer](#) [Procedure](#) [Occurrence/Scan](#) [Value](#) [Patient Reason for Visit](#) [External Cause of Morbidity](#) [Other Insurance](#)

Detail

Line Number	Revenue Code	HIPPS Code	Rendering Provider	Referring Provider	Procedure Code	Units	Charge	Status	Allowed Amount
A	0	663	1234567890		T1016	1.00	\$500.00		\$0.00

type data below for new record.

Line Number 0

Revenue Code 663 [Search]

From Date of Service*

To Date of Service*

Procedure Code T1016 [Search]

Modifiers [Search]

Units* 1.00

Status

Professional Service Description

Rendering Provider 1234567890 NPI [Search]

Referring Provider [Search]

Charge \$500.00

Allowed Amount \$0.00

Figure 80 Institutional Claim Panel—Detail Section Updated

4. Refer to the [Submit an Institutional Claim chapter](#) of this user guide for complete claim submission instructions.

5 Prior Authorization Search-Bulk

CLTS providers can search for and view PA information in bulk via the PA Search-Bulk link on their secure provider page.

1. On the secure Provider page, click **PA Search-Bulk**.

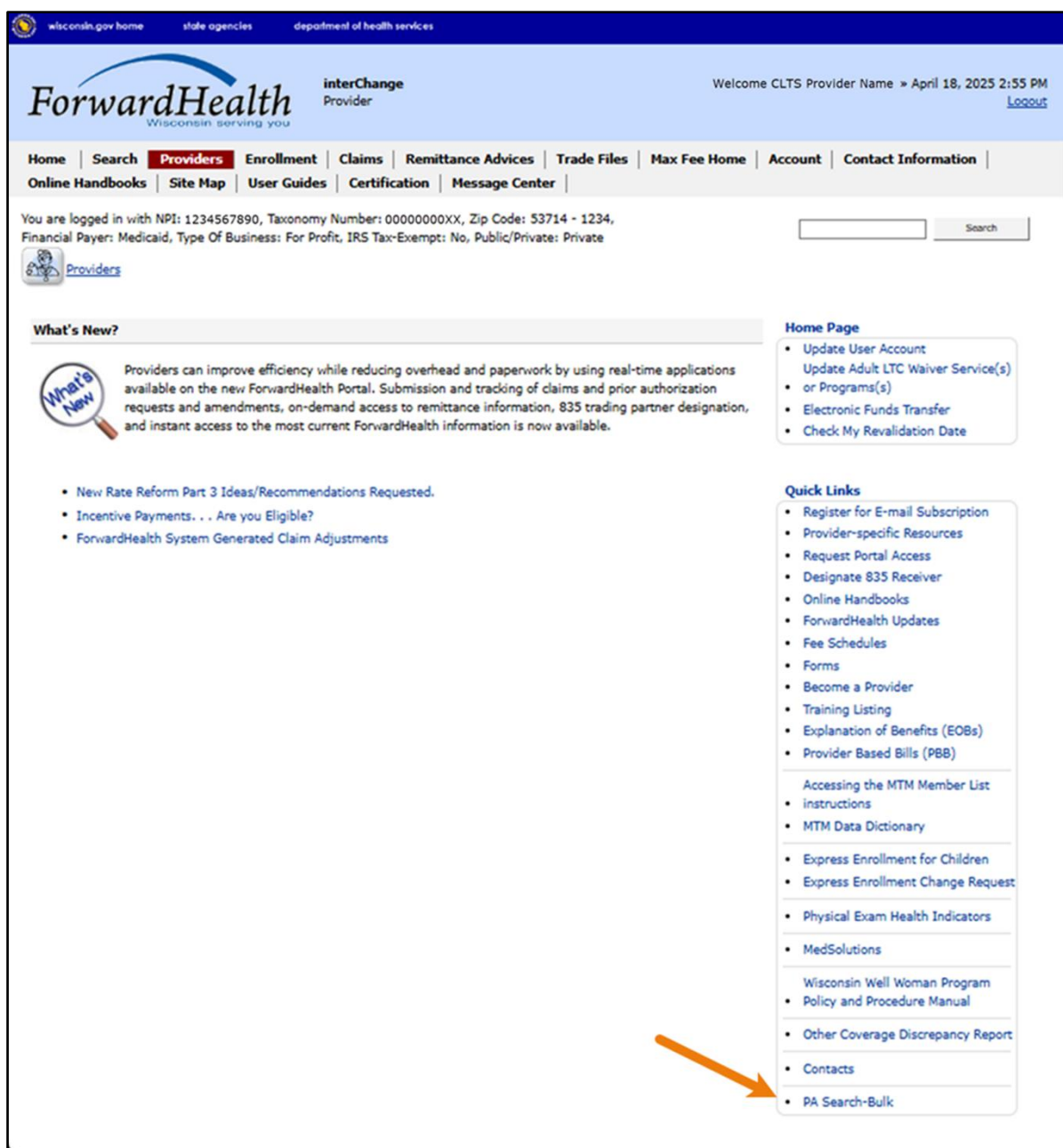


Figure 81 Secure Provider Page—PA Search-Bulk

The PA Search-Bulk panel will be displayed.

PA Search-Bulk

Required fields are indicated with an asterisk(*).

Search Criteria

CWA ID

Provider ID

PA Number

CWA PA Number

Member ID

Service Code

From DOS*

To DOS*

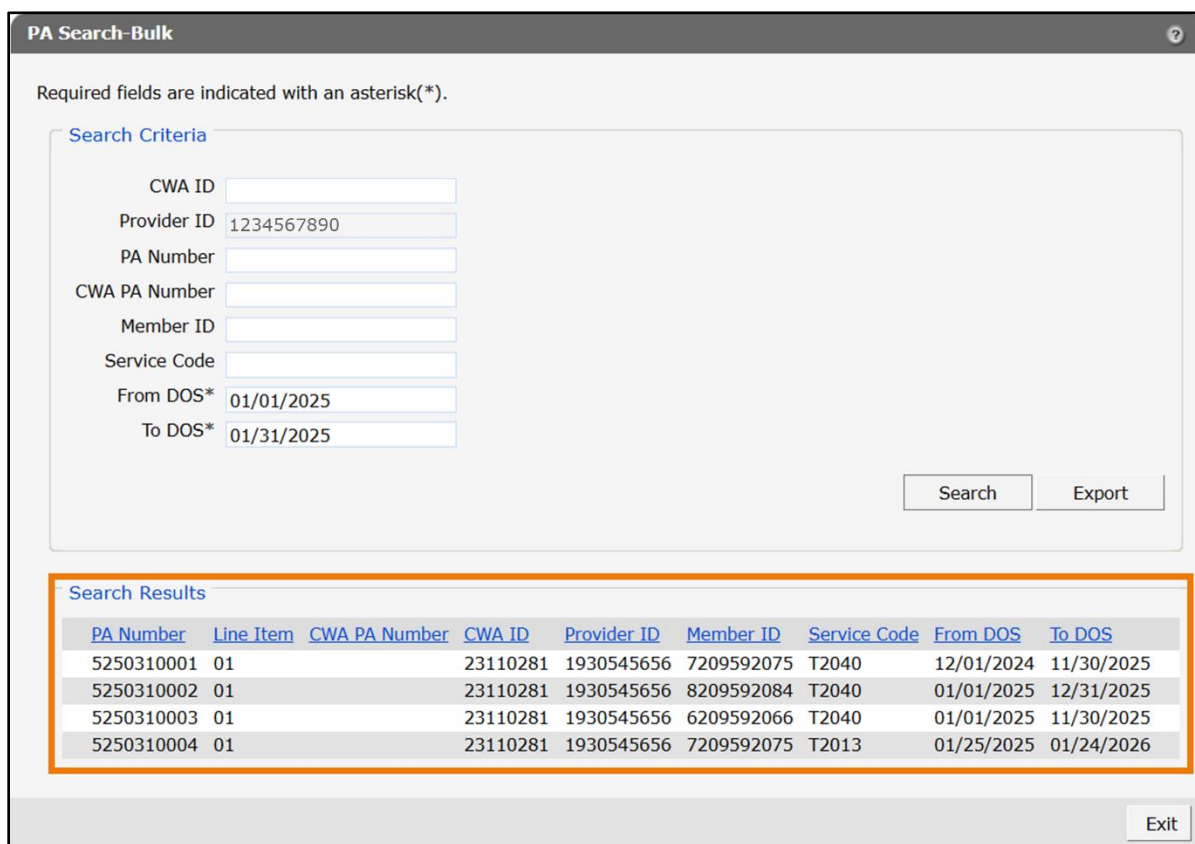
Search Results

*** No rows found ***

Figure 82 PA Search-Bulk Panel

2. Enter the information into the following fields. In order to search, users are required to enter the desired date span in the From DOS* and To DOS* fields in MM/CC/CCYY format.
 - CWA ID—This is the number identifying the waiver agency.
 - Provider ID—This is the number identifying the provider.
 - PA Number—This is the number assigned to a PA request.
 - CWA PA Number—This is the PA number assigned by the CWA.
 - Member ID—This is the recipient’s ID as specified on the PA request.
 - Service Code—This is the service code as specified on the PA request.
 - From DOS*—This is the authorized PA start date.
 - To DOS*—This is the authorized PA stop date.

- Click **Search**. The search results will be displayed at the bottom of the panel.



PA Search-Bulk

Required fields are indicated with an asterisk(*).

Search Criteria

CWA ID

Provider ID

PA Number

CWA PA Number

Member ID

Service Code

From DOS*

To DOS*

Search Results

PA Number	Line Item	CWA PA Number	CWA ID	Provider ID	Member ID	Service Code	From DOS	To DOS
5250310001	01		23110281	1930545656	7209592075	T2040	12/01/2024	11/30/2025
5250310002	01		23110281	1930545656	8209592084	T2040	01/01/2025	12/31/2025
5250310003	01		23110281	1930545656	6209592066	T2040	01/01/2025	11/30/2025
5250310004	01		23110281	1930545656	7209592075	T2013	01/25/2025	01/24/2026

Figure 83 PA Search-Bulk-Search Results

- Click **Export**. A PA bulk report Excel file will be downloaded.
- Navigate to the location where the file was downloaded on the computer.

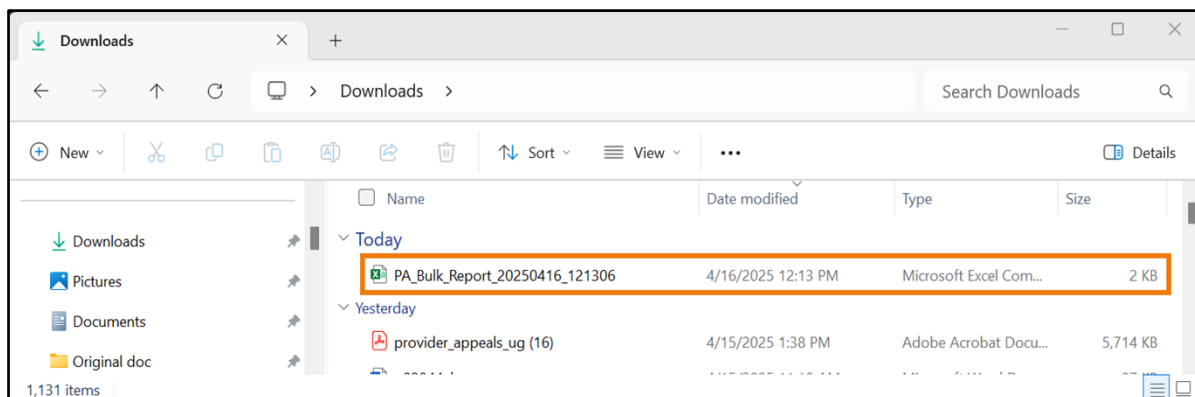


Figure 84 Downloads

6. Double-click to open the file. The comma-separated values file will be displayed in Excel.

PA Number	Line Item	CWA	PA N	CWA ID	Billing Prc	Member ID	First Name	Last Name	Start Date	End Date	Amendme	Primary D	Secondary D	Rendering Service Co	Service Co	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Units	Units Use	Units Rem	Dollars Ac	Dollars Un	Dollars Re	External Text
5.25E+09	1	23110281	1.93E+09	7.21E+09	JOSE	CLTS	20241201	20251130	N			1.93E+09	T2040	FINANCIA	GT	HQ	UN			5	0	5	200	0	200	
5.25E+09	1	23110281	1.93E+09	6.21E+09	SOPHIA	CLTS	20250101	20251231	N			1.93E+09	T2040	FINANCIA	GT	HQ	UN			5	0	5	200	0	200	
5.25E+09	1	23110281	1.93E+09	6.21E+09	MARIANA	CLTS	20250101	20251130	N			1.93E+09	T2040	FINANCIA	GT	HQ	UN			5	0	5	200	0	200	
5.25E+09	1	23110281	1.93E+09	7.21E+09	JOSE	CLTS	20250125	20260124	Y			1.93E+09	T2013	HABIL ED	GT					10	0	10	100	0	100	

Figure 85 Microsoft Excel Window-PA Bulk Report

Information for the following fields will be displayed:

- **PA Number**—This is the number assigned to a PA request.
- **Line Item Number**—This represents the PA line item number for the PA record. Each PA record may have up to 10 line items.
- **CWA PA Number**—This is the PA number assigned by the CWA.
- **CWA ID**—This is the number identifying the waiver agency.
- **Billing Provider ID**—This is the billing provider’s ID as specified on the PA request.
- **Member ID**—This is the recipient’s ID as specified on the PA request.
- **First Name**—This is the recipient’s first name.
- **Last Name**—This is the recipient’s last name.
- **Start Date**—This is the authorized PA start date.
- **End Date**—This is the authorized PA stop date.
- **Amendment Status**—Indicates “Y” or “N” if the PA has been amended.
- **Primary Diagnosis Code**—This is the primary diagnosis code as specified on the PA request.
- **Secondary Diagnosis Code**—This is the secondary diagnosis code as specified on the PA request.
- **Rendering Provider ID**—This is the performing provider ID as specified on the PA request.
- **Service Code**—This is the service code as specified on the PA request.
- **Service Code Description**—This is the service code description. This allows the entry of descriptions for unlisted procedure codes.
- **Modifiers 1–4**—These are procedure code modifiers of the PA.

- Units Authorized—This is the number of units authorized for the PA line item service.
 - Units Used—This is the number of services that have been used to date for a service/PA line item for a particular claim detail.
 - Units Remaining—This indicates the remaining units quantity, which is calculated by subtracting the used units quantity from the authorized units quantity.
 - Dollars Authorized—This is the dollar amount authorized for the PA line item service.
 - Dollars Used—This is the dollar amount that has been used to date for a service/PA line item for a particular detail.
 - Dollars Remaining—This indicates the remaining units quantity, which is calculated by subtracting the used amount from the authorized amount.
 - External Text—This displays the WPS assigned PA number for the converted PAs.
7. Certain column field names may be cut off or may show scientific notation in place of long numbers such as PA numbers.

The screenshot shows an Excel window with a table. The 'PA Number' column contains values in scientific notation (5.25E+09), which are truncated. An orange box highlights these values. The table has columns: PA Number, Line Item, CWA PA N, CWA ID, and Billing Pr.

PA Number	Line Item	CWA PA N	CWA ID	Billing Pr
5.25E+09	1		23110281	1930
5.25E+09	1		23110281	1930
5.25E+09	1		23110281	1930
5.25E+09	1		23110281	1930

Figure 86 Microsoft Excel Window

8. To correct this, click and drag the vertical line at the top of the field column to expand the column.

The screenshot shows the same Excel window after the 'PA Number' column has been expanded. The values are now displayed in full (e.g., 5250310001). An orange box highlights these values. A red arrow points to the vertical line at the top of the column header, indicating where to click and drag to expand the column.

PA Number	Line Item	CWA PA N	CWA ID	Billing Pr
5250310001	1		23110281	1930
5250310002	1		23110281	1930
5250310003	1		23110281	1930
5250310004	1		23110281	1930

Figure 87 Microsoft Excel Window

9. Click Save As and name the file.
10. Choose a location on the computer or network and save the file.