

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 ForwardHealth Provider 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 ForwardHealth Portal (the Portal) at forwardhealth.wi.gov/.

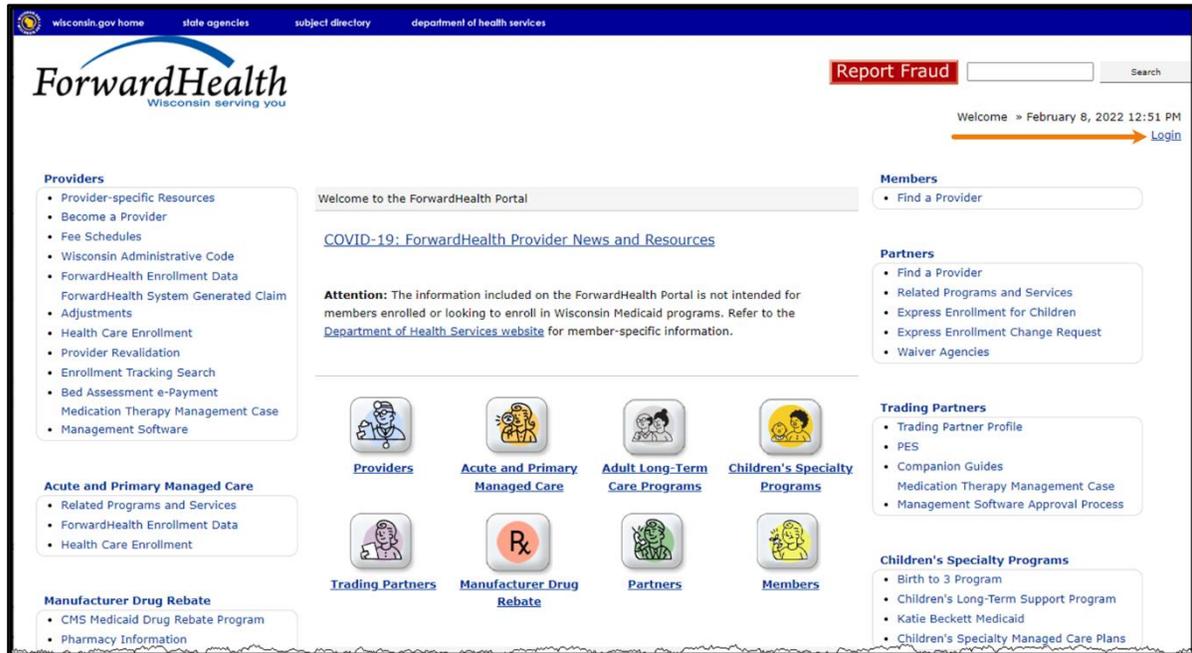
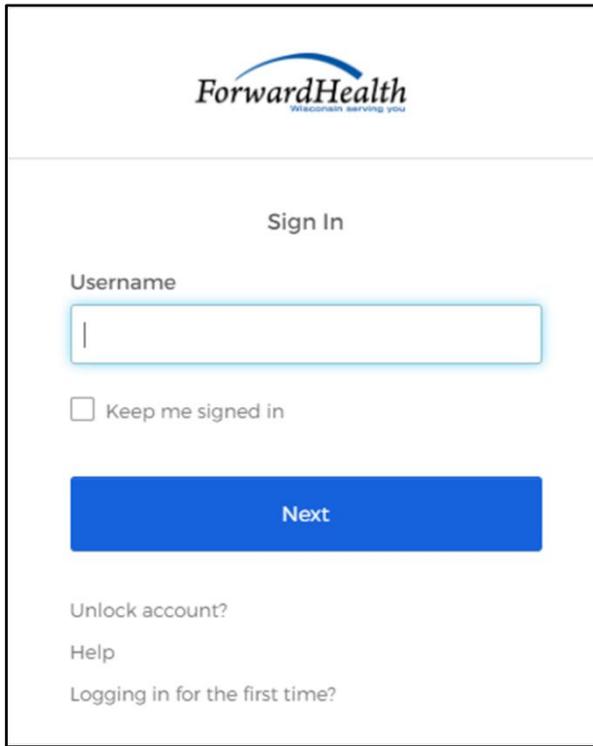


Figure 1 ForwardHealth Portal Homepage

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



ForwardHealth
WISCONSIN SERVING YOU

Sign In

Username

Keep me signed in

Next

[Unlock account?](#)

[Help](#)

[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.

Figure 3 Verify With Your Password Box

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

Figure 4 Secure Provider Page

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

Claims

Claims Submission Options
Providers may submit claims to ForwardHealth electronically or on paper. Providers are encouraged to submit claims electronically as it improves efficiency, reduces billing and processing errors, and allows for the timely processing of payments.

Providers may begin the claim processing function by clicking on the following options.

What would you like to do?

- [Claim search](#)
- [Claims Submission Report](#)
- [Submit Dental Claim](#)
- [Submit Institutional Claim](#)
- [Submit Compound/Noncompound Claim](#)
- [Submit Professional Claim](#)
- [Upload Claim Attachments](#)
- [WWWP Reporting Form Search](#)
- [Submit WWWP Breast Cancer Diagnostic and Follow Up Report](#)
- [Submit WWWP Cervical Cancer Diagnostic and Follow Up Report](#)
- [Submit WWWP Breast and Cervical Cancer Screening Activity Report](#)
- [Private Duty Nursing - Prior Authorization Claims Report](#)

Providers having difficulties determining which method to use when submitting a claim, or in submitting a claim through the Portal, may call provider services at 800-947-9627.

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] [Search] [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	<input type="text"/>	Coinsurance 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.

The screenshot shows the 'Institutional Claim' form with the following fields and values:

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

At the bottom of the form, there are several tabs: [Diagnosis](#), [Condition](#), [Medicare](#), [Payer](#), [Procedure](#), [Occurrence/Span](#), [Value](#), [Patient Reason for Visit](#), [External Cause of Morbidity](#), and [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.

The screenshot shows the 'Institutional Claim' form. At the top, it states 'Required fields are indicated with an asterisk (*)'. The 'Provider ID' field is a drop-down menu currently showing '1234567890 NPI'. An orange arrow points to this field with the text 'Click arrow to select sub-part NPI'. Below it, the 'Member ID*' field shows '1234567890 NPI' and '0987654321 SUB' as options. Other fields include 'ICN', 'Last Name', 'First Name, MI', 'Date of Birth', 'Type Of Bill*', 'From Date of Service*', 'To Date of Service*', 'Patient Status*', and 'Point of Origin*'. The 'Date of Birth' field is partially obscured by a watermark.

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.

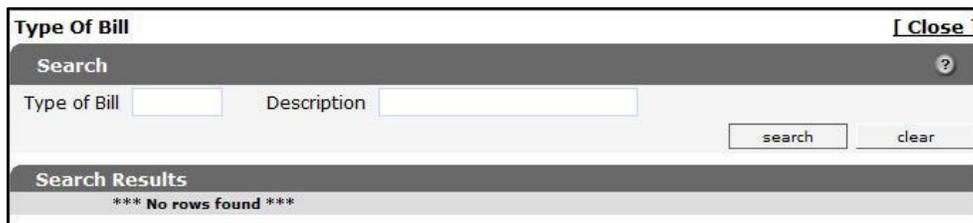


Figure 9 Type of Bill Search Panel

- 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.

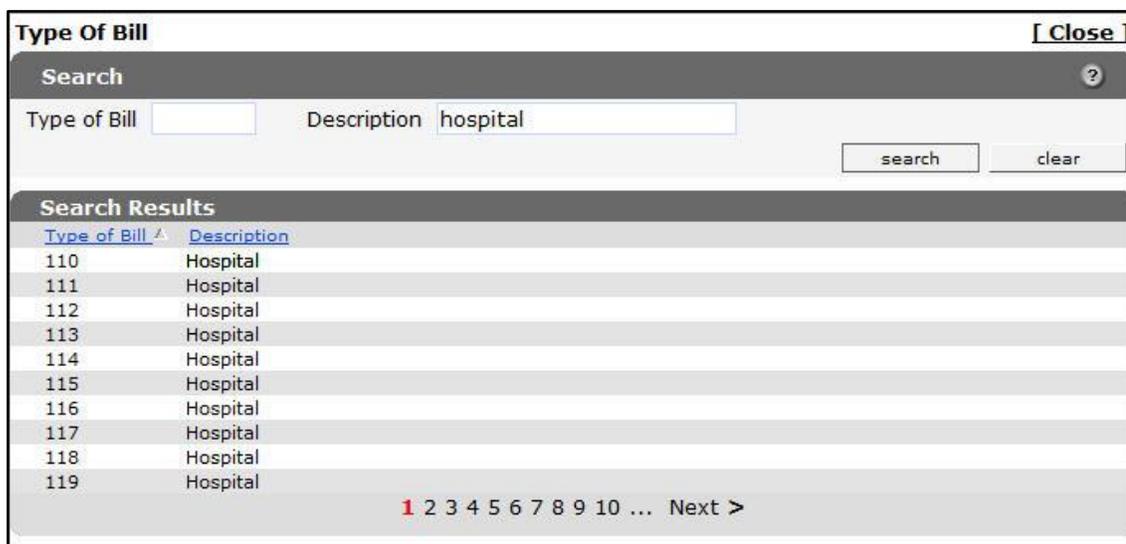


Figure 10 Type of Bill Search Results Panel

- 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 shows the 'Institutional Claim' form with various input fields. At the bottom, a navigation bar contains several tabs: **Diagnosis**, Condition, Medicare Payer, Procedure, Occurrence/Soan, Value, Patient Reason for Visit, External Cause of Morbidity, and Other Insurance. The 'Diagnosis' tab is highlighted with a red box and an orange arrow pointing to it.

Figure 11 Diagnosis Link

The Diagnosis panel will be displayed.

The screenshot shows a 'Diagnosis' panel with a header 'Diagnosis' and a sub-header 'Admit Diagnosis'. Below this, there are 24 rows, each representing a diagnosis field from 'Diagnosis 1' to 'Diagnosis 24'. Each row contains a text input field, a '[Search]' button, and a dropdown arrow.

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.

The screenshot shows a 'Diagnosis 1' search panel with a '[Close]' button in the top right. The panel has a 'Search' section with a 'Diagnosis' input field, an 'ICD Version' dropdown menu, and a 'Description' input field. Below these are 'search' and 'clear' buttons. A 'Search Results' section at the bottom displays '*** No rows found ***'.

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.

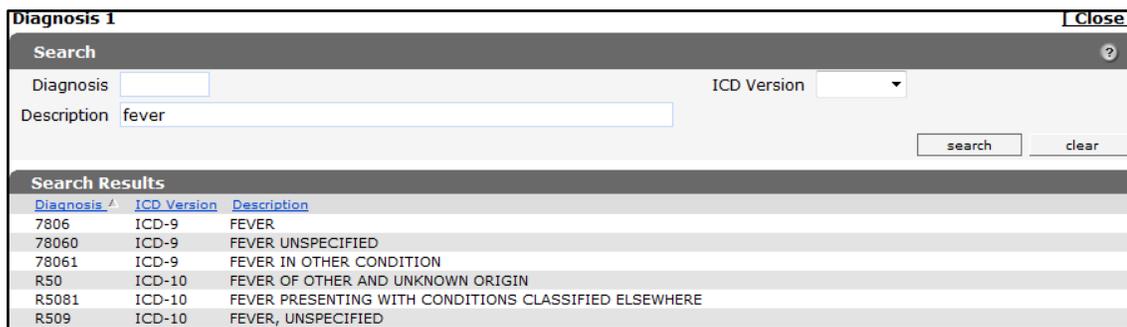


Figure 14 Diagnosis Search Results Panel

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

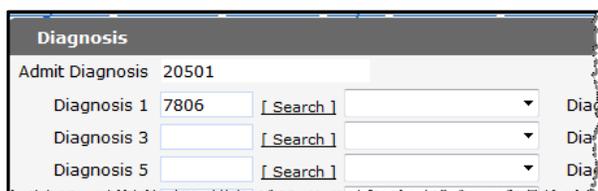


Figure 15 Diagnosis Code Added to the Claim Form

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:

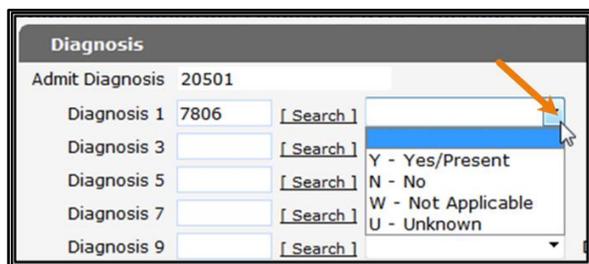


Figure 16 POA Code Indicator

- **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.

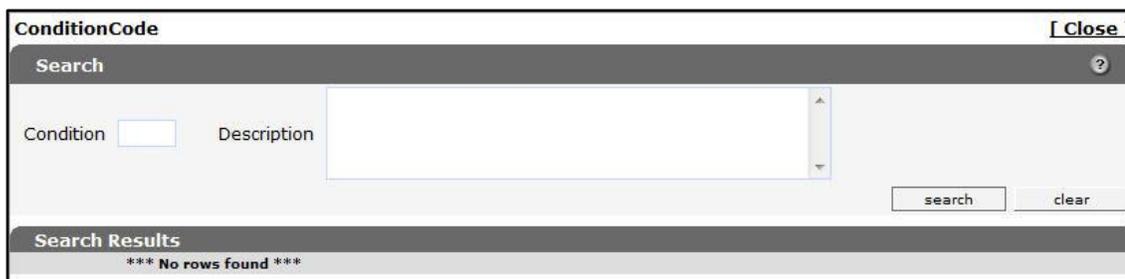


Figure 19 Condition Code Search Panel

- 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.



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.



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.

The screenshot shows a window titled "Payer" with a grey header. Below the header, it says "*** No rows found ***" and "Select row above to update -or- click Add button below." There are three input fields: "Sequence" (a text box), "Prior Payment" (a text box), and "Payer" (a dropdown menu). At the bottom right, there are two buttons: "Delete" and "Add".

Figure 23 Payer Panel

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

The screenshot shows the "Payer" window with a table. The table has three columns: "Sequence", "Payer", and "Prior Payment". The first row has the value "A" in the "Sequence" column, "0" in the "Payer" column, and "\$0.00" in the "Prior Payment" column. Below the table, it says "Type data below for new record." There are three input fields: "Sequence*" (a text box with "0"), "Prior Payment" (a text box with "\$0.00"), and "Payer*" (a dropdown menu). At the bottom right, there are two buttons: "Delete" and "Add".

Figure 24 Payer Panel With Added Row

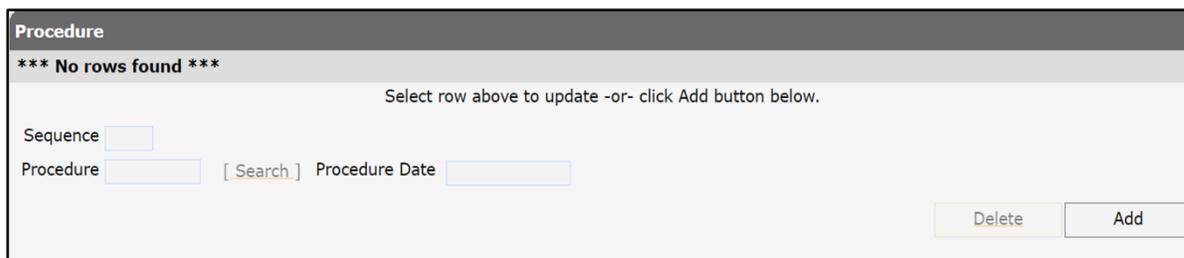
3. The Sequence field gives numerical order to the OI information. Enter a **1** for the first added row. If multiple commercial insurance companies paid on the claim, enter numbers in numerical order for each row added.
4. Enter the amount received from the payer prior to this billing in the Prior Payment 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](#).

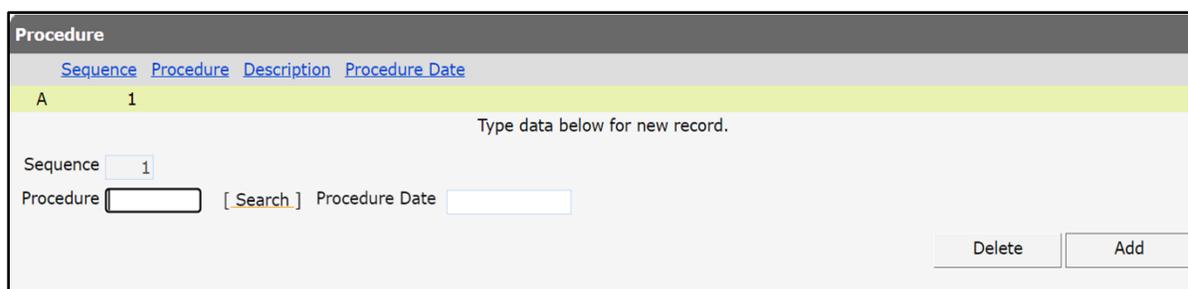
1. Click **Procedure** at the bottom of the Institutional Claim panel. The Procedure panel will be displayed.



The screenshot shows a web interface titled "Procedure". At the top, it displays "*** No rows found ***". Below this, there is a message: "Select row above to update -or- click Add button below." There are three input fields: "Sequence" (empty), "Procedure" (empty), and "Procedure Date" (empty). A "[Search]" button is located between the "Procedure" and "Procedure Date" fields. 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 with one row added. The row is highlighted in yellow and contains the text "A 1". Above the row, there are four column headers: "Sequence", "Procedure", "Description", and "Procedure Date". Below the row, there is a message: "Type data below for new record." There are three input fields: "Sequence" (containing "1"), "Procedure" (empty), and "Procedure Date" (empty). A "[Search]" button is located between the "Procedure" and "Procedure Date" fields. 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 a panel titled "Occurrence/Span" with a message: "*** No rows found ***". Below the message, it says "Select row above to update -or- click Add button below." There are four input fields: "Sequence" (empty), "From Date" (empty), "Occurrence Code" (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", "To Date". A single row is added with "A" in the Sequence column and "0" in the Occurrence Code column. Below the table, it says "Type data below for new record." The "Sequence" field now contains the value "1". The "From Date*" field is empty, and the "To Date" field is empty. The "[Search]" link is still present. "Delete" and "Add" buttons are at the bottom right.

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.



Figure 29 Value Panel

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

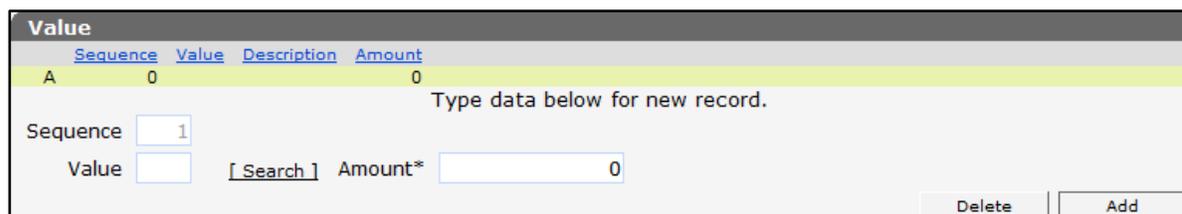


Figure 30 Value Panel With Added Row

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.



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.

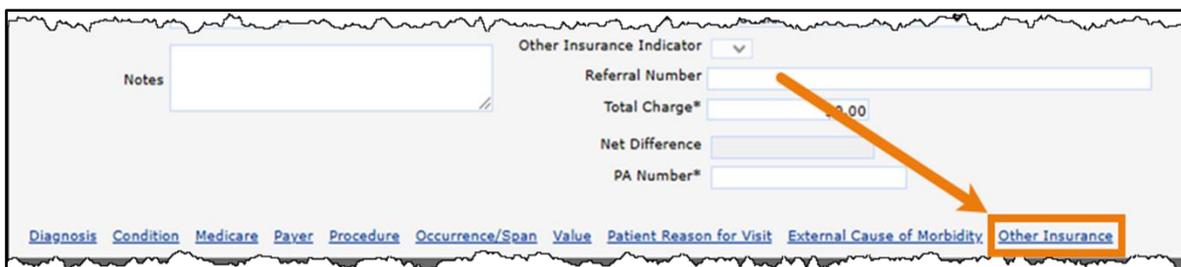


Figure 33 Other Insurance Link

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.

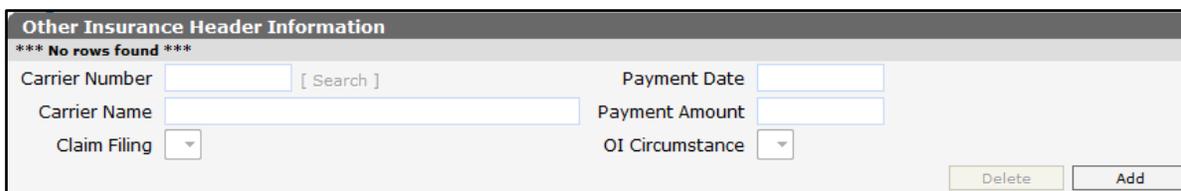


Figure 34 Other Insurance Header Information Panel

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.

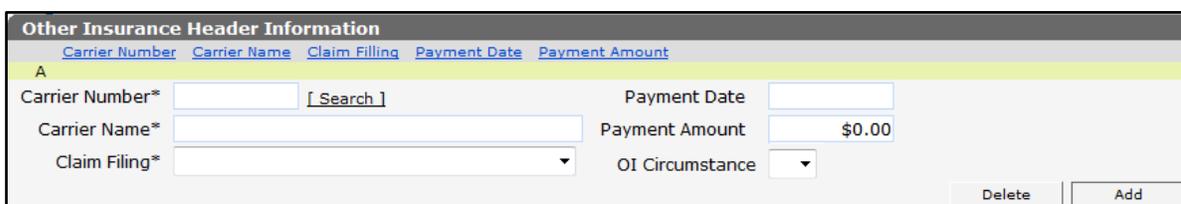


Figure 35 Add Other Insurance

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.

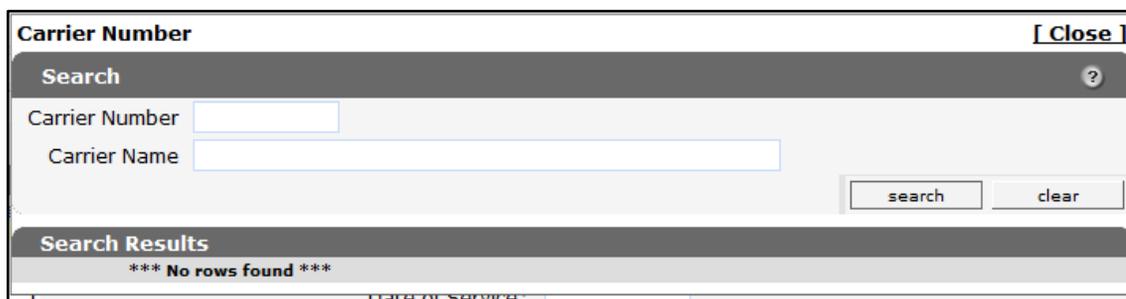


Figure 36 Carrier Number Search Panel

- 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.

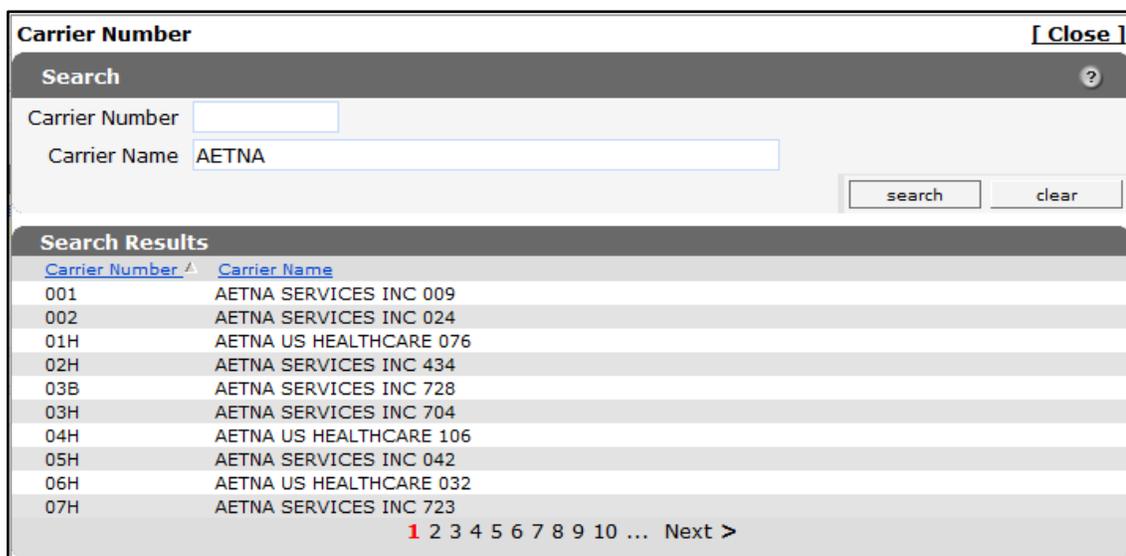


Figure 37 Carrier Number Search Results Panel

- 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.

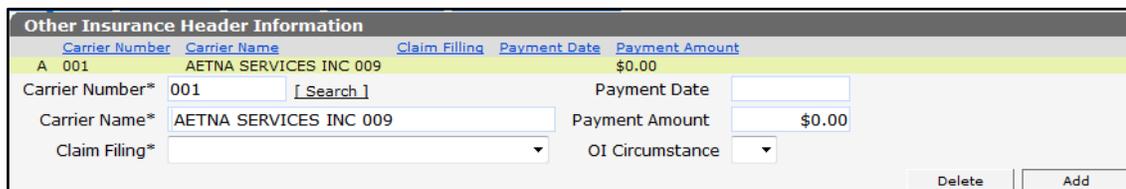


Figure 38 Carrier Number and Name Added to Institutional Claim Form

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.

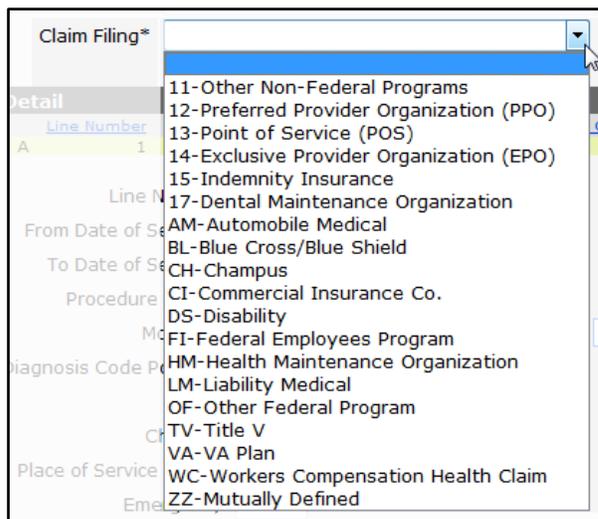


Figure 39 Claim Filing Drop-Down Menu

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.

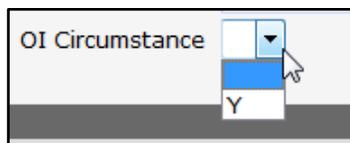


Figure 40 OI Circumstance Drop-Down Menu

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]

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 Institutional 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

Delete Add

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

Delete Add

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.

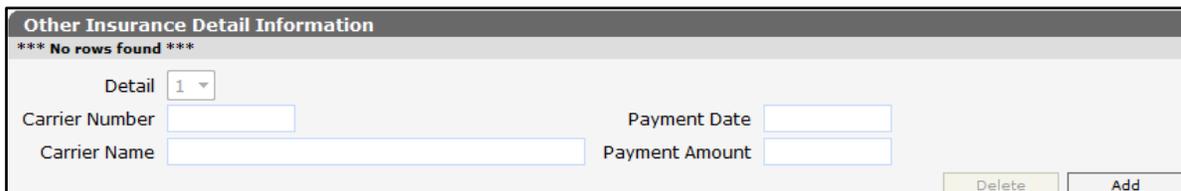


Figure 45 Other Insurance Detail Information Panel

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.

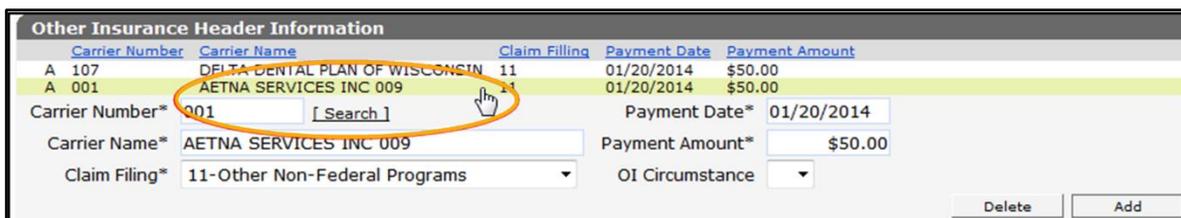


Figure 46 Select Carrier in Header

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**.

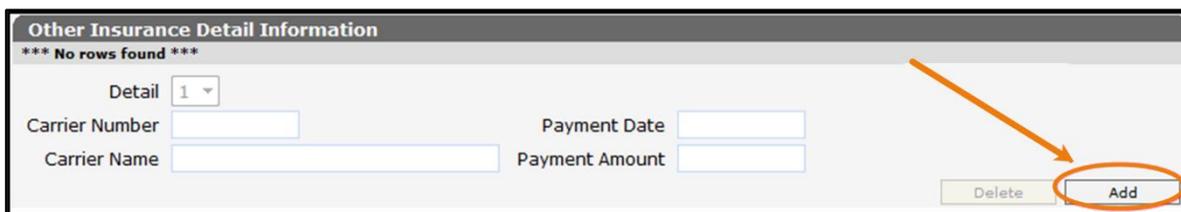


Figure 47 Other Insurance Detail Panel

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.

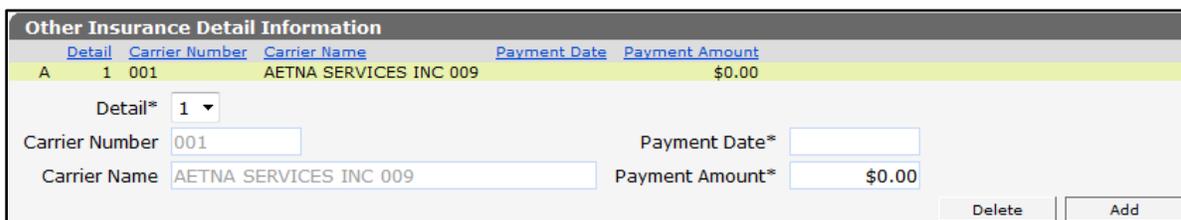


Figure 48 Carrier Added to Other Insurance Detail Information Panel

- 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.

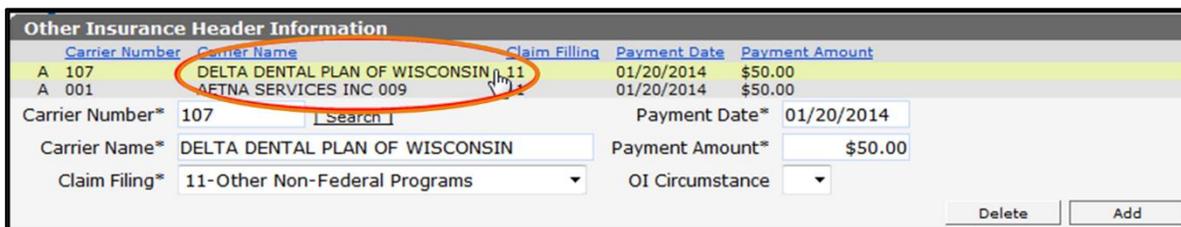


Figure 49 Select Additional Carrier in Header

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

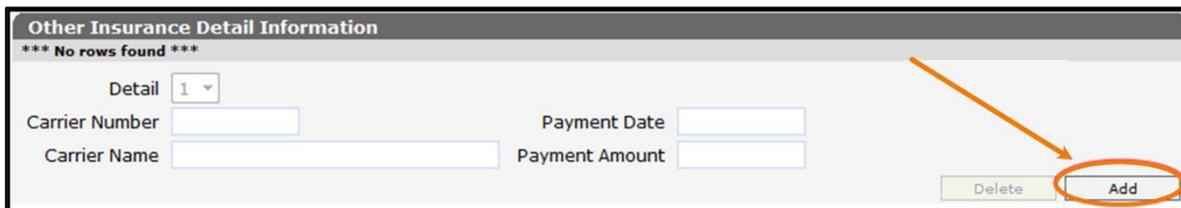


Figure 50 Blank Other Insurance Detail Information Panel

7. 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

8. 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.

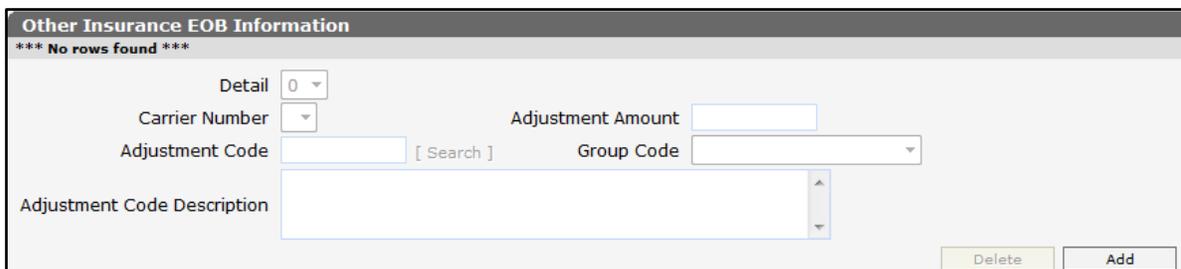


Figure 52 Other Insurance EOB Information Panel

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:

1. 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.

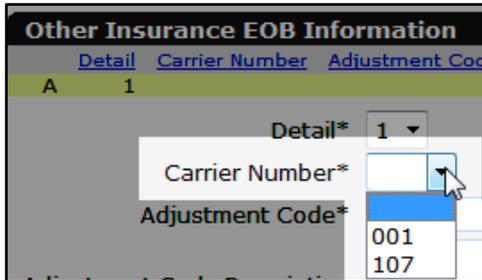


Figure 53 Select Carrier Number

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.

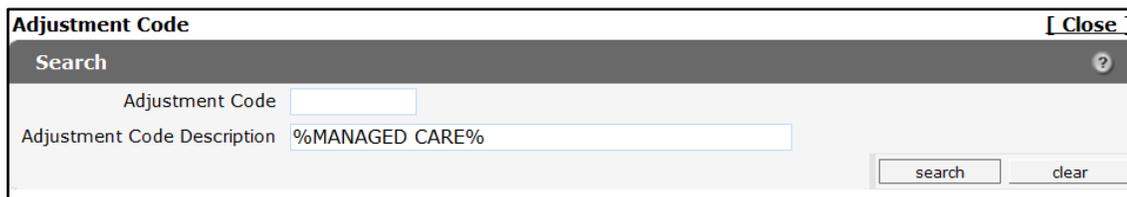


Figure 57 Wild Card Search

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



Figure 58 Exact Description Search Results

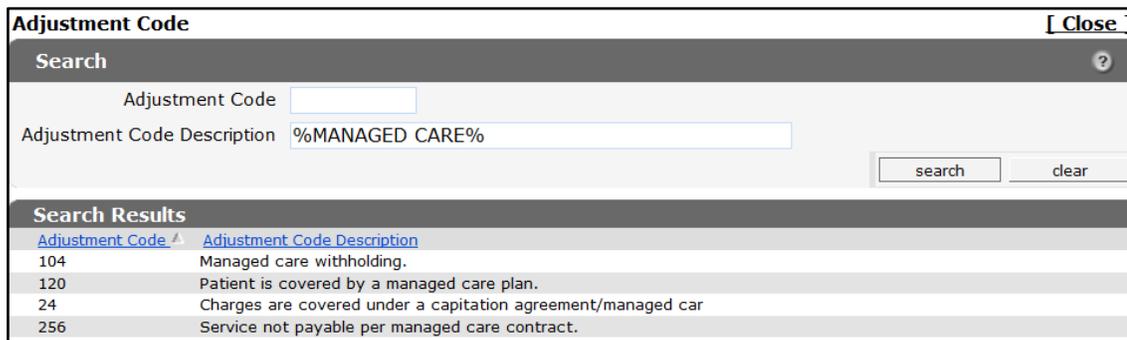


Figure 59 Wild Card Search Results

- 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.

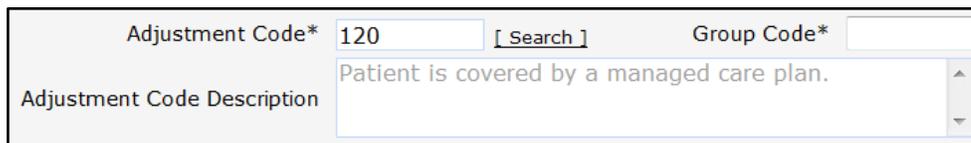


Figure 60 Adjustment Code and Description Added to the Panel

The following list includes some common American National Standards Institute (ANSI) codes that are used by ForwardHealth to process claims. The most current and complete listing of all valid ANSI codes are available [online](#).

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.

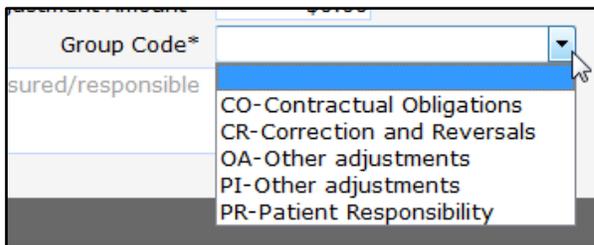


Figure 61 Select Group Code

- 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 copay 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 copay amount.

3.6 Attachments Panel

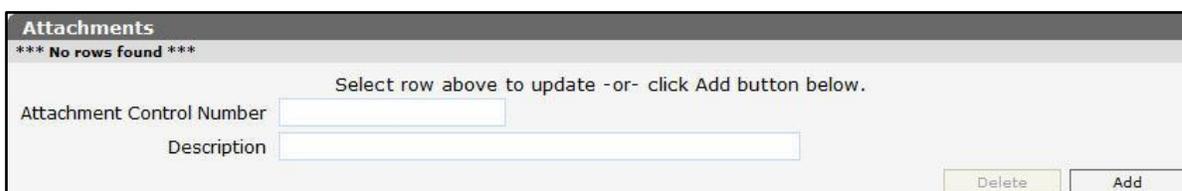


Figure 64 Attachments Panel

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.



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.



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.

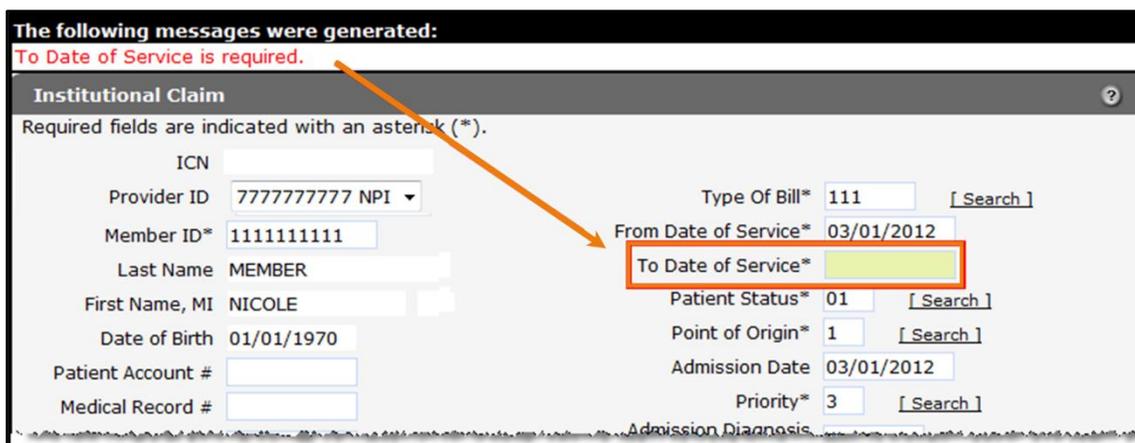


Figure 67 Error Message

- 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:

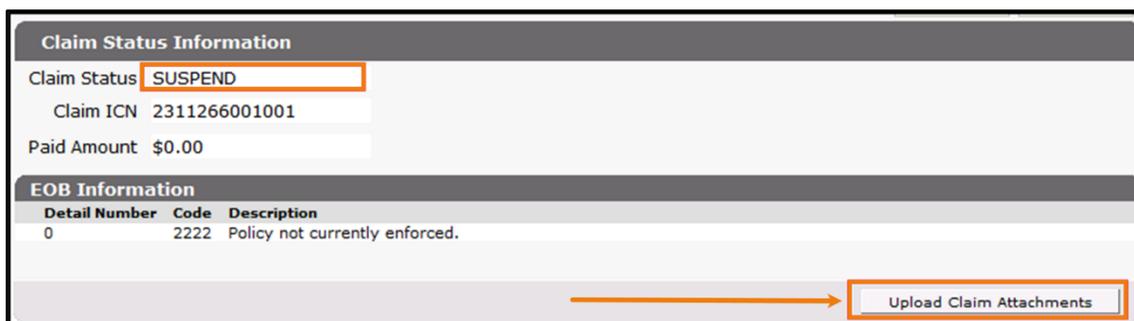


Figure 68 Submitted Claim With Attachments

- 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.

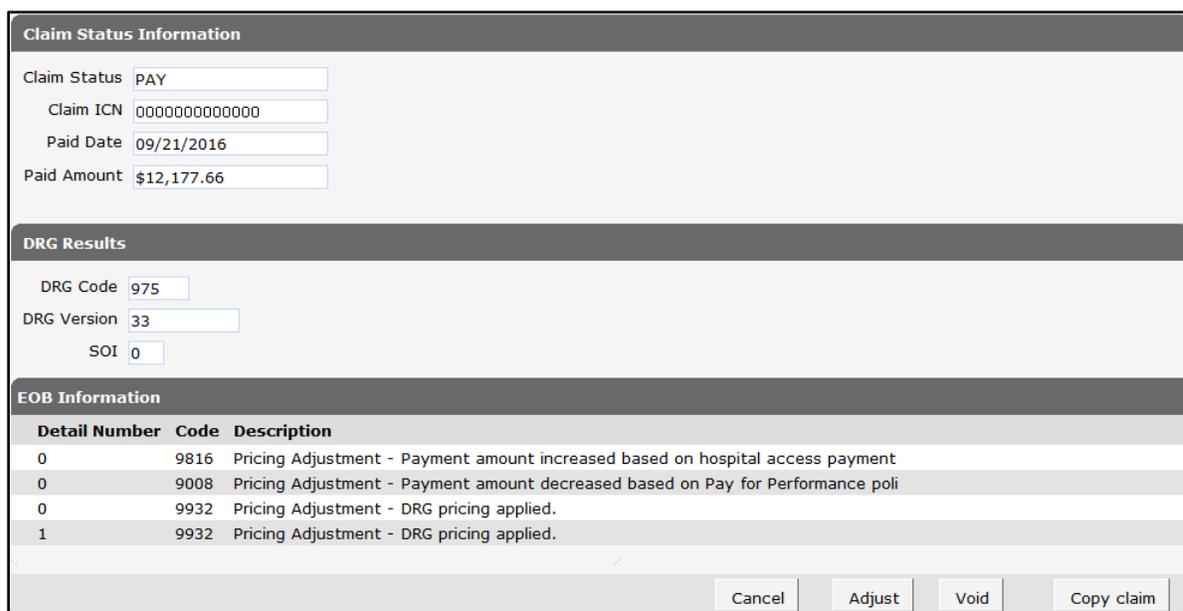


Figure 69 Claim Status Information, DRG Results, and EOB Information Panels

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 for services provided to CLTS Program participants.

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

Claims

Claims Submission Options
Providers may submit claims to ForwardHealth electronically or on paper. Providers are encouraged to submit claims electronically as it improves efficiency, reduces billing and processing errors, and allows for the timely processing of payments.

Providers may begin the claim processing function by clicking on the following options.

What would you like to do?

- [Claim search](#)
- [Claims Submission Report](#)
- [Submit Institutional Claim](#)
- [Submit Professional Claim](#)
- [Upload Claim Attachments](#)
- [Create a Claim From PA](#)

Providers having difficulties determining which method to use when submitting a claim, or in submitting a claim through the Portal, may call provider services at 800-947-9627.

Figure 70 Claims Page

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

Find PA Record

To view a PA record enter the PA Number in the PA Number field and select "View PA Record".

PA Number

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)
117 - PA Botox to Treat Migraines
117 - Physician services, including rural health clinics and federally qualified health centers

Member ID

Requested Start Date

PA Status

Amendment Status

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

- Enter the PA number in the PA number field.

- 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 PA number entered is valid, the PA Record panel will be displayed with information that was previously submitted. Note: Confirm the PA has an approved status at the top of the page. Users may only create a claim for approved PAs.

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: 55555554 | 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: [Field]
 Process Type: 147 - Childrens Long-Term Support
 Program: Medicaid
 HealthCheck Other Service: No | Start Date - SOI: [Field]
 Requested Start Date: 01/01/2024 | First Date of Treatment - SOI: [Field]
 Primary Diagnosis Code: Z418 | Description: ENCNR FOR OTH PROC FOR PURPOSE OTH THAN REMEDY HEALTH STATI
 Secondary Diagnosis Code: [Field] | Description: [Field]
 National Provider Identifier- Prescribing/Referring/Ordering Provider: [Field] | Name - Prescribing/Referring/Ordering Provider: [Field]

[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: [Field]
 Service Code Type: Revenue Code
 Service Code: 0663
 Service Code Description: [Field]
 Tooth: [Field] | Area of the Oral Cavity: [Field]
 Modifiers: [Field] [Field] [Field]
 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](#)

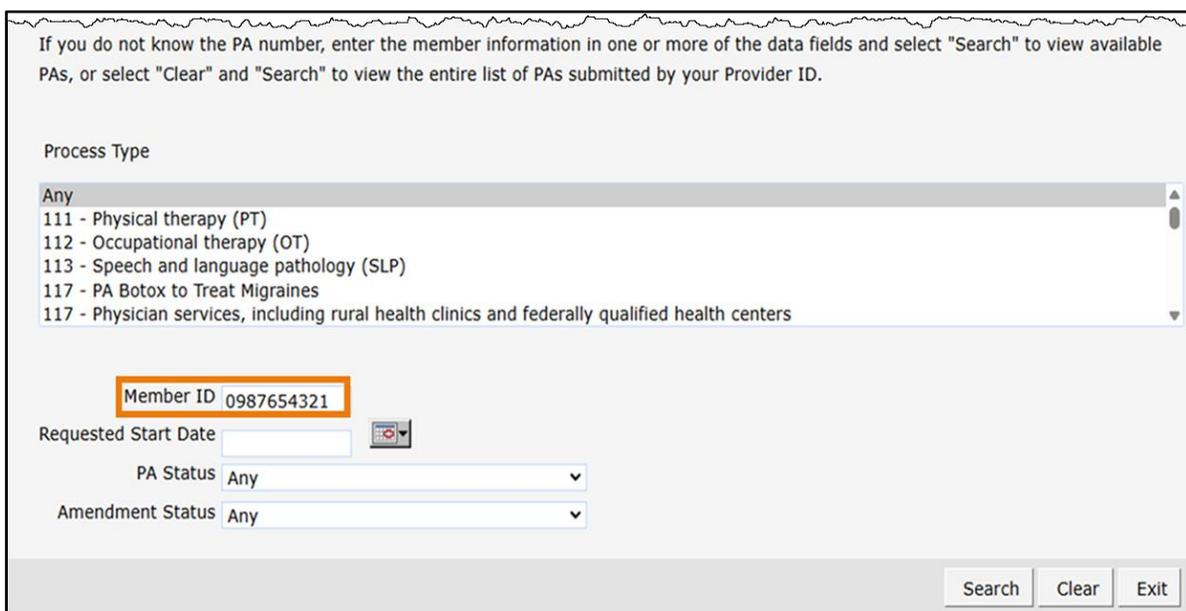
Figure 73 PA Record Panel

- Proceed to [Step 11](#).

4.2 Search by Other Criteria

7. 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.
8. 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)
117 - PA Botox to Treat Migraines
117 - Physician services, including rural health clinics and federally qualified health centers

Member ID 0987654321

Requested Start Date

PA Status Any

Amendment Status Any

Search Clear Exit

Figure 74 Search by Other Criteria

9. 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 panel will be displayed.

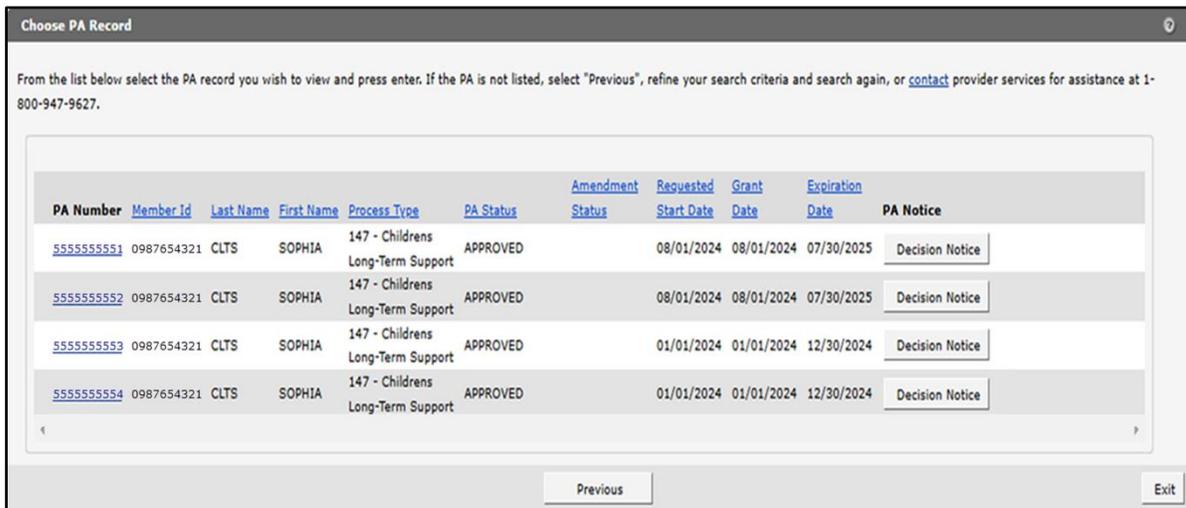


Figure 76 Choose PA Record Panel

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.

- Click the hyperlink of the desired PA number under the PA Number column.

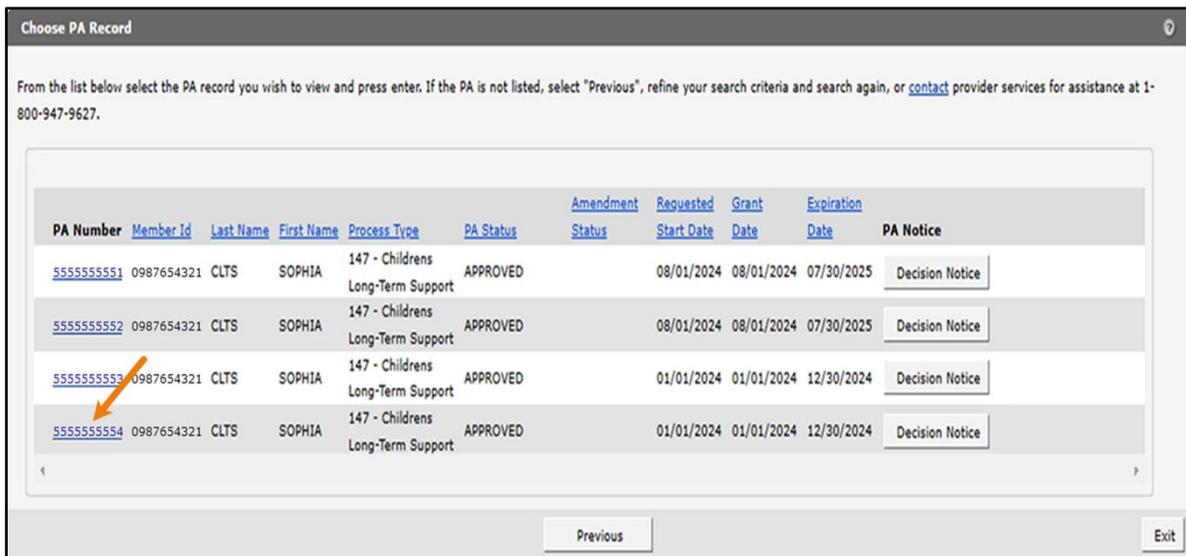


Figure 77 Choose PA Record Panel—Hyperlink

The PA Record panel will be displayed with information that was previously submitted. Note: Confirm the PA has an approved status at the top of the page. Users may only create a claim for approved PAs.

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: ENCNTN 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 78 PA Record Panel

11. Review the PA details making sure the information aligns with the claim being submitted. Confirm that this information is correct and matches the services that should be billed:

- Units
- Procedure code
- Dollars
- Dates of service are after the requested start date

12. If the information is correct and matches the services that should be billed, proceed to [Step 13](#).

If the information does not match the services that should be billed, an adjustment will need to be made to the PA. Revisit the list of PAs for the client or reach out to the county waiver agency (CWA) for an updated PA for the services.

4.3 Create a Claim From Prior Authorization

13. Click **Create a Claim From PA** on the PA Record panel.

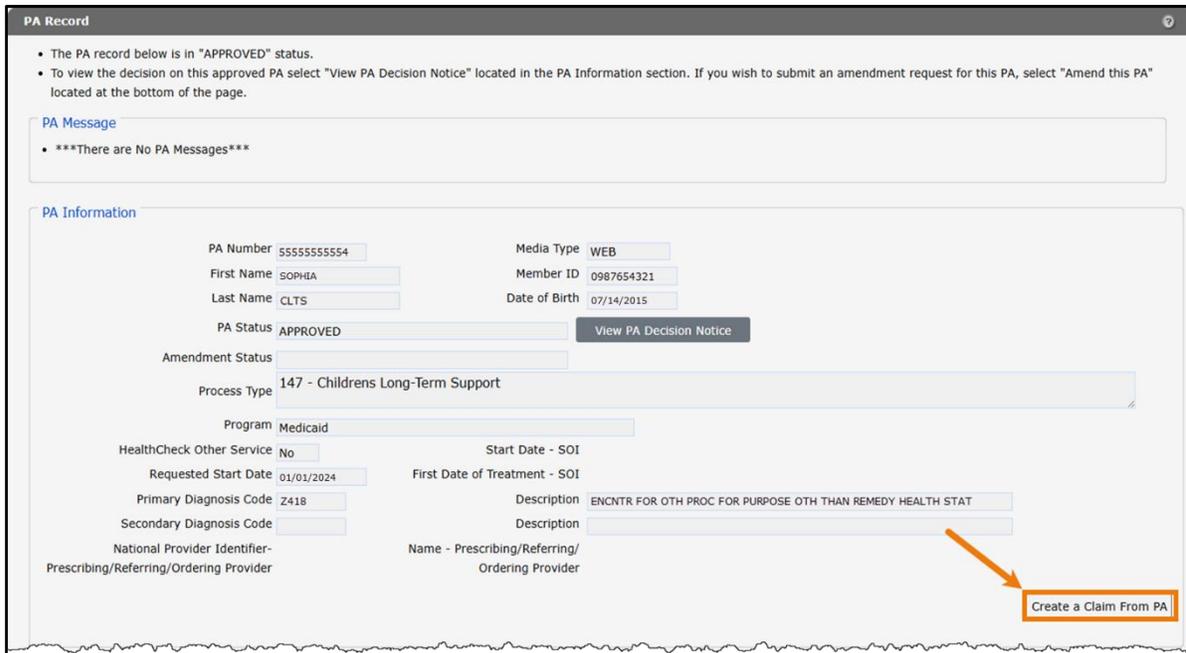


Figure 79 PA Record Panel—Create a Claim From PA Link

The Institutional Claim panel 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/Seqn](#)
[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

From Date of Service

To Date of Service

Procedure Code [Search]

Modifiers [Search]

Units

Status

Professional Service Description

Revenue Code [Search]

HIPPS Code [Search]

Rendering Provider [Search]

Referring Provider [Search]

Charge [Search]

Allowed Amount

[NDCs for JCode](#)

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 <input type="text"/> =	

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 80 Institutional Claim Panel

14. Click the line below the “Detail” section to open the template.

Diagnosis Condition Medicare Payer Procedure Occurrence/Sean 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 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

Delete Add

Figure 81 Institutional Claim Panel—Detail Section

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

Diagnosis Condition Medicare Payer Procedure Occurrence/Sean 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					1.00	\$500.00		\$0.00

Type data below for new record.

Line Number 0 Revenue Code 663 [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* 1.00 Charge \$500.00

Status Allowed Amount \$0.00

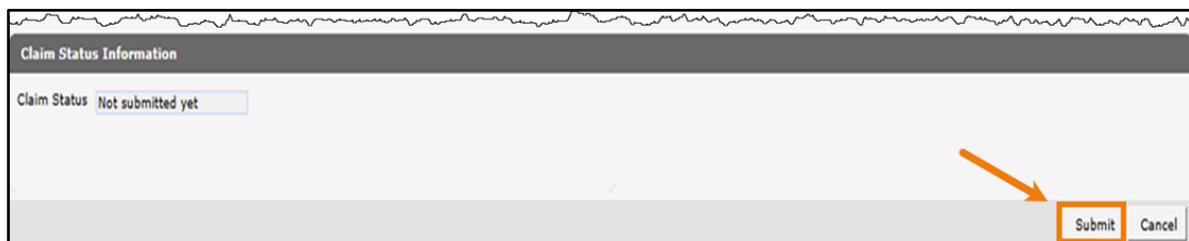
Professional Service Description

Delete Add

Figure 82 Institutional Claim Panel—Detail Section

- Verify and enter information in the From Date of Service and To Date of Service fields.
- Verify the procedure code is correct in the Procedure Code field.
- Add and/or verify that modifiers are correct in the Modifiers field.

18. Enter the diagnosis code pointer, usually the number 1, in the Diagnosis Code Pointers field. This connects the claim information to the diagnosis code on the PA submitted by the CWA.
19. Verify the units in the Units field. The number in this field may need to be changed to match the number of units completed on the date of service billed.
20. Verify and/or update the charge in the Charge field. Note: There are two places to verify charges on the claim:
 - Under the “Institutional Claim” section where the client’s name and information are listed—the total charge may need to be updated to match the charge under the Detail part of the claim
 - Under the “Detail” section
21. Enter the place of service (POS) code in the Place of Service Code field. Refer to the [Children’s Long-Term Support \(CLTS\) Program Benefit Code Crosswalk, P-02283](#), to confirm the correct POS, if necessary.
22. Leave the “Medicare Information (Detail)” section blank.
23. Only click Add in the “Attachments” section if billing procedure codes that require attachments. Refer to the [Children’s Long-Term Support Program Claim Attachments and Instructions](#) for a list of procedure codes that require an attachment and instructions to add it.
24. Click **Submit** once the necessary claim information has been entered and verified.



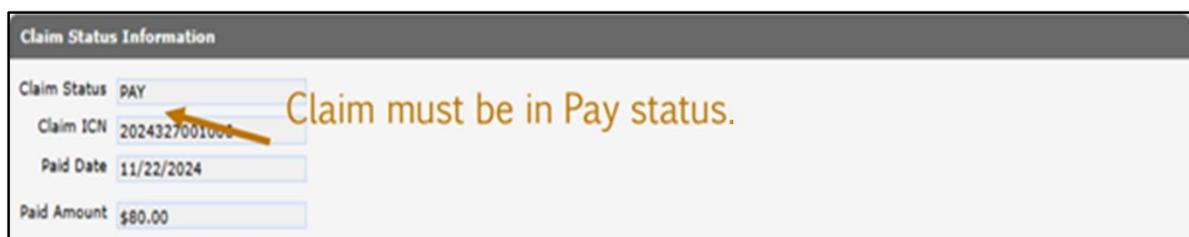
Claim Status Information

Claim Status Not submitted yet

Submit Cancel

Figure 83 Institutional Claim Panel—Submit

25. The status of the claim will be displayed.



Claim Status Information

Claim Status PAY

Claim ICN 2024327001000

Paid Date 11/22/2024

Paid Amount \$80.00

Claim must be in Pay status.

Figure 84 Claim Status Information Panel

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**.

The screenshot displays the ForwardHealth Provider Portal interface. At the top, there is a navigation bar with links for 'Home', 'Search', 'Providers', 'Enrollment', 'Claims', 'Remittance Advices', 'Trade Files', 'Max Fee Home', 'Account', and 'Contact Information'. Below this, a search bar is visible. The main content area is divided into several sections: 'What's New?' with a magnifying glass icon and a text block, 'Home Page' with a list of links, and 'Quick Links' with a list of links. An orange arrow points to the 'PA Search-Bulk' link in the 'Quick Links' section.

ForwardHealth Wisconsin serving you

interChange Provider

Welcome CLTS Provider Name » April 18, 2025 2:55 PM [Logout](#)

Home | Search **Providers** | Enrollment | Claims | Remittance Advices | Trade Files | Max Fee Home | Account | Contact Information |

Online Handbooks | Site Map | User Guides | Certification | Message Center |

You are logged in with NPI: 1234567890, Taxonomy Number: 00000000XX, Zip Code: 53714 - 1234,
Financial Payer: Medicaid, Type Of Business: For Profit, IRS Tax-Exempt: No, Public/Private: Private

[Providers](#)

What's New?

Providers can improve efficiency while reducing overhead and paperwork by using real-time applications available on the new ForwardHealth Portal. Submission and tracking of claims and prior authorization requests and amendments, on-demand access to remittance information, 835 trading partner designation, and instant access to the most current ForwardHealth information is now available.

- New Rate Reform Part 3 Ideas/Recommendations Requested.
- Incentive Payments. . . Are you Eligible?
- ForwardHealth System Generated Claim Adjustments

Home Page

- Update User Account
- Update Adult LTC Waiver Service(s) or Programs(s)
- Electronic Funds Transfer
- Check My Revalidation Date

Quick Links

- Register for E-mail Subscription
- Provider-specific Resources
- Request Portal Access
- Designate 835 Receiver
- Online Handbooks
- ForwardHealth Updates
- Fee Schedules
- Forms
- Become a Provider
- Training Listing
- Explanation of Benefits (EOBs)
- Provider Based Bills (PBB)

Accessing the MTM Member List instructions

- MTM Data Dictionary

Express Enrollment for Children

- Express Enrollment Change Request

Physical Exam Health Indicators

- MedSolutions

Wisconsin Well Woman Program

- Policy and Procedure Manual

Other Coverage Discrepancy Report

- Contacts
- PA Search-Bulk

Figure 85 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 86 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.

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

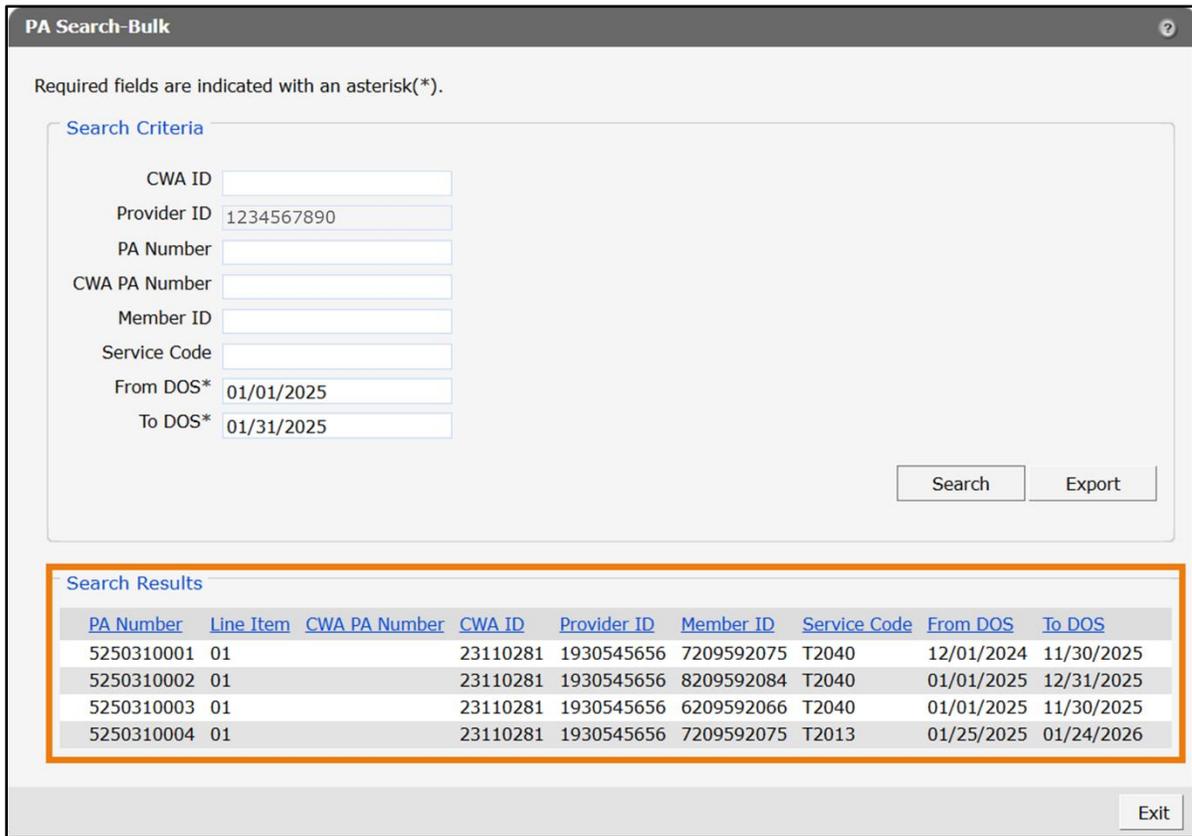


Figure 87 PA Search-Bulk-Search Results

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

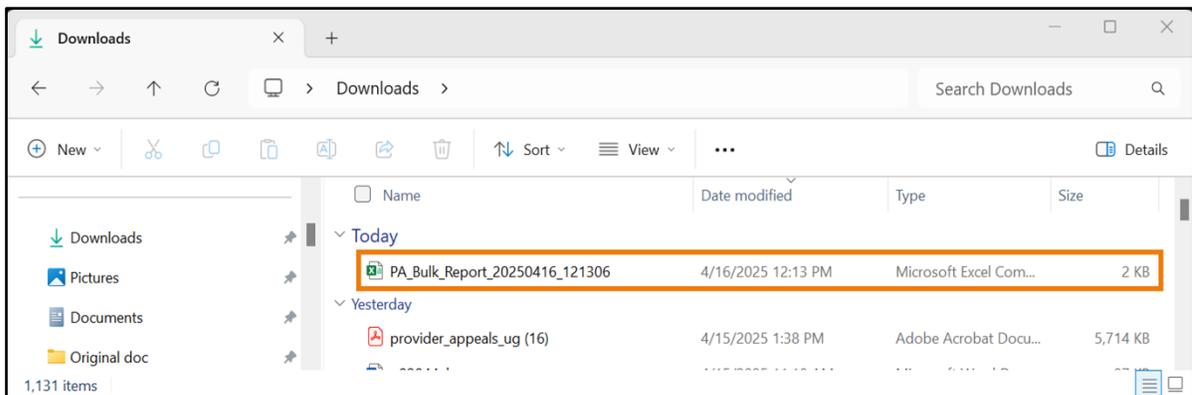


Figure 88 Downloads

- 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.

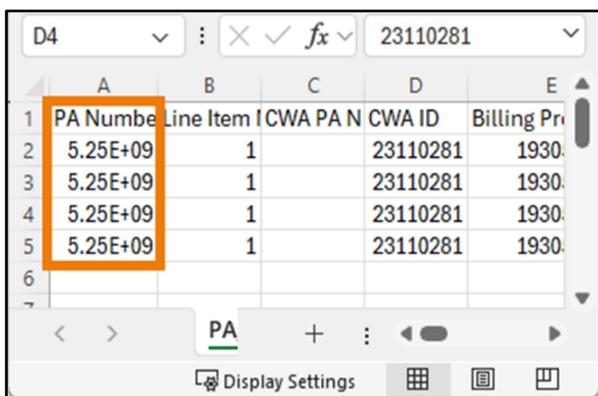


Figure 90 Microsoft Excel Window

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

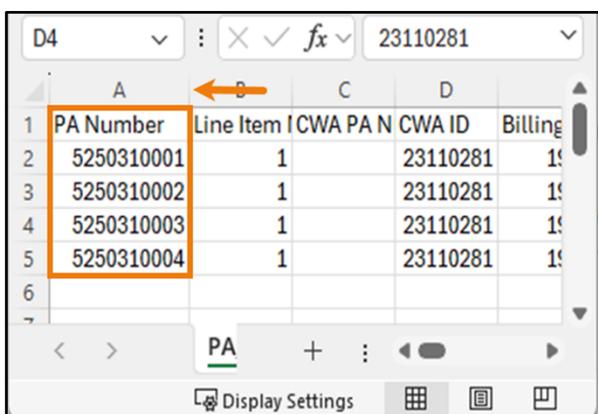


Figure 91 Microsoft Excel Window

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