



COMPLIANCE . INTEGRATION . COLLABORATION .

Provider Portal

KDP Quick Start Guide

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Chapter 1 DHMH Provider Portal Overview

In this chapter

- Provider Portal Overview
- Provider Portal Login

PROVIDER PORTAL OVERVIEW

DHMH Provider Portal is a web-based tool that simplifies communications with your payers with instant connectivity through a single point of access. This advanced tool provides responses upon request for the claims being processed at the payers' organizations. This efficient feature-rich tool is available for providers, individuals, and submitters, directing any request for information concerning the patient(s). The portal provides responses about claim status, and claim payment amount. The portal also facilitates uploading the provider claim files, viewing the uploaded claim history, and editing the provider's profile for administrators. Hence, you are able to increase your productivity and guarantee a higher percentage of accurate and precise information, and speed up the payment procedures by automating the whole process.

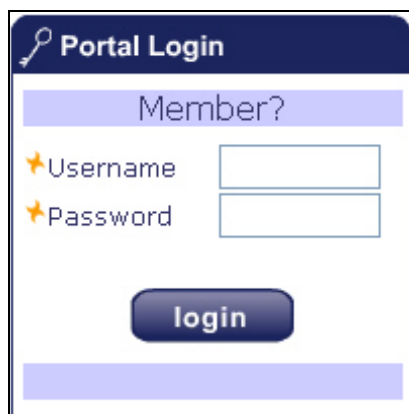
DHMH Provider Portal consists of several features, each of which forms an indispensable component in the claim-handling process. These features are:

- Eligibility
- Claim Status
- Claim Payment
- Claim Submission
- Testing and Validation

PROVIDER PORTAL LOGIN

In this section you log on to DHMH Provider Portal, and start to benefit from its functionalities.

If you are logging in for the first time, please use the username and password assigned to you by DHMH. Make sure to change your password after login.



1. Enter your ID in the “Username” field.
2. Enter your password in the “Password” field.
3. Click “Login” to log in.

If you don't have a username or password, contact DHMH by clicking the "Support" button below. Provide the information requested, and DHMH will contact you for the signup process.

Chapter 2 Claim Submission Basics

In this Chapter

- Claim Submission
- HCFA Claim Form
- HCFA 1500 Mandatory Fields in KDP
- UB92 Claim Form
- UB 92 Mandatory Fields in KDP
- Upload Files

CLAIM SUBMISSION

This feature enables you to submit professional, institutional, and health insurance claims. You can also view, edit, and/or delete any of the submitted claims.

When you select the Claim Submission item, a tree with two sub-items will be displayed. These items are two types of claims.

The two types of Claims are:

- HCFA Claim Form where you can add, edit or delete a HCFA form
- UB92 Claim Form where you can add, edit or delete a UB form

HCFA CLAIM FORM

ADD HCFA

1. Click the Claim Submission item from the main features tree and a sub menu will be displayed with the two types of claims: HCFA 1500 and UB 92.
2. Click HCFA 1500 sub item and a sub tree will be displayed with "Add", "Edit" and "Delete" items.
3. Choose "Add" and the "Health Insurance Claim Form" window will be displayed with the form fields to be filled out with the necessary information.

How to fill out a HCFA Claim Form?

Program Name* Kidney Disease Program		<input type="radio"/> EOB <input type="radio"/> No EOB	
Service Type*		<input checked="" type="radio"/> Medicare <input checked="" type="radio"/> No Medicare	
1. MEDICARE MEDICAID CHAMPUS CHAMPVA GRP HEALTH PLAN FECA BLK LUNG OTHER		1a. INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1)	
<input type="checkbox"/> Medicare # <input type="checkbox"/> Medicaid # <input type="checkbox"/> Sponsor SSN <input type="checkbox"/> VA File # <input checked="" type="checkbox"/> SSN/ID <input type="checkbox"/> SSN <input type="checkbox"/> ID		[Redacted]	
2. Patient's Name (Last, First, MI)		3. Patient's Birth Date Sex	
[Redacted]		[Redacted]	
5. Patient's Address (No., Street)		6. Patient Relationship to Insured	
[Redacted]		<input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
City State Zip Code		8. PATIENT STATUS	
[Redacted] MD [Redacted]		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	
Telephone (Include Area Code)		<input type="checkbox"/> Employed <input type="checkbox"/> FTS <input type="checkbox"/> PTS	
[Redacted]		10. Is Patient's Condition Related to	
9. Other Insured's Name (Last, First, MI)		A. Employment? (Current or Previous)	
[Redacted]		<input type="radio"/> Yes <input type="radio"/> No	
A. Other Insured's Policy or Group #		B. Auto Accident?	
[Redacted]		<input type="radio"/> Yes <input type="radio"/> No	
B. Other Insured's DOB Sex		PLACE (State)	
[Redacted]		[Redacted]	
C. Other Employer's Name or School Name		C. Other Accident?	
[Redacted]		<input type="radio"/> Yes <input type="radio"/> No	
D. Other Insurance Plan or Program Name		10D. Reserved for local use	
[Redacted]		[Redacted]	
READ BACK OF FORM BEFORE COMPLETING AND SIGNING THIS FORM.			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.			
Patient/Guardian Sign		Date	
<input type="radio"/> Yes <input type="radio"/> No		[Redacted]	
4. Insured's Name (Last, First, MI)		7. Insured's Address (No., Street)	
[Redacted]		[Redacted]	
City State Zip Code		11. Insured's Policy Group or FECA Number	
[Redacted]		[Redacted]	
Telephone (Include Area Code)		A. Insured's DOB Sex	
[Redacted]		[Redacted]	
B. Employer's Name or School Name		C. Insurance Plan Name or Program Name	
[Redacted]		[Redacted]	
D. Is There Another Health Benefit Plan?		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
<input type="radio"/> Yes <input type="radio"/> No		[Redacted]	
If Yes, Return to and Complete Item 9 A-D			

- Select the Program Name from the related drop down list.
- Select the Service Type from the related drop down list.

Note: After selecting the program name and the service type, all the mandatory fields will be marked with red, and they are different according to the program name. These fields are required and must be filled in. The mandatory fields marked with red in the screenshots are related to the Kidney Disease Program.

- Select the EOB radio Button if you will attach the EOB of the patient.
- If applicable select the radio button of Medicare or No Medicare.

- Select the type of the health insurance coverage applicable to the claim by checking on the relevant checkbox in item number (1): Medicare, Medicaid, Champus, Champva, Group Health Plan, FECA BLK LUNG, or Other.
- In item number (2), enter the patient's last name, first name, and middle initial respectively.
- In item (3), enter the patient's birth date in the following format (MM/DD/YY), and determine the patient's gender by selecting its related drop down list (M/F).
- In item number (4), enter the insured's last name, first name, and middle initial, each in its related field.
- In item (5), enter the patient's address, city, select the state from the relevant drop down list then enter the zip code, and the telephone number
- Determine the patient's relationship to the insured (whether self, spouse, child or other), by checking the related checkbox in item number (6).
- In item (7), enter the insured's address, city, select state, then enter the zip code, and the telephone number
- In item (8), determine the patient's status (single, married, other, employed, full-time student or part-time student), by checking the related checkbox.
- If the patient is covered under any other insured person, you have to fill in the data fields in item (9). Enter the other insured's last name, first name and middle initial in the related fields.
- Enter the name of the policy or group of the other insured in the related field item (9) A.
- In field (9) B, enter the other insured's birth date in the following format: (MM/DD/YY), and determine the other insured's gender from the related drop down list.
- Enter the employer's name or school name in the related text box in item (9) C.
- Enter the name of the insurance plan or program name in the related field (9) D.
- Determine the patient's health condition in item number (10), whether it is related to employment (10) A, auto accident, or other type of accident, by

checking either of the corresponding “Yes” or “No” boxes from the related fields (10) B and (10) C.

Note that if it is related to an auto accident, you have to specify the state where it occurred from the “State” drop down list. . In case you need to add anything for internal local use, add it in the “Reserved for Local Use” field (10) D.

- Fill in the information of the main insured in the data fields of item number (11). Enter the insured’s policy group or FECA number in the related fields.
- Enter the insured’s birth date in the related field (month month/day day/year year), and determine the insured’s gender (male/female) from the related drop down list (11) A.
- Enter the employer’s name or school name in the related field in item number (11) B.
- Enter the name of the insurance plan or program name in item number (11) C.
- Determine whether there is any other health benefit plan or not by checking either “Yes” or “No” from field (11) D. If you selected “Yes”, you have to fill in the data fields in item number (9) from (9) A to (9) D.
- Term number (12) requires the patient’s or authorized person’s signature (guardian) and date authorizing the release of any information necessary to process the claim and pay government benefits. Check either “Yes” or “No”, and enter the current date in the “Date” field.
- Item number (13) requires the insured’s or authorized person’s signature and date for authorizing the release to pay the medical benefits to the undersigned physician or supplier. Check either “Yes” or “No.”

14. Date of Current: Illness(First Symptom) or Injury (Accident) or Pregnancy (LMP) <input type="text"/>		15. If Patient Has Had Same or Similar Illness. Give First Date <input type="text"/>		<input type="radio"/> Yes <input type="radio"/> No							
17. Name of Referring Physician or Other Source <input type="text"/>		17A. ID # of Referring Physician <input type="text"/>		16. Dates Patient Unable to Work in Current Occupation From <input type="text"/> To <input type="text"/>							
19. Reserved For Local Use <input type="text"/>				18. Hospitalization Dates Related to Current Services From <input type="text"/> To <input type="text"/>							
				20. Outside Lab? <input type="radio"/> Yes <input type="radio"/> No \$Charges <input type="text"/>							
21. Diagnosis or Nature of Illness or Injury. (Relate Items 1,2,3 or 4 to Item 24E by Line) 1. <input type="text"/>		3. <input type="text"/>		22. Medicaid Resubmission Code ORIGINAL REF# <input type="text"/>							
2. <input type="text"/>		4. <input type="text"/>		23. Prior Authorization # <input type="text"/>							
24.	A	B	C	D	E	F	G	H	I	J	K
Date(s) of Service From To (MM/DD/YYYY)	Place of Service	Type of Service	Type of Procedures, Services, or Supplies (CPT/HCPCS Modifier)	Diagnosis Code	\$Charges	Days or Units	EPSDT Family Plan	EMG	COB	Reserved for Local Use	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

- In item number (14) determine the date (month month/day day/year year) of the first symptom of the illness, injury (accident) or pregnancy.
- If the patient has had the same illness before, determine the first date (month month/day day/year year) in item number (15).
- In item (16) determine the date range (month month/day day/year year) in which the patient has been unable to work at current occupation.
- Enter the name of the referring physician in the data field of item number (17).
- In item number (17 A) enter the ID number of the referring physician.
- In item number (18) enter the date range (month month/day day/year year) of hospitalization related to the current services.
- In case you need to add anything for internal local use, add it in the “Reserved for Local Use” field in item number (19).
- Determine if the claim includes charges for a service provided by an outside lab by selecting “Yes” or “No” in item number (20), and specify the charge amount incurred by the lab work.

- In item (21) fill in the diagnosis of illness or injury as applicable in the four available data fields. These have to be related to the diagnosis codes in item number (24 E).
- Enter the Medicaid resubmission code and the original reference code in item number (22).
- Enter the prior authorization number in the related field in item number (23). This number is unique for each claim and each insurance company.
- Item number (24) is divided into several data field sections, each identified by an alphabetical letter from (A-K): Determine the date range of the services provided (MM/DD/YY) in the “From” and “To” fields in item number (24) A.
- Determine the place of service in the related data fields in item number (24) B.
- Enter the type of service provided in the related fields in item number (24) C.
- In the “Procedures, Services Or Supplies” section, enter the code or term of the procedure or service in the “CPT/HCPCS” field, and fill in up to four procedure modifiers in the related text boxes in item number (24) D.

Note: HCPCS= Health Care Financing Administration Common Procedure Coding System. CPT= (American Medical Association) Current Procedural Terminology.

- Enter the diagnosis code in its related text box in number (24) E. This is related to the illness or injury diagnosis entered in item number (21).
- Enter the service charge fees in dollars in the “Charges” field(s) in item number (24) F.
- Specify the days or units of time for providing the services in the “Days or Units” field(s) in item number (24) G.
- Determine whether there is an EPSDT family plan or not by entering “Y” for yes or “N” for no in the related field(s) in item number (24) H.

Note: EPSDT= Early & Periodic Screening, Diagnosis & Treatment.

- Put an “x” in the “EMG” field(s) if this is an emergency case in item number (24) I.

- In the “COB” field(s) determine if there will be any coordination of benefits, (where two insured persons coordinate for patient responsibility in case they may pay for him/her), by entering “Y” for yes or “N” for no in item number (24) J.

Note: COB= Coordination of benefits.

- In case you need to add anything for internal local use, add it in the “Reserved for Local Use” field(s) in item number (24) K.

24. A	B	C	D	E	F	G	H	I	J	K
Date(s) of Service From To (MM/DD/YYYY)	Place of Service	Type of Service	Procedures, Services, or Supplies (CPT/HCPCS Modifier)	Diagnosis Code	\$Charges	Days or Units	EPSDT Family Plan	EMG	COB	Reserved for Local Use
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25. Fed Tax ID <input type="text"/>	Provider Suffix/No <input type="text"/>	26. Patient Account # <input type="text"/>	27. Accept Assignment ?(for govI,claims,see back) <input type="radio"/> Yes <input type="radio"/> No	28. Total Charge \$ <input type="text"/>	29. Amount Paid \$ <input type="text"/>	30. Balance Due \$ <input type="text"/>
31. Signature of Physician or Supplier including degrees or credentials. (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. Name and Address of Facility where services were rendered(if other than home or office)		33. Physician's Supplier's Billing Name		
Physician Sign <input type="text"/>	Date <input type="text"/>	Address <input type="text"/>		Address <input type="text"/>		
		City <input type="text"/>		Address2 <input type="text"/>		
		State <input type="text"/>		City <input type="text"/>		
		City <input type="text"/>		State <input type="text"/>		
		State <input type="text"/>		Zip Code <input type="text"/>		
		Zip Code <input type="text"/>		Phone (<input type="text"/>) <input type="text"/>		
				Pin # <input type="text"/>		
				Group # <input type="text"/>		

- In item number (25), enter the federal tax ID number and the provider suffix/No in the related fields, and determine the ID type, whether “SSN” or “EIN” by checking the related check box.
- In item number (26), enter the patient’s account number assigned by the provider.
- In item number (27), determine whether the provider accepts assignment of Medicaid benefits or not by checking “Yes” or “No”.

- In item number (28) you have to enter the total charge of all the services provided.
- Enter the charge amount previously paid on claim (by patient or other payer) in the "Amount Paid" field in item number (29).
- The amount due to be paid should be entered in the "Balance Due" field" in item number (30).
- Item number (31) requires the signature of the physician or the service supplier, including degrees or credentials, and date. Enter the signature, and enter the date in the "Date" field (month month/day day/year year).
- Item number (32) requires the name and detailed address of the facility (address, city, state, and zip code) where the services were rendered (other than home or office).
- Item number (33) requires the name, detailed address, phone number, the "PIN #" (a number that identifies the individual servicing practitioner, and is unique for each insurance company) and the "Group #" (a number that identifies where the service was performed (Tax ID or SSN).
- Click "Attach File" if you want to attach a file with the form and then click "Save" to perform the action.

EDIT HCFA

This feature allows you to edit in the information of saved claim(s). Or through this feature you can also select a claim form and submit it.

1. Select Claim Submission item from the main features tree and a sub menu will be displayed with the three types of claims: HCFA 1500, and UB 92 Claim.
2. Select the HCFA sub item and a sub tree will be displayed with "Add", "Edit" and "Delete" items.
3. Select "Edit" and the "Search" window will be displayed.

Edit

Edit Claim(s)

★ Patient last Name

★ Insured ID Number

★ Federal Tax ID

★ Status

★ Program Name

<input type="checkbox"/>	Submission Date	Patient Last Name	Provider ID	Total Charge	Insured No.	Status
<input type="checkbox"/>	6/2/2005	Duo	123456789	50		open

4. You have to select a program name that is the only mandatory field in this form then you can also refine your search by entering data in the rest of the fields which are: patient last name, Insured ID number, Federal Tax ID and Status.
5. Click "Search" to find the claim form that you are searching for and the "Search Results" will be displayed.
6. Select the claim form you want to submit by checking the related check box and then Click "Generate Batch".

7. You can also edit in any claim form by clicking on the "Submission Date".

Note that if there are no search results for the criteria you entered a message will be displayed on the form saying that "Your Search did not match any claim". In this case you can broaden your search criteria to get more results.

DELETE HCFA

This function allows you to delete any of the previously submitted HCFA claims through the Search feature.

1. Select Claim Submission item from the main features tree and a sub menu will be displayed with the two types of claims: HCFA 1500, and UB 92.
2. Select the HCFA 1500 sub item and a sub tree will be displayed with "Add", "Edit" and "Delete" items.
3. Select "Delete" and the "Search" window will be displayed.

Delete

Delete Claim(s)

★ Patient last Name

★ Insured ID Number

★ Federal Tax ID

★ Status

★ Program Name

	Submission Date	Patient Last Name	Provider ID	Total Charge	Insured No.	Status
<input type="checkbox"/>	6/2/2005	Duo	123456789	50		open

4. Search by the Criteria from the related drop down list for program name field.

Note: You have to select the Program Name in your search or the process will not be finished successfully.

5. Enter the Value you want to search by in the "Value" field. For example: if you search for a Federal Tax ID, type in a valid federal tax ID in the corresponding field.

6. Click “Search” to find the item that you are searching for and the “Search Results” window will be displayed.
7. Select the claim form you want to delete by checking the related check box and then Click “Delete”.
8. Or select “Search” and the “Search Result” window is displayed where you can select any item and click “Delete”.

HCFA 1500 MANDATORY FIELDS IN KDP

Field No.	Field Name	Fields Status
	Service Type	Mandatory
	Medicare or Non Medicare	Mandatory
2	Patient's Last Name	Mandatory
10D	Reserved for local use	Mandatory Enter KDP #. It must be 6 digits
21	Diagnosis or Nature of illness or injury	Mandatory <i>At least the first one of the four fields should be filled</i>
24 A, D, F, G	Date of Service(s) From (MM/DD/YY), CPT Code/HCPCS, Charges, Days or Units	Mandatory <i>Modifiers are optional</i>
25	Federal Tax ID	Mandatory <i>Provider Suffix/No is optional. If filled, it should be max. 4 digits</i>

UB92 CLAIM FORM

ADD UB92

1. Select Claim Submission item from the main features tree and a sub menu will be displayed with the two types of claims: HCFA 1500, and UB 92 Claim.
2. Select the UB 92 sub item and a sub tree will be displayed with “Add”, “Edit” and “Delete” items.
3. Select “Add” and the “UB-92” window will be displayed with the form fields to be filled in with the necessary information”.
4. Select the Program Name from the related drop down list.
5. Select Service Type from the related drop down list.

Note: After selecting the program name and the service type, all the mandatory fields will be marked with red, and they are different according to the program name. These fields are required and must be filled in. The mandatory fields marked with red in the screenshots are related to the Kidney Disease Program.

6. Check EOB check box if you will attach EOB of the patient.
7. If applicable check whether this claim is medicare or non medicare through selecting the relevant radio button.

How to fill out a UB92 Claim Form?

* Program Name * Kidney Disease Program		* Service Type * <input type="radio"/> EOB <input type="radio"/> No EOB <input checked="" type="checkbox"/> Medicare <input checked="" type="checkbox"/> No Medicare	
1. Provider Name Address line 1 Address line 2 City State MD Zip Phone Number		2. Referring Physician 3. Patient Control No. 4. Type of Bill	
5. FED TAX No. Provider Suffix/No FROM TO		6. STATEMENT COVERS PERIOD FROM TO 7. COV. D 8. N-C D. 9. C-I D. 10. L-R D. 11	
12. PATIENT NAME (Last, First, Middle)		13. PATIENT ADDRESS City State MD Zip	
14. BIRTHDATE 15. SEX 16. MS 17. DATE 18. HR 19. TYPE 20. SRC		21. D 22. STAT 23. MEDICAL RECORD NO. 24. 25. 26. 27. 28. 29. 30. 31. CONDITION CODES	
32. OCCURENCE CODE DATE 33. OCCURENCE CODE DATE 34. OCCURENCE CODE DATE 35. OCCURENCE CODE DATE 36. OCCURENCE SPAN CODE FROM THROUGH		37. A B C	

- In item number (1), enter the provider’s name, detailed address (address, city, state, and zip code) and phone number.
- In item number (2) enter the name of the referring physician in the “Referring Physician” field.
- In item number (3), enter the patient’s control or account number assigned by the provider in the “Patient Control No.” field.
- Enter the type of bill code in item number (4) “Type of Bill”.
- Enter the federal tax ID number in item number (5) related field and enter provider suffix number when required.
- Specify the date range of the statement covering the period in item number (6) in the “From” and “To” fields.
- Enter the number of covered days in item number (7) in the “Cov. D” field.

- Enter the number of non-covered days in item number (8) in the “N- CD” field.
- Enter the number of coinsurance days in item number (9) in the “C- ID” field.
- Enter the number of lifetime reserve days in item number (10) in the “L- RD” field.
- In item number (12), enter the patient’s last name, first name, and middle initial, each in its related field.
- Enter the patient’s detailed address (address, city, state, zip code) in the related fields in item number (13).
- Enter the patient’s birth date in the “Birth Date” field in item number (14).
- Select the patient’s gender (female or male) from the “Sex” drop down list in item number (15).
- Determine the marital status of the patient in the “MS” field in item number (16).
- In item number (17) enter the date the patient is admitted for this stay in the “Admission Date” field.
- In item number (18) enter the code of the admission hour in the “HR” field.
- Enter the type of admission code in the “Type” field in item number (19). Note that the valid types of admission codes are: emergency, urgent, elective, newborn, information not available.
- Enter the source of admission code in the “SRC” field in item number (20).
- Specify the discharge hour in the “D HR” field in item number (21).
- Determine the patient’s discharge status in the “Stat” field in item number (22).
- Enter the patient’s medical record number in the related field in item number (23).
- In the data fields of item numbers (24-30), enter the condition codes.
- Enter the occurrence codes and dates in the related fields in item numbers (32-35).

- Enter the occurrence code and specify the date range of the occurrence span in the related fields in item number (36).
- Enter the internal control numbers in the related fields in item (37). This is the document control number assigned to the original bill processed by the intermediary to facilitate subsequent processing of any adjustment or cancelled claim.

32 OCCURENCE CODE DATE		33 OCCURENCE CODE DATE		34 OCCURENCE CODE DATE		35 OCCURENCE CODE DATE		36 OCCURENCE SPAN CODE FROM THROUGH			37 A <input type="text"/> B <input type="text"/> C <input type="text"/>				
38 PRIMARY Subscriber NAME <input type="text"/>						39 VALUE CODES CODE AMOUNT			40 VALUE CODES CODE AMOUNT			41 VALUE CODES CODE AMOUNT			
ADDRESS <input type="text"/>						a <input type="text"/>			b <input type="text"/>			c <input type="text"/>			
CITY <input type="text"/>						b <input type="text"/>			c <input type="text"/>			d <input type="text"/>			
STATE <input type="text"/>						c <input type="text"/>			d <input type="text"/>						
ZIP CODE <input type="text"/>						d <input type="text"/>									
42 REV CD		43 DESCRIPTION		44 HCPCS/RATES		45 SERV DATES		46 SERV UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1															
2															
3															
4															
5															
6															
7															
8															
9															

- Enter the details of the primary subscriber (name, address, city, state, zip code and phone number) in the related fields in item (38).
- Enter the value codes and amounts in their relevant fields in items number (39-41).
- Enter the revenue codes in their related fields in item number (42). A revenue code is a code that identifies the specific type of service being billed by line item.
- In item number (43) enter detailed description of the related revenue categories included in the claim.

- Item number (44) requires the entry of the procedure codes/rates.
- Enter the date of service provided in the “Serv. Date” field in item number (45).
- In item number (46) enter the number of units (hours, days/sessions, tests/services or items) rendered for each service.
- In item number (47) enter the total charges pertaining to the related revenue code for the current billing period.
- Enter the non-covered charges in item number (48).

50 PAYER		51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST.AMOUNT DUE	56
A					0		
B							
C							
57		DUE FROM PATIENT					
58. INSURED'S NAME		59 P.REL	60 CERT.-SSN-HIC.-ID NO.		61 GROUP NAME	62 INSURANCE GROUP NO.	
A							
B							
C							
63. TREATMENT AUTHORIZATION CODES		64 ESC	65 EMPLOYER NAME		66 EMPLOYER LOCATION		
A					Address City State Zip		
B					Address City State Zip		
C					Address City State Zip		

- Enter the payer identification (name or code) in item number (50). In the three data fields enter the primary, secondary and tertiary payers.
- Enter the provider's number in item number (51).
- Enter the release of information certification indicator in item number (52).
- Enter the assignment of benefits certification indicator (Yes or No) in item number (53).

- Enter the amounts of prior payments in the data fields of item number (54).
- Enter the estimated amount due in item number (55).
- In item number (58) enter the insured person's last name, first name and middle initial as they appear on the identification card.
- Determine the patient's relationship to the insured; by selecting the relevant code from the "P.Rel" drop down list in item number (59).
- In item number (60) enter the insured's identification number in the "Cert.-SSN-HIC.-ID No" data fields. Note that "Cert.-SSN-HIC.-ID No" = Certificate/Social Security Number/Health Insurance Claim/Identification Number.
- Enter the insured's group name in the "Group Name" field in item number (61).
- Enter the insurance group number as shown on the ID card in the related field in item number (62).
- Enter the treatment authorization codes in the related fields in item number (63).
- Determine the employment status code from the "ESC" drop down lists in item number (64).
- Enter the employer's name in the related fields in item number (65).
- Enter the employer's location in the related fields in item number (66).

67 PRIN. DIAG. CD.		OTHER DIAG CODES							76 ADM. DIAG. CD 77 E-CODE 78	
<input type="text"/>		68CODE	69CODE	70CODE	71CODE	72CODE	73CODE	74CODE	75CODE	<input type="text"/>
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
79 P.C.	80 PRINCIPAL PROCEDURE		81 OTHER PROCEDURE		OTHER PROCEDURE		82 ATTENDING PHYS. ID			
<input type="text"/>	CODE	DATE	CODE	DATE	CODE	DATE	ID: <input type="text"/>			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			
	OTHER PROCEDURE		OTHER PROCEDURE		OTHER PROCEDURE		83 OTHER PHYS. ID			
	CODE	DATE	CODE	DATE	CODE	DATE	ID: <input type="text"/>			
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			
84 REMARKS							OTHER PHYS ID			
<input type="text"/>							ID: <input type="text"/>			
							<input type="text"/>			
							<input type="text"/>			
							85 PROVIDER REPRESENTATIVE			
							<input type="radio"/> Yes <input type="radio"/> No			
							86 DATE			
							<input type="text"/>			
<input type="button" value="Attach File"/> <input type="button" value="Save"/>										

- Enter the principal diagnosis code in the “Prin. Diag. CD.” In item number (67).
- Enter the codes of other diagnosis in the data fields of items (68-75).
- Enter the admitting diagnosis code in item number (76) data field.
- Enter the code of the external cause of injury in the “E-Code” field in item number (77).
- Enter the procedure code method in the “P.C.” field of item number (79). The procedure code method is an indicator that identifies the coding method used for procedure coding on the bill.
- In the data fields of item number (80) enter the principal procedure code and date in the related fields. The principal procedure code is a code that identifies the principal procedure performed during the period covered by this bill, and the date is the date on which the principal procedure described on the bill is performed.
- In the data fields of item number (81) enter the codes and dates of other procedures performed.

- Enter the ID number and name (last name, first name, and middle initial) of the attending physician (service provider) in the related fields of item number (82).
- In the data fields of item number (83) enter the ID numbers and names (last name, first name, and middle initial) of other licensed physicians (service providers).
- In case of any remarks, comments, details or any additional information, enter them in the “Remarks” fields in item number (84).
- Determine whether you are a provider representative or no by checking either “Yes” or “No” in item number (85).
- Enter the current date in the “Date” field in item number (86).
- Click "Attach File" if you want to attach a file with the form and then click "Save" to perform the action.

Note: When you enter the required information for the claim form of any program and then click save, the claim form will be saved for later use. But you have to generate the batch before proceeding.

EDIT UB92

This feature allows you to edit in the information of saved claim(s). Or through this feature you can also select a claim form and submit it.

1. Select Claim Submission item from the main features tree and a sub menu will be displayed with the three types of claims: HCFA 1500, and UB 92 Claim.
2. Select the UB 92 sub item and a sub tree will be displayed with "Add", "Edit" and "Delete" items.
3. Select "Edit" and the "Search" window will be displayed.

Edit

Edit Claim(s)

★ Patient last Name

★ Insured ID Number

★ Federal Tax ID

★ Status

★ Program Name

<input type="checkbox"/>	Submission Date	Patient Last Name	Provider ID	Total Charge	Insured No.	Status
<input type="checkbox"/>	6/2/2005	Duo	123456789	50		open

4. You have to select a program name that is the only mandatory field in this form then you can also refine your search by entering data in the rest of the fields which are: patient last name, Insured ID number, Federal Tax ID and Status.
5. Click "Search" to find the claim form that you are searching for and the "Search Results" will be displayed.
6. Search by the Criteria from the related drop down list or enter for example "Patient Last Name" in the related text box.

7. Click "Search" to find the claim form that you are searching for and the "Search Results" will be displayed.
8. Select the claim form you want to submit by checking the related check box and then Click "Generate Batch".
9. You can also edit in any claim form by clicking on the "Submission Date".

DELETE UB92

This function allows you to delete any of the previously submitted UB claims through the Search feature.

1. Select Claim Submission item from the main features tree and a sub menu will be displayed with the three types of claims: HCFA 1500, and UB 92 Claim.
2. Select the UB 92 sub item and a sub tree will be displayed with "Add", "Edit" and "Delete" items.
3. Select "Delete" and the "Search" window will be displayed.

Delete

Delete Claim(s)

★ Patient last Name

★ Insured ID Number

★ Federal Tax ID

★ Status

★ Program Name

	Submission Date	Patient Last Name	Provider ID	Total Charge	Insured No.	Status
<input type="checkbox"/>	6/2/2005	Duo	123456789	50		open

4. Search by the Criteria from the related drop down list.

Note: You have to select the Program Name in your search or the process will not be completed successfully.

5. Enter the Value you want to search by in the "Value" field. For example: if you search for a claim number, select = criteria and type in the value field.

6. Click "Search" to find the item that you are searching for and the "Search Results" window will be displayed.
7. Select the claim form you want to delete by checking the related check box and then Click "Delete".
8. Or select "Search" without typing a value in the "Value" field and all the "Search Result" window is displayed where you can select any item and click "Delete".

UB 92 MANDATORY FIELDS IN KDP

Field No.	Field Name	KDP
	Service Type	Mandatory
	Medicare or Non Medicare	Mandatory
5	Federal Tax ID	Mandatory <i>Provider Suffix No. is Optional. It should be Max. 4 digits</i>
6	Statement covers period (From)	Mandatory
12	Patient Name (Last Name only)	Mandatory
14	Birthdate	Mandatory
55	Est. Amount Due	Mandatory
60	CERT.-SSN-HIC.-ID NO.	Mandatory <i>Note: You have to enter the KDP number in this field or in the second field below.</i> <i>KDP # must be 6 digits</i>
67	PRIN. DIAG. CD.	Mandatory

UPLOAD FILES

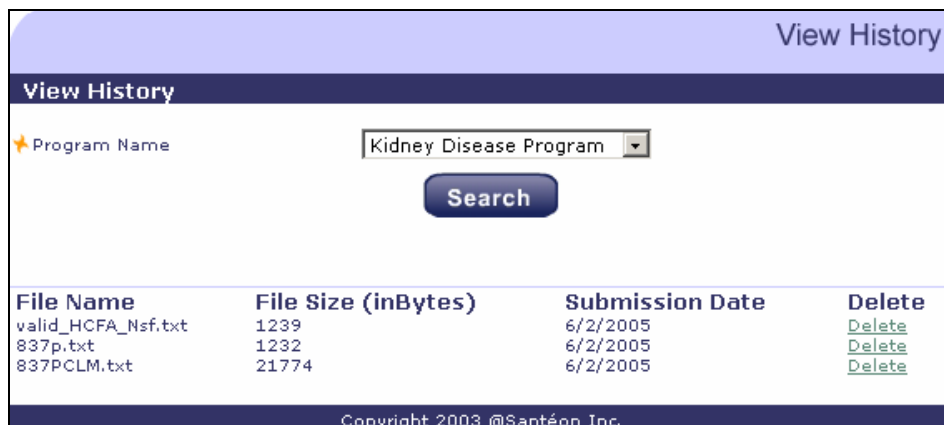
1. Select Claim Submission item from the main features tree and a sub menu will be displayed with the two types of claims You will find a link named Upload Files under the claim submission item
2. Select the Upload files sub item and the “Upload Files” page will be displayed.

The screenshot shows the 'Upload Files' interface. At the top right, there is a header with a folder icon and the text 'Upload Files'. Below this is a dark blue bar with the text 'Upload A File'. The main content area has a light blue background and contains three rows of form fields, each preceded by a star icon. The first row is 'Select Program Name' with a dropdown menu showing 'Kidney Disease Program'. The second row is 'Select Document Type' with a dropdown menu showing 'X12'. The third row is 'Select File to Upload' with a text input field containing 'C:\Documents and Settings' and a 'Browse...' button. At the bottom center of the form is a dark blue 'Upload' button.

3. Select Program Name from the related drop down list.
4. Select Document Type (X12 document) from the related drop down list.
5. Select a file to be uploaded by clicking the “Browse” button to select the path of the file to be saved. Then click “Open” after selecting the file.
6. Click “Upload” to start uploading the document and perform the action.

UPLOAD HISTORY

In this section, all the uploaded files will be displayed with a File History including the File Name, File Size, Submission Date, and an option to delete.



The screenshot shows a web interface titled "View History". At the top right of the interface is a "View History" link. Below the title is a "View History" header. Underneath, there is a "Program Name" dropdown menu with "Kidney Disease Program" selected. A "Search" button is positioned below the dropdown. The main content area displays a table with the following data:

File Name	File Size (inBytes)	Submission Date	Delete
valid_HCFA_Nsf.txt	1239	6/2/2005	Delete
837p.txt	1232	6/2/2005	Delete
837PCLM.txt	21774	6/2/2005	Delete

At the bottom of the interface, there is a copyright notice: "Copyright 2003 @Santéon Inc."

1. Select Program Name from the related drop down list.
2. Click "Search" and all the uploaded files in the selected program will be displayed.