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INITIAL SCREEN

Select *New Claim* from menu on left.

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This screen is displayed.

Submission Reason: Choose *Original* if you are submitting a new claim or the resubmission of a previously denied claim. Choose *Replace* if you are submitting an Adjustment and choose *Void* if you are voiding a claim. If you choose Replace or Void, you must enter the Payer Claim Control Number of the paid claim.

Effective 4/1/12, Certified Home Health Agencies will indicate the type of Episodic Payment System claim they are submitting in this field. Choose *Interim* if you are a Certified Home Health Agency submitting an

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Episodic Payment System claim that is Interim. Choose *Final* if you are a Certified Home Health Agency submitting an Episodic Payment System claim that is Final or Partial. The Payer Claim Control Number field will also appear when selecting *Interim* or *Final*. This is not a required field for the *Interim* and *Final* options and should only be completed when adjusting a paid CHHA EPS claim.
Note: The Payer Claim Control Number field will only appear if you select Replace, Void, Interim or Final from the drop down. This number was reported on the provider's remittance as the Transaction Control Number (TCN).

NPI Number: The NPI in this field defaults to the current NPI for the MMIS provider ID to which it maps. If you are billing for a date of service when the NPI for the **same** MMIS provider ID was different, enter the old NPI in this field.

Payer Claim Control Number: Enter the payer claim control number (also called a TCN), if you are submitting an Adjustment or Void to a previously processed claim. **Note**: This field will only appear if doing an adjustment or void.

Patient Control Number: Enter the Patient Control Number. This is also referred to as the Office Account number. You may enter up to 20 characters and each number should be unique to the patient. This field is required on all claims.

Location Information: Institutional providers that are required to submit with an NPI must enter the address of the service location including the Zip + 4. Location code is not used if submitting with a NPI. Some provider types do not meet the HIPAA standard's definition of a 'Health Care Provider'. These providers are exempt from using a NPI and should continue to use location code 003 or higher. **Note***: The Location Code field will only appear if the provider in the drop down is exempt from NPI.

Client Information: Enter the client ID, then click on *Go*.

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GENERAL CLAIM INFORMATION

If the client ID you have entered is a valid ID, the system will present you with this page.

•• **New Claim**

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● General Claim Information

* Indicates required field(s)

Submission Reason: Original ▼   **NPI Number:** 1111111111

* Patient Control Number: 123

Location Information

Address Line 1: 1 Main St.

Address Line 2:

City: Nowhere

State: NY ▼

Zip Code: 11111 – 1111

● Client Information

* Enter a Client ID: AA11111A   ▶ Go

Jay Doe
Adress Line 1
Address Line 2
City, State, Zip

* DOB: 01/01/0001 🗓

* Gender: F ▼

* Type of Claim: ▼

Dental
Professional
Professional Real Time
Institutional

Next ▶

==

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The client's name, address, DOB and gender will automatically populate. The DOB and gender fields have options to allow you to change the DOB and gender if necessary. If the client displayed is not correct because you entered the wrong ID, you may enter a new client ID and click on *Go*.

Type of Claim: Enter the type of claim you want to submit and click on *Next*. The types of claims allowed are:

- Dental
- Professional
- Professional Real Time
- Institutional

Ordered Amb and Lab by a Hospital/Clinic can be billed as an Institutional claim type with no submitted rate code.

Orthodontics in a Clinic setting MUST be billed as Dental only.

Click on *Next*.

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INSTITUTIONAL CLAIM INFORMATION

Once you have chosen the Claim Type and this page is displayed, you cannot change the Claim Submission Reason, Patient Control Number, Client ID or Claim Type.

Facility Type: Enter the facility type that most appropriately describes the visit.

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Assignments of Benefits: Always YES

Release of Information: Choose the correct option from the drop down list.

Accept Assignment: Must be A to indicate the provider is enrolled in Medicaid.

Auto Accident State: When the claim is the result of an auto accident, enter the state in which the accident occurred.

Admission Type: This is a required field. Pick the appropriate Admission Type code from the list.

Patient Status: This is a required field. Pick the appropriate status code from the list.

Admission Source: For Inpatient claims ONLY, pick a code from the list. Admission Source may be required depending on the Admission Type selected.

Statement Covers: ePACES requires a date on this tab.
    From - / To - Enter the From and To dates of the claim here. If billing for ONE day, that date should be entered as BOTH the From and the To date.

        Note: Individual dates of service entered on the service line level MUST fall within the date range specified here on the claim level.

Admission Date: For inpatient claims only, enter the date the patient was admitted.

Admission Hour: For Inpatient claims only, enter the admission hour in 24-hour time. Ex: 3:00 PM is 1500.

Discharge Hour: For Inpatient claims only enter the discharge hour using 24-hour time. (When the discharge date is different than the To Date of the claim, it is entered as an Occurrence Span code below)

Medical Record Number: Required on all Inpatient claims, optional for other claim types.

Prior Authorization Number: If the claim requires a Prior Approval, then enter the PA number here.

Certificate Category: If billing for a well care visit for a child, please select option from the drop down.

Condition Codes: Enter the appropriate condition code for EPSDT billing.

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Value Codes: Value Codes are used to enter a variety of information. The Code identifies the type of entry made in the Value field and the corresponding information is entered in the value field.

Code 24 = Rate Code and the Value entry is the rate code.

Code 22 = Surplus Amount and the Value entry is the Surplus Amount.

Code 23 = NAMI Amount and the Value entry is the client's NAMI.

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Code 54 = Birth Weight and the Value is the birth weight of a baby in grams which is needed on all DRG Inpatient claims if the baby is 28 days old or less.

Code 80 = Covered Days. For Inpatient, Nursing Home, Hospice, Child Care, ICF, ALP, and Day Treatment (**not OMH clinics**) claims, the NUMBER OF DAYS CLAIMED MUST BE ENTERED AS THE VALUE. The days for these types of claims are NOT entered on the service line. The service Units/Days entry is for those providers who bill hourly and daily type claims (see list on the last page).

For Nursing Home and ICF claims where the provider is billing for hospital and therapeutic days, the number of days is entered as a value for Code 80 AND must also be entered in the Units/Days field on the service line.

Code 81 = Non-covered days. If there are Medicaid non-covered days in the billing period, enter the number of Non-covered days in the Value field. Note: This entry only applies to the same providers who report covered days above.

Code 82 = Coinsurance Days. For Inpatient claims, enter the number of coinsurance days in the Value field.

Note: The Medicare Covered days are entered in the Other Insurance tab and the number of Medicare Covered days INCLUDES the number of LTR and Coinsurance days entered here. The Coinsurance amount and Deductible amount are entered on the Other Insurance tab also. There is no entry for the LTR amount.

Code 83 = LTR Days. For Inpatient claims, the Value entry is the number of Lifetime Reserve Days (LTR).

Code FC = Patient Paid Amount and the Value entry is the sum of all amounts paid on the claim by the patient or his/her representative, if any.

Condition Codes:
Some claims require condition codes and some do not. Condition codes include the Abortion/Sterilization codes (There is no code for not applicable, if no condition codes apply then don't enter a code and the system will default this to not applicable). Other condition codes are Copay exception, EPSDT/CHAP and Condition Code 61 for Inpatient Cost Outliers. (The Cost Outlier charges are entered on the service line with revenue codes.)

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Occurrence Span

Code	From	Through

> Add

Code	From	Through

Service Authorization Exception Code :

Delay Reason:

< Previous   Next >

> Delete Claim   > Finish   > Save As Draft   > Cancel

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Occurrence Span Codes: This entry is used for different purposes on different claims types.
On Inpatient claims enter Code 42 to report the discharge date in the From date field.
To report an ALC date on an Inpatient DRG claim, enter code 75 with the date ALC started and ended.
For an ALC claim, the code 75 must also be entered with the dates the ALC started and ended.
Accident codes are reported as an Occurrence Code. If no accident is involved, then no accident code is reported.

Service Authorization Exception code: If a Clinic is billing for any exempt specialty then SA Exception Code 7 must be entered to ensure an exempt Specialty Code is derived.

Delay reason: If the date of service is over 90 days old on the day of submission, then a 90-day reason code must be entered to allow processing of the claim.

PROVIDER INFORMATION TAB

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··• New Claim - 837 Institutional

| General Claim Information | Institutional Claim Information | Physician Information | Diagnosis/ Procedure | Other Payers | Service Line(s) |

Indicates required field(s) if entering information for a provider type

• Attending/Servicing Physician

• Use an Existing Provider

* Select a Name:

[▼]   ► Go

OR Search for a Medicaid Provider: OR   **• Enter a New Non-Medicaid Provider**

Last Name: [   ]   * NPI #: [   ]   ► Go

Provider Number: [   ]

► Go

• Operating Physician

• Use an Existing Provider

* Select a Name:

[▼]   ► Go

OR Search for a Medicaid Provider: OR   **• Enter a New Non-Medicaid Provider**

Last Name: [   ]   * NPI #: [   ]   ► Go

Provider Number: [   ]

► Go

• Referring Physician

• Use an Existing Provider   **• Enter a New Non-Medicaid Provider**

* Select a Name:

[▼]   ► Go

OR Search for a Medicaid Provider: OR *   NPI #:   [   ]

Last Name: [   ]   AND/OR

Provider Number: [   ]   State License #: [   ]

► Go   ► Go

► Previous   Next ►

► Delete Claim ► Finish ► Save As Draft ► Cancel

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Attending/Servicing Physician: The Attending Physician is required. The attending provider is defined as the physician with overall responsibility for the episode of care included within the claim.

To use an Existing provider - If the Attending/Service provider is already entered in the support file as a Medicaid provider using their NPI, you can pick the name of the provider from the drop down list to use on the claim. Then click on *GO*. The information for that provider is automatically entered. OMH, OMRDD and OASAS providers should enter the MMIS ID for unlicensed service providers here.

To enter a New Non-Medicaid Provider – Enter the NPI of the non-Medicaid provider. Then click on *GO*.

Operating Physician: See the information for Attending/Servicing Physician above.

Referring Physician: If a referring provider is required, then enter the referring provider's information here in the same manner as described above.

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DIAGNOSIS / PROCEDURE TAB

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ICD-9/ICD-10: This is defaulted to ICD-10

Principal Diagnosis: Enter the Principal Diagnosis Code without the decimal. **Note**: If submitting an Inpatient claim, include an Upper Case POA code (keyed in or chosen from the pop-up menu).

Reason For Visit Diagnosis: Enter diagnosis information indicating the patient's reason for visit when billing for "unscheduled outpatient" visits.

Admitting Diagnosis: For inpatient claims, enter the Admitting Diagnosis code without the decimal.

Other Diagnosis: If there are any other diagnosis codes, enter the code without the decimal. **Note**: If submitting an Inpatient claim, include an Upper Case POA code (keyed in or chosen from the pop-up menu).

External Cause of Injury Code: Enter "E-Codes" when applicable.

Principal Procedure: Only Inpatient claims use ICD-10 procedure codes for the Principal Procedure field. NO other claims use this entry. If a procedure code is entered, the date the procedure was performed must also be entered.

Principal Procedure Date: Enter a date only if a Principal Procedure field has an entry.

Other Procedures Code: Only Inpatient claims use ICD-10 procedure codes for the Other Procedure Code field. NO other claims use this entry. If a procedure code is entered, the date the procedure was performed must also be entered.

Other Procedures Date: Enter a date only if an Other Procedure Code field has an entry.

Click on *Next* to go to the next tab.

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OTHER PAYERS TAB

This tab may be used to report payments received from Medicare and/or Third Party Insurance.

Please note: Providers are required to report other payer payments and adjustments as they were reported by the other payer. In other words, if the other payer provided line level payments and adjustments, providers are required to report those payments and adjustments at the line level. If the other payer provided claim level payments and adjustments, providers are required to report those payments and adjustments at the claim level.

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OTHER PAYER DETAILS

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New Claim - 837 Institutional

General Claim Information	Institutional Claim Information	Physician Information	Diagnosis/ Procedure	Other Payers	Service Line(s)

* Indicates required field(s) if entering information on this tab

Other Payer Details

Next Other Payer   View Other Payers

● **Other Payer Information**

* Other Payer Name: [▼]

* Payer Sequence Number: [▼]

Other Payer Paid Amount: $ [ ]

Other Payer Claim Control Number: [ ]

Remaining Patient Responsibility: $ [ ]

Total Non Covered Amount: $ [ ]

Date Claim Paid: [ ] 📅

Covered Days: [ ]

● **Other Subscriber**

* Last Name: [ ]

* First Name: [ ]

* Member ID: [ ]

Address Line 1: [ ]

Address Line 2: [ ]

* City: [ ]

* State: [NY ▼]

* Zip Code: [ ] - [ ]

* Country: [US ▼]

● **Other Subscriber Information**

* Relationship: [ ] 🔲▶

* Payer Type: [ ] 🔲▶

Group Number: [ ]

Group Name: [ ]

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Other Payer Name: Enter the Other Payer Name or select from payers previously added in the support files using the drop down list.

Payer Sequence Number: The coverage sequence of the other payer (i.e. where in the sequence of submissions does this payer fall), choose Primary, Secondary or Tertiary.

Other Payer Paid Amount: Enter the total amount paid by the other insurance for the entire claim.

Other Provider Claim Control Number: If available, enter the claim control number from the other payer.

Remaining Patient Liability: This amount the provider believes is due and owing after the Other Payer's adjudication.

Total Non Covered Amount: Only enter an amount in this field if there is documentation stating that the other payer will not cover this service and you are not billing the other payer. The amount entered must equal the Total Claim Charge Amount.

Date Claim Paid: The date that the other carrier paid or denied the claim.

Covered Days: This entry is used to indicate the number of days covered by the Other Payer (either Medicare or Commercial Insurance).

Note: Sometimes a Commercial payer will pay a lump sum and not an amount associated with a number of days. In that case, enter the days as zeros and enter the amount paid in the paid field.

If Medicare Part B covered the claim, no days should be entered.

If Medicare Part A covered the claim using Part A days, Coinsurance days and or Lifetime Reserve days, the covered days entry should include the sum of all the days covered by Medicare.

Other Subscriber: Enter the Name, Primary ID, Address, and other demographic information pertaining to the subscriber of the Other Payer.

Other Subscriber Information:

Relationship: Pick the appropriate entry from the drop down list.

Payer Type: Enter the Code representing the Other Payer from the drop down list.

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Note: If code 16 is entered on a claim, that claim cannot have Medicare Part A and/or Medicare Part B. The 16 code indicates the client is enrolled in a Medicare Managed Care plan and no longer has traditional Medicare coverage.

Group Number: Enter the Subscriber's group number for the other payer when applicable.

Group Name: Enter the Subscriber's group name for the other payer when a group number is not present, but the group name is.

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Claim Adjustments: If the other payer reported claim adjustments at the claim level, enter the adjustment information here.

Claim Adjustment Group: Enter the Group Code as received from the other payer.

Reason Code: Enter the Claim Adjustment Reason Code as received from the other payer.

Adjustment Amount: Enter the adjustment amount as received from the other payer.

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Adjustment Quantity: Enter the quantity as received from the other payer.

Assignment of Benefits: Always YES.

Release of Information: Pick an entry from the drop down list.

SERVICE LINE TAB

Line Item Ctl # - Not required. When used, the value provided will be returned on the 835 (electronic remittance advice) and may be used as an index to your system.

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Date of Service: Only use this field for outpatient services or Certified Home Health Agency EPS claims when the From and Thru dates entered at the claim level is more than one day. Otherwise, leave blank.

Rev Code: Enter the applicable revenue code for the type of claim submitted.

Procedure Codes & Mod: Enter the procedure code and modifier combinations that accurately reflect the services performed.

Charge Amount: Enter the amount charged.

Service Count: Enter the applicable service count for the procedure/modifier combination.
PROVIDERS BILLING FOR A NUMBER OF UNITS (PCA, HOME HEALTH CASE MANAGEMENT ETC.) MUST ENTER AN APPROPRIATE REVENUE CODE WITH THE NUMBER OF UNITS ENTERED IN THE SERVICE COUNT!

Add: Click Add to attach the service line to the claim, the service line will then display above. Continue entering service line information and adding as needed.

Export Function
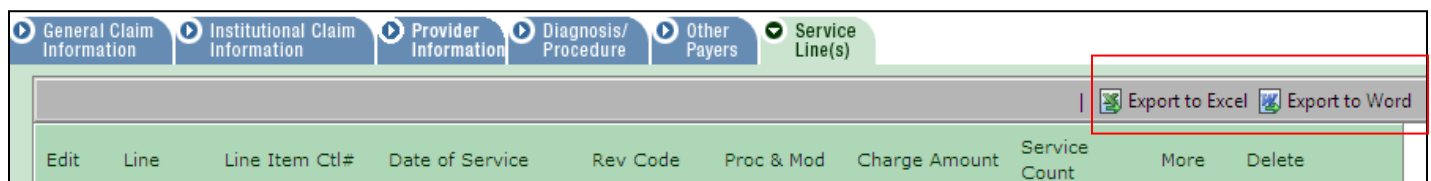
Export to Excel will display the list of service lines entered on the claim with the total charges in an Excel document.

Export to Word will display the list of service lines entered on the claim with the total charges in a Word document.

Editing a Service Line

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Click the **Edit** icon that corresponds to the service line which will be updated. This will open the service line to allow changes.

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Click **Finish** to save the changes made on the edited service line.
Click **Cancel** to close out of Edit option for the service line. No changes will be saved to the line when Cancel is selected.

More: This option allows a provider to enter additional line specific information. Use the *More* button in order to report the prior payer's adjudication information, NDC, and/or National Drug Unit Count. NDC information is required for Ordered Ambulatory Providers billing for physician-administered drugs.

To enter the NDC click on the *More* button.

Edit	Line	Line Item Ctl#	Date of Service	Rev Code	Proc & Mod	Charge Amount	Service Count	More	Delete
✏️	1		10/01/2012	0123		$100.00	1.00 UN	➕	🗑️

Enter the NDC information in the *Drug Identification* section.

Drug Identification

National Drug Code:

National Drug Unit Count: [ ] [Unit ▼]

Prescription/Compound Number (s): ⦿ Pharmacy Prescription Number   ◯ Link Sequence Number

If a client has Medicare and/or a Third Party Insurance, the payment information may be entered on the claim line level using the *More* button. Scroll to the bottom of the screen to enter the information.

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Line Adjudication Information

Other Payer Name: [▼]

Service Line Paid Amount: $ [   ]

Revenue Code: [   ]

Paid HCPCS Code: [   ]

Modifiers: [   ] [   ]
           [   ] [   ]

Paid Service Unit Count: [   ]

Bundled Line Number: [   ]

Date Claim Paid: [   ] 🗓

Remaining Patient liability: [   ]

Claim Adjustment Group	Reason Code	Adjustment Amount	Adjustment Quantity
[ ]	[ ]	$ [ ]	[ ]
[ ]	[ ]	$ [ ]	[ ]
[ ]	[ ]	$ [ ]	[ ]
[ ]	[ ]	$ [ ]	[ ]
[ ]	[ ]	$ [ ]	[ ]

▶ Next Line Adjudication   ▶ View All Line Adjudication

▶ Close

◀ Previous

▶ Delete Claim   ▶ Finish   ▶ Save As Draft   ▶ Cancel

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CLAIM ENTRY CONFIRMATION WINDOW

This is the response page displayed when you click on the *Finish* button.

The ePACES System will assign a Status to the claim and display it on this response.

- **Draft:** You may save a claim as a draft if you do not have all of the required information to complete the claim. Editing a claim that has been saved as a draft is the same as continuing the claim entry process. If a claim is saved as a draft, no validation of the data has been performed.
- **Errors:** When you enter a claim and click on *Finish*, the validation process is triggered. If errors exist, the claim will be placed in an Error status.
- **Complete:** The claim has been fully entered and has passed all validation editing. You may edit a claim that is in a Complete status.
- **Batched:** After the Build Claim Batch process has been completed, the claim will have a status of Batched. You cannot edit a claim with a status of Batched. If you do need to edit a claim that has been Batched, you must find the batch containing the claim and click on the *Remove* button. When you do

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this, the status of all claims in the batch will be changed to complete and you can edit it. After you edit, you must re-batch the claims.

- **Sent:** When you submit the claim, the Status will be changed to Sent.
- **Replaced:** When a Replacement claim has been submitted, the Sent claim that is being replaced will have the Status changed to Replaced.

- **Voided:** When a Void claim was submitted, the Sent claim being voided will have the Status changed to Voided.

From this page you can click on the appropriate button to perform the following options:

- **Edit Current Claim:** Can be used to edit the claim.
- **Enter Another New Claim:** Can be used to add another institutional claim.
- **Validate Current Claim:** Can be used to check for errors.

Click on the *Build a Claim Batch Option* on the Main Menu in order to batch the claims. This will bring you to the Build Claim Batch window.

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BUILD CLAIM BATCH WINDOW

Claims that have been successfully entered into the ePACES System must be Batched before they can be submitted for processing. Only claims with a status of Complete may be batched.

The claims in a Complete status that are eligible for batching will have a check mark in the box to the left of the line. If you want to batch all the claims that are checked, click on the *Build Batch* button. You also have the option of unchecking claims so that they will not be included in the current batch. Once you have done so, click on the *Build Batch* button in order to build a batch with the selected claims.
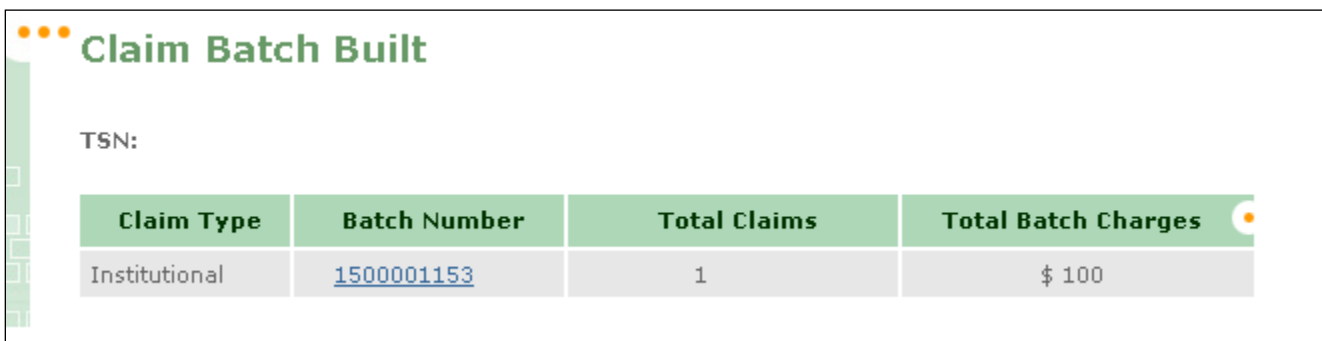
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CLAIM BATCH BUILT CONFIRMATION WINDOW

This window will be displayed to confirm that the batch has been built.

Claim Batch Built

TSN:

Claim Type	Batch Number	Total Claims	Total Batch Charges
Institutional	1500001153	1	$ 100

This confirmation window displays the Claim Type, assigns the Batch number and gives the total number of claims and batch charges.

Choose the *Submit Claim Batches* option from the Main Menu to submit the batch.

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SUBMIT CLAIM BATCHES

Click on the *Submit All Selected Batches* button to submit all of the batches that are checked and selected for submission. You also have the option of unchecking claim batches so they will not be submitted at this time. Batches that are unchecked will remain batched together and can be submitted at a later date.

Click on *Submit Claim Batch* to submit the claims. You will receive a message that states "The following claim batches have been submitted" and the batches will be displayed. To check to see if the batch was received, click on the "View Previously Submitted Batches" link.

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CLAIM BATCHES SUBMITTED

You will receive a Functional Acknowledgement as a response to the batch being sent. It will indicate if the batch is Accepted or Rejected.

This screen will display a list of all previously submitted batches in Batch Number order. The Submit Date and the Total Claims (in the batch) and the Total Rejected will be provided.

Click on the link under Batch Number and the Batch will be displayed.

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VIEW BATCH

This screen displays each individual claim within the batch. The Error Text column will display error messages that apply to a specific claim. Click on the link provided on the Patient Control Number field to open the claim.

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EDIT CLAIM - DRAFT, ERRORS OR COMPLETE

There are many reasons why you may need to edit an existing claim. For example, you may not have had all of the information when initially entering the claim and therefore saved it in Draft status. You also may have finished the claim, but when it went through the validation process, errors were found that need to be fixed in order to successfully submit the claim for processing. Additionally, you now have the ability to edit and resend a claim that is in a Sent status.

When in edit mode, all data on the claim may be edited except for the Submission Type, Client ID and Date Of Birth, Gender and Type of Claim which are located on the General Information Tab. The process of editing a claim and entering a claim are very similar in navigation.

Depending on the status of the claim, the editing process differs slightly.

- **DRAFT:** Editing a claim that has been saved as a Draft is a continuation of the Claim Entry process. If a claim is saved as a draft, no validation has been done to the data entered. Once you complete entering information and click Finish, the data will be sent through the standard claim validation and will either have a status of "Complete" or "Errors", depending on the outcome.
- **ERRORS:** A claim in Error status has been entered and Finished, thus triggering the validation process. When errors exist, a table will be displayed on the confirmation page indicating the error and its location on the claim. Once the errors have been fixed and you click Finish the claim will be sent through the validation process again to confirm the errors have been resolved.
- **COMPLETE:** Editing a claim that has been fully entered and passed all validation, therefore has a status of Complete, is similar to editing a claim in Draft. You may change any data on any of the tabs, with the exception of the General Information Tab, and then *Finish* the claim, thereby initiating the validation process. Assuming all changes made were valid, the claim will once again have a status of Complete, awaiting the batching process; otherwise, it will be placed in Error status.
- **BATCHED:** A Batched claim MAY NOT be edited. In order to edit a claim that has been batched, you must find the batch containing the claim and delete the batch, which will reset all the status of all the claims in that batch to Complete. You may then edit the claim as it is now in a Complete status. Once you have completed the editing of the claim, you may re-batch the claims.
- **SENT:** A claim that has already been sent for processing and therefore has a status of Sent may not be edited; it may however be replaced or edited as an Original claim and resent. If a sent claim must be replaced, clicking the Replace Claim button will generate a new claim with a Claim Submission Reason of "Replacement". You may then make any edits necessary to the new claim. A Replacement claim requires the Payer Claim Control Number to be populated. These new claims will go through the standard validation, batching, and submittal process to be sent to the Payer. If a sent claim must be edited and resent, clicking the **Edit Claim button will generate a new claim with a Claim Submission Reason of "Original". You may then make any edits necessary to the new claim**

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and it does not require the Payer Claim Control Number to be populated. (See below for expanded instructions for editing a sent claim.)

- **REPLACED:** Once a Replacement claim has been generated to replace a Sent claim, the Sent claim will then have a status of Replaced. A Replaced claim may not be edited, it may only be viewed.
- **VOIDED:** Once a Void claim has been generated to replace a Sent claim (see Deleting a Sent Claim for more details in the Help documentation) the Sent claim will then have a status of Voided. A Voided claim may not be edited, it may only be viewed.

EDIT A SENT CLAIM

The Edit Claim button only appears on claims in a Sent status at the bottom of the screen next to the Void Claim and Replace Claim buttons. Sent claims may be accessed through the Find Claims function. This function allows you to edit and resubmit a claim that was previously sent for processing.

When the Edit Claim function is selected, the Submission Reason will change to Original. All of the information on the claim may be modified except for the Submission Reason, Client ID, DOB and Gender. Unlike a void or an adjustment, **there is no association to the previously sent claim**. You will not need the Payer Claim Control number (TCN) to re-submit the claim. All of the information on the sent claim is copied to the new claim **except** for the *More Details* information on the Service Lines. However, any line adjudication information will be copied over to the new claim.

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This screen will display once the provider clicks the Edit Claim button. The provider will need to click YES if he/she wants to edit the claim. If he/she clicks NO the provider will be brought back to the previous screen.

Again, the following fields **cannot** be changed.
- Submission Reason
- Client ID
- Date Of Birth

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- ▪ Gender
- ▪ Type of Claim (e.g. Professional, Institutional & Dental)

A provider can use one claim repeatedly for the same client to save time. As long as he/she changes the appropriate information such as Date of Service and Procedure codes. It is also the provider's responsibility to make sure the eligibility information, such as other insurance, is still the same.

ROSTER BILLING

Roster billing is used for when a provider has seen many clients for the same procedure on the same date of service, such as administering the Flu Vaccine.

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New Claim

General Claim Information

* Indicates required field(s)

Submission Reason: Original   **NPI Number:** 1111111111

*Patient Control Number: 123458

Location Information

Address Line 1:

Address Line 2:

City:

State: NY

Zip Code: 12143- 0023

Client Information

*
Enter a Client ID:
                    AA11111A   ▶ **Replicate Claim For New Client**

JOHN SMITH
123 Street
Nowhere, NY 12345

*DOB: 01/01/0001

*Gender: M

*Type of Claim: Institutional

                                                            Next ▶

▶ **Delete Claim**   ▶ **Finish**   ▶ **Save As Draft**   ▶ **Cancel**

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Replicate Claim For New Client: You will enter one claim. You can use this button by going to *Find Claims* and clicking on the claim you wish to use. Once you click on the claim, the *Replicate Claim for New Client* button will appear on the General Claim Information Tab.

Clicking on the button will allow the provider to erase the old client id, and enter the new client ID and patient control number.

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Once you enter this information, you want to click *Go* next to the client ID. This will change the client information. Then you can click on *Next* at the bottom of the screen. You can then click on *Finish* on the bottom of the screen to complete the claim.