
ePACES Professional Claim

REFERENCE GUIDE

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INITIAL SCREEN

The screenshot shows the initial screen of the ePACES application. At the top, there is a green header with the eMedNY logo and the text 'ePACES'. To the right of the header, there are links for 'Help' and 'Log Out'. Below the header, there is a 'Change Provider:' dropdown menu with a 'Go' button. The main content area is white and features a large 'ePACES' logo in the center. To the left of the logo, there is a navigation menu with the following categories and links:

- Claims**
 - New Claim
 - Find Claims
 - Real Time Responses
 - Build Claim Batch
 - Submit Claim Batches
 - Status Inquiry
 - Status Responses
- Eligibility**
 - Request
 - Responses
- PA/DVS**
 - Initial Request
 - Revise/Cancel Request
 - Responses
 - Image Upload
 - PA Roster
 - PA Roster Downloads
- Support Files**
 - Provider
 - Other Payer
 - Submitter
- User Admin**
 - Add/Edit Users

Below the navigation menu, there is a 'welcome to' message followed by the ePACES logo. To the right of the logo, there are three paragraphs of text:

The New York State Department of Health invites you to use the ePACES application to request and receive a variety of HIPAA-compliant Medicaid transactions. Using the links in the menu-bar on the left and the Help link on the top right of each page, you will be able to easily navigate through all the available functionality. If you do not see the necessary links in the menu at the left, please contact your Primary Administrator.

Please make sure your Provider Name is displayed at the top of the page before continuing. If your Provider Name is incorrect or not available in the "Change Provider" drop-down box at the top of the page, please contact the CSC HelpDesk at 800-343-9000.

For further information, please visit these sites:
[eMedNY](#) [DOH](#)

Choose **New Claim**.

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GENERAL CLAIM INFORMATION TAB

☑
General Claim Information

* Indicates required field(s)

Submission Reason: **NPI Number:**

* **Payer Claim Control Number:**

* **Patient Control Number:**

Submission Reason: Choose *Original* if you are submitting a new claim or resubmitting a previously denied or rejected 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. This number appears on the remittance statement as a transaction control number (TCN). The Payer Claim Control Number field will only appear if you select *Replace* or *Void* from the drop down.

Note: Options *Interim* and *Final* also appear in the drop down menu. These are only for use by Certified Home Health Agencies.

NPI Number: The NPI in this field is defaulted to the current NPI for the MMIS provider ID to which it maps. If you are billing 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 paid 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 for which you are submitting a claim. This field is required on all claims.

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Location Information

Address Line 1:	<input style="width: 60%;" type="text"/>
Address Line 2:	<input style="width: 60%;" type="text"/>
City:	<input style="width: 60%;" type="text"/>
State:	<input style="width: 60%;" type="text" value="NY"/> ▼
Zip Code:	<input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/>

Client Information

Enter a Client ID:

* **Location Information:** Enter the address where the service was performed including your Zip + 4 postal code.

Non-Emergency Transportation only: You may enter the 3-digit locator code assigned to the location you are billing from if you are not required to submit with an NPI. Locator codes range 003 and higher.

Location Information

Location Code:	<input style="width: 60%;" type="text"/>
----------------	--

Note: The Locator Code field will only appear if the provider in the drop down box is an atypical provider such as a non-emergency transportation provider.

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

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

● **General Claim Information**
* Indicates required field(s)

Submission Reason: NPI Number:

* Patient Control Number:

Location Information

Address Line 1:

Address Line 2:

City:

State:

Zip Code: -

● **Client Information**

* Enter a Client ID:

JANE DOE
1 MAIN ST
ANY TOWN
NY, 12345

* DOB:

* Gender:

* Type of Claim:

Dental
 Professional
 Professional Real Time
 Institutional

The client's name, address, DOB and gender will be automatically populated. 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

In order for this to be submitted as a Professional Claim, select *Professional* from the drop down.

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PROFESSIONAL CLAIM INFORMATION TAB

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.

* Indicates required field(s)

* Place of Service:

* Provider Signature On File? Yes No

* Assignment of Benefits?

* Release of Information?

* Accept Assignment?

* Signature Source: Patient Other

* Exempt from Copay?: Yes No

* Is Patient Pregnant?: Yes No

* **Place of Service:** Choose the Place of Service code from the drop down box. The Place of Service identifies where you saw the patient. The most common Place of Service codes are:

11 – Office	12 – Recipient Home
21 – Inpatient Hospital	22 – Outpatient Hospital
23 – Emergency Room	31 – Skilled Nursing Facility
41 – Ambulance Land	42 – Ambulance Air or Water
99 – Other Unlisted Facility	

* **Provider Signature on File:** Entry must be YES to indicate that the Provider has a current certification statement on file to allow them to submit electronically.

* **Assignment of Benefits:** Entry must be Y for Yes to indicate payment will be made to the Provider.

* **Release of Information:** Enter a Y for Yes - Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim. Enter an 'I' for Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes.

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

* **Signature Source:** Choose the appropriate option of Patient or Other.

* **Exempt From Copay?:** Choose Yes or No on whether the member is exempt from copay.

* **Is Patient Pregnant?:** Field is defaulted to No. If the member is pregnant, click Yes.

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Patient Amount Paid:	\$	<input type="text"/>			
Prior Auth or Referral #:		<input type="text"/>			
Mammography Certification Number:		<input type="text"/>			
CLIA Number:		<input type="text"/>			
• Certification Information					
Certification Category	Condition Codes				
<input style="width: 100%;" type="text"/>	<input style="width: 15%;" type="text"/>	<input style="width: 15%;" type="text"/>	<input style="width: 15%;" type="text"/>	<input style="width: 15%;" type="text"/>	<input style="width: 15%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 15%;" type="text"/>	<input style="width: 15%;" type="text"/>	<input style="width: 15%;" type="text"/>	<input style="width: 15%;" type="text"/>	<input style="width: 15%;" type="text"/>
<input style="width: 100%;" type="text"/>	<input style="width: 15%;" type="text"/>	<input style="width: 15%;" type="text"/>	<input style="width: 15%;" type="text"/>	<input style="width: 15%;" type="text"/>	<input style="width: 15%;" type="text"/>
Enter More Certification Information...					

Patient Amount Paid: This field is used to indicate the amount paid, if any, by the member.

Prior Authorization or Referral #: Enter in prior approval number or Referral number if applicable.

Mammography Certification Number: Required when billing for mammography services.

CLIA Number: Required for all CLIA certified facilities performing CLIA covered laboratory services.

Certification Category: Enter a certification category if billing for Early Periodic Screening Diagnosis and Treatment (EPSDT).


Condition Codes: If you indicated a certification category, enter the appropriate condition code:


- AV Patient refused referral
- NU No Referral Made
- S2 Under Treatment for referred diagnostic or corrective health problem
- ST Patient is referred or scheduled for new services as a result of the screening


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Dates


Admission Date: 


Discharge Date: 


Onset of Current Illness or Injury Date: 


Last X-Ray Date: 


Last Menstrual Period Date: 


Hearing and Vision Prescription Date: 


Disability From Date: 


Disability Through Date: 

Assumed Care Date: 

Relinquished Care Date: 

Acute manifestation Date: 

Initial Treatment Date: 

Last Seen Date: 

Dates: Enter the dates listed below as applicable.

- Admission Date
- Discharge Date
- Onset of Current Illness or Injury Date
- Last X-Ray Date
- Last Menstrual Period Date
- Hearing and Vision Prescription Date
- Disability From Date
- Disability Through Date
- Assumed Care Date
- Relinquished Care Date
- Acute Manifestation Date
- Initial Treatment Date
- Last Seen Date


Related Causes Information

Related Causes:
(select up to 2)

Employment

Other Accident

Auto Accident: NY US

Accident Date: 

Related Causes Information: This field is used to indicate that the claim is being submitted because of an accident or work related incident. If applicable, enter a check next to the appropriate cause and enter the accident date. If Auto Accident is checked, use the drop down boxes to indicate the State and Country. Leave blank if the claim is unrelated to an accident.

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• Transport Information	
• Ambulance Transport Patient Weight: <input type="text"/> lbs. Ambulance Transport Reason: <input type="text"/> Transport Distance: <input type="text"/> miles Ambulance Condition Codes: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	• Non Emergency Transport * Driver License: <input type="text"/> * License Plate Number: <input type="text"/>
• Transportation Pick UP/Drop Off Location	
Pick UP	Drop Off
Address Line 1: <input type="text"/>	Address Line 1: <input type="text"/>
Address Line 2: <input type="text"/>	Address Line 2: <input type="text"/>
City: <input type="text"/>	City: <input type="text"/>
State: <input type="text" value="NY"/>	State: <input type="text" value="NY"/>
Zip Code: <input type="text"/> - <input type="text"/>	Zip Code: <input type="text"/> - <input type="text"/>

Transport Information

Ambulance Transport: completed for ambulance services only

Non-Emergency Transport:

* **Driver License:** If billing for non-emergency transportation, enter the license number of the driver.

* **License Plate Number:** If billing for non-emergency transportation, enter the license plate number of the vehicle.

Service Authorization Exception Code:	<input type="text"/>
Special Program Indicator:	<input type="text"/>
Delay Reason:	<input type="text"/>
Patient Weight (EPO patients):	<input type="text"/> lbs.

Service Authorization Exception Code: The following list shows the acceptable HIPAA SA Exception Codes:

- 1 = Immediate/Urgent Care
- 2 = Services Rendered in a Retroactive Period
- 3 = Emergency Care
- 4 = Client has Temporary Medicaid
- 5 = Request from County for Second Opinion to Determine if Recipient can work
- 6 = Request for Override Pending
- 7 = Special Handling

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Special Program Indicator: Entry will be one of the following Special Program codes to indicate if the services are related to PHCP or Disability:

- 02** = Physically Handicapped Children's Program. This value will be processed as the PHCP indicator.
- 03** = Special Federal Funding. We will ignore this value if entered.
- 05** = Disability. This value will be processed as the Possible Disability indicator.
- 09** = Second Opinion or Surgery. We will ignore this value if entered.

Delay Reason: This field is the Over 90 Day indicator. One of the following codes is used to indicate why the claim is being submitted over 90 days from the service date.

- 1** = Proof of Eligibility Unknown or Unavailable
- 2** = Litigation
- 3** = Authorization Delays
- 4** = Delay in Certifying Provider
- 5** = Delay in Supplying Billing Forms
- 7** = Third Party Processing Delay
- 8** = Delay in Eligibility Determination
- 9** = Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
- 10** = Administrative Delay in the Prior Approval Process
- 11** = Other (Interrupted Maternity Care or IPRO Denial/Reversal)
- 15** = Natural Disaster

Patient Weight (EPO patients): Leave this field blank.

The screenshot shows a web form interface for entering condition codes. It features two columns of input fields, each labeled 'Code' at the top and bottom. Each input field has a small dropdown arrow icon to its right. Below the code fields is a section titled 'Group Provider (use if a different entity than the Billing Provider)' which includes a 'Group Provider Number:' label, an input field, and a 'Go' button. At the bottom of the form are several navigation buttons: 'Previous', 'Next', 'Delete Claim', 'Finish', 'Save As Draft', and 'Cancel'.

Condition Codes: If the procedure is for an Abortion/Sterilization, select the applicable code from the list. Only the following Abortion Codes may be reported in this field:

- AA** = Abortion performed due to rape
- AB** = Abortion performed due to incest
- AC** = Abortion due to serious fetal defect or serious deformity or abnormality
- AD** = Abortion due to life endangering physical condition caused by or arising from pregnancy
- AE** = Abortion due to physical health of mother that is not life endangering
- AF** = Abortion due to emotional/physiological health of mother
- AG** = Abortion due to social or economic reasons
- AH** = Elective Abortion
- AI** = Sterilization

Group Provider Number: If you would like payment to go to the group, enter the group NPI in this field.

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PROVIDER INFORMATION TAB

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

Rendering Provider

- Use an Existing Provider**
 - *Select a Name:
- OR Search for a Medicaid Provider:**
 - Last Name:
 - Provider Number:

Enter a New Non-Medicaid Provider

* NPI #:

Referring Provider

- Use an Existing Provider**
 - *Select a Name:
- OR Search for a Medicaid Provider:**
 - Last Name:
 - Provider Number:

Enter a New Non-Medicaid Provider

NPI #:

AND/OR

State License #:

Rendering Provider: The Rendering Provider is used to identify the actual provider of service when that person is different from the provider selected as the Billing Provider.

Please Take Note: If a Physician Assistant or Clinical Social Worker is entered as a Rendering Provider, the Supervising Provider field must be completed.

Referring Provider: This field is used to identify the Referring Provider when necessary. The Referring Provider is required in certain cases such as a Restricted Recipient, private duty nursing claims, and required Podiatry referrals for children under 21 years of age.

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Primary Care Provider

- **Use an Existing Provider**
*Select a Name: Go
- OR Search for a Medicaid Provider:
Last Name:
Provider Number: Go

Enter a New Non-Medicaid Provider

NPI #:

AND/OR
State License #: Go

Supervising Provider

- **Use an Existing Provider**
*Select a Name: Go
- OR Search for a Medicaid Provider:
Last Name:
Provider Number: Go

Enter a New Non-Medicaid Provider

* NPI #: Go

Previous
Next

Delete Claim
Finish
Save As Draft
Cancel

Primary Care Provider: This field is used to report additional referrals if more than one referral exists and there is a requirement to report the additional referral. If a Primary Care Provider is entered, a Referring Provider must also be entered.

Supervising Provider: Enter the Billing Provider's number in this section when the Rendering Provider is a Physician Assistant or Clinical Social Worker.

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DIAGNOSIS TAB

The screenshot displays the 'Diagnosis' tab in the ePACES Professional Claim system. The interface includes a navigation bar at the top with the following tabs: General Claim Information, Professional Claim Information, Provider Information, **Diagnosis** (selected), Other Payers, and Service Line(s). Below the navigation bar, the 'Diagnosis Information' section is highlighted in green. It features radio buttons for selecting between ICD-9 and ICD-10, with ICD-10 currently selected. There are 12 numbered diagnosis input fields arranged in two columns (Diagnosis 1-6 on the left, Diagnosis 7-12 on the right). Below this section is the 'Anesthesia Related Procedure' section, also highlighted in green, which contains two input fields for 'Anesthesia Related Procedure Code 1' and 'Anesthesia Related Procedure Code 2'. At the bottom of the form, there are navigation buttons: 'Previous', 'Next', 'Delete Claim', 'Finish', 'Save As Draft', and 'Cancel'.

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

* **Diagnosis Information:** Enter at least one diagnosis code. Up to 12 diagnosis codes may be entered on a claim, but they cannot be duplicated. The diagnosis pointer on the claim line corresponds to the codes entered here. **Do not include the decimal point when entering the diagnosis code.**

Anesthesia Related Procedure: If billing for anesthesia services, enter the procedure code(s) for the surgery in this field.

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OTHER PAYERS TAB

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

•• New Claim - 837 Professional

▶ General Claim Information
▶ Professional Claim Information
▶ Physician Information
▶ Diagnosis
▼ Other Payers
▶ Service Line(s)

* Indicates required field(s)

All Other Payers

Line #	Other Payer Name	Paid Amount	Date Claim Paid	Other Subscriber Name	Remove
(No Other Payers Found)					

▶ Add New Payer
◀ Previous
Next ▶

▶ Delete Claim
▶ Finish
▶ Save As Draft
▶ Cancel

All Other Payers: If more than one other payer's information applies, click on the *Add New Payer* button.

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OTHER PAYER DETAILS

This tab is used to indicate details about the Other Payer. If you are reporting payment from a third party insurance, all required fields on this tab must be completed.

* 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:

* Payer Type:

Other Payer Paid Amount: \$

Other Payer Claim Control Number: \$

Date Claim Paid:

Other Payer Information

* **Other Payer Name:** If the Other Payer Support File has already been populated with the Other Payer, you may choose it from the drop down list. If the other payer is not in the dropdown list, you can add it by clicking on the *Other Payer* link under Support Files on the left hand side.

* **Payer Sequence Number:** Enter the sequence number as Primary, Secondary or Tertiary.

* **Payer Type:** Enter the other payer type. Ex: MB for Medicare Part B.

Other Payer Paid Amount: If reporting Other Payer Paid information, enter the amount paid by the Other Payer in this field. Enter the total amount paid by the other insurance for the entire claim.

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

Date Claim Paid: Enter the date you received payment from the Other Payer.

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Other Subscriber

* Last Name:

* First Name:

* Primary ID:

Address Line 1:

Address Line 2:


* City:

* State:

* Zip Code: -

* Country:

Other Subscriber Information

* Relationship: 

Group Number:

Group Name:

Other Subscriber

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

Other Subscriber Information

* **Relationship:** Enter the appropriate code from the drop down list to indicate the Subscriber's relationship to the member.

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

Group Name: Optional. 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			
Claim Adjustment Group	Reason Code	Adjustment Amount	Adjustment Quantity
<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"/>	<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="button" value="Add"/>			
Claim Adjustment Group	Reason Code	Adjustment Amount	Adjustment Quantity

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.

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

Other Insurance Coverage Information	
* Assignment of Benefits?	<input type="text"/> <input type="button" value="v"/>
* Patient Signature Source?	<input type="text"/> <input type="button" value="v"/>
* Release of Information?	<input type="text"/> <input type="button" value="v"/>

Other Insurance Coverage Information

* **Assignment of Benefits:** Enter Yes or No.

* **Patient Signature Source:** Choose the appropriate code from the drop down list.

* **Release of Information:** Choose the appropriate code (Y or I) from the drop down list.

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Amounts

Remaining Patient Liability: \$

Non Covered Charge Amount: \$

Next Other Payer View Other Payers

Previous Next

Delete Claim Finish Save As Draft Cancel

Amounts

Remaining Patient Liability: Leave blank.

Non Covered Charge 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.

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SERVICE LINE TAB

General Claim Information		Professional Claim Information		Physician Information		Diagnosis		Other Payers		Service Line(s)	
Line	Item Ctl #	*Svc Date:	*Proc & Mod	*Chrg Amount	*Svc Count	Place of Svc	*DX Pointer	*Emgcy	More	Del.	
1	<input type="text"/>	From: <input type="text"/> To: <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> Uni <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No			
2	<input type="text"/>	From: <input type="text"/> To: <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> Unit <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No			
3	<input type="text"/>	From: <input type="text"/> To: <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> Unit <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No			
4	<input type="text"/>	From: <input type="text"/> To: <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> Unit <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No			
5	<input type="text"/>	From: <input type="text"/> To: <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> Unit <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No			
Total Claim Charges: \$0.00											
<input type="button" value="Add More Service Lines"/>											
<input type="button" value="Previous"/>											
<input type="button" value="Delete Claim"/> <input type="button" value="Finish"/> <input type="button" value="Save As Draft"/> <input type="button" value="Cancel"/>											

Line: Indicates the line number on the claim. You can enter up to 5 service lines using this page. Click on the *Add More Services Lines* button to allow entry of an additional 5 lines. Each time you click on that button, you are given 5 more lines up to a maximum of 50 claim lines.

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.

* **Svc Dates From/To:** Enter the service date in *From* if you are only billing for a single day for that claim line. For Physicians or Nurse Practitioners who are block billing consecutive inpatient hospital visits in the same month, the *From/To* dates may be used.

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* **Proc & Mod:** Enter the procedure code that describes the service you are billing. You may enter up to 4 modifiers as necessary to identify special circumstances.

* **Chrg Amount:** Enter the total amount charged.

* **Svc Count:** Enter the number of units.

Place of Svc: Enter the Place of Service Code if the code you entered on the Professional Claim Information Tab is different. This is done if you indicated Office Visit on the header, then needed to bill Inpatient Services as well.

* **DX Pointer:** Enter the appropriate number corresponding to the diagnosis code entered on the Diagnosis Tab. The first pointer indicates which diagnosis code is considered to be the primary diagnosis for this claim line. You may enter up to 4 pointers per claim line.

* **Emergency:** Select Yes or No to indicate if the service rendered was related to an emergency.

More: Click on this button to add additional details pertaining to this claim line. You may use this area to indicate additional data that may be different from what was entered at the claim level. Some examples of how the *More* button may be used are:

- To indicate a paid amount from Medicare and/or Other Payers at the line level
- To indicate a Prior Approval Number at the line level
- To indicate EPSDT (CHAP) at the line level
- To indicate Family Planning at the line level
- To indicate Copay Exemption at the line level
- To indicate the NDC and National Drug Unit Count when billing physician-administered drugs

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MORE BUTTON

More Details - Service Line: When clicked, the *More* button allows you to enter additional information for the claim line.

More Details - Service Line #1

Close

Line	Line Item Ctl#	Svc Date	Proc & Mod	Chrg Amount	Svc Count	Place of Svc	DX Pointer	Emgcy
1		9/18/2018-	99213	37.41	1.00		1	No

Dates

Last X-Ray Date:

Product Shipped Date:

Initial Treatment Date:

Prescription Date:

ESRD Related Test Results

Test Performed:

Test Results:

Measurement Identifier: Test Results Original

Test Performed Date:

Dates: If applicable.

ESRD Related Test Results: If applicable.

Drug Identification

National Drug Code:

National Drug Unit Count: Unit

Prescription Number or Compound Drug Association Number:

Prescription Number Link Sequence Number

Drug Identification: These fields are required if billing for a drug code requiring an NDC on the claim.

National Drug Code: Enter NDC number.

National Drug Unit Count: Enter number of units given.

Prescription Number or Compound Drug Association Number: Optional. Enter the prescription number or compound drug association number in this field.

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Prior Authorization #:	<input type="text"/>
CLIA Number:	<input type="text"/>
Sales Tax Amount:	\$ <input type="text"/>
Services a result of EPSDT Referral?:	<input type="radio"/> Yes <input type="radio"/> No
Family Planning Service?:	<input type="radio"/> Yes <input type="radio"/> No
Obstetric Anesthesia Addtl Units :	<input type="text"/>

Prior Authorization #: PA number can be entered using the *More* button if you are billing for different lines that require a different PA number on each line.

CLIA Number: If applicable.

Sales Tax Amount: If applicable.

Services a result of EPSDT Referral? If the service was performed as the result of a screening referral, enter Yes here. DME should leave this field blank.

Family Planning Service?: If Family Planning applies for this line and is not indicated on the Professional Claim Information tab, enter Yes here.

Obstetric Anesthesia Addtl Units: If applicable.

ePACES Professional Claim

REFERENCE GUIDE

The screenshot displays a web form with three main sections:

- Purchased Service Provider:**
 - Use an Existing Provider:** Includes a dropdown menu for "Select a Name:" with a "Go" button. Below it, "OR Search for a Medicaid Provider:" has fields for "Last Name:" and "Provider Number:" with "Go" buttons.
 - Enter a New Non-Medicaid Provider:** Includes fields for "NPI #:", "AND/OR", and "State License #:" with a "Go" button.
- Ordering Provider (to report for DME services captured at the service line):** This section is identical in structure to the "Purchased Service Provider" section.
- Durable Medical Equipment Rental Services:** Includes fields for "Length of Medical Necessity:" (with "days" text), "DME Rental Price:" (with "\$" text), "DME Purchase Price:" (with "\$" text), and "Rental Unit Price Indicator:" (with a dropdown menu).

Purchased Service Provider: If applicable.

Ordering Provider: DME and Transportation Providers use this field to report the Ordering Provider.

Durable Medical Equipment Rental Services: Leave the corresponding fields blank.


ePACES Professional Claim

REFERENCE GUIDE





Transport Information

Ambulance Transport

Patient Weight:
lbs.

Ambulance Transport Reason: 

Transport Distance:
miles

Ambulance Condition Codes: 
 
 
 

Non Emergency Transport

* Driver License:

* Plate License:

Transportation Pick UP/Drop off Location

Pick UP		Drop Off	
Address Line 1:	<input type="text"/>	Address Line 1:	<input type="text"/>
Address Line 2:	<input type="text"/>	Address Line 2:	<input type="text"/>
City:	<input type="text"/>	City:	<input type="text"/>
State:	<input type="text" value="NY"/>	State:	<input type="text" value="NY"/>
Zip Code:	<input type="text"/> - <input type="text"/>	Zip Code:	<input type="text"/> - <input type="text"/>

Procedure Description :

Transport Information

Non Emergency Transport: You can enter the license number and plate number on the *More* button instead of on the professional claim tab if a different driver or vehicle is used for different service lines.

ePACES Professional Claim

REFERENCE GUIDE

Line Adjudication Information and Claim Adjustment Fields

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.

Line Adjudication Information

Other Payer Name:


Service Line Paid Amount: \$

Paid HCPCS Code:

Modifiers:

Paid Service Unit Count:

Bundled Line Number:

Date Claim Paid: 

Remaining Patient Liability:

Other Payer Name: If the Other Payer Support File was already populated with the Other Payer, you may choose it from the drop down list.

Service Line Paid Amount: If reporting Other Payer Paid information, enter the amount paid by the Other Payer for the line item/procedure in this field.

Paid HCPCS Code: Enter the procedure code that describes the service you are billing on this line.

Modifiers: You may enter up to 4 modifiers as necessary to identify special circumstances.

Paid Service Unit Count: Enter the number of units applicable to the line item/procedure.

Bundled Line Number: Leave blank.

Date Claim Paid: Enter the date you received payment from the Other Payer.

Remaining Patient Liability: Leave blank.

ePACES Professional Claim

REFERENCE GUIDE

If the other payer reported adjustments at the line level, enter the adjustment information here.

Claim Adjustment Group	Reason Code	Adjustment Amount	Adjustment Quantity
<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"/>	<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"/>

[Add](#)

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](#)

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.

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

To go back to the service line tab, click on *Close*.

When you have entered the claim lines you want to submit, click on the *Finish* button.

ePACES Professional Claim

REFERENCE GUIDE

CLAIM ENTRY CONFIRMATION WINDOW

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

Claim Entered

Claim Entry Status: Complete **Claim Type:** Professional

Client ID: AA00000Z **Patient Control Num.:** 12345

Note: Please use your browser to print this screen if you wish to maintain a copy.

▶ Edit Current Claim
▶ Enter Another New Claim
▶ Validate Current Claim

This claim still needs to be batched and submitted for claims adjudication processing.

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 enter a new Professional claim.
- **Validate Current Claim:** Can be used to check the current claim for errors.

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 was 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 is fully entered and 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 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 being replaced will have the Status changed to Replaced.
- **Voided:** When a Void claim has been submitted, the Sent claim being voided will have the Status changed to Voided.

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.

ePACES Professional Claim

REFERENCE GUIDE

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 can be batched.

Claims in a Complete status 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.

Build Claim Batch

Claim(s) by User ID:

Select which claim(s) you want to batch and build the batch.

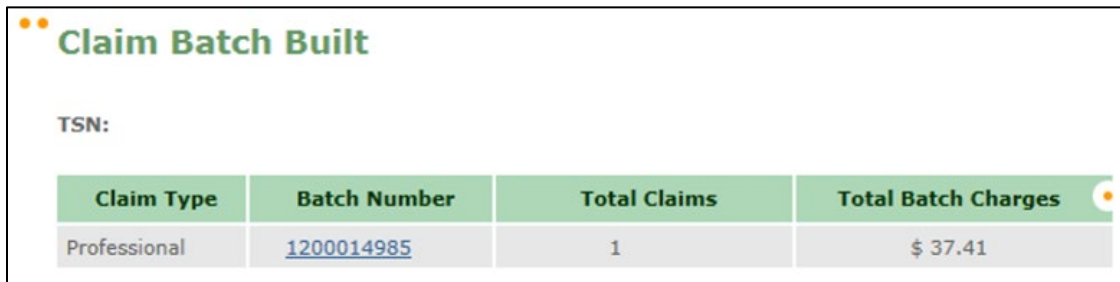
UnCheck All Check All Add to Batch	Patient Control #	Entry Status	Client ID	Client Name	Type of Claim	Total Charges
<input checked="" type="checkbox"/>	12345	Complete	AA00000Z	DOE, JANE	Professional	\$45.00
UnCheck All Check All Add to Batch	Patient Control #	Entry Status	Client ID	Client Name	Type of Claim	Total Charges

ePACES Professional Claim

REFERENCE GUIDE

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
Professional	1200014985	1	\$ 37.41

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.

ePACES Professional Claim

REFERENCE GUIDE

SUBMIT CLAIM BATCHES

Submit Claim Batches

Claim(s) by User ID: ▶ Go

[View Previously Submitted Batches](#)

Check All Submit UnCheck All	Batch Number	Batch Date	Type Of Claim	Total Claims	Total Batch Charges	Remove
<input checked="" type="checkbox"/>	1200014985	9/19/2018	Professional	1	\$ 37.41	

Check All Submit UnCheck All	Batch Number	Batch Date	Type Of Claim	Total Claims	Total Batch Charges	Remove

▶ Submit All Selected 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.

To check to see if the batch was received, click on the *View Previously Submitted Batches* link.

ePACES Professional Claim

REFERENCE GUIDE

CLAIM BATCHES SUBMITTED

Submit Claim Batches

Claim(s) by User ID: ▶ Go

[View Previously Submitted Batches](#)

The following claim batches have been submitted:

Batch Number	Submit Date	Type Of Claim	Total Claims	Total Batch Charges	Total Rejected
1200014985	09/19/2018	Professional	1	\$ 37.41	
Batch Number	Submit Date	Type Of Claim	Total Claims	Total Batch Charges	Total 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 in the Batch Number column and the claims submitted within the batch will be displayed.

ePACES Professional Claim

REFERENCE GUIDE

VIEW BATCH

**** Batch # 1200014985**

TSN:

Batch Date: 9/19/2018

Patient Control#	Client ID	Client Name	Type Of Claim	Total Charges	Initial Claim Status/Response	Error Text
12345	AA00000Z	JANE DOE	Professional	\$ 37.41	Details	
					Total Batch Charges	\$ 37.41

This screen will display each individual claim within the batch. The Error Text column will display error messages that apply to a specific claim. Click on the *Details* link in the Initial Claim Status/Response column to check the status of the claim.

Client Information

Client ID: AA00000Z

Name: JANE DOE

Address: 1 MAIN ST
ANY TOWN
NY, 12345

Date of Birth: 01/01/1910

Gender: F

Claim Level Status

(F1) - Finalized/Payment-The claim/line has been paid. (3) - Claim has been adjudicated and is awaiting payment cycle.

Payer Claim ID	Charge Amount	Paid Amount	Dates of Service	Status Date
182	30	37.41	09/18/2018	10/2/2018

Line Level Status

Primary Status	Line ID	Procedure Code	Line Charge Amount	Paid Amount	Qty.	Status Date
(F1) - Finalized/Payment-The claim/line has been paid. (3) - Claim has been adjudicated and is awaiting payment	1	99213	37.41	37.41	1.00	10/2/2018

If the claim status is denied or rejected, click the *Close* button at the bottom of the response screen to return to the view batch screen. Clicking the link provided in the Patient Control Number column will open the claim for editing.

ePACES Professional Claim

REFERENCE GUIDE

EDITING A 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 must 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 is 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 message is displayed on the confirmation page indicating the error on the claim. Once the errors are 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, if the batch has not been submitted, 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 be replaced or edited as an Original claim and resent. If a Sent claim must be replaced, clicking the *Replace Claim* button generates 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 Claim Original Reference Number to be populated. These new claims will go through the standard validation, batching, and submittal process to be sent to the Payer. You can only replace a claim that has been paid. **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 and it does not require the Claim Original Reference Number to be populated.** You can edit a claim that has been denied in order to resend a new corrected claim. (See below for expanded instructions on 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.

ePACES Professional Claim

REFERENCE GUIDE

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 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 Claim Original Ref. Num. 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.

Professional Real Time Information Professional Claim Information Provider Information Diagnosis Other Payers Service Line(s)

* Indicates required field(s)

Submission Reason: Original NPI Number:

* Patient Control Number: 12345

Location Information

Address Line 1: 1 MAIN STREET
 Address Line 2:
 City: ANY TOWN
 State: NY
 Zip Code: 12345 - 1234

* **Client Information**

* Enter a Client ID: AA00000Z ▶ Replicate Claim For New Client

JANE DOE
 1 MAIN ST
 ANY TOWN
 NY, 12345

* DOB: 01/01/1910

* Gender: F

* Type of Claim: Professional ▶ Next

▶ Void Claim ▶ Replace Claim ▶ Edit Claim

This screen will display once the provider clicks the *Edit Claim* button. You need to click **YES** if you want to edit the claim. If you click **NO** you are brought back to the previous screen.

ePACES Professional Claim

REFERENCE GUIDE

Do you wish to edit and resend this claim?

Yes No

The screenshot shows the 'Professional Claim Information' tab of the ePACES system. The form is divided into several sections:

- Submission Reason:** Original
- NPI Number:** (Field)
- Patient Control Number:** 12345
- Location Information:**
 - Address Line 1: 1 MAIN STREET
 - Address Line 2: (Field)
 - City: ANY TOWN
 - State: NY
 - Zip Code: 12345 - 1234
- Client Information:**
 - Enter a Client ID: AA00000Z
 - Replicate Claim For New Client (Button)
 - JANE DOE
1 MAIN ST
ANY TOWN
NY, 12345
 - DOB: 01/01/1910
 - Gender: F
- Type of Claim:** Professional

A 'Next' button is located at the bottom right of the form.

Again, the following fields **cannot** be changed.

- Submission Reason
- Client ID
- Date Of Birth
- Gender
- Type of Claim (e.g. Professional, Institutional & Dental)

A provider can use one claim repeatedly for the same recipient to save time, as long as you change the 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.

ePACES Professional Claim

REFERENCE GUIDE

ROSTER BILLING

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

Replicate Claim For New Client: The provider 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.

General Claim Information Professional Claim Information Provider Information Diagnosis Other Payers Service Line(s)

Submission Reason: Original NPI Number:

* Patient Control Number: 12345

Location Information

Address Line 1: 1 MAIN STREET
Address Line 2:
City: ANY TOWN
State: NY
Zip Code: 12345 - 1234

* **Client Information**

* Enter a Client ID: AA00000Z **Replicate Claim For New Client**

JANE DOE
1 MAIN ST
ANY TOWN
NY, 12345

* DOB: 01/01/1910

* Gender: F

* Type of Claim: Professional

Next

ePACES Professional Claim

REFERENCE GUIDE

The screenshot displays the 'General Claim Information' tab of the ePACES Professional Claim form. At the top, there are navigation tabs for 'General Claim Information', 'Dental Claim Information', 'Provider Information', 'Diagnosis', 'Other Payers', and 'Service Line(s)'. A legend indicates that an asterisk (*) denotes a required field. The form contains the following fields and elements:

- Submission Reason:** Original
- NPI Number:** (empty field)
- Patient Control Number:** (empty field)
- Location Information:**
 - Address Line 1:** 1 MAIN ST
 - Address Line 2:** (empty field)
 - City:** ANY TOWN
 - State:** NY
 - Zip Code:** 12345 - 1234
- Client Information:**
 - Enter a Client ID:** (empty field) with a **Go** button next to it.
 - Client details: JANE DOE, 1 MAIN ST, ANY TOWN, NY, 12345
 - DOB:** (empty field) with a calendar icon.
 - Gender:** (dropdown menu)
- Type of Claim:** Professional
- Next** button at the bottom right.

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.