
ePACES Dental Claim

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INITIAL SCREEN

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welcome to

ePACES

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: Original ▼ NPI Number: 0123456789

* 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 is reported on the provider's remittance as the 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 you are submitting a claim for. This field is required on all claims.

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Location Information

Address Line 1:

Address Line 2:

City:

State:

Zip Code: -

Client Information

✖ Enter a Client ID:

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

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

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

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● **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 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 change the 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 Dental Claim, select *Dental* from the drop down.

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DENTAL 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.

The screenshot shows the 'Dental Claim Information' tab in the ePACES system. The tab is highlighted in blue. Below the tab are several fields for data entry:

- Place of Service:** A text input field with a dropdown arrow icon.
- Assignment of Benefits?:** A text input field with a dropdown arrow icon.
- Release of Information?:** A text input field containing the letter 'Y' and a dropdown arrow icon.
- Accept Assignment?:** A text input field with a dropdown arrow icon.
- Patient Paid Amount:** A text input field with a dollar sign (\$) and a dropdown arrow icon.
- Prior Authorization Number:** A text input field.

A note at the top right of the form area states: '* Indicates required field(s) if entering information on this tab'.

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

- | | |
|-------------------------|-------------------------------|
| 11 – Office | 12 – Recipient Home |
| 21 – Inpatient Hospital | 22 – Outpatient Hospital |
| 23 – Emergency Room | 31 – Skilled Nursing Facility |

* **Assignment of Benefits:** This entry must be 'Yes' to indicate payment will be made to the Provider. The system will default this field to Yes.

* **Release of Information:** Enter a Y for Yes - Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim. The system will default this field to Yes.

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

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

Prior Authorization Number: Enter the prior approval or DVS number in the box provided if the service you are billing for requires prior authorization.

The screenshot shows the 'Dates' and 'Related Causes Information' sections of the form:

- Dates:**
 - From Date:** A text input field with a calendar icon.
 - To Date:** A text input field with a calendar icon.
- Related Causes Information:**
 - Related Causes: (select up to 2):**
 - Other Accident
 - Employment
 - Auto Accident In: NY US (with dropdown arrows)
 - Accident Date:** A text input field with a calendar icon.

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* **Dates:** The Provider must enter a 'From' date. This would be the earliest date of service you are entering on the service line.


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.

Orthodontic Information

Orthodontic Treatment Months:

Orthodontic Treatment Months Remaining:

Orthodontic Treatment Indicator : (Orthodontic services rendered, no Monthly information available)

Orthodontic Banding Date: 








Orthodontic Information: If applicable.

Orthodontic Treatment Months: Enter the total months, whole or partial, of orthodontic treatment.

Orthodontic Treatment Months Remaining: Enter the total months, whole or partial, of orthodontic treatment remaining. If entered, the number must be less than the number entered in total months.

Orthodontic Treatment Indicator: Click on the box if there are Orthodontic services rendered, but no Monthly information is available.

Orthodontic Banding Date: Enter up to five dates in the fields provided.

Tooth Number	Tooth Status	Tooth Number	Tooth Status
<input type="text"/>		<input type="text"/>	
<input type="text"/>		<input type="text"/>	
<input type="text"/>		<input type="text"/>	
			
Tooth Number	Tooth Status	Tooth Number	Tooth Status

Tooth Information

Tooth information may be entered here at the claim level or may be entered at the service line level on the Service Line tab. It is recommended that the Service Line tab be used rather than this section.

Tooth Number: This field is used to report either a missing tooth or a tooth to be extracted in the future.

Tooth Status: Choose the appropriate tooth status from the drop down list.

Enter More Tooth Numbers: If more than six tooth numbers need to be entered, click on this link to display additional lines.

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Special Program Indicators - Special Program Indicator: This entry will be one of the following Special Program codes to indicate if the services are related to CHAP, PHCP, or Disability:

01 = Early and Periodic Screening, Diagnosis and Treatment (EPSDT) or Child Health Assessment Program (CHAP). We will ignore this value if provided. If claim is for a well care exam, the CHAP Referral code must be indicated in the CRC segment.

02 = Physically Handicapped Children's Program. This value will be processed as the PHCP indicator. Enter 02 when billing orthodontic procedures.

03 = Special Federal Funding. We will ignore this value if entered.

05 = Disability. This value will be processed as the Possibility Disability indicator.

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 (not allowed for electronic claims including ePACES)

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

15 = Natural Disaster

Claim Note: Not required.

Group Provider: Enter the NPI number assigned to the Group if you want payment made to the Group.

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PROVIDER INFORMATION TAB

General Claim Information | Dental Claim Information | **Provider Information** | Diagnosis | Other Payers | Service Line(s)

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

Referring Provider
 • Use an Existing Provider
 *Select a Name:
 OR Search for a Medicaid Provider:
 Last Name:
 Provider Number:
 OR
 • Enter a New Non-Medicaid Provider
 NPI #:
 AND/OR
 State License #:

Rendering Provider or Assistant Surgeon
 • Use an Existing Provider
 *Select a Name:
 OR Search for a Medicaid Provider:
 Last Name:
 Provider Number:
 OR
 • Enter a New Non-Medicaid Provider
 NPI #:

Taxonomy Code:

Supervising Provider
 • Use an Existing Provider
 *Select a Name:
 OR Search for a Medicaid Provider:
 Last Name:
 Provider Number:
 OR
 • Enter a New Non-Medicaid Provider
 NPI #:

Referring Provider: This field is used to indicate a Referring Provider if necessary. The Referring Provider is required in certain cases such as a Restricted Recipient.

Rendering Provider or Assistant Surgeon: The Rendering Provider section is used to indicate a Service Provider if necessary.

Supervising Provider: Not applicable.

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DIAGNOSIS TAB

The screenshot shows the 'Diagnosis' tab selected in the ePACES Dental Claim system. The 'Diagnosis Information' section is active, featuring radio buttons for 'ICD-9' and 'ICD-10'. Below this, there are four input fields labeled 'Diagnosis 1', 'Diagnosis 2', 'Diagnosis 3', and 'Diagnosis 4'. At the bottom of the form, there are navigation buttons: 'Previous', 'Next', 'Delete Claim', 'Finish', 'Save As Draft', and 'Cancel'.

Currently, this tab is not be used for Dental. Please click on the *Next* button.

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.

The screenshot shows the 'Other Payers' tab selected in the ePACES Dental Claim system. The 'All Other Payers' section is active, displaying a table with the following columns: 'Line #', 'Other Payer Name', 'Paid Amount', 'Date Claim Paid', 'Other Subscriber Name', and 'Remove'. Below the table, there is a message '(No Other Payers Found)'. At the bottom of the form, there are navigation buttons: 'Previous', 'Next', 'Delete Claim', 'Finish', 'Save As Draft', and 'Cancel'. A note '* Indicates required field(s)' is visible in the top right corner of the form area.

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.

Other Payer Information

- * **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.
- * **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:

Member ID:

Address Line 1:

Address Line 2:

City:

State: ▼


Zip Code: -

Country: ▼

Other Subscriber

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

Other Subscriber Information

Relationship: 

Group Number:

Group Name:

Other Subscriber Information

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

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.

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The screenshot displays a web-based form for entering dental claim information. It is divided into two main sections: 'Other Insurance Coverage Information' and 'Amounts'. The 'Other Insurance Coverage Information' section contains two fields: 'Assignment of Benefits?' with a text input and a dropdown menu, and 'Release of Information?' with a text input containing 'Y' and a dropdown menu. The 'Amounts' section contains two fields: 'Remaining Patient liability : \$' and 'Non Covered Amount : \$', both with text input boxes. At the bottom of the form, there are several navigation buttons: 'Next Other Payer', 'View Other Payers', 'Previous', 'Next', 'Delete Claim', 'Finish', 'Save As Draft', and 'Cancel'.

Other Insurance Coverage Information

- * **Assignment of Benefits:** Enter Yes or No.
- * **Release of Information:** Choose the appropriate code (Y or I) from the drop down list.

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
Dental Claim Information
Provider Information
Diagnosis
Other Payers
Service Line(s)

* Indicates required field(s)

Ln	Line Item Ctl#	DOS	ADA Code *	Proc. Count *	Oral Cavity Area	Tooth Num	Tooth Surface Codes	Amt Chrg *	More	Del. *
1	<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="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> I <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> O	\$ <input type="text"/>		
2	<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="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> I <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> O	\$ <input type="text"/>		
3	<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="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> I <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> O	\$ <input type="text"/>		
4	<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="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> I <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> O	\$ <input type="text"/>		
5	<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="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> I <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> O	\$ <input type="text"/>		
Total Claim Charges \$0.00										

Add More Service Lines
Previous

Delete Claim
Finish
Save As Draft
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#: Optional. When used, the value provided will be returned on the 835 (electronic remittance advice) and may be used as an index to your system.

* **DOS:** Enter the service date in this field.

* **ADA Code:** Enter the procedure code that describes the service for which you are billing.

* **Proc Count:** Enter the number of units (times performed).

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Oral Cavity Area: Enter the 2-digit code to identify the area of the oral cavity if the procedure billed requires quadrant or arch identification. Identification will be shown in the following manner:

Quadrant Identification:

- **10** = Upper Right
- **20** = Upper Left
- **30** = Lower Left
- **40** = Lower Right

Arch Identification:

- **01** = Arch Upper
- **02** = Arch Lower
- **00** = Entire Oral Cavity

Tooth Number: Enter the tooth identification (or choose from the drop down box) if the procedure being billed requires tooth identification.

Tooth Surface Codes: Place a check mark in the box next to the appropriate surface if the procedure requires surface identification. Surface Identification is as follows:

- **M** = Mesial
- **I/O** = Incisal/Occlusal
- **D** = Distal
- **F/B** = Facial/Buccal
- **L** = Lingual

* **Amount Charged:** Enter the amount charged for the procedure billed on this line.

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More: Click on this button to add more 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 claim line level.
- To indicate a Prior Approval Number or DVS number at the line level.
- To indicate a Place of Service Code at the line level.

* Indicates required field(s)

More Details - Service Line #1

➤ Close

Line	Line Item Ctl#	DOS	ADA Code	Proc Count	Oral Cavity Area	Tooth Num	Tooth Surface Codes	Amt Chrg
1		9/18/2018	D1110	1.00				45.00

• **DX Pointer**

• **Additional Tooth Information**

Tooth Number	Tooth Surface Codes	Tooth Number	Tooth Surface Codes
<input style="width: 30px;" type="text"/> [lookup]	<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> I <input type="checkbox"/> F <input type="checkbox"/> D	<input style="width: 30px;" type="text"/> [lookup]	<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> I <input type="checkbox"/> F <input type="checkbox"/> D
<input style="width: 30px;" type="text"/> [lookup]	<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> I <input type="checkbox"/> F <input type="checkbox"/> D	<input style="width: 30px;" type="text"/> [lookup]	<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> I <input type="checkbox"/> F <input type="checkbox"/> D
<input style="width: 30px;" type="text"/> [lookup]	<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> I <input type="checkbox"/> F <input type="checkbox"/> D	<input style="width: 30px;" type="text"/> [lookup]	<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> I <input type="checkbox"/> F <input type="checkbox"/> D
<input style="width: 30px;" type="text"/> [lookup]	<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> I <input type="checkbox"/> F <input type="checkbox"/> D	<input style="width: 30px;" type="text"/> [lookup]	<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> I <input type="checkbox"/> F <input type="checkbox"/> D
<input style="width: 30px;" type="text"/> [lookup]	<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> I <input type="checkbox"/> F <input type="checkbox"/> D	<input style="width: 30px;" type="text"/> [lookup]	<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> I <input type="checkbox"/> F <input type="checkbox"/> D
<input style="width: 30px;" type="text"/> [lookup]	<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> I <input type="checkbox"/> F <input type="checkbox"/> D	<input style="width: 30px;" type="text"/> [lookup]	<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> I <input type="checkbox"/> F <input type="checkbox"/> D
<input style="width: 30px;" type="text"/> [lookup]	<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> I <input type="checkbox"/> F <input type="checkbox"/> D	<input style="width: 30px;" type="text"/> [lookup]	<input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> M <input type="checkbox"/> L <input type="checkbox"/> I <input type="checkbox"/> F <input type="checkbox"/> D

➤ Enter Another

Place of Service: [lookup]

Prosthesis, Crown, Or Inlay Code: Initial Placement Replacement

Prior Placement Date: Actual Prior Placement Date Estimated

[calendar]

Orthodontic Banding Date: [calendar]

Replacement Date: [calendar]

Prior Authorization Number:

Treatment Start Date: [calendar]

Treatment Completion Date: [calendar]

Procedure Code Description:

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

Line Adjudication Information


Other Payer Name:

Service Line Paid Amount: \$

Paid ADA Code:

Paid Service Unit Count:

Bundled Line Number:

Date Claim Paid: 

Remaining Patient liability :

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](#)

Delete: Click on *Delete* to delete the claim line.

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.

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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:** Dental

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

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

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 add another Dental claim.
- **Validate Current Claim:** Click this button before you batch this claim.

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 was 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 was 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 the claim(s), 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 has been submitted, the Sent claim that is 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 Dental 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 may be batched.

Build Claim Batch

Claim(s) by User ID: TEST123

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	AA0000Z	DOE, JANE	Dental	\$45.00

The 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.

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
Dental	1200014986	1	\$ 45

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 Dental Claim

REFERENCE GUIDE

SUBMIT CLAIM BATCHES

Submit Claim Batches

Claim(s) by User ID:

[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"/>	1200014986	9/20/2018	Dental	1	\$ 45.00	

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

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.

ePACES Dental Claim

REFERENCE GUIDE

CLAIM BATCHES SUBMITTED

•• Claim Batches Submitted

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
1200014986	09/20/2018	Dental	1	\$ 45.00	

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.

VIEW BATCH

•• Batch # 1200014986

TSN:

Batch Date: 9/20/2018

Patient Control#	Client ID	Client Name	Type Of Claim	Total Charges	Initial Claim Status/Response	Error Text
12345	AA00000Z	DOE, JANE	Dental	\$ 45.00	Details	

Total Batch Charges: \$ 45.00

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.

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 Dental Claim

REFERENCE GUIDE

EDITING A CLAIM BASED ON STATUS

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 existed 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 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 was 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 was fully entered, passed all validation, and 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 that has not been submitted 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 statuses 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 have a status of Voided. A Voided claim may not be edited, it may only be viewed. You can only void a claim that has been paid.

ePACES Dental Claim

REFERENCE GUIDE

EDITING 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.

The screenshot displays the 'General Claim Information' tab of the ePACES Dental Claim form. The form is divided into several sections:

- Submission Reason:** Original
- NPI Number:** (field)
- Patient Control Number:** 12345
- Location Information:**
 - Address Line 1: 1 MAIN ST
 - 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:** Dental

At the bottom of the form, there are three buttons: 'Void Claim', 'Replace Claim', and 'Edit Claim'. The 'Edit Claim' button is highlighted with a red box.

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 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.

ePACES Dental Claim

REFERENCE GUIDE

This screen displays once the provider clicks the *Edit Claim* button. Click on *YES* to edit the claim. If the provider clicks on *NO*, they are returned to the previous screen.

Do you wish to edit and resend this claim?

Yes No

General Claim Information
 Dental 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 ST
 Address Line 2:
 City: ANY TOWN
 State: NY
 Zip Code: 12345 - 1234

Client Information

* Enter a Client ID: AA00000Z

JANE DOE
 1 MAIN ST
 ANY TOWN
 NY, 12345

* DOB: 01/01/1910

* Gender: F

* Type of Claim: Dental

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 member to save time. As long as they change the information such as Date of Service and Procedure codes. It is also the provider's responsibility to ensure that the eligibility information, such as other insurance, is still the same.

ePACES Dental Claim

REFERENCE GUIDE

ROSTER BILLING

Roster billing is used when a provider performed the same procedure for multiple patients on the same date of service.

General Claim Information | Dental 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 ST
 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: Dental Next

Void Claim Replace Claim Edit Claim

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.

ePACES Dental Claim

REFERENCE GUIDE

The screenshot displays a web form for entering dental claim information. At the top, there are six tabs: General Claim Information (selected), 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 text input field)
- Location Information:** A bordered box containing:
 - Address Line 1:** 1 MAIN ST
 - Address Line 2:** (empty)
 - City:** ANY TOWN
 - State:** NY
 - Zip Code:** 12345 - 1234
- Client Information:** A section with:
 - Enter a Client ID:** (empty text input field) followed by a **Go** button.
 - Client details: JANE DOE, 1 MAIN ST, ANY TOWN, NY, 12345.
 - DOB:** (empty text input field) with a calendar icon.
 - Gender:** (dropdown menu with a downward arrow).
- Type of Claim:** Dental
- Next** button (with a right arrow icon) 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.