

Simplifying Secondary Claims through the Provider Portal & EDI

2016 Spring Provider Training



**Hewlett Packard
Enterprise**

Oklahoma
HealthCare
Authority

AGENDA

- Claim Submission – Provider Portal
 - Commercial Insurance
 - HMO Copay
- Claim Submission – Electronic Data Interchange (EDI)
- Claim Submission – Medicare Crossover
 - Changes to the process
 - 1500 Claim Submission
 - UB-04 Claim Submission
- Reminder
- Questions



PROFESSIONAL CLAIMS ON THE PORTAL



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COMMERCIAL INSURANCE (PROFESSIONAL)

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Step 1—Primary Paid

Provider Information

This panel contains provider information.

Billing Provider ID	0123456789	ID Type	NPI	Name	Bob SoonerCare, MD
Zip Code		Contract Code	-	Taxonomy	
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>	SC Provider Number	100000000D
Ordering Provider ID	<input type="text"/>	ID Type	<input type="text"/>	Ordering Zip Code	<input type="text"/>

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID	<input type="text"/>	First Name		Middle	
Last Name					
Birth Date					

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type	<input type="text"/>	Date of Current	<input type="text"/>
Accident Related	<input type="text"/>	Expected Delivery Date	<input type="text"/>
Patient Account Number	<input type="text"/>	To Date	-
From Date	-	HMO Copay	No
CLIA Number	<input type="text"/>	Total Charged Amount	\$0.00
*Other Insurance	<input type="text" value="Include"/>		

Continue **Cancel**

COMMERCIAL INSURANCE (PROFESSIONAL)

Step 2—Primary Paid

[Expand All](#) | [Collapse All](#)

Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	ICD Version	Diagnosis Code	Action
1			

1 *ICD Version

*Diagnosis Code

[Add](#)

[Reset](#)

Other Insurance Details

TPL Amount

Key in the amount paid by the primary insurance

[Back to Step 1](#)

[Continue](#)

[Cancel](#)

COMMERCIAL INSURANCE (PROFESSIONAL)

Submit Professional Claim: Step 1

* Indicates a required field.

Claim Type

Step 1—Primary Denied

Provider Information

This panel contains provider information.

Billing Provider ID 0123456789

ID Type NPI

Name Bob SoonerCare, MD

Zip Code

Contract Code -

Taxonomy

SC Provider Number 100000000D

Referring Provider ID

ID Type

Ordering Provider ID

ID Type

Ordering Zip Code

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name

First Name

Middle

Birth Date

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type

Date of Current

Accident Related

Patient Account Number

Expected Delivery Date

From Date -

To Date -

CLIA Number

*Other Insurance

HMO Copay

Total Charged Amount \$0.00

Continue

Cancel

COMMERCIAL INSURANCE (PROFESSIONAL)

Step 3—Primary Denied

Attachments [-]

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
<input type="checkbox"/> Click to collapse.	*Transmission Method FT-File Transfer <input type="button" value="v"/>	*Upload File <input type="text"/> <input type="button" value="Browse..."/>		*Attachment Type OZ-Support Data for Claim <input type="button" value="v"/>	
	Description Insurance Denial attached				

[Go to Top](#)

NO attachment cover sheet required

COMMERCIAL INSURANCE (PROFESSIONAL)

Step 3—Primary Denied

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to collapse.					
	*Transmission Method	FX-By Fax		*Attachment Type	
				OZ-Support Data for Claim	
	Description	Insurance Denial attached			

[Add](#) [Cancel](#)

[Back to Step 1](#) [Back to Step 2](#) [Submit](#) [Cancel](#)

Attachment cover sheet required



Your Claim was successfully submitted. The claim status is Suspended.

The Claim ID is 2300123987456

Click **Attachment Coversheet(s)** to view the claim attachments coversheet(s).

Click **Print Preview** to view the claim details as they have been saved on the payer's system.

Click **Copy** to copy member or claim data.

Click **View** to view the details of the submitted claim.

Attachment Coversheet(s)

Print Preview

Copy

New

View

ATTACHMENT COVER SHEET

Oklahoma Health Care Authority
Electronic Claim Paper Attachment Form
Cover Sheet

Four fields below are required and must match claim.

1. **Provider Number** 100000000D
2. **Client ID Number** 001122334
3. **Attachment Control Number** 2001070899555
4. **Claim Number** 2310001111111
5. **Date/Time** 7/15/2015 9:41 AM

Purpose:

This form is to be used when a claim requiring a paper attachment is being submitted electronically. Submission of this completed form along with the required attachment and electronically submitted claim will allow the appropriate review process to be conducted by the OHCA.

Instructions:

1. In box 1, fill in the pay to Provider Number that will be used for filing the electronic claim.
2. In box 2, fill in the nine-digit client identification number that was submitted on the electronic claim.
3. In box 3, fill in the Attachment Control Number (ACN) that was used for filing the electronic claim. The ACN on this form must be the same number as the assigned control number field of the SoonerCare Portal screen (Medicaid on the Web) or the PWK segment of the 837 transaction. Make sure the ACN is clear and legible on the HCA-13. Illegible information could delay or stop the attachment process. Alphabetic and numeric are the only characters that should be used in the ACN selection. Do not use dashes and spaces in the ACNs.
4. In box 4, fill in the identification number that was assigned to the electronically submitted claim.
5. Place the completed form on top of the attachment(s) for each electronic claim.
6. Mail to EDS, P.O. Box 18500 OKC, OK 73154, fax 405-947-3394

Note: Do not place another Fax Cover Sheet on top.
***This form is for use with electronically filed claims requiring attachments.**

Sender's Name: _____ **Phone Number:** _____

This fax contains confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately by phone if you have received this e-fax by mistake and destroy the fax you received. Fax transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete. The sender therefore does not accept liability for any errors or omissions in the contents of this message, which arise as a result of fax transmission.

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Revised 06/24/09

HCA-13

Print

Close

HMO COPAY (PROFESSIONAL)

Submit Professional Claim: Step 1

* Indicates a required field.

Claim Type

Step 1—HMO Copay

Provider Information

This panel contains provider information.

Billing Provider ID 0123456789

ID Type NPI

Name Bob SoonerCare, MD

Zip Code

Contract Code

Taxonomy

SC Provider Number 100000000D

Referring Provider ID

ID Type

Ordering Provider ID

ID Type

Ordering Zip Code

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name

First Name

Middle

Birth Date

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type

Date of Current

Accident Related

Expected Delivery Date

Patient Account Number

From Date

To Date

CLIA Number

*Other Insurance None

HMO Copay Yes

Total Charged Amount \$0.00

Continue

Cancel

CLAIM SUBMISSION – HMO COPAY

Step 3 – Attachment

- When billing for the copay, only submit one line of service with the amount of the copay, as the billed amount
- The process for sending your attachment is the same as for commercial insurance: you can fax or upload your documentation
 - Make sure to use the **Fax Cover Sheet** generated by the Portal if you choose Fax



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INSTITUTIONAL CLAIMS ON THE PORTAL



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COMMERCIAL INSURANCE (INSTITUTIONAL)

Submit Institutional Claim: Step 1



* Indicates a required field.

Claim Type

Step 1—Primary Paid

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID	100000000D	ID Type	NPI	Name	Bob SooneCare, MD
Zip Code		Taxonomy		SC Provider Number	100000000D
Institutional Provider ID	<input type="text" value="0123456789"/>	ID Type	<input type="text" value="NPI"/>		
Attending Provider ID	<input type="text"/>	ID Type	<input type="text"/>		
Operating Provider ID	<input type="text"/>	ID Type	<input type="text"/>		
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>		

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name

First Name

Middle

Birth Date

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

*Covered Dates	<input type="text"/> - *	<input type="text"/>	Covered Days	<input type="text"/>
*Admission Date/Hour	<input type="text"/> (hh:mm)		Discharge Hour	<input type="text"/> (hh:mm)
*Admission Type	<input type="text"/>		*Admission Source	<input type="text"/>
*Admitting ICD Version	<input type="text" value="ICD-9-CM"/>		*Admitting Diagnosis	<input type="text"/>
*Patient Status	<input type="text"/>		*Type of Bill	<input type="text"/>
Patient Account Number	<input type="text"/>		Other Insurance	<input type="text" value="Include"/>
HMO Copay	<input type="text" value="No"/>			

Total Charged Amount \$0.00

Continue

Cancel

COMMERCIAL INSURANCE (INSTITUTIONAL)

Step 2—Primary Paid

Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	ICD Version	Diagnosis Code	POA	Action
<u>1</u>				

1 *ICD Version *Diagnosis Code

Present on Admission

Emergency Diagnosis Code

Only one emergency diagnosis code is allowed per claim.

ICD Version Diagnosis Code

Other Insurance Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	Payer Code	Prior Amount	Estimated Amount Due	Action
<u>1</u>				

1 *Payer Code *Prior Amount Estimated Amount Due



COMMERCIAL INSURANCE (INSTITUTIONAL)

Submit Institutional Claim: Step 1

* Indicates a required field.

Claim Type

Step 1—Primary Denied

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID	100000000D	ID Type	NPI	Name	Bob SoonerCare, MD
Zip Code		Contract Code	-	SC Provider Number	100000000D
Institutional Provider ID	<input type="text" value="0123456789"/>	Taxonomy			
Attending Provider ID	<input type="text"/>	ID Type	<input type="text" value="NPI"/>		
Operating Provider ID	<input type="text"/>	ID Type	<input type="text"/>		
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>		

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID	<input type="text"/>	First Name		Middle	
Last Name					
Birth Date					

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

*Covered Dates	<input type="text"/> - <input type="text"/>	Covered Days	<input type="text"/>
*Admission Date/Hour	<input type="text"/> (hh:mm)	Discharge Hour	<input type="text"/> (hh:mm)
*Admission Type	<input type="text"/>	*Admission Source	<input type="text"/>
*Admitting ICD Version	<input type="text" value="ICD-9-CM"/>	*Admitting Diagnosis	<input type="text"/>
*Patient Status	<input type="text"/>	*Type of Bill	<input type="text"/>
Patient Account Number	<input type="text"/>	Other Insurance	<input type="text" value="Denied"/>
HMO Copy	<input type="text" value="No"/>		

Total Charged Amount \$0.00

Continue

Cancel

COMMERCIAL INSURANCE (INSTITUTIONAL)

Step 3—Primary Denied

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
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Click to collapse.

*Transmission Method

*Upload File

*Attachment Type

Description

NO attachment cover sheet required

[Go to Top](#)

COMMERCIAL INSURANCE (INSTITUTIONAL)

Step 3—Primary Denied

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to collapse.					
*Transmission Method	FX-By Fax				
*Attachment Type	OZ-Support Data for Claim				
Description	Insurance Denial attached				

[Add](#) [Cancel](#)

→ [Back to Step 1](#) [Back to Step 2](#) → [Submit](#) [Cancel](#)

Attachment cover sheet required



Your Claim was successfully submitted. The claim status is Suspended.

The Claim ID is 2300123987456

Click **Attachment Coversheet(s)** to view the claim attachments coversheet(s).

Click **Print Preview** to view the claim details as they have been saved on the payer's system.

Click **Copy** to copy member or claim data.

Click **View** to view the details of the submitted claim.

Attachment Coversheet(s)

Print Preview

Copy

New

View

ATTACHMENT COVER SHEET

Oklahoma Health Care Authority
Electronic Claim Paper Attachment Form
Cover Sheet

Four fields below are required and must match claim.

1. **Provider Number** 100000000D
2. **Client ID Number** 001122334
3. **Attachment Control Number** 2001070899555
4. **Claim Number** 2310001111111
5. **Date/Time** 7/15/2015 9:41 AM

Purpose:

This form is to be used when a claim requiring a paper attachment is being submitted electronically. Submission of this completed form along with the required attachment and electronically submitted claim will allow the appropriate review process to be conducted by the OHCA.

Instructions:

1. In box 1, fill in the pay to Provider Number that will be used for filing the electronic claim.
2. In box 2, fill in the nine-digit client identification number that was submitted on the electronic claim.
3. In box 3, fill in the Attachment Control Number (ACN) that was used for filing the electronic claim. The ACN on this form must be the same number as the assigned control number field of the SoonerCare Portal screen (Medicaid on the Web) or the PWK segment of the 837 transaction. Make sure the ACN is clear and legible on the HCA-13. Illegible information could delay or stop the attachment process. Alphabetic and numeric are the only characters that should be used in the ACN selection. Do not use dashes and spaces in the ACNs.
4. In box 4, fill in the identification number that was assigned to the electronically submitted claim.
5. Place the completed form on top of the attachment(s) for each electronic claim.
6. Mail to EDS, P.O. Box 18500 OKC, OK 73154, fax 405-947-3394

Note: Do not place another Fax Cover Sheet on top.

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Print

Close

INSTITUTIONAL CLAIM – HMO COPAY

Submit Institutional Claim: Step 1

* Indicates a required field.

Claim Type

Step 1—HMO Copay

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID	100000000D	ID Type	NPI	Name	Bob SoonerCare, MD
Zip Code		Contract Code	_	SC Provider Number	100000000D
Institutional Provider ID	0123456789	Taxonomy			
Attending Provider ID	<input type="text"/>	ID Type	<input type="text" value="NPI"/>		
Operating Provider ID	<input type="text"/>	ID Type	<input type="text"/>		
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>		

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name First Name Middle

Birth Date

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

*Covered Dates	<input type="text"/> - * <input type="text"/>	Covered Days	<input type="text"/>
*Admission Date/Hour	<input type="text"/> (hh:mm)	Discharge Hour	<input type="text"/> (hh:mm)
*Admission Type	<input type="text"/>	*Admission Source	<input type="text"/>
*Admitting ICD Version	ICD-9-CM	*Admitting Diagnosis	<input type="text"/>
*Patient Status	<input type="text"/>	*Type of Bill	<input type="text"/>
Patient Account Number	<input type="text"/>	Other Insurance	None
 HMO Copay	<input type="text" value="Yes"/>	Total Charged Amount	\$0.00

Continue

Cancel

CLAIM SUBMISSION – HMO COPAY

Step 3 – Attachment

- When billing for the copay, only submit one line of service with the amount of the copay, as the billed amount
- The process for sending your attachment is the same as for commercial insurance; you can fax or upload your documentation
 - Make sure to use the **Fax Cover Sheet** generated by the Portal if you choose Fax



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DENTAL CLAIMS



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COMMERCIAL INSURANCE (DENTAL)

Step 1, 2—Primary Paid

Submit Dental Claim: Step 1

* Indicates a required field.

Provider Information

This panel contains provider information.

Billing Provider ID 0123456789
Zip Code

ID Type NPI

Name Bob SoonerCare, MD
SC Provider Number 100000000D

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

***Member ID**

Last Name
Birth Date

First Name

Middle

Claim Information

Enter information applicable to the claim. If a TPL Amount needs to be entered, then Include should be selected in the Other Insurance dropdown. A TPL Amount can be entered on Submit Step 2.

Accident Related

Emergency

***Place of Treatment** 11-Office

Patient Account Number

Other Insurance Include

Total Charged Amount \$0.00

Continue

Cancel

Other Insurance Details

TPL Amount

Back to Step 1

Continue

Cancel

Step 1

Step 2

COMMERCIAL INSURANCE (DENTAL)

Step 1—Primary Denied

Submit Dental Claim: Step 1



* Indicates a required field.

Provider Information

This panel contains provider information.

Billing Provider ID 0123456789
Zip Code

ID Type NPI

Name Bob SoonerCare, MD
SC Provider Number 100000000D

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

***Member ID**

Last Name
Birth Date

First Name

Middle

Claim Information

Enter information applicable to the claim. If a TPL Amount needs to be entered, then Include should be selected in the Other Insurance dropdown. A TPL Amount can be entered on Submit Step 2.

Accident Related

Emergency

***Place of Treatment** 11-Office

Patient Account Number

Other Insurance Denied ←

Total Charged Amount \$0.00

Continue

Cancel

COMMERCIAL INSURANCE (DENTAL)

Step 3—Primary Denied

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to collapse.					
	*Transmission Method	FT-File Transfer			
	*Upload File				Browse...
	*Attachment Type	OZ-Support Data for Claim			
	Description	Insurance Denial attached			

[Add](#) [Cancel](#)

[Back to Step 1](#) [Back to Step 2](#) [Submit](#) [Cancel](#)

NO attachment cover sheet required

[Go to Top](#)

COMMERCIAL INSURANCE (DENTAL)

Step 3—Primary Denied

Attachments [-]

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
[-] Click to collapse.					
	*Transmission Method	FX-By Fax		*Attachment Type	OZ-Support Data for Claim
	Description	Insurance Denial attached			

Attachment cover sheet required

→

→



Your Claim was successfully submitted. The claim status is Suspended.

The Claim ID is 2300123987456

Click **Attachment Coversheet(s)** to view the claim attachments coversheet(s).

Click **Print Preview** to view the claim details as they have been saved on the payer's system.

Click **Copy** to copy member or claim data.

Click **View** to view the details of the submitted claim.

Attachment Coversheet(s)

Print Preview

Copy

New

View

ATTACHMENT COVER SHEET

Oklahoma Health Care Authority
Electronic Claim Paper Attachment Form
Cover Sheet

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5. Place the completed form on top of the attachment(s) for each electronic claim.
6. Mail to EDS, P.O. Box 18500 OKC, OK 73154, fax 405-947-3394

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Print

Close

ELECTRONIC DATA INTERCHANGE (EDI)



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EDI CLAIM SUBMISSION

If the Primary payer paid:

- Under Other Subscriber Information, in loop 2320, send the SBR Segment, the CAS Segment and the AMT Segment with the amount paid
 - No attachment is required

If the Primary denied the claim or applied it to deductible:

- The same procedure is followed, with 0.00 entered in the SMT Segment
 - You will then add an attachment to the claim



EDI CLAIM SUBMISSION

Adding an attachment to an EDI claim:

- In loop 2400 of the PWK segment, put a unique Attachment Transaction Number (see ANSI Guidelines)
- Once the claim has been submitted and received by OHCA, fill out the HCA-13—cover sheet for an electronic claim—using the Attachment Transaction number, and fax/mail in with the proper documentation
NOTE: Don't send the attachment until the claim has been received by the payer
- For specific information on loops and segments, contact your clearinghouse or software vendor



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CROSSOVER CLAIMS



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CROSSOVER CLAIMS—WHAT IS CHANGING?

- Crossover Claims will soon be processed at the detail level
- The **date of service** will determine how the claim is processed:
 - For claims that crossover automatically from Medicare: no action is needed by the provider
 - For claims submitted on the Provider Portal:
 - **Part B** claims will be processed at the detail level, based on the date of service
 - **Part A** claims will continue to process at the header level
 - Paper crossover claims will still be accepted, but changes will be made to that process as well



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CROSSOVER PROFESSIONAL

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type Crossover Professional 

Provider Information

This panel contains provider information.

Billing Provider ID	ID Type NPI	Name PISTOL PETE
Zip Code 74012	Contract Code _	Taxonomy
Referring Provider ID <input type="text"/>	ID Type <input type="text"/>	SC Provider Number
Ordering Provider ID <input type="text"/>	ID Type <input type="text"/>	Ordering Zip Code <input type="text"/>

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name	First Name	Middle
Birth Date		

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type <input type="text"/>	Date of Current <input type="text"/>
Accident Related <input type="text"/>	
Patient Account Number <input type="text"/>	Expected Delivery Date <input type="text"/>
*From Date <input type="text"/>	*To Date <input type="text"/>
CLIA Number <input type="text"/>	<input type="text"/>
*Other Insurance <input type="text"/>	

Total Charged Amount \$0.00



From and To Date boxes have been added to Step 1. These dates will determine how the claim will be processed (header or detail level)

CROSSOVER PROFESSIONAL – HEADER

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type

Provider Information

This panel contains provider information.

Billing Provider ID	ID Type	Name
Zip Code	Taxonomy	SC Provider Number
Referring Provider ID <input type="text"/>	ID Type <input type="text"/>	
Ordering Provider ID <input type="text"/>	ID Type <input type="text"/>	Ordering Zip Code <input type="text"/>

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

* **Member ID**

Last Name	First Name	Middle
Birth Date		

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type <input type="text"/>	Date of Current <input type="text"/>
Accident Related <input type="text"/>	
Patient Account Number <input type="text"/>	Expected Delivery Date <input type="text"/>
* From Date <input type="text"/>	* To Date <input type="text"/>
CLIA Number <input type="text"/>	
* Other Insurance <input type="text"/>	

Total Charged Amount \$0.00

Medicare Crossover Details

Medicare Crossover Instructions

Allowed Medicare Amount <input type="text" value="\$0.00"/>	Co-insurance Amount <input type="text" value="\$0.00"/>
Deductible Amount <input type="text" value="\$0.00"/>	Psychiatric Services Amount <input type="text" value="\$0.00"/>
Medicare Payment Amount <input type="text" value="\$0.00"/>	* Medicare Payment Date <input type="text"/>

CROSSOVER PROFESSIONAL – DETAIL

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
<u>1</u>	11/01/2015	11/11/2015	01-Pharmacy	0001M-INFECTIOUS DIS HCV 6 ASSAYS	\$11.00	1.00 Unit	Remove
2							

2 *From Date To Date *Place of Service EMG

*Procedure Code Modifiers *Diagnosis Pointers

Charge Amount *Units Unit Type Unit EPSDT

CLIA Number

Rendering Provider ID ID Type Zip Code Contract Code

Taxonomy

Ordering Provider ID ID Type Zip Code

NDC for Item 2

Medicare Crossover Details for Item 2

Medicare Crossover Details must be entered in this step for each Service Detail item if the From Date is on or after [Configurable Claim Parm Date]

Allowed Medicare Amount	<input type="text" value="\$0.00"/>	Co-insurance Amount	<input type="text" value="\$0.00"/>
Deductible Amount	<input type="text" value="\$0.00"/>	Psychiatric Services Amount	<input type="text" value="\$0.00"/>
Medicare Payment Amount	<input type="text" value="\$0.00"/>	*Medicare Payment Date	<input type="text"/>

Attachments

Key the crossover information for this line of service only

Repeat this process for each line of service

CROSSOVER INSTITUTIONAL (PART A)

Medicare Part A claims will continue to process at the header level

Submit Institutional Claim: Step 1 ?

* Indicates a required field.

Claim Type Crossover Inpatient

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID	0123456789	ID Type	NPI	Name	Bob SoonerCare, MD
Zip Code	Contract Code	Taxonomy	SC Provider Number		100000000D
Institutional Provider ID	0123456789	ID Type	NPI		
Attending Provider ID	<input type="text"/>	ID Type	<input type="text"/>		
Operating Provider ID	<input type="text"/>	ID Type	<input type="text"/>		
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>		

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

* Member ID

Last Name	First Name	Middle
Birth Date		

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

* Covered Dates <input type="text"/> - * <input type="text"/>	Covered Days <input type="text"/>
* Admission Date/Hour <input type="text"/> (hh:mm)	Discharge Hour <input type="text"/> (hh:mm)
* Admission Type <input type="text"/>	* Admission Source <input type="text"/>
* Admitting ICD Version ICD-9-CM	* Admitting Diagnosis <input type="text"/>
Patient Status <input type="text"/>	* Type of Bill <input type="text"/>
Patient Account Number <input type="text"/>	Other Insurance None
Total Charged Amount \$0.00	

Medicare Crossover Details

Institutional Medicare Crossover Instructions

Deductible Amount <input type="text" value="\$0.00"/>	Co-insurance Amount <input type="text" value="\$0.00"/>
Blood Deductible Amount <input type="text" value="\$0.00"/>	* Medicare Payment Date <input type="text"/>

Continue Cancel

CROSSOVER INSTITUTIONAL (PART B) – DETAIL

Medicare Part B claims will process at the detail level

Submit Institutional Claim: Step 1 ?

* Indicates a required field.

Claim Type Crossover Outpatient ▼

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID 0123456789	ID Type NPI	Name Bob SoonerCare, MD
Zip Code	Contract Code -	SC Provider Number 100000000D
Institutional Provider ID 0123456789	Taxonomy	
Attending Provider ID <input type="text"/>	ID Type NPI	
Operating Provider ID <input type="text"/>	ID Type <input type="text"/>	
Referring Provider ID <input type="text"/>	ID Type <input type="text"/>	

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID <input type="text"/>	First Name	Middle
Last Name		
Birth Date		

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

*Covered Dates <input type="text"/> - <input type="text"/>	Covered Days <input type="text"/>
*Admission Date/Hour <input type="text"/> (hh:mm)	Discharge Hour <input type="text"/> (hh:mm)
*Admission Type <input type="text"/>	*Admission Source <input type="text"/>
*Admitting ICD Version ICD-9-CM ▼	*Admitting Diagnosis <input type="text"/>
Patient Status <input type="text"/>	*Type of Bill <input type="text"/>
Patient Account Number <input type="text"/>	Other Insurance None ▼
	Total Charged Amount \$0.00

Medicare Crossover Details

Institutional Medicare Crossover Instructions

Deductible Amount <input type="text" value="\$0.00"/>	Co-insurance Amount <input type="text" value="\$0.00"/>
Blood Deductible Amount <input type="text" value="\$0.00"/>	*Medicare Payment Date <input type="text"/>

CROSSOVER INSTITUTIONAL (PART B) - DETAIL

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
1	0-TESTING	0001F-HEART FAILURE ASSESSED	11/01/2015	11/10/2015	1.00 Unit	\$11.00	Remove
2							

2 *Revenue Code HCPCS/Proc Code

Modifiers

*From Date *To Date *Units *Unit Type

Charge Amount

NDC for Item 2

Medicare Crossover Details for Item 2

Medicare Crossover Details must be entered in this step for each Service Detail item if the Covered From Date is on or after

Deductible Amount \$0.00

Blood Deductible Amount \$0.00

Medicare Payment Amount \$0.00

Co-insurance Amount \$0.00

*Medicare Payment Date

Add

Attachments

[Back to Step 1](#) [Back to Step 2](#) [Submit](#) [Cancel](#)

Key the crossover information for this line of service only

A FEW IMPORTANT THINGS TO REMEMBER...

Eligibility

- Check at each visit

Ordering Provider

- Must be an individual provider
- Must be contracted with SoonerCare

Timely Filing

- Six (6) months and 12 months

Web Alerts

- Sign up at www.okhca.org/provider/webalerts



Hewlett Packard
Enterprise

Oklahoma
HealthCare
Authority

RESOURCES

Internet Help Desk

- 800-522-0114 or 405-522-6205; Option 2, 1

EDI Help Desk

- 800-522-0114 or 405-522-6205; Option 2, 2

SoonerCare Field Representatives

- Quick Reference Guide



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Oklahoma
HealthCare
Authority