Keying a Professional Claim

ConnectCenter provides the ability to create a CMS 1500 professional claim through the Claims menu, Create a Claim option. There are minimum field requirements to create a basic valid claim. This guide lists fields that are commonly required.

Topics covered

Keying Tips

- Prior to keying claims, it is **highly recommended** that frequently used providers be entered in Provider Management. See the "Getting Started with Provider Management" guide for additional information. More information included in Provider Management records means more provider detail can be automatically retrieved into your claims for both rendering and billing provider fields. Most importantly, you should specify a default Billing provider so that the billing provider related fields can be completed for you, whenever you open a new claim. If your rendering provider is not the same as your billing provider, it is also recommended that you choose a default rendering provider.

- Because ConnectCenter requires the entry of a lot of payer and provider information that is typically the same between different claims, you will find that **copying** an existing claim becomes another valuable short-cut in creating new claims.

    - You should copy only claims that have already been validated, sent to the clearinghouse, and accepted by the payer.

    - Whenever you need to bill for a patient for whom you have successfully submitted a previous claim in ConnectCenter, copy that claim to save time. Use Claims > Claim Search to search by the patient's name or ID. You may also want to select a Status of "Accepted." Select any claim from the list of matching claims and choose Copy. Update details such as the service dates that are different on the new claim.

    - If you perform the same services much more often than you see the see the same patient, you may wish to create template claims for your frequent services. To do this, you can save a claim that has common procedure and diagnosis code details but leave the patient and insured information empty. It can be helpful to enter something descriptive (e.g. migraine headache) as the patient name. Later, when its time to create a claim for this type of service, select the incomplete claim from the Incomplete claim list and choose copy to open a new claim while preserving the template for later use. You will only need to add the patient information and update details such as the service dates to complete the new claim.

- Any data that resides on multiple tabs need only be updated on one tab.

    - For example, if the Patient Last Name is updated on the Claim Detail tab under the Patient Information section, then the Patient Last Name field on

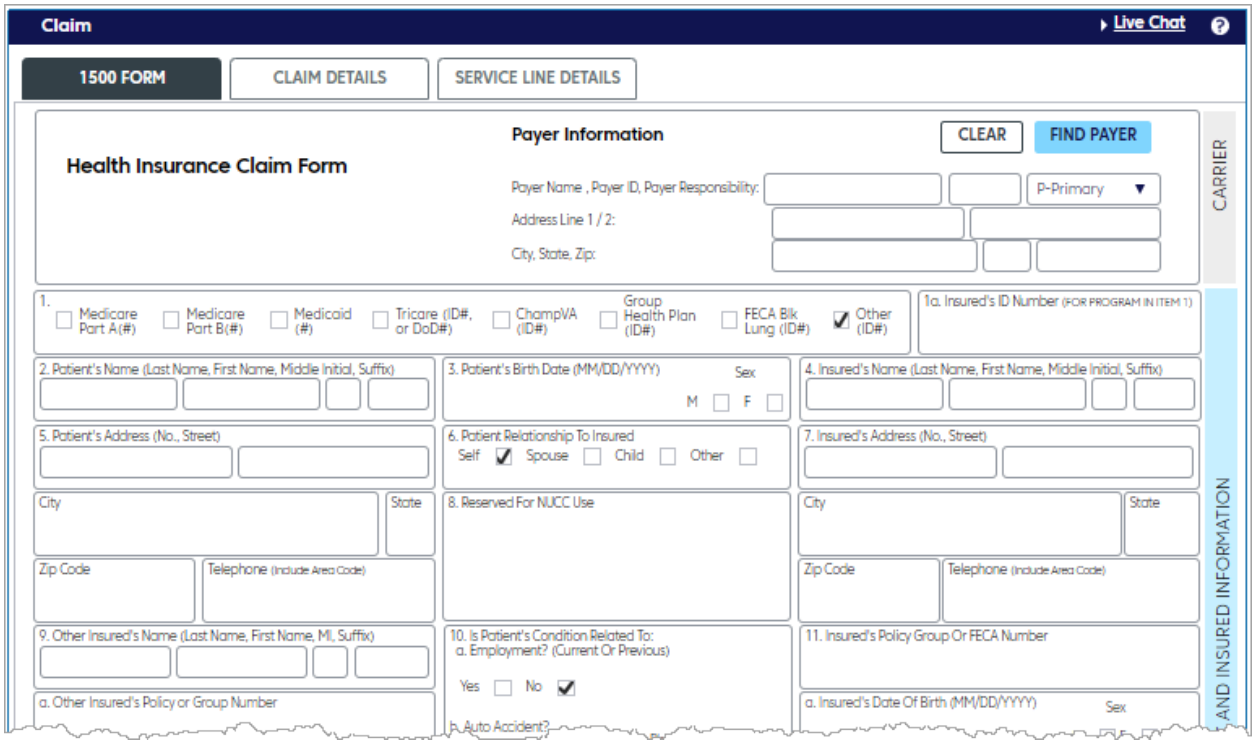
the 1500 tab will be automatically updated.

- At any time while creating your claim you can click 'Validate'. Validate will alert you to errors on the claim that would otherwise prevent the claim from being processed.
    - Errors displayed after validation will be highlighted in several ways:
        - A list of errors will be displayed at the top of the claim form. Many of these have clickable error messages that will take you directly to the field containing the error.
        - Every field containing an error will be highlighted in red
    - Only claims that are error free can be sent to the clearinghouse for processing.
    - It is recommended that you wait to 'Validate' your claim until you have completed all data you expect will be needed; clicking 'Validate' too early in the data entry process will result in false errors stemming from omission of fields that have not yet been entered. However, if you are not certain which fields are required, "Validate" is a quick way to find out.
- ConnectCenter autosaves your claim as you make changes. Claims will be saved as work in progress prior to sending the claim to the clearinghouse. Until the claim is submitted to the clearinghouse, it will have an Incomplete status and will appear in the Incomplete worklist.
- Only claims that have NOT been sent and accepted by the payer can be deleted or edited.
- **Pro Tip:** Another short-cut for claims creation is to start by checking member eligibility. This short-cut is particularly useful when you have not previously (or recently) sent a claim for a particular patient via ConnectCenter.

  Once you've retrieved the member's benefits, look for the button labeled "Use Member For" and the dropdown list that will say "Select Transaction." Change the transaction to Professional Claim and click the button. Patient, Provider and Payer information will be taken from the eligibility response and used to start a new claim. By combining this tip with the tip recommending saving default billing and rendering providers, a significant amount of the claim can be prefilled for you.

Expert Tip: If you or a colleague checked the member's eligibility in the past, choose "Search Eligibility History" from the Verification menu. You should be able to easily find the previously submitted member benefit inquiry so that you can initiate your claim from there, rather than needing to check eligibility status again. From the saved eligibility response, set the **Use Member For** transaction type to **Professional Claim** and click **User Member For** button.

1500 Form



Important Fields

For customers that have used Emdeon Office for keying claims, the last column in the tables that follow will tell you what field you utilized in that system to send the same piece of information. If you are new to creating claims, then the column labeled Emdeon Section should be ignored.

Box	Label / Description	Emdeon Section / Field
	Payer Information • Use the Find Payer button to find your payer. A complete list of all payers available to you can be found here. • The Payer Responsibility will default to Primary. If Amerihealth Caritas is the secondary or tertiary payer, you should change this selection.	New Claim Setup Select a payer from the drop-down list given in Step 3
	Payer Information • Payer address is ***optional*** but will not be returned from the Find Payer results. If you choose to enter a payer address in a claim, that address will be stored for use in all future claims for the same payer ID. • Do not enter dashes (-) in the extended zip code.	Pre-filled based on selected payer
1	Payer Type (Claim Filing Indicator) • Select Medicaid. Your choice of claim filing indicator in the first claim you create will become the default value for all future claims sent to the same payer.	Not displayed
1a	Insured's ID • Required	Payer/Insured Information Insured's ID/Cert #

Box	Label / Description	Emdeon Section / Field
2	Patient's Name • **If the patient is the insured**, patient name, address and other information will be automatically copied from the insured information which means that **Box 2, Box 3** and **Box 5** do not have to be completed. By contrast, the Emdeon Office application hid the Insured demographic fields so that only the patient fields were required for subscriber patients. • If the patient is **not** the insured, both the patient and insured fields will be required.	Patient Information Last Name, First Name, MI
3	Patient's Birth Date and Gender • If the patient is the insured, the patient related fields **are not needed**	Patient Information Date of Birth
4	Insured's Name • Required	Insurance Information Last Name, First Name, M.I.
5	Patient's Address • If the patient is the subscriber, the patient related fields **are not needed** • Do not enter dashes (-) in the extended zip code.	Patient Information Street Address 1, Street Address 2, City, State, Zip
6	Patient Relationship to Insured • Required • If ***Self*** is selected, any patient related information in boxes 2, 3 and 5 will be **removed** when the claim is submitted	Insurance Information Patient Relationship to Insured

Box	Label / Description	Emdeon Section / Field
7	Insured's Address • Required • Address, City, State, Zip Code, no dashes	Insurance Information Street Address 1, Street Address 2, City, State, Zip
9	Other Insured's Name and Policy or Group Number • Do not use unless this is a secondary or tertiary claim. For primary claims, field 9 should be omitted even if the patient ***does*** have other insurance	Supplemental Claims Insured ID, within the Insurance tab *Requires user to check "Route Claim for Supplemental Data Entry"
11	Insured's Policy Group or FECA Number • Optional	Payer/Insured Information Group ID#
11d	Is there another health benefit plan? • Will default to "N" • Do not change to "Y" unless this is a secondary or tertiary claim. For primary claims, field 11d should be "N"	Insurance Information Other Insurance Indicator
12	Patient's or Authorized Person's Signature • Will default "Y" in the Signed field • You do not need to enter a name or signature in this field	Insurance Information Release of Information Indicator

Box	Label / Description	Emdeon Section / Field
13	Insured's or Authorized Person's Signature • Will default "Y" in the Signed field • You do not need to enter a name or signature in this field	Provider Information Certification Indicator
21	Diagnosis Code • Enter ***without*** the decimal point • If you are uncertain of the code, try typing key words that are likely to be part of the code description. A list of matching codes and code descriptions will pop-up for your selection.	Patient Information Diagnosis Code

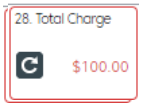
Box	Label / Description	Emdeon Section / Field

22	Resubmission Code.
	• Defaults to New Claim
	• When using the Replacement option to indicate correction of a prior claim, include the Payer's Claim Control Number in Box 22's Original Ref No. field.
	• There are several places where Payer Claim Control Number **may** be found:
	  • The summary tab of the original claim
	  • On a remittance advice
	  • In the top portion of a Claim Status inquiry response. For payers that support claim status inquiry, this search is available in several places:
	  ○ From the Claims menu, Claim Status option
	  ○ If the original claim was submitted in ConnectCenter, then use Claims > Claim Search to find the original claim. A Claim Status icon will display in the search results list for all payers that support claim status inquiry
	  ○ The Summary tab of the original claim will contain a Claim Status button if the payer supports Claim Status
		Other Information
		Resubmission Code

24	**Service Line Information**	**Claim Line Information**
24A	Dates of Service • Should have MM/DD/YYYY format • Click in the white area under the line number and gray bar to find the data entry field • End date may be omitted if it matches start date	Start Date and End Date Note: ConnectCenter is much less tolerant of variation in date entry formats.

Box	Label / Description	Emdeon Section / Field
24B	Place of Service This type-ahead field allows you to type part of the name of the location (for example "offic") and all place of service descriptions containing that text will be displayed. Click on the description you need to select it. Once selected, the 2-digit code for that place of service will display. You may also type the code into the Place of Service field.	Place Code
24D	CPT/HCPCS • Procedures, Services or Supplies • If you are uncertain of the code, try typing key words that are likely to be part of the code description. A list of matching codes and code descriptions will pop-up for your selection.	Proc
24E	Diagnosis Pointer **Alpha** indicators such as "A"	ICD Pointers **Numeric** Pointers
24F	Charges • Be sure to total all line charges in Box 28	Charges

Box	Label / Description	Emdeon Section / Field
24G	Days or Units • Enter the quantity of days, units or minutes and not the unit type. • If your claim requires that the service be expressed in minutes, the Unit/Basis measurement can be modified by accessing the **Service Line Details tab.** In the section, Service Line Information, Service Line Supplemental Information, enter MJ in the Unit/Basis Measurement Code field for EACH applicable service line. (See the Service Line section below, for more information)	Unit Qty
24J	Rendering Provider NPI • If the Rendering Provider is applicable to the entire claim do **not** use this field. Instead add this information on the **Claim Detail Tab**. • If you have previously set a Rendering Provider default, NPI, name and other details will default at the claim level and ***not*** the line level • If a Rendering Provider NPI is entered on a service line, the Rendering provider name must be provided on the **Service Line Details Tab.** • Use the + icon (**Find Provider**) to retrieve a rendering provider from Provider Management, as this will allow you to retrieve NPI, atypical provider ID, provider name and taxonomy all at once. (Note, only those provider details you have entered in Provider Management will be available to retrieve.) If **Find Provider** is used to retrieve rendering provider name and NPI, then the above instruction, that you must add name in the **Service Line Details Tab**, is completed for you.	Performing Provider # Performing provider for the entire claim is selected in Step 3 of the New Claim setup page, as part of selecting Service Provider.

Box	Label / Description	Emdeon Section / Field
25	Federal Tax ID Number • No dashes • If you create a Provider Management record for your Billing Provider and include Tax ID in that record, Box 25 (Tax ID) will be automatically completed when Box 33 is filled in using either Find Provider or default billing provider. • When Tax ID is taken from the Provider Management record for the Billing Provider, Tax ID type will also be set to match the Tax ID type indicated in provider management. • Tax ID type will default to EIN (Employer ID) rather than Social Security Number unless the type is updated in Provider Management.	Selected in Step 2 of the New Claim setup page, as part of choosing the Pay To provider and address.
26	Patient Account Number • Required	Patient Information Patient Account #
27	Accepts Assignment? • Defaults to Assigned.	Provider Information Accepts Assignment?
28	Total Charges  • Click the refresh button to calculate total charges based on the amounts entered in 24F for all service lines.	Claim Line Information Total
31	Signature of Physician or Supplier • Will default "Y" in the Signed field • You do not need to enter a name or signature in this field	

Box	Label / Description	Emdeon Section / Field
32	Service Facility Location Information and NPI • Optional • Use the green + button to select a saved facility or location from the provider list. • Do not enter dashes (-) in the extended zip code	Other Facility Information Name, Number, Street Address 1, Street Address 2, City, State, Zip, Facility/Lab NPI

33	Billing Provider Info
	• Name, NPI, Address, City, State, Zip Code, Telephone number and Taxonomy code
	  • Zip code must be 9 digits. If you do not know the final 4 digits, you may use 0000.
	  • Do not use a dash
	• If you have specified a default billing provider, these fields will prefill on all new claims. To set or change the default billing provider select the green + button from Box 33. Click the green circle in the Default Provider column, to choose which providers should become the billing provider default.
	• If you have not set a default billing provider, or to override it, use the green + button to select the correct provider from the list.
	• Note, only those provider details you have entered in Provider Management will be available to retrieve.
	• If you choose to manually key in provider information instead of using Provider Management to fill the billing provider section, you will need to comply with these additional guidelines:
	  • Do not use dashes in the phone number. A phone extension should be represented by a 'x' and then the digits. There should be no spaces between the base telephone number and the extension.
	  • An extension should be represented by a 'x' and then a number{s}. There should be no spaces between the base telephone number and the extension.
	  • The Other ID field is most often used for Taxonomy code. When used for Taxonomy, the 33B qualifier code field must contain PXC
	  • If the billing provider does not have an NPI (which makes the provider an *atypical provider*) the billing Provider's atypical provider identifier (API) must be
		Selected in Step 2 of the New Claim setup page, as part of choosing the Pay To provider and address.

Box	Label / Description	Emdeon Section / Field
	included on the claim. If entered in the box 33 Other ID field, then the box 33B qualifier codes must be G2. • If you need to include both a taxonomy code and an API, place the taxonomy in box 33 and enter the API in the Billing Provider Other ID field, on the Claim Details tab	

Claim Details Tab

Although the 1500 claim form contains the most critical fields needed on a claim, some fields will be found on the Claim Details tab or the Service Lines Details tab instead.

Note, each field on the 1500 form is duplicated on either the Claim Details or Service Line Details tab. For each field that is found on more than one tab, updating the field on one form will also update that field on the alternate tab. For example, if the Patient Last Name is updated on the Claim Detail tab under the Patient Information section, the Patient Last Name field on the 1500 tab will be automatically updated.

A few of the more important fields that can ***only*** be found on the Claim Details tab are described below.

Section	Label / Description	Emdeon Section / Field
Payer	Claim Filing Ind • Your choice of claim filing indicator in the first claim you create will become the default value for all future • This field is paired with the Payer Type options in Box 1 of the 1500 Form. However, this drop-down list makes available additional payer types	Not Displayed
Billing Provider	Commercial ID's If you are an atypical provider who does not have an NPI, then your atypical ID must be entered as a Commercial ID with an ID Type of G2. Commercial ID should be used even if your atypical ID (or API) is a Medicaid ID. An API is a payer issued identifier. In the case of a Medicaid plan, it may be the state issued provider ID. **Tip!** The API can be retrieved from saved provider information using Find Provider (or by setting a default billing provider. If you are not an atypical provider, the commercial IDs field can also be used as follows: • Use FY as the ID type for the Claim Office Number • Use G2 as the ID type for the Commercial Number • Use LU as the ID type for the Location Number	Selected in Step 2 of the New Claim setup page, as part of choosing the Pay To provider and address.

Section	Label / Description	Emdeon Section / Field
Billing Provider	State License Number	Selected in Step 2 of the New Claim setup page, as part of choosing the Pay To provider and address.
Billing Provider	UPIN Number	Selected in Step 2 of the New Claim setup page, as part of choosing the Pay To provider and address.
Other Providers, Referring Provider Information	NPI	Other Information Referring Provider NPI
Other Providers, Referring Provider Information	ID's • Use 0B as the ID type for the State License Number • Use G2 as the ID type for the Commercial Number • Use 1G as the ID type for the UPIN	Other Information • Referring Provider # is used to collect IDs that are not an NPI • Referring Provider Tax ID Type is used to select whether the Referring Provider # is a Tax ID, License Number or UPIN

Section	Label / Description	Emdeon Section / Field
Rendering Provider	Claim Level Rendering Provider is often not required. In those cases where it is needed, all the following details are required: • provider name must be supplied • either NPI or atypical provider ID must be included • taxonomy is recommended.	Performing Provider # Typically performing provider for the entire claim is selected in Step 3 of the New Claim setup page, as part of selecting Service Provider

More About the Rendering Provider

In many cases, rendering provider information is not needed:

- If the Rendering Provider is the same for **every** line on the claim, then Rendering Provider should **not** be included on **service lines**
- If some service lines have a different Rendering Provider than other lines, then one provider should be identified as *primary*. Only the **service lines** for the non-primary providers should include Rendering Provider information.
- If the primary Rendering Provider NPI is the **same** as the Billing Provider NPI, do **not** enter claim level Rendering Provider information on the **Claim Details** tab. Only when these NPIs are different in the **Claim Details** Rendering Provider required.

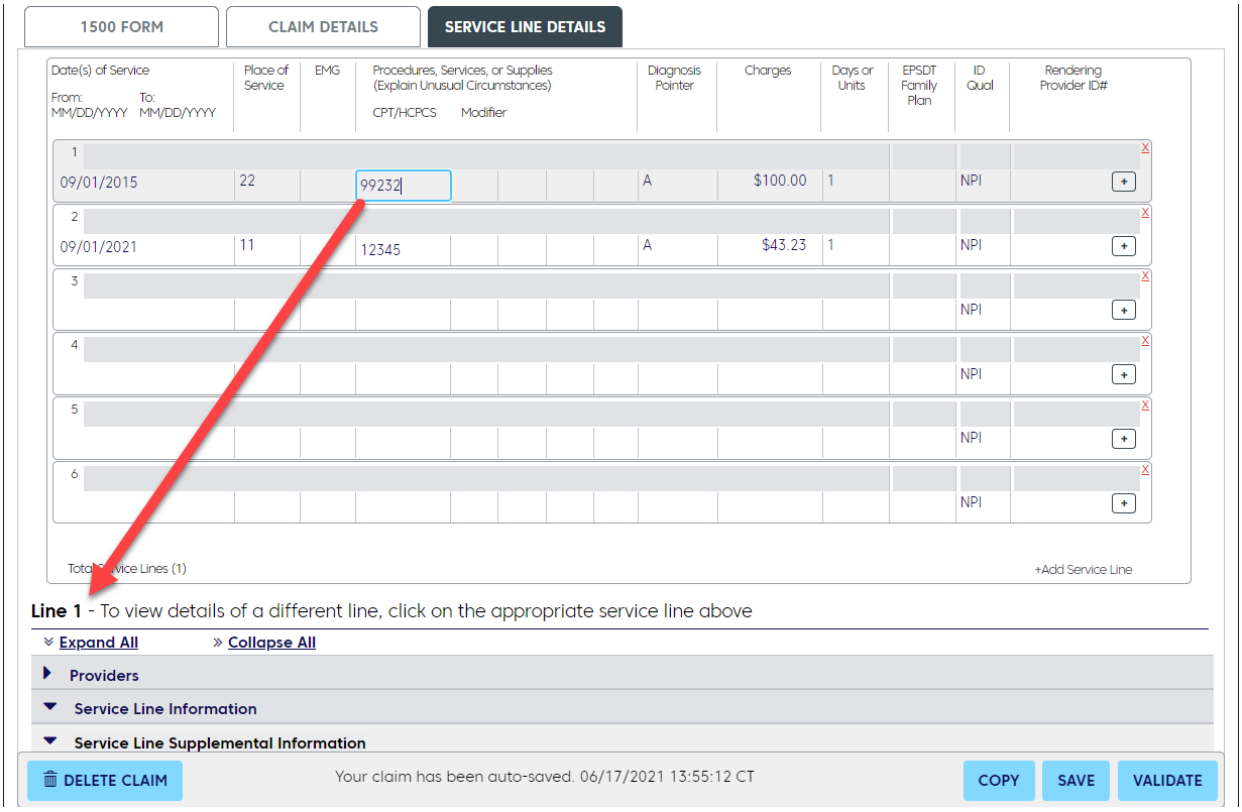
For those who need to include a Rendering Provider on the **Claim Details** tab, several short cuts are available that will help to fill all required fields at once.

- Each of these short cuts can prefill only the provider information that has previously been stored in Provider Management.
- we highly recommend setting a default rendering provider so that rendering provider fields are completed for you on every new claim. A default can be set in either Admin > Provider Management or by opening Find Provider from the Claim Details Rendering Provider section and clicking the green circle found on the right side of the provider table.
- If you bill for multiple rendering providers, it may be better to use **Find Provider** to select the provider for a new claim, instead of setting a default. **Find Provider** can also be used to over-ride a default that is incorrect on a specific claim.

Service Line Detail Tab

For each service line, all the detailed information described below can be entered. The top of the **Service Line Details** tab will display summary information about each service line included in the claim and will exactly match the details shown on the 1500 Form

When completing service line details on the lower portion of the **Service Line Detail** tab, be sure to select which service line your details supplement by clicking the appropriate line at the top of the form. A blue outline should appear highlighting the field you've clicked. In addition, the entire selected row will be highlighted in gray. Above the line dividing the top half of the page from the bottom half, the line number of the currently selected line will display.



Service Line Details

Section	Label/Description	Emdeon Section/Field
Providers Rendering	• If the Rendering Provider NPI is applicable to the entire claim add this information on the Claim Detail Tab, rather than each individual service line. • If a Rendering Provider NPI is included on a service line, the Rendering provider name must be provided in the Rendering Provider section • Use the + icon in the service line section or the Find Provider button in the Rendering Provider section of the Service Line tab to retrieve a Rendering Provider from Provider Management, as this will allow you to retrieve NPI, atypical provider ID, provider name and taxonomy all at once. (Note, only those provider details you have saved in Provider Management will be available to retrieve.) If Find Provider is used to retrieve Rendering Provider name and NPI, then the above instruction, that you must add name in the Service Line Details section, is completed for you.	Performing Provider # Typically performing provider for the entire claim is selected in Step 3 of the New Claim setup page, as part of selecting Service Provider.

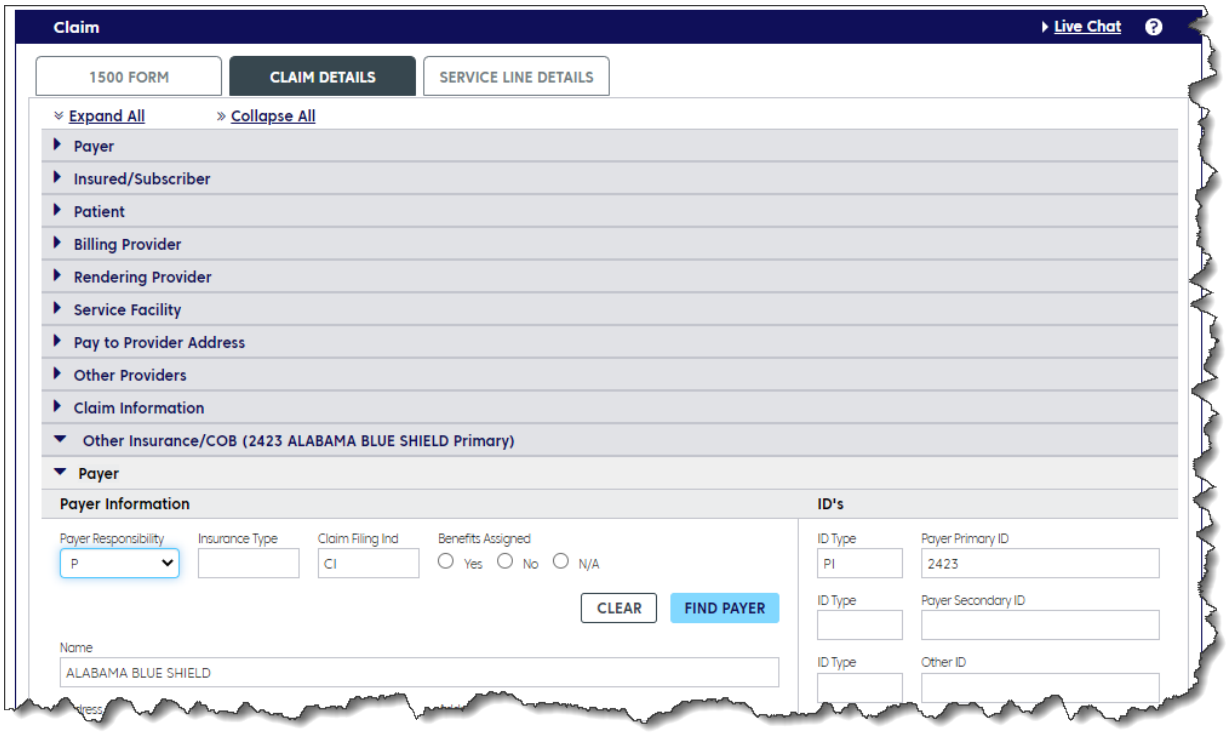
Section	Label/Description	Emdeon Section/Field
Providers Ordering	NPI ID Type/Other ID Last Name, First Name, Middle Name, Suffix	Additional Claim Line Information Provider Information Ordering Provider NPI Ordering Provider UPIN Ordering Provider Name
Providers Supervising	NPI ID Type / Other ID Last Name, First Name, Middle Name, Suffix	Additional Claim Line Information Provider Information Supervising Provider NPI Supervising Provider UPIN Supervising Provider ID Supervising Provider Name
Providers Purchased Services	Entity Type: Yes/No Purchased Service Charge Amount NPI ID Type / Other ID	Additional Claim Line Information Service Information • Purchased Service: Y/N • Purchased Service Charge Provider Information • Purchased Service Provider NPI, • Purchased Service Provider #

Section	Label/Description	Emdeon Section/Field
Supplemental Information	CLIA #	Additional Claim Line Information Provider Information CLIA #
Supplemental Information	Mammography Certification #	Additional Claim Line Information Provider Information Mammography Cert Number
Supplemental Information	Hospice Employee	Additional Claim Line Information Provider Information Hospice Employee
Drug Information	NDC or Universal Product ID # of Units Measurement Basis RX#	Additional Claim Line Information Service Information • National Drug Code • NDC Quantity • NDC Units of Measure • Prescription Number • NDC Link Sequence #

Section	Label/Description	Emdeon Section/Field
Test Results	Hemoglobin/Hematocrit/Both Date ID, Qualifier, Value	Additional Claim Line Information Service Information • Hemoglobin/Hematocrit Date • Hemoglobin g/dl • Hematocrit %

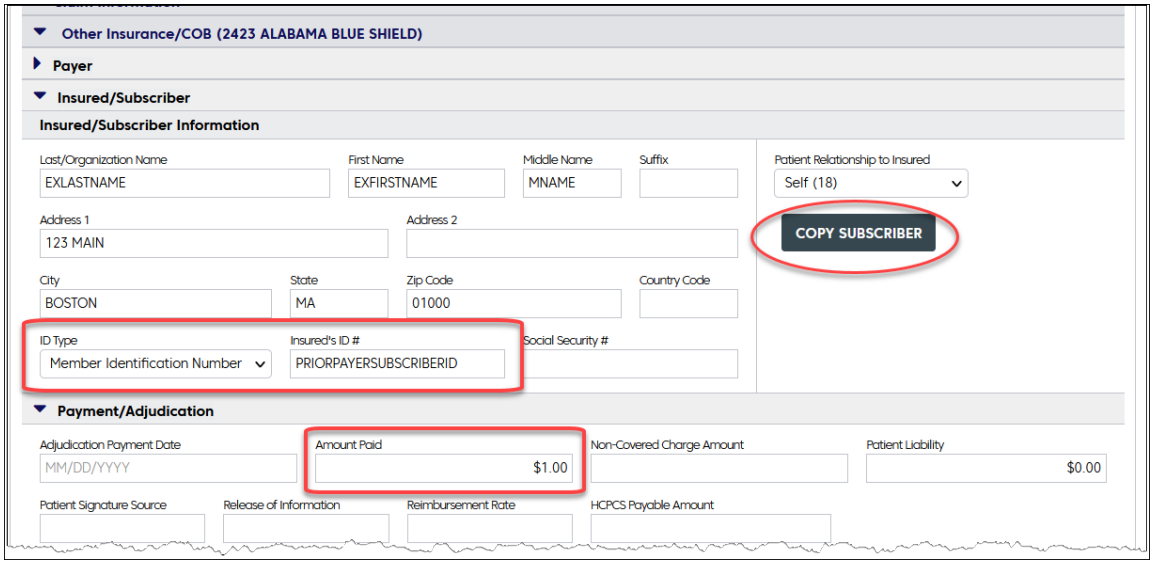
Special Cases – Secondary Claims

To submit secondary or tertiary claims, prior payment information will need to be entered on both the Claim Details and Service Line Details sections, in the Other Insurance/COB sections



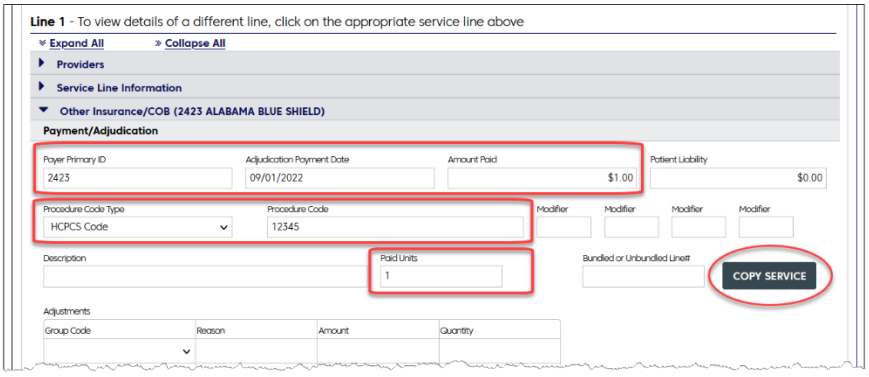
Claim Details Tab	
Section	**Label / Description**
Other Insurance/COB Payer Payer Information	• Payer Responsibility – Choose Primary or Secondary. Sequence identifier must be lower than the Payer Responsibility number indicated at the top of the 1500 Form. • Claim Filing Indicator is required • Use Find Payer to retrieve the name and ID of the prior payer. If you choose instead to manually enter the prior payer information, be sure to enter PI in the ID Type field

Claim Details Tab	
Section	**Label / Description**
Other Insurance/COB **Insured/Subscriber Information**	Apart from the Insured ID#, Subscriber information is typically the same or at least similar between the prior payer and the current payer. Use the **Copy Subscriber** button to copy demographic details already entered on the claim. • **Insured ID#** is required and should **not** be the same as the Subscriber ID from box 1A. • Choose "Member Identification #" as **ID Type** • **Patient Relationship to Insured** is required
Other Insurance/COB **Payment/Adjudication**	Prior payment dollar amounts must be entered at the line level. However, the sum of all prior payments from the service line section must also be reported on the Claim Details tab in the Payment/Adjudication section. • Amount Paid is required • Adjudication Payment Date is best to *omit* at the claim level

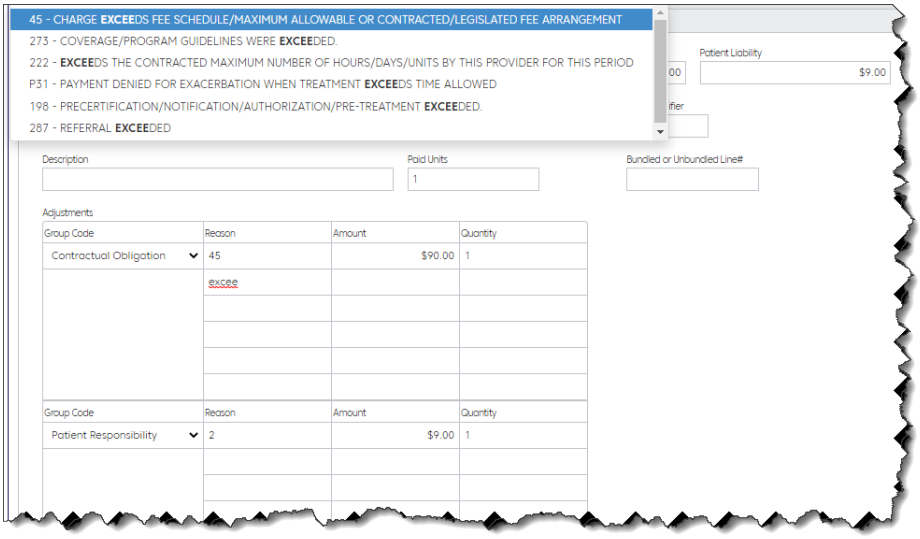


For each Service Line that was previously paid you will need to provide the information described below. Select the correct service line from the top portion of the page and then open the Other Insurance/COB section on the bottom of the page to access the details described.

Service Line Details – Other Insurance/COB Section	
Section / Label	**Instructions**
Payment / Adjudication **Payer Primary ID**	• Copy the Payer ID you entered on the Claim Detail tab. The ID will also be present on the Other Insurance/COB title bar. Use the **Copy Service** button to copy this and other service line.
Payment / Adjudication **Adjudication Payment Date**	• Enter the date of prior payment
Payment / Adjudication **Amount Paid**	• Enter the total amount paid by the prior payer for the service described on this line • This prior payment amount entered here, when added to all of the adjustment amounts described in the next section of this document, should equal the total charge for the current line, as entered on the 1500 Form (also present in the top half of this page)
Payment / Adjudication **Procedure Code**	• Copy the procedure code entered on the service line to the Procedure Code field. • Use the **Copy Service** button.
Payment / Adjudication **Paid Units**	• Use the **Copy Service** button to copy quantity included in the service line details



Service Line Details – Other Insurance/COB Section – Adjustment Detail **For each Service Line, you may include up to 5 groups of adjustments. Each group of codes may contain up to 5 adjustments.**	
Section / Label	**Instructions**
Payment / Adjudication **Group Code**	• Select one of the 5 adjustment Group codes from the drop-down list in the Group Code column
Payment / Adjudication **Reason**	• Up to 6 adjustments can be entered per Group. • Each requires a Reason code. For help finding the correct code, use the type-ahead search. Begin typing a word that you would expect to find in the description of the code and a list of matching codes will be displayed for your selection
Payment / Adjudication **Amount**	• Dollar amount of adjustment • Remember that sum of all of the adjustments, for all of the groups along with the amount of prior payment, needs to add to the same amount entered as the line-item charge amount on the 1500 Form tab for the current service line
Payment / Adjudication **Quantity**	• Numeric value of units included in the adjustment



Special Cases – Ambulance Information

Ambulance information can be entered at both the claim level and the service line level. The most important fields can be found in the Property & Casualty sections, as described below.

Section	Label / Description
Property & Casualty, Ambulance **Pick Up Location**	• Address 1 • Address 2 • City • State • Zip Code • Country Code
Property & Casualty, Ambulance **Drop-off Location**	• Address 1 • Address 2 • City • State • Zip Code • Country Code
Property & Casualty, Ambulance **Other Information**	• Patient Weight
Property & Casualty, Ambulance **Other Information**	• Transport Distance

Section	Label / Description
Property & Casualty, Ambulance **Other Information**	• Transport Reason Code – Enter one of the following codes A – Patient transported to nearest facility B – Patient transported to preferred physician C – Patient transported for nearness of family members D – Patient transported for specialist or for specialized equipment E – Patient transported to Rehab Facility
Property & Casualty, Ambulance **Other Information**	• Round Trip Purpose
Property & Casualty, Ambulance **Other Information**	• Stretcher Purpose
Property & Casualty, Ambulance **Other Information**	• If you need to set a condition codes, select Yes and use one of the following codes 01 – Patient was admitted to hospital 04 – Patient was moved by stretcher 05 – Patient was unconscious or in shock 06 – Patient was transported in an emergency 07 – Patient had to be physically restrained 08 – Patient had visible hemorrhaging 09 – Ambulance service was medically necessary 12 – Patient is confided to a bed or chair • NOTE: The Yes/No indicator is not needed at the service line level