Emdeon Office

Claims User Guide

October 18, 2011

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ERA Summary by Day Report 137
File Summary Report 137
Patient Payment Summary by Day Report 138
Payment Detail Report 138
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Audit History Report 140
Claim Detail Report 142
Claim Summary Report 149
ERA Summary by Day Report 151
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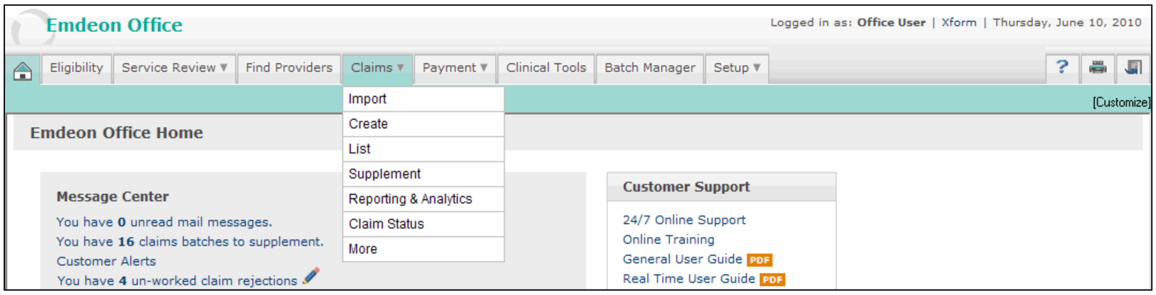
Claims

Overview

The down arrow on the **Claims** tab indicates there is a sub-menu below it. When the **Claims** tab is selected, the following options appear:


Emdeon Office
Logged in as: Office User | Xform | Thursday, June 10, 2010
Eligibility
Service Review ▼
Find Providers
Claims ▼
Payment ▼
Clinical Tools
Batch Manager
Setup ▼
?
[Customize]
Import
Create
List
Supplement
Reporting & Analytics
Claim Status
More
Emdeon Office Home
Message Center
Customer Alerts
Customer Support
24/7 Online Support
Online Training
General User Guide PDF
Real Time User Guide PDF

You have **0** unread mail messages.
You have **16** claims batches to supplement.
You have **4** un-worked claim rejections

Import

Import allows users to submit primary and secondary claims respectively from a provider's workstation to Emdeon Office for processing.

Create

Create allows users to enter claim information directly into an HCFA 1500 claim form. See the **New Claim** section (page 25) for instructions. Before creating a claim for the first time, you must first complete **Provider Setup** (page 16).

List

List allows users to view, edit, and submit claims. Before using Claim List, you must have completed and saved one or more claim forms. You can sort the list of claims by clicking on any of the column headings.

Supplement

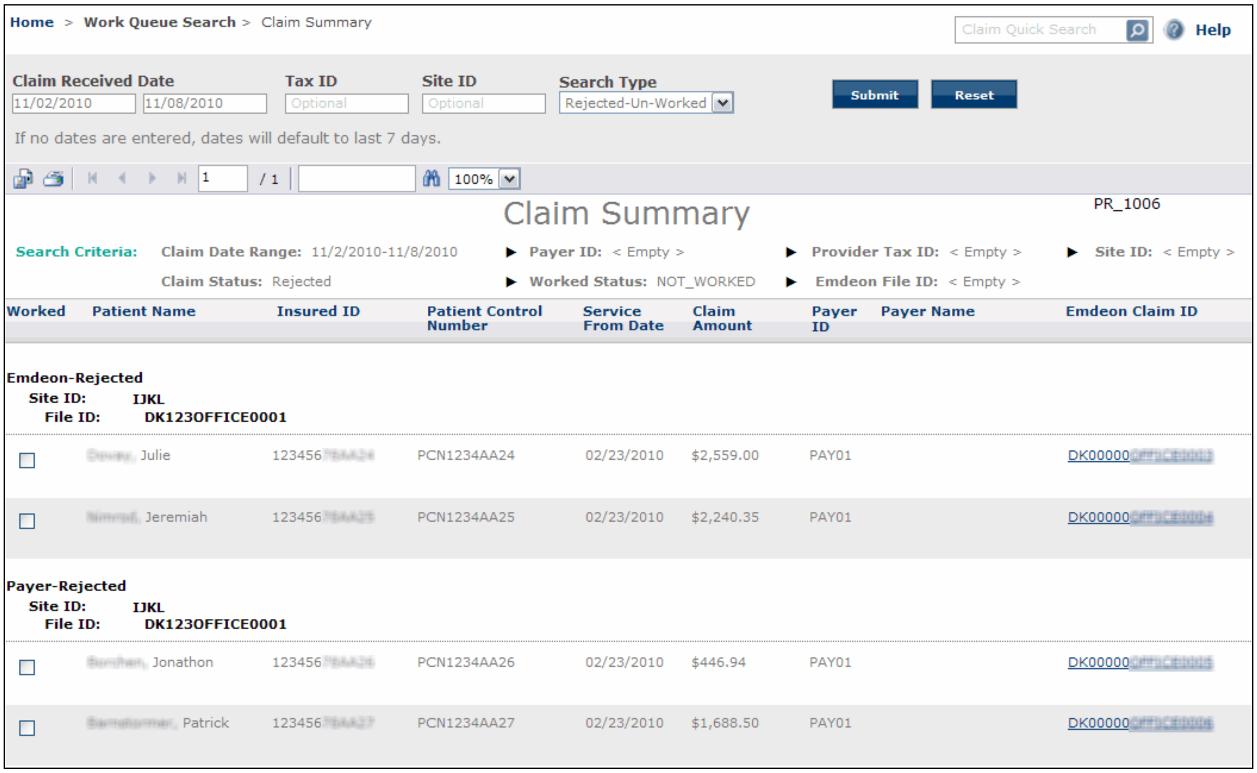
Supplement allows users to submit secondary claims from a provider's workstation to Emdeon Office for processing.

Reporting & Analytics

Reporting & Analytics can be used by providers and practices to view summary and detailed information on submitted claims. It provides users with a tool to view status of claims with the payer. Additionally, it provides a tool for tracking claims rejections and work completed on rejections.

Un-Worked Claim Rejections

You can access a claim rejections report from the home page. The "un-worked claim rejections" link shows how many un-worked claim rejections you currently have. Click the link to launch a default claim rejection report in Reporting & Analytics that includes all un-worked claim rejections from the last seven days.



Claim Received Date: 11/02/2010 11/08/2010
Tax ID: Optional
Site ID: Optional
Search Type: Rejected-Un-Worked

If no dates are entered, dates will default to last 7 days.

1 / 1 100%

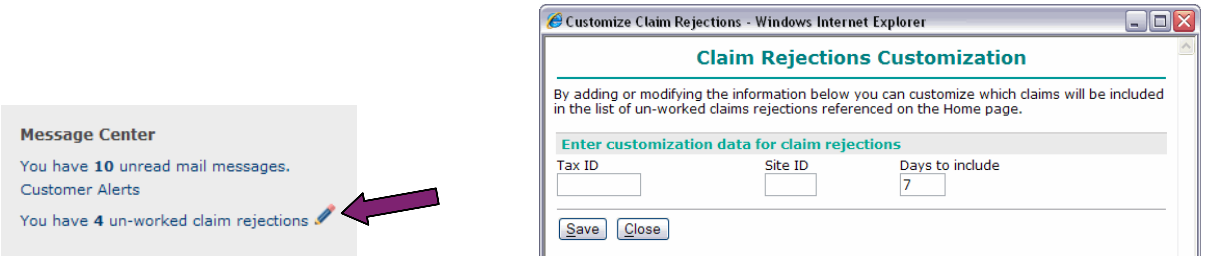
Claim Summary

PR_1006

Search Criteria: **Claim Date Range:** 11/2/2010-11/8/2010 ▶ **Payer ID:** < Empty > ▶ **Provider Tax ID:** < Empty > ▶ **Site ID:** < Empty >
Claim Status: Rejected ▶ **Worked Status:** NOT_WORKED ▶ **Emdeon File ID:** < Empty >

Worked	Patient Name	Insured ID	Patient Control Number	Service From Date	Claim Amount	Payer ID	Payer Name	Emdeon Claim ID
Emdeon-Rejected **Site ID: IJKL** **File ID: DK123OFFICE0001**								
☐	[redacted], Julie	123456[redacted]	PCN1234AA24	02/23/2010	$2,559.00	PAY01		DK00000[redacted]
☐	[redacted], Jeremiah	123456[redacted]	PCN1234AA25	02/23/2010	$2,240.35	PAY01		DK00000[redacted]
Payer-Rejected **Site ID: IJKL** **File ID: DK123OFFICE0001**								
☐	[redacted], Jonathon	123456[redacted]	PCN1234AA26	02/23/2010	$446.94	PAY01		DK00000[redacted]
☐	[redacted], Patrick	123456[redacted]	PCN1234AA27	02/23/2010	$1,688.50	PAY01		DK00000[redacted]

To customize which claims will be included in the list of un-worked claim rejections that appear on the report, click the pencil icon. Type a tax ID, site ID, or different number of days and click **Save**. For hints on entering values, click in each box and look at the bottom of the screen.



Message Center

You have **10** unread mail messages.

Customer Alerts

You have **4** un-worked claim rejections

Claim Rejections Customization

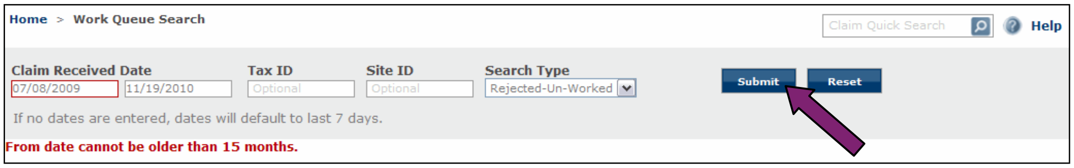
By adding or modifying the information below you can customize which claims will be included in the list of un-worked claims rejections referenced on the Home page.

Enter customization data for claim rejections

Tax ID:
Site ID:
Days to include: 7

You will receive an error message under the following conditions:

- If the values you enter generate more than 1,000 un-worked claim rejections.
- If you enter a number larger than 450 in the **Days to include** box.
- If you enter a site ID and enter a number larger than 60 in the **Days to include** box.



Claim Received Date: 07/08/2009 11/19/2010
Tax ID: Optional
Site ID: Optional
Search Type: Rejected-Un-Worked

If no dates are entered, dates will default to last 7 days.

From date cannot be older than 15 months.

Modify the search criteria on the claim rejection report page and click **Submit** to relaunch the report.

For help with Reporting & Analytics, please refer to the **Reporting & Analytics** section on page 87.

Claim Status

Claim Status allows user to monitor their claims for status information and reimbursements and to correct and resubmit claims without re-entering patient/provider data.

More

More contains links to claims resources.

The following table describes in detail each link on the **Claims** > **More** page.

Link	Description
Payer Enrollment	Takes you to the Payer Enrollment page of www.emdeon.com, where you can access Claims Payer Enrollment forms.
Add Providers or Payers	Allows you to add providers or payers for claims submission. This feature is covered in detail in **Add Providers or Payers** (page 9).
Change or Remove Providers or Payers	Allows you to change or remove providers or payers you have already enrolled for claims submission. These features are covered in detail in **Change or Remove Providers or Payers** (page 10).
CMS NPI Enrollment	Takes you to CMS' National Plan and Provider Enumeration System, from which you can apply for a National Provider Identifier.
NPI Crosswalk	Takes you to the Enrollment Manager.
NPI Crosswalk Reports	Reports on the success or failure of NPI inclusion in submitted claims.
Crosswalk User Guide	Opens the NPI Crosswalk User Guide.*
Crosswalk Quick Reference	Opens the quick reference guide for using the NPI Crosswalk.*
Complete Emdeon Payer List	A complete list of Emdeon payers.
Claims Resource Center	Takes you to Emdeon's Claim Resource Center.
Claims User Guide	Opens the Claims User Guide.*

*These guides are in pdf format and require that you have the Adobe® Reader® installed on your computer. The Reader can be downloaded free of charge from www.adobe.com.

Send Claims

Benefits of Sending Claims through Emdeon Office

- Submit claims to hundreds of commercial and government payers
- Edit and submit secondary claims. Data from the primary claim is used to create the secondary claim resulting in improved efficiency and time savings.
- Upload print image and electronic claim files
- Use your own Practice Management system to generate claim files.

A claim file must contain professional (physician) claims only.

Your management system may save claims in a file as you enter them, or you may choose to save or “print” claims to a file. You’ll need to ask your practice management system vendor for details on how to create the claim file and where you can find it on the PC.

Send Claims Requirements

Unlike real-time transactions, claim transactions sent through **Claim Entry** and **Send Claims** require additional enrollment.

Additionally, before submitting a claim file using the Send Claims service, your claim file format must be validated, otherwise, your claim file may be successfully transmitted but it will not be processed at the Claim Processing Center and you will not be notified.

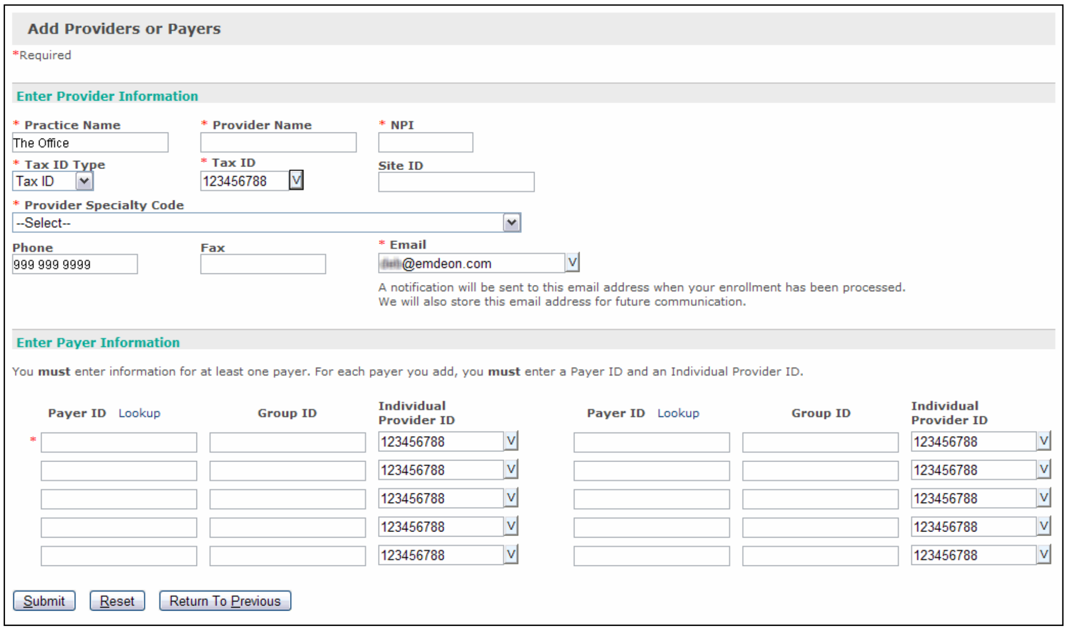
If you have not validated your claim file format with a help desk representative please contact 1-877-469-3263 for additional information.

Add Providers or Payers

Use this procedure to add a provider for claim submission or add a payer for a provider who has already been enrolled for claim submission. The enrollment team will complete the process and will notify you by email when the enrollment has been processed.

1. Select **Claims** > **More** from the main menu. The Claims Additional Resources window appears.
2. Click the “Add Providers or Payers” link. The Add Providers or Payers window appears.

***Note**: Because this page reflects information currently on file, many boxes will be pre-filled with information that will likely not need to be changed.*



Add Providers or Payers

*Required

Enter Provider Information

* Practice Name: The Office
* Provider Name:
* NPI:
* Tax ID Type: Tax ID
* Tax ID: 123456788
Site ID:
* Provider Specialty Code: --Select--
Phone: 999 999 9999
Fax:
* Email: [redacted]@emdeon.com

A notification will be sent to this email address when your enrollment has been processed.
We will also store this email address for future communication.

Enter Payer Information

You **must** enter information for at least one payer. For each payer you add, you **must** enter a Payer ID and an Individual Provider ID.

	Payer ID Lookup	Group ID	Individual Provider ID	Payer ID Lookup	Group ID	Individual Provider ID
*			123456788			123456788
			123456788			123456788
			123456788			123456788
			123456788			123456788
			123456788			123456788

3. In the **Enter Provider Information** section, enter the provider's identifying information. Required items are marked with a red asterisk (*).

***Note**: If you are adding a payer for a provider who is already enrolled, duplicate the identifying information for the provider supplied during the initial enrollment process.*

Please note the following about this section:

- **Tax ID** - Select a tax ID from the list or type a new tax ID in the box. This list is made up of all the tax IDs your account is currently configured to send claims for.
- **Email** - Select an email address from the list or type a new email address in the box. We will also store this email address for future communications about your account or enrollment for additional services.

4. In the **Enter Payer Information** section, you *must* enter at least one payer.

Please note the following about this section:

- **Payer ID** - If you do not know the payer ID, click the "Lookup" link to search for the payer ID.
- **Individual Provider ID** - Select a provider ID from the list or type a new provider ID in the box. This list is made up of all the provider IDs your account is currently configured to send claims for.

5. Click **Submit**.
6. On the page that appears, you will see "Your request has been successfully submitted for enrollment." Click **Add or Change Another Provider** or **Return To Home Page**.

Change or Remove Providers or Payers

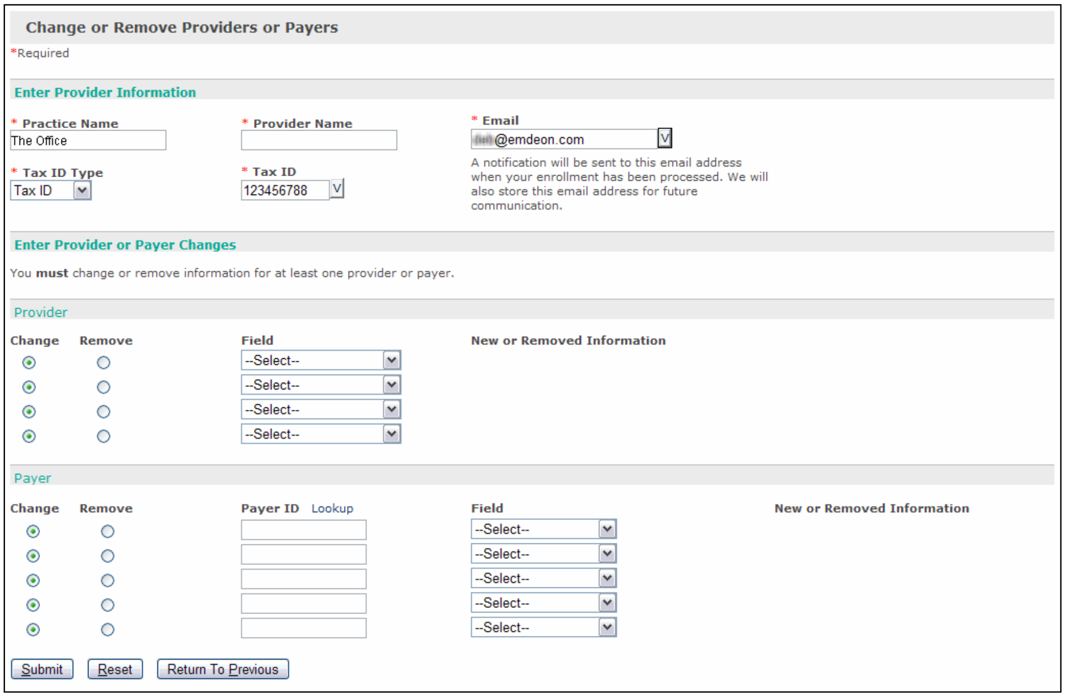
Use this procedure to change or remove provider or payer information for a provider you have already enrolled, or to remove a provider or payer. The enrollment team will complete the process and will notify you by email when the enrollment has been processed.

***Note**: You can do any or all of the procedures listed below on the Change or Remove Providers or Payer page.*

Change Information for Providers or Payers

1. Select **Claims** > **More** from the main menu. The Claims Additional Resources window appears.
2. Click the "Change or Remove Providers or Payers" link. The Change or Remove Providers window appears.

***Note**: Because this page reflects information currently on file, many boxes will be pre-filled with information that will likely not need to be changed.*



Change or Remove Providers or Payers

*Required

Enter Provider Information

* Practice Name: The Office
* Provider Name:
* Email: [redacted]@emdeon.com
* Tax ID Type: Tax ID
* Tax ID: 123456788

A notification will be sent to this email address when your enrollment has been processed. We will also store this email address for future communication.

Enter Provider or Payer Changes

You **must** change or remove information for at least one provider or payer.

Provider

Change	Remove	Field	New or Removed Information
●	○	--Select--	
●	○	--Select--	
●	○	--Select--	
●	○	--Select--	

Payer

Change	Remove	Payer ID Lookup	Field	New or Removed Information
●	○		--Select--	
●	○		--Select--	
●	○		--Select--	
●	○		--Select--	
●	○		--Select--	

3. In the **Enter Provider Information** section, enter the provider's identifying information. Required items are marked with a red asterisk (*).

   Please note the following about this section:

   - **Tax ID** - Select a tax ID from the list or type a new tax ID in the box. This list is made up of all the tax IDs your account is currently configured to send claims for.
   - **Email** - Select an email address from the list or type a new email address in the box. We will also store this email address for future communications about your account or enrollment for additional services.

4. In the **Enter Provider or Payer Changes** section, you *must* make changes to one provider or payer. You can make changes to both provider and payer information on this page.
5. If you want to change *provider* information, do the following:

   - In the first row of the **Provider** section under **Enter Provider or Payer Changes**, ensure that **Change** is selected (it is selected by default).
   - Select an item from the **Field** list.
   - Type the new information in the **New or Removed Information** box that appears.
   - Complete additional rows as needed. If you want to change *payer* information, do the following:
   - In the first row of the **Payer** section under **Enter Provider or Payer Changes**, ensure that **Change** is selected (it is selected by default).
   - In the **Payer ID** box, type the payer ID of the payer whose information you want to change.

   ***Note**: If you do not know the payer ID, click the "Lookup" link to search for the payer ID.*

   - Select an item from the **Field** list.
   - Type the new information in the **New or Removed Information** box that appears.
   - Complete additional rows as needed.

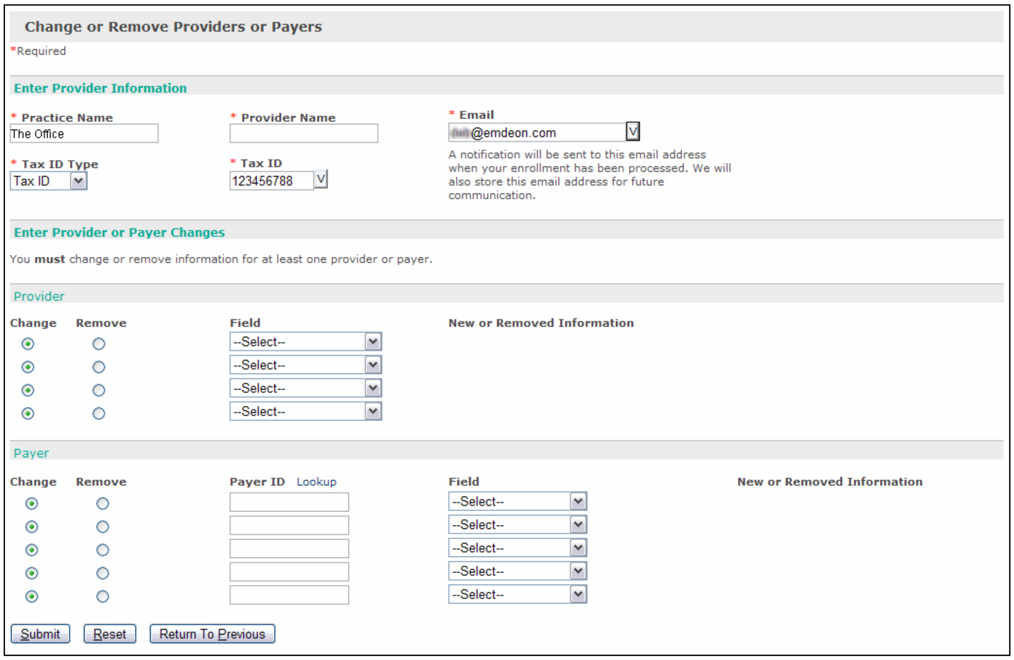
6. Click **Submit**.
7. On the page that appears, you will see "Your request has been successfully submitted for enrollment." Click **Add or Change Another Provider** or **Return to Home Page**.

Remove Information for Providers or Payers

The following steps allow you to remove pieces of information for providers or payers. If you want to remove an entire practice/facility, provider, or payer, refer to **Remove Providers or Payers** on page 13.

1. Select **Claims** > **More** from the main menu. The Claims Additional Resources page opens.
2. Click the "Change or Remove Claims Providers" link. The Change or Remove Providers window opens.

***Note**: Because this page reflects information currently on file, many boxes will be pre-filled with information that will likely not need to be changed.*



Change or Remove Providers or Payers

*Required

Enter Provider Information

* Practice Name: The Office

* Provider Name:

* Email: [redacted]@emdeon.com

* Tax ID Type: Tax ID

* Tax ID: 123456788

A notification will be sent to this email address when your enrollment has been processed. We will also store this email address for future communication.

Enter Provider or Payer Changes

You **must** change or remove information for at least one provider or payer.

Provider

Change	Remove	Field	New or Removed Information
●	○	--Select--	
●	○	--Select--	
●	○	--Select--	
●	○	--Select--	

Payer

Change	Remove	Payer ID Lookup	Field	New or Removed Information
●	○		--Select--	
●	○		--Select--	
●	○		--Select--	
●	○		--Select--	
●	○		--Select--	

3. In the **Enter Provider Information** section, enter the provider's identifying information. Required items are marked with a red asterisk (*).

   Please note the following about this section:

   - **Tax ID** - Select a tax ID from the list or type a new tax ID in the box. This list is made up of all the tax IDs your account is currently configured to send claims for.
   - **Email** - Select an email address from the list or type a new email address in the box. We will also store this email address for future communications about your account or enrollment for additional services.

4. In the **Enter Provider or Payer Changes** section, you *must* make changes to at least one provider or payer. You can remove information for both providers and payers on this page.
5. If you want to remove **provider** information, do the following:

   - In the first row of the **Provider** section under **Enter Provider or Payer Changes**, click **Remove**.
   - Select an item from the **Field** list.
   - Type the information you want to remove in the **New or Removed Information** box that appears.
   - Complete additional rows as needed.

6. If you want to remove **payer** information, do the following:

   - In the first row of the **Payer** section under **Enter Provider or Payer Changes**, click **Remove**.
   - In the **Payer ID** box, type the payer ID of the payer whose information you want to change.

***Note**: If you do not know the payer ID, click the "Lookup" link to search for the payer ID.*

- Select an item from the **Field** list.
- Type the information you want to remove in the **New or Removed Information** box that appears.
- Complete additional rows as needed.

7. Click **Submit**.
8. On the page that appears, you will see "Your request has been successfully submitted for enrollment." Click **Add or Change Another Provider** or **Return to Home Page**.

Remove Providers or Payers

Removing a practice/facility, provider, or payer means that you will no longer be able to submit claims using that entity.

To remove a practice/facility, provider, or payer, follow steps 1-3 of the previous section, and then continue as follows:

Remove a Practice/Facility

1. In the first row of the **Provider** section under **Enter Provider or Payer Changes**, click **Remove**.
2. Select "Practice/Facility Name" from the **Field** list.
3. Type the practice/facility name in the **New or Removed Information** box that appears.
4. Complete additional rows as needed.
5. Click **Submit**.
6. On the page that appears, you will see "Your request has been successfully submitted for enrollment." **Click Add or Change Another Provider** or **Return to Home Page**.

Remove a Provider

1. In the first row of the **Provider** section under **Enter Provider or Payer Changes**, click **Remove**.
2. Select "Provider Name" from the **Field** list.
3. Type the provider name in the **New or Removed Information** box that appears.
4. Complete additional rows as needed.
5. Click **Submit**.
6. On the page that appears, you will see "Your request has been successfully submitted for enrollment." Click **Add or Change Another Provider** or **Return to Home Page**.

Remove a Payer

1. In the first row of the **Payer** section under **Enter Provider or Payer Changes**, click **Remove**.
2. Select "Payer ID" from the **Field** list.
3. In the **Payer ID** box, type the payer ID.

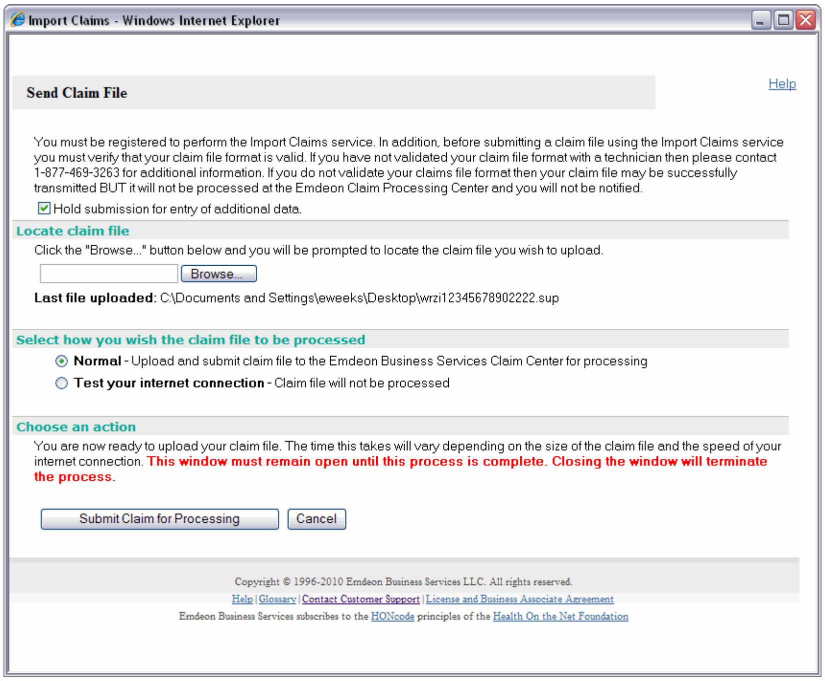
***Note**: If you do not know the payer ID, click the "Lookup" link to search for the payer ID.*

4. Type the payer ID in the **New or Removed Information** box that appears.
5. Complete additional rows as needed.
6. Click **Submit**.
7. On the page that appears, you will see "Your request has been successfully submitted for enrollment." Click **Add or Change Another Provider** or **Return to Home Page**.

Submit a Claim File for Processing

Follow these steps to upload and submit a claim file:

1. Create a claim file using your Practice Management System.
2. Select **Claims** > **Import** from the main menu. The Import Claims main window opens. Read the explanatory text if you are not familiar with claim file formats.
3. Click **Proceed to Next Step**. The Send Claim File form opens in a separate window.



Send Claim File

You must be registered to perform the Import Claims service. In addition, before submitting a claim file using the Import Claims service you must verify that your claim file format is valid. If you have not validated your claim file format with a technician then please contact 1-877-469-3263 for additional information. If you do not validate your claims file format then your claim file may be successfully transmitted BUT it will not be processed at the Emdeon Claim Processing Center and you will not be notified.

☑ Hold submission for entry of additional data.

Locate claim file

Click the "Browse..." button below and you will be prompted to locate the claim file you wish to upload.

Last file uploaded: C:\Documents and Settings\eweeks\Desktop\wrzi12345678902222.sup

Select how you wish the claim file to be processed

● **Normal** - Upload and submit claim file to the Emdeon Business Services Claim Center for processing

○ **Test your internet connection** - Claim file will not be processed

Choose an action

You are now ready to upload your claim file. The time this takes will vary depending on the size of the claim file and the speed of your internet connection. **This window must remain open until this process is complete. Closing the window will terminate the process.**

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Help | Glossary | Contact Customer Support | License and Business Associate Agreement

Emdeon Business Services subscribes to the HONcode principles of the Health On the Net Foundation

***Note**: You must be registered to use the Import Claims service. In addition, before submitting a claim file using the Import Claims service you must verify that your claim file format is valid. If you have not validated your claim file format with a help desk representative, please contact customer support for additional information.*

4. The "Hold submission for entry of additional data" check box should only be checked if you are planning to enter prior payment information to generate secondary claims. Otherwise it should be clear.

***Note**: For information on secondary claims, refer to **Supplement Claims** on page 33.*

5. Click **Browse...** to locate the claim file. Select the claim file you want to send for processing and click **Open**. The file name populates the field.
6. Select the mode in which to send the file.
   - **Normal** - Your file is encrypted, transmitted, authenticated, validated, and delivered for processing.
   - **Test your internet connection** - This option allows you to test your internet connection before actually sending the file for processing. The claim file is neither transmitted, nor presented for processing at any time.
7. Click **Submit Claim for Processing**. Once the file is submitted, a message appears indicating whether the transmission succeeded or failed.

***Note**: Leave the Send Claims window open during file transmission. Closing the window indicates that you want to terminate the connection and abort the transmission. You can minimize the* *window, but it must not be closed or the process will end immediately.*

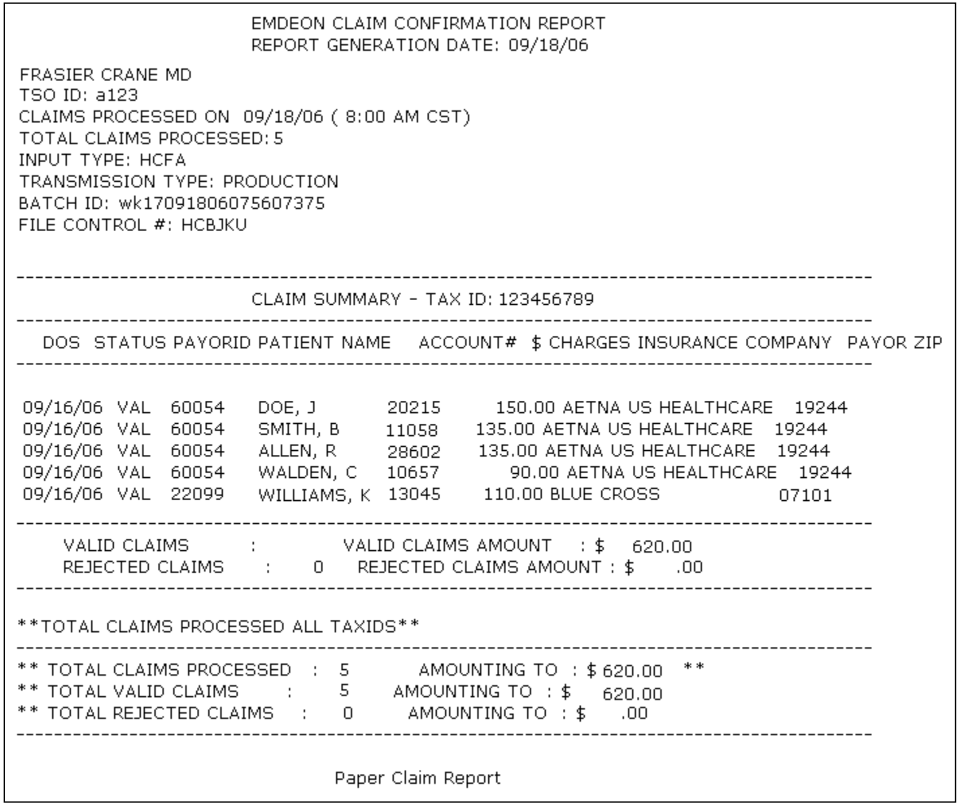
8. When the claim is received and processed, a claim status report is sent to your Emdeon Office mail inbox.
9. Click **Cancel** to close the Send Claim File window after your claim file is successfully transmitted.
10. Check your Emdeon Office mail inbox for messages about the status of your claims.

Verify Claims Transmission

Once your claims are processed, a claim status report is sent via Emdeon Office mail to your inbox confirming the status of the claims. Follow these steps to view this report:

1. Click the **mail messages** link on the home page.
2. To view the message, double-click the message or single click the message and then click the **Open** icon.

   The following is an example of a Level 1 Claim Status Report:



```
                         EMDEON CLAIM CONFIRMATION REPORT
                         REPORT GENERATION DATE: 09/18/06
FRASIER CRANE MD
TSO ID: a123
CLAIMS PROCESSED ON  09/18/06 ( 8:00 AM CST)
TOTAL CLAIMS PROCESSED: 5
INPUT TYPE: HCFA
TRANSMISSION TYPE: PRODUCTION
BATCH ID: wk17091806075607375
FILE CONTROL #: HCBJKU


--------------------------------------------------------------------------------------
                         CLAIM SUMMARY - TAX ID: 123456789
--------------------------------------------------------------------------------------
  DOS  STATUS PAYORID PATIENT NAME    ACCOUNT#  $ CHARGES INSURANCE COMPANY  PAYOR ZIP
--------------------------------------------------------------------------------------

 09/16/06  VAL   60054    DOE, J        20215      150.00 AETNA US HEALTHCARE   19244
 09/16/06  VAL   60054    SMITH, B      11058    135.00 AETNA US HEALTHCARE   19244
 09/16/06  VAL   60054    ALLEN, R      28602    135.00 AETNA US HEALTHCARE   19244
 09/16/06  VAL   60054    WALDEN, C     10657       90.00 AETNA US HEALTHCARE   19244
 09/16/06  VAL   22099    WILLIAMS, K  13045     110.00 BLUE CROSS              07101

--------------------------------------------------------------------------------------
     VALID CLAIMS        :           VALID CLAIMS AMOUNT    : $    620.00
     REJECTED CLAIMS     :      0    REJECTED CLAIMS AMOUNT : $      .00
--------------------------------------------------------------------------------------

**TOTAL CLAIMS PROCESSED ALL TAXIDS**
--------------------------------------------------------------------------------------
** TOTAL CLAIMS PROCESSED   :   5         AMOUNTING TO  : $ 620.00   **
** TOTAL VALID CLAIMS       :   5      AMOUNTING TO  : $    620.00
** TOTAL REJECTED CLAIMS    :   0       AMOUNTING TO  : $     .00
--------------------------------------------------------------------------------------

                                  Paper Claim Report
```

Send Claims Tips

The following information will help you resolve and prevent issues with claim files.

- If your claim file cannot reach the Emdeon Office Processing Center, Send Claims generates a transmission failure message and posts it in the Send Claim File window. Help identify the source of the problem by making a note of the error message before closing the message window.
- Do not close the Send Claim File window during processing. The Send Claim File window must remain open throughout your session, or your claims will not be processed. You may minimize the window, but it must not be closed, or your session will terminate and your claim submission process will end. Since transmission failure messages appear in your Send Claim File window, which is not visible once your session terminates, you will not notice your transmission has failed until much later.

Claim Entry

Overview

The **Claim Entry** service is designed to meet the needs of small to medium size health care provider offices, by allowing manual data entry of claims that can be electronically sent to a processing center. In addition, Claim Entry lets you work with payers that do not accept electronic claims. Once these payers are set up, all claims sent to these payers are automatically converted to paper claims and sent by mail.

Benefits

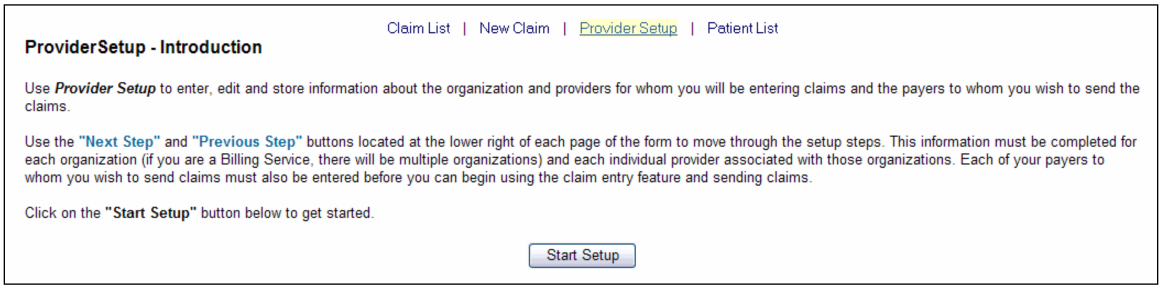
- You can manually create HCFA 1500 claims and submit to hundreds of government and commercial payers
- Data from patient database is integrated into the claim forms
- Claims sent to payers that do not accept electronic claims are converted to paper claims and mailed to the payer
- Allows editing and resubmitting claims

Features

- Claim List
- New Claim
- Provider Setup
- Patient List

Provider Setup

Provider Setup is the starting point for claims entry. This feature allows you to store provider- and payer-specific information, which is used to generate new claims. Provider Setup information must be entered before creating claims.



ProviderSetup - Introduction

Use ***Provider Setup*** to enter, edit and store information about the organization and providers for whom you will be entering claims and the payers to whom you wish to send the claims.

Use the **"Next Step"** and **"Previous Step"** buttons located at the lower right of each page of the form to move through the setup steps. This information must be completed for each organization (if you are a Billing Service, there will be multiple organizations) and each individual provider associated with those organizations. Each of your payers to whom you wish to send claims must also be entered before you can begin using the claim entry feature and sending claims.

Click on the **"Start Setup"** button below to get started.

Once the provider data is stored, it automatically populates fields on a claim form, eliminating the need to re-enter existing data.

There are six steps involved in setting up a provider organization. These steps must be performed in sequence the first time you set up an organization:

Step	**Provider Data**	**Description**
1	Provider Organization/Facility	The onscreen instructions will help you complete all the required fields in this section.
2	Tax IDs	Enter at least one Tax ID for the organization.
3	Addresses	In the first field, **Location Name/Description**, enter either the name of the organization or the practice. If you have multiple office locations, enter the location names. Click **Save Address** and the next screen will allow setup of multiple addresses. If there are multiple locations, check the appropriate box to indicate where each address is, where services are performed, and if this is the address where payments are to be sent.

Step	Provider Data	Description
4	Providers	You must enter either the healthcare provider's Universal Provider Identification Number (UPIN) or state license number. You can also enter your NPI number to be used in New Claims. When entering multiple providers, click **Save and Add New Provider**. You must click **Save** or your information will be lost.
5	Payers	These are the insurance companies, government plans, and Health Maintenance Organizations to whom claims are submitted. Use the drop-down list to individually select the payers you want to add. You can personalize your payer list by selecting the "Edit Payer List" link located next to the payer drop-down list. If your account is set up with only one payer, you will not see this link. If you leave the **Payer-Assigned Provider Number** field blank and save, the system will automatically populate the field with "NPI".
6	Submitter	This is the person or company responsible for submitting claims for a provider. Most of this information is pre-populated.

Note: *All required fields are marked with a red asterisk (*).Failure to complete one of the required fields will prevent you from advancing to the next screen.*

National Provider Identifier (NPI) and Tax ID Qualifier

Emdeon Office offers providers the ability to automatically populate fields on a new claims form by saving provider data through Provider Setup.

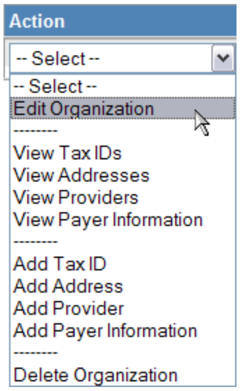
When setting up a new provider (or editing an existing one), NPI and Tax ID Qualifier data must be saved in order for the data to be automatically populated into new claims forms.

Note: *Saving this data will allow for one-time entry of the information and will save the user time entering new claims. If the data is not saved using this method, users will be required to use the NPI crosswalk in order to include NPI, and they must manually enter Tax ID Qualifier tags in the claim line level comments.*

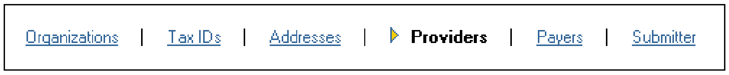
Set Up NPI for Claim Entry

Note: *For existing providers already set up for Claim Entry, skip to Step 4.*

1. Select **Claims** > **Create**, and then click the "Provider Setup" link.
2. Select "Edit Organization" from the **Action** drop-down menu.

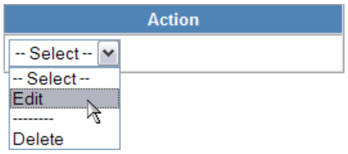


3. Select the "Providers" link.


Organizations | Tax IDs | Addresses | Providers | Payers | Submitter

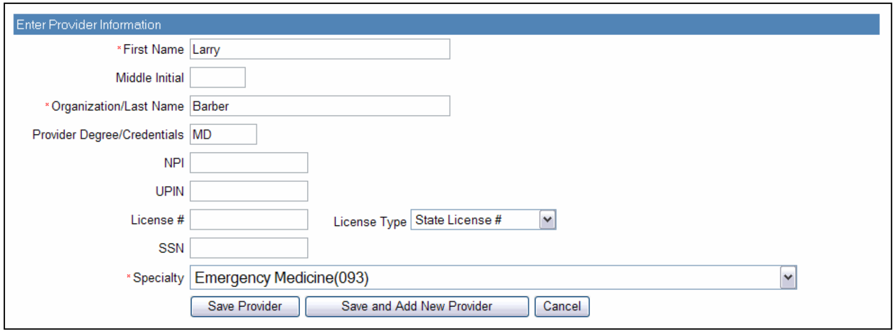
Note: *Provider NPI is not a required field under the "Providers" link, but if it is not entered through Provider Setup, users must use the NPI crosswalk to handle NPI, or the claims will be* *rejected.*

4. Select "Edit" from the **Action** drop-down menu.


Action
-- Select --
-- Select --
Edit

Delete

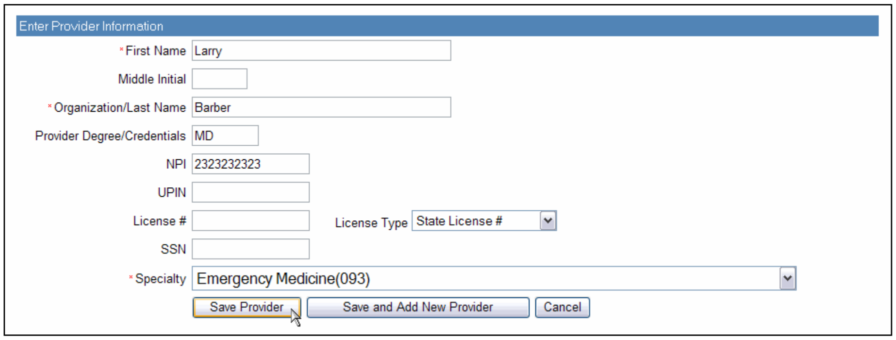
The Provider Information screen appears.


Enter Provider Information

* First Name: Larry
Middle Initial:
* Organization/Last Name: Barber
Provider Degree/Credentials: MD
NPI:
UPIN:
License #:
License Type: State License #
SSN:
* Specialty: Emergency Medicine(093)

Save Provider
Save and Add New Provider
Cancel

5. Enter the provider's ten-digit NPI number, and select the **Save Provider** button after NPI information is entered.


Enter Provider Information

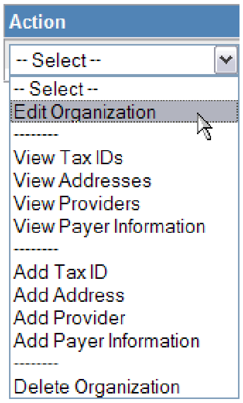
* First Name: Larry
Middle Initial:
* Organization/Last Name: Barber
Provider Degree/Credentials: MD
NPI: 2323232323
UPIN:
License #:
License Type: State License #
SSN:
* Specialty: Emergency Medicine(093)

Save Provider
Save and Add New Provider
Cancel

Set Up Tax ID Qualifier for Claim Entry

Note: *For existing providers already set up for Claim Entry, skip to Step 4 below.*

1. Select **Claims** > **Create**, and then click the "Provider Setup" link.
2. Select "Edit Organization" from the **Action** drop-down menu.

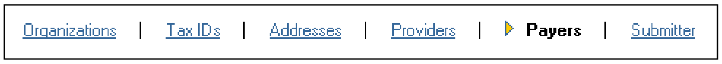

Action
-- Select --
-- Select --
Edit Organization

View Tax IDs
View Addresses
View Providers
View Payer Information

Add Tax ID
Add Address
Add Provider
Add Payer Information

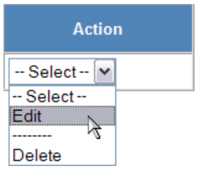
Delete Organization

3. Select the "Payers" link.


Organizations | Tax IDs | Addresses | Providers | ▶ Payers | Submitter

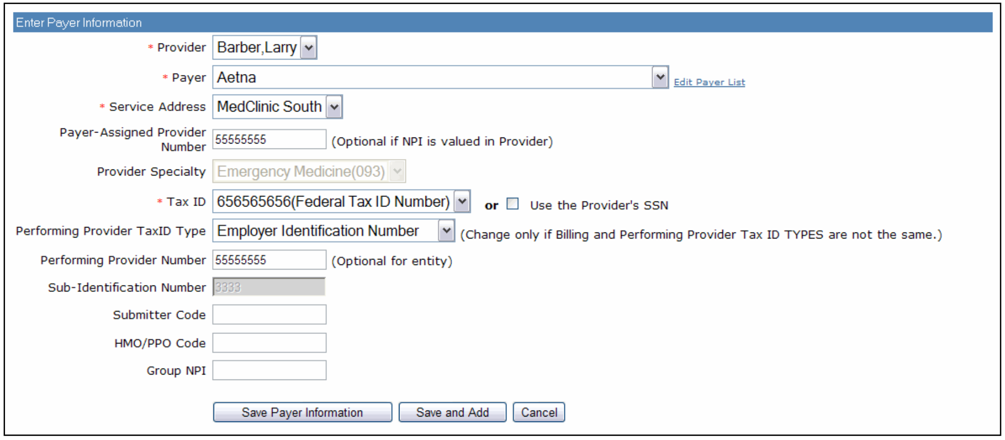
***Note**: **Performing Provider Tax ID Type** is not a required field under the "Payers" link, but if it is not entered, users must manually enter the Tax ID Qualifier tags in new claims forms' claim line level comments, or the claims will be rejected.*

4. Select "Edit" from the **Action** drop-down menu.


Action
-- Select --
-- Select --
Edit

Delete

The Payer Information screen will appear.

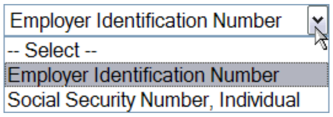


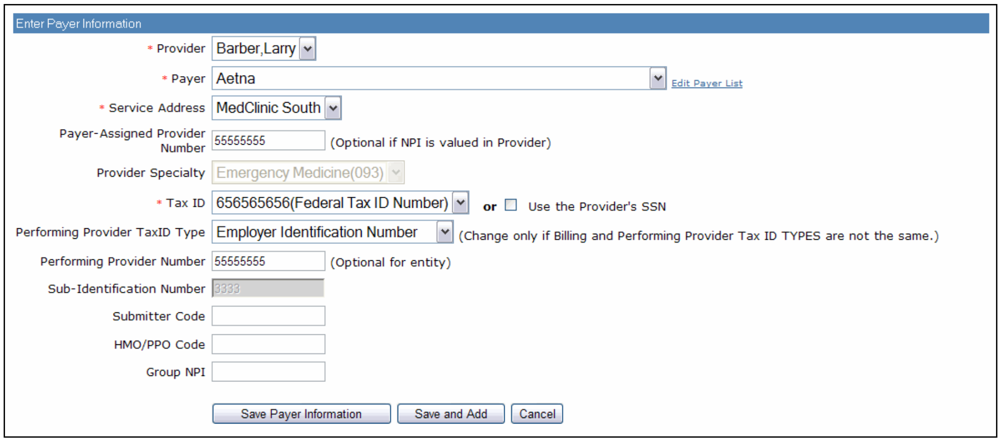
Enter Payer Information

* Provider	Barber,Larry	
* Payer	Aetna	Edit Payer List
* Service Address	MedClinic South	
Payer-Assigned Provider Number	55555555	(Optional if NPI is valued in Provider)
Provider Specialty	Emergency Medicine(093)	
* Tax ID	656565656(Federal Tax ID Number)	or ☐ Use the Provider's SSN
Performing Provider TaxID Type	Employer Identification Number	(Change only if Billing and Performing Provider Tax ID TYPES are not the same.)
Performing Provider Number	55555555	(Optional for entity)
Sub-Identification Number	3333	
Submitter Code		
HMO/PPO Code		
Group NPI		

Save Payer Information
Save and Add
Cancel

5. Select "Employer Identification Number" or "Social Security Number" as the Performing Provider Tax ID Type from the drop-down menu.


Employer Identification Number
-- Select --
Employer Identification Number
Social Security Number, Individual



Enter Payer Information

* Provider	Barber,Larry	
* Payer	Aetna	Edit Payer List
* Service Address	MedClinic South	
Payer-Assigned Provider Number	55555555	(Optional if NPI is valued in Provider)
Provider Specialty	Emergency Medicine(093)	
* Tax ID	656565656(Federal Tax ID Number)	or ☐ Use the Provider's SSN
Performing Provider TaxID Type	Employer Identification Number	(Change only if Billing and Performing Provider Tax ID TYPES are not the same.)
Performing Provider Number	55555555	(Optional for entity)
Sub-Identification Number	3333	
Submitter Code		
HMO/PPO Code		
Group NPI		

Save Payer Information
Save and Add
Cancel

6. Select **Save Payer Information** to save and exit or **Save and Add** to add the Tax ID Qualifier for other payers.

Claim Line Level Comments

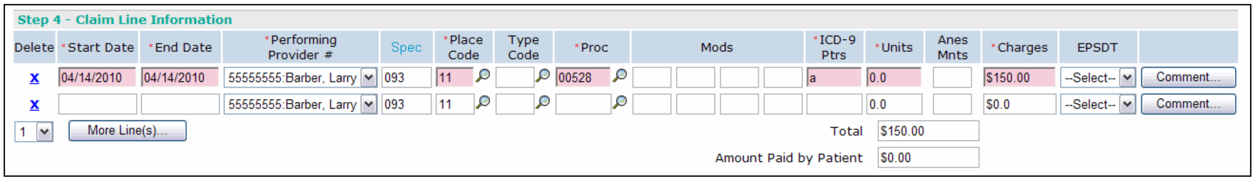
Claim line level comments can be used to pass claim data by using concatenated tags.

NPI and Tax ID Qualifier

After setting up provider NPI and Tax ID Qualifier information in the "Provider Setup" tool, all new claims forms will be automatically populated with the Provider NPI and Tax ID Qualifier data.

NPI and Tax ID Qualifier data must be present at the claim line level (Step 4 in the new claim form) for each procedure submitted in a claim for the claim to be processed.

The NPI and Tax ID Qualifier data tags will be displayed for the user in the "Comment…" window for line level comments.

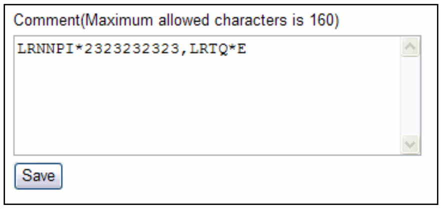


Step 4 - Claim Line Information

Delete	*Start Date	*End Date	*Performing Provider #	Spec	*Place Code	Type Code	*Proc	Mods	*ICD-9 Ptrs	*Units	Anes Mnts	*Charges	EPSDT	
x	04/14/2010	04/14/2010	55555555:Barber, Larry	093	11		00528		a	0.0		$150.00	--Select--	Comment...
x			55555555:Barber, Larry	093	11					0.0		$0.0	--Select--	Comment...

Total: $150.00
Amount Paid by Patient: $0.00

After selecting the **Comment…** button, the Additional Claim Line Information window will appear.



Comment(Maximum allowed characters is 160)

```
LRNNPI*2323232323,LRTQ*E
```

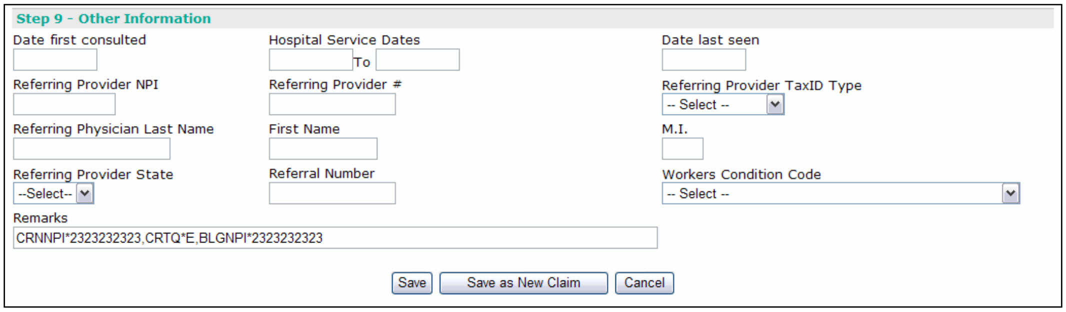
The NPI and Tax ID Qualifier tags will be visible in the **Comment** field.

Enter Attachment Information

There are many times when a provider needs to convey to a payer that a claim has attachment information associated with it. To convey that attachment information exists for a claim, the user should:

- Proceed to the end of the **Remarks** field.

***Note:** The Remarks field is not the Comment field. The **Remarks** field is at the bottom of the form under Other Information (see below).*



Step 9 - Other Information

Date first consulted:
Hospital Service Dates: To
Date last seen:
Referring Provider NPI:
Referring Provider #:
Referring Provider TaxID Type: -- Select --
Referring Physician Last Name:
First Name:
M.I.:
Referring Provider State: --Select--
Referral Number:
Workers Condition Code: -- Select --
Remarks: CRNNPI*2323232323,CRTQ*E,BLGNPI*2323232323

- Add a comma
- Enter the PWK* tag

The PWK* tag should then be followed by:

- a 1 position Documentation Indicator
- a 1 position Documentation Type Code
- a 3 to 30 position Attachment Control Number

1 position Documentation Indicator

The first character after the PWK* tag should be the Documentation Indicator. It should be one of the following codes:

Code	Meaning
1	By Mail
2	FAX
3	Available on Request at Provider Site

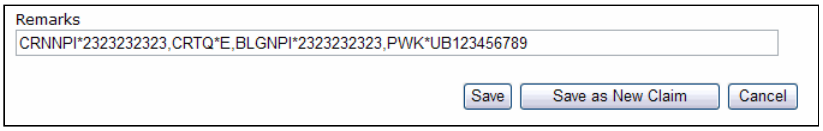
1 position Documentation Type Code

The second character after the PWK* tag should be the Documentation Type. It should be one of the following codes:

Code	Meaning
A	DME prescription
B	Explanation of benefits (Coordination of Benefits
C	Diagnostic report
D	Operative note
E	PEN certification
F	Ambulance certification
G	Physical therapy certification
H	Chiropractic justification
I	Prosthetics or Orthotic Certification
J	Oxygen prescription
Y	Multiple documentation items
Z	Other

3 to 30 position Attachment Control Number

Positions 3 through 30 after the PWK* tag should contain the attachment control number. This number, usually assigned by the provider, will be recorded on the attachment and will provide a cross-reference between the attachment and the claim.



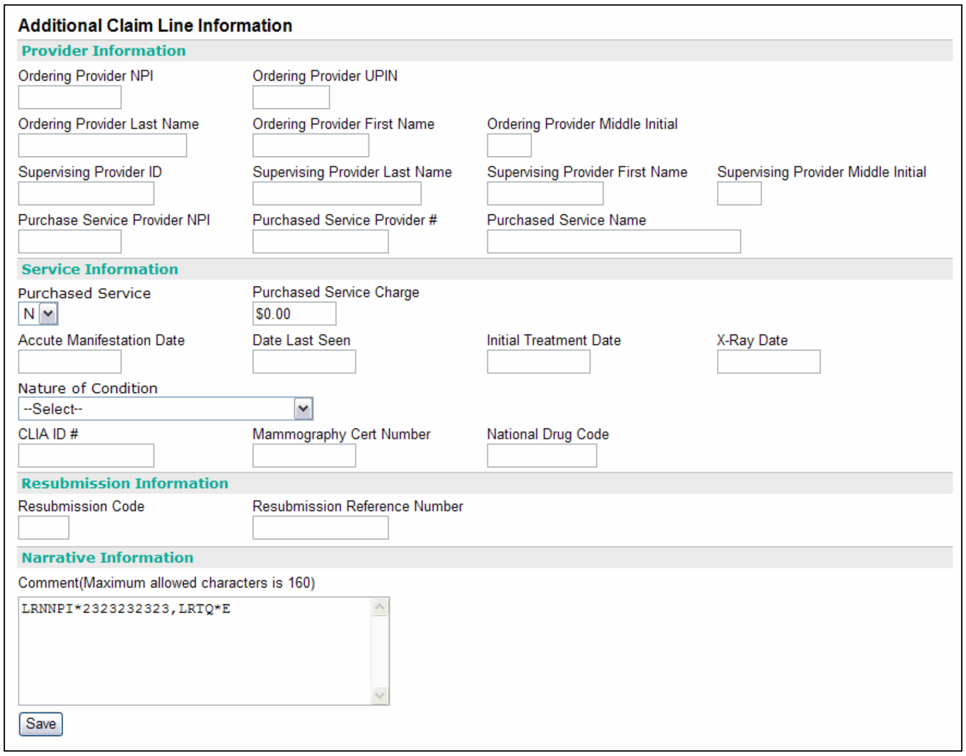
Remarks
CRNNPI*2323232323,CRTQ*E,BLGNPI*2323232323,PWK*UB123456789

Note: *In order to avoid claim rejections, it is important that the information following the PWK* tag is entered in the order as described above and using the values described above.*

Additional Claim Line Information Fields

While NPI and Tax ID Qualifier tags are required to process the claim, other claim information can be contained in claim line level comment tags as well.

When users enter values for any of the fields on the screen, tags will be automatically populated for them in the Comment section. (NPI and Tax ID Qualifier tags will already be present.)


Additional Claim Line Information
Provider Information
Ordering Provider NPI
Ordering Provider UPIN
Ordering Provider Last Name
Ordering Provider First Name
Ordering Provider Middle Initial
Supervising Provider ID
Supervising Provider Last Name
Supervising Provider First Name
Supervising Provider Middle Initial
Purchase Service Provider NPI
Purchased Service Provider #
Purchased Service Name
Service Information
Accute Manifestation Date
Date Last Seen
Initial Treatment Date
X-Ray Date
CLIA ID #
Mammography Cert Number
National Drug Code
Resubmission Information
Resubmission Code
Resubmission Reference Number
Narrative Information
Save

Purchased Service: N

Purchased Service Charge: $0.00

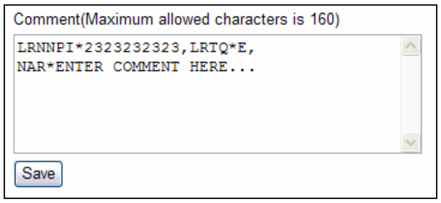
Nature of Condition: --Select--

Comment(Maximum allowed characters is 160)

```
LRNNPI*2323232323,LRTQ*E
```

User Comments

If users want to insert their own comments, they can by entering their comments after the auto-populated tags, separated by a comma and using the prefix "**NAR***" followed by the comments. See the example below.



Comment(Maximum allowed characters is 160)

```
LRNNPI*2323232323,LRTQ*E,
NAR*ENTER COMMENT HERE...
```

Patient List

Patient List is used to store, manage, and retrieve patient demographic information. When creating a claim for a patient whose data is already stored in the database, the stored data automatically populates fields on the claim form.

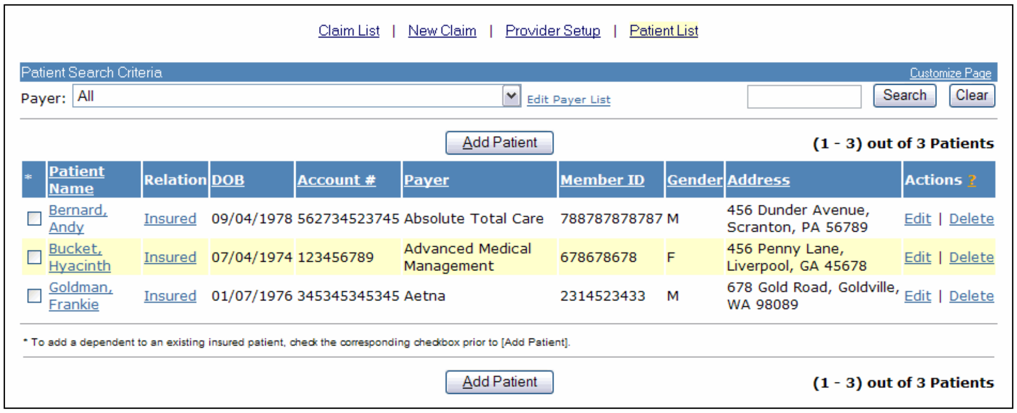
Before using Patient List for the first time, you must first complete the **Provider Setup** section on page 16. This is because for each patient record, you will be asked to select a payer, and this information is stored in Provider Setup.

Click "Customize" to specify what information you want to appear on the Patient List. Click the **Clear** button to clear the **Search** field.

Add a Patient

Follow these steps to add a patient record:

1. Select **Claims** > **Create** on the main menu, and then select **Patient List**. The Patient List screen appears. If there are any saved patient records, they will appear listed on the screen as shown on the illustration.


Claim List | New Claim | Provider Setup | Patient List
Patient Search Criteria
Customize Page
Edit Payer List
Search
Clear
Add Patient
Add Patient

Payer: All

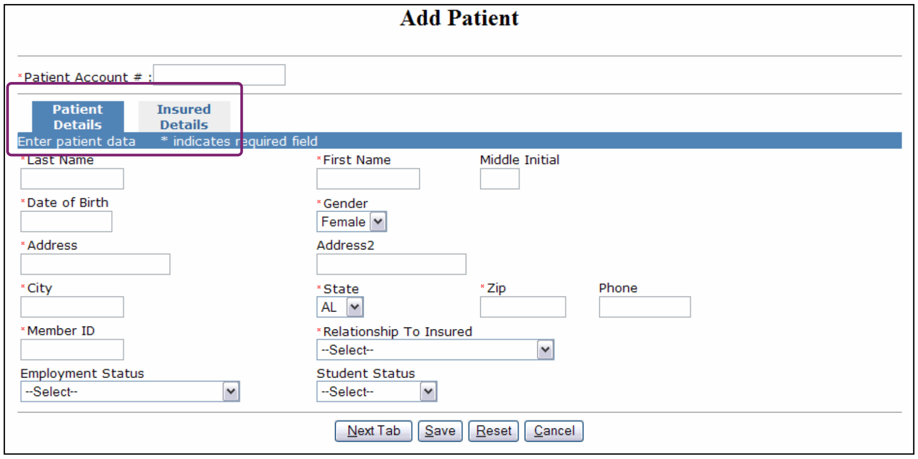
(1 - 3) out of 3 Patients

*	Patient Name	Relation	DOB	Account #	Payer	Member ID	Gender	Address	Actions ?
☐	Bernard, Andy	Insured	09/04/1978	562734523745	Absolute Total Care	788787878787	M	456 Dunder Avenue, Scranton, PA 56789	Edit | Delete
☐	Bucket, Hyacinth	Insured	07/04/1974	123456789	Advanced Medical Management	678678678	F	456 Penny Lane, Liverpool, GA 45678	Edit | Delete
☐	Goldman, Frankie	Insured	01/07/1976	345345345345	Aetna	2314523433	M	678 Gold Road, Goldville, WA 98089	Edit | Delete

* To add a dependent to an existing insured patient, check the corresponding checkbox prior to [Add Patient].

(1 - 3) out of 3 Patients

2. Select a payer from the Payer drop-down list and click **Add Patient**. The Add Patient screen appears.
3. Required fields are preceded by a red asterisk. Notice there are two tabs: Patient Details and Insurance Details. If the patient and the insured are not the same, then both sections must be completed before saving the patient record.


Add Patient
*Patient Account # :
Patient Details
Insured Details
Enter patient data
* indicates required field
*Last Name
*First Name
Middle Initial
*Date of Birth
*Address
Address2
*City
*Zip
Phone
*Member ID
Next Tab
Save
Reset
Cancel

*Gender: Female

*State: AL

*Relationship To Insured: --Select--

Employment Status: --Select--

Student Status: --Select--

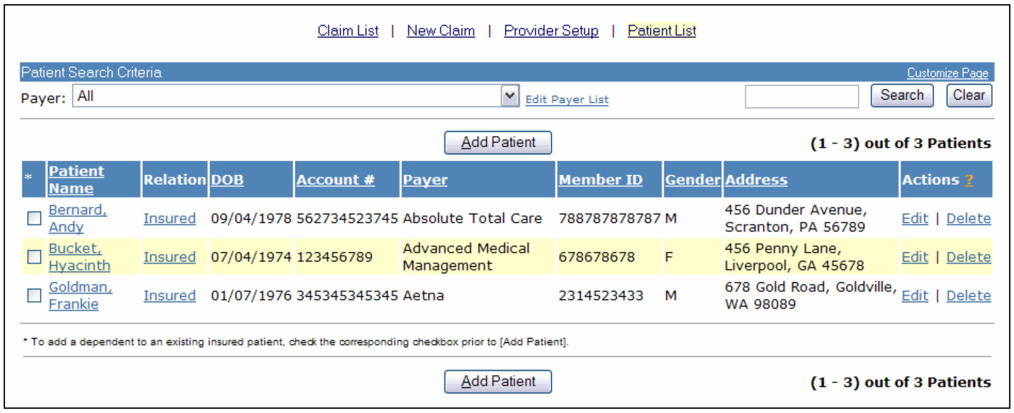
4. Enter the patient data and when you are finished, click **Save** to save the record. A Patient Entry Status message appears confirming the record has been saved.
5. To enter more patient records, return to the previous window by clicking **To Patient List** and repeat the previous steps.

6. To return to the patient record and make changes to it or to print the record, click **Previous Screen**. Once you enter a patient record, you can print a hard copy of it by pressing CTRL + P on your keyboard.

Search for a Patient Record

Follow these steps to search for a patient record:

1. Use the field next to the **Search** button to enter your search criteria. You can search for a patient by using any character string found on the record, such as First and Last name, Address, City, and State.



(1 - 3) out of 3 Patients

*	Patient Name	Relation	DOB	Account #	Payer	Member ID	Gender	Address	Actions ?
☐	Bernard, Andy	Insured	09/04/1978	562734523745	Absolute Total Care	788787878787	M	456 Dunder Avenue, Scranton, PA 56789	Edit | Delete
☐	Bucket, Hyacinth	Insured	07/04/1974	123456789	Advanced Medical Management	678678678	F	456 Penny Lane, Liverpool, GA 45678	Edit | Delete
☐	Goldman, Frankie	Insured	01/07/1976	345345345345	Aetna	2314523433	M	678 Gold Road, Goldville, WA 98089	Edit | Delete

* To add a dependent to an existing insured patient, check the corresponding checkbox prior to [Add Patient].

(1 - 3) out of 3 Patients

2. Press **Enter** on your keyboard or click **Search** to start the search.
3. If no patients are found or if the record you are trying to locate is not on the list, try expanding your search criteria by entering less specific data.

Edit a Patient Record

Follow these steps to edit a patient record:

1. If necessary, use the search procedure described above to find the patient record you wish to edit.
2. When you find the patient record, click on the hyperlinked Patient Name or the "Edit" link in the **Action** column. The Edit Patient window appears, showing the patient record.
3. Edit the data as needed and when you are finished, click **Save** to save your changes or click **Cancel** to leave the record unchanged.

Delete a Patient Record

Follow these steps to delete a patient record:

1. From the Patient List window, find the patient record you wish to delete and click the "Delete" link in the **Action** column. A confirmation dialog box appears asking if you want to delete the record.
2. Click **OK** to delete the record or click **Cancel** to keep the record.

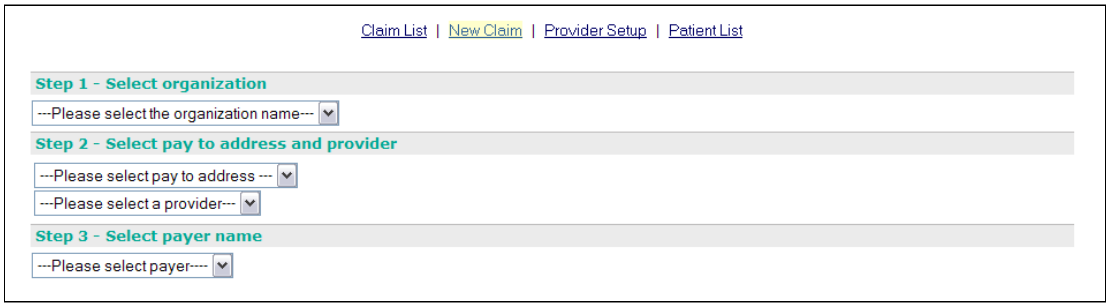
New Claim

New Claim allows you to enter claim information directly into a HCFA 1500 claim form.

***Note**: Before using New Claim for the first time, you must complete the **Provider Setup** section on page 16.*

Follow these steps to enter a new claim:

1. Select **Claims** > **Create**, and click the "New Claim" link.



Claim List | New Claim | Provider Setup | Patient List

Step 1 - Select organization

---Please select the organization name---

Step 2 - Select pay to address and provider

---Please select pay to address ---

---Please select a provider---

Step 3 - Select payer name

---Please select payer----

2. In Step 1, select the organization for which you wish to submit the claim.
3. In Step 2, select the pay to address and the provider name for the claim.
4. In Step 3, select the payer name from the drop-down menu. Step 4 appears.
5. Select a service address by clicking the option button next to it.
6. Click **Continue to Claim Data**. The claim data entry form appears.
7. Clicking the **Select Patient** button at the top of the screen opens a list of patients associated with the selected payer. If you select one of the patients from the list, the patient's demographic and payer data will populate the claim entry form. This step is optional.
8. Enter the ICD-9 Diagnosis Code(s) and Procedure information. Additional required fields are highlighted in pink and preceded by a red asterisk (*).

***Note**: To progress through the required fields, use these shortcuts:*
Forward: CTRL + >
Backward: CTRL + <

9. Complete the rest of the claim form.
10. To use the **Supplement Claims** feature, enter SUP* in the **Comment** field.
11. To print a paper copy of the claim form, press CTRL + P on your keyboard.
12. When you finish the form, select **Save** at the end of the page to save your work. A Save Confirmation screen appears with instructions for creating a new claim, adding the claim to a batch for submission, and submitting claims.
    - To submit another claim using the same provider and payer, click **New Claim** located in the upper right corner of the screen.
    - To submit a claim for a different provider or payer, click **Close** to return to the New Claim screen.
    - To create a claim batch, click **Close** and select "Claim List."

Claim List

Claim List allows you to view, edit, submit, and manage claims. Before using Claim List for the first time, you must have completed and saved one or more claim forms. Any claim can be edited and saved as a new claim, which helps to avoid re-keying the same information for multiple claims per patient or multiple patients with similar services.

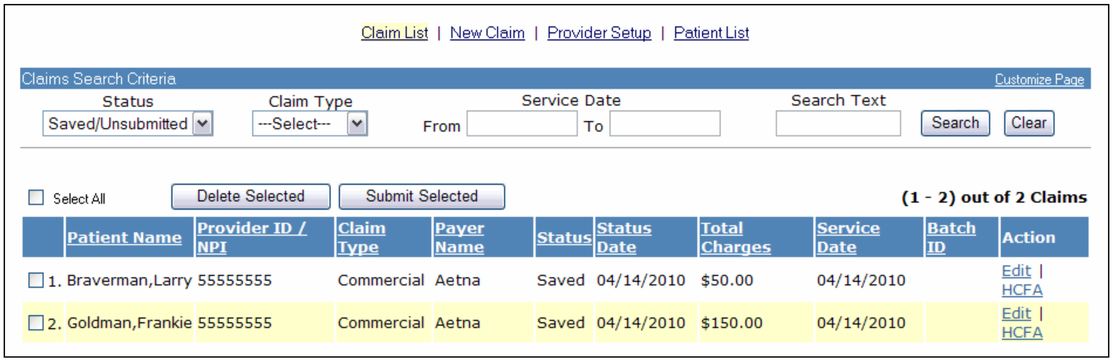
This service provides search criteria to assist in selecting groups of claims for submission. Click the **Clear** button to reset all fields to their original settings.

Click "Customize Page" to specify what information you want to appear on the Claim List. You can sort the list of claims by clicking on any of the column headings.

Use Claim List

Follow these steps to work with claims:

1. Select **Claims** > **Create**, and click the "Claim List" link. If any claims have been created and saved they will appear listed on the screen as shown below:



Status: Saved/Unsubmitted
Claim Type: ---Select---
Service Date From: To:
Search Text:

(1 - 2) out of 2 Claims

	Patient Name	Provider ID / NPI	Claim Type	Payer Name	Status	Status Date	Total Charges	Service Date	Batch ID	Action
☐ 1.	Braverman,Larry	55555555	Commercial	Aetna	Saved	04/14/2010	$50.00	04/14/2010		Edit | HCFA
☐ 2.	Goldman,Frankie	55555555	Commercial	Aetna	Saved	04/14/2010	$150.00	04/14/2010		Edit | HCFA

   To search for a claim, use the **Claims Search Criteria** fields located at the top of the screen.

   - Click **Search** to perform a search.
   - Click **Clear** to reset all search fields to their original settings.
   - The **Search Text** box can be used to search on data contained in a claim, like "Patient Name" and "Provider ID."
   - Click **Clear** and then click **Search** to show the full claim list.

2. Check the box to the left of the claim you wish to submit or delete, or click "Edit" next to the claim you wish to edit. When you select the action you wish to take, the claim will appear in a separate window.
3. To the right of the claim, click "HCFA" to view the HCFA format of this claim.

Check Claims

Overview

The **Claim Status** service allows you to check the status of a previously submitted claim, regardless of whether the claim was submitted manually or electronically. This tool allows you to manage claim rejections, reimbursements, and online claim adjustments, which eliminates having to re-key information and generate duplicate forms.

Key Features

- Fast access to real-time claim status information for multiple payers
- Individual and batch functionality for improve productivity
- Time-saving batch management features: sort, move, copy, delete
- Ability to track claims throughout the reimbursement cycle
- Verify that claims have been received by payers
- Quickly determine the status of claims
- Expedite follow up on rejected claims
- Obtain enrollment forms by selecting **Setup** > **More** and clicking the "Payer Enrollment" link

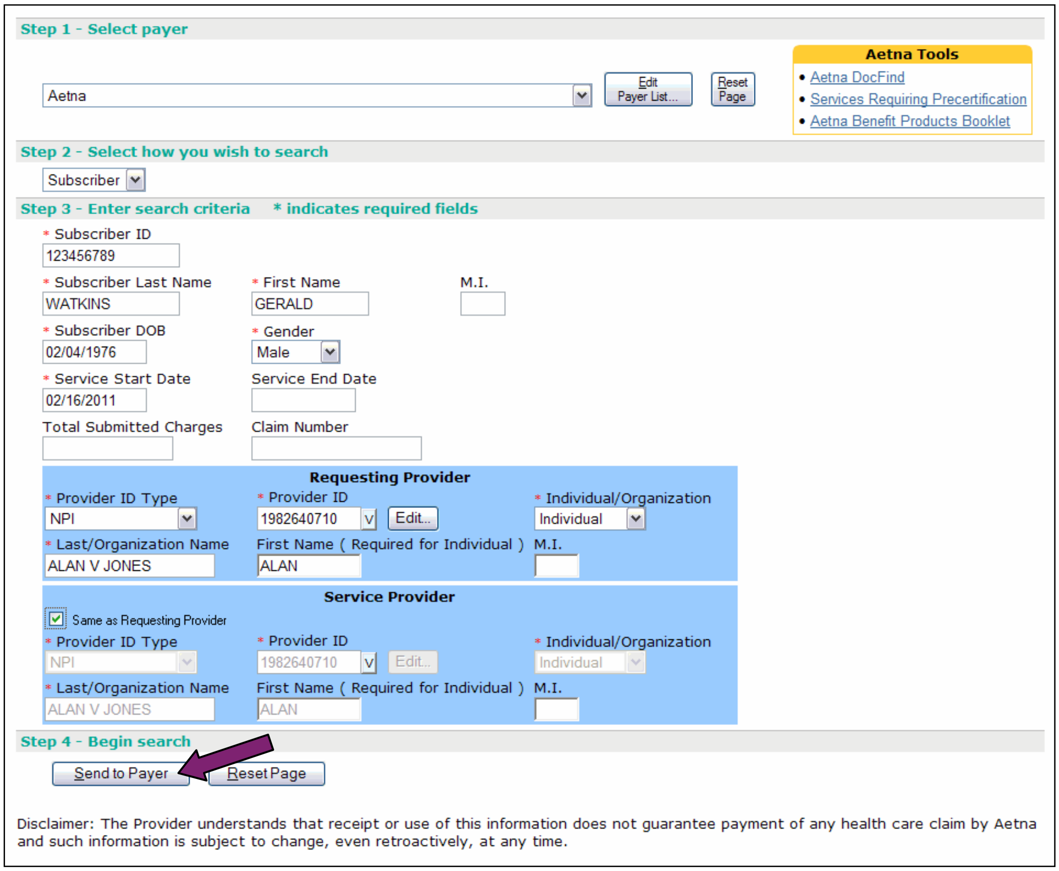
Check a Claim's Status

1. Select **Claims** > **Claim Status** on the main menu.
2. Select a payer.

***Note**: The claim status request screen varies depending on the payer.*

3. Select a search type (if applicable).
4. Enter search criteria to locate the claim.
5. Enter requesting provider and service provider information (if applicable). To find a provider ID, click the **Edit** button.
6. If the **Requesting Provider** is the same as the **Service Provider**, click the "Same as Requesting Provider" check box. This populates the Service Provider fields with Requesting Provider information.

7. Click **Send to Payer** to process your query.



Step 1 - Select payer

Aetna

Aetna Tools

- Aetna DocFind
- Services Requiring Precertification
- Aetna Benefit Products Booklet

Step 2 - Select how you wish to search

Subscriber

Step 3 - Enter search criteria * indicates required fields

* Subscriber ID: 123456789

* Subscriber Last Name: WATKINS
* First Name: GERALD
M.I.:

* Subscriber DOB: 02/04/1976
* Gender: Male

* Service Start Date: 02/16/2011
Service End Date:

Total Submitted Charges:
Claim Number:

Requesting Provider

* Provider ID Type: NPI
* Provider ID: 1982640710
* Individual/Organization: Individual
* Last/Organization Name: ALAN V JONES
First Name (Required for Individual): ALAN
M.I.:

Service Provider

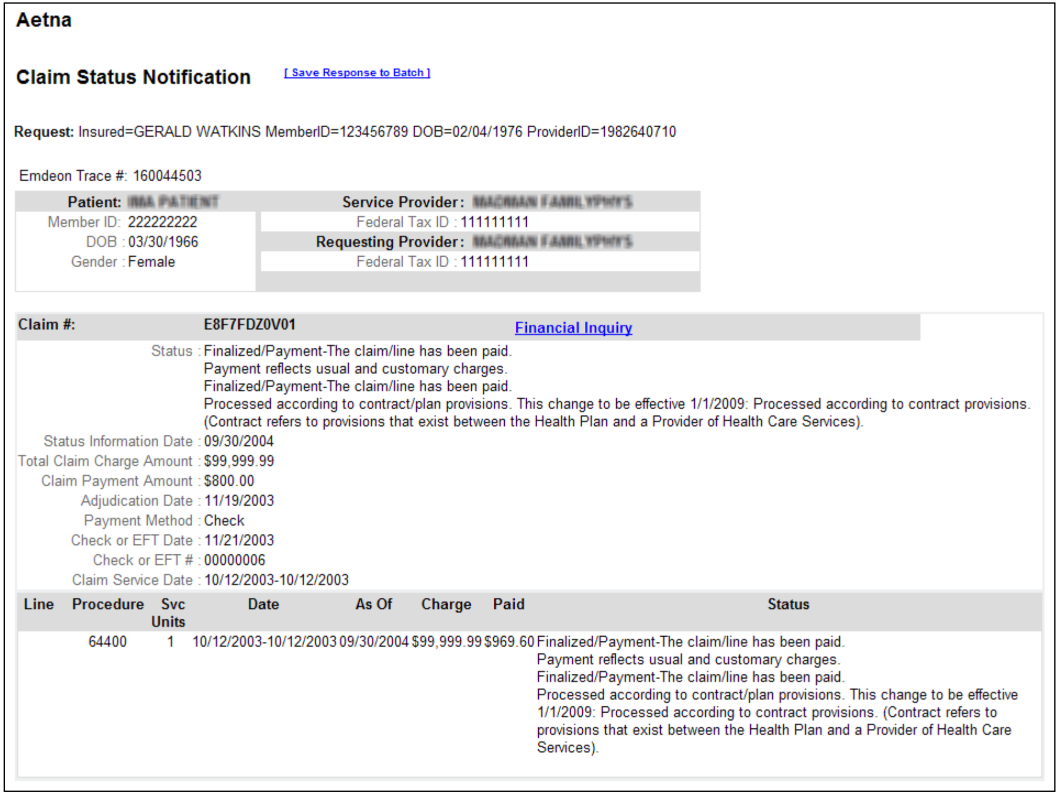
☑ Same as Requesting Provider

* Provider ID Type: NPI
* Provider ID: 1982640710
* Individual/Organization: Individual
* Last/Organization Name: ALAN V JONES
First Name (Required for Individual): ALAN
M.I.:

Step 4 - Begin search

Disclaimer: The Provider understands that receipt or use of this information does not guarantee payment of any health care claim by Aetna and such information is subject to change, even retroactively, at any time.

The following illustration shows results of this inquiry.



Aetna

Claim Status Notification [Save Response to Batch]

Request: Insured=GERALD WATKINS MemberID=123456789 DOB=02/04/1976 ProviderID=1982640710

Emdeon Trace #: 160044503

Patient: [redacted]
Member ID: 222222222
DOB : 03/30/1966
Gender : Female

Service Provider: [redacted]
Federal Tax ID : 111111111
Requesting Provider: [redacted]
Federal Tax ID : 111111111

Claim #: E8F7FDZ0V01 Financial Inquiry

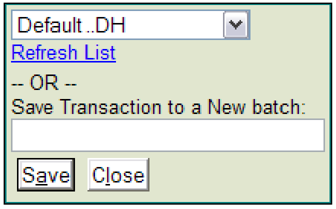
Status : Finalized/Payment-The claim/line has been paid.
Payment reflects usual and customary charges.
Finalized/Payment-The claim/line has been paid.
Processed according to contract/plan provisions. This change to be effective 1/1/2009: Processed according to contract provisions. (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services).
Status Information Date : 09/30/2004
Total Claim Charge Amount : $99,999.99
Claim Payment Amount : $800.00
Adjudication Date : 11/19/2003
Payment Method : Check
Check or EFT Date : 11/21/2003
Check or EFT # : 00000006
Claim Service Date : 10/12/2003-10/12/2003

Line	Procedure	Svc Units	Date	As Of	Charge	Paid	Status
	64400	1	10/12/2003-10/12/2003	09/30/2004	$99,999.99	$969.60	Finalized/Payment-The claim/line has been paid. Payment reflects usual and customary charges. Finalized/Payment-The claim/line has been paid. Processed according to contract/plan provisions. This change to be effective 1/1/2009: Processed according to contract provisions. (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services).

8. Click “Save Response to Batch” to save the response to a new or existing batch.

Note: *The “Save Response to Batch” link appears only if batching is off.*

The following window appears:



Do one of the following:

- To save the response to an existing batch, choose the batch from the list. Click “Refresh List” if your batch does not appear in the list.
- To save the response to a new batch, enter the batch name.

Click **Save**.

9. Click **Return to Previous** to return to the Claim Status request screen. Do not click the **Back** button on your browser since this may cause unpredictable results.

Claim Status Information

Emdeon Office provides the following claim status information:

- Claim status
- Claim number
- Trace number
- Patient/insured data
- Provider data
- Claim amount
- Payment amount

Claim Adjustment

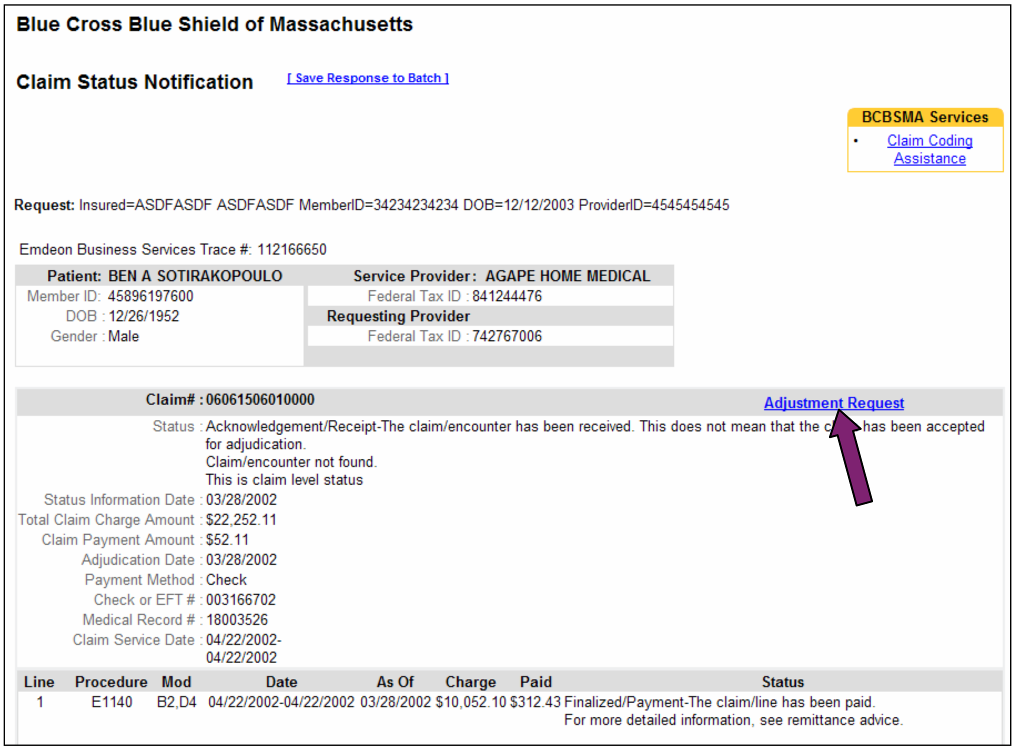
You can request a claim adjustment for some payers using Claim Status or Batch Manager.

Note*: Claim Adjustment is only available for the payers who support the function.*

Request a Claim Adjustment from Check Claims

1. Select **Claims** > **Claim Status** from the main menu.
2. Select a payer.
3. Enter search criteria in the remaining fields on the form.
4. Click **Send to Payer**. After a few seconds, a Claim Status Notification appears with one or more claims matching your search criteria.

5. Locate the claim you want to modify and click the "Adjustment Request" link.



Blue Cross Blue Shield of Massachusetts

Claim Status Notification

Request: Insured=ASDFASDF ASDFASDF MemberID=34234234234 DOB=12/12/2003 ProviderID=4545454545

Emdeon Business Services Trace #: 112166650

Patient: BEN A SOTIRAKOPOULO
Member ID: 45896197600
DOB : 12/26/1952
Gender : Male

Service Provider: AGAPE HOME MEDICAL
Federal Tax ID : 841244476

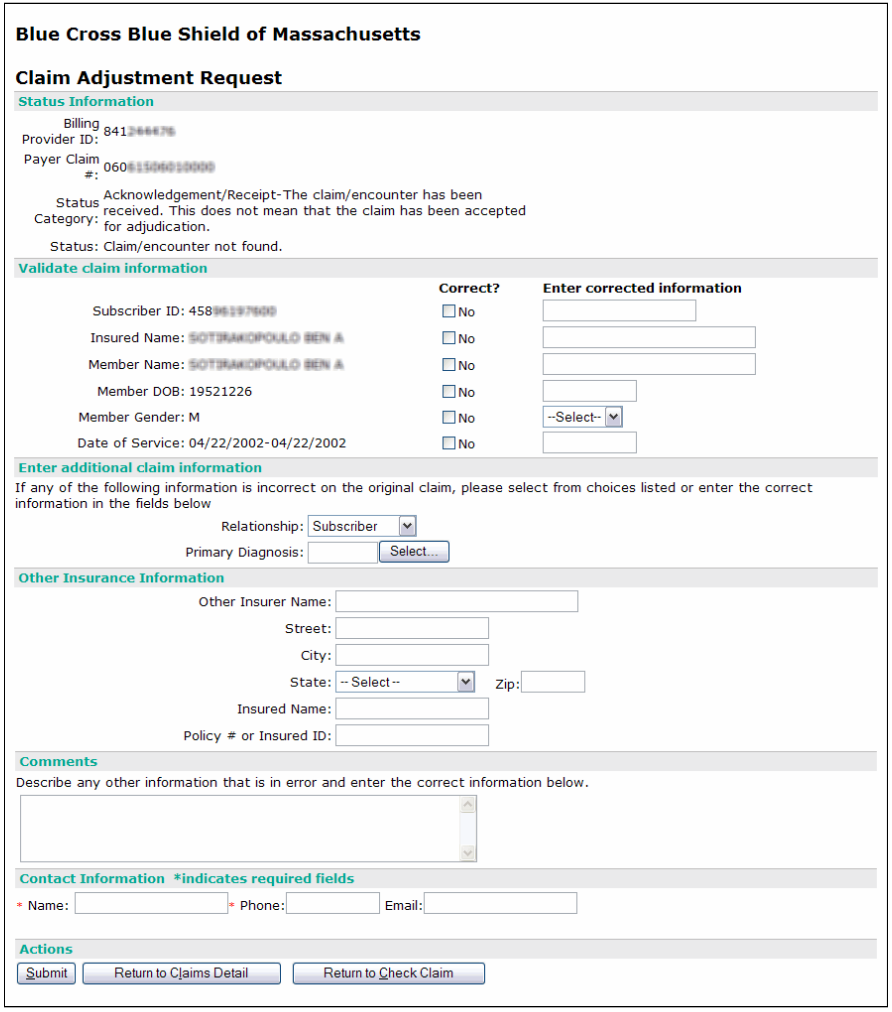
Requesting Provider
Federal Tax ID : 742767006

Claim# : 06061506010000

Status : Acknowledgement/Receipt-The claim/encounter has been received. This does not mean that the c has been accepted for adjudication.
Claim/encounter not found.
This is claim level status
Status Information Date : 03/28/2002
Total Claim Charge Amount : $22,252.11
Claim Payment Amount : $52.11
Adjudication Date : 03/28/2002
Payment Method : Check
Check or EFT # : 003166702
Medical Record # : 18003526
Claim Service Date : 04/22/2002-04/22/2002

Line	Procedure	Mod	Date	As Of	Charge	Paid	Status
1	E1140	B2,D4	04/22/2002-04/22/2002	03/28/2002	$10,052.10	$312.43	Finalized/Payment-The claim/line has been paid. For more detailed information, see remittance advice.

A Claim Adjustment Request data entry form appears showing the patient and claim information.



Blue Cross Blue Shield of Massachusetts

Claim Adjustment Request

Status Information

Billing Provider ID: 841[redacted]
Payer Claim #: 060[redacted]
Status Category: Acknowledgement/Receipt-The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.
Status: Claim/encounter not found.

Validate claim information

	Correct?	Enter corrected information
Subscriber ID: 458[redacted]	☐ No	
Insured Name: [redacted]	☐ No	
Member Name: [redacted]	☐ No	
Member DOB: 19521226	☐ No	
Member Gender: M	☐ No	--Select--
Date of Service: 04/22/2002-04/22/2002	☐ No	

Enter additional claim information

If any of the following information is incorrect on the original claim, please select from choices listed or enter the correct information in the fields below

Relationship: Subscriber
Primary Diagnosis:

Other Insurance Information

Other Insurer Name:
Street:
City:
State: -- Select -- Zip:
Insured Name:
Policy # or Insured ID:

Comments

Describe any other information that is in error and enter the correct information below.

Contact Information *indicates required fields

* Name: * Phone: Email:

Actions

6. In the **Validate Claim Information** section, review the data elements carried over from the claim. If you want to modify the information, click **No** in the **Correct?** column and type the correct information in the box.
7. The next step varies depending on the payer:
    - *Blue Cross Blue Shield of Massachusetts*: Update information in the **Enter Additional Claim Information** and **Other Insurance Information** sections if necessary.
    - *Coventry plans*: Indicate the Reason for Adjustment by selecting a value from the list. Indicate all the claim lines that need to be modified, if applicable, and include any pertinent comments for each modified item.
8. Use the **Comments** field to type any additional information that may be relevant to the claim, up to 250 characters. Be as specific as possible in making your request. If none of the data elements referenced above pertain to your inquiry, you can complete the **Comments** section only.
9. In the **Contact Information** section, type the name and phone number of a contact person.
10. When you finish entering the correct claim data, click **Submit**. A Claim Adjustment Confirmation appears. Use the browser's **Print** button to print the confirmation notice for future reference.
11. Next, do one of the following:
    - To return to the previous Claim Status Notification screen, click **Return to Claims Detail**. This is the claim detail screen you created the adjustment request from.
    - To return to the Claim Status screen, click **Return to Check Claim**. This will take you to a new input screen where you can inquire on another claim.

Request a Claim Adjustment from Batch Manager

1. Select **Batch Manager** from the main menu.
2. Select or search for the batch that contains the transaction(s) you want to modify.
3. On the Batch Inquiry screen, click the link in the **Responses** column. The Claim Status Notification appears.
4. Click the "Adjustment Request" link. The Claim Adjustment Request data entry form appears.
5. Follow steps 6–10 above in the **Request a Claim Adjustment from Check Claims** section.

Claim Financial Inquiry

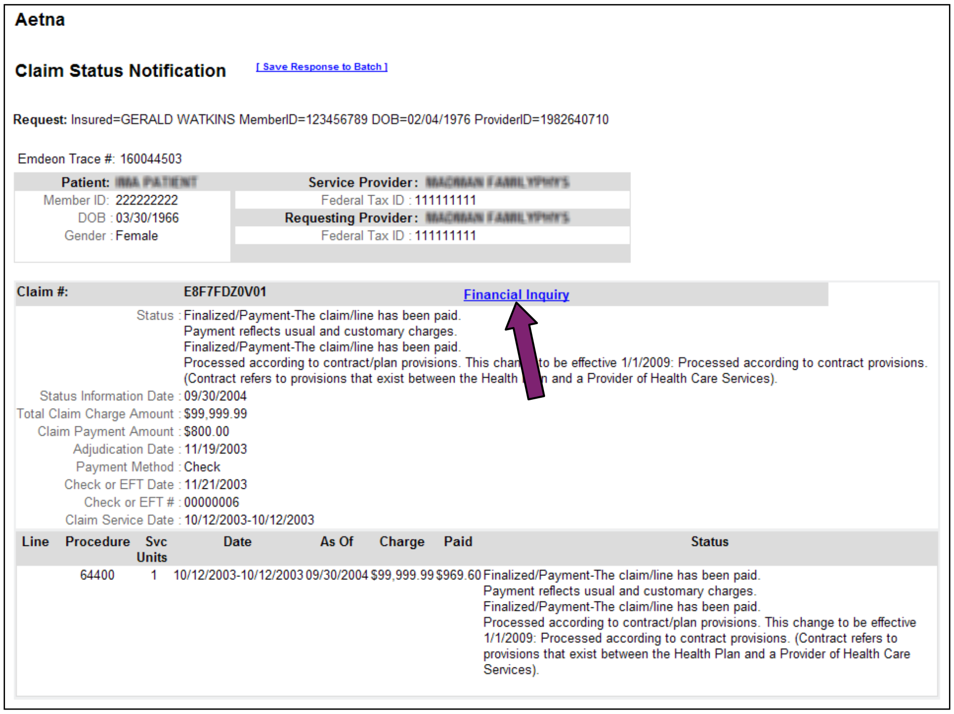
The Claim Financial Inquiry (CFI) transaction allows you to receive a more detailed response when checking the status of a claim. The CFI transaction occurs after a Claim Status Notification has been returned by a claim status transaction.

Note*: The CFI transaction is only available for the payers who support the transaction.*

Request a Claim Financial Inquiry

1. Select **Claims** > **Claim Status** from the main menu.
2. Select a payer.
3. Enter search criteria in the remaining fields on the form.
4. Click **Send to Payer**. After a few seconds, a Claim Status Notification appears with one or more claims matching your search criteria.
5. Select the claim you want to receive a CFI response for.

6. If the payer supports the CFI transaction, there will be a “Financial Inquiry” link near the **Claim #** section. Click the “Financial Inquiry” link.



Aetna

Claim Status Notification [Save Response to Batch]

Request: Insured=GERALD WATKINS MemberID=123456789 DOB=02/04/1976 ProviderID=1982640710

Emdeon Trace #: 160044503

Patient: [redacted]
Member ID: 222222222
DOB : 03/30/1966
Gender : Female

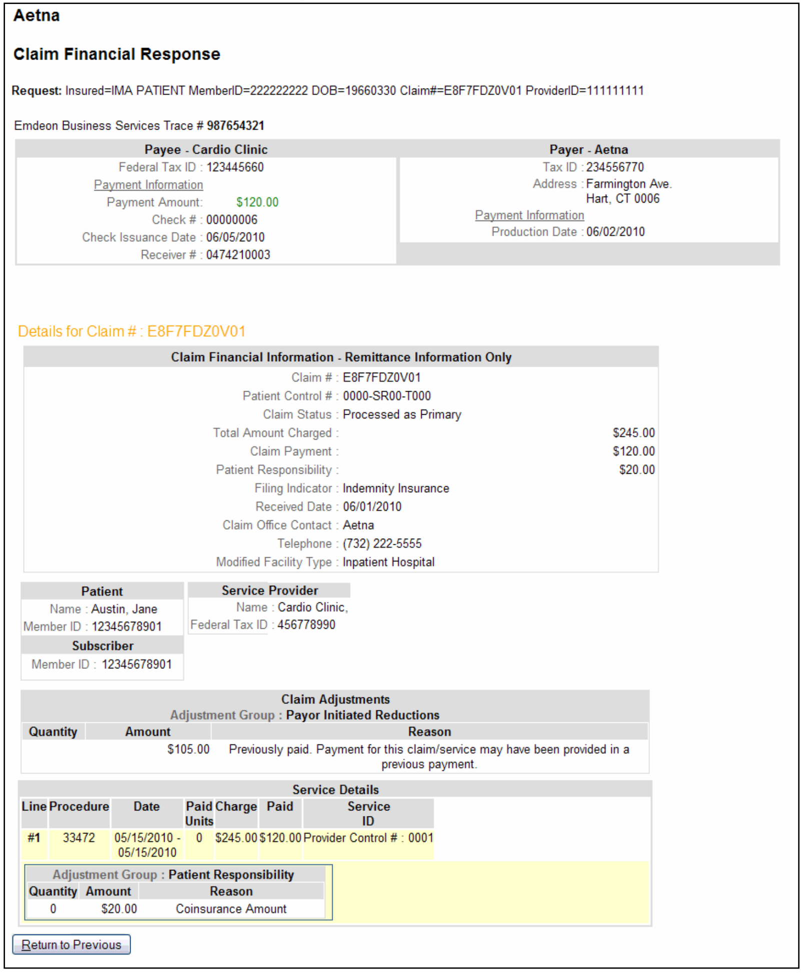
Service Provider: [redacted]
Federal Tax ID : 111111111
Requesting Provider: [redacted]
Federal Tax ID : 111111111

Claim #: E8F7FDZ0V01 Financial Inquiry

Status : Finalized/Payment-The claim/line has been paid.
Payment reflects usual and customary charges.
Finalized/Payment-The claim/line has been paid.
Processed according to contract/plan provisions. This chan to be effective 1/1/2009: Processed according to contract provisions.
(Contract refers to provisions that exist between the Health n and a Provider of Health Care Services).
Status Information Date : 09/30/2004
Total Claim Charge Amount : $99,999.99
Claim Payment Amount : $800.00
Adjudication Date : 11/19/2003
Payment Method : Check
Check or EFT Date : 11/21/2003
Check or EFT # : 00000006
Claim Service Date : 10/12/2003-10/12/2003

Line	Procedure	Svc Units	Date	As Of	Charge	Paid	Status
	64400	1	10/12/2003-10/12/2003	09/30/2004	$99,999.99	$969.60	Finalized/Payment-The claim/line has been paid. Payment reflects usual and customary charges. Finalized/Payment-The claim/line has been paid. Processed according to contract/plan provisions. This change to be effective 1/1/2009: Processed according to contract provisions. (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services).

The Claim Financial Response will be returned.



Aetna

Claim Financial Response

Request: Insured=IMA PATIENT MemberID=222222222 DOB=19660330 Claim#=E8F7FDZ0V01 ProviderID=111111111

Emdeon Business Services Trace # **987654321**

Payee - Cardio Clinic
Federal Tax ID : 123445660
Payment Information
Payment Amount: $120.00
Check # : 00000006
Check Issuance Date : 06/05/2010
Receiver # : 0474210003

Payer - Aetna
Tax ID : 234556770
Address : Farmington Ave.
Hart, CT 0006
Payment Information
Production Date : 06/02/2010

Details for Claim # : E8F7FDZ0V01

Claim Financial Information - Remittance Information Only
Claim # : E8F7FDZ0V01
Patient Control # : 0000-SR00-T000
Claim Status : Processed as Primary
Total Amount Charged : $245.00
Claim Payment : $120.00
Patient Responsibility : $20.00
Filing Indicator : Indemnity Insurance
Received Date : 06/01/2010
Claim Office Contact : Aetna
Telephone : (732) 222-5555
Modified Facility Type : Inpatient Hospital

Patient
Name : Austin, Jane
Member ID : 12345678901

Subscriber
Member ID : 12345678901

Service Provider
Name : Cardio Clinic,
Federal Tax ID : 456778990

Claim Adjustments
Adjustment Group : **Payor Initiated Reductions**

Quantity	Amount	Reason
	$105.00	Previously paid. Payment for this claim/service may have been provided in a previous payment.

Service Details

Line	Procedure	Date	Paid Units	Charge	Paid	Service ID
#1	33472	05/15/2010 - 05/15/2010	0	$245.00	$120.00	Provider Control # : 0001

Adjustment Group : **Patient Responsibility**

Quantity	Amount	Reason
0	$20.00	Coinsurance Amount

7. Click the **Return to Previous** button to return to the Claim Status Notification response.

Supplement Claims

Overview

This section describes how to supplement primary and secondary claims and how to generate and submit secondary claims through Emdeon Office. It is assumed that you are already familiar with the **Send Claims** feature in Emdeon Office (page 9).

Secondary Claims

A secondary claim is a request for payment to a secondary payer after the primary payer has met its portion of responsibility for the claim.

A secondary claim is created by merging data from:

1. Existing data on the primary claim and
2. Supplemental data entered by Emdeon Office users through the Supplement Claims feature. This supplemental data is obtained from printed EOBs and electronic remittance files sent by primary payers.

Secondary Claims in Office

Currently, there are two ways to create secondary claims in Office: through Supplement Claims and through Reporting & Analytics (see **Secondary Claims** on page 169 in the Reporting & Analytics section). This section describes how to create secondary claims through Supplement Claims, but there are some fundamental differences between the two methods.

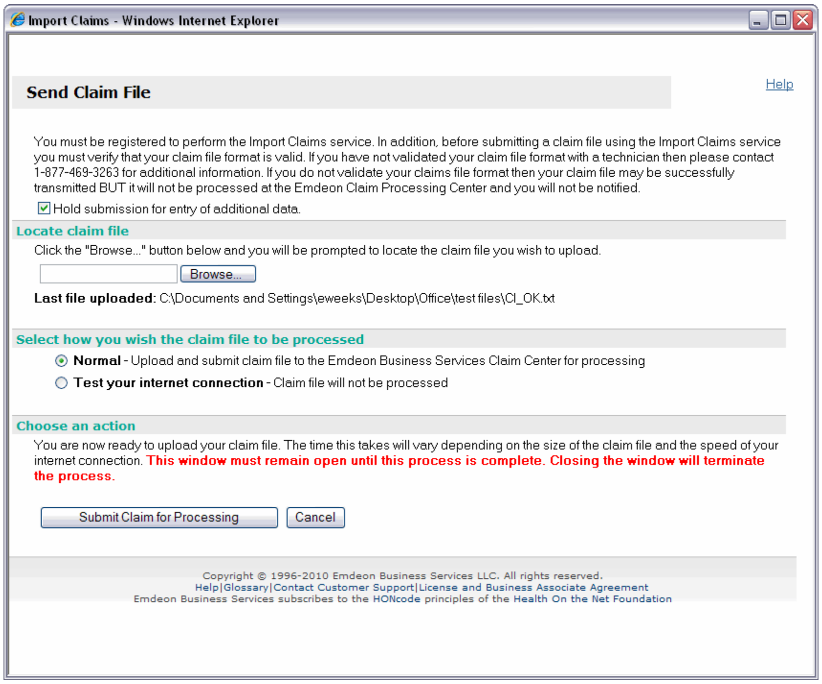
Feature	Secondary Claims: Supplement Claims	Secondary Claims: Reporting & Analytics
Create secondary claim	Upload a primary claim for the purpose of converting it to a secondary claim to submit to another payer. Make changes needed to create the secondary claim immediately after you upload the claim. The changes you make are independent of the submission of the primary claim to the primary payer.	Create a secondary claim only from a primary claim that has already been submitted through the Emdeon clearinghouse to the payer. Using this method, you will upload the claim once, not twice.
Change field values	Make changes only to certain fields	Make changes to any field
Submission format	Submit claims in multiple formats	Submit claims only in ANSI X12 4010 or NSF+ format

Secondary Claims Workflow

The following steps describe the typical workflow for a batch file containing claims needing to be supplemented and sent to secondary payers:

1. Select **Claims** > **Import**. Click the **Proceed to Next Step** button.

2. On the Send Claim File screen, select the “Hold submission for entry of additional data” check box, as shown on the next illustration.


Import Claims - Windows Internet Explorer
Help
Browse...
Submit Claim for Processing
Cancel
Help|Glossary|Contact Customer Support|License and Business Associate Agreement

Send Claim File

You must be registered to perform the Import Claims service. In addition, before submitting a claim file using the Import Claims service you must verify that your claim file format is valid. If you have not validated your claim file format with a technician then please contact 1-877-469-3263 for additional information. If you do not validate your claims file format then your claim file may be successfully transmitted BUT it will not be processed at the Emdeon Claim Processing Center and you will not be notified.

☑ Hold submission for entry of additional data.

Locate claim file

Click the "Browse..." button below and you will be prompted to locate the claim file you wish to upload.

Last file uploaded: C:\Documents and Settings\eweeks\Desktop\Office\test files\CI_OK.txt

Select how you wish the claim file to be processed

● **Normal** - Upload and submit claim file to the Emdeon Business Services Claim Center for processing
○ **Test your internet connection** - Claim file will not be processed

Choose an action

You are now ready to upload your claim file. The time this takes will vary depending on the size of the claim file and the speed of your internet connection. **This window must remain open until this process is complete. Closing the window will terminate the process.**

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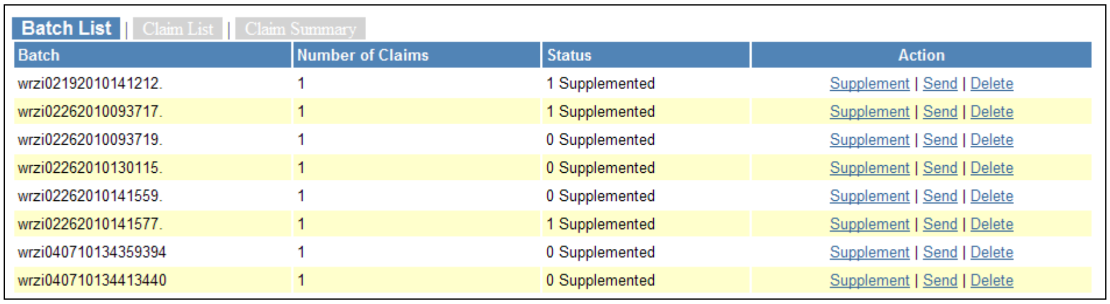
3. Using the **Browse...** button, locate the file to be uploaded and click **Submit Claim for Processing**.
4. Return to the home page and select **Claims** > **Supplement** to open the Supplement Claims application. A list of batches appears.



Batch	Number of Claims	Status	Action
wrzi02192010141212.	1	1 Supplemented	Supplement | Send | Delete
wrzi02262010093717.	1	1 Supplemented	Supplement | Send | Delete
wrzi02262010093719.	1	0 Supplemented	Supplement | Send | Delete
wrzi02262010130115.	1	0 Supplemented	Supplement | Send | Delete
wrzi02262010141559.	1	0 Supplemented	Supplement | Send | Delete
wrzi02262010141577.	1	1 Supplemented	Supplement | Send | Delete
wrzi040710134359394	1	0 Supplemented	Supplement | Send | Delete
wrzi040710134413440	1	0 Supplemented	Supplement | Send | Delete

5. Select the batch containing the claims you would like to supplement by clicking the appropriate “Supplement” link.
6. Enter supplemental data using the various data entry screens.
7. When you are finished working with the claims, return to the Batch List and click “Send” to submit the batch for processing.

Alternate Workflow using Claim Entry

When claims are entered through the Claim Entry feature:

1. Enter claims through **Claims** > **Create**, making sure to indicate “Sup*” in the **Remarks** field. This tells the system to hold submission of the claim to allow entry of data for secondary claims.
2. Execute batching/claims submission from Claim Entry as usual. Files tagged with “Sup*” in the **Remarks** field are not sent for processing.
3. Proceed to **Claims** > **Supplement** to supplement and submit claims using steps 4-7 listed above. When claims are sent through **Supplement**, the system removes the “Sup*” tag from the claim and releases it to NEIC for processing.

Email Notifications

After you upload a supplemental batch, you will receive an email notification indicating the batch is pending and that you need to supplement, send, or delete the batch. If the batch remains in a pending state for over four days, you will receive additional email notifications reminding you that action is needed.

Troubleshooting Guide

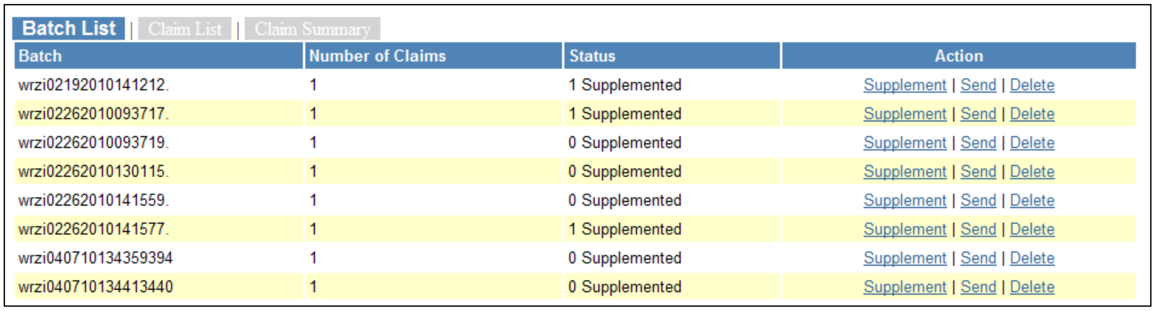
For a list of common issues and error messages you may encounter when working with Supplement Claims, refer to the **Troubleshooting Guide** on page 56.

Output Format

At the bottom left of every screen, there is a note indicating the type of output format used: NSF 2.5, NSF+, or 4010. The Claim Level and Line Level Entries screens will vary depending on which output format is used.

Batch List

When you select **Claims** > **Supplement**, a list of batches that have been flagged as needing to be held for the entry of supplemental data appears. The **Status** column indicates the number of claims that have already been supplemented in each batch.

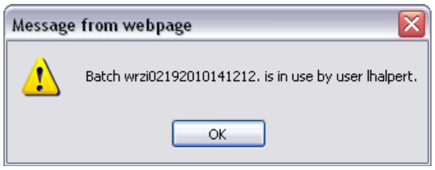


Batch	Number of Claims	Status	Action
wrzi02192010141212.	1	1 Supplemented	Supplement | Send | Delete
wrzi02262010093717.	1	1 Supplemented	Supplement | Send | Delete
wrzi02262010093719.	1	0 Supplemented	Supplement | Send | Delete
wrzi02262010130115.	1	0 Supplemented	Supplement | Send | Delete
wrzi02262010141559.	1	0 Supplemented	Supplement | Send | Delete
wrzi02262010141577.	1	1 Supplemented	Supplement | Send | Delete
wrzi040710134359394	1	0 Supplemented	Supplement | Send | Delete
wrzi040710134413440	1	0 Supplemented	Supplement | Send | Delete

Action Column

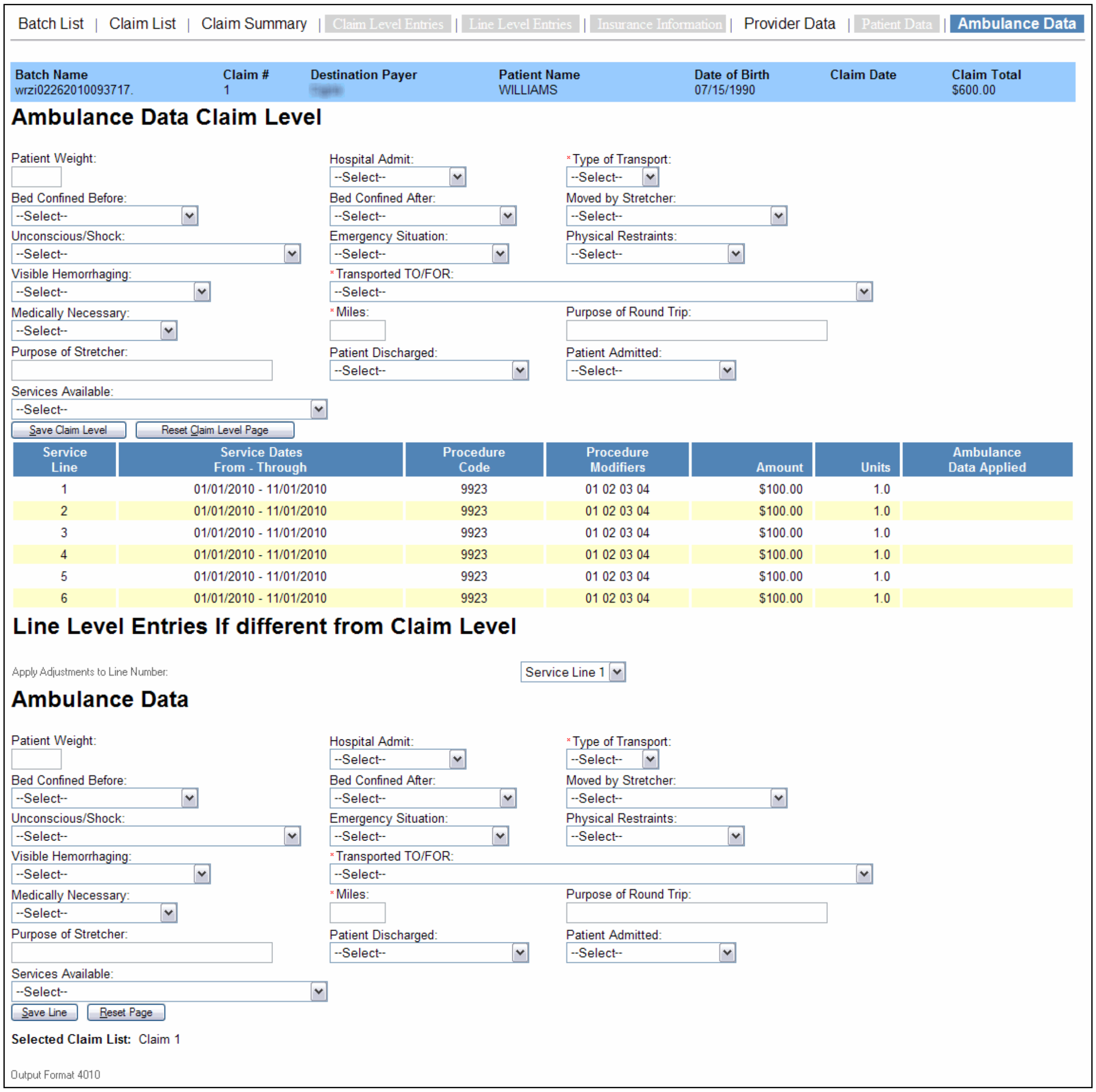
In the **Action** column, you can select “Supplement,” “Send,” and “Delete.”

- The “Supplement” link opens the Claim List screen, which lists the claims in a batch that can be supplemented. When you select a batch to supplement, a file locking mechanism prevents other users from accessing the same batch. This way, only one user is allowed to work on one batch at a time. If other users select the same batch to work on, they will see an alert message as shown below.



Batch wrzi02192010141212. is in use by user lhalpert.

- The “Send” link sends a batch of claims that was previously held for the entry of supplemental data. If there are no errors within the supplemented data, the file is sent to Emdeon Office for processing and the batch is removed from the list. If the system detects any errors in the additional data entered, an error message will appear on the screen and the batch will not be removed from the list. Once all errors are corrected and a batch is re-sent, the batch will be removed from the list. To view some sample error messages you may encounter when sending a batch, see **Ambulance Data**
- **The** 4010 Ambulance Data screen functions similarly to that of NSF+: you can add ambulance data to both primary and secondary claims, and available data pre-populates the appropriate fields (see **Ambulance Data** on page 48). However, with 4010, you have the ability to add claim level ambulance data as well as line level ambulance data. Entering ambulance information at the claim level negates the need for you to include it for each service line when there are no differences to report at the line level.


Batch List | Claim List | Claim Summary | Claim Level Entries | Line Level Entries | Insurance Information | Provider Data | Patient Data | Ambulance Data

Batch Name	Claim #	Destination Payer	Patient Name	Date of Birth	Claim Date	Claim Total
wrzi02262010093717.	1	[redacted]	WILLIAMS	07/15/1990		$600.00

Ambulance Data Claim Level

Patient Weight:
Hospital Admit: --Select--
*Type of Transport: --Select--
Bed Confined Before: --Select--
Bed Confined After: --Select--
Moved by Stretcher: --Select--
Unconscious/Shock: --Select--
Emergency Situation: --Select--
Physical Restraints: --Select--
Visible Hemorrhaging: --Select--
*Transported TO/FOR: --Select--
Medically Necessary: --Select--
*Miles:
Purpose of Round Trip:
Purpose of Stretcher:
Patient Discharged: --Select--
Patient Admitted: --Select--
Services Available: --Select--

Service Line	Service Dates From - Through	Procedure Code	Procedure Modifiers	Amount	Units	Ambulance Data Applied
1	01/01/2010 - 11/01/2010	9923	01 02 03 04	$100.00	1.0	
2	01/01/2010 - 11/01/2010	9923	01 02 03 04	$100.00	1.0	
3	01/01/2010 - 11/01/2010	9923	01 02 03 04	$100.00	1.0	
4	01/01/2010 - 11/01/2010	9923	01 02 03 04	$100.00	1.0	
5	01/01/2010 - 11/01/2010	9923	01 02 03 04	$100.00	1.0	
6	01/01/2010 - 11/01/2010	9923	01 02 03 04	$100.00	1.0	

Line Level Entries If different from Claim Level

Apply Adjustments to Line Number: Service Line 1

Ambulance Data

Patient Weight:
Hospital Admit: --Select--
*Type of Transport: --Select--
Bed Confined Before: --Select--
Bed Confined After: --Select--
Moved by Stretcher: --Select--
Unconscious/Shock: --Select--
Emergency Situation: --Select--
Physical Restraints: --Select--
Visible Hemorrhaging: --Select--
*Transported TO/FOR: --Select--
Medically Necessary: --Select--
*Miles:
Purpose of Round Trip:
Purpose of Stretcher:
Patient Discharged: --Select--
Patient Admitted: --Select--
Services Available: --Select--

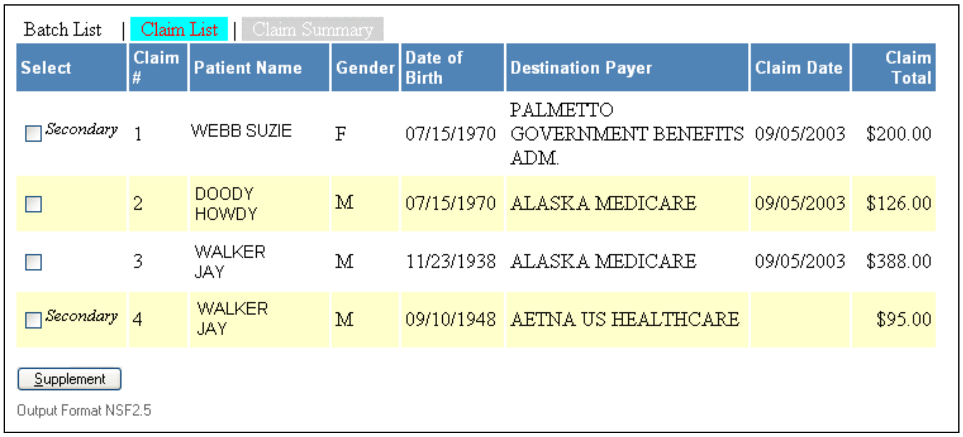
Selected Claim List: Claim 1

Output Format 4010

- Sample Error Messages on page 53.
- The “Delete” link deletes the batch. You may need to delete a batch if you realize you have already uploaded that batch and want to avoid sending duplicate claims or if you wish to print out the batch from your Practice Management System instead of sending it electronically.

Claim List

This screen opens when you click the “Supplement” link on the Batch List screen.

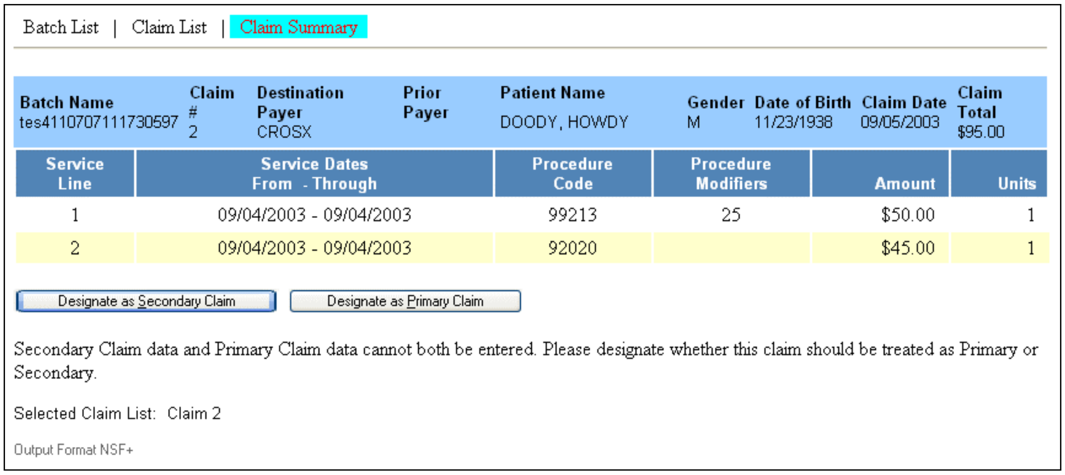


Select	Claim #	Patient Name	Gender	Date of Birth	Destination Payer	Claim Date	Claim Total
☐ Secondary	1	WEBB SUZIE	F	07/15/1970	PALMETTO GOVERNMENT BENEFITS ADM.	09/05/2003	$200.00
☐	2	DOODY HOWDY	M	07/15/1970	ALASKA MEDICARE	09/05/2003	$126.00
☐	3	WALKER JAY	M	11/23/1938	ALASKA MEDICARE	09/05/2003	$388.00
☐ Secondary	4	WALKER JAY	M	09/10/1948	AETNA US HEALTHCARE		$95.00

Output Format NSF2.5

Until you select one or more claims to supplement, only the tabs shown on the above illustration will appear. Some of the claims will show the label **Secondary** in the **Select** column indicating they have been previously supplemented and flagged as Secondary claims. Clicking the **Supplement** button opens the Claim Summary screen. This is true for all claim types: NSF 2.5, NSF+, and 4010.

If the selected claim has not been designated as Primary or Secondary, the Claim Summary screen appears, as shown on the following illustration:


Batch List | Claim List | Claim Summary
Designate as Secondary Claim
Designate as Primary Claim

Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
tes4110707111730597	2	CROSX		DOODY, HOWDY	M	11/23/1938	09/05/2003	$95.00

Service Line	Service Dates From - Through	Procedure Code	Procedure Modifiers	Amount	Units
1	09/04/2003 - 09/04/2003	99213	25	$50.00	1
2	09/04/2003 - 09/04/2003	92020		$45.00	1

Secondary Claim data and Primary Claim data cannot both be entered. Please designate whether this claim should be treated as Primary or Secondary.

Selected Claim List: Claim 2

Output Format NSF+

Once a batch and an associated claim have been selected, the Claim Summary screen (shown above) allows you the option of designating the claim as either Primary, for the purpose of adding other insurance information, or as Secondary, for the purpose of adding primary payer payment information.

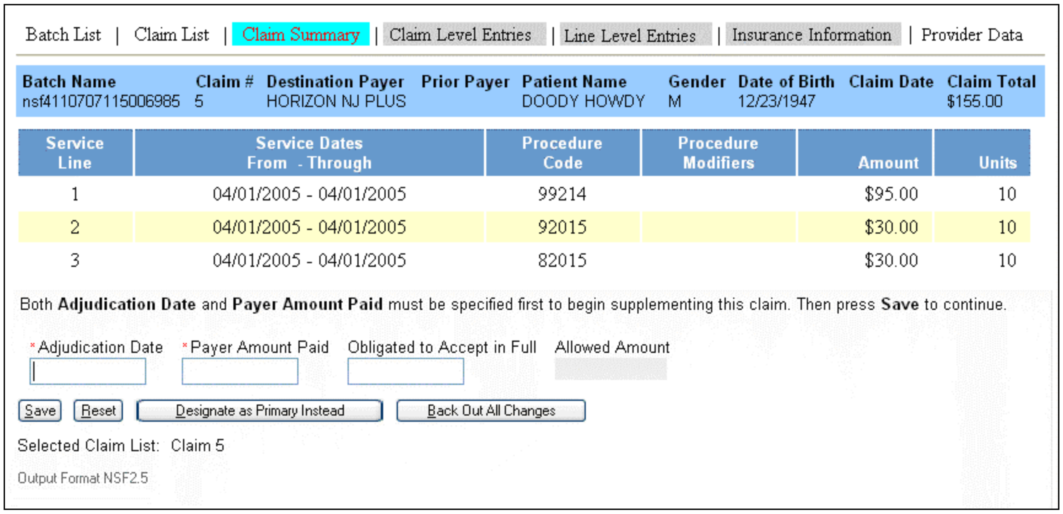
- If you select **Designate as Primary Claim,** the Insurance Information tab displays.
- If you select **Designate as Secondary Claim**, three more tabs display: Claim Level Entries, Line Level Entries, and Insurance Information, as the next section explains.

NSF 2.5 Claims

This section applies to NSF 2.5 claims only. If you work with another type of claim, please skip to **NSF+ Claims** on page 44 or **4010 Claims** on page 51.

Claim Summary – Secondary Claim

When you select a secondary claim to supplement, all tabs become available. The Claim Summary screen for a secondary claim appears as shown on the next illustration:



Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
nsf4110707115006985	5	HORIZON NJ PLUS		DOODY HOWDY	M	12/23/1947		$155.00

Service Line	Service Dates From - Through	Procedure Code	Procedure Modifiers	Amount	Units
1	04/01/2005 - 04/01/2005	99214		$95.00	10
2	04/01/2005 - 04/01/2005	92015		$30.00	10
3	04/01/2005 - 04/01/2005	82015		$30.00	10

Both **Adjudication Date** and **Payer Amount Paid** must be specified first to begin supplementing this claim. Then press **Save** to continue.

Selected Claim List: Claim 5

Output Format NSF2.5

If the **Payer Amount Paid** is 0.00, you are directed to the Claim Level Entries screen to enter denial reasons. (See **Claim Level Entries – NSF 2.5** on page 38).

If the **Payer Amount Paid** is a dollar amount greater than zero, you are directed to the Line Level Entries screen to enter applied amounts. (See **Line Level Entries – NSF 2.5** on page 39).

Two new fields on this screen are described below:

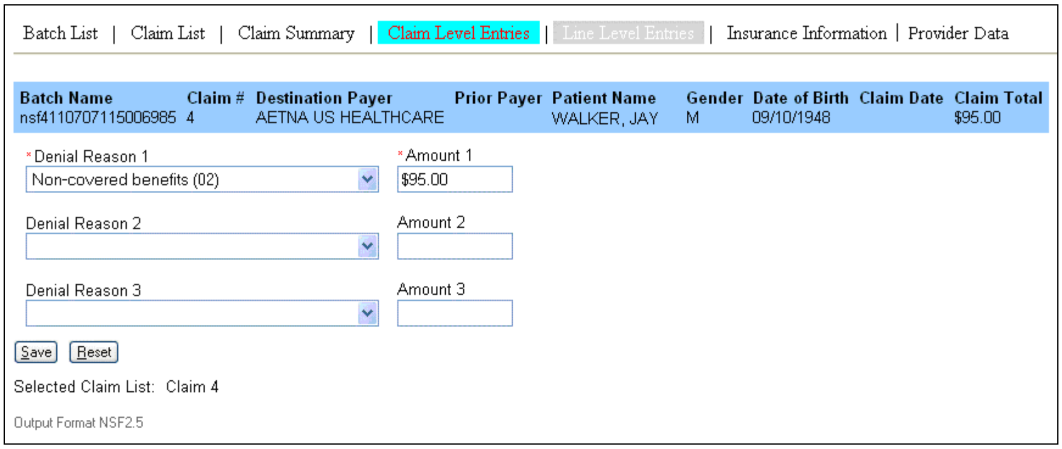
Field	Description
Obligated to Accept in Full	Optional field. This is the amount the provider agreed to accept as payment in full, under contract provisions. This field should only be used if the entire claim was applied to the Obligated to Accept in Full Amount and the information will not be reported at the service line. Total Obligated to Accept Amounts may be entered at both the line and claim level but not both.
Allowed Amount	Optional field. Maximum amount a provider is allowed to charge for services under contract provisions. Allowed Amounts may be entered at the line level and if entered, will result in their claim level total being incremented.

If you select **Back Out All Changes**, the claim will revert to its original state and the previous Claim Summary screen will appear.

Claim Level Entries – NSF 2.5

The Claim Level Entries screen is used to enter denial reasons and denied amounts.

When the **Payer Amount Paid** on a claim equals 0.00, you must go to this screen to enter the denial reasons. This information is obtained from the EOB (Explanation of Benefits) or remittance sent by the primary payer.


Batch List | Claim List | Claim Summary | Claim Level Entries | Line Level Entries | Insurance Information | Provider Data
Save
Reset

Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
nsf4110707115006985	4	AETNA US HEALTHCARE		WALKER, JAY	M	09/10/1948		$95.00

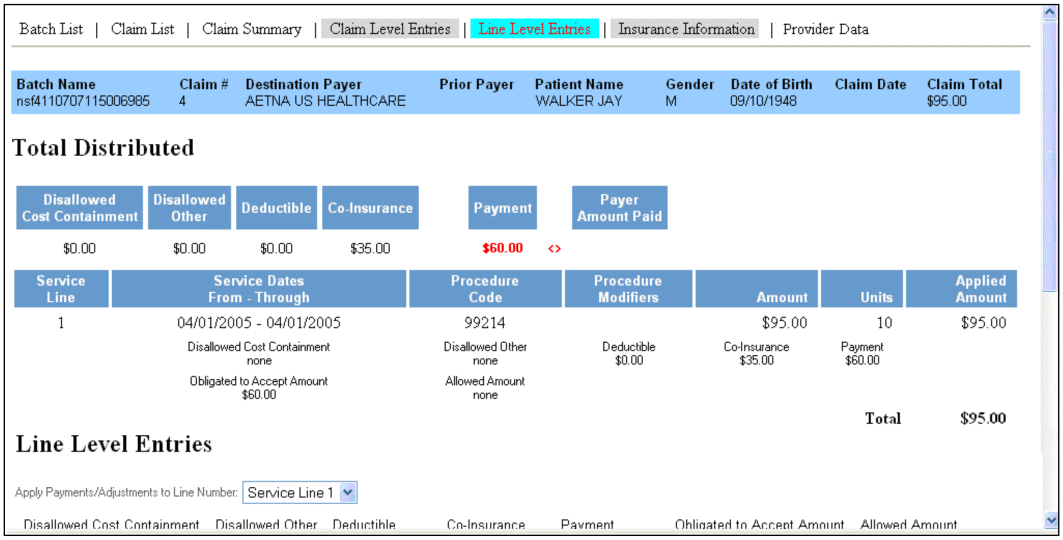
*Denial Reason 1: Non-covered benefits (02)
*Amount 1: $95.00
Denial Reason 2:
Amount 2:
Denial Reason 3:
Amount 3:

Selected Claim List: Claim 4

Output Format NSF2.5

Line Level Entries – NSF 2.5

This screen allows you to enter payments and adjustment amounts for each service line on a claim. Obtain these amounts from the EOB (Explanation of Benefits) or remittance sent by the primary payer.


Batch List | Claim List | Claim Summary | Claim Level Entries | Line Level Entries | Insurance Information | Provider Data
<>

Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
nsf4110707115006985	4	AETNA US HEALTHCARE		WALKER JAY	M	09/10/1948		$95.00

Total Distributed

Disallowed Cost Containment	Disallowed Other	Deductible	Co-Insurance	Payment	Payer Amount Paid
$0.00	$0.00	$0.00	$35.00	$60.00	

Service Line	Service Dates From - Through	Procedure Code	Procedure Modifiers	Amount	Units	Applied Amount
1	04/01/2005 - 04/01/2005	99214		$95.00	10	$95.00
	Disallowed Cost Containment none Obligated to Accept Amount $60.00	Disallowed Other none Allowed Amount none	Deductible $0.00	Co-Insurance $35.00	Payment $60.00	
					Total	$95.00

Line Level Entries

Apply Payments/Adjustments to Line Number: Service Line 1

Disallowed Cost Containment Disallowed Other Deductible Co-Insurance Payment Obligated to Accept Amount Allowed Amount

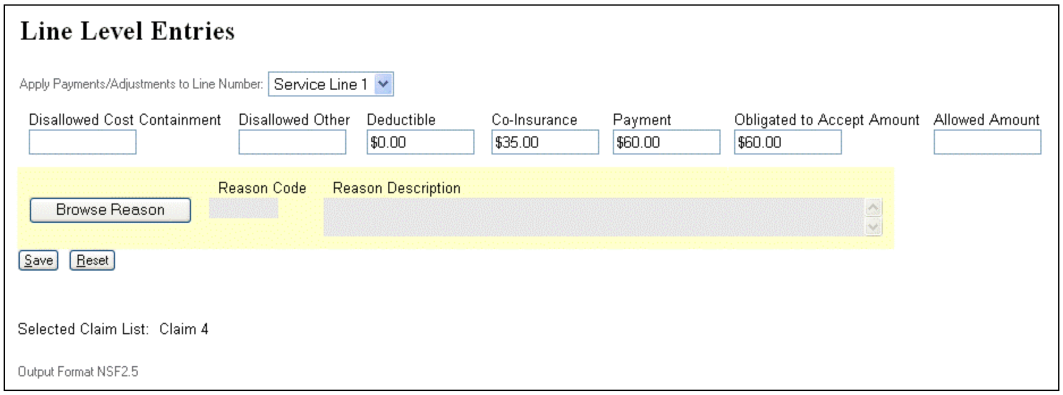
At the top of the screen under **Total Distributed** there is a row of summary dollar amounts (these amounts are described in detail on the following table). Next to each service line there is also an **Applied Amount** column.

These amount fields are used to aid you in determining that you have fully accounted for the difference in the amount the payer paid on the claim versus the adjustments that occurred to the claim.

The following table contains definitions for the amounts shown on the Line Level Entries screen under **Total Distributed**.

Adjustment Data	Description
Disallowed Cost Containment	The portion of line charges disallowed by the payer due to the failure of either the provider or insured to meet the cost containment provisions of the insurance plan.
Disallowed Other	The portion of line charges disallowed by the payer for reasons OTHER than the failure of the provider or insured to meet the cost containment provisions of the insurance plan.
Deductible	Any applicable deductible amount. If the patient has already met their deductible for the year, this field will contain zeroes, or be empty meaning that no deductible amount was applied to the claim.

Adjustment Data	Description
Co-Insurance	An agreement between the insured and the insurer where the insured agrees to cover a set percentage of the covered costs after the deductible has been paid. The coinsurance is typically 20% of the allowed amount. On this screen, coinsurance is the amount applied toward the coinsurance by the primary payer.
Payment	The amount paid by the insured on the claim.
Payer Amount Paid	The amount paid the payer on the claim. The Payer Paid Amount is taken from the Claim Level Entry screen where the payer amount paid was initially entered and is simply a visual aid for you to be able to compare the amounts entered at the line level against the claim level payment.
Applied Amount	This column is a total of the payments and adjustments entered for each service line.



Line Level Entries

Apply Payments/Adjustments to Line Number: Service Line 1

Disallowed Cost Containment	Disallowed Other	Deductible	Co-Insurance	Payment	Obligated to Accept Amount	Allowed Amount
		$0.00	$35.00	$60.00	$60.00	

Reason Code
Reason Description

Selected Claim List: Claim 4

Output Format NSF2.5

The bottom portion of the screen (above) allows entering data for each service line. Two new optional fields are described below:

Adjustment Data	Description
Obligated to Accept Amount	Optional field. This is the amount the provider agreed to accept as payment in full, under contract provisions. This field should only be used if the entire claim was applied to the Obligated to Accept in Full Amount and the information will not be reported at the service line. Total Obligated to Accept Amounts may be entered at both the line and claim level but not both. **Note**: Obligated to Accept Amount can be valued for the service line or for the entire claim but not both.
Allowed Amount	Optional field. Maximum amount a provider is allowed to charge for services under contract provisions. Allowed Amounts may be entered at the line level and if entered, will result in their claim level total being incremented.

You can browse and search for claim adjustment reason codes and explanations by clicking the **Browse Reason** button. This feature is particularly helpful for users who rely upon remittances that lack code descriptions to determine which adjustment field (Disallowed Cost Containment, Disallowed Other, Deductible, etc.) an amount should be attributed to.

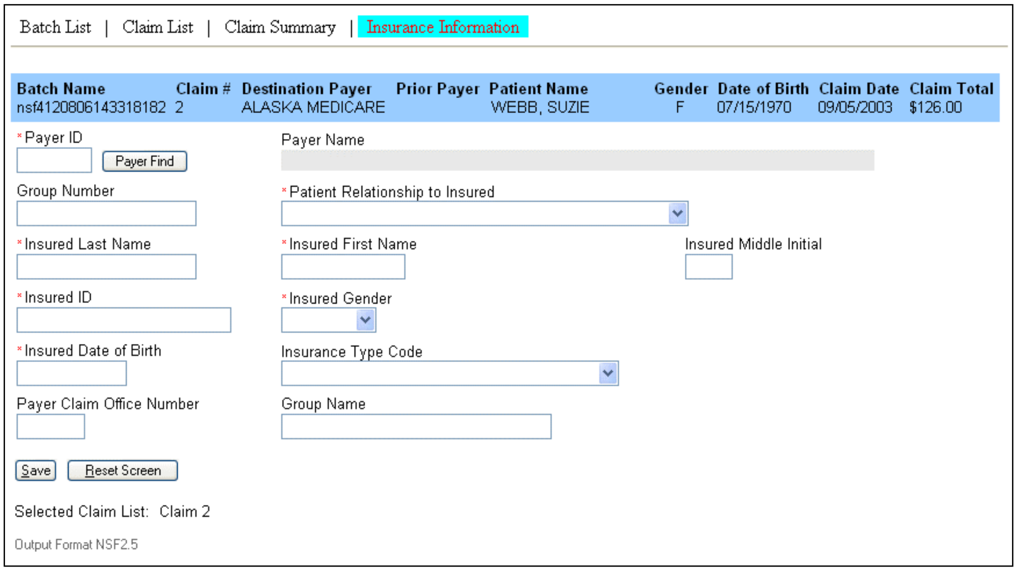
The Disallowed Cost Containment, Disallowed Other, Deductible, Co-insurance, and Payment amounts (displayed at the top of the screen) will increase appropriately as these Line Level amounts are entered for each service line. All changes must be saved in between service lines and before leaving the screen.

Insurance Information – NSF 2.5

The Insurance Information screen varies based on whether the claim is primary or secondary. All fields are editable except for the **Payer Name** which populates based on the selected Payer ID. Any data present in the claim will pre-populate the screen.

Primary Claims

When a primary claim is selected, the **Insurance Information** tab allows you to add information identifying the secondary payer. This is particularly necessary for the successful submission of Medicare Crossover claims.


Batch List | Claim List | Claim Summary | Insurance Information
*Payer ID
Payer Find
Payer Name
Group Number
*Patient Relationship to Insured
*Insured Last Name
*Insured First Name
Insured Middle Initial
*Insured ID
*Insured Gender
*Insured Date of Birth
Insurance Type Code
Payer Claim Office Number
Group Name
Save
Reset Screen

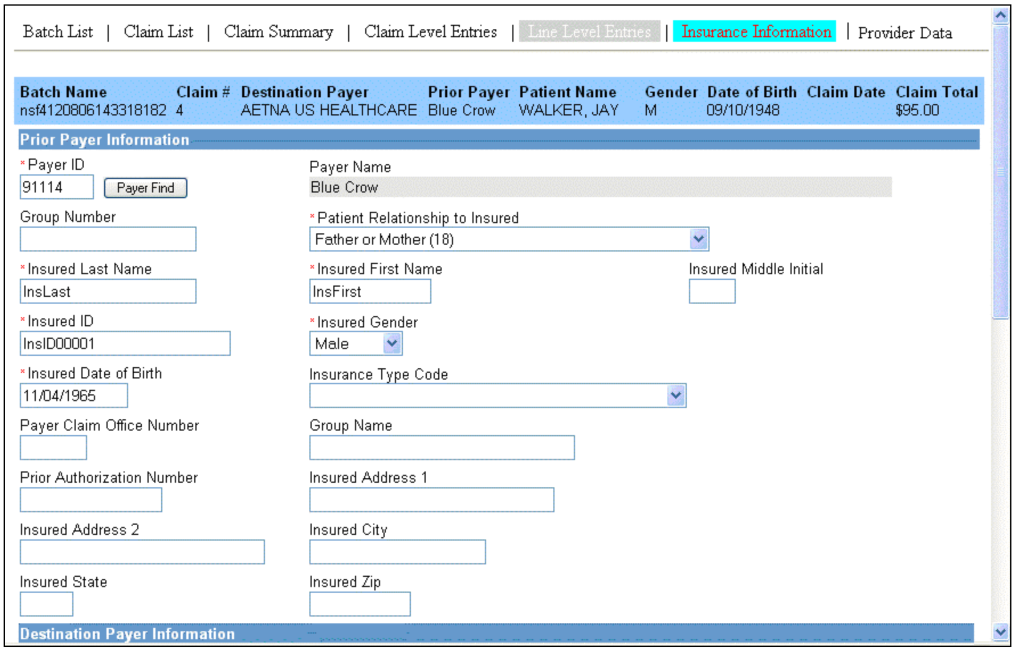
Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
nsf4120806143318182	2	ALASKA MEDICARE		WEBB, SUZIE	F	07/15/1970	09/05/2003	$126.00

Selected Claim List: Claim 2

Output Format NSF2.5

Secondary Claims

For secondary claims, the **Insurance Information** tab displays insurance information for both payers. You may view, edit, and add insurance information for both prior/primary payers and secondary/destination payers.


Batch List | Claim List | Claim Summary | Claim Level Entries | Line Level Entries | Insurance Information | Provider Data
Payer Find
Group Number
Insured Middle Initial
Insurance Type Code
Payer Claim Office Number
Group Name
Prior Authorization Number
Insured Address 1
Insured Address 2
Insured City
Insured State
Insured Zip

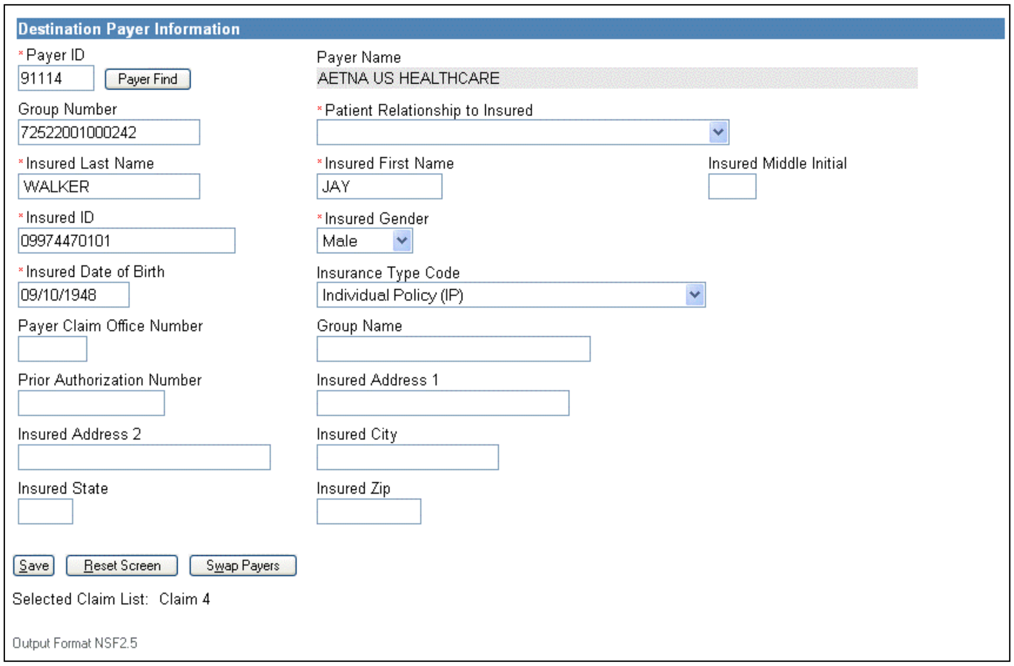
Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
nsf4120806143318182	4	AETNA US HEALTHCARE	Blue Crow	WALKER, JAY	M	09/10/1948		$95.00

Prior Payer Information

*Payer ID: 91114
Payer Name: Blue Crow
*Patient Relationship to Insured: Father or Mother (18)
*Insured Last Name: InsLast
*Insured First Name: InsFirst
*Insured ID: InsID00001
*Insured Gender: Male
*Insured Date of Birth: 11/04/1965

Destination Payer Information

The bottom portion of the screen, shown on the next illustration, allows you to enter necessary information for the receiving payer in the event that more data is needed to successfully adjudicate the claim.



Destination Payer Information

*Payer ID: 91114
Payer Name: AETNA US HEALTHCARE
Group Number: 72522001000242
*Patient Relationship to Insured:
*Insured Last Name: WALKER
*Insured First Name: JAY
Insured Middle Initial:
*Insured ID: 09974470101
*Insured Gender: Male
*Insured Date of Birth: 09/10/1948
Insurance Type Code: Individual Policy (IP)
Payer Claim Office Number:
Group Name:
Prior Authorization Number:
Insured Address 1:
Insured Address 2:
Insured City:
Insured State:
Insured Zip:

Selected Claim List: Claim 4

Output Format NSF2.5

Payer Search

The **Payer Find** button opens a search screen. You may search by payer name or ID. Both search fields accept partial data entries followed by a wild card character or asterisk (%, *). Neither field is case-sensitive. You may enter upper- or lowercase.

For example:

- A search on "SM*" on the Payer ID will return all payers whose Payer IDs begin with SM.
- A search on "blue*" on the Payer Name will return all BlueCross BlueShield payers.

Swap Payers

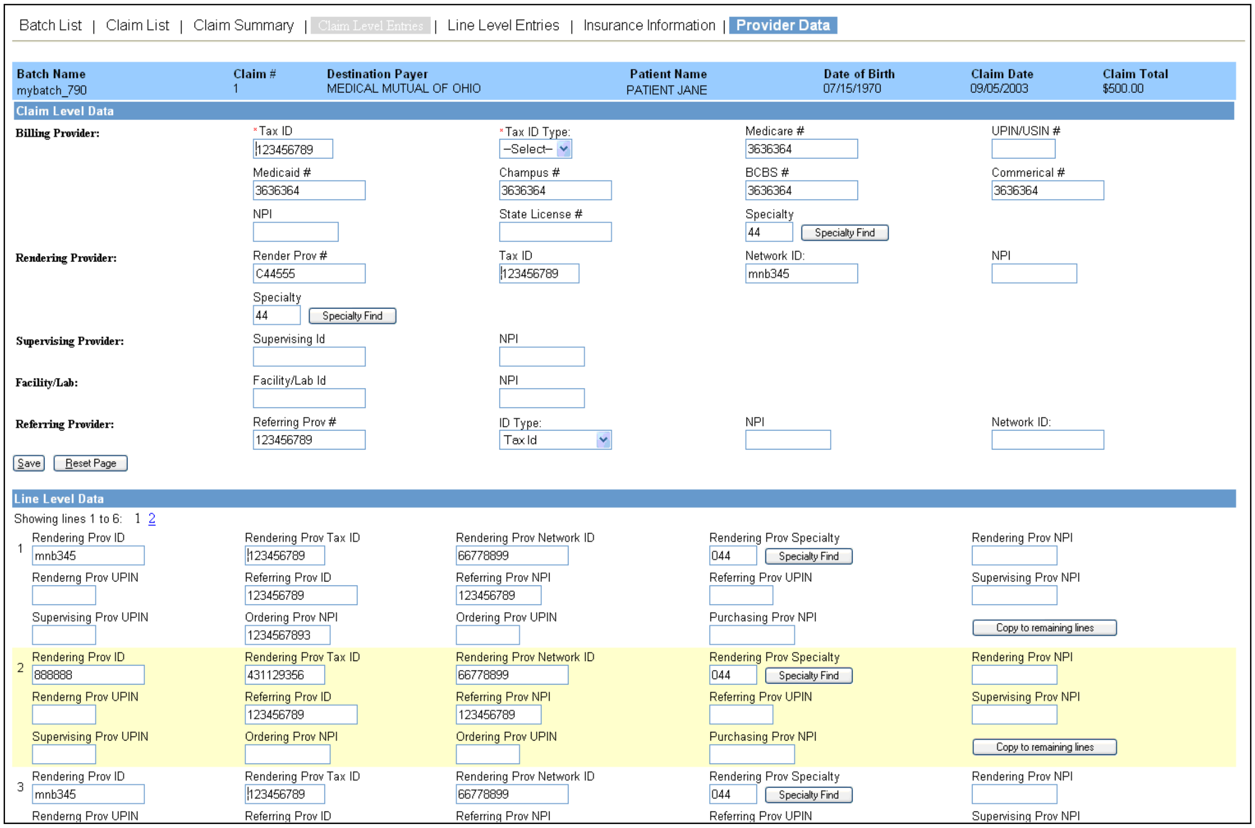
The **Swap Payers** button allows you to swap the primary and secondary payers if you notice they are reversed in the supplemental claim screens. This feature is also helpful if you wish to form a secondary claim using data from the original, primary claim.

You can determine if the payers are reversed on the supplemental claims screens by examining the Explanation of Benefits or ERA. The primary payer would be the one who created the ERA as they paid first. If the payer who created the ERA appears in the destination payer field, then it needs to be reversed since that payer has already made payments on the claim.

In this case, swapping the prior and destination payers ensures the claim is directed to the correct payer and the payment information is associated with the correct payer.

Provider Data – NSF 2.5

The Provider Data screen allows you to edit provider identifiers and other information at the claim level and line level. Any data present in the claim will pre-populate the screen.


Batch List | Claim List | Claim Summary | Claim Level Entries | Line Level Entries | Insurance Information | Provider Data
Claim Level Data
*Tax ID Type: –Select–
NPI
State License #
UPIN/USIN #
Specialty Find
Supervising Provider:
Supervising Id
NPI
Facility/Lab:
Facility/Lab Id
NPI
Save
Reset Page
Line Level Data
Rendering Prov NPI
Renderng Prov UPIN
Referring Prov UPIN
Supervising Prov NPI
Supervising Prov UPIN
Ordering Prov UPIN
Purchasing Prov NPI
Copy to remaining lines

Batch Name	Claim #	Destination Payer	Patient Name	Date of Birth	Claim Date	Claim Total
mybatch_790	1	MEDICAL MUTUAL OF OHIO	PATIENT JANE	07/15/1970	09/05/2003	$500.00

Billing Provider:
*Tax ID: 123456789
Medicare #: 3636364
Medicaid #: 3636364
Champus #: 3636364
BCBS #: 3636364
Commerical #: 3636364
Specialty: 44

Rendering Provider:
Render Prov #: C44555
Tax ID: 123456789
Network ID: mnb345
Specialty: 44

Referring Provider:
Referring Prov #: 123456789
ID Type: Tax Id

Showing lines 1 to 6: 1 2

	Rendering Prov ID	Rendering Prov Tax ID	Rendering Prov Network ID	Rendering Prov Specialty	Referring Prov ID	Referring Prov NPI	Ordering Prov NPI
1	mnb345	123456789	66778899	044	123456789	123456789	1234567893
2	888888	431129356	66778899	044	123456789	123456789	
3	mnb345	123456789	66778899	044			

Up to six line items appear in the Line Level Data area of the Provider Data screen. Scroll down to view all six line items.

The total number of pages of line items appears directly under the Line Level Data heading and also at the bottom of the page. To view another page of line items, click the number of the page you wish to view.

Note*: In order to preserve your changes on a page, you must click the* ***Save*** *button before viewing another page.*

Claim level data can be edited and saved from any Provider Data page.

Copy to Remaining Lines

The **Copy to Remaining Lines** button allows you to copy the provider data in all fields of the line item in which the button is located to all remaining line items, including those on subsequent pages. Fields in preceding line items are not affected.

Specialty Find

The **Specialty Find** button opens a search screen. You can search by specialty code or description. Both search fields accept partial data entries followed by a wild card character or asterisk (%, *). Neither field is case-sensitive. You can enter upper- or lowercase.

For example:

- A search on "3*" on the Specialty Code will return all specialty codes that begin with 3, such as "30 and "33."
- A search on "*de*" on the Specialty Description will return all specialty codes with the letters "de" in any portion of the description, such as "Dental Hygienist" and "Independently Billing Radiology Group."

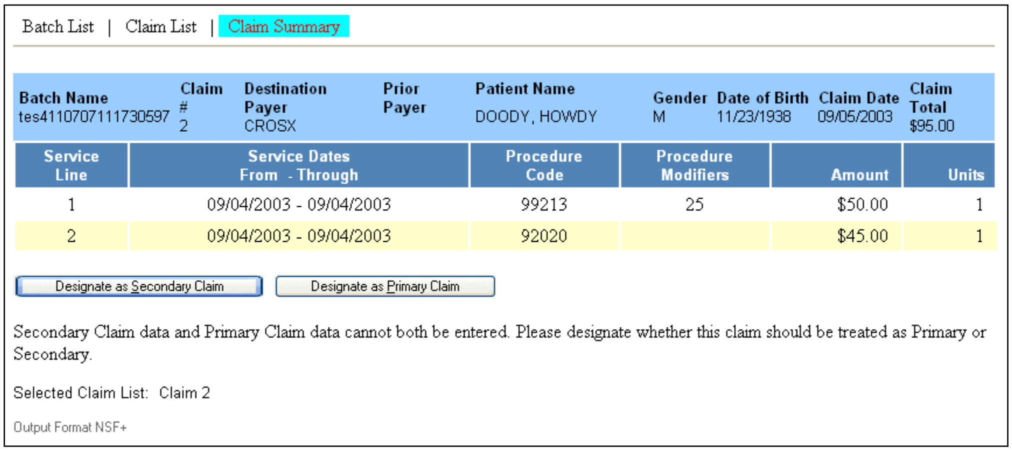
Save and Reset Page

Each **Save** button on the page saves all data on the current page, including both claim level and line level data.

The **Reset Page** button clears any changes you have made on the current page since your last save, including both claim level and line level data.

NSF+ Claims

This section applies to NSF+ claims only. If you work with another type of claim, please skip to **NSF 2.5 Claims** on page 38 or **4010 Claims** on page 51.


Batch List | Claim List | Claim Summary
Designate as Secondary Claim
Designate as Primary Claim

Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
tes4110707111730597	2	CROSX		DOODY, HOWDY	M	11/23/1938	09/05/2003	$95.00

Service Line	Service Dates From - Through	Procedure Code	Procedure Modifiers	Amount	Units
1	09/04/2003 - 09/04/2003	99213	25	$50.00	1
2	09/04/2003 - 09/04/2003	92020		$45.00	1

Secondary Claim data and Primary Claim data cannot both be entered. Please designate whether this claim should be treated as Primary or Secondary.

Selected Claim List: Claim 2

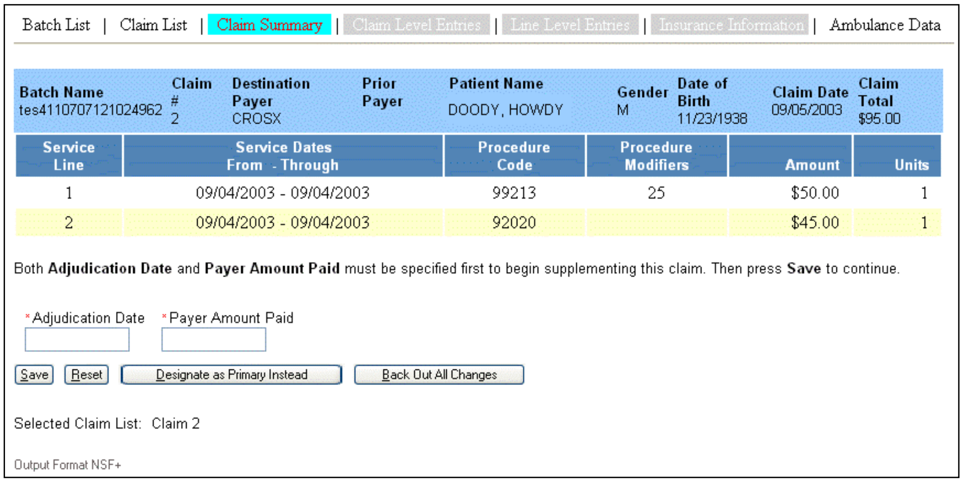
Output Format NSF+

On this screen you have the option of designating the claim as Secondary or Primary by clicking the appropriate button.

- If you select **Designate as Primary Claim** the Insurance Information tab displays.
- If you select **Designate as Secondary Claim**, three more tabs display: Claim Level Entries, Line Level Entries and Insurance Information, as shown on the next illustration.

Claim Summary

This screen shows detailed information on selected claims.


Batch List | Claim List | Claim Summary | Claim Level Entries | Line Level Entries | Insurance Information | Ambulance Data

Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
tes4110707121024962	2	CROSX		DOODY, HOWDY	M	11/23/1938	09/05/2003	$95.00

Service Line	Service Dates From - Through	Procedure Code	Procedure Modifiers	Amount	Units
1	09/04/2003 - 09/04/2003	99213	25	$50.00	1
2	09/04/2003 - 09/04/2003	92020		$45.00	1

Both **Adjudication Date** and **Payer Amount Paid** must be specified first to begin supplementing this claim. Then press **Save** to continue.

*Adjudication Date:
*Payer Amount Paid:

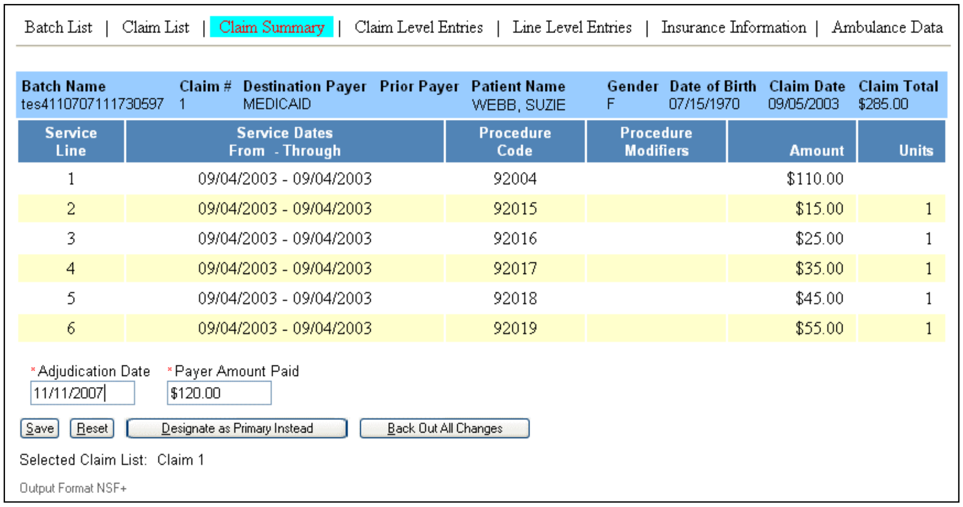
Save
Reset
Designate as Primary Instead
Back Out All Changes

Selected Claim List: Claim 2

Output Format NSF+

Message	Action
Both **Adjudication Date** and **Payer Amount Paid** must be specified first to begin supplementing this claim.	This message appears if the **Adjudication Date** and **Payer Amount Paid** fields are empty. Enter the missing data from the EOB and click **Save**. The payer paid amount comes from the EOB (Explanation of Benefits) report sent by the primary payer.

If you select **Back Out All Changes,** the claim will revert to its original state and the previous Claim Summary screen will appear.


Batch List | Claim List | Claim Summary | Claim Level Entries | Line Level Entries | Insurance Information | Ambulance Data

Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
tes4110707111730597	1	MEDICAID		WEBB, SUZIE	F	07/15/1970	09/05/2003	$285.00

Service Line	Service Dates From - Through	Procedure Code	Procedure Modifiers	Amount	Units
1	09/04/2003 - 09/04/2003	92004		$110.00	
2	09/04/2003 - 09/04/2003	92015		$15.00	1
3	09/04/2003 - 09/04/2003	92016		$25.00	1
4	09/04/2003 - 09/04/2003	92017		$35.00	1
5	09/04/2003 - 09/04/2003	92018		$45.00	1
6	09/04/2003 - 09/04/2003	92019		$55.00	1

*Adjudication Date: 11/11/2007
*Payer Amount Paid: $120.00

Save
Reset
Designate as Primary Instead
Back Out All Changes

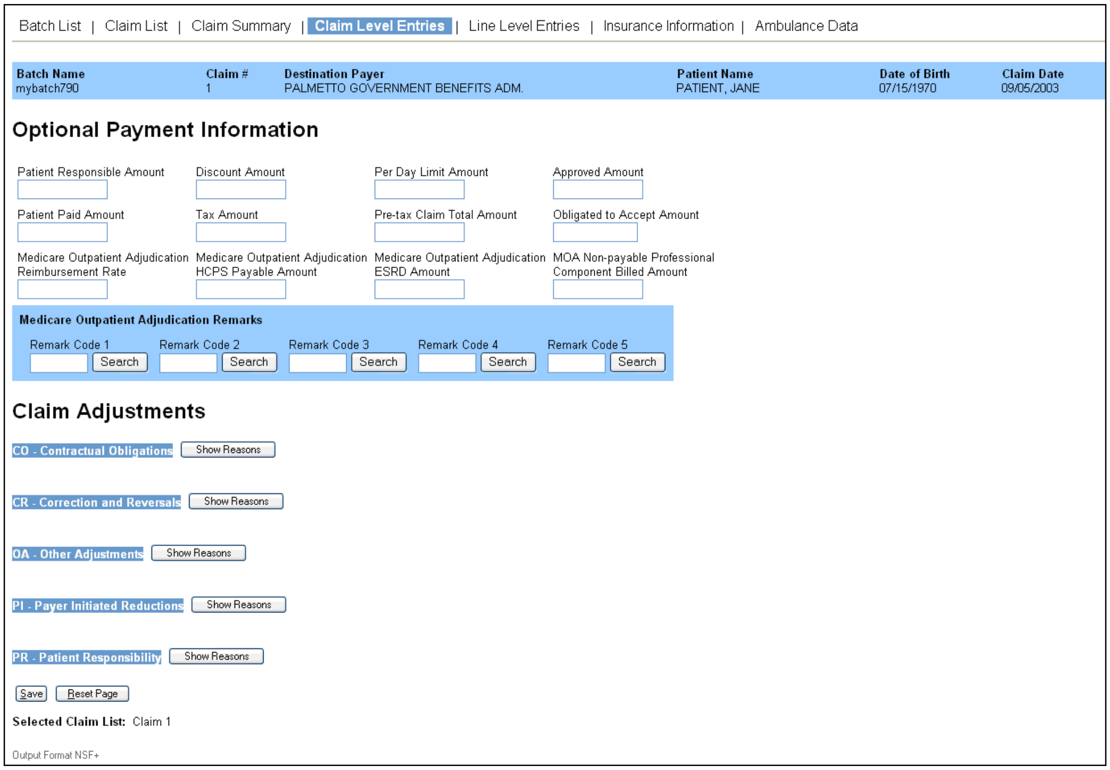
Selected Claim List: Claim 1

Output Format NSF+

Claim Level Entries – NSF+

The Claim Level Entries screen is used to enter claim level adjustment reasons and amounts.

The information needed to complete the **Optional Payment Information** and **Claim Adjustments** fields is obtained from the Remittance Advice Notice sent by the primary payer.


Batch List | Claim List | Claim Summary | Claim Level Entries | Line Level Entries | Insurance Information | Ambulance Data
Optional Payment Information
Patient Responsible Amount
Discount Amount
Per Day Limit Amount
Approved Amount
Patient Paid Amount
Tax Amount
Pre-tax Claim Total Amount
Obligated to Accept Amount
Medicare Outpatient Adjudication Reimbursement Rate
Medicare Outpatient Adjudication HCPS Payable Amount
Medicare Outpatient Adjudication ESRD Amount
MOA Non-payable Professional Component Billed Amount
Medicare Outpatient Adjudication Remarks
Remark Code 1
Search
Remark Code 2
Search
Remark Code 3
Search
Remark Code 4
Search
Remark Code 5
Search
Claim Adjustments
CO - Contractual Obligations
Show Reasons
CR - Correction and Reversals
Show Reasons
OA - Other Adjustments
Show Reasons
PI - Payer Initiated Reductions
Show Reasons
PR - Patient Responsibility
Show Reasons
Save
Reset Page

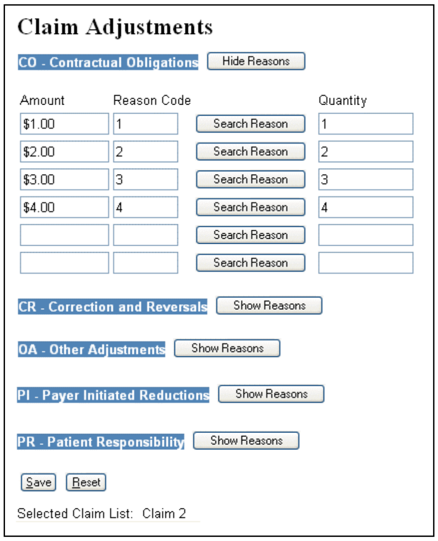
Batch Name	Claim #	Destination Payer	Patient Name	Date of Birth	Claim Date
mybatch790	1	PALMETTO GOVERNMENT BENEFITS ADM.	PATIENT, JANE	07/15/1970	09/05/2003

Selected Claim List: Claim 1

Output Format NSF+

Adjustments

The **Claim Adjustments** portion of the Claim Level Entries screen, shown on the next illustration, allows you to enter up to 5 group codes per line (highlighted in blue) and up to 6 reason codes per group code.


Claim Adjustments
CO - Contractual Obligations
Hide Reasons
Search Reason
Search Reason
Search Reason
Search Reason
Search Reason
Search Reason
CR - Correction and Reversals
Show Reasons
OA - Other Adjustments
Show Reasons
PI - Payer Initiated Reductions
Show Reasons
PR - Patient Responsibility
Show Reasons
Save
Reset

Amount	Reason Code	Quantity
$1.00	1	1
$2.00	2	2
$3.00	3	3
$4.00	4	4

Selected Claim List: Claim 2

If a Group Code is entered, at least one valid reason code and an amount greater than 0.00 must be entered. Otherwise, you will not be able to save entries.

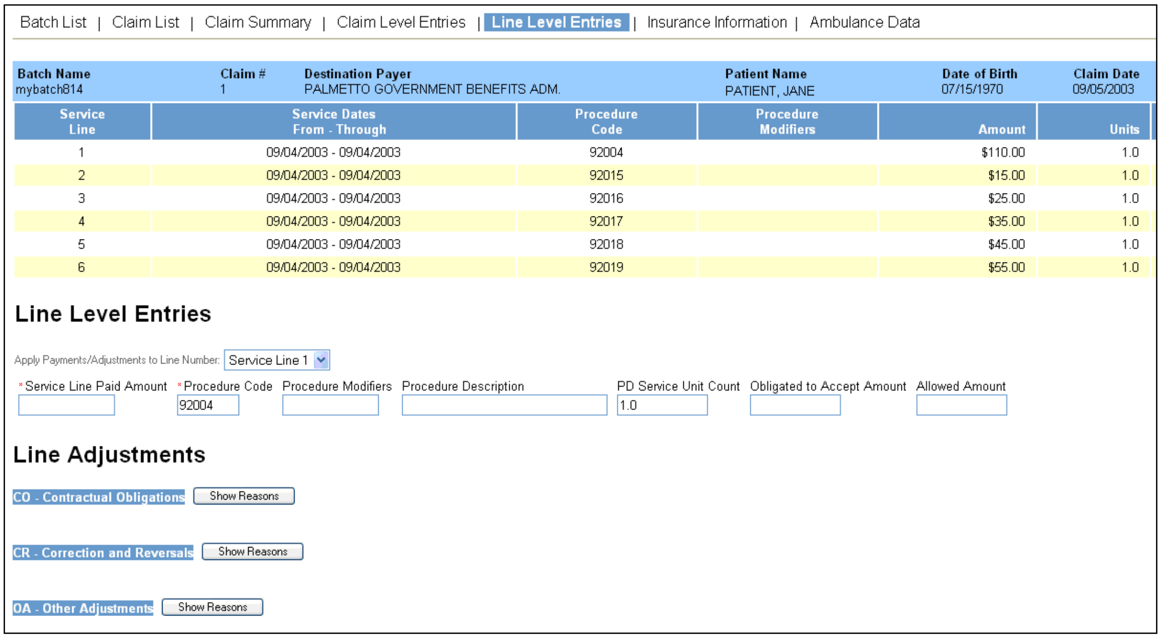
***Note**: You have the option of entering adjustments at the claim level or at the line level. This is why the **Adjustments** section is identical on both the Claim Level and Line Level Entries screens.*

The following table describes the **Adjustments** section of the screen:

Button/Field	**Description**
Show Reasons	These buttons expand the view to reveal 6 reason codes for each group code.
Hide Reasons	These buttons collapse the view and delete the reasons for the selected group code.
Search Reasons	Each of these buttons opens a search screen. You may enter an alpha-numeric code in the **Reason Code** field or you may enter a wild card (* or %) to display all the possible reason codes and their respective descriptions. The **Reason Description** field does not accept partial text entries so you must enter the full description in this field (for example: "Major Medical Adjustment").
Amount	The unpaid or denied dollar amount associated with a reason code.
Reason Code	The code associated with the reason for an adjustment, such as a denial or reduction in payment from the amount billed on a claim.
Quantity	The adjusted units of service if applicable.

Line Level Entries – NSF+

This screen allows you to enter payments and adjustment amounts for each service line on a claim. Obtain these amounts from the EOB (Explanation of Benefits) or remittance sent by the primary payer.


Batch List | Claim List | Claim Summary | Claim Level Entries | Line Level Entries | Insurance Information | Ambulance Data

Batch Name	Claim #	Destination Payer	Patient Name	Date of Birth	Claim Date
mybatch814	1	PALMETTO GOVERNMENT BENEFITS ADM.	PATIENT, JANE	07/15/1970	09/05/2003

Service Line	Service Dates From - Through	Procedure Code	Procedure Modifiers	Amount	Units
1	09/04/2003 - 09/04/2003	92004		$110.00	1.0
2	09/04/2003 - 09/04/2003	92015		$15.00	1.0
3	09/04/2003 - 09/04/2003	92016		$25.00	1.0
4	09/04/2003 - 09/04/2003	92017		$35.00	1.0
5	09/04/2003 - 09/04/2003	92018		$45.00	1.0
6	09/04/2003 - 09/04/2003	92019		$55.00	1.0

Line Level Entries

Apply Payments/Adjustments to Line Number: Service Line 1

*Service Line Paid Amount	*Procedure Code	Procedure Modifiers	Procedure Description	PD Service Unit Count	Obligated to Accept Amount	Allowed Amount
	92004			1.0		

Line Adjustments

The following table describes some of the fields on the Line Level Entries screen:

Field	Description
Procedure Code	A numeric code that describes the service.
Procedure Modifiers	Abbreviation on Remittance = MODS Procedure Modifiers are two position alpha or numeric codes appended to procedure codes that provide additional information about the billed procedure. In some cases, addition of a modifier may directly affect payment.
Amount	The dollar amount charged for the service.
Units	The quantity of service delivered. (This number can be milligrams, cc's, minutes etc.)
PD Service Unit Count	Paid Service Unit Count. This is the number of service units the primary payer paid for. The default value for this field is Units.
Obligated to Accept Amount	The dollar amount the provider has agreed to accept as payment in full, under contract provisions. Obligated to Accept Amounts may be entered at both the line and claim level but not both.
Allowed Amount	The maximum dollar amount a provider is allowed to charge for services under contract provisions.

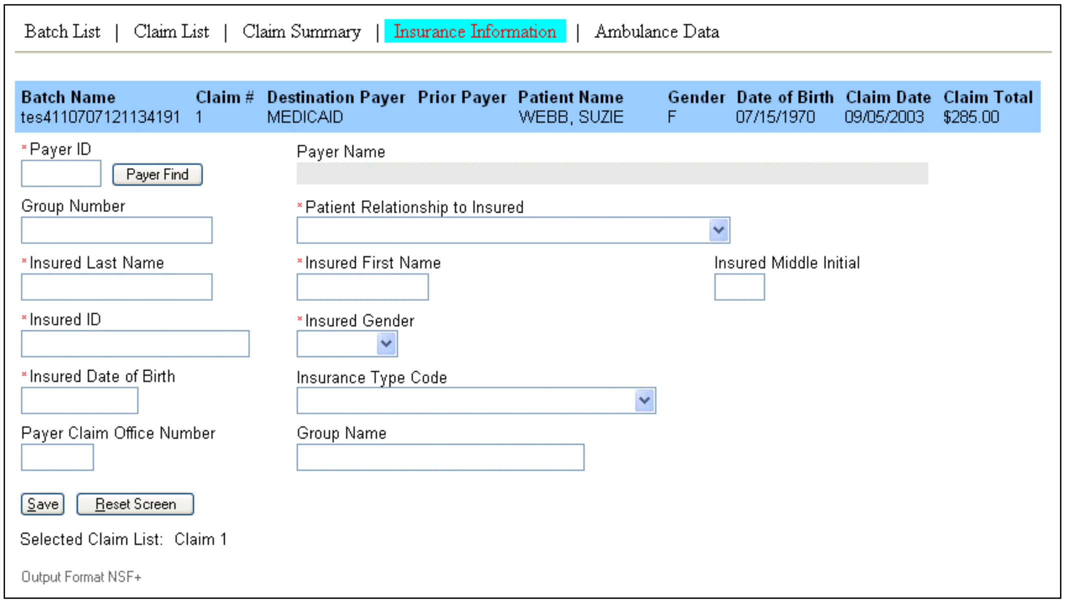
***Note**: The **Adjustments** portion of the Line Level Entries screen is identical to the one described in **Adjustments** on page 46.*

Insurance Information – NSF+

The Insurance Information screen varies based on whether the claim is primary or secondary. All fields are editable except for the **Payer Name,** which populates based on the selected Payer ID.

Primary Claims

When a primary claim is selected, the **Insurance Information** tab allows you to add information identifying the secondary payer. This is particularly necessary for the successful submission of Medicare Crossover claims.


Batch List | Claim List | Claim Summary | Insurance Information | Ambulance Data
*Payer ID
Payer Find
Payer Name
Group Number
*Patient Relationship to Insured
*Insured Last Name
*Insured First Name
Insured Middle Initial
*Insured ID
*Insured Gender
*Insured Date of Birth
Insurance Type Code
Payer Claim Office Number
Group Name
Save
Reset Screen

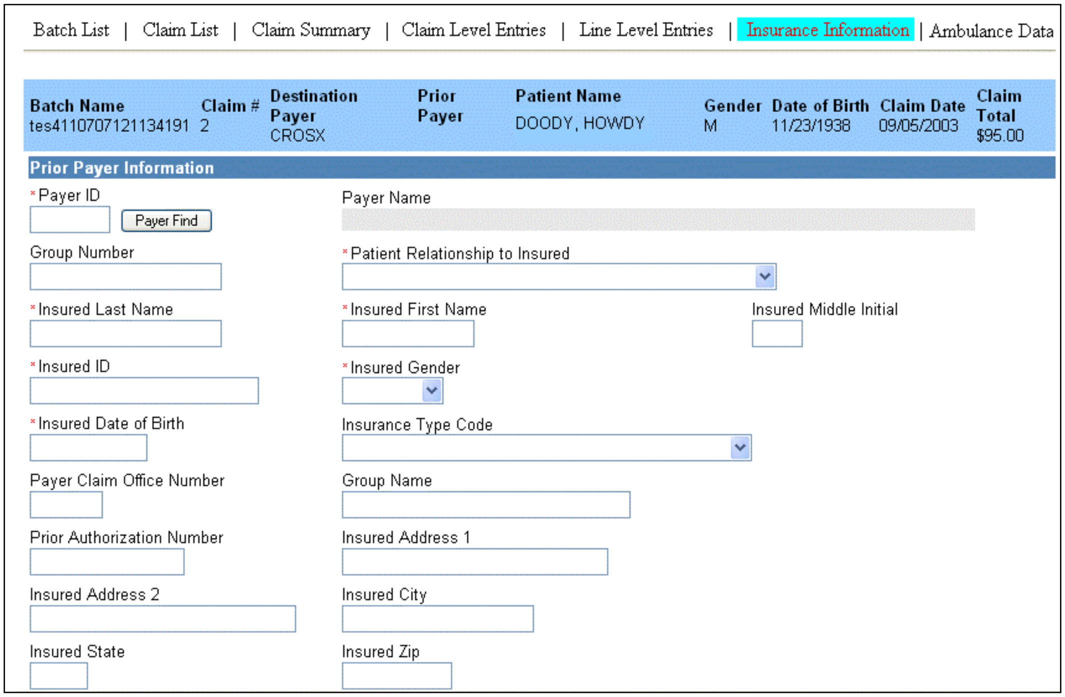
Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
tes4110707121134191	1	MEDICAID		WEBB, SUZIE	F	07/15/1970	09/05/2003	$285.00

Selected Claim List: Claim 1

Output Format NSF+

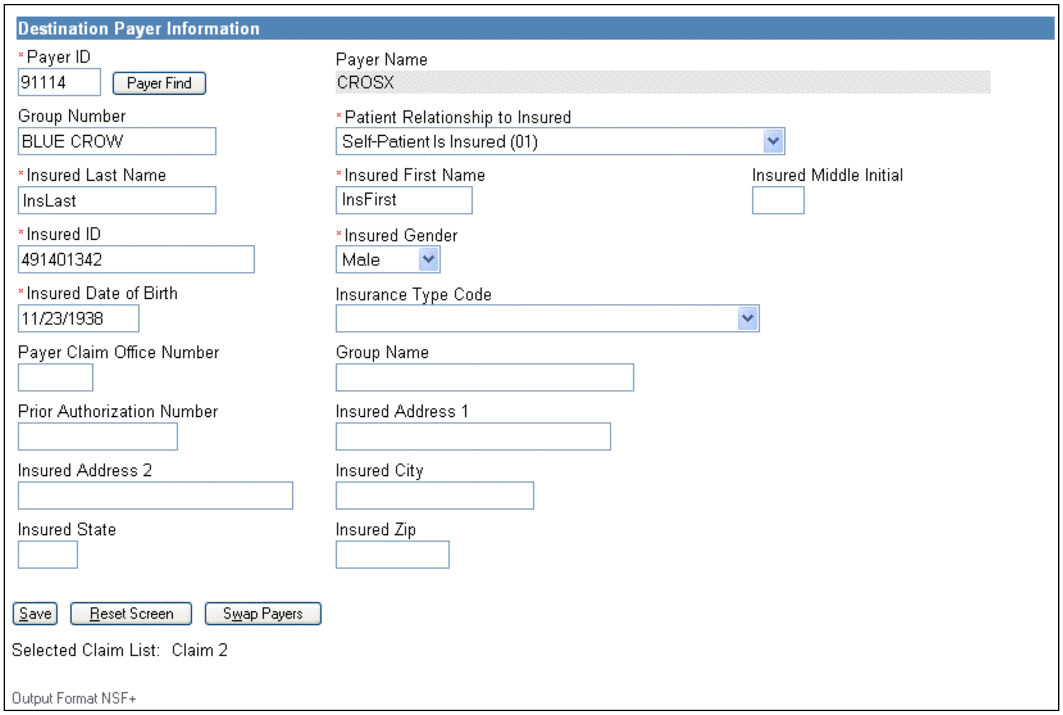
Secondary Claims

For secondary claims, the **Insurance Information** tab displays insurance information for both payers. You may view, edit and add insurance information for both prior/primary payers and secondary/destination payers, as shown on the next illustration.


Batch List | Claim List | Claim Summary | Claim Level Entries | Line Level Entries | Insurance Information | Ambulance Data
Prior Payer Information
Payer ID
Payer Find
Payer Name
Group Number
Patient Relationship to Insured
Insured Last Name
Insured First Name
Insured Middle Initial
Insured ID
Insured Gender
Insured Date of Birth
Insurance Type Code
Payer Claim Office Number
Group Name
Prior Authorization Number
Insured Address 1
Insured Address 2
Insured City
Insured State
Insured Zip

Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
tes4110707121134191	2	CROSX		DOODY, HOWDY	M	11/23/1938	09/05/2003	$95.00

The bottom portion of the screen, shown on the next illustration, allows you to enter necessary information for the receiving payer in the event that more data is needed to successfully adjudicate the claim.


Destination Payer Information
Payer Find
Insured Middle Initial
Insurance Type Code
Payer Claim Office Number
Group Name
Prior Authorization Number
Insured Address 1
Insured Address 2
Insured City
Insured State
Insured Zip
Save
Reset Screen
Swap Payers

Payer ID: 91114
Payer Name: CROSX
Group Number: BLUE CROW
Patient Relationship to Insured: Self-Patient Is Insured (01)
Insured Last Name: InsLast
Insured First Name: InsFirst
Insured ID: 491401342
Insured Gender: Male
Insured Date of Birth: 11/23/1938

Selected Claim List: Claim 2

Output Format NSF+

Payer Search

The **Payer Find** button opens a search screen. You may search by payer name or ID. Both search fields accept partial data entries followed by a wild card character or asterisk (%, *). Neither field is case-sensitive. You may enter upper- or lowercase.

For example:

- A search on "SM*" on the Payer ID will return all payers whose Payer IDs begin with SM.
- A search on "blue*" on the Payer Name will return all Blue Cross and Blue Shield payers.

Swap Payers

The **Swap Payers** button allows you to swap the primary and secondary payers if you notice they are reversed in the supplemental claim screens. This feature is also helpful if you wish to form a secondary claim using data from the original, primary claim.

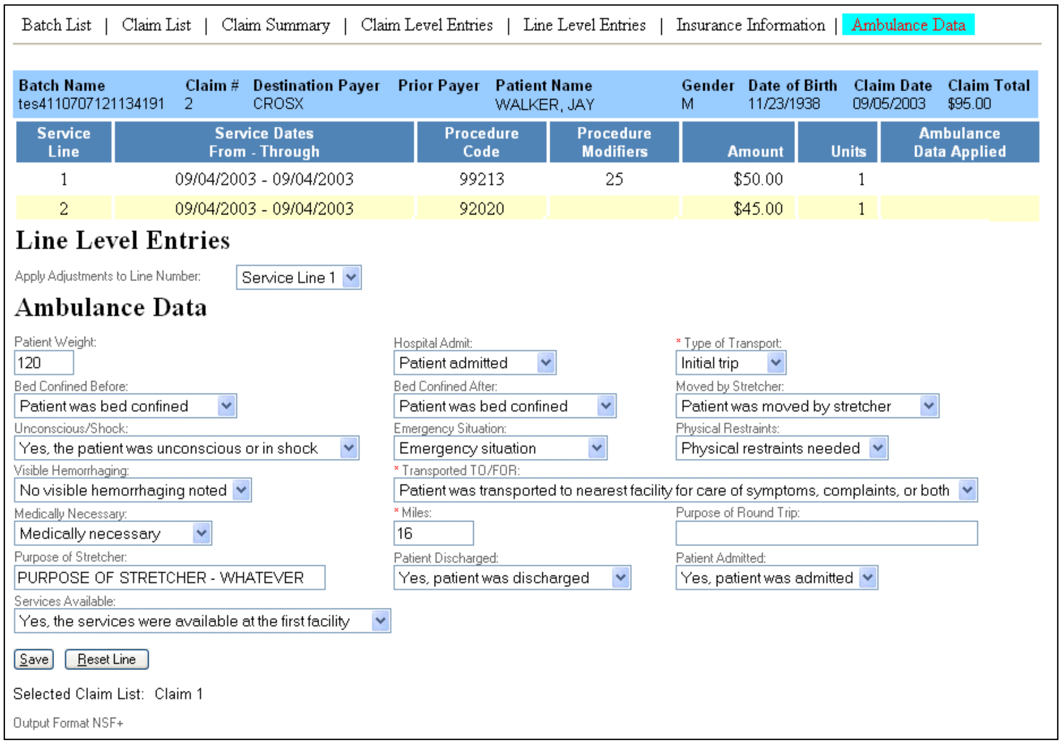
You can determine if the payers are reversed on the supplemental claims screens by examining the Explanation of Benefits or ERA. The primary payer would be the one who created the ERA as they paid first. If the payer who created the ERA appears in the destination payer field, then it needs to be reversed since that payer has already made payments on the claim.

In this case, swapping the prior and destination payers ensures the claim is directed to the correct payer and the payment information is associated with the correct payer.

Ambulance Data

If you are an HCFA/CMS 1500 upload customer who currently submits ambulance claims using your 1500 form, the Ambulance Data screen allows you to supplement primary and secondary claims with ambulance information.

After selecting a claim and identifying the claim service lines that pertain to ambulance data, detailed information may be added using the Ambulance Data entry screen.


Batch List | Claim List | Claim Summary | Claim Level Entries | Line Level Entries | Insurance Information | Ambulance Data

Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
tes4110707121134191	2	CROSX		WALKER, JAY	M	11/23/1938	09/05/2003	$95.00

Service Line	Service Dates From - Through	Procedure Code	Procedure Modifiers	Amount	Units	Ambulance Data Applied
1	09/04/2003 - 09/04/2003	99213	25	$50.00	1	
2	09/04/2003 - 09/04/2003	92020		$45.00	1	

Line Level Entries

Apply Adjustments to Line Number: Service Line 1

Ambulance Data

Patient Weight: 120
Hospital Admit: Patient admitted
* Type of Transport: Initial trip
Bed Confined Before: Patient was bed confined
Bed Confined After: Patient was bed confined
Moved by Stretcher: Patient was moved by stretcher
Unconscious/Shock: Yes, the patient was unconscious or in shock
Emergency Situation: Emergency situation
Physical Restraints: Physical restraints needed
Visible Hemorrhaging: No visible hemorrhaging noted
* Transported TO/FOR: Patient was transported to nearest facility for care of symptoms, complaints, or both
Medically Necessary: Medically necessary
* Miles: 16
Purpose of Round Trip:
Purpose of Stretcher: PURPOSE OF STRETCHER - WHATEVER
Patient Discharged: Yes, patient was discharged
Patient Admitted: Yes, patient was admitted
Services Available: Yes, the services were available at the first facility

Selected Claim List: Claim 1

Output Format NSF+

The data on this screen can be updated independently or in conjunction with primary payer data or secondary claim data. Any available data from the input file pre-populates the Ambulance Data fields.

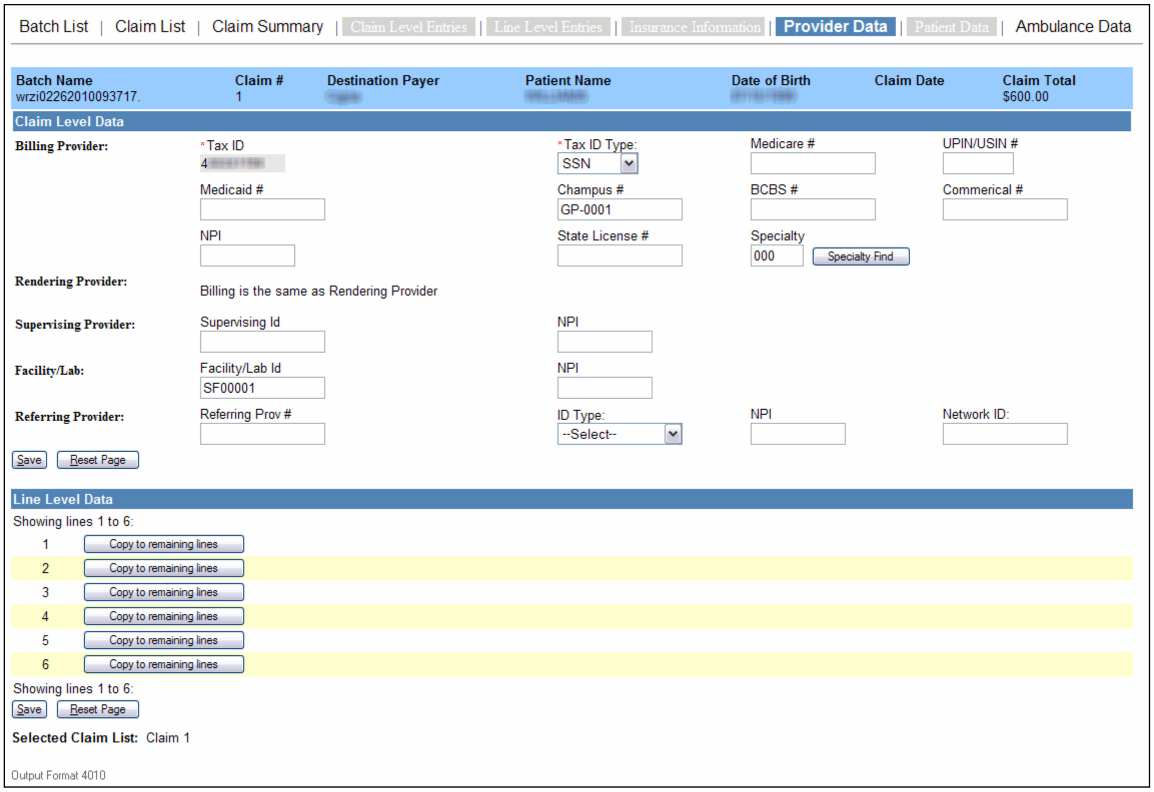
4010 Claims

This section applies to 4010 claims only. If you work with another type of claim, refer to **NSF 2.5 Claims** on page 38 or **NSF+ Claims** on page 44.

The 4010 claims output format is similar to NSF+, but it has several enhancements. Refer to the **NSF+ Claims** section beginning on page 44 for explanations of Claim Summary, Claim Level Entries, and Insurance Information. Below are details concerning the screens and features that have been enhanced or added.

Provider Data

The functionality of the Provider Data screen is similar to that of NSF 2.5, but with 4010, there are additional controls that prevent you from entering conflicting information or information for which sufficient supporting data does not exist in the original claim.


Batch List | Claim List | Claim Summary | Claim Level Entries | Line Level Entries | Insurance Information | Provider Data | Patient Data | Ambulance Data

Batch Name	Claim #	Destination Payer	Patient Name	Date of Birth	Claim Date	Claim Total
wrzi02262010093717.	1	[redacted]	[redacted]	[redacted]		$600.00

Claim Level Data

Billing Provider:
*Tax ID: 4[redacted]
*Tax ID Type: SSN
Medicare #:
UPIN/USIN #:
Medicaid #:
Champus #: GP-0001
BCBS #:
Commerical #:
NPI:
State License #:
Specialty: 000

Rendering Provider: Billing is the same as Rendering Provider

Supervising Provider:
Supervising Id:
NPI:

Facility/Lab:
Facility/Lab Id: SF00001
NPI:

Referring Provider:
Referring Prov #:
ID Type: --Select--
NPI:
Network ID:

Line Level Data

Showing lines 1 to 6:

1	Copy to remaining lines
2	Copy to remaining lines
3	Copy to remaining lines
4	Copy to remaining lines
5	Copy to remaining lines
6	Copy to remaining lines

Showing lines 1 to 6:

Selected Claim List: Claim 1

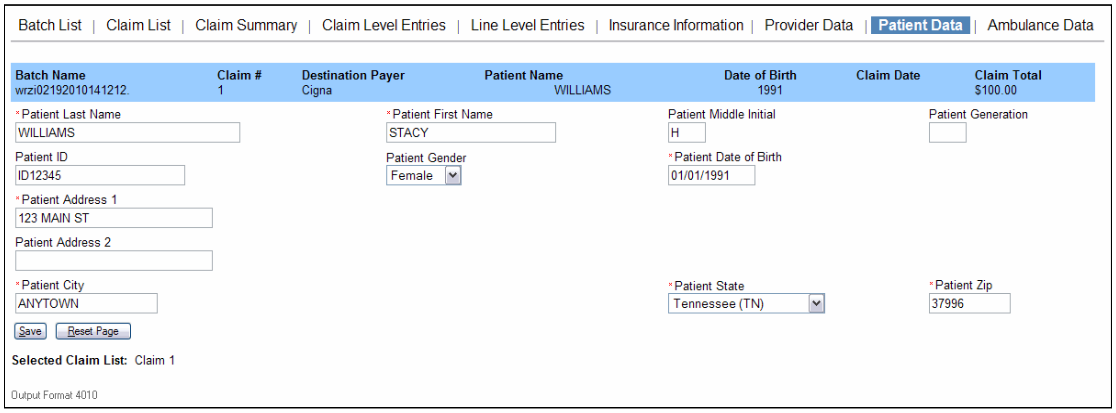
Output Format 4010

You can edit all fields except for the **Tax ID** for the Billing Provider. When the billing provider is the same as the rendering provider, the Billing Provider fields will appear, but the Rendering Provider fields will not. Instead, the following phrase will appear in the Rendering Provider section: "Billing is the same as Rendering Provider" (see above).

The Provider Data screen will only display fields for the providers or provider types that were present on the claim that was entered originally. For example, if the original claim did not contain a service facility provider/provider identifier, the fields corresponding to service facility provider will be absent from the Provider Data screen.

Patient Data

Patient Data is a new screen for 4010. Enter identifying information about the patient here.


Batch List | Claim List | Claim Summary | Claim Level Entries | Line Level Entries | Insurance Information | Provider Data | Patient Data | Ambulance Data
Save
Reset Page

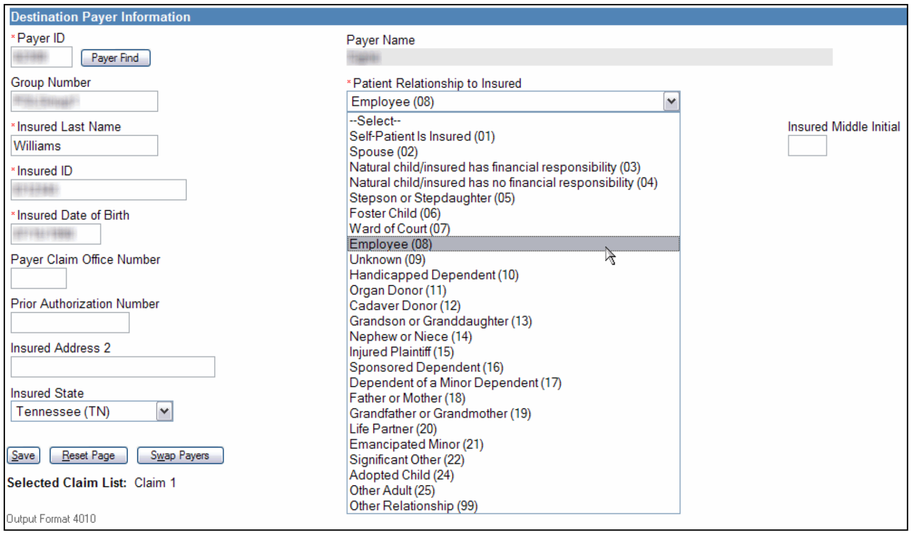
Batch Name	Claim #	Destination Payer	Patient Name	Date of Birth	Claim Date	Claim Total
wrzi02192010141212.	1	Cigna	WILLIAMS	1991		$100.00

*Patient Last Name: WILLIAMS
*Patient First Name: STACY
Patient Middle Initial: H
Patient Generation:
Patient ID: ID12345
Patient Gender: Female
*Patient Date of Birth: 01/01/1991
*Patient Address 1: 123 MAIN ST
Patient Address 2:
*Patient City: ANYTOWN
*Patient State: Tennessee (TN)
*Patient Zip: 37996

Selected Claim List: Claim 1

Output Format 4010

***Note**: The Patient Data screen is only active when the **Patient Relationship to Insured** field is a value other than **Self-Patient Is Insured (01)** for the Destination Payer on the Insurance Information screen.*


Payer Find
--Select--
Self-Patient Is Insured (01)
Spouse (02)
Natural child/insured has financial responsibility (03)
Natural child/insured has no financial responsibility (04)
Stepson or Stepdaughter (05)
Foster Child (06)
Ward of Court (07)
Employee (08)
Unknown (09)
Handicapped Dependent (10)
Organ Donor (11)
Cadaver Donor (12)
Grandson or Granddaughter (13)
Nephew or Niece (14)
Injured Plaintiff (15)
Sponsored Dependent (16)
Dependent of a Minor Dependent (17)
Father or Mother (18)
Grandfather or Grandmother (19)
Life Partner (20)
Emancipated Minor (21)
Significant Other (22)
Adopted Child (24)
Other Adult (25)
Other Relationship (99)
Save
Reset Page
Swap Payers

Destination Payer Information

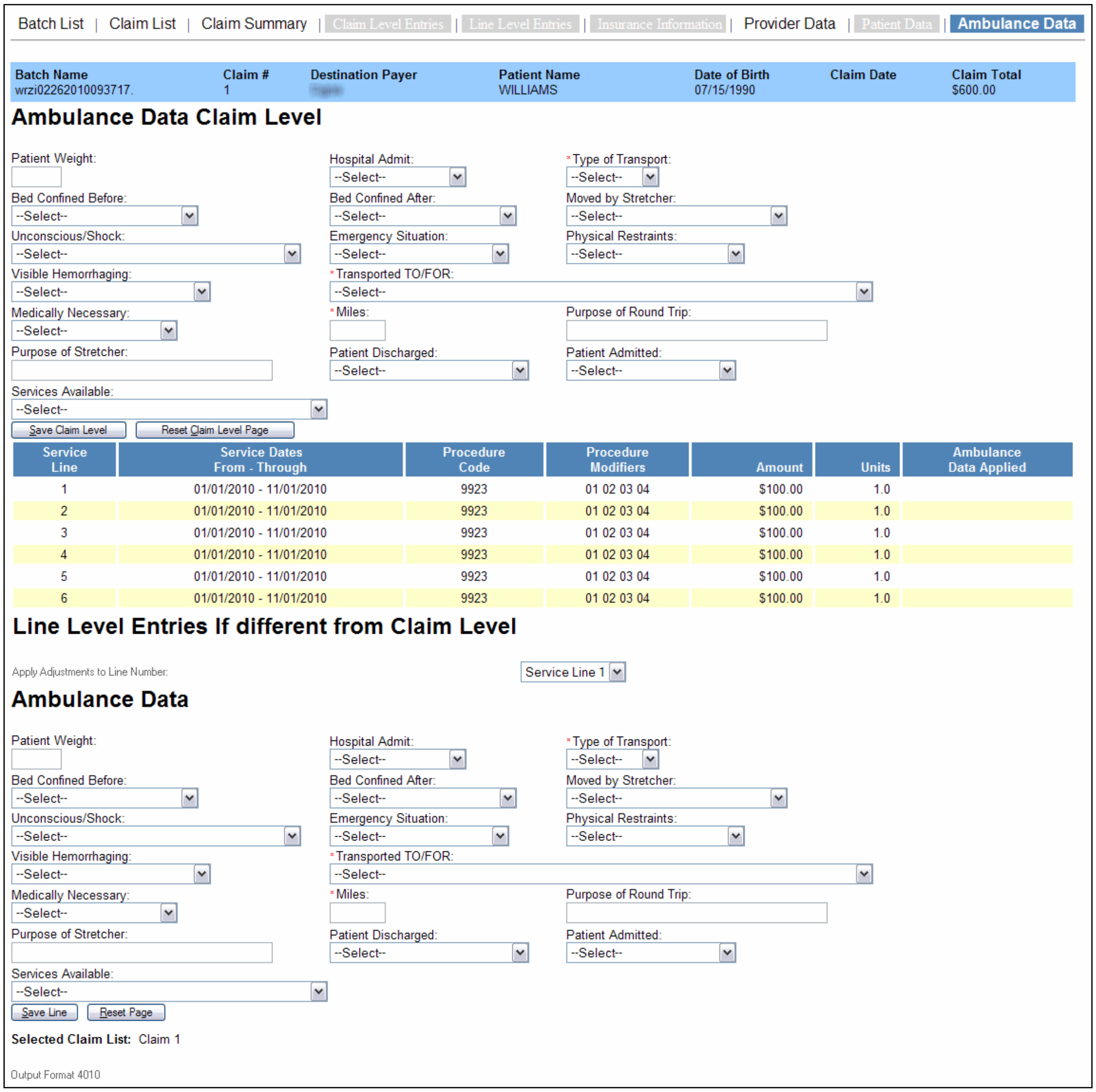
*Payer ID: [redacted]
Payer Name: [redacted]
Group Number: [redacted]
*Patient Relationship to Insured: Employee (08)
*Insured Last Name: Williams
Insured Middle Initial:
*Insured ID: [redacted]
*Insured Date of Birth: [redacted]
Payer Claim Office Number:
Prior Authorization Number:
Insured Address 2:
Insured State: Tennessee (TN)

Selected Claim List: Claim 1

Output Format 4010

Ambulance Data

The 4010 Ambulance Data screen functions similarly to that of NSF+: you can add ambulance data to both primary and secondary claims, and available data pre-populates the appropriate fields (see **Ambulance Data** on page 50). However, with 4010, you have the ability to add claim level ambulance data as well as line level ambulance data. Entering ambulance information at the claim level negates the need for you to include it for each service line when there are no differences to report at the line level.


Batch List | Claim List | Claim Summary | Claim Level Entries | Line Level Entries | Insurance Information | Provider Data | Patient Data | Ambulance Data

Batch Name	Claim #	Destination Payer	Patient Name	Date of Birth	Claim Date	Claim Total
wrzi02262010093717.	1	[redacted]	WILLIAMS	07/15/1990		$600.00

Ambulance Data Claim Level

Patient Weight:
Hospital Admit: --Select--
*Type of Transport: --Select--
Bed Confined Before: --Select--
Bed Confined After: --Select--
Moved by Stretcher: --Select--
Unconscious/Shock: --Select--
Emergency Situation: --Select--
Physical Restraints: --Select--
Visible Hemorrhaging: --Select--
*Transported TO/FOR: --Select--
Medically Necessary: --Select--
*Miles:
Purpose of Round Trip:
Purpose of Stretcher:
Patient Discharged: --Select--
Patient Admitted: --Select--
Services Available: --Select--

Service Line	Service Dates From - Through	Procedure Code	Procedure Modifiers	Amount	Units	Ambulance Data Applied
1	01/01/2010 - 11/01/2010	9923	01 02 03 04	$100.00	1.0	
2	01/01/2010 - 11/01/2010	9923	01 02 03 04	$100.00	1.0	
3	01/01/2010 - 11/01/2010	9923	01 02 03 04	$100.00	1.0	
4	01/01/2010 - 11/01/2010	9923	01 02 03 04	$100.00	1.0	
5	01/01/2010 - 11/01/2010	9923	01 02 03 04	$100.00	1.0	
6	01/01/2010 - 11/01/2010	9923	01 02 03 04	$100.00	1.0	

Line Level Entries If different from Claim Level

Apply Adjustments to Line Number: Service Line 1

Ambulance Data

Patient Weight:
Hospital Admit: --Select--
*Type of Transport: --Select--
Bed Confined Before: --Select--
Bed Confined After: --Select--
Moved by Stretcher: --Select--
Unconscious/Shock: --Select--
Emergency Situation: --Select--
Physical Restraints: --Select--
Visible Hemorrhaging: --Select--
*Transported TO/FOR: --Select--
Medically Necessary: --Select--
*Miles:
Purpose of Round Trip:
Purpose of Stretcher:
Patient Discharged: --Select--
Patient Admitted: --Select--
Services Available: --Select--

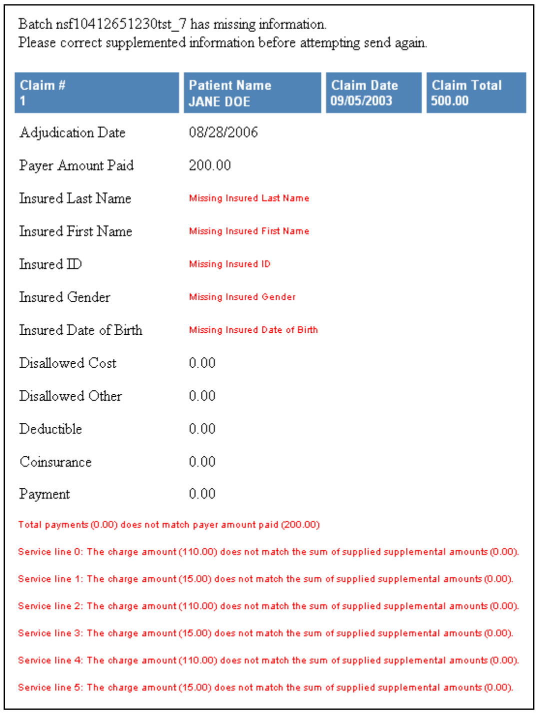
Selected Claim List: Claim 1

Output Format 4010

Sample Error Messages

The following are sample error messages that may appear when sending a batch of claims that have errors in any supplemental data entered.

Sample NSF2.5 Error Message:



Batch nsf10412651230tst_7 has missing information.
Please correct supplemented information before attempting send again.

Claim #	Patient Name	Claim Date	Claim Total
1	JANE DOE	09/05/2003	500.00

Adjudication Date	08/28/2006
Payer Amount Paid	200.00
Insured Last Name	Missing Insured Last Name
Insured First Name	Missing Insured First Name
Insured ID	Missing Insured ID
Insured Gender	Missing Insured Gender
Insured Date of Birth	Missing Insured Date of Birth
Disallowed Cost	0.00
Disallowed Other	0.00
Deductible	0.00
Coinsurance	0.00
Payment	0.00

Total payments (0.00) does not match payer amount paid (200.00)

Service line 0: The charge amount (110.00) does not match the sum of supplied supplemental amounts (0.00).

Service line 1: The charge amount (15.00) does not match the sum of supplied supplemental amounts (0.00).

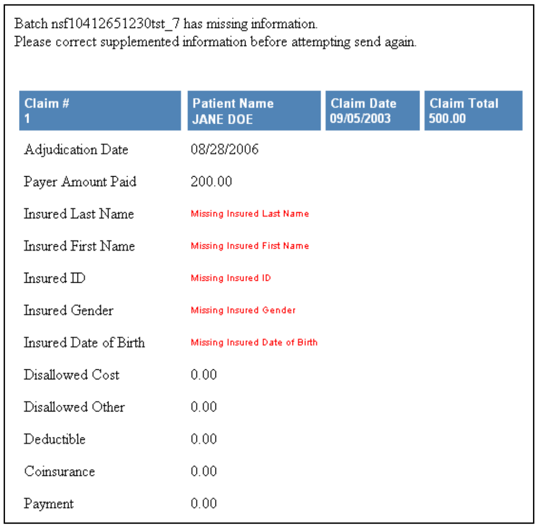
Service line 2: The charge amount (110.00) does not match the sum of supplied supplemental amounts (0.00).

Service line 3: The charge amount (15.00) does not match the sum of supplied supplemental amounts (0.00).

Service line 4: The charge amount (110.00) does not match the sum of supplied supplemental amounts (0.00).

Service line 5: The charge amount (15.00) does not match the sum of supplied supplemental amounts (0.00).

Sample NSF+ Error Message:

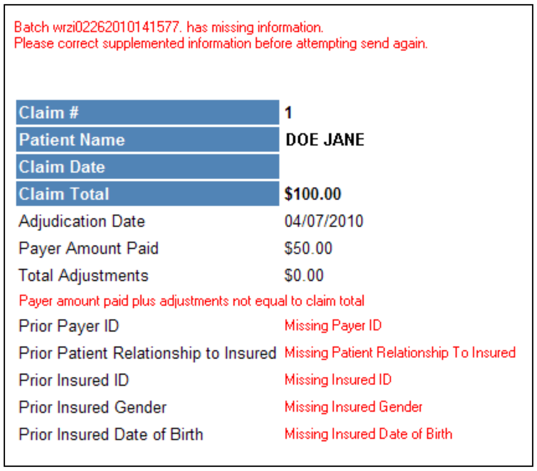


Batch nsf10412651230tst_7 has missing information.
Please correct supplemented information before attempting send again.

Claim #	Patient Name	Claim Date	Claim Total
1	JANE DOE	09/05/2003	500.00

Adjudication Date	08/28/2006
Payer Amount Paid	200.00
Insured Last Name	Missing Insured Last Name
Insured First Name	Missing Insured First Name
Insured ID	Missing Insured ID
Insured Gender	Missing Insured Gender
Insured Date of Birth	Missing Insured Date of Birth
Disallowed Cost	0.00
Disallowed Other	0.00
Deductible	0.00
Coinsurance	0.00
Payment	0.00

Sample 4010 Error Message:



Batch wrzi02262010141577. has missing information.
Please correct supplemented information before attempting send again.

Claim #	**1**
Patient Name	**DOE JANE**
Claim Date	
Claim Total	**$100.00**
Adjudication Date	04/07/2010
Payer Amount Paid	$50.00
Total Adjustments	$0.00
Payer amount paid plus adjustments not equal to claim total	
Prior Payer ID	Missing Payer ID
Prior Patient Relationship to Insured	Missing Patient Relationship To Insured
Prior Insured ID	Missing Insured ID
Prior Insured Gender	Missing Insured Gender
Prior Insured Date of Birth	Missing Insured Date of Birth

Abbreviations Used in Remittance Advice Notices

To save space, a number of abbreviations are used in a remittance advice. The following table is included as a reference.

Abbreviation	Description
PT RESP	Patient Responsibility. Includes total coinsurance, deductible, non-covered services, and psychiatric limitation.
PERF PROV	Performing Provider Number
SERV DATE	Date of Service
POS	Place of Service
NOS	Number of Services
PROC	Procedure Code
MODS	Modifiers. Modifiers are two-digit codes appended to procedure codes and/or HCPCS codes, to provide additional information about the billed procedure. In some cases, addition of a modifier may directly affect payment.
BILLED	Billed Amount
ALLOWED	Allowed Amount (prior to deductions or offsets)
DEDUCT	Deductible Due (amounts applied to patient's deductible will appear here)
COINS	Coinsurance Due (patient's 20%)
PROV PD	Amount Paid to Provider (prior to adjustments)
RC AMOUNT	Reason Code other than deductible and coinsurance. If more than one, additional adjustment codes will appear on the next line.
HIC	Medicare Health Insurance Claim number (patient's "Medicare Number")
ACNT	Patient account number assigned by the provider
ICN	Internal Control Number (also known as DCN)
ASG	Whether assignment accepted (Y = yes or N = no)
MOA	Medicare Outpatient Adjudication Remark Code. For a complete list of MOA codes click Search, and on the search screen enter a wild card in the Remark Code field (* or %) and click Search.
REM	Remark Codes
NET	The amount paid for the claim after adjustments
ADJS	Adjustments

The following abbreviations appear as adjustments:

Abbreviation	Description
PREV PD	Amounts previously paid on this claim will appear here
PD TO BENE	Amounts collected over the co-pay will appear here (This amount will be paid to the patient for this claim)
INT	Interest
MSP	Medicare Secondary Payer (Amount paid by insurer primary to Medicare)
OTHER	Other claim level adjustments that apply
FCN	Financial control number of prior claim(s) that contributed to the overpayment or that explains the reason for the offset
BF	Balance Forward (This applies to suppressed checks for less than $1.00.)

Troubleshooting Guide

The following table lists common issues and error messages you may encounter when working with Supplement Claims.

Problem/Scenario	Possible Causes	Action Required by User
A batch has been indicated as needing to be held for entry of prior payment data accidentally (i.e. the user wants to send the batch without entering any supplemental data).	N/A	The user should proceed to the Supplement Claims function and select Send from the batch list. **Note**: If the user entered the claim using the Claim Entry feature in Emdeon Office, they will need to remove the “Sup*” indicator in the remarks field before attempting to send.
The user has forgotten to indicate that claims needed to be held for the entry of prior payment information.	N/A	The user needs to re-upload the batch indicating that the batch contains claims requiring supplemental information. **Note**: Any unaffected claims may result in rejections at the Emdeon Clearinghouse for duplicate claim.
The user would like to use the Supplement Claims feature but receives email notification upon upload that a supplemental batch was received and if their submission was unintentional they should resubmit or if their submission was intentional they should contact Customer Support.	The user has not been set up within Emdeon to take advantage of the Secondary Claims feature. The user is not eligible to be set up as a Secondary Claims user (due to the input format of their data).	The user should contact customer service to determine if they have an eligible set up to take advantage of the Secondary Claims feature. If they have an eligible set up to take advantage of the Secondary Claims feature, Customer Support can perform the necessary activation of the feature.
Customer receives email notification that a batch is over 4 days old.	Customer has uploaded the batch indicating it as needing to be supplemented but has yet to complete the necessary steps to complete submission.	Customer needs to proceed to the Supplement Claims function at which point they may supplement, send, or delete the batch.
Customer has selected a batch under the Supplement Claims feature but is unable to select and supplement a particular claim.	The secondary payer may not be able to receive secondary claims electronically. There are multiple errors associated with the original claim data.	If the description under the Payer Name reads Non EDI Payer, the payer is unable to receive secondary claims and the user will be unable to supplement. If the description reads otherwise, the user should contact Customer Support for assistance with the claim errors.
The user has selected a claim to supplement and the destination and prior payer are presented in reverse order.	There is a variance in their software and the order in which it provides payer information.	The user should use the “Swap Payers” function to properly set the destination and prior payers.

Problem/Scenario	Possible Causes	Action Required by User
A batch of claims no longer appears under the Batch List in the Supplement Claims function.	The user has either sent or deleted the batch.	If the batch was deleted and needs to be sent, the user will need to re-enter the batch. If the batch was sent, the user should confirm with other users at their site that the desired entries were made prior to sending the batch.
After sending the batch under the Supplement Claim function the user receives subsequent reject notifications.	N/A	The user needs to correct the errors, re-load the batch, and re-enter any applicable supplemental information.
The user receives a message that a batch is in use by another user.	Only one user can access a given batch at a time under the Supplement Claims feature.	The user needs to wait for the other user at their site to release the batch.

Report

Overview

This section contains information on the text-readable reports generated from Emdeon's processing system and returned to the submitter's Emdeon email. Understanding these reports will provide a submitter the necessary knowledge to effectively manage their electronic claims. While each report displays unique and specific claims information, the following information and features are common to all reports referenced in this section:

- All reports must be requested through an Emdeon representative.
- All reports are 80 characters wide and 60 lines long.
- All reports are formatted as ASCII-text and should be printed using a text-capable program. Wrapping of text may occur; therefore, it is important to establish the correct text size through your computer.

Emdeon's Provider Reports

The following table is a brief overview of the reports available from Emdeon for providers. An example of each report is included along with field description information. We recommend that you use the **Reporting & Analytics** (page 87) solution for claim status information in place of these reports. Turn on or turn off the delivery of some or all of these reports by clicking **Setup** > **My Account**; detailed information about changing your report delivery options can be found in the General User Guide.

Report #	Emdeon Report Title	Timing*	Purpose of the Report
RPT-00	Customer Service Alert	Daily – Alerts for the business day	Provides a complete listing of all batch system Customer Service Alerts, CSAs, for the business day. The report does not contain real-time Customer Service Alerts. Depending upon the vendor's preferences, the RPT-00 can be for vendors only or for vendors and providers. There is no preference to add or remove RPT-00, only a vendor option to indicate if the provider is to receive the CSA in addition to the Vendor.
RPT-02	File Status Report	Within 4 hours of time file submitted to Emdeon	Provides an initial analysis of the file, by displaying file status of accepted or rejected and a description of the status. It also indicates the total number of claims and $ value if the file contains valid claims. The RPT-02 report is generated within a few hours after the file has been received from the clearinghouse. In order for the RPT-02 to be generated, a submitter's transmitted file must be received and opened by the clearinghouse with the file's Summary record residing in the Repository database. There is no sorting of information within the report.
RPT-03	File Summary Report	Within 48 hours of time file submitted to Emdeon	Provides summarized information on the quantity of accepted and rejected claims, as well as the total number of claims received by Emdeon for each submitted file. In order for the RPT-03 to generate, all claims contained within the submitter's file need to be processed and contain status record information. There is no sorting of information within the report.
RPT-04	File Detail Summary Report	Within 48 hours of time file submitted to Emdeon	Contains a detail summary of the file submitted for processing. It provides a file roll-up listing all accepted and rejected claims contained in each file submitted to Emdeon. It also contains payer name/id and status of claim. In order for the RPT-04 to generate, all claims contained within the submitter's file need to be processed and contain status record information. Information is sorted by Customer and then by Patient (Last Name, First Initial, Middle Initial).
RPT-04A	Amended File Detail Summary Report	Daily – includes claims with an amended status within the last 24 hours	Contains a detailed listing of all claims for which the status was amended during the previous processing day. Claim statuses are amended when a pending claim is processed and/or when a claim is reprocessed at Emdeon. It also contains payer name/id and amended status of the claim. Information is sorted by Customer and then by Patient (Last Name, First Initial, Middle Initial).

Report #	Emdeon Report Title	Timing*	Purpose of the Report
RPT-05	Batch and Claim Level Rejection Report	Within 48 hours of time file submitted to Emdeon	Contains rejected batches and claims listed with detailed error explanations. In order to prevent "lost" claims, the RPT-05 report must be reviewed and worked after each file transmission. Claims that are listed as rejected are not forwarded to the payer(s) for processing. These rejected claims must be corrected and re-submitted (either electronically or on paper) for processing. In order for the RPT-05 to generate, all claims contained within the submitter's file need to be processed and contain status record information. Information is sorted by Customer and then by Patient (Last Name, First Initial, Middle Initial).
RPT-05A	Amended Batch and Claim Level Rejection Report	Daily – includes claims with an amended status within the last 24 hours	Contains rejected batches and claims listed with detailed error explanations. In order to prevent "lost" claims, the RPT-05A report must be reviewed and worked after each file transmission. Claims that are listed as rejected are not forwarded to the payer(s) for processing. These rejected claims must be corrected and re-submitted (either electronically or on paper) for processing. In order for the RPT-05 to generate, all claims contained within the submitter's file need to be processed and contain status record information. Information is sorted by Customer and then by Patient (Last Name, First Initial, Middle Initial).
RPT-08	Provider Monthly Summary	Monthly – by the 5th calendar day	Displays the number and $ value of claims accepted and forwarded by Emdeon for the month. Monthly and Y-T-D Totals for both accepted and rejected claims are included as well as the provider's top 25 errors for the month. Information is sorted by Customer ID, Payer, and Error Frequency. Y-T-D totals include data for claims processed by Emdeon beginning September 1st, 2001.
RPT-10	Provider Claim Status Report	Daily – includes payer status updates received in the last 24 hours	Contains information provided by payers who receive claims from Emdeon for adjudication. Not all payers who receive claims from Emdeon provide information for this Claim Status Report, and the amount/frequency of information produced will vary from payer to payer. The RPT-10 does not return Unprocessed, Request for Additional Information, or Rejected statuses. This report is generated daily for each submitter for payer status updates received within the previous 24 hours. Information is sorted by Customer ID, Status, and then by Payer.
RPT-11	Special Handling/ Unprocessed Claims Report	Daily – includes payer status updates received in the last 24 hours	Contains information provided by payers who receive claims from Emdeon for adjudication. Not all payers who receive claims from Emdeon provide information for this report, and the amount/frequency of information produced will vary from payer to payer. The RPT-11 returns Unprocessed, Request for Additional Information, and Rejected Statuses only. This report is generated daily for each submitter for payer status updates received within the previous 24 hours. Information is sorted by Customer ID, Status, and then by Payer.

***Daily** reports are generated on a daily basis assuming that the submitter is part of a Submitter Report Group that receives the report and if the submitter has had claims volume with the report's specific parameters at Emdeon in a given day. **Next Business Day** reports are generated on a next business day basis assuming that the submitter is part of a Submitter Report Group that receives the report and if the submitter has had claims volume with the report's specific parameters at Emdeon in a given timeframe. **Monthly** reports are generated on a monthly basis assuming that the submitter is part of a Submitter Report Group that receives the report and if the submitter has had claims volume with the report's specific parameters at Emdeon in a given month.

Report Sequence, Frequency, and Usage Information

The following sequence, frequency, and usage information is provided for each report referenced in this guide.

RPT-00	Customer Service Alert
Sequence	By customer ID
Frequency	Daily – includes all Customer Service Alerts within past 24 hours
Usage	To provide a listing of all batch system related Customer Service Alerts

RPT-02	File Status Report
Sequence	By file submitted

RPT-02	File Status Report
Frequency	Daily if claim data is submitted by 8:00 p.m. Eastern time
Usage	To monitor whether the file transmitted to Emdeon was accepted for processing or was rejected by the clearinghouse

RPT-03	File Summary Report
Sequence	By file submitted
Frequency	Next business day if claim data is submitted by 8:00 p.m. Eastern time
Usage	To monitor daily number of accepted and rejected claims and charges per file submitted

RPT-04	File Detail Summary Report
Sequence	By file submitted, by customer and by patient
Frequency	Next business day if claim data is submitted by 8:00 p.m. Eastern time
Usage	To monitor daily claims submitted to Emdeon for future reference

RPT-05	Batch and Claim Level Rejection Report
Sequence	By file submitted, by customer, and by patient
Frequency	Next business day if claim data is submitted by 8:00 p.m. Eastern time
Usage	To monitor daily batch and claim level rejections. Contains detailed error explanations necessary to correct any rejected claims. This report is very important and should be worked/reviewed daily.

RPT-08	Provider Monthly Summary
Sequence	By customer, by payer, and by error
Frequency	Monthly, by the 5th business day if claim data is submitted by 8:00 p.m. Eastern time
Usage	Monitors overall monthly customer statistics, claims forwarded to the listed insurance payers and the most frequent claim level rejections. Management could use this report.

RPT-10	Provider Claim Status Report
Sequence	By customer, by status, and by payer
Frequency	Daily for each submitter for payer status updates received within the previous 24 hours if claim data is submitted by 8:00 p.m. Eastern time
Usage	To monitor status of claims submitted electronically to payers. **Note**: Not all payers provide a claim status electronically, and the amount/frequency of returned information varies. The RPT-10 does not return Unprocessed, Request for Additional Information, or Rejected statuses.

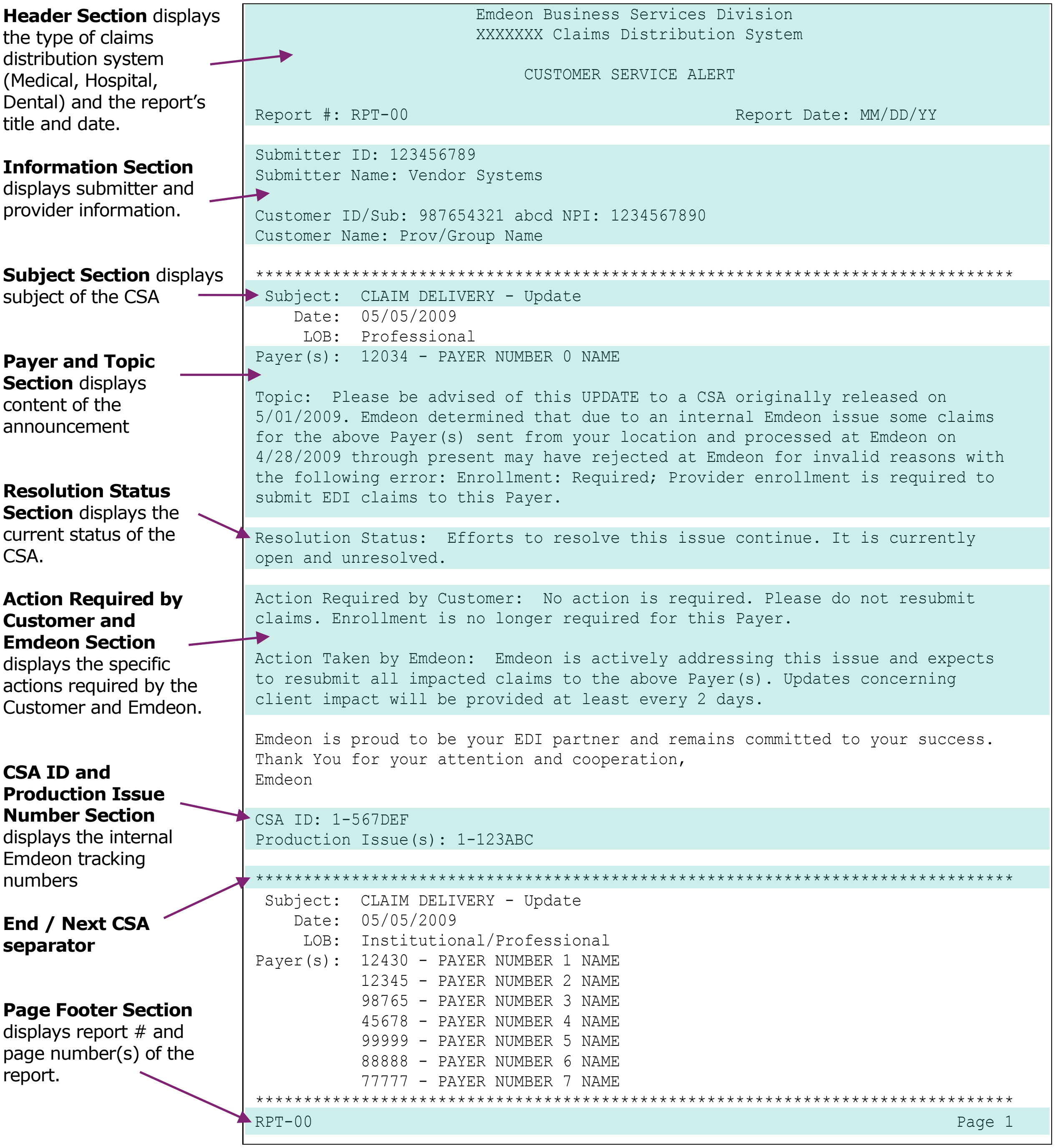
RPT-11	Special Handling/Unprocessed Claims Report
Sequence	By customer ID, by status, and by payer
Frequency	Daily for each submitter for payer status updates received within the previous 24 hours if claim data is submitted by 8:00 p.m. Eastern time
Usage	To monitor and inform of the status of unprocessed, request for additional information, and rejected statuses only on claims submitted electronically to payers. **Note**: Not all payers provide a claim status electronically, and the amount/frequency of returned information varies.

RPT-00 (Customer Service Alerts)

The RPT-00 report is intended for Vendors only or for Vendors and Providers depending upon the Vendors preference. The RPT-00 is a listing of all pertinent Customer Service Alerts for the processing day.

RPT-00 Report Sample

The following sample is provided to illustrate the various sections and fields contained in the RPT-00 report.



Header Section displays the type of claims distribution system (Medical, Hospital, Dental) and the report's title and date.

Information Section displays submitter and provider information.

Subject Section displays subject of the CSA

Payer and Topic Section displays content of the announcement

Resolution Status Section displays the current status of the CSA.

Action Required by Customer and Emdeon Section displays the specific actions required by the Customer and Emdeon.

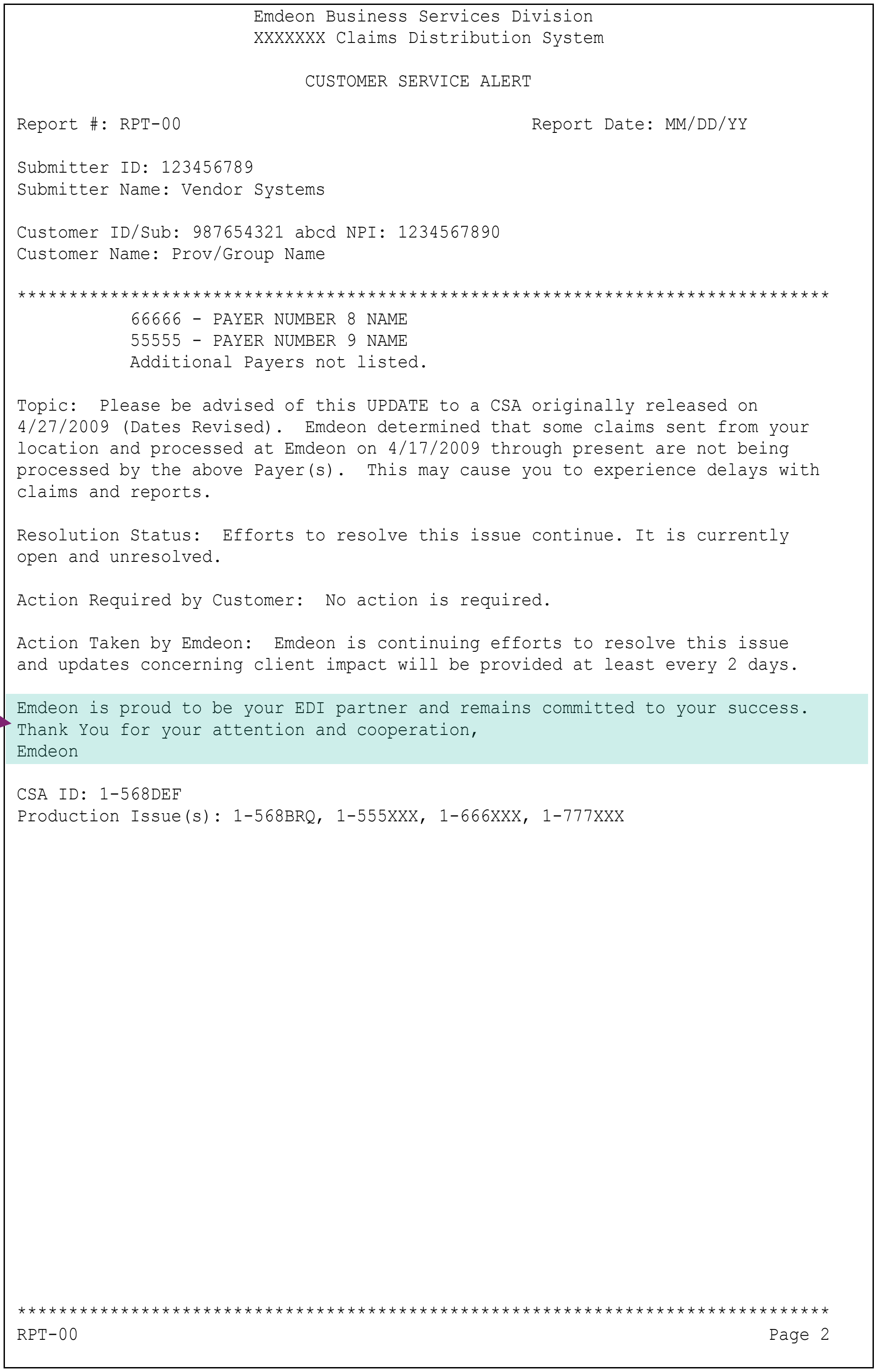
CSA ID and Production Issue Number Section displays the internal Emdeon tracking numbers

End / Next CSA separator

Page Footer Section displays report # and page number(s) of the report.

```
                         Emdeon Business Services Division
                         XXXXXXX Claims Distribution System

                              CUSTOMER SERVICE ALERT

Report #: RPT-00                                  Report Date: MM/DD/YY

Submitter ID: 123456789
Submitter Name: Vendor Systems

Customer ID/Sub: 987654321 abcd NPI: 1234567890
Customer Name: Prov/Group Name

******************************************************************************
 Subject:  CLAIM DELIVERY - Update
    Date:  05/05/2009
     LOB:  Professional
Payer(s):  12034 - PAYER NUMBER 0 NAME

Topic:  Please be advised of this UPDATE to a CSA originally released on
5/01/2009. Emdeon determined that due to an internal Emdeon issue some claims
for the above Payer(s) sent from your location and processed at Emdeon on
4/28/2009 through present may have rejected at Emdeon for invalid reasons with
the following error: Enrollment: Required; Provider enrollment is required to
submit EDI claims to this Payer.

Resolution Status:  Efforts to resolve this issue continue. It is currently
open and unresolved.

Action Required by Customer:  No action is required. Please do not resubmit
claims. Enrollment is no longer required for this Payer.

Action Taken by Emdeon:  Emdeon is actively addressing this issue and expects
to resubmit all impacted claims to the above Payer(s). Updates concerning
client impact will be provided at least every 2 days.

Emdeon is proud to be your EDI partner and remains committed to your success.
Thank You for your attention and cooperation,
Emdeon

CSA ID: 1-567DEF
Production Issue(s): 1-123ABC

******************************************************************************
 Subject:  CLAIM DELIVERY - Update
    Date:  05/05/2009
     LOB:  Institutional/Professional
Payer(s):  12430 - PAYER NUMBER 1 NAME
           12345 - PAYER NUMBER 2 NAME
           98765 - PAYER NUMBER 3 NAME
           45678 - PAYER NUMBER 4 NAME
           99999 - PAYER NUMBER 5 NAME
           88888 - PAYER NUMBER 6 NAME
           77777 - PAYER NUMBER 7 NAME
******************************************************************************
RPT-00                                                                 Page 1
```

RPT-00 (continued)



```
                       Emdeon Business Services Division
                       XXXXXXX Claims Distribution System

                            CUSTOMER SERVICE ALERT

Report #: RPT-00                                  Report Date: MM/DD/YY

Submitter ID: 123456789
Submitter Name: Vendor Systems

Customer ID/Sub: 987654321 abcd NPI: 1234567890
Customer Name: Prov/Group Name

*******************************************************************************
           66666 - PAYER NUMBER 8 NAME
           55555 - PAYER NUMBER 9 NAME
           Additional Payers not listed.

Topic:  Please be advised of this UPDATE to a CSA originally released on
4/27/2009 (Dates Revised).  Emdeon determined that some claims sent from your
location and processed at Emdeon on 4/17/2009 through present are not being
processed by the above Payer(s).  This may cause you to experience delays with
claims and reports.

Resolution Status:  Efforts to resolve this issue continue. It is currently
open and unresolved.

Action Required by Customer:  No action is required.

Action Taken by Emdeon:  Emdeon is continuing efforts to resolve this issue
and updates concerning client impact will be provided at least every 2 days.

Emdeon is proud to be your EDI partner and remains committed to your success.
Thank You for your attention and cooperation,
Emdeon

CSA ID: 1-568DEF
Production Issue(s): 1-568BRQ, 1-555XXX, 1-666XXX, 1-777XXX









*******************************************************************************
RPT-00                                                                   Page 2
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Closing Comments Section

RPT-00 Detailed Information

Sorting Sequence	By customer ID
Frequency of Report	Daily – includes all batch system Customer Service Alerts within the past 24 hours
Purpose of Report	To inform the customer of all pertinent Customer Service Alerts

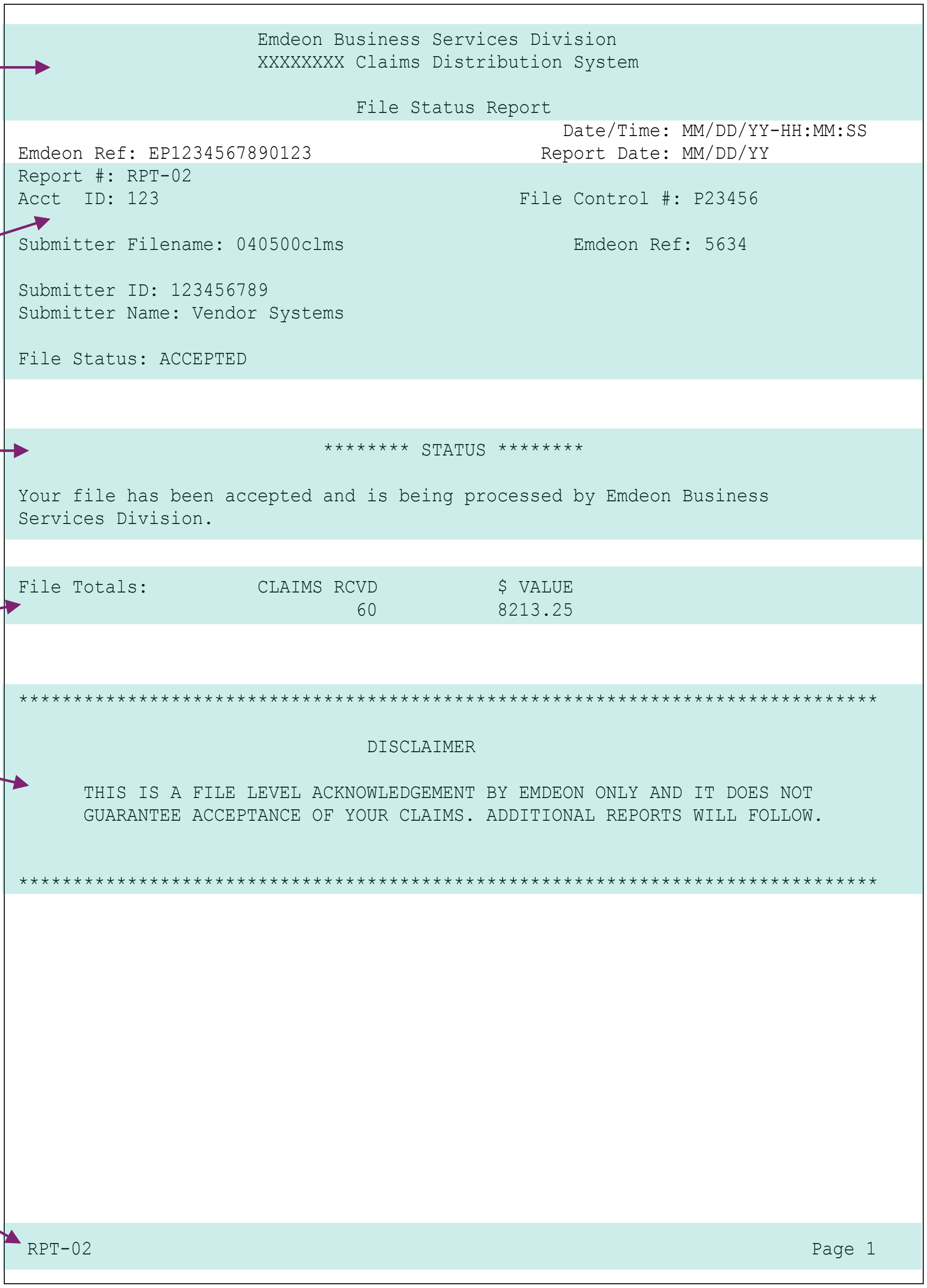
Report Field Name	Description
Report Date	The date the report was generated by Emdeon.
Report #	The Emdeon report number
Submitter ID	The identifier used by Emdeon to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
Submitter Name	The name of the submitter
Customer ID	The identifier used by Emdeon to identify the customer
Customer Name	The name of the customer
SUBJECT: Subject Date Line of Business	The subject of the Customer Service Alert The date the announcement is for The line of business affected
PAYER and TOPIC: Payers Topic	The payers affected by the announcement A brief text describing the announcement
RESOLUTION STATUS	The current status of the issue
ACTION REQUIRED by CUSTOMER and EMDEON: Required by customer Required by Emdeon	The specific actions requested of the customer The steps Emdeon will be taking to resolve the issue
CSA ID and PRODUCTION ISSUE NUMBER: CSA ID Production Issue Number	The ID number associated with this Customer Service Alert The associated Emdeon production issue ticket for this Customer Service Alert

RPT-02 (Customer Service Alerts)

The RPT-02 report gives an initial analysis of the file received. It shows a file status of accepted or rejected and a description of the status. It also indicates the total number of claims and $ value if the file contains valid claims.

RPT-02 Report Sample

The following sample is provided to illustrate the various sections and fields contained in the RPT-02 report.



```
                       Emdeon Business Services Division
                       XXXXXXXX Claims Distribution System

                                File Status Report
                                                   Date/Time: MM/DD/YY-HH:MM:SS
Emdeon Ref: EP1234567890123                      Report Date: MM/DD/YY
Report #: RPT-02
Acct  ID: 123                                  File Control #: P23456

Submitter Filename: 040500clms                      Emdeon Ref: 5634

Submitter ID: 123456789
Submitter Name: Vendor Systems

File Status: ACCEPTED


                             ******** STATUS ********

Your file has been accepted and is being processed by Emdeon Business
Services Division.

File Totals:          CLAIMS RCVD            $ VALUE
                               60            8213.25


******************************************************************************

                                  DISCLAIMER

      THIS IS A FILE LEVEL ACKNOWLEDGEMENT BY EMDEON ONLY AND IT DOES NOT
      GUARANTEE ACCEPTANCE OF YOUR CLAIMS. ADDITIONAL REPORTS WILL FOLLOW.


******************************************************************************




 RPT-02                                                                 Page 1
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Header Section displays the type of claims distribution system (Medical, Hospital, Dental) and the report's title.

Information Section displays data on your transmitted file. This information can be used for locating your file in Emdeon's processing system.

File Status Section displays message on the status of your transmitted file.

File Totals Section displays quantity and dollar value of claims in your submitted file.

Disclaimer Section displays text message explaining the intent of the report. This displays only once on the report.

Page Footer Section displays report # and page number(s) of the report.

RPT-02 Report Detailed Information

Sorting Sequence	By file submitted
Frequency of Report	Daily if claim data is submitted by 8:00 p.m. Eastern time
Purpose of Report	To monitor whether the file transmitted was accepted for processing or rejected

Report Field Name	**Description**
Date/Time	The date/time the claims file was processed by Emdeon. Format is MM/DD/YY-HH:MM:SS
Report #	The Emdeon report number
Acct ID	The submitter's login/account ID assigned by Emdeon
File Control #	Control number assigned to the file by the originator of the submitted transaction
Submitter Filename	The file name assigned by the submitter
Emdeon Ref	The tracking number assigned by the Emdeon clearinghouse to identify the file. This value can be used for referencing purposes.
Submitter ID	The identifier used by Emdeon to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
File Status	Indicates if the claims batch was ACCEPTED or REJECTED
STATUS	A description of the submitter's batch file status being processed by the Emdeon system. For example, a status could be a duplicate file, unknown submitter, incomplete file, accepted file but stopped during processing, etc.
File Totals: CLAIMS RCVD $ VALUE	 The number of claims received in the file. The dollar value of the claims contained in the received file.
DISCLAIMER	Text message explaining that the report is a file level acknowledgement and that it does not guarantee acceptance of the submitter's claims.

RPT-03 (File Summary Report)

The RPT-03 report gives a summary of the file submitted for processing. This report informs the submitter of how many claims were accepted and/or rejected, as well as the total number of claims received by Emdeon for each file submitted.

RPT-03 Report Sample

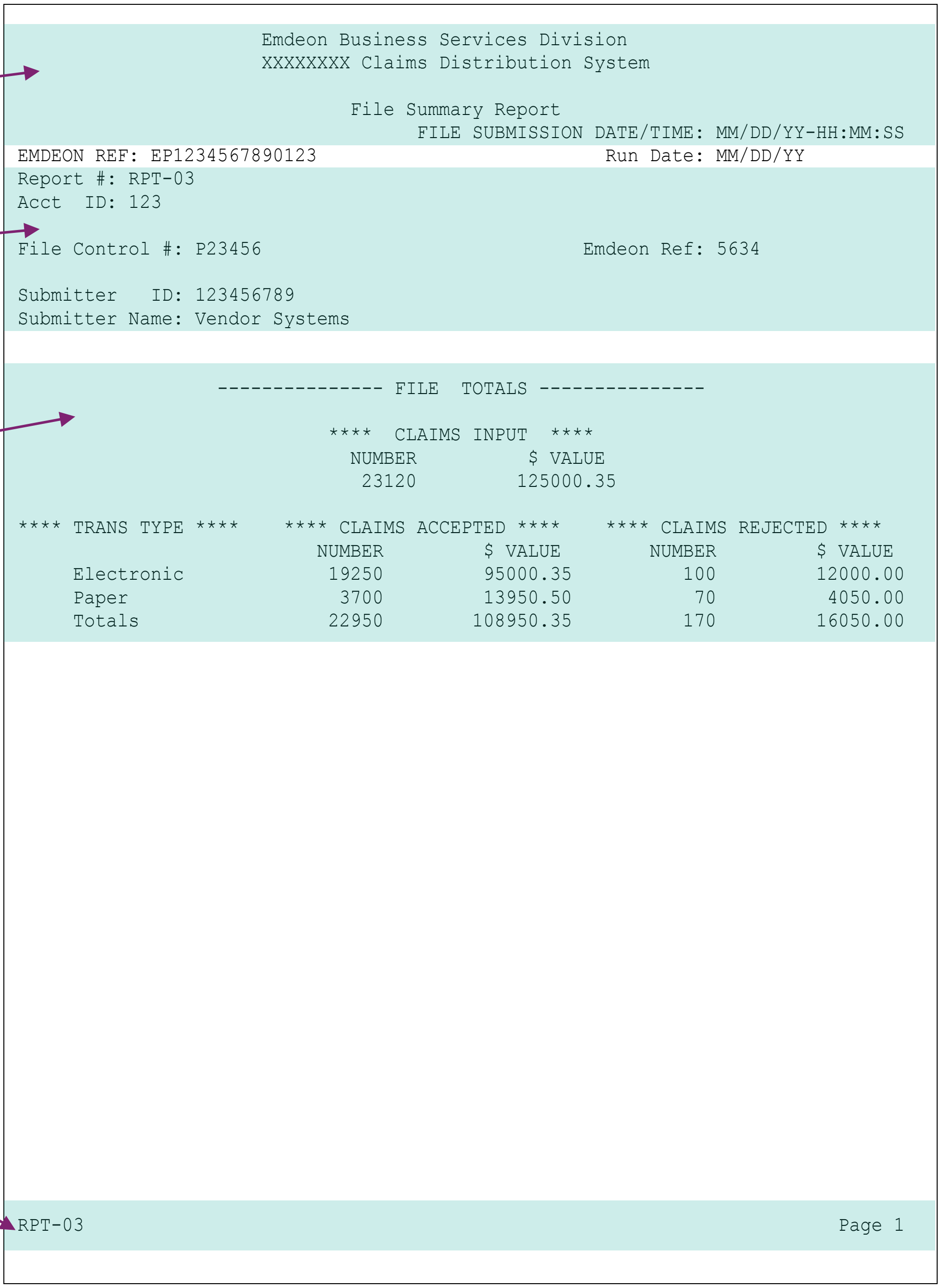
The following sample is provided to illustrate the various sections and fields contained in the RPT-03 report.

Header Section displays the type of claims distribution system (Medical, Hospital, Dental) and the report's title and run date.

Information Section displays data on your transmitted file. This information can be used for locating your file in Emdeon's processing system.

File Totals Section displays quantity and dollar value of claims in your submitted file. The total number of accepted and rejected claims is displayed.

Page Footer Section displays report # and page number(s) of the report.



```
                      Emdeon Business Services Division
                      XXXXXXXX Claims Distribution System

                              File Summary Report
                                    FILE SUBMISSION DATE/TIME: MM/DD/YY-HH:MM:SS
EMDEON REF: EP1234567890123                          Run Date: MM/DD/YY
Report #: RPT-03
Acct  ID: 123

File Control #: P23456                             Emdeon Ref: 5634

Submitter   ID: 123456789
Submitter Name: Vendor Systems


                  --------------- FILE  TOTALS ---------------

                            ****  CLAIMS INPUT  ****
                              NUMBER          $ VALUE
                               23120         125000.35

**** TRANS TYPE ****    **** CLAIMS ACCEPTED ****    **** CLAIMS REJECTED ****
                           NUMBER         $ VALUE        NUMBER         $ VALUE
     Electronic             19250         95000.35          100        12000.00
     Paper                   3700         13950.50           70         4050.00
     Totals                 22950        108950.35          170        16050.00









RPT-03                                                                    Page 1
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RPT-03 Detailed Information

Sorting Sequence	By file submitted
Frequency of Report	Next business day if claim data is submitted by 8:00 p.m. Eastern time
Purpose of Report	To monitor daily number of accepted and rejected claims and charges per file submitted.

Report Field Name	Description
Run Date	The date the report was generated by Emdeon
Report #	The Emdeon report number
Acct ID	The submitter's login/account ID assigned by Emdeon
File Control #	Control number assigned to the file by the originator of the submitted transaction
Emdeon Ref	The tracking number assigned by the Emdeon clearinghouse to identify the file. This value can be used for referencing purposes.
Submitter ID	The identifier used by Emdeon to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
Submitter Name	The name of the submitter
FILE TOTALS: CLAIMS INPUT NUMBER $ VALUE	 The total number of claims contained in the submitted claims file The total monetary value of the claims contained in the submitted claims file
TRANS TYPE: Electronic Paper Totals	 Indicates that the claim was transmitted electronically Indicates that the claim was transmitted on paper Indicates the total number of claims submitted
CLAIMS ACCEPTED	The number (NUMBER) and $ value ($ VALUE) of the claims accepted in the file submitted
CLAIMS REJECTED	The number (NUMBER) and $ value ($ VALUE) of the claims rejected in the file submitted

RPT-04 (File Detail Summary Report)

The RPT-04 report gives a detail summary of the file submitted for processing. This report is a file roll-up listing all accepted and rejected claims contained in each file submitted to Emdeon. The RPT-04 also contains payer name/ID and status of claim.

RPT-04 Report Sample

The following sample is provided to illustrate the various sections and fields contained in the RPT-04 report.

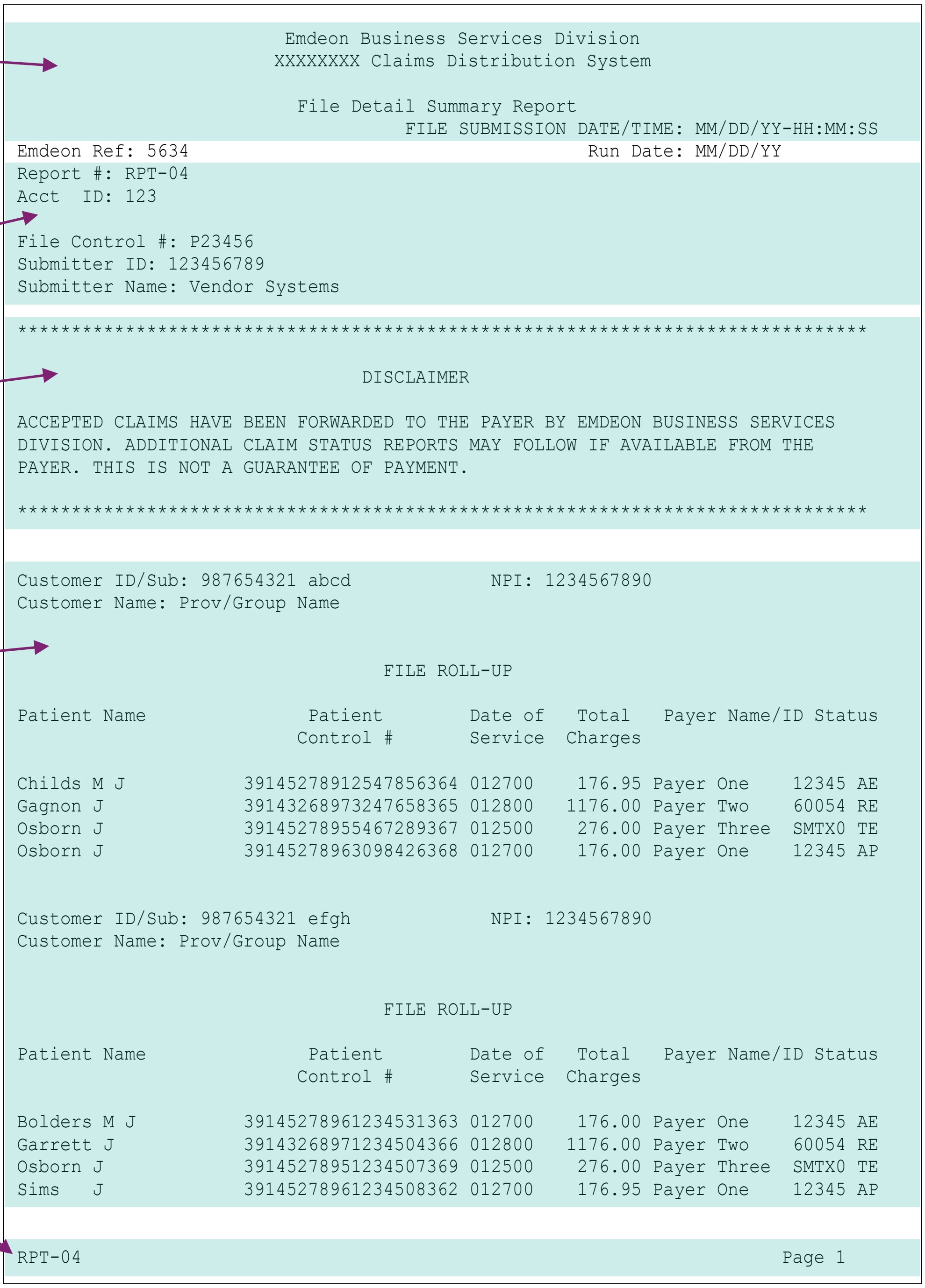
Header Section displays the type of claims distribution system (Medical, Hospital, Dental) and the report's title and run date.

Information Section displays data on your transmitted file. This information can be used for locating your file in Emdeon's processing system.

Disclaimer Section displays text message explaining the intent of the report. This displays only once on the report.

File Roll-Up Section displays header and detail areas of a claim record. Patient and Payer information is displayed.

Page Footer Section displays report # and page number(s) of the report.



```
                         Emdeon Business Services Division
                        XXXXXXXX Claims Distribution System

                          File Detail Summary Report
                                    FILE SUBMISSION DATE/TIME: MM/DD/YY-HH:MM:SS
Emdeon Ref: 5634                                     Run Date: MM/DD/YY
Report #: RPT-04
Acct  ID: 123

File Control #: P23456
Submitter ID: 123456789
Submitter Name: Vendor Systems

*******************************************************************************

                                DISCLAIMER

ACCEPTED CLAIMS HAVE BEEN FORWARDED TO THE PAYER BY EMDEON BUSINESS SERVICES
DIVISION. ADDITIONAL CLAIM STATUS REPORTS MAY FOLLOW IF AVAILABLE FROM THE
PAYER. THIS IS NOT A GUARANTEE OF PAYMENT.

*******************************************************************************


Customer ID/Sub: 987654321 abcd             NPI: 1234567890
Customer Name: Prov/Group Name


                                  FILE ROLL-UP

Patient Name               Patient        Date of   Total   Payer Name/ID Status
                          Control #       Service  Charges

Childs M J           39145278912547856364 012700    176.95 Payer One    12345 AE
Gagnon J             39143268973247658365 012800   1176.00 Payer Two    60054 RE
Osborn J             39145278955467289367 012500    276.00 Payer Three  SMTX0 TE
Osborn J             39145278963098426368 012700    176.00 Payer One    12345 AP


Customer ID/Sub: 987654321 efgh             NPI: 1234567890
Customer Name: Prov/Group Name


                                  FILE ROLL-UP

Patient Name               Patient        Date of   Total   Payer Name/ID Status
                          Control #       Service  Charges

Bolders M J          39145278961234531363 012700    176.00 Payer One    12345 AE
Garrett J            39143268971234504366 012800   1176.00 Payer Two    60054 RE
Osborn J             39145278951234507369 012500    276.00 Payer Three  SMTX0 TE
Sims   J             39145278961234508362 012700    176.95 Payer One    12345 AP


RPT-04                                                                 Page 1
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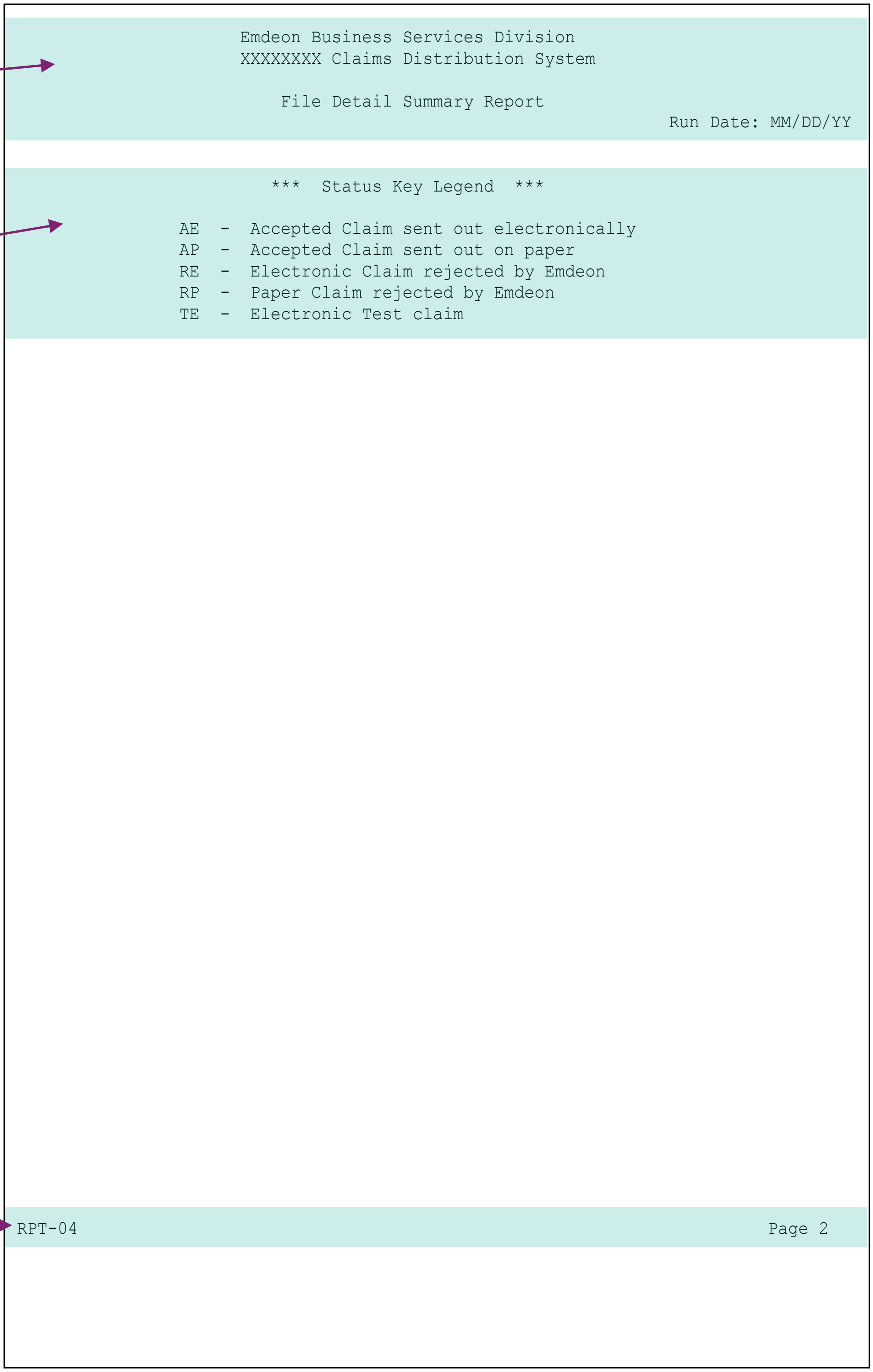
RPT-04 (continued)



```
                    Emdeon Business Services Division
                    XXXXXXXX Claims Distribution System

                        File Detail Summary Report
                                                          Run Date: MM/DD/YY

                           ***  Status Key Legend  ***

              AE  -  Accepted Claim sent out electronically
              AP  -  Accepted Claim sent out on paper
              RE  -  Electronic Claim rejected by Emdeon
              RP  -  Paper Claim rejected by Emdeon
              TE  -  Electronic Test claim

RPT-04                                                                Page 2
```

Header Section displays the type of claims distribution system (Medical, Hospital, Dental) and the report's title and run date.

Status Key Legend Section displays status acronyms and values.

Page Footer Section displays report # and page number(s) of the report.

RPT-04 Detailed Information

Sorting Sequence	By file submitted, by customer, and by patient
Frequency of Report	Next business day if claim data is submitted by 8:00 p.m. Eastern time
Purpose of Report	To monitor daily claims submitted to Emdeon for future reference

Report Field Name	**Description**
Run Date	The date the report was generated by Emdeon
Report #	The Emdeon report number
Acct ID	The submitter's login/account ID assigned by Emdeon
File Control #	Control number assigned to the file by the originator of the submitted transaction
Emdeon Ref	The tracking number assigned by the Emdeon clearinghouse to identify the file. This value can be used for referencing purposes.
Submitter ID	The identifier used by Emdeon to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
Submitter Name	The name of the submitter
DISCLAIMER	Text message explaining that the report is for status information only
Customer ID/Sub	The ID and Sub ID used by Emdeon to identify the customer
Customer Name	The name of the customer
FILE ROLL-UP:	
Patient Name	The name of the patient on the claim. This includes last name, first initial, and middle initial.
Patient Control #	The unique identifier assigned by the provider identifying the patient
Date of Service	The date the services were rendered. This is the "From" date.
Total Charges	The total $ amount of the claim
Payer Name/ID	The name and ID of the payer
Status	Shows the status of the claim. For example, AE, AP, RE, RP, TE. See the Status Key Legend field description below.
Status Key Legend	Describes each status acronym AE - Accepted claim sent out electronically AP - Accepted claim sent out on paper RE - Electronic claim rejected by Emdeon RP - Paper claim rejected by Emdeon TE - Electronic test claim

RPT-04A (Amended File Detail Summary Report)

The RPT-04 report gives a detail summary of the file submitted for processing. This report is a file roll-up listing all accepted and rejected claims contained in each file submitted to Emdeon. The RPT-04 also contains payer name/ID and status of claim.

RPT-04A Report Sample

The following sample is provided to illustrate the various sections and fields contained in the RPT-04 report.

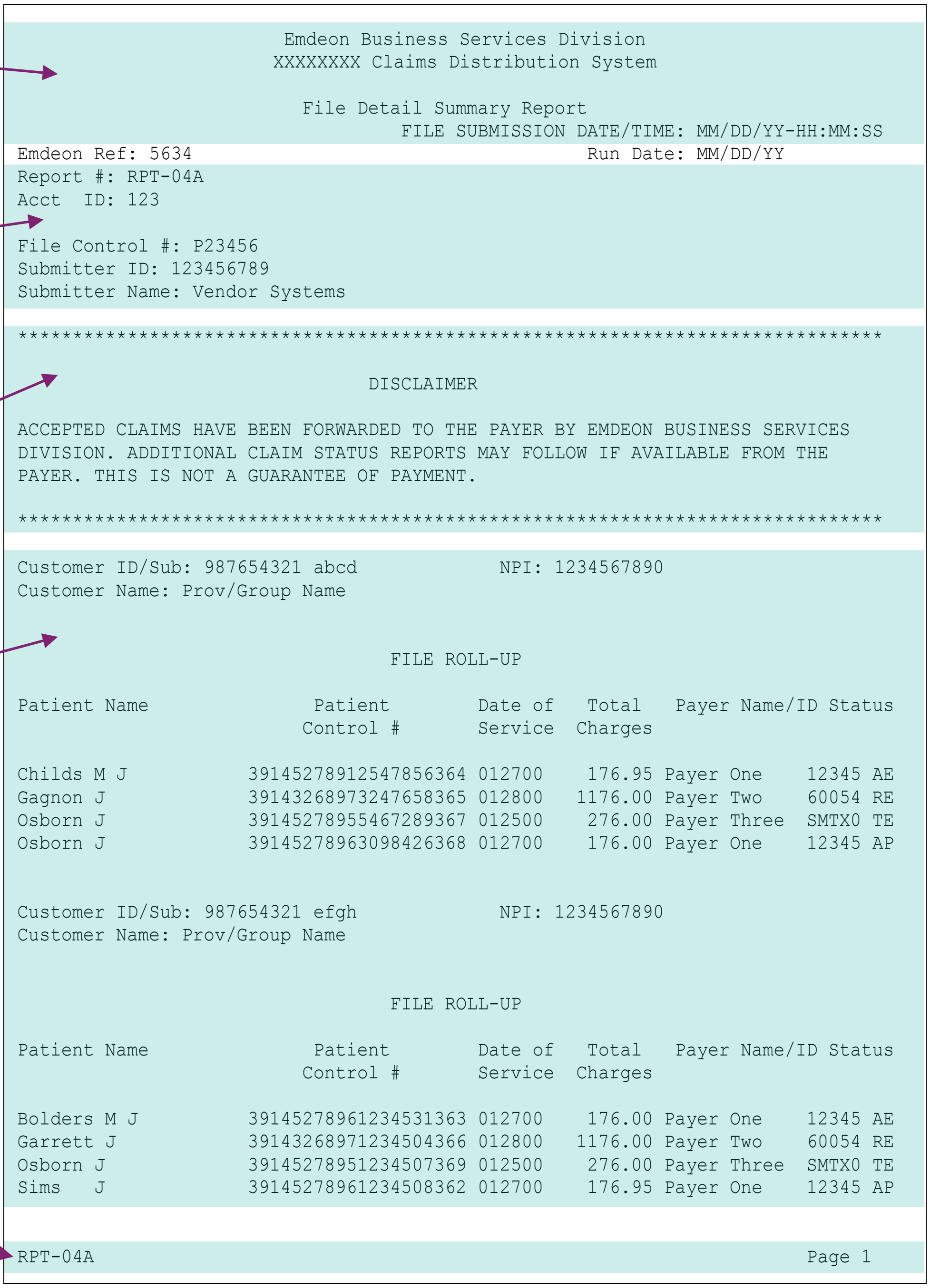
Header Section displays the type of claims distribution system (Medical, Hospital, Dental) and the report's title and run date.

Information Section displays data on your transmitted file. This information can be used for locating your file in Emdeon's processing system.

Disclaimer Section displays text message explaining the intent of the report. This displays only once on the report.

File Roll-Up Section displays header and detail areas of a claim record. Patient and Payer information is displayed.

Page Footer Section displays report # and page number(s) of the report.



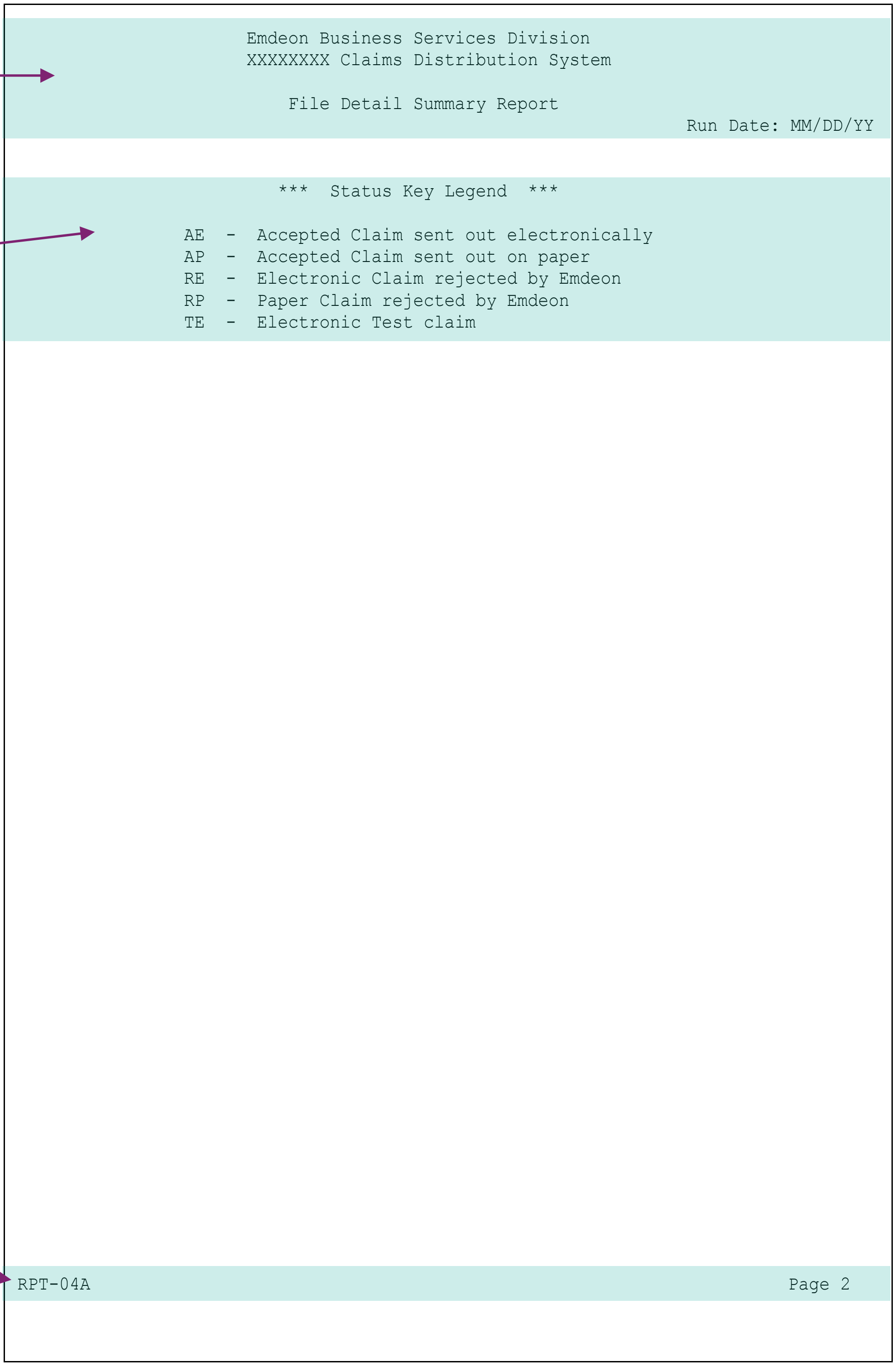
```
                        Emdeon Business Services Division
                       XXXXXXXX Claims Distribution System

                          File Detail Summary Report
                                   FILE SUBMISSION DATE/TIME: MM/DD/YY-HH:MM:SS
Emdeon Ref: 5634                                    Run Date: MM/DD/YY
Report #: RPT-04A
Acct  ID: 123

File Control #: P23456
Submitter ID: 123456789
Submitter Name: Vendor Systems

*******************************************************************************

                                DISCLAIMER

ACCEPTED CLAIMS HAVE BEEN FORWARDED TO THE PAYER BY EMDEON BUSINESS SERVICES
DIVISION. ADDITIONAL CLAIM STATUS REPORTS MAY FOLLOW IF AVAILABLE FROM THE
PAYER. THIS IS NOT A GUARANTEE OF PAYMENT.

*******************************************************************************

Customer ID/Sub: 987654321 abcd             NPI: 1234567890
Customer Name: Prov/Group Name


                                  FILE ROLL-UP

Patient Name               Patient        Date of   Total   Payer Name/ID Status
                          Control #       Service  Charges

Childs M J           39145278912547856364 012700    176.95 Payer One    12345 AE
Gagnon J             39143268973247658365 012800   1176.00 Payer Two    60054 RE
Osborn J             39145278955467289367 012500    276.00 Payer Three  SMTX0 TE
Osborn J             39145278963098426368 012700    176.00 Payer One    12345 AP


Customer ID/Sub: 987654321 efgh             NPI: 1234567890
Customer Name: Prov/Group Name


                                  FILE ROLL-UP

Patient Name               Patient        Date of   Total   Payer Name/ID Status
                          Control #       Service  Charges

Bolders M J          39145278961234531363 012700    176.00 Payer One    12345 AE
Garrett J            39143268971234504366 012800   1176.00 Payer Two    60054 RE
Osborn J             39145278951234507369 012500    276.00 Payer Three  SMTX0 TE
Sims   J             39145278961234508362 012700    176.95 Payer One    12345 AP


RPT-04A                                                                 Page 1
```

RPT-04A (continued)

Header Section displays the type of claims distribution system (Medical, Hospital, Dental) and the report's title and run date.

Status Key Legend Section displays status acronyms and values.

Page Footer Section displays report # and page number(s) of the report.



```
                       Emdeon Business Services Division
                       XXXXXXXX Claims Distribution System

                           File Detail Summary Report
                                                           Run Date: MM/DD/YY

                             ***  Status Key Legend  ***

                 AE  -  Accepted Claim sent out electronically
                 AP  -  Accepted Claim sent out on paper
                 RE  -  Electronic Claim rejected by Emdeon
                 RP  -  Paper Claim rejected by Emdeon
                 TE  -  Electronic Test claim





 RPT-04A                                                                 Page 2
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RPT-04A Detailed Information

Sorting Sequence	By file submitted, by customer, and by patient
Frequency of Report	Next business day if claim data is submitted by 8:00 p.m. Eastern time
Purpose of Report	To monitor daily claims submitted to Emdeon for future reference

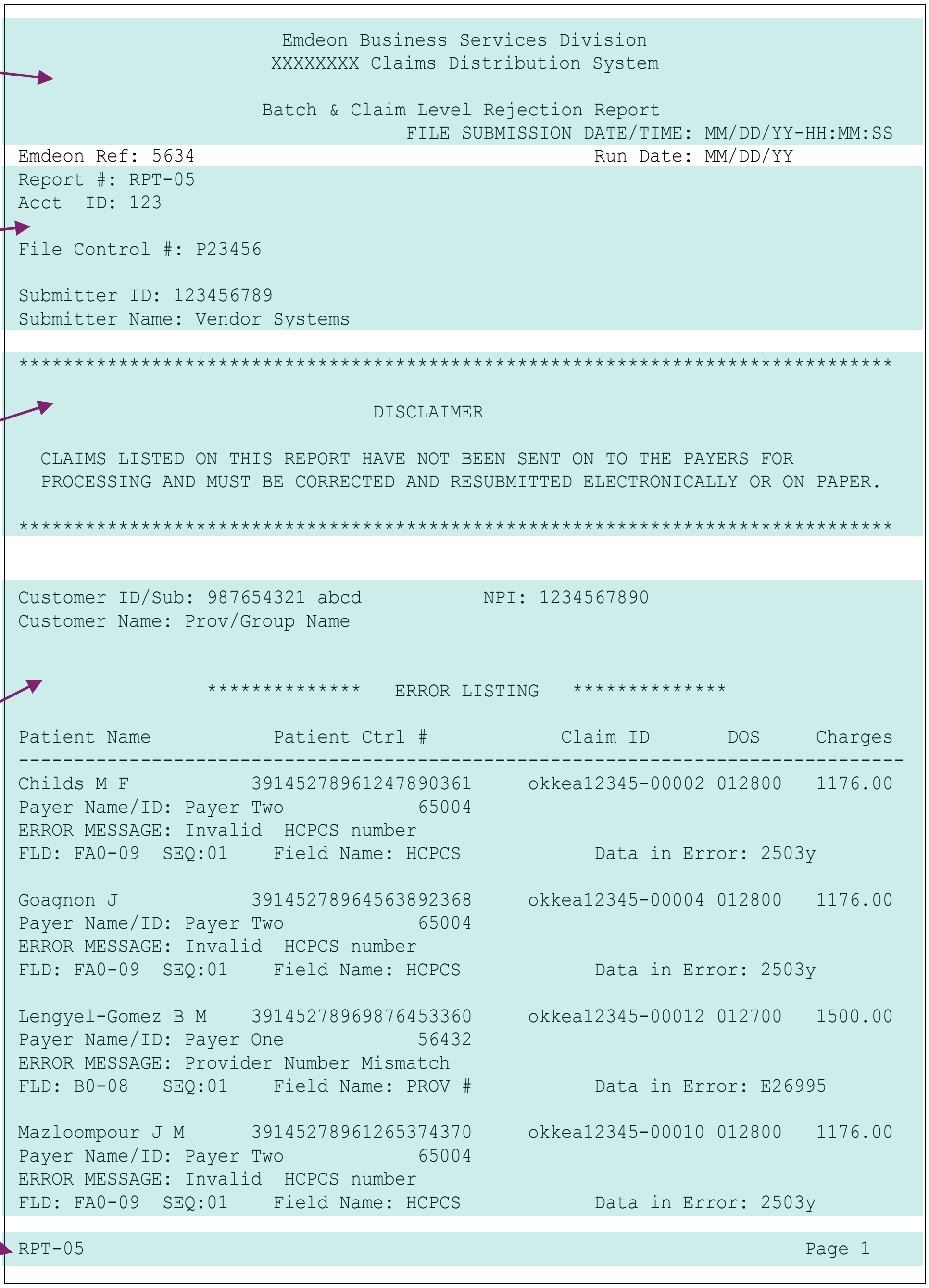
Report Field Name	Description
Run Date	The date the report was generated by Emdeon
Report #	The Emdeon report number
Acct ID	The submitter's login/account ID assigned by Emdeon
File Control #	Control number assigned to the file by the originator of the submitted transaction
Emdeon Ref	The tracking number assigned by the Emdeon clearinghouse to identify the file. This value can be used for referencing purposes.
Submitter ID	The identifier used by Emdeon to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
Submitter Name	The name of the submitter
DISCLAIMER	Text message explaining that the report is for status information only
Customer ID/Sub	The ID and Sub ID used by Emdeon to identify the customer
Customer Name	The name of the customer
FILE ROLL-UP:	
Patient Name	The name of the patient on the claim. This includes last name, first initial, and middle initial.
Patient Control #	The unique identifier assigned by the provider identifying the patient
Date of Service	The date the services were rendered. This is the "From" date.
Total Charges	The total $ amount of the claim
Payer Name/ID	The name and ID of the payer
Status	Shows the status of the claim. For example, AE, AP, RE, RP, TE. See the Status Key Legend field description.
Status Key Legend	Describes each status acronym. AE - Accepted claim sent out electronically AP - Accepted claim sent out on paper RE - Electronic claim rejected by Emdeon RP - Paper claim rejected by Emdeon TE - Electronic test claim

RPT-05 (Batch & Claim Level Rejection Report)

The RPT-05 report contains rejected batches and claims listed with detailed error explanations. In order to prevent “lost” claims, the RPT-05 report must be reviewed and worked after each file transmission. Claims that are listed as rejected are not forwarded to the payer(s) for processing. Rather, these rejected claims must be corrected and then resubmitted (either electronically or on paper) for processing.

RPT-05 Report Sample

The following sample is provided to illustrate the various sections and fields contained in the RPT-05 report.



```
                        Emdeon Business Services Division
                       XXXXXXXX Claims Distribution System

                      Batch & Claim Level Rejection Report
                                   FILE SUBMISSION DATE/TIME: MM/DD/YY-HH:MM:SS
Emdeon Ref: 5634                                    Run Date: MM/DD/YY
Report #: RPT-05
Acct  ID: 123

File Control #: P23456

Submitter ID: 123456789
Submitter Name: Vendor Systems

********************************************************************************

                                DISCLAIMER

  CLAIMS LISTED ON THIS REPORT HAVE NOT BEEN SENT ON TO THE PAYERS FOR
  PROCESSING AND MUST BE CORRECTED AND RESUBMITTED ELECTRONICALLY OR ON PAPER.

********************************************************************************


Customer ID/Sub: 987654321 abcd           NPI: 1234567890
Customer Name: Prov/Group Name


                 **************   ERROR LISTING   **************

Patient Name           Patient Ctrl #            Claim ID       DOS     Charges
---------------------------------------------------------------------------------
Childs M F           39145278961247890361     okkea12345-00002 012800   1176.00
Payer Name/ID: Payer Two            65004
ERROR MESSAGE: Invalid  HCPCS number
FLD: FA0-09  SEQ:01    Field Name: HCPCS            Data in Error: 2503y

Goagnon J            39145278964563892368     okkea12345-00004 012800   1176.00
Payer Name/ID: Payer Two            65004
ERROR MESSAGE: Invalid  HCPCS number
FLD: FA0-09  SEQ:01    Field Name: HCPCS            Data in Error: 2503y

Lengyel-Gomez B M    39145278969876453360     okkea12345-00012 012700   1500.00
Payer Name/ID: Payer One            56432
ERROR MESSAGE: Provider Number Mismatch
FLD: B0-08   SEQ:01    Field Name: PROV #           Data in Error: E26995

Mazloompour J M      39145278961265374370     okkea12345-00010 012800   1176.00
Payer Name/ID: Payer Two            65004
ERROR MESSAGE: Invalid  HCPCS number
FLD: FA0-09  SEQ:01    Field Name: HCPCS            Data in Error: 2503y

RPT-05                                                                 Page 1
```

Header Section displays the type of claims distribution system (Medical, Hospital, Dental) and the report’s title and run date.

Information Section displays data on your transmitted file. This information can be used for locating your file in Emdeon’s processing system.

Disclaimer Section displays text message explaining the intent of the report. This displays only once on the report.

Error Header and Detail Section displays claims that are in error in the submitted claims file by provider. The field in error and actual data value are displayed.

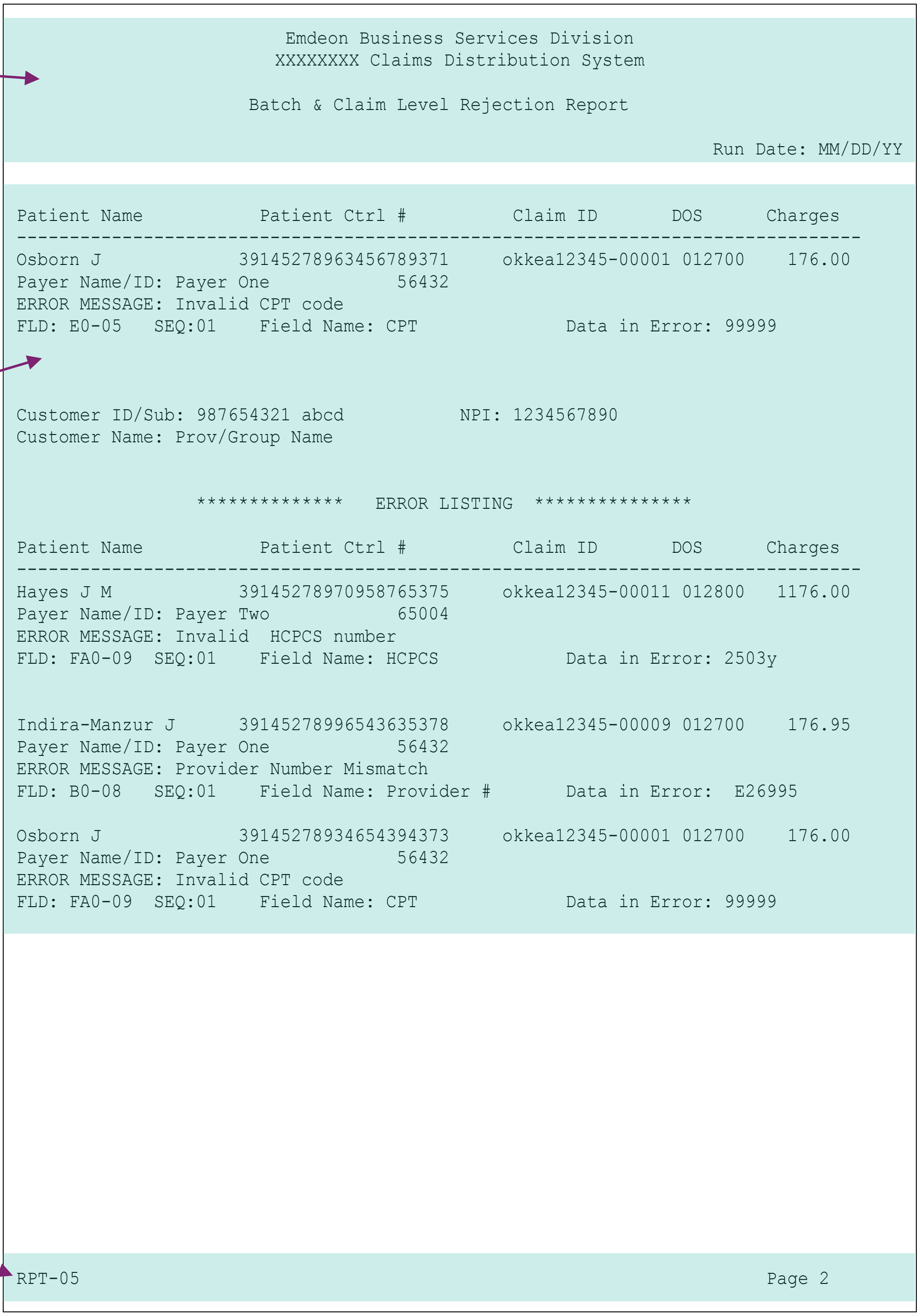
Page Footer Section displays report # and page number(s) of the report.

RPT-05 (continued)

Header Section displays the type of claims distribution system (Medical, Hospital, Dental) and the report's title and run date.

Error Header and Detail Section displays claims that are in error in the submitted claims file. The field in error and actual data value are displayed.

Page Footer Section displays report # and page number(s) of the report.



```
                         Emdeon Business Services Division
                        XXXXXXXX Claims Distribution System

                      Batch & Claim Level Rejection Report

                                                                 Run Date: MM/DD/YY

Patient Name          Patient Ctrl #          Claim ID       DOS      Charges
--------------------------------------------------------------------------------
Osborn J            39145278963456789371     okkea12345-00001 012700    176.00
Payer Name/ID: Payer One             56432
ERROR MESSAGE: Invalid CPT code
FLD: E0-05   SEQ:01    Field Name: CPT             Data in Error: 99999



Customer ID/Sub: 987654321 abcd           NPI: 1234567890
Customer Name: Prov/Group Name


                 **************   ERROR LISTING  ***************

Patient Name          Patient Ctrl #          Claim ID       DOS      Charges
--------------------------------------------------------------------------------
Hayes J M           39145278970958765375     okkea12345-00011 012800   1176.00
Payer Name/ID: Payer Two             65004
ERROR MESSAGE: Invalid  HCPCS number
FLD: FA0-09  SEQ:01    Field Name: HCPCS           Data in Error: 2503y


Indira-Manzur J     39145278996543635378     okkea12345-00009 012700    176.95
Payer Name/ID: Payer One             56432
ERROR MESSAGE: Provider Number Mismatch
FLD: B0-08   SEQ:01    Field Name: Provider #      Data in Error:  E26995

Osborn J            39145278934654394373     okkea12345-00001 012700    176.00
Payer Name/ID: Payer One             56432
ERROR MESSAGE: Invalid CPT code
FLD: FA0-09  SEQ:01    Field Name: CPT             Data in Error: 99999















RPT-05                                                                Page 2
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RPT-05 Detailed Information

Sorting Sequence	By file submitted, by customer, and by patient
Frequency of Report	Next business day if claim data is submitted by 8:00 p.m. Eastern time
Purpose of Report	To monitor daily batch and claim level rejections. Contains detailed error explanations necessary to correct any rejected claims. This report is very important and must be worked and reviewed daily.

Report Field Name	Description
Run Date	The date the report was generated by Emdeon
Report #	The Emdeon report number
Acct ID	The submitter's login/account ID assigned by Emdeon
File Control #	Control number assigned to the file by the originator of the submitted transaction
Emdeon Ref	The tracking number assigned by the Emdeon clearinghouse to identify the file. This value can be used for referencing purposes.
Submitter ID	The identifier used by Emdeon to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
Submitter Name	The name of the submitter
Customer ID/Sub	The ID and Sub ID used by Emdeon to identify the customer
Customer Name	The name of the customer
ERROR LISTING:	
Patient Name	The name of the patient on the claim. This includes last name, first initial, and middle initial.
Patient Ctrl #	The unique identifier assigned by the provider identifying the patient
Claim ID	The unique claim identifier assigned by Emdeon
DOS	The date from which the services were started (rendered) for the patient. This is also known as the "From" date.
Charges	The total amount of the claim
Payer Name/ID	The name of the payer and the identifier assigned by Emdeon
ERROR MESSAGE	The description of the error
FLD	The field containing the data in error
SEQ	The sequence number of the field containing the data in error
Field Name	The name of the field containing the data that is in error
Data in Error	The data causing the error in the claim. The actual data that is in error will display on the report.

RPT-05A (Amended Batch & Claim Level Rejection Report)

The RPT-05 report contains rejected batches and claims listed with detailed error explanations. In order to prevent "lost" claims, the RPT-05 report must be reviewed and worked after each file transmission. Claims that are listed as rejected are not forwarded to the payer(s) for processing. Rather, these rejected claims must be corrected and then resubmitted (either electronically or on paper) for processing.

RPT-05A Report Sample

The following sample is provided to illustrate the various sections and fields contained in the RPT-05 report.

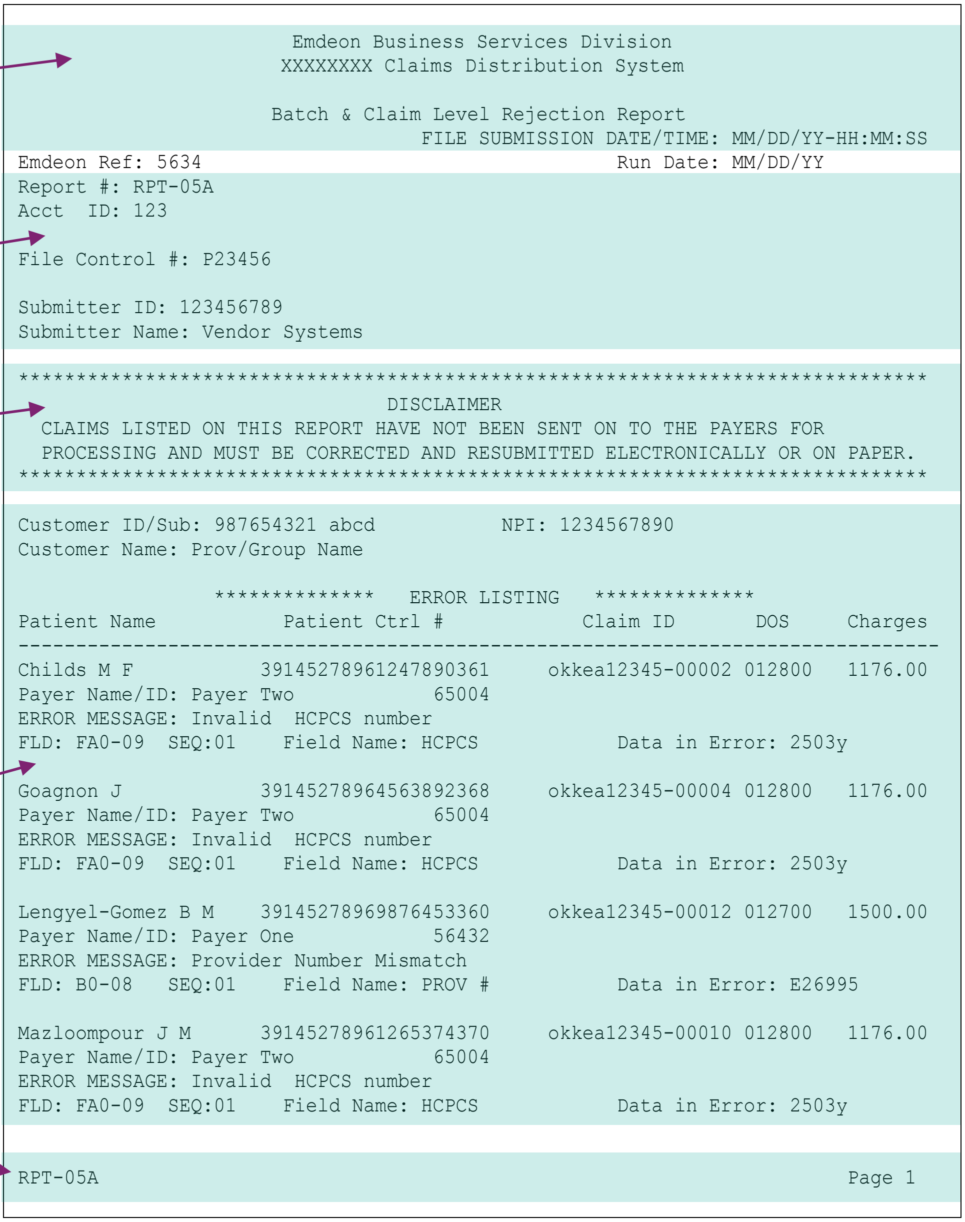
Header Section displays the type of claims distribution system (Medical, Hospital, Dental) and the report's title and run date.

Information Section displays data on your transmitted file. This information can be used for locating your file in Emdeon's processing system.

Disclaimer Section displays text message explaining the intent of the report. This displays only once on the report.

Error Header and Detail Section displays claims that are in error in the submitted claims file by provider. The field in error and actual data value are displayed.

Page Footer Section displays report # and page number(s) of the report.



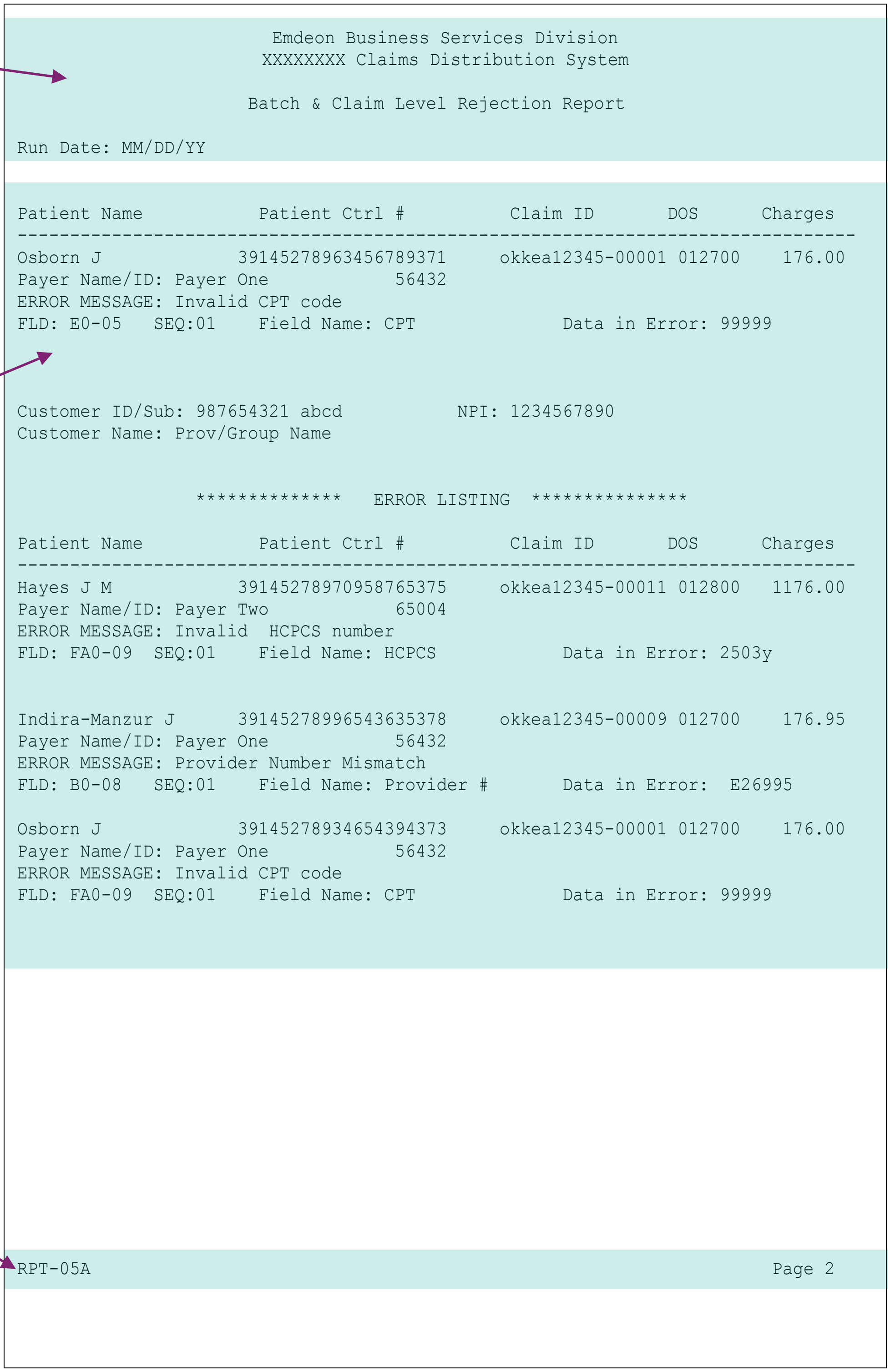
```
                        Emdeon Business Services Division
                       XXXXXXXX Claims Distribution System

                         Batch & Claim Level Rejection Report
                                      FILE SUBMISSION DATE/TIME: MM/DD/YY-HH:MM:SS
Emdeon Ref: 5634                                            Run Date: MM/DD/YY
Report #: RPT-05A
Acct  ID: 123

File Control #: P23456

Submitter ID: 123456789
Submitter Name: Vendor Systems

*******************************************************************************
                                   DISCLAIMER
  CLAIMS LISTED ON THIS REPORT HAVE NOT BEEN SENT ON TO THE PAYERS FOR
  PROCESSING AND MUST BE CORRECTED AND RESUBMITTED ELECTRONICALLY OR ON PAPER.
*******************************************************************************

Customer ID/Sub: 987654321 abcd           NPI: 1234567890
Customer Name: Prov/Group Name

                 **************   ERROR LISTING   **************
Patient Name           Patient Ctrl #            Claim ID       DOS     Charges
--------------------------------------------------------------------------------
Childs M F           39145278961247890361     okkea12345-00002 012800   1176.00
Payer Name/ID: Payer Two            65004
ERROR MESSAGE: Invalid  HCPCS number
FLD: FA0-09  SEQ:01    Field Name: HCPCS            Data in Error: 2503y

Goagnon J            39145278964563892368     okkea12345-00004 012800   1176.00
Payer Name/ID: Payer Two            65004
ERROR MESSAGE: Invalid  HCPCS number
FLD: FA0-09  SEQ:01    Field Name: HCPCS            Data in Error: 2503y

Lengyel-Gomez B M    39145278969876453360     okkea12345-00012 012700   1500.00
Payer Name/ID: Payer One            56432
ERROR MESSAGE: Provider Number Mismatch
FLD: B0-08   SEQ:01    Field Name: PROV #           Data in Error: E26995

Mazloompour J M      39145278961265374370     okkea12345-00010 012800   1176.00
Payer Name/ID: Payer Two            65004
ERROR MESSAGE: Invalid  HCPCS number
FLD: FA0-09  SEQ:01    Field Name: HCPCS            Data in Error: 2503y

RPT-05A                                                                 Page 1
```

RPT-05A (continued)

Header Section displays the type of claims distribution system (Medical, Hospital, Dental) and the report's title and run date.

Error Header and Detail Section displays claims that are in error in the submitted claims file. The field in error and actual data value are displayed.

Page Footer Section displays report # and page number(s) of the report.



```
                        Emdeon Business Services Division
                       XXXXXXXX Claims Distribution System

                      Batch & Claim Level Rejection Report

Run Date: MM/DD/YY


Patient Name           Patient Ctrl #         Claim ID       DOS      Charges
--------------------------------------------------------------------------------
Osborn J             39145278963456789371     okkea12345-00001 012700    176.00
Payer Name/ID: Payer One            56432
ERROR MESSAGE: Invalid CPT code
FLD: E0-05   SEQ:01    Field Name: CPT                  Data in Error: 99999



Customer ID/Sub: 987654321 abcd          NPI: 1234567890
Customer Name: Prov/Group Name



                 **************   ERROR LISTING  ***************

Patient Name           Patient Ctrl #         Claim ID       DOS      Charges
--------------------------------------------------------------------------------
Hayes J M            39145278970958765375     okkea12345-00011 012800   1176.00
Payer Name/ID: Payer Two            65004
ERROR MESSAGE: Invalid  HCPCS number
FLD: FA0-09  SEQ:01    Field Name: HCPCS                Data in Error: 2503y


Indira-Manzur J      39145278996543635378     okkea12345-00009 012700    176.95
Payer Name/ID: Payer One            56432
ERROR MESSAGE: Provider Number Mismatch
FLD: B0-08   SEQ:01    Field Name: Provider #           Data in Error:  E26995

Osborn J             39145278934654394373     okkea12345-00001 012700    176.00
Payer Name/ID: Payer One            56432
ERROR MESSAGE: Invalid CPT code
FLD: FA0-09  SEQ:01    Field Name: CPT                  Data in Error: 99999










RPT-05A                                                                 Page 2
```

RPT-05A Detailed Information

Sorting Sequence	By file submitted, by customer, and by patient
Frequency of Report	Next business day if claim data is submitted by 8:00 p.m. Eastern time
Purpose of Report	To monitor daily batch and claim level rejections. Contains detailed error explanations necessary to correct any rejected claims. This report is very important and must be worked and reviewed daily.

Report Field Name	Description
Run Date	The date the report was generated by Emdeon
Report #	The Emdeon report number
Acct ID	The submitter's login/account ID assigned by Emdeon
File Control #	Control number assigned to the file by the originator of the submitted transaction
Emdeon Ref	The tracking number assigned by the Emdeon clearinghouse to identify the file. This value can be used for referencing purposes.
Submitter ID	The identifier used by Emdeon to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
Submitter Name	The name of the submitter
Customer ID/Sub	The ID and Sub ID used by Emdeon to identify the customer
Customer Name	The name of the customer
ERROR LISTING:	
Patient Name	The name of the patient on the claim. This includes last name, first initial, and middle initial.
Patient Ctrl #	The unique identifier assigned by the provider identifying the patient
Claim ID	The unique claim identifier assigned by Emdeon
DOS	The date from which the services were started (rendered) for the patient. This is also known as the "From" date.
Charges	The total amount of the claim
Payer Name/ID	The name of the payer and the identifier assigned by Emdeon
ERROR MESSAGE	The description of the error
FLD	The field containing the data in error
SEQ	The sequence number of the field containing the data in error
Field Name	The name of the field containing the data that is in error
Data in Error	The data causing the error in the claim. The actual data that is in error will display on the report.

RPT-08 (Provider Monthly Summary)

The RPT-08 is a monthly report showing the number of accepted and $ value of claims a provider has sent to the carrier(s) for the month. Monthly and Y-T-D totals for both accepted and rejected claims are included as well as the provider's top 25 errors for the month.

RPT-08 Report Sample

The following sample is provided to illustrate the various sections and fields contained in the RPT-08 report.

Header Section displays the type of claims distribution system (Medical, Hospital, Dental) and the report's title and date.

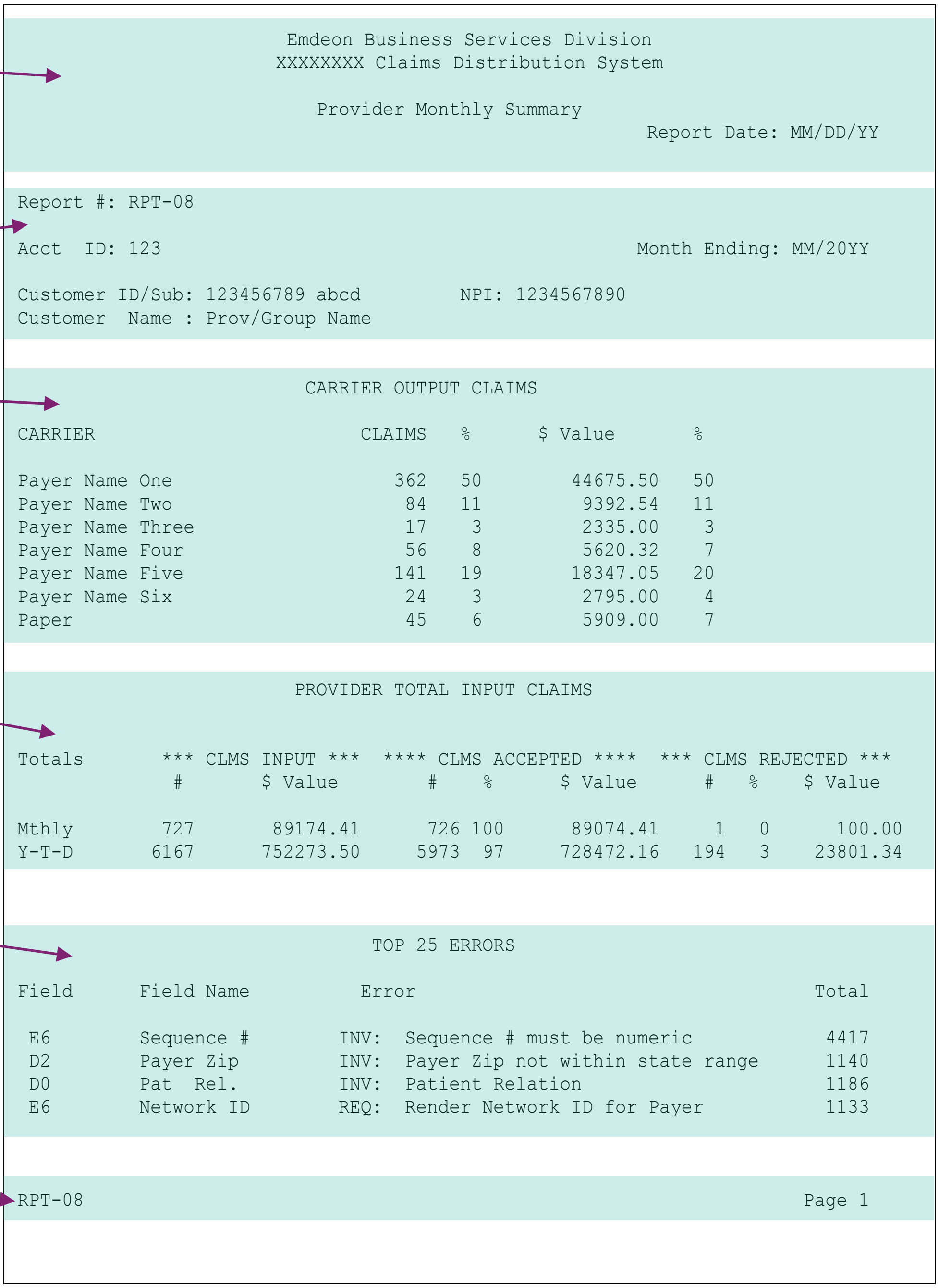
Information Section displays provider and month-end information.

Carrier Statistics Section displays number of claims submitted for that month to the listed payer(s).

Provider Totals Statistics Section displays monthly and Y-T-D* totals of the number and $ value of claims submitted.

Top 25 Errors Section displays the top 25 errors existing in all submitted claims files for the month. The field, field name, error message, and total are displayed.

Page Footer Section displays report # and page number(s) of the report.



```
                          Emdeon Business Services Division
                         XXXXXXXX Claims Distribution System

                              Provider Monthly Summary
                                                         Report Date: MM/DD/YY

Report #: RPT-08

Acct  ID: 123                                                Month Ending: MM/20YY

Customer ID/Sub: 123456789 abcd        NPI: 1234567890
Customer  Name : Prov/Group Name


                              CARRIER OUTPUT CLAIMS

CARRIER                        CLAIMS   %      $ Value       %

Payer Name One                    362   50        44675.50   50
Payer Name Two                     84   11         9392.54   11
Payer Name Three                   17    3         2335.00    3
Payer Name Four                    56    8         5620.32    7
Payer Name Five                   141   19        18347.05   20
Payer Name Six                     24    3         2795.00    4
Paper                              45    6         5909.00    7


                             PROVIDER TOTAL INPUT CLAIMS


Totals       *** CLMS INPUT ***  **** CLMS ACCEPTED ****  *** CLMS REJECTED ***
              #       $ Value        #    %       $ Value      #   %     $ Value

Mthly        727      89174.41      726 100      89074.41      1   0      100.00
Y-T-D       6167     752273.50     5973  97     728472.16    194   3    23801.34


                                    TOP 25 ERRORS

Field      Field Name          Error                                       Total

 E6        Sequence #        INV:  Sequence # must be numeric               4417
 D2        Payer Zip         INV:  Payer Zip not within state range         1140
 D0        Pat  Rel.         INV:  Patient Relation                         1186
 E6        Network ID        REQ:  Render Network ID for Payer              1133


RPT-08                                                                    Page 1
```

RPT-08 Detailed Information

Sorting Sequence	By customer, by payer, and by error
Frequency of Report	Monthly, by the 5th business day if claim data is submitted by 8:00 p.m. Eastern time
Purpose of Report	Monitors overall monthly customer statistics, claims forwarded to the listed insurance payers and the most frequent claim level rejections. Management could use this report.

Report Field Name	**Description**
Report Date	The date the report was generated by Emdeon
Report #	The Emdeon report number
Acct ID	The submitter's login/account ID assigned by Emdeon
Month Ending	The month for which this summary was generated
Customer ID/Sub	The ID/Sub ID used by Emdeon to identify the customer
Customer Name	The name of the customer
CARRIER OUTPUT CLAIMS: CARRIER CLAIMS % $ VALUE	 The name of the payer where the claims were forwarded by Emdeon to the payer for the month The number of claims forwarded by Emdeon to the payer for the month The percentage of total claims forwarded by Emdeon to the payer for the month The $ amount forwarded by Emdeon to the payer for claims submitted by the provider for the month
PROVIDER TOTAL INPUT CLAIMS: Totals Mthly Y-T-D*	 The monthly provider totals of the number of claims, percentage, and values categorized by CLMS INPUT, CLMS ACCEPTED, and CLMS REJECTED The year-to-date provider totals of the number of claims, percentage, and values categorized by CLMS INPUT, CLMS ACCEPTED, and CLMS REJECTED
TOP 25 ERRORS: Field Field Name Error Total	 The field containing the data in error The name of the field containing the data in error The description of the error The total number of claims that contained that error for the month

*Y-T-D totals include data for claims processed by Emdeon beginning September 1st, 2001.

RPT-10 (Provider Claim Status)

The RPT-10 report contains information provided from payers who are receiving claims for adjudication from Emdeon. Not all payers who process claims through the Emdeon system provide information for this Provider Claim Status Report, and the amount/frequency of information produced will vary from payer to payer.

RPT-10 Report Sample

The following sample is provided to illustrate the various sections and fields contained in the RPT-10 report.

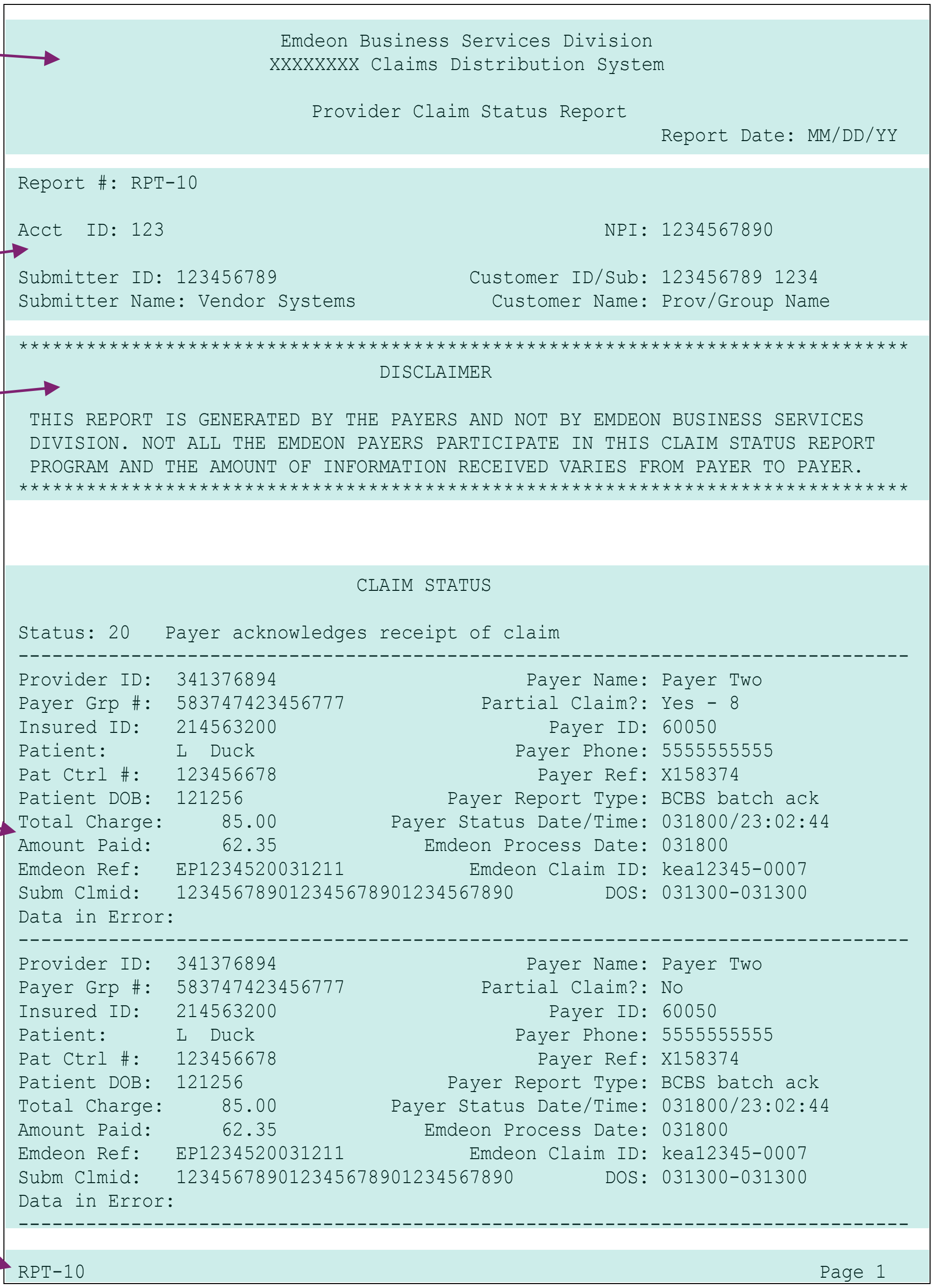
Header Section displays the type of claims distribution system (Medical, Hospital, Dental) and the report's title and date.

Information Section displays data provider information. When applicable, vendor information also displays.

Disclaimer Section displays text message explaining the intent of the report. This displays only once on the report.

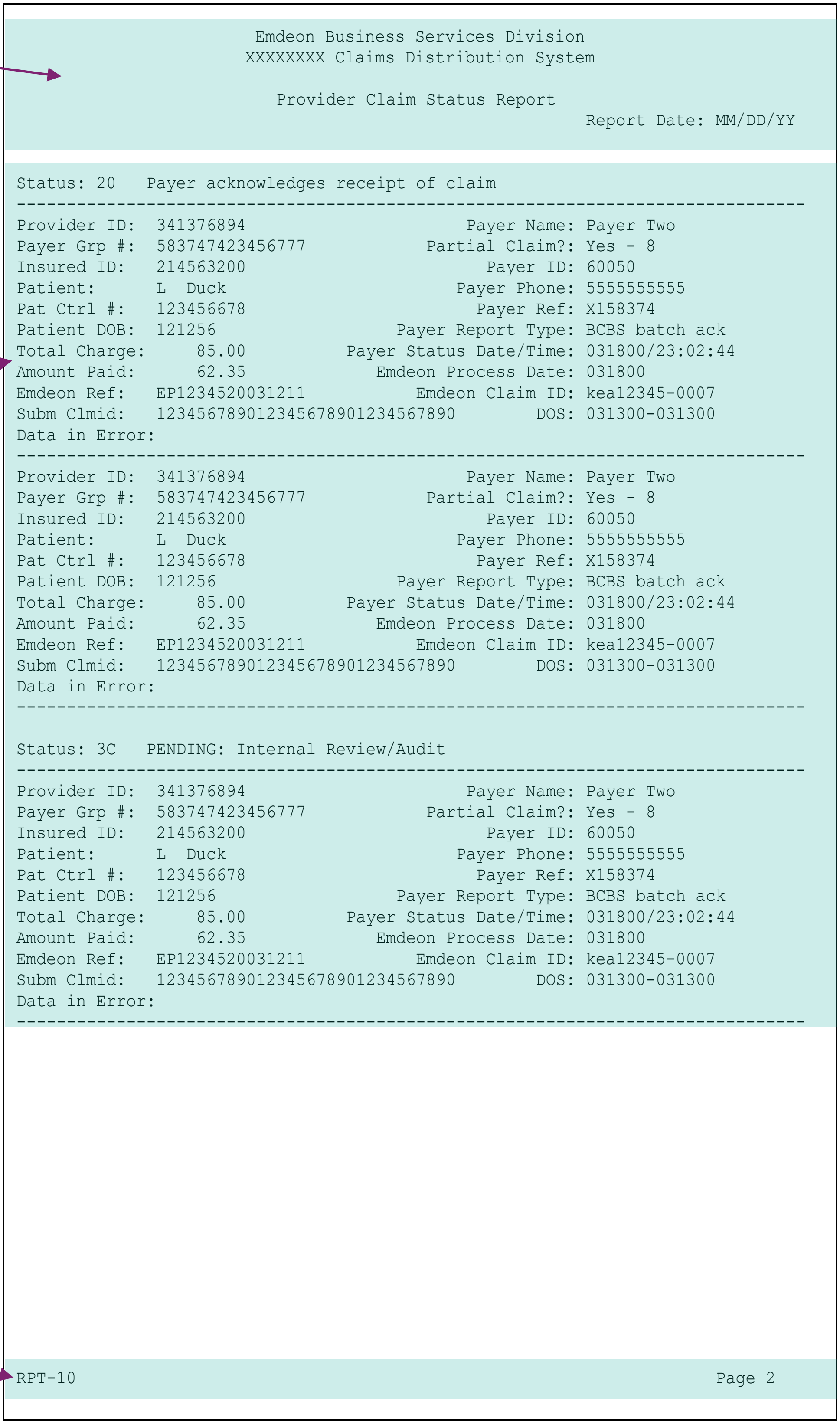
Claim Status Header and Detail Section displays (on a daily basis) the status of claims if a status on a submitted claim has been received from the payer. Claims are grouped according to status, then payer.

Page Footer Section displays report # and page number(s) of the report.



```
                       Emdeon Business Services Division
                     XXXXXXXX Claims Distribution System

                          Provider Claim Status Report
                                               Report Date: MM/DD/YY

Report #: RPT-10

Acct  ID: 123                                   NPI: 1234567890

Submitter ID: 123456789                 Customer ID/Sub: 123456789 1234
Submitter Name: Vendor Systems            Customer Name: Prov/Group Name

*******************************************************************************
                                  DISCLAIMER

 THIS REPORT IS GENERATED BY THE PAYERS AND NOT BY EMDEON BUSINESS SERVICES
 DIVISION. NOT ALL THE EMDEON PAYERS PARTICIPATE IN THIS CLAIM STATUS REPORT
 PROGRAM AND THE AMOUNT OF INFORMATION RECEIVED VARIES FROM PAYER TO PAYER.
*******************************************************************************


                               CLAIM STATUS

Status: 20   Payer acknowledges receipt of claim
-------------------------------------------------------------------------------
Provider ID:  341376894                       Payer Name: Payer Two
Payer Grp #:  583747423456777             Partial Claim?: Yes - 8
Insured ID:   214563200                         Payer ID: 60050
Patient:      L  Duck                        Payer Phone: 5555555555
Pat Ctrl #:   123456678                        Payer Ref: X158374
Patient DOB:  121256                   Payer Report Type: BCBS batch ack
Total Charge:     85.00           Payer Status Date/Time: 031800/23:02:44
Amount Paid:      62.35              Emdeon Process Date: 031800
Emdeon Ref:   EP1234520031211            Emdeon Claim ID: kea12345-0007
Subm Clmid:   123456789012345678901234567890         DOS: 031300-031300
Data in Error:
-------------------------------------------------------------------------------
Provider ID:  341376894                       Payer Name: Payer Two
Payer Grp #:  583747423456777             Partial Claim?: No
Insured ID:   214563200                         Payer ID: 60050
Patient:      L  Duck                        Payer Phone: 5555555555
Pat Ctrl #:   123456678                        Payer Ref: X158374
Patient DOB:  121256                   Payer Report Type: BCBS batch ack
Total Charge:     85.00           Payer Status Date/Time: 031800/23:02:44
Amount Paid:      62.35              Emdeon Process Date: 031800
Emdeon Ref:   EP1234520031211            Emdeon Claim ID: kea12345-0007
Subm Clmid:   123456789012345678901234567890         DOS: 031300-031300
Data in Error:
-------------------------------------------------------------------------------

RPT-10                                                                 Page 1
```

RPT-10 (continued)



```
                        Emdeon Business Services Division
                       XXXXXXXX Claims Distribution System

                          Provider Claim Status Report
                                                         Report Date: MM/DD/YY

Status: 20   Payer acknowledges receipt of claim
-------------------------------------------------------------------------------
Provider ID:  341376894                      Payer Name: Payer Two
Payer Grp #:  583747423456777            Partial Claim?: Yes - 8
Insured ID:   214563200                        Payer ID: 60050
Patient:      L  Duck                       Payer Phone: 5555555555
Pat Ctrl #:   123456678                       Payer Ref: X158374
Patient DOB:  121256                  Payer Report Type: BCBS batch ack
Total Charge:     85.00          Payer Status Date/Time: 031800/23:02:44
Amount Paid:      62.35             Emdeon Process Date: 031800
Emdeon Ref:   EP1234520031211           Emdeon Claim ID: kea12345-0007
Subm Clmid:   123456789012345678901234567890        DOS: 031300-031300
Data in Error:
-------------------------------------------------------------------------------
Provider ID:  341376894                      Payer Name: Payer Two
Payer Grp #:  583747423456777            Partial Claim?: Yes - 8
Insured ID:   214563200                        Payer ID: 60050
Patient:      L  Duck                       Payer Phone: 5555555555
Pat Ctrl #:   123456678                       Payer Ref: X158374
Patient DOB:  121256                  Payer Report Type: BCBS batch ack
Total Charge:     85.00          Payer Status Date/Time: 031800/23:02:44
Amount Paid:      62.35             Emdeon Process Date: 031800
Emdeon Ref:   EP1234520031211           Emdeon Claim ID: kea12345-0007
Subm Clmid:   123456789012345678901234567890        DOS: 031300-031300
Data in Error:
-------------------------------------------------------------------------------

Status: 3C   PENDING: Internal Review/Audit
-------------------------------------------------------------------------------
Provider ID:  341376894                      Payer Name: Payer Two
Payer Grp #:  583747423456777            Partial Claim?: Yes - 8
Insured ID:   214563200                        Payer ID: 60050
Patient:      L  Duck                       Payer Phone: 5555555555
Pat Ctrl #:   123456678                       Payer Ref: X158374
Patient DOB:  121256                  Payer Report Type: BCBS batch ack
Total Charge:     85.00          Payer Status Date/Time: 031800/23:02:44
Amount Paid:      62.35             Emdeon Process Date: 031800
Emdeon Ref:   EP1234520031211           Emdeon Claim ID: kea12345-0007
Subm Clmid:   123456789012345678901234567890        DOS: 031300-031300
Data in Error:
-------------------------------------------------------------------------------




RPT-10                                                                Page  2
```

Header Section displays the type of claims distribution system (Medical, Hospital, Dental) and the report's title and date.

Claim Status Header and Detail Sections displays (on a daily basis) the status of claims if a status on a submitted claim has been received from the payer. Claims are grouped according to status, then payer.

Page Footer Section displays report # and page number(s) of the report.

RPT-10 Detailed Information

Sorting Sequence	By customer, by status, and by payer
Frequency of Report	Daily if claim data is submitted by 8:00 p.m. Eastern time
Purpose of Report	To monitor status of claims submitted electronically to payers. **Note**: Not all payers provide a claim status electronically, and the amount/frequency of returned information varies. The RPT-10 does not return Unprocessed, Request for Additional Information, or Rejected statuses.

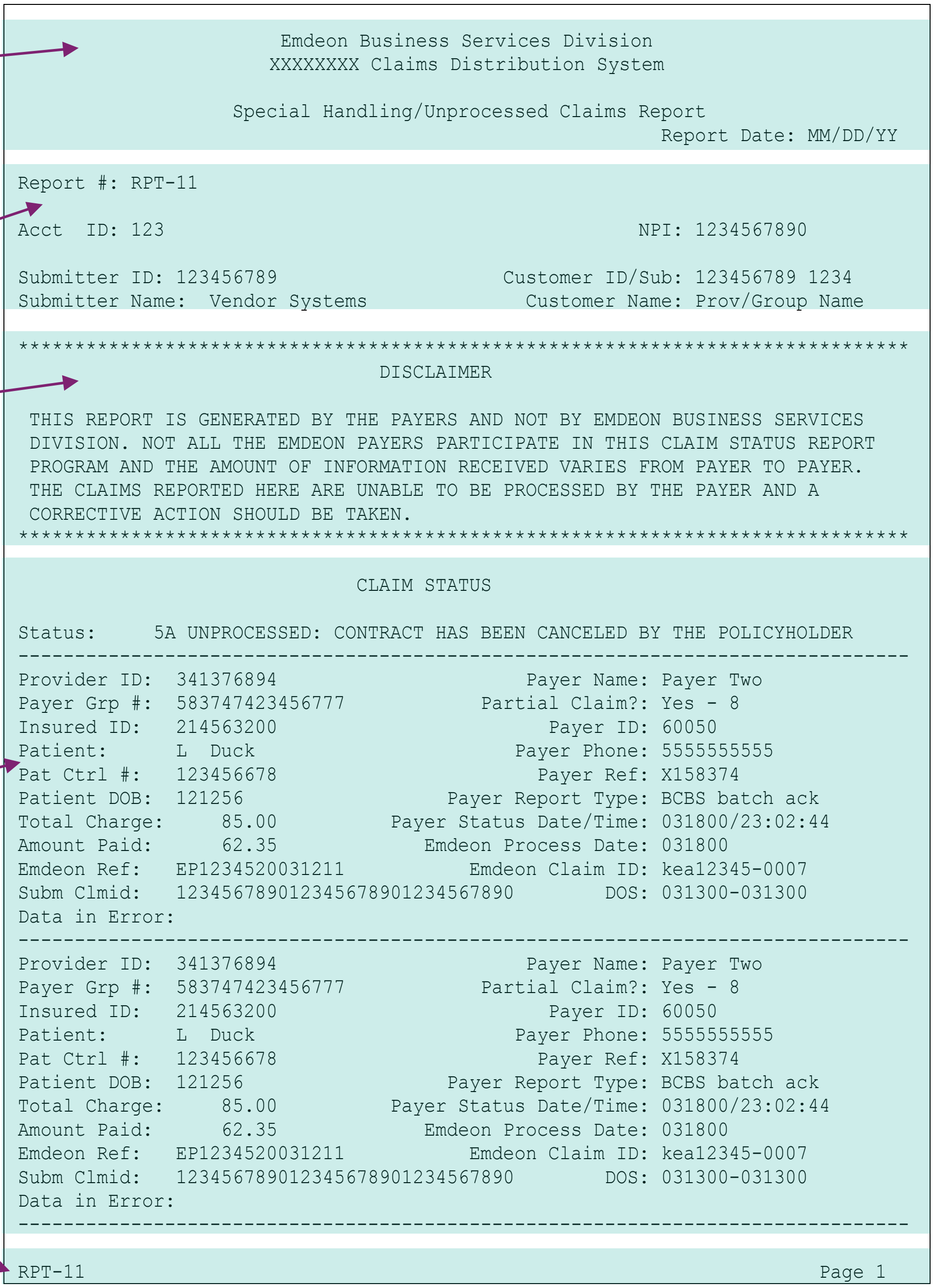
Report Field Name	**Description**
Report Date	The date the report was generated by Emdeon
Report #	The Emdeon report number
Acct ID	The submitter's login/account ID assigned by Emdeon
Submitter ID	The identifier used by Emdeon to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
Submitter Name	The name of the submitter
Customer ID/Sub	The ID/Sub ID used by Emdeon to identify the customer
Customer Name	The name of the customer
DISCLAIMER	Text message explaining that the report is generated if information is available from the payer(s)
CLAIM STATUS:	
Status	Indicates the status of the claim and the reason for the status. These status codes could be payer proprietary codes, ANSI defined codes, or clearinghouse-defined codes for the payer(s).
Provider ID	The provider number assigned to the provider by the payer. It could be a unique ID or a tax ID for commercial payers.
Insured ID	The ID of the insured
Patient	The name of the patient
Pat. Ctrl #	The unique identifier assigned by the provider identifying the patient
Total Charges	The total amount of charges for the claim
Amount Paid	The payment amount that will be made for the claim by the payer
DOS	The beginning and ending date for the services rendered that the claim is covering
Status Data	Data referenced by status message
Payer Name	The name of the payer providing status
Payer ID	The electronic ID of the payer providing status
Payer Phone	The phone number the payer would like the provider to use to make inquiries
Payer Ref	The unique payer-assigned number to the claim
Payer Status Date	The date the status was generated by the payer
Emdeon Process Date	The date Emdeon processed the claim
Emdeon Claim ID	The unique claim identifier assigned by Emdeon

RPT-11 (Special Handling/Unprocessed Claims Report)

The RPT-11 report contains information provided by payers who receive claims from Emdeon for adjudication. Not all payers who receive claims from Emdeon provide information for this report, and the amount/frequency of information produced will vary from payer to payer. The RPT-11 returns Unprocessed, Request for Additional Information, and Rejected statuses only.

RPT-11 Report Sample

The following sample is provided to illustrate the various sections and fields contained in the RPT-11 report.



```
                     Emdeon Business Services Division
                     XXXXXXXX Claims Distribution System

                   Special Handling/Unprocessed Claims Report
                                                     Report Date: MM/DD/YY

Report #: RPT-11

Acct  ID: 123                                        NPI: 1234567890

Submitter ID: 123456789                   Customer ID/Sub: 123456789 1234
Submitter Name:  Vendor Systems             Customer Name: Prov/Group Name

*******************************************************************************
                                DISCLAIMER

 THIS REPORT IS GENERATED BY THE PAYERS AND NOT BY EMDEON BUSINESS SERVICES
 DIVISION. NOT ALL THE EMDEON PAYERS PARTICIPATE IN THIS CLAIM STATUS REPORT
 PROGRAM AND THE AMOUNT OF INFORMATION RECEIVED VARIES FROM PAYER TO PAYER.
 THE CLAIMS REPORTED HERE ARE UNABLE TO BE PROCESSED BY THE PAYER AND A
 CORRECTIVE ACTION SHOULD BE TAKEN.
*******************************************************************************

                              CLAIM STATUS

Status:     5A UNPROCESSED: CONTRACT HAS BEEN CANCELED BY THE POLICYHOLDER
-------------------------------------------------------------------------------
Provider ID:  341376894                         Payer Name: Payer Two
Payer Grp #:  583747423456777               Partial Claim?: Yes - 8
Insured ID:   214563200                           Payer ID: 60050
Patient:      L  Duck                          Payer Phone: 5555555555
Pat Ctrl #:   123456678                          Payer Ref: X158374
Patient DOB:  121256                     Payer Report Type: BCBS batch ack
Total Charge:     85.00             Payer Status Date/Time: 031800/23:02:44
Amount Paid:      62.35                Emdeon Process Date: 031800
Emdeon Ref:   EP1234520031211              Emdeon Claim ID: kea12345-0007
Subm Clmid:   123456789012345678901234567890        DOS: 031300-031300
Data in Error:
-------------------------------------------------------------------------------
Provider ID:  341376894                         Payer Name: Payer Two
Payer Grp #:  583747423456777               Partial Claim?: Yes - 8
Insured ID:   214563200                           Payer ID: 60050
Patient:      L  Duck                          Payer Phone: 5555555555
Pat Ctrl #:   123456678                          Payer Ref: X158374
Patient DOB:  121256                     Payer Report Type: BCBS batch ack
Total Charge:     85.00             Payer Status Date/Time: 031800/23:02:44
Amount Paid:      62.35                Emdeon Process Date: 031800
Emdeon Ref:   EP1234520031211              Emdeon Claim ID: kea12345-0007
Subm Clmid:   123456789012345678901234567890        DOS: 031300-031300
Data in Error:
-------------------------------------------------------------------------------

RPT-11                                                                Page 1
```

Header Section displays the type of claims distribution system (Medical, Hospital, Dental) and the report's title and date.

Information Section displays data provider information. When applicable, vendor information also displays.

Disclaimer Section displays text message explaining the intent of the report. This displays only once on the report.

Claim Status Header and Detail Section displays (on a daily basis) the status of claims if a status on a submitted claim has been received from the payer. Claims are grouped according to status, then payer.

Page Footer Section displays report # and page number(s) of the report.

RPT-11 Detailed Information

Sorting Sequence	By customer ID, by status, and by payer
Frequency of Report	Daily for each submitter for payer status updates received within the previous 24 hours if claim data is submitted by 8:00 p.m. Eastern time
Purpose of Report	To monitor and inform of the status of unprocessed, request for additional information, and rejected statuses only on claims submitted electronically to payers. **Note**: Not all payers provide a claim status electronically, and the amount/frequency of returned information varies.

Report Field Name	Description
Report Date	The date the report was generated by Emdeon
Report #	The Emdeon report number
Acct ID	The submitter's login/account ID assigned by Emdeon
Submitter ID	The identifier used by Emdeon to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
Submitter Name	The name of the submitter
Customer ID/Sub	The ID/Sub ID used by Emdeon to identify the customer
Customer Name	The name of the customer
DISCLAIMER	Text message explaining that the report is generated if information is available from the payer(s)
CLAIM STATUS:	
Status	Indicates the status of the claim and the reason for the status. These status codes could be payer proprietary codes, ANSI defined codes, or clearinghouse-defined codes for the payer(s).
Provider ID	The provider number assigned to the provider by the payer. It could be a unique ID or a tax ID for commercial payers.
Insured ID	The ID of the insured
Patient	The name of the patient
Pat. Ctrl #	The unique identifier assigned by the provider identifying the patient
Total Charge	The total amount of charges for the claim
Amount Paid	The payment amount that will be made for the claim by the payer
DOS	The beginning and ending date for the services rendered that the claim is covering
Payer Name	The name of the payer providing status
Payer ID	The electronic ID of the payer providing status
Payer Phone	The phone number the payer would like the provider to use to make inquiries
Payer Ref	The unique payer-assigned number to the claim
Payer Status Date	The date the status was generated by the payer
Emdeon Process Date	The date Emdeon processed the claim
Emdeon Claim ID	The unique claim identifier assigned by Emdeon

Reporting & Analytics

Introduction

When your practice or site submits claims to the Emdeon clearinghouse, Emdeon retains and archives all claim data per regulatory guidelines. Through a secure, web-based portal, Reporting & Analytics gives you quick online access and detailed views of the previous 15 months of your claims data. Reporting & Analytics enables you to customize and submit several claim search options that focus on data specific to a patient, payer, or a patient claim status. These options are designed to provide you with the type of summary or detailed information you need to do the following:

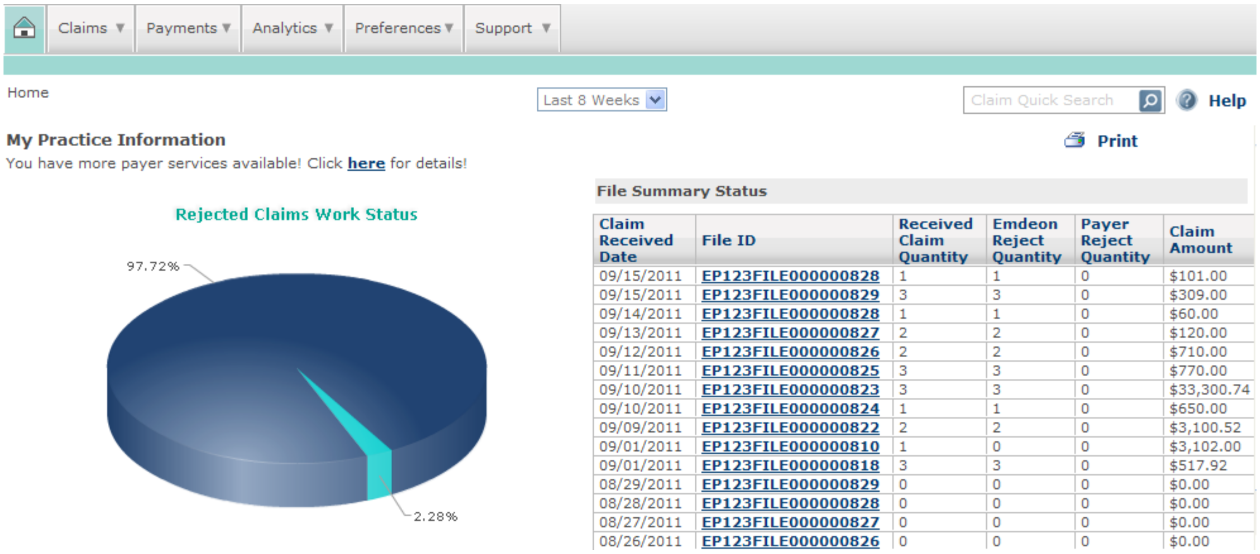
- Track claims through their life cycle from first submission through payment
- Monitor progress according to claim status
- Identify claims that need rework, or that have been reworked
- Evaluate trends to make needed adjustments to claims administration
- Expedite claims payment

***Note**: All confidential data has been obscured in the following images.*

Fundamentals

Access Reporting & Analytics

When you access Reporting & Analytics through Emdeon Office by selecting **Claims** > **Reporting & Analytics**, the Reporting & Analytics home page will appear. This screen provides the launching point for initiating search queries and other product functions.



My Practice Information

You have more payer services available! Click **here** for details!

File Summary Status

Claim Received Date	File ID	Received Claim Quantity	Emdeon Reject Quantity	Payer Reject Quantity	Claim Amount
09/15/2011	EP123FILE000000828	1	1	0	$101.00
09/15/2011	EP123FILE000000829	3	3	0	$309.00
09/14/2011	EP123FILE000000828	1	1	0	$60.00
09/13/2011	EP123FILE000000827	2	2	0	$120.00
09/12/2011	EP123FILE000000826	2	2	0	$710.00
09/11/2011	EP123FILE000000825	3	3	0	$770.00
09/10/2011	EP123FILE000000823	3	3	0	$33,300.74
09/10/2011	EP123FILE000000824	1	1	0	$650.00
09/09/2011	EP123FILE000000822	2	2	0	$3,100.52
09/01/2011	EP123FILE000000810	1	0	0	$3,102.00
09/01/2011	EP123FILE000000818	3	3	0	$517.92
08/29/2011	EP123FILE000000829	0	0	0	$0.00
08/28/2011	EP123FILE000000828	0	0	0	$0.00
08/27/2011	EP123FILE000000827	0	0	0	$0.00
08/26/2011	EP123FILE000000826	0	0	0	$0.00

Use Search Date Ranges

To optimize system performance, use a date range of seven days or less, if possible. For selected searches, you can select either **Claim Received Date** or **Service Date**. If the date fields are left blank, Reporting & Analytics will set the date range to the previous seven days by default.

Limit a Search

When you perform a higher-level (summary) search, Reporting & Analytics displays the first 1,000 rows of data that match your specified search criteria.

If any search returns more than 1,000 rows of data, Reporting & Analytics displays a message to indicate that there are more items in the database that match your search criteria than can be displayed. If you see this message and have not found the data you want, return to the Search screen and re-enter your search with more restrictive criteria. (For example, consider using a more narrow date range.)

Filter a Search by Tax ID or Site ID

Searching against a specific Tax ID or Site ID is especially helpful for:

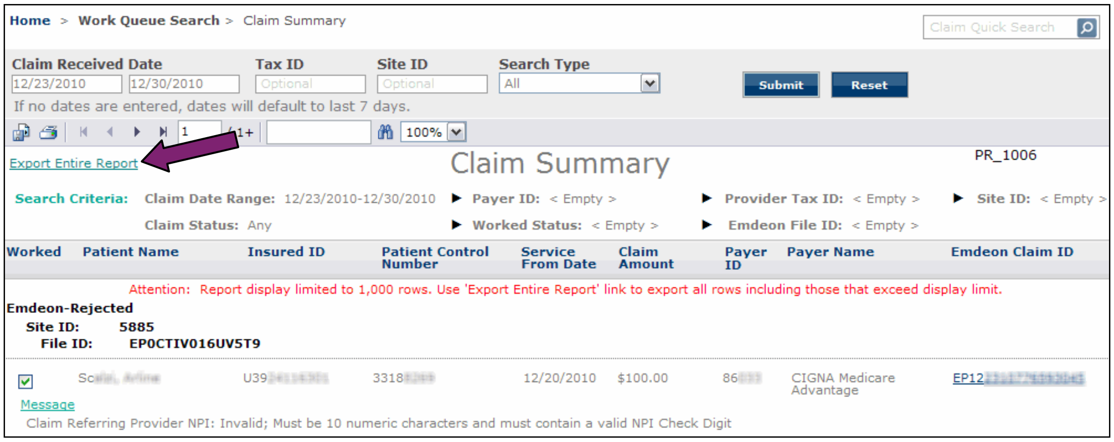
- Limiting search results to a specific provider or specialty area within a practice (by using the associated Tax ID as search criteria).
- Limiting search results to a specific practice site for providers using multiple site ids for claims submission.

Use Claim Quick Search

There are no date range options in Quick Search. A 30-day date range is used by default. For detailed information about this search, see **Claim Quick Search** on page 104.

Export Entire Report

To view all rows of a report with more than 1,000 rows, you can export the report to a Microsoft Excel spreadsheet (.xls). Click the “Export Entire Report” link located at the upper left of the report. The link is available only when a report exceeds 1,000 rows.



Claim Received Date: 12/23/2010 – 12/30/2010
Tax ID: Optional
Site ID: Optional
Search Type: All
If no dates are entered, dates will default to last 7 days.

Claim Summary

PR_1006

Search Criteria: Claim Date Range: 12/23/2010-12/30/2010 ▶ Payer ID: < Empty > ▶ Provider Tax ID: < Empty > ▶ Site ID: < Empty >
Claim Status: Any ▶ Worked Status: < Empty > ▶ Emdeon File ID: < Empty >

Worked	Patient Name	Insured ID	Patient Control Number	Service From Date	Claim Amount	Payer ID	Payer Name	Emdeon Claim ID
☑	Sc[redacted]	U39[redacted]	3318[redacted]	12/20/2010	$100.00	86[redacted]	CIGNA Medicare Advantage	EP12[redacted]

Attention: Report display limited to 1,000 rows. Use 'Export Entire Report' link to export all rows including those that exceed display limit.

Emdeon-Rejected
Site ID: 5885
File ID: EP0CTIV016UV5T9

Claim Referring Provider NPI: Invalid; Must be 10 numeric characters and must contain a valid NPI Check Digit

This feature works for the following reports:

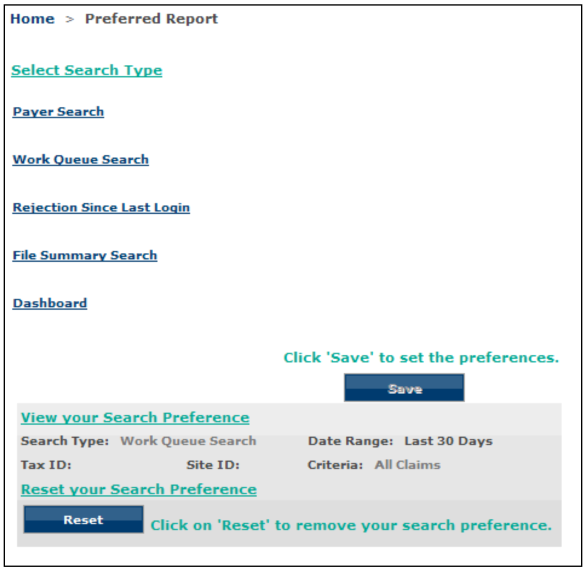
- Claim Summary
- File Summary Report
- Summary by Payer ID by Day
- Summary by Payer ID
- Insured Detail Report

Set User Preferences

User preferences allow you to set up a default search or system action (e.g., display dashboards). The default search/action runs automatically upon access to Reporting & Analytics.

Note: *The preference selections remain in effect until cancelled.*

Set up a default search/action for any of the searches in the image below:



Home > Preferred Report

Select Search Type

Payer Search

Work Queue Search

Rejection Since Last Login

File Summary Search

Dashboard

Click 'Save' to set the preferences.

View your Search Preference

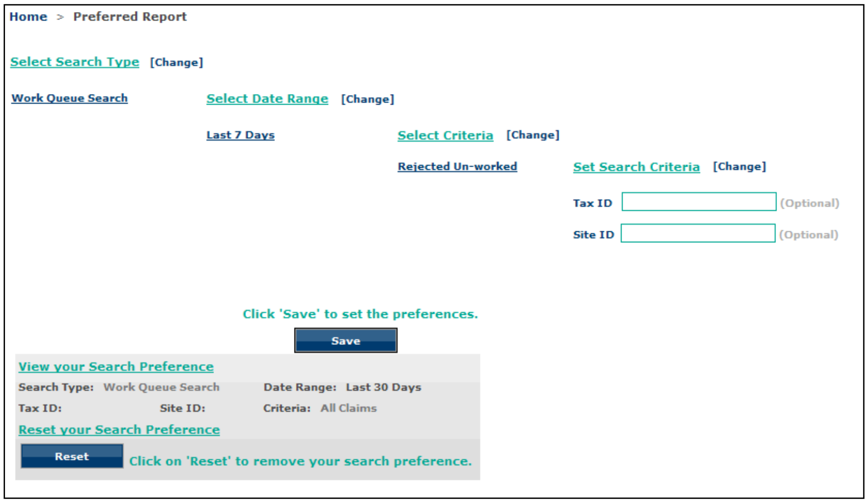
Search Type: Work Queue Search
Date Range: Last 30 Days
Tax ID:
Site ID:
Criteria: All Claims

Reset your Search Preference

Click on 'Reset' to remove your search preference.

Click on the option to be implemented. User Preferences are specific to your user ID; the selections you make are applied to your user ID only.

Work Queue Search set in Preferences example:



Home > Preferred Report

Select Search Type [Change]

Work Queue Search

Select Date Range [Change]

Last 7 Days

Select Criteria [Change]

Rejected Un-worked

Set Search Criteria [Change]

Tax ID (Optional)
Site ID (Optional)

Click 'Save' to set the preferences.

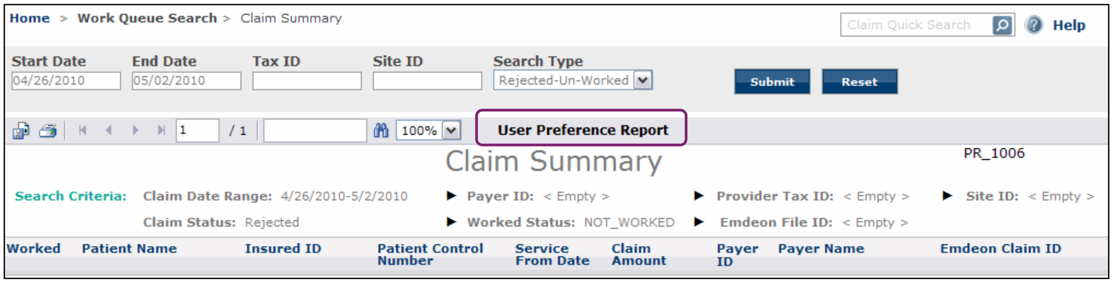
View your Search Preference

Search Type: Work Queue Search
Date Range: Last 30 Days
Tax ID:
Site ID:
Criteria: All Claims

Reset your Search Preference

Click on 'Reset' to remove your search preference.

Your saved preferences become active the next time you access Reporting & Analytics. The term **User Preference Report** is shown at the top of the report.



Start Date: 04/26/2010
End Date: 05/02/2010
Tax ID:
Site ID:
Search Type: Rejected-Un-Worked

1 / 1 100%

Search Criteria: Claim Date Range: 4/26/2010-5/2/2010 ▶ Payer ID: < Empty > ▶ Provider Tax ID: < Empty > ▶ Site ID: < Empty >
Claim Status: Rejected ▶ Worked Status: NOT_WORKED ▶ Emdeon File ID: < Empty >

Worked	Patient Name	Insured ID	Patient Control Number	Service From Date	Claim Amount	Payer ID	Payer Name	Emdeon Claim ID

Set Up a User Preference (Default) Search

1. Click **Preferences** in the navigation bar.
2. Click on the desired search type.
3. Specify your search options (making your changes in each sub-section, as applicable).
4. Optionally, click any "[Change]" link to view additional selection options.
5. Click **Save**.
6. Click the "Home" link on the Breadcrumb bar to return to the Reporting & Analytics main screen, or select another function from the navigation bar.

   When you next access Reporting & Analytics, your selected search will automatically run (with your saved criteria).

Cancel a User Preference (Default) Search

1. When you access Reporting & Analytics, your previously defined default/preferred search runs.
2. After the report displays, click the "Home" link on the Breadcrumb bar to return to the main page or select a different search with the drop-down menus.
3. To cancel the Preferred Search, click the **Preferences** tab to access the setup screen.
4. In the Preferences screen click **Reset** to cancel the user preference settings.
5. You can now define a different search preference.

Customizable Alerts

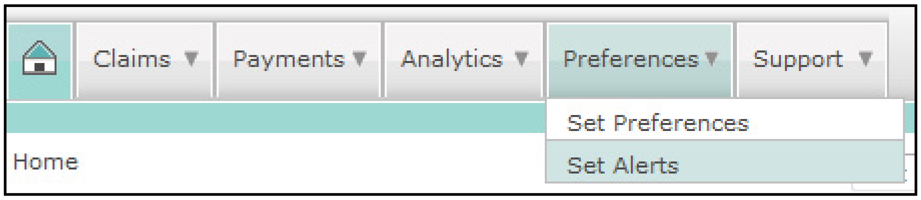
Introduction

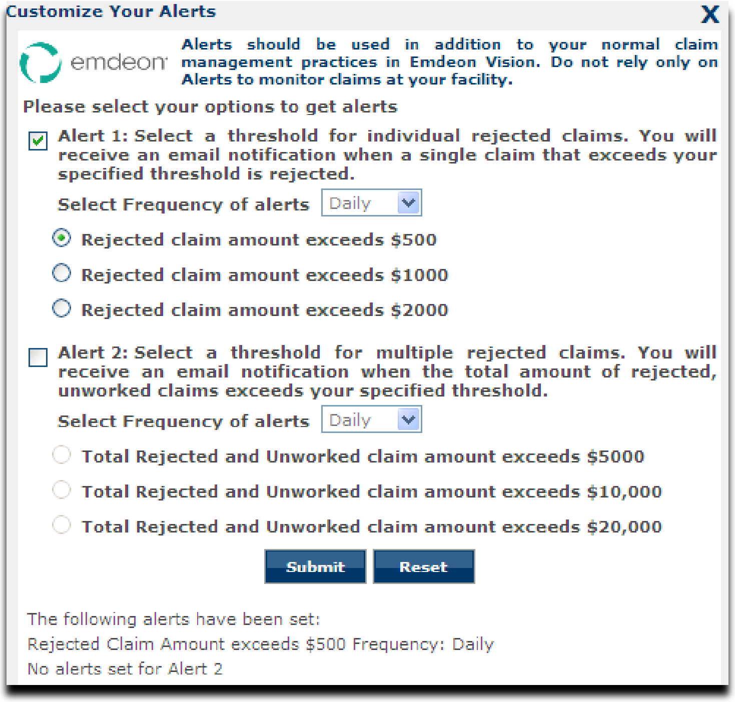
Use Customizable Alerts to stay informed via email when your specified claim rejection amount threshold(s) are exceeded. Alert notifications are sent to the email address on file for your account. To verify or update your existing email address, go to manage users under the Setup tab in Office to search for and edit users.

No PHI is included in any Alert.

> ***Note*** *Do not reply to Reporting & Analytics email Alerts.*

Click on **Preferences > Set Alerts**.





Alerts should be used in addition to your normal claim management practices in Emdeon Vision. Do not rely only on Alerts to monitor claims at your facility.

Please select your options to get alerts

☑ Alert 1: Select a threshold for individual rejected claims. You will receive an email notification when a single claim that exceeds your specified threshold is rejected.

Select Frequency of alerts: Daily

● Rejected claim amount exceeds $500
○ Rejected claim amount exceeds $1000
○ Rejected claim amount exceeds $2000

☐ Alert 2: Select a threshold for multiple rejected claims. You will receive an email notification when the total amount of rejected, unworked claims exceeds your specified threshold.

Select Frequency of alerts: Daily

○ Total Rejected and Unworked claim amount exceeds $5000
○ Total Rejected and Unworked claim amount exceeds $10,000
○ Total Rejected and Unworked claim amount exceeds $20,000

The following alerts have been set:
Rejected Claim Amount exceeds $500 Frequency: Daily
No alerts set for Alert 2

Email Alert Frequency

You can receive email Alerts daily or weekly. Alerts are generated *only* if your selected threshold is reached.

Setup Alerts

Click on Preferences>Set Alerts. The Customize Alerts popup window displays.

Two types of Alerts are available, individual claim-specific (Alert 1) or combined claims totals (Alert 2). Place a check in the checkbox for the Alert type you want.

You can select one Alert type or both.

Set the frequency for each Alert by selecting Daily or Weekly for each Alert.

- ✓ **Weekly Alert** emails are generated every Monday morning at 6am EST and include last 7 days of claims data from claims received between yesterday (Sunday) and the previous Monday.
- ✓ **Daily Alert** emails are generated at 6am EST every day and include claims data of claims received the previous day.

Select monetary Alert level for each Alert type by placing a check in the applicable checkbox. You can select one Alert level per Alert type.

Alert 1: Threshold Alert for rejected amounts (in US dollars) for individual claims.

- ✓ Rejected amount exceeds $500.
- ✓ Rejected amount exceeds $1000.
- ✓ Rejected amount exceeds $2000.

Alert 2: Threshold Alert for total dollar amounts (in US dollars) for combined rejected and unworked claims.

- ✓ Rejected amount exceeds $5,000.
- ✓ Rejected amount exceeds $10,000.
- ✓ Rejected amount exceeds $20,000.

Click **Submit** to save your Alert settings.

After settings are saved, your saved Alerts and their frequency are displayed in a message at the bottom of the Customize Alerts window. This information is always displayed whenever the Alerts window is accessed.

- ✓ If no Alert is set the following message is displayed: There are no Alerts set.

Receiving Email Alerts from Emdeon Reporting & Analytics

Do Not Reply to Alert Email

Email Alerts contain an introductory statement identifying the communication as an Alert from Emdeon. Do not reply to the Alert email. Note: The terms 'Emdeon Vision' and 'Reporting & Analytics' are used interchangeably in this section.

Alert Email Format - Alert 1

For Alert 1, the user will receive the following message:

"This is an alert from Emdeon Claim Vision. <Number of claims> rejected claims exceed your rejected claim amount alert threshold of <threshold value> per claim. Please visit Emdeon Vision to review these claims."

Claim rejection information for individual claims (Alert 1) is organized in a table format with the following column headings:

- ✓ Claim ID
- ✓ Claim Amount
- ✓ Rejected by
  (Either Emdeon or payer - If by payer, payer ID is displayed.)
- ✓ Rejection Date
- ✓ Rejection Reason

The table is limited to ten claims and the sort order is by rejected claim amount.

Alert Email Format - Alert 2

For Alert 2, the user will receive the following message:

This is an alert from Emdeon Claim Vision. The total claim amount of your rejected and unworked claims is <value> which exceeds your <threshold value> setting. Please visit Emdeon Vision to review these claims.

As rejected, unworked claims are "worked" in Reporting & Analytics; these changes should be reflected by this Alert. That is, as rejected, unworked claims are corrected in Vision, the claims causing this threshold to be exceeded should be reduced, eventually to the point where the threshold is no longer exceeded.

Alert Email Identification

Email address of Emdeon Vision Alerts is *VisionAlerts@emdeon.com*.

Note *Please do not send emails to this address, or reply to Vision Alert emails.*

Use the Worked Claim Feature

A claim can be marked "worked" at the Claim Detail level. This feature is used for claims that require edits or additional information prior to resubmission when the first-pass claim has been rejected by Emdeon or the payer. The "Worked Claim" feature enables you to quickly identify those rejected claims that have been worked, and those un-worked claims that require attention.

The term "Worked" may be used to signify any of the following claim conditions:

- The claim has been accessed for corrective action (edits or additional information), but has not been completely corrected for resubmission.
- Required corrective action (edits or additional required information) is complete, but the claim has not been resubmitted.
- All required corrective action (edits or additional required information) has been completed, and the claim has been resubmitted.

***Note**: The definition of the terms "Worked" and "Un-Worked" as they relate to your practice's workflow should be understood by all Reporting & Analytics users within your practice/organization.*

View Worked vs. Un-worked Claims

Work Queue search enables you to quickly identify worked and un-worked claims. For more information on performing this search option, please see **Rejection Since Last** Login Search

Access this search by selecting **Claims** > **Rejection Since Last Login**. This search displays a Claim Summary report of all claims that have been rejected since you last accessed Reporting & Analytics.

***Note**: There are no search criteria associated with this report. Click **Submit** to run the search.*

Work Queue Search on page 129.

Update Claim "Worked" Status

The Claim Detail Report includes a "Worked" check box that is unchecked by default. To mark a claim as "Worked" simply click once in the check box (this will place a check in the box).

The "Worked/Un-worked" status can be viewed in the Claim Summary Report. In the Claim Detail Report "Worked" status of the claim is shown by a check in the "Worked/Un-worked" check box, see **Descriptions and functions** of key user fields in the Claim Detail section are presented below.

Worked Status Indicator on page 142.

My Practice Landing Page

Change View with Date Range

Use the date range list to change the current Landing Page view. When you change the date range, the view automatically updates.

Landing Page and Preferred Reports

If you have set a Preferred Report in User Preferences, the Preferred Report displays when you access Reporting & Analytics instead of the Landing Page. To view the Landing Page instead of a Preferred Report on login, cancel the selected Preferred Report by clicking **Preferences**, and then **Reset**.

Data Displayed in Landing Page

- Rejected Claims "'Worked' Status" Clickable Pie Chart

  Use the date range list to view any rejected claims for your Provider Organization for the selected date range. All rejected claims with status of "Worked" or "Un-worked" are included in the pie chart. Click a pie slice to view a Claim Summary report that contains data based on the criteria of the pie slice.

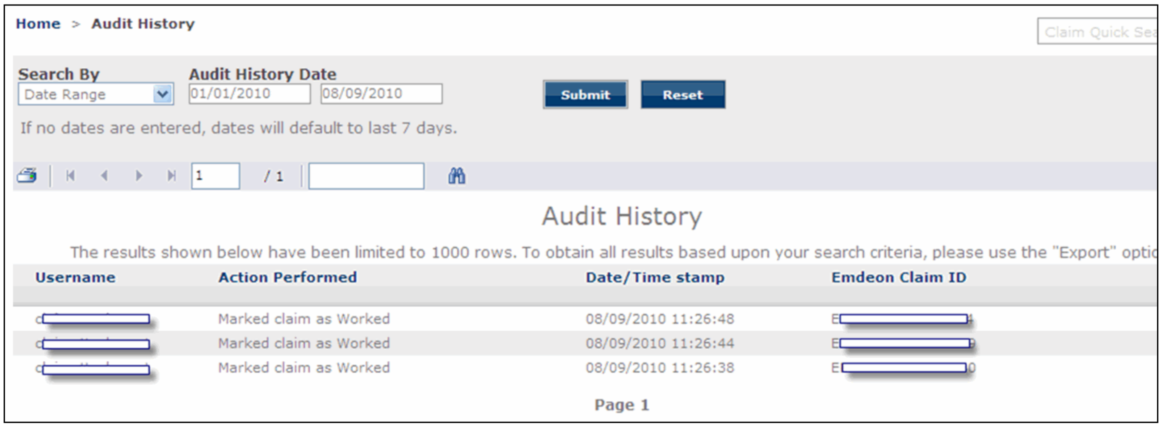
- File Summary Status Clickable Table

  All batches submitted during the date range displayed in the date list are displayed. You can readily view the number of batches, value, and if any batches are missing (based on your local knowledge of what is expected to have been submitted). The **Claim Amount** column shows which batches have the most claim dollars at risk. Click the File ID number to view details of any claims in the selected batch.

- Run a Quick Search

  You can do a Quick Search on numerous data points found in a claim. Please see **Audit History Search**

Access this search by selecting **Analytics** > **Audit History**. Run a search to display an Audit History report of all applicable or matching claims whose "worked/unworked" status has changed. Search for updated claims by single date (or date range) or by Emdeon Claim ID number.



Search By: Date Range

Audit History Date: 01/01/2010 08/09/2010

If no dates are entered, dates will default to last 7 days.

Audit History

The results shown below have been limited to 1000 rows. To obtain all results based upon your search criteria, please use the "Export" optio

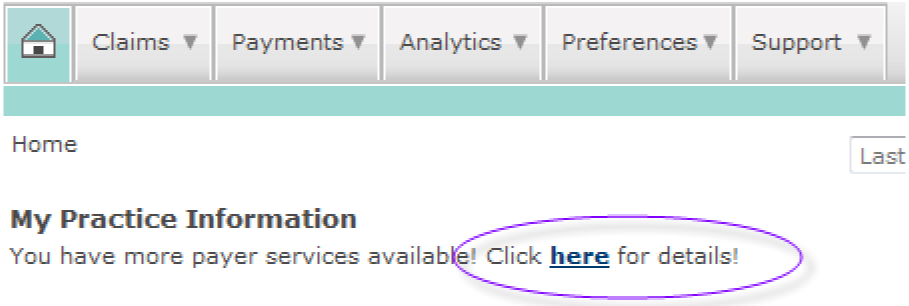
Username	Action Performed	Date/Time stamp	Emdeon Claim ID
[redacted]	Marked claim as Worked	08/09/2010 11:26:48	[redacted]
[redacted]	Marked claim as Worked	08/09/2010 11:26:44	[redacted]
[redacted]	Marked claim as Worked	08/09/2010 11:26:38	[redacted]

Page 1

Claim Quick Search on page 103 for more information.

Access Service Enrollment Matrix

Click the link in the Home/My Practice Information landing page. The link is accessible in the upper left section of the screen. "You have more payer services available! Click here for details."

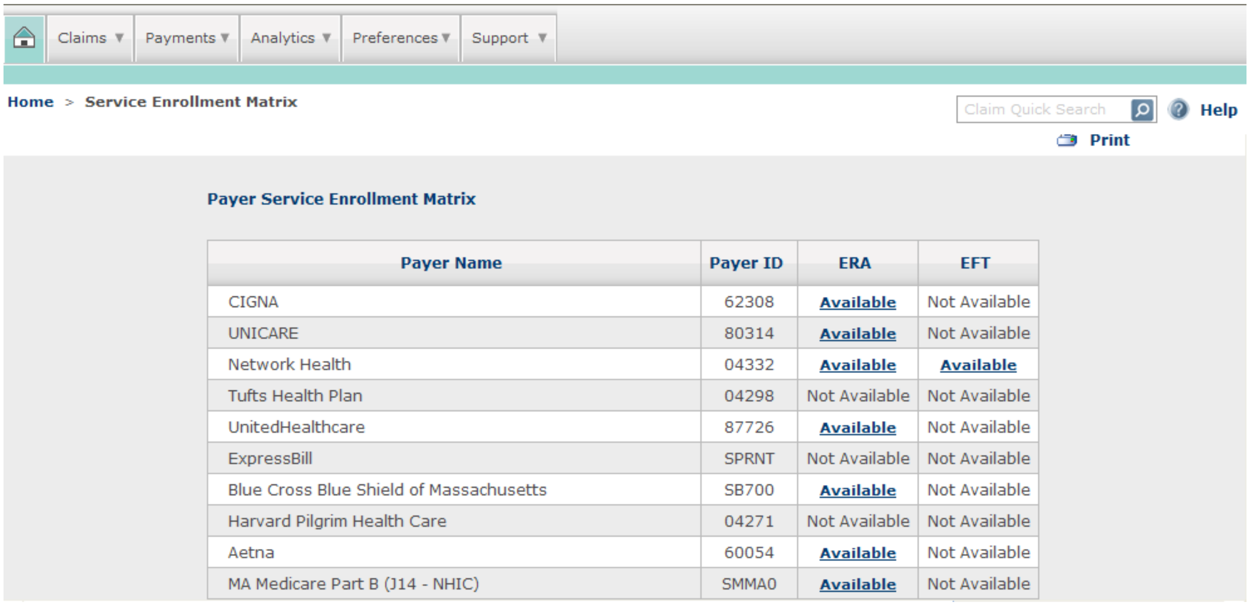


My Practice Information

You have more payer services available! Click here for details!

Which Payer Services are Available?

Vision includes numerous services that facilitate effective information/data exchanges between providers and payers. You can easily determine which functions a particular payer supports, and review the availability of features.



Payer Service Enrollment Matrix

Payer Name	Payer ID	ERA	EFT
CIGNA	62308	Available	Not Available
UNICARE	80314	Available	Not Available
Network Health	04332	Available	Available
Tufts Health Plan	04298	Not Available	Not Available
UnitedHealthcare	87726	Available	Not Available
ExpressBill	SPRNT	Not Available	Not Available
Blue Cross Blue Shield of Massachusetts	SB700	Available	Not Available
Harvard Pilgrim Health Care	04271	Not Available	Not Available
Aetna	60054	Available	Not Available
MA Medicare Part B (J14 - NHIC)	SMMA0	Available	Not Available

Review Payer Offerings

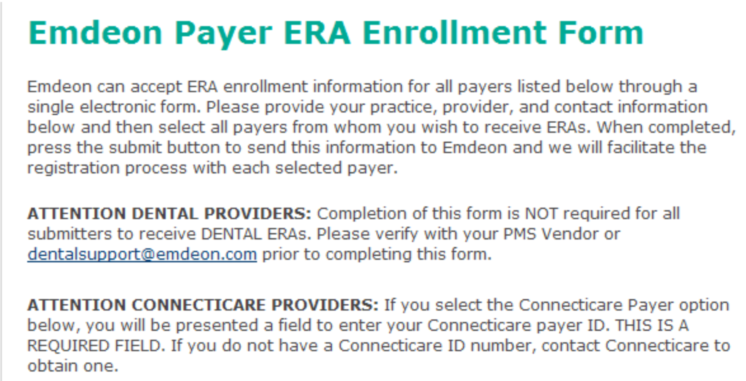
The offerings of each payer are displayed in the payer row of the Service Enrollment table.

- ✓ **Available**
  If the payer offers this function but your account is not currently configured to use it, "Available" appears in the applicable box in the table. Click link to display instructions and a registration form in a separate window to setup your account for the EFT function.
  Note:
  If you click on the *Available* link in the ERA or Claims columns an instructional message is displayed.
- ✓ **Not Available**
  If the payer does not offer this function "Not Available" appears in the applicable box in the table.

Payer Functions

The following payer offerings/functions are displayed as column headers in the Service Enrollment matrix table. Look on the row for a specific payer to determine if a particular function is available (for your account) from that payer.

- ✓ Payer Name
- ✓ Payer ID
- ✓ ERA
  - Possible values are Available, Not Available, and Yes.
  - ERA - Electronic Remittance Advice; an electronic version of a payment explanation which provides details about providers' claim(s) payment, and if the claim(s) is denied. If claim was denied the ERA includes the required explanations. The industry standard for sending of ERA data is the HIPAA X12N 835 standard.
- ✓ EFT
  - Possible values are Available, Not Available, and Yes.
  - EFT - Electronic Funds Transfer; electronic receipt of funds from payers.

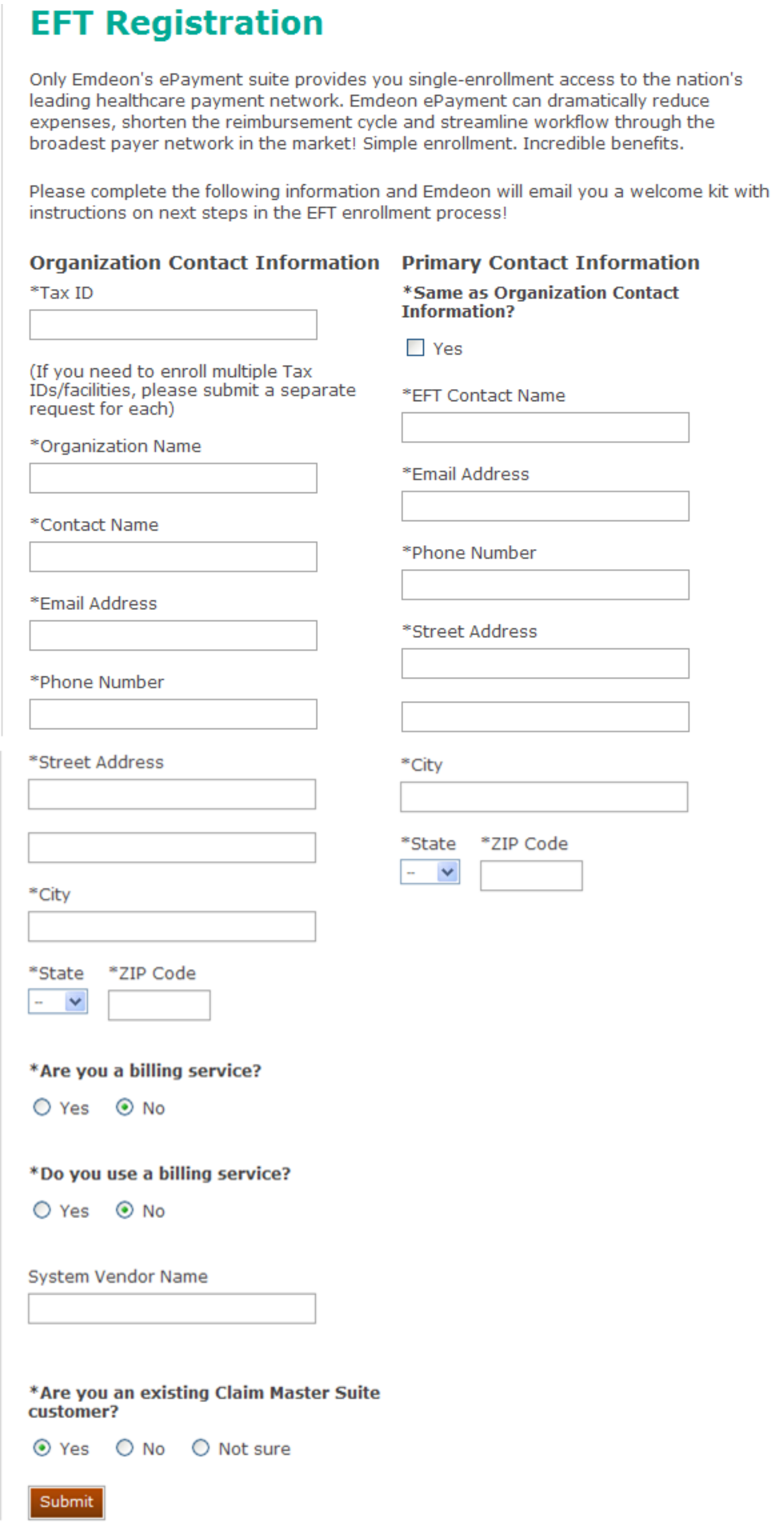


Emdeon Payer ERA Enrollment Form

Emdeon can accept ERA enrollment information for all payers listed below through a single electronic form. Please provide your practice, provider, and contact information below and then select all payers from whom you wish to receive ERAs. When completed, press the submit button to send this information to Emdeon and we will facilitate the registration process with each selected payer.

ATTENTION DENTAL PROVIDERS: Completion of this form is NOT required for all submitters to receive DENTAL ERAs. Please verify with your PMS Vendor or dentalsupport@emdeon.com prior to completing this form.

ATTENTION CONNECTICARE PROVIDERS: If you select the Connecticare Payer option below, you will be presented a field to enter your Connecticare payer ID. THIS IS A REQUIRED FIELD. If you do not have a Connecticare ID number, contact Connecticare to obtain one.



EFT Registration

Only Emdeon's ePayment suite provides you single-enrollment access to the nation's leading healthcare payment network. Emdeon ePayment can dramatically reduce expenses, shorten the reimbursement cycle and streamline workflow through the broadest payer network in the market! Simple enrollment. Incredible benefits.

Please complete the following information and Emdeon will email you a welcome kit with instructions on next steps in the EFT enrollment process!

Organization Contact Information

*Tax ID

(If you need to enroll multiple Tax IDs/facilities, please submit a separate request for each)

*Organization Name

*Contact Name

*Email Address

*Phone Number

*Street Address

*City

*State --
*ZIP Code

***Are you a billing service?**

○ Yes ● No

***Do you use a billing service?**

○ Yes ● No

System Vendor Name

***Are you an existing Claim Master Suite customer?**

● Yes ○ No ○ Not sure

Submit

Primary Contact Information

***Same as Organization Contact Information?**

☐ Yes

*EFT Contact Name

*Email Address

*Phone Number

*Street Address

*City

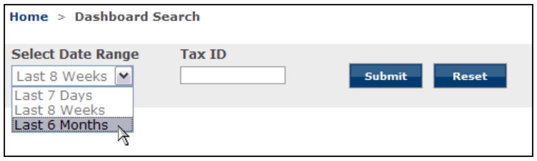
*State --
*ZIP Code

Dashboard Overview

The Reporting & Analytics Dashboard includes four views, three of which provide a clickable graphical representation of important claim data.

- Claim acceptance/rejection status percentages
- Highest dollar amounts for rejected claims by payer
- Monthly dollar sum totals for submitted claims
- Frequently occurring reasons for claim rejections

This information can be helpful in analyzing your practice’s performance, and help in increasing efficiencies and reducing rejections.


Home > Dashboard Search
Select Date Range
Last 8 Weeks
Last 7 Days
Last 8 Weeks
Last 6 Months
Tax ID
Submit
Reset

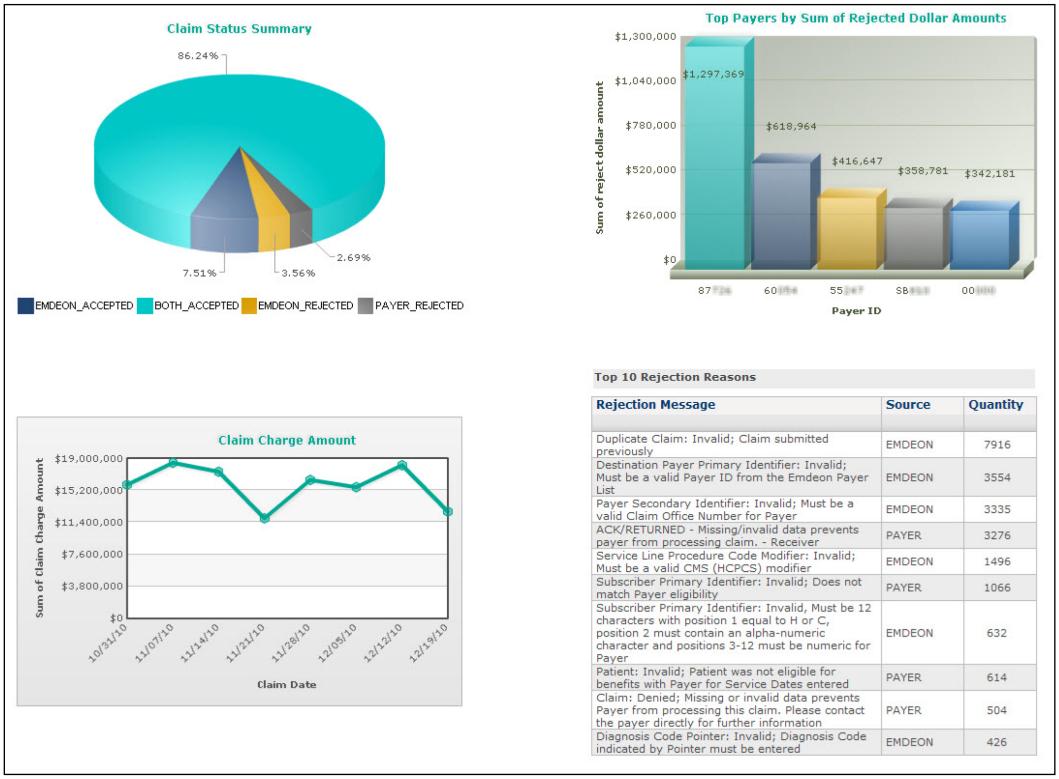
Use the **Select Date Range** drop-down list to set the date range. The optional **Provider Tax ID** field allows you to limit the displayed dashboard data to only those claim summaries for a specific provider or specialty area (or site) within your practice for which a Tax ID is set up. Click **Submit** to display dashboards.

***Note**: Tax ID must be a valid 9-digit numeric string.*

Dashboard Views

The Reporting & Analytics Dashboard includes four views:

- Claim Status Summary (pie chart)
- Top Payers by Sum of Rejected Dollar Amounts (bar graph)
- Claim Charge Amount (line graph)
- Top 10 Rejection Reasons (text table)


Claim Status Summary
86.24%
7.51%
3.56%
2.69%
EMDEON_ACCEPTED
BOTH_ACCEPTED
EMDEON_REJECTED
PAYER_REJECTED
Top Payers by Sum of Rejected Dollar Amounts
Sum of reject dollar amount
$1,300,000
$1,040,000
$780,000
$520,000
$260,000
$0
$1,297,369
$618,964
$416,647
$358,781
$342,181
87[redacted]
60[redacted]
55[redacted]
SB[redacted]
00[redacted]
Payer ID
Claim Charge Amount
Sum of Claim Charge Amount
$19,000,000
$15,200,000
$11,400,000
$7,600,000
$3,800,000
$0
10/31/10
11/07/10
11/14/10
11/21/10
11/28/10
12/05/10
12/12/10
12/19/10
Claim Date

Top 10 Rejection Reasons

Rejection Message	Source	Quantity
Duplicate Claim: Invalid; Claim submitted previously	EMDEON	7916
Destination Payer Primary Identifier: Invalid; Must be a valid Payer ID from the Emdeon Payer List	EMDEON	3554
Payer Secondary Identifier: Invalid; Must be a valid Claim Office Number for Payer	EMDEON	3335
ACK/RETURNED - Missing/invalid data prevents payer from processing claim. - Receiver	PAYER	3276
Service Line Procedure Code Modifier: Invalid; Must be a valid CMS (HCPCS) modifier	EMDEON	1496
Subscriber Primary Identifier: Invalid; Does not match Payer eligibility	PAYER	1066
Subscriber Primary Identifier: Invalid, Must be 12 characters with position 1 equal to H or C, position 2 must contain an alpha-numeric character and positions 3-12 must be numeric for Payer	EMDEON	632
Patient: Invalid; Patient was not eligible for benefits with Payer for Service Dates entered	PAYER	614
Claim: Denied; Missing or invalid data prevents Payer from processing this claim. Please contact the payer directly for further information	PAYER	504
Diagnosis Code Pointer: Invalid; Diagnosis Code indicated by Pointer must be entered	EMDEON	426

The table below describes the information that is provided in each of the four dashboard views.

Dashboard View	Information Provided for Specified Date Range	Drill-Down to Claim Summary Report
Claim Status Summary	Clickable pie chart: • claims accepted at Emdeon clearinghouse, but no status received yet from payer • claims accepted at Emdeon clearinghouse and by payer • claims rejected by Emdeon clearinghouse • claims rejected by payer	Yes – for claim status
Top Payers by Sum of Rejected Dollar Amounts	Displays a bar graph for each of 5 payers (the top 5 payers by Payer ID) with the largest rejected claim dollar amounts	Yes – for selected payer
Claim Charge Amount	Displays total charges for all claims submitted to the Emdeon clearinghouse during the specified time period	Yes – for selected day, week, or month
Top 10 Rejection Reasons	Displays count and detailed description of the top 10 reasons why claims were rejected, either by the Emdeon clearinghouse or by the payer	No – this table is not clickable

Access Dashboard Views

1. Select **Analytics** > **Dashboard**.
2. Select a date range from the drop-down list.
3. Enter a Provider Tax ID (optional) to limit the display to only a specific provider or specialty area (or site) within your practice for which a Tax ID is set up.

***Note**: Provider Tax ID is a 9-digit numeric string.*

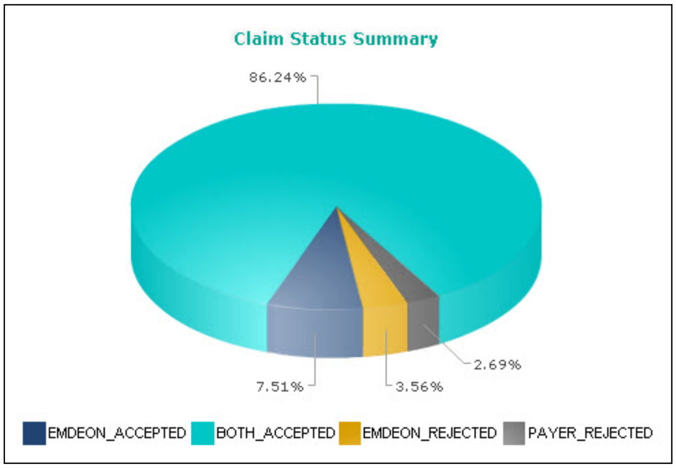
4. Click **Submit**.

Dashboard Search

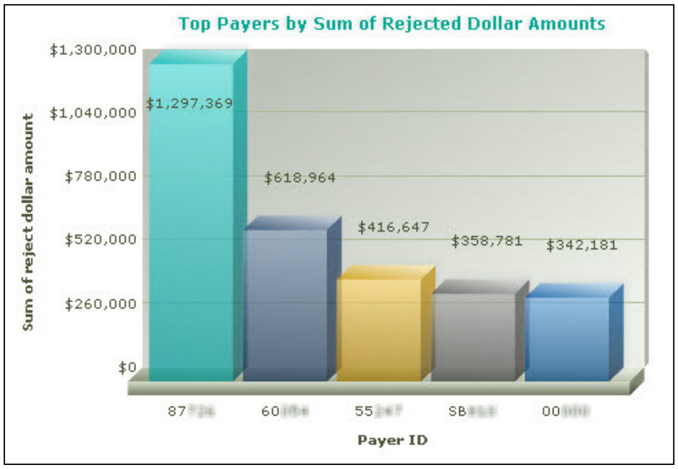
Access this search by selecting **Analytics** > **Dashboard**. Use this search to launch a dashboard view of your claims processing in Reporting & Analytics for the date range selected. Leave the **Tax ID** field blank to view data specific to your own provider tax ID. For more information, see **Dashboard Overview** on page 97.

***Note**: If your account is an organization-level account, you can see a dashboard view of data for all the provider tax IDs associated with your organization ID by leaving the **Tax ID** field empty. Enter a specific provider tax ID in the **Tax ID** field to limit the dashboard data to only the specified provider tax ID.*

Claim Status Summary

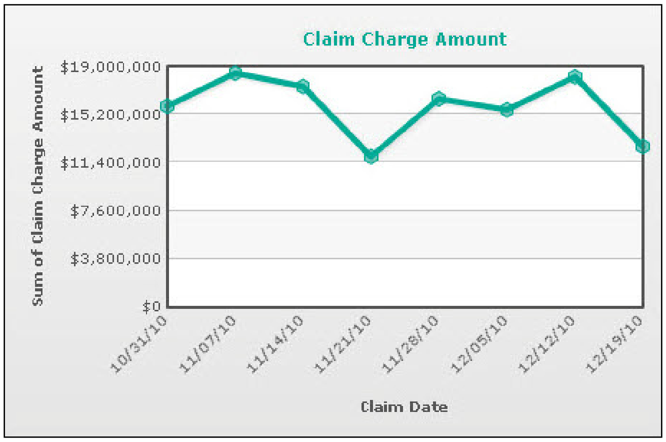


Top Payers by Sum of Rejected Dollar Amounts



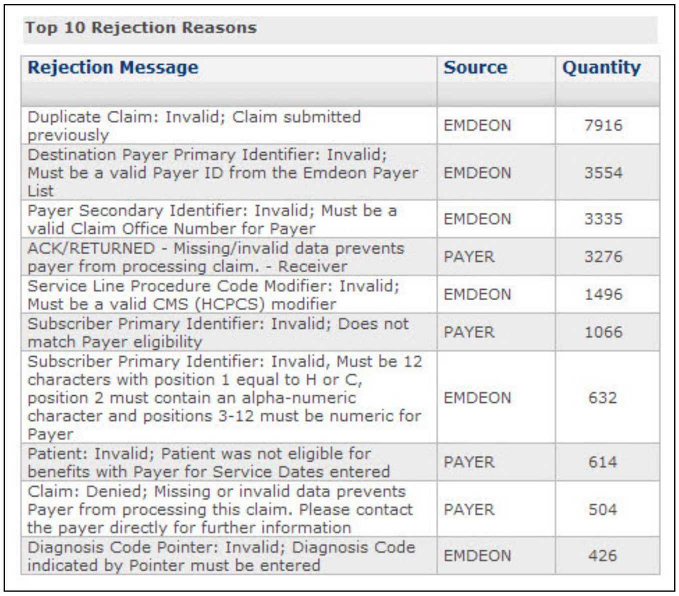
The dollar amount increments shown on the “y” (vertical) axis are determined according to the amounts calculated for the top five payers.

Claim Charge Amount



The dollar amount increments shown on the “y” (vertical) axis are determined according to the claim dollar amounts calculated for the specified day, week, or month.

Top 10 Rejection Reasons



Top 10 Rejection Reasons

Rejection Message	Source	Quantity
Duplicate Claim: Invalid; Claim submitted previously	EMDEON	7916
Destination Payer Primary Identifier: Invalid; Must be a valid Payer ID from the Emdeon Payer List	EMDEON	3554
Payer Secondary Identifier: Invalid; Must be a valid Claim Office Number for Payer	EMDEON	3335
ACK/RETURNED - Missing/invalid data prevents payer from processing claim. - Receiver	PAYER	3276
Service Line Procedure Code Modifier: Invalid; Must be a valid CMS (HCPCS) modifier	EMDEON	1496
Subscriber Primary Identifier: Invalid; Does not match Payer eligibility	PAYER	1066
Subscriber Primary Identifier: Invalid, Must be 12 characters with position 1 equal to H or C, position 2 must contain an alpha-numeric character and positions 3-12 must be numeric for Payer	EMDEON	632
Patient: Invalid; Patient was not eligible for benefits with Payer for Service Dates entered	PAYER	614
Claim: Denied; Missing or invalid data prevents Payer from processing this claim. Please contact the payer directly for further information	PAYER	504
Diagnosis Code Pointer: Invalid; Diagnosis Code indicated by Pointer must be entered	EMDEON	426

The Top 10 Rejection Reasons table is not currently clickable.

Accessing Claim Detail through Dashboard Views

You can access two kinds of reports via the clickable dashboard views, Claim Summary Report and Claim Detail Report. Both reports are described in detail in the following section of this document. A Claim Summary Report can be accessed by clicking on a pie chart pie piece, graph point, or graph bar.

Note: *The Top 10 Reject Reasons table is not clickable.*

Dashboard views are built upon pre-selected search criteria but with a user-defined date range. The criteria of the views are displayed on the dashboards themselves:

- By claim status.
- By significant rejection dollar amounts (for payers with the highest dollar amounts.
- By claim charge dollar amounts for a selected time period (day, week, or month).

Claim Data Searches

These searches are currently available in Reporting & Analytics:

- Audit History Search
- Claim Quick Search
- Claims with ERA Search
- File Summary Search
- Patient Search
- Patient Pay Search
- Payer Search
- Rejection Since Last Login Search
- Work Queue Search

Options by Search Type

Search Type	Available Search Options	Search Criteria
Audit History Search	Display claims that have "worked" or "unworked" status change during the specified date range or specific date	• Date • Emdeon Claim ID
Claim Quick Search	Quickly access claim information based on known search criteria	• Emdeon Claim ID • Submitter Claim ID • Payer Claim ID • Insured ID • PCN (Patient Control Number) • Patient Last Name (with optional date of birth) • Patient date of birth
Claims with ERA Search	Find claims that have ERAs associated with them.	Use (optional) Tax ID or Site ID to limit search results. If your practice is part of a large organization, using your own Tax ID or Site ID will help limit search results.
File Summary Search	View all claims by claim batch that were received by Emdeon during a time frame (date range). Each claim batch is identified by a File ID (Emdeon batch identifier).	• Received Date range **and optionally**, either or both of the following: • Tax ID • Site ID
Patient Pay Search	1. View all patient payments made through Patient Pay Online for a specified date range 2. View all patient payments made through Patient Pay Online for a specified date range and a specific patient name or patient account number.	*Search by Transaction Date:* • Transaction Date range **and optionally** • Worked status *Search by Patient Name:* • Transaction Date range • Patient Name *Search by Patient Account Number:* • Transaction Date range • Patient Account Number

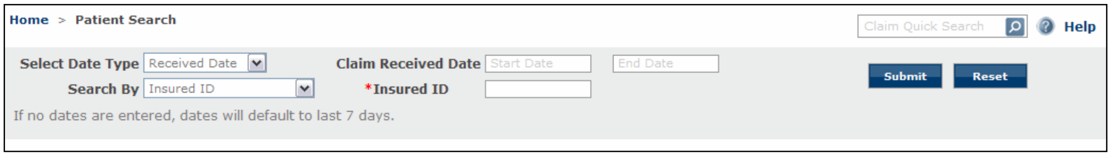
Search Type	Available Search Options	Search Criteria
Patient Search	1. View all claims for a specific insured party and dependents (by Insured ID) 2. Locate all claims for a specific Patient Control Number (PCN) 3. Locate all claims for a specific patient	• Date range (service date OR received date) **and one** of the following • Insured ID • PCN • Patient Last Name (with optional date of birth)
Payer Search	1. Display a summary of all claims 2. Display a summary of all claims for a specific payer	• Received Date range **and optionally**, any combination of the following: • Tax ID • Site ID • Payer ID
Rejection Since Last Login Search	View all claims that have been rejected by all payers since last user login	None required
Work Queue Search	1. Display a summary of all claims for a specific status 2. Display a summary of all claims for Rejected Claims with "Worked" or "Un-Worked" sub-status	• Received Date range • Claim Status **and optionally** • Tax ID • Site ID • If Rejected status selected: "All," "Worked," or "Un-worked" sub-status

***Note**: The table in the **Search Results** section on page 130 lists each search and reporting results.*

Work with Search

Required fields are indicated by a red asterisk (*).

Enter a date range for your search. You can manually enter a date (mm/dd/yyyy format) or use the calendar tool. If no dates are selected the default date range (inclusive of the last seven days) is entered automatically.



Select Date Type: Received Date

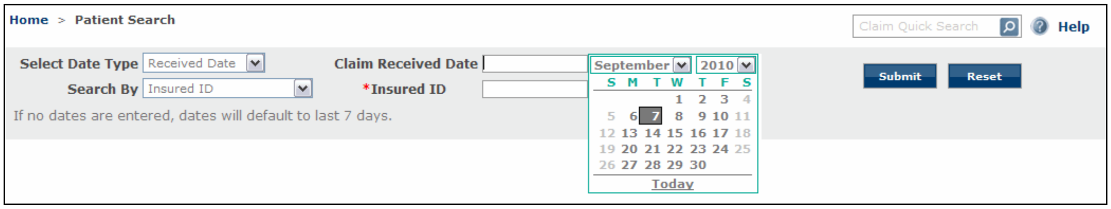
Claim Received Date: Start Date End Date

Search By: Insured ID

*Insured ID

If no dates are entered, dates will default to last 7 days.

Date fields without calendar tool shown.



Select Date Type: Received Date

Claim Received Date

Search By: Insured ID

*Insured ID

If no dates are entered, dates will default to last 7 days.

Date field with calendar tool shown. Click in the date field to show the calendar tool for that field.

Run a Search

1. Select a search type.
2. Enter all required data.
3. Enter any desired optional data.
4. Select a date range (if applicable). If dates are not selected, Reporting & Analytics will enter the default date range automatically.
5. Default date range is the last seven days.
6. Click **Submit**.
7. Results can be searched and/or printed.

***Note**: If no matches are found, change your search criteria, then rerun the search.*

8. After the report displays click on any underlined hyperlink for further details. For more information, see **Detail Links** on page 130.

Work with Dates

Date Criteria are Retained across Searches

The date or date range used in your most recent search is retained across all searches during a session. When you select a different search type, the date or date range from the previous search is automatically entered in the date fields of the new search. The purpose of this date retention functionality is to save time and keystrokes as you navigate from search to search.

Run a Single Date Search

If you enter a date in either the **Start Date** or **End Date** field only, when you click **Submit**, the remaining open field is filled with the same date. The resulting search will run on a single date only.

Use Default Date Range

If both date fields are left empty, the system will automatically enter a date range of the last 7 days (inclusive of today) when you click **Submit**.

Date Format Options

Basic syntax of manually entered dates: mm/dd/yyyy.

Additional allowed date configurations:

- **Month** can be entered as either *mm* or *m*.
- **Day** can be entered as either *dd* or *d*.
- **Year** can be entered as either *yyyy* or *yy*.

Date Entry Shortcut

- Type the letter **t** to enter today’s date in date field.

  Type the letter **t** in the date field to place today’s date in that field. The letter **t** is displayed until you click **Submit**, after which **t** is replaced with today’s date.

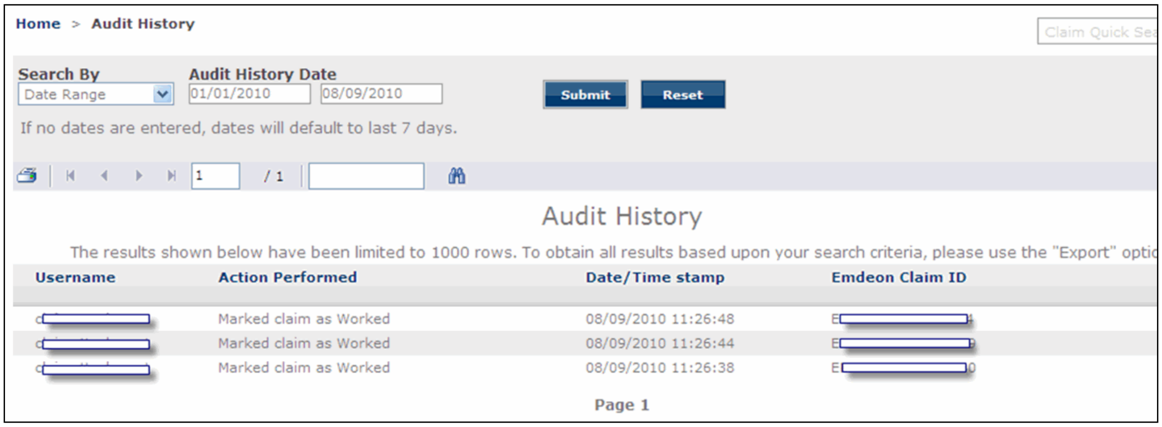
- Use **t-xx** to enter a past date in the date field.

  For example, type **t-3** in the date field to enter the date that occurred three days before today. The shortcut that you typed, **t-3** in this case, is displayed in the date field until you click Submit, after which **t-3** is replaced with a format-compliant date.

Note*: Claims data for the previous 15 months can be viewed in Reporting & Analytics.*

Audit History Search

Access this search by selecting **Analytics** > **Audit History**. Run a search to display an Audit History report of all applicable or matching claims whose “worked/unworked” status has changed. Search for updated claims by single date (or date range) or by Emdeon Claim ID number.



Search By: Date Range

Audit History Date: 01/01/2010 – 08/09/2010

If no dates are entered, dates will default to last 7 days.

1 / 1

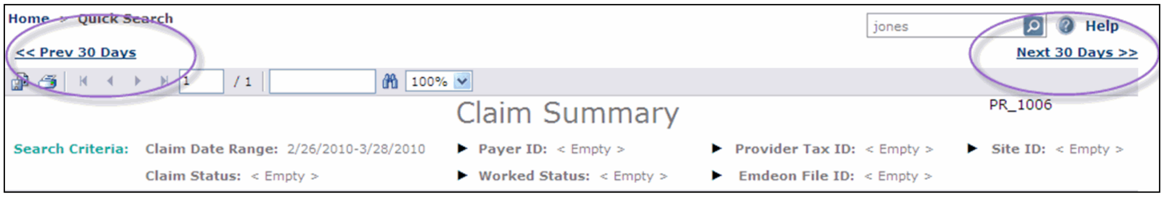
Audit History

The results shown below have been limited to 1000 rows. To obtain all results based upon your search criteria, please use the "Export" optic

Username	Action Performed	Date/Time stamp	Emdeon Claim ID
[redacted]	Marked claim as Worked	08/09/2010 11:26:48	[redacted]
[redacted]	Marked claim as Worked	08/09/2010 11:26:44	[redacted]
[redacted]	Marked claim as Worked	08/09/2010 11:26:38	[redacted]

Claim Quick Search

This search field is located in the upper right corner of the landing page. When searching with IDs or any allowable data element in Quick Search, only those claims that exactly match your search criteria are displayed. However, when searching by a patient first or last name, you can use a name segment (three consecutive letters must be used).



jones

1 / 1

Claim Summary

PR_1006

Search Criteria: Claim Date Range: 2/26/2010-3/28/2010 ▶ Payer ID: < Empty > ▶ Provider Tax ID: < Empty > ▶ Site ID: < Empty >
Claim Status: < Empty > ▶ Worked Status: < Empty > ▶ Emdeon File ID: < Empty >

***Note**: The 30-day navigation links display at the top of the resulting report after a Quick Search is performed. If your search returns no results when the report is loaded, you can use the "Prev 30 days" link to search for results of your initial search for an earlier time period.*

Claim Quick Search Results

Quick Search results are delivered in a Claim Summary Report (see **Claim Summary Report** on page 149).

Launch a Quick Search

Enter one or more criteria in the search field, and then click the search icon at the right of the field. At least one search criteria must be entered to run a search. (Search criteria are not case sensitive.) There are no date range selection options in "Quick Search." A 30-day date range is used by default.

Search Results

If a search results in a single matching claim only, the Claim Detail for that claim is displayed. When more than one claim match the search criteria all matching claims for the previous 30 days are displayed in the Claim Summary report. Click "View More" to see claims older than 30 days.

***Note**: Reporting & Analytics can search up to 15 months of claims data.*

Allowed Search Criteria

Only those claims that match all entered search criteria are displayed. Search criteria must match the format of at least one of the following searchable claim fields.

Searchable Claim Field	Description
PCN	Patient Control Number. An alphanumeric string that can include up to 20 characters.

Searchable Claim Field	Description
Insured ID	An alphanumeric string that can include up to 20 characters.
Patient Name (Last Name and/or First Name)	Enter a patient's exact first name and/or the exact spelling of the last name. The only claims shown are those that match exactly the criteria entered. To search on the patient's full name, use quotations: "John Smith".
Patient DOB	Use the format mm/dd/yyyy (or m/d/yy) to locate claims. A forward slash (/) must be used when searching against a date. For example, to find claims for January 4, 2008, enter either 01/04/2008 or 1/4/08.
Emdeon Claim ID	CORN. This ID contains 17 characters (two letters followed by 15 numbers). All 17 characters must be entered.
Submitter Claim ID	This ID is applied to a claim by the provider's submission application vendor at the time of submission.
Payer Claim ID	This ID is assigned to a claim by the payer.

Combining Criteria

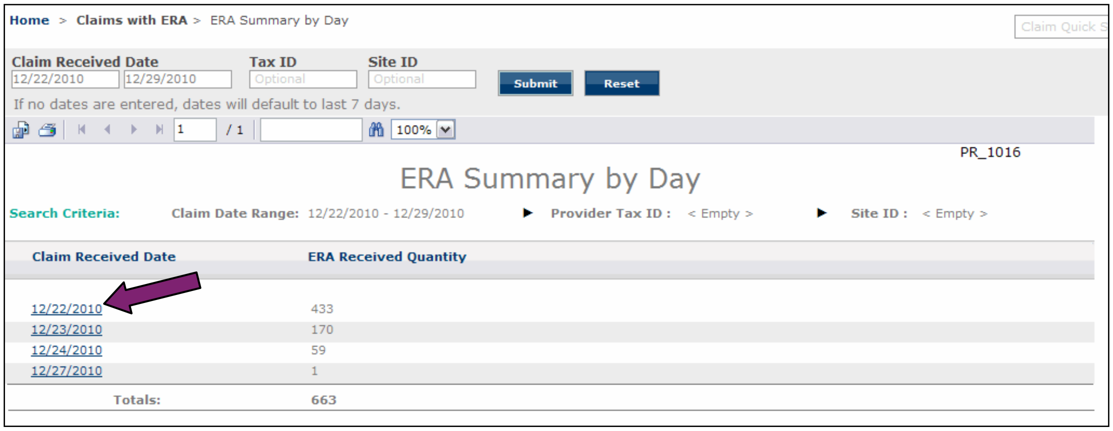
Use a separator for effective searching.

Character or Word Used	Result
Space or comma (,)	All claims that include one or more keywords are shown; inclusive search.
Plus symbol (+) or the word *and*	The resulting search is exclusive. That is, only those claims are shown that match ALL the search criteria.
The word *or*	The resulting search shows all those claims that match at least one of the criteria. That is, if *Jones* and *Louie* are the keywords, claims for Jones and claims for Louie are both shown. Those claims for *Louie Jones* are also shown (see below).
Quotes ('' or "")	Use single or double quotes to search for multiple keywords, as in a name. For example, to locate claims for an individual named John Adams, place quotes on both ends of the name: "John Adams". The benefit of this type of search is that the results are limited to only those claims that match *John Adams*; claims that match only *John* or only *Adams* are not shown. (Claims for Lou Adams or John Hancock are not shown.)

Claims with ERA Search

Access this search by selecting **Payments** > **Claims with ERA**. Use this search to locate claims that have ERAs for a specified date or date range. Searches can also be performed on a specific tax ID or site ID, which are useful if you are part of a large organization.

Click the link in the Claim Received Date column to view the Claim Summary Report.



Home > Claims with ERA > ERA Summary by Day

Claim Received Date: 12/22/2010 12/29/2010
Tax ID: Optional
Site ID: Optional

If no dates are entered, dates will default to last 7 days.

1 / 1 100%

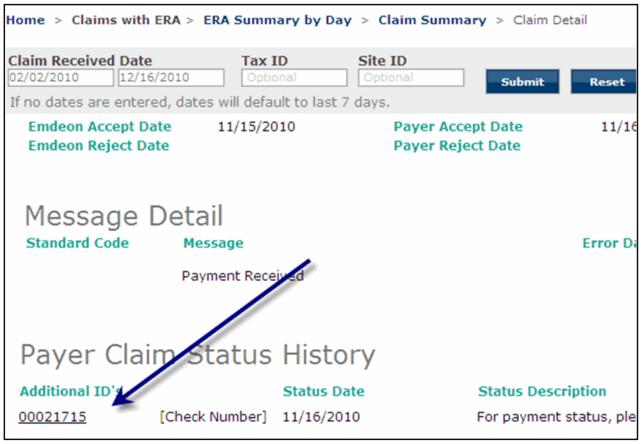
PR_1016

ERA Summary by Day

Search Criteria: Claim Date Range: 12/22/2010 - 12/29/2010 ▶ Provider Tax ID : < Empty > ▶ Site ID : < Empty >

Claim Received Date	ERA Received Quantity
12/22/2010	433
12/23/2010	170
12/24/2010	59
12/27/2010	1
Totals:	663

When viewing the Claim Detail of a claim that has ERA(s) associated to it, the Additional ID heading in the Payer Claim Status History section of the Claim Detail includes a check number link.



Home > Claims with ERA > ERA Summary by Day > Claim Summary > Claim Detail

Claim Received Date: 02/02/2010 – 12/16/2010
Tax ID: Optional
Site ID: Optional

If no dates are entered, dates will default to last 7 days.

Emdeon Accept Date: 11/15/2010
Emdeon Reject Date:
Payer Accept Date: 11/16
Payer Reject Date:

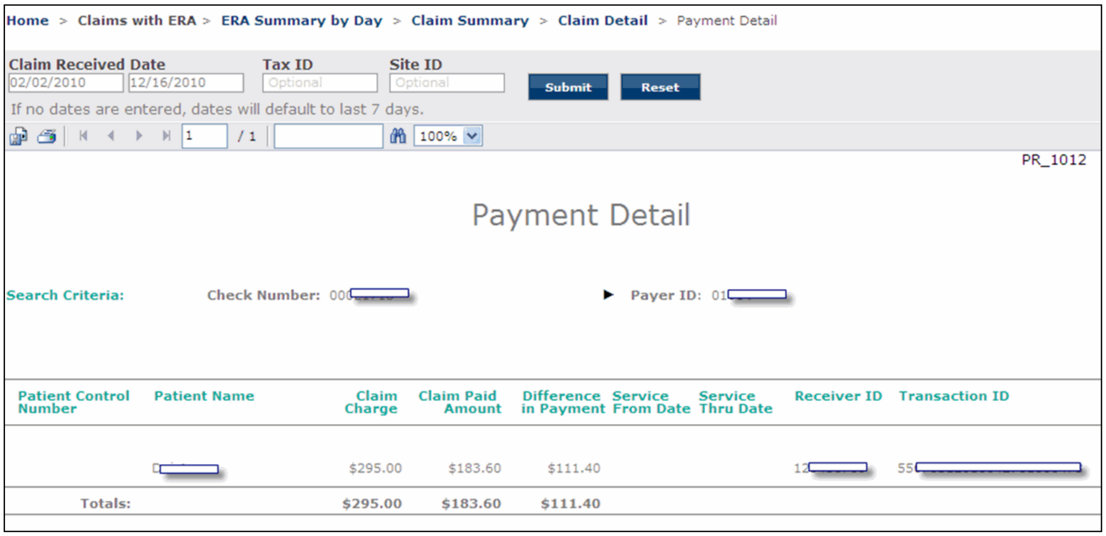
Message Detail

Standard Code	Message	Error Da
	Payment Received	

Payer Claim Status History

Additional ID's		Status Date	Status Description
00021715	[Check Number]	11/16/2010	For payment status, ple

Click the check number link to view the Payment Detail for the selected check.



Home > Claims with ERA > ERA Summary by Day > Claim Summary > Claim Detail > Payment Detail

Claim Received Date: 02/02/2010 – 12/16/2010
Tax ID: Optional
Site ID: Optional

If no dates are entered, dates will default to last 7 days.

PR_1012

Payment Detail

Search Criteria: Check Number: [redacted] ▶ Payer ID: [redacted]

Patient Control Number	Patient Name	Claim Charge	Claim Paid Amount	Difference in Payment	Service From Date	Service Thru Date	Receiver ID	Transaction ID
	[redacted]	$295.00	$183.60	$111.40			[redacted]	[redacted]
Totals:		$295.00	$183.60	$111.40				

File Summary Search

Access this search by selecting **Claims** > **File Summary Search**. A successful File Summary search displays a File Summary Report that provides details on all claim batches submitted to the Emdeon clearinghouse during the specified (or default) date range. Each claim batch is identified by a File ID (Emdeon batch identifier). For more information, see **ERA Linking in** Claim Detail

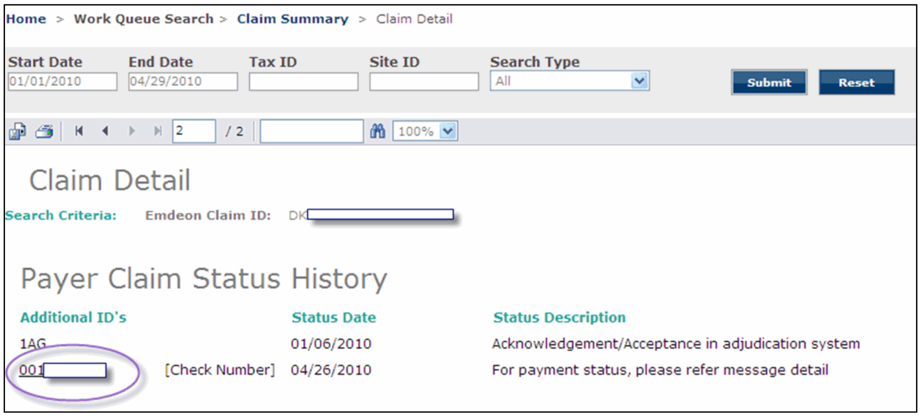
If your practice has ERA contracts with payers, ERA data is displayed in the “Payer Claim Status History” under certain conditions.

The claim has associated ERA(s).

Your practice has ERA contract with the payer on the claim.

If an ERA is associated to the claim a generic message is displayed in the **Status Description** field.

If the claim has been paid (and there is an ERA associated to the claim), the check number is displayed in the **Additional ID’s** column. Click the check number to display the Payment Detail report.



Start Date: 01/01/2010
End Date: 04/29/2010
Tax ID:
Site ID:
Search Type: All

Page: 2

Claim Detail

Search Criteria: Emdeon Claim ID: DK[redacted]

Payer Claim Status History

Additional ID's		Status Date	Status Description
1AG		01/06/2010	Acknowledgement/Acceptance in adjudication system
001[redacted]	[Check Number]	04/26/2010	For payment status, please refer message detail

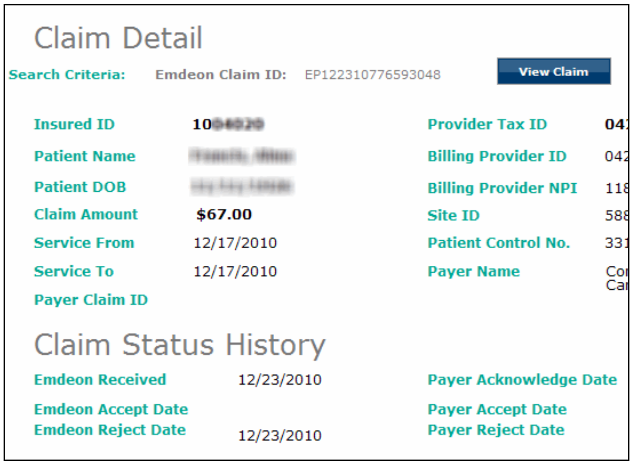
Payment Detail Report

If a linked check number is displayed in the Claim Detail Report you can access the Payment Detail report by clicking the check number.

The Payment Detail report provides key information on the claim (and the payment) including claim amount and the difference between paid amount and claim amount.

Payer Claim ID in Claim Detail Report

If the payer has received the claim and if the payer issues claim IDs to Emdeon, then the payer's claim ID appears in the **Payer Claim ID** field. However, a blank **Payer Claim ID** field does not necessarily mean that the payer has not received the claim.



Claim Detail

Search Criteria: Emdeon Claim ID: EP122310776593048

Insured ID	10[redacted]	Provider Tax ID	04
Patient Name	[redacted]	Billing Provider ID	042
Patient DOB	[redacted]	Billing Provider NPI	118
Claim Amount	$67.00	Site ID	588
Service From	12/17/2010	Patient Control No.	331
Service To	12/17/2010	Payer Name	Co Ca
Payer Claim ID			

Claim Status History

Emdeon Received	12/23/2010	Payer Acknowledge Date	
Emdeon Accept Date		Payer Accept Date	
Emdeon Reject Date	12/23/2010	Payer Reject Date	

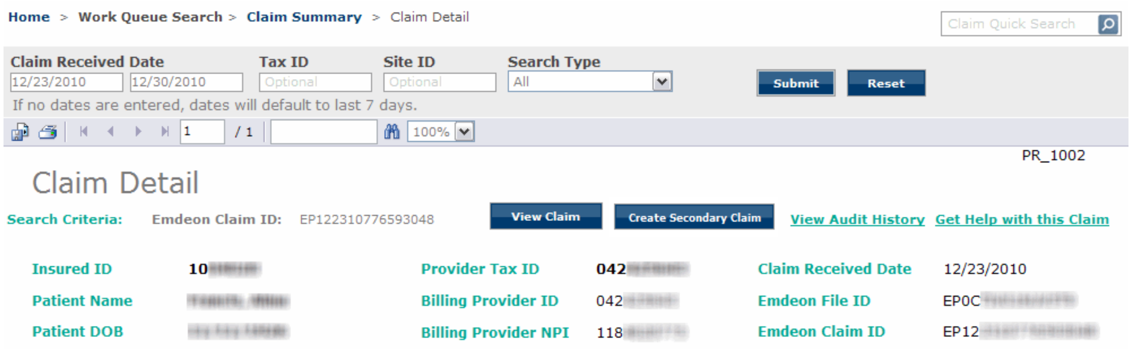
In the screen shot above, no payer claim ID appears in the Claim Detail report because the claim was rejected at Emdeon.

> ***Note**: While most payers do issue claim IDs upon receipt of a claim (which appear in the Claim Detail report) some payers do not.*

View Audit History

> ***Note**: This function, which allows you to view the audit history in a Claim Detail Report, is different from the Audit History Report which is generated by performing an Audit History search (see **Audit History Report** on p. 110).*

Click the "View Audit History" link to view the audit history of a claim.


Home > Work Queue Search > Claim Summary > Claim Detail

Claim Received Date: 12/23/2010 – 12/30/2010
Tax ID: Optional
Site ID: Optional
Search Type: All

If no dates are entered, dates will default to last 7 days.

PR_1002

Claim Detail

Search Criteria: Emdeon Claim ID: EP122310776593048

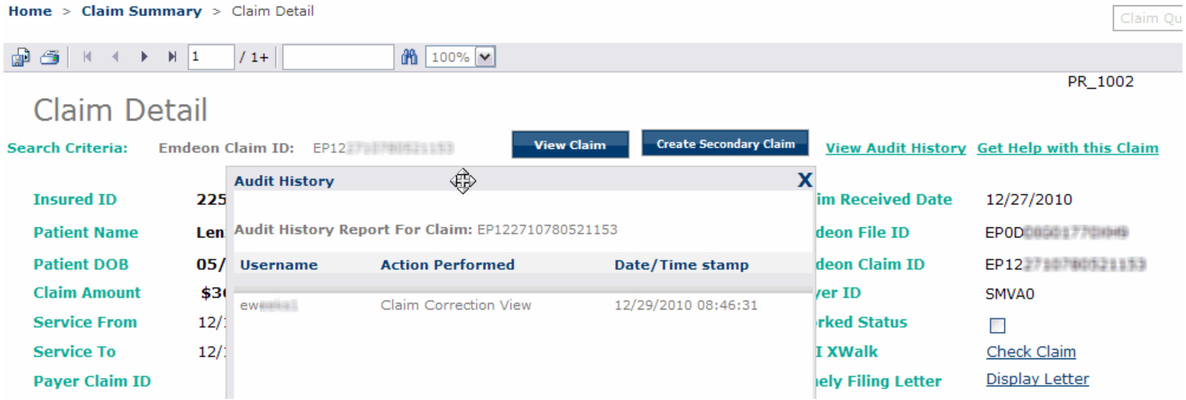
Insured ID	10[redacted]	Provider Tax ID	042[redacted]	Claim Received Date	12/23/2010
Patient Name	[redacted]	Billing Provider ID	042[redacted]	Emdeon File ID	EP0C[redacted]
Patient DOB	[redacted]	Billing Provider NPI	118[redacted]	Emdeon Claim ID	EP12[redacted]

The following actions are tracked in Audit History:

- Click on **View Claim** button
- Click on “Eligibility” link
- Click on “Claim Status” link
- All “Worked/Unworked” status changes for the last 15 months on the claim are shown with username and date/time stamp

If the Audit History report is longer than 1,000, rows the report can be exported in Microsoft Excel format. The export will include all rows including those rows that were not displayed due to the 1,000 row display limit.

When you click the “View Audit History” link, a new window appears. The Audit History window can be moved in the same manner that the Help window can be moved (click and drag the title bar of the window).


Home > Claim Summary > Claim Detail

PR_1002

Claim Detail

Search Criteria: Emdeon Claim ID: EP12[redacted]

Audit History

Audit History Report For Claim: EP122710780521153

Username	Action Performed	Date/Time stamp
ew[redacted]	Claim Correction View	12/29/2010 08:46:31

Insured ID	225	im Received Date	12/27/2010
Patient Name	Len	deon File ID	EP0D[redacted]
Patient DOB	05/	deon Claim ID	EP12[redacted]
Claim Amount	$3	yer ID	SMVA0
Service From	12/	rked Status	☐
Service To	12/	I XWalk	Check Claim
Payer Claim ID		ely Filing Letter	Display Letter

Workers’ Compensation Attachments

Overview

Reporting & Analytics provides you with a convenient and powerful way to manage workers’ compensation claims.

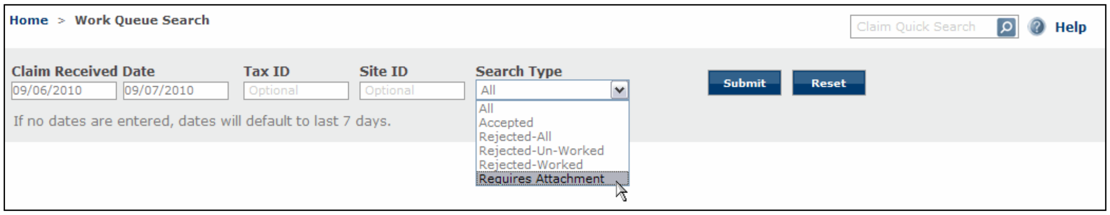
Functionality includes both claim management and the ability to respond directly to payers with requested attachments. Workers’ Compensation Attachments is available by subscription only from Reporting & Analytics.

If you have pending workers’ compensation claims, you can easily find those claims and respond to payer requests for further documentation.

Locate Claims Easily

To locate claims in Reporting & Analytics that the payer requires additional information for, begin the search by selecting **Claims** > **Work Queue Search**.

In the **Search Type** drop-down list, select “Requires Attachment”. Enter your Tax ID or Site ID for a more specific search (both fields are optional).



Claim Received Date: 09/06/2010 – 09/07/2010
Tax ID: Optional
Site ID: Optional
Search Type: All

If no dates are entered, dates will default to last 7 days.

- All
- Accepted
- Rejected-All
- Rejected-Un-Worked
- Rejected-Worked
- Requires Attachment

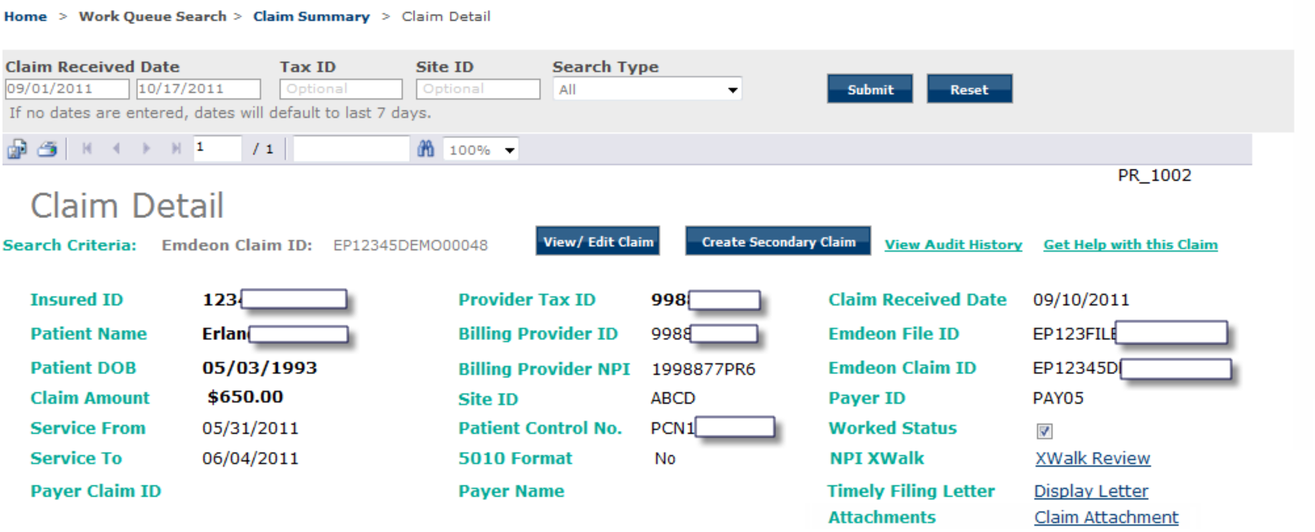
All claims that match the selected search criteria for which the payer on workers' compensation claim(s) has requested additional documentation are shown.

Payer Allowed Response Period

On workers' compensation claims that require attachments, payers provide a 15-day response period, during which time the provider can upload files and send them to the payer. If the provider does not respond within the 15-day response period, the claim is rejected and no longer appears in the **Work Queue Search** > "Requires Attachment" search results report.

Access Attachments Functionality

In the Claim Summary report, click the highlighted **Emdeon Claim ID** to show the Claim Detail report for the selected claim. In the far right column of the Claim Detail report, click the "Claim Attachment" link to show the workers' compensation attachments application window.



Claim Received Date: 09/01/2011 – 10/17/2011
Tax ID: Optional
Site ID: Optional
Search Type: All

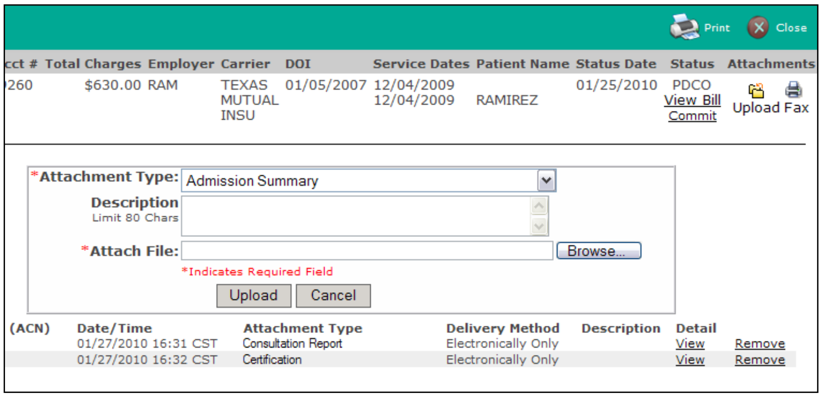
If no dates are entered, dates will default to last 7 days.

Claim Detail

Search Criteria: Emdeon Claim ID: EP12345DEMO00048

Insured ID	123[redacted]	Provider Tax ID	998[redacted]	Claim Received Date	09/10/2011
Patient Name	Erlan[redacted]	Billing Provider ID	998[redacted]	Emdeon File ID	EP123FILE[redacted]
Patient DOB	05/03/1993	Billing Provider NPI	1998877PR6	Emdeon Claim ID	EP12345D[redacted]
Claim Amount	$650.00	Site ID	ABCD	Payer ID	PAY05
Service From	05/31/2011	Patient Control No.	PCN1[redacted]	Worked Status	☑
Service To	06/04/2011	5010 Format	No	NPI XWalk	XWalk Review
Payer Claim ID		Payer Name		Timely Filing Letter	Display Letter
				Attachments	Claim Attachment

Workers' compensation attachments window within Reporting & Analytics:



cct #	Total Charges	Employer	Carrier	DOI	Service Dates	Patient Name	Status Date	Status	Attachments
260	$630.00	RAM	TEXAS MUTUAL INSU	01/05/2007	12/04/2009 12/04/2009	RAMIREZ	01/25/2010	PDCO View Bill Commit	Upload Fax

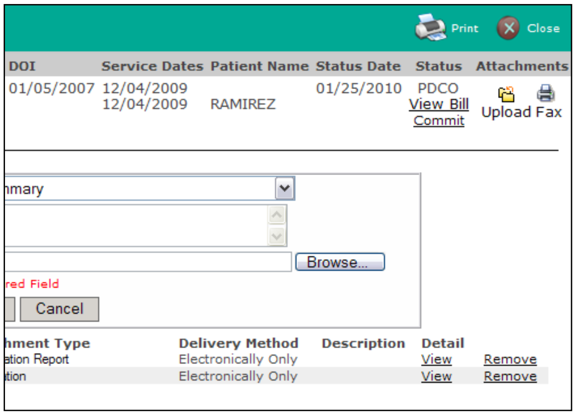
*Attachment Type: Admission Summary
Description (Limit 80 Chars):
*Attach File:
*Indicates Required Field

(ACN)	Date/Time	Attachment Type	Delivery Method	Description	Detail	
	01/27/2010 16:31 CST	Consultation Report	Electronically Only		View	Remove
	01/27/2010 16:32 CST	Certification	Electronically Only		View	Remove

Click the **Upload** button at the upper right to show the Upload fields. Click the **Upload** button directly beneath the **Attach File** field for each attachment to add to the bill. After all files are uploaded, click the "Commit" link to send your bill and files to the payer for review.

Use the Workers' Compensation Attachments Interface

1. Click the "Claim Attachment" link in the Claim Detail report. The workers' compensation claim attachment window appears.
2. To view an attachment, click the applicable "View" link. A graphic or PDF viewer appears.
3. Click the **Print** button to print a summary view. You can print uploaded files directly from the View window.
4. Click **Upload** in the upper right corner to show the file upload window. Only PDF and TIFF format files can be uploaded.
   - Click **Browse** to locate the file to upload.
   - Select an attachment type from the **Attachment Type** drop-down list (required field).
   - Enter a description of the file (optional field).
   - Click the **Upload** button to upload the file. Repeat these four steps for each file to attach to the claim.
5. Status conditions:



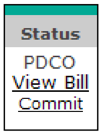
DOI	Service Dates	Patient Name	Status Date	Status	Attachments
01/05/2007	12/04/2009 12/04/2009	RAMIREZ	01/25/2010	PDCO View Bill Commit	Upload Fax

hment Type	Delivery Method	Description	Detail	
ation Report	Electronically Only		View	Remove
tion	Electronically Only		View	Remove

   - PNDA – Pending Attachments. Attachments are pending to be sent to the payer.
   - PDCO – Pending Commit. You can add files while bill is in this status. Click the "Commit" link to send the bill with attachments to the payer for review. Do not click "Commit" until all of your files are attached.
   - PEND – All attachments and bill documents are ready to be sent to payer. This status occurs after "Commit" is clicked. This status is the condition prior to **SENT**. No action can be taken in the workers' compensation claim attachment window while in this status.
   - SENT – Bill and attachments sent to payer.

   ***Note**: After bill and attachments are sent, the **Upload** and **Fax** buttons are removed.*

6. Fax documents so that they are correctly received by the payer.
   - If you have paper documents that you want to scan and send to the payer, click **Fax**.
   - Print the fax cover sheet, and then fax all paper documents to the payer (at the fax number shown on the fax cover sheet) with fax cover sheet as the first document in the communication. Using the fax cover sheet ensures that your faxed documents are associated to the bill.
7. You can view or remove uploaded files from the bill prior to clicking "Commit." Once committed, uploaded files cannot be removed.
8. Review the billing image created by clicking the "View Bill" link (located in the **Status** column in the upper right of the workers' compensation attachments window).



Status
PDCO View Bill Commit

9. Click "Commit" to send uploaded files to payer for review.

***Note**: You must click "Commit" to complete the bill/claim submission process. If "Commit" is not clicked, attached files are not sent to the payer, and the claim will remain in **PDCO**/Pending Commitment status.*

View and Edit Claim

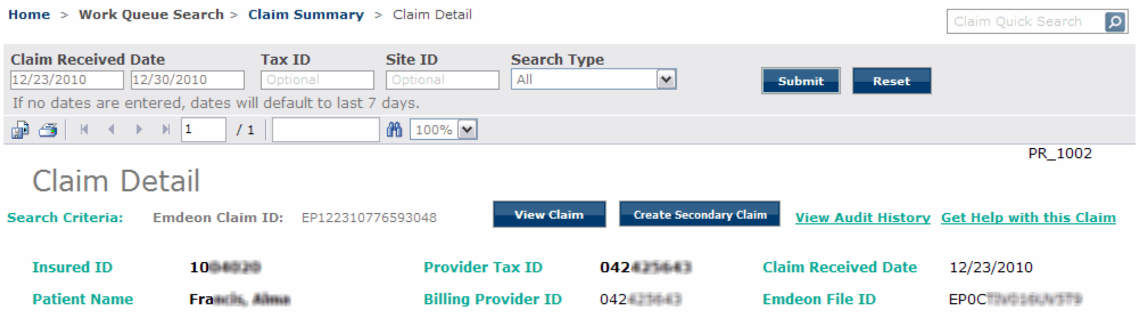
View and Edit Claims

Viewing and editing claims is a feature you can access through the Claim Detail Report. For details on how to view and edit claims, see the **View and Edit Claims** section on page 126.

"Get Help with this Claim" Link

Using the "Get Help with this Claim" link enables you to access Customer Service Alerts (CSAs) and submit a support ticket for the claim you are viewing.

1. In a Claim Detail report, click the "Get Help with this Claim" link.



Home > Work Queue Search > Claim Summary > Claim Detail

Claim Received Date: 12/23/2010 – 12/30/2010
Tax ID: Optional
Site ID: Optional
Search Type: All

If no dates are entered, dates will default to last 7 days.

PR_1002

Claim Detail

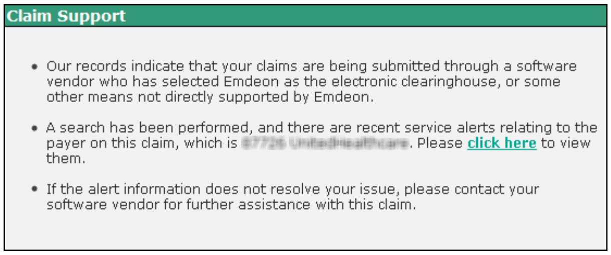
Search Criteria: Emdeon Claim ID: EP122310776593048

Insured ID: 10[redacted]
Provider Tax ID: 042[redacted]
Claim Received Date: 12/23/2010
Patient Name: Fra[redacted]
Billing Provider ID: 042[redacted]
Emdeon File ID: EP0C[redacted]

2. The "Claim Support" message window appears.

   Two links may be available:

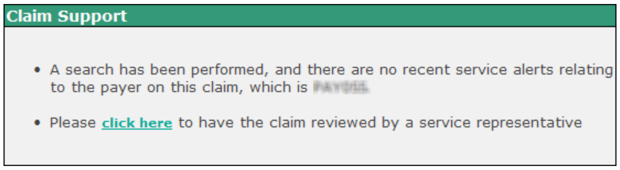
   - Customer Alerts link – If there are recent (last 30 days) Customer Service Alerts (CSAs) on the claim from the payer, a link to the CSA will appear. Hover your cursor over the CSA to view a short description. Click the link to view the CSA.



Claim Support

- Our records indicate that your claims are being submitted through a software vendor who has selected Emdeon as the electronic clearinghouse, or some other means not directly supported by Emdeon.
- A search has been performed, and there are recent service alerts relating to the payer on this claim, which is [redacted]. Please click here to view them.
- If the alert information does not resolve your issue, please contact your software vendor for further assistance with this claim.

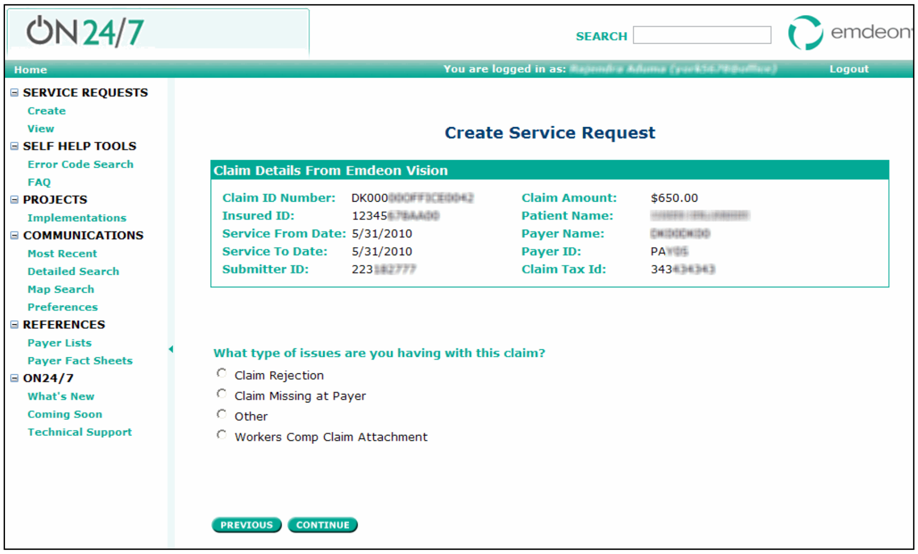
   - Service Request link – This link appears for all claims in Reporting & Analytics. Click the link to create a service request for the claim you are viewing.



Claim Support

- A search has been performed, and there are no recent service alerts relating to the payer on this claim, which is [redacted]
- Please click here to have the claim reviewed by a service representative

3. If you click the service request link, the Create Service Request form appears. The form is pre-populated with key details from the claim.


ON24/7
SEARCH
emdeon
Home
You are logged in as: [redacted]
Logout
SERVICE REQUESTS
Create
View
SELF HELP TOOLS
Error Code Search
FAQ
PROJECTS
Implementations
COMMUNICATIONS
Most Recent
Detailed Search
Map Search
Preferences
REFERENCES
Payer Lists
Payer Fact Sheets
ON24/7
What's New
Coming Soon
Technical Support
PREVIOUS
CONTINUE

Create Service Request

Claim Details From Emdeon Vision

Claim ID Number:	DK000[redacted]	Claim Amount:	$650.00
Insured ID:	12345[redacted]	Patient Name:	[redacted]
Service From Date:	5/31/2010	Payer Name:	[redacted]
Service To Date:	5/31/2010	Payer ID:	PA[redacted]
Submitter ID:	223[redacted]	Claim Tax Id:	343[redacted]

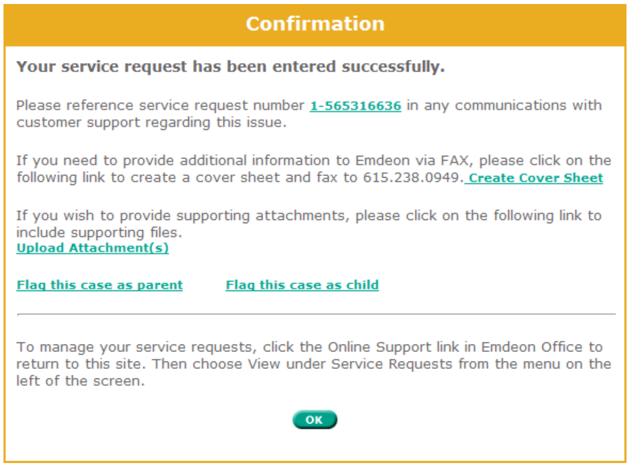
What type of issues are you having with this claim?

○ Claim Rejection
○ Claim Missing at Payer
○ Other
○ Workers Comp Claim Attachment

4. Click the option that describes the issue you are having with the claim, and then click **Continue**.
5. Enter identifying information on the pages that follow, clicking **Continue** at the bottom of each page. You will be able to review the information you entered before you submit the service request.
6. If you would like to change the information you entered, click **Start Over**.

   Note: *Clicking* ***Start Over*** *does not erase the claim information that was present when you created the service request.*

7. Click **Submit**.
8. The Confirmation window appears, where you can choose from several options or close the window by clicking **OK**.



Confirmation

Your service request has been entered successfully.

Please reference service request number 1-565316636 in any communications with customer support regarding this issue.

If you need to provide additional information to Emdeon via FAX, please click on the following link to create a cover sheet and fax to 615.238.0949. Create Cover Sheet

If you wish to provide supporting attachments, please click on the following link to include supporting files.
Upload Attachment(s)

Flag this case as parent   Flag this case as child

To manage your service requests, click the Online Support link in Emdeon Office to return to this site. Then choose View under Service Requests from the menu on the left of the screen.

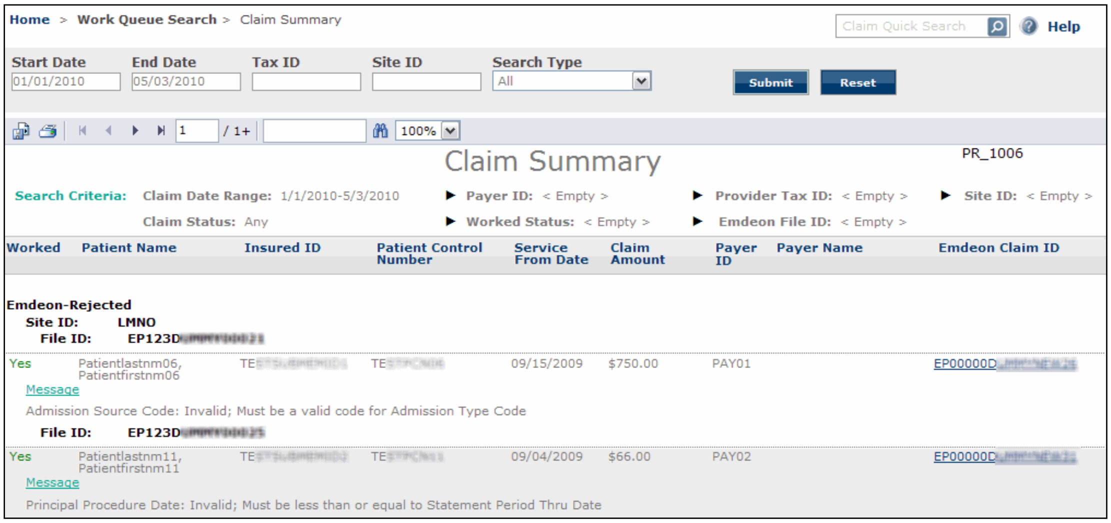
- **Service request reference number** – Click to access details on the service request: view the request history, add a comment, add files, flag, etc.
- **Create Cover Sheet** – If you need to fax documents to Emdeon relating to the service request, click this link to open a fax cover sheet. The cover sheet is pre-populated with information that will associate the fax with the service request. Print the cover sheet and use it as the first page of the fax you send to Emdeon regarding the service request.
- **Upload Attachments** – Click to upload any standard file type up to 50 MB. You can upload only one file at a time.
- **Flag this case as parent** – If you need to link cases with related issues, click to set the service request as a parent in relation to one or more service requests. Use the search function to locate a service request, select the check box next to the service request, and then click **Save**. This will create a hierarchical linkage.
- **Flag this case as child** – If you need to link cases with related issues, click to set the service request as a child in relation to another service request. Use the search function to locate a

service request, select the check box next to the service request, and then click **Save**. This will create a hierarchical linkage.

Claim Summary Report

The Claim Summary Report can be generated from several areas within Reporting & Analytics:

- Run a Work Queue search for any claim status.
- Click a link in the **Claim Received Date** column on the Summary by Payer by Day report.
- Run a Rejection Since Last Login search.
- Click a link in the **File ID** column of the File Summary report.
- Run a Quick search.
- Click on a pie chart slice, graph bar, or graph data point in the Dashboard view.



Start Date: 01/01/2010
End Date: 05/03/2010
Tax ID:
Site ID:
Search Type: All

Claim Summary
PR_1006

Search Criteria: Claim Date Range: 1/1/2010-5/3/2010
Claim Status: Any
Payer ID: < Empty >
Worked Status: < Empty >
Provider Tax ID: < Empty >
Emdeon File ID: < Empty >
Site ID: < Empty >

Worked	Patient Name	Insured ID	Patient Control Number	Service From Date	Claim Amount	Payer ID	Payer Name	Emdeon Claim ID
Emdeon-Rejected								
Site ID: LMNO								
File ID: EP123D[redacted]								
Yes	Patientlastnm06, Patientfirstnm06	TE[redacted]	TE[redacted]	09/15/2009	$750.00	PAY01		EP00000D[redacted]
Message Admission Source Code: Invalid; Must be a valid code for Admission Type Code								
File ID: EP123D[redacted]								
Yes	Patientlastnm11, Patientfirstnm11	TE[redacted]	TE[redacted]	09/04/2009	$66.00	PAY02		EP00000D[redacted]
Message Principal Procedure Date: Invalid; Must be less than or equal to Statement Period Thru Date								

Claim Summary Column Headings

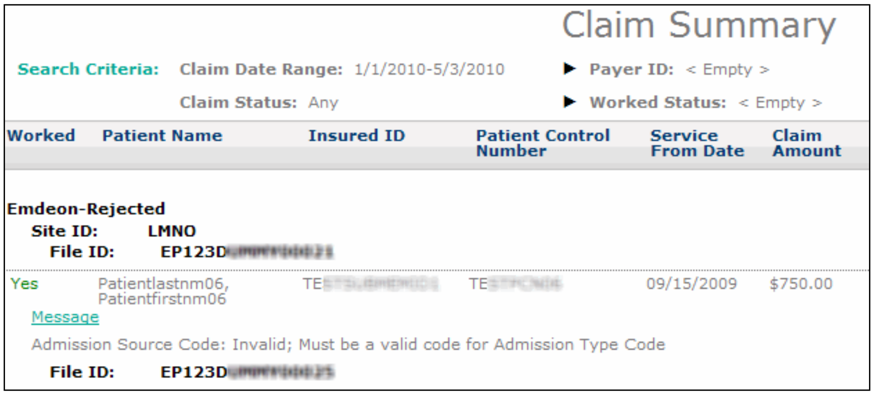
Heading	Description
Worked	"Worked" progress status; determined by the "Worked" check box in the Claim Detail report
Patient Name	Name of the patient submitted on the claim
Insured ID	Insured ID submitted on the claim
Patient Control Number	Provider's control/tracking number for patient on claim
Service From Date	Date of service
Claim Amount	Dollar amount (in US dollars) of the submitted claim
Payer ID	Payer ID submitted on the claim
Payer Name	Payer name submitted on the claim
Emdeon Claim ID	Claim ID assigned by Emdeon for the specific claim

Claim Summary Report List Order

1. Emdeon Rejected – Claims rejected by Emdeon
2. Payer Rejected – Claims rejected by the payer
3. Emdeon Accepted – Claims accepted by Emdeon but no notification from the payer received
4. Accepted – Claims accepted by payer and the claim is pending adjudication

> ***Note****: File ID is the second level of sorting That is, the first level is one of the four levels listed above, the second level sort is by File ID (File ID: includes both Site ID and Emdeon Batch File number, where applicable.)*

Layered sorting of Claim Summary results:



Claim Summary

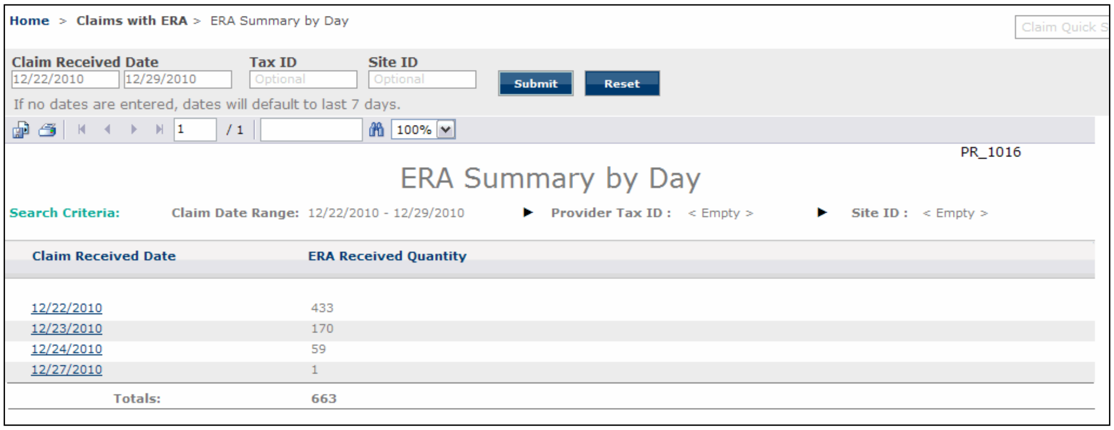
Search Criteria: **Claim Date Range:** 1/1/2010-5/3/2010 ▶ **Payer ID:** < Empty >
Claim Status: Any ▶ **Worked Status:** < Empty >

Worked	Patient Name	Insured ID	Patient Control Number	Service From Date	Claim Amount
Emdeon-Rejected					
Site ID: **LMNO**					
File ID: **EP123D**[redacted]					
Yes	Patientlastnm06, Patientfirstnm06	TE[redacted]	TE[redacted]	09/15/2009	$750.00

Message
Admission Source Code: Invalid; Must be a valid code for Admission Type Code
File ID: **EP123D**[redacted]

ERA Summary by Day Report

This report is generated from the Claims with ERA search.



Home > Claims with ERA > ERA Summary by Day

Claim Received Date: 12/22/2010 – 12/29/2010 Tax ID: Optional Site ID: Optional
If no dates are entered, dates will default to last 7 days.

PR_1016

ERA Summary by Day

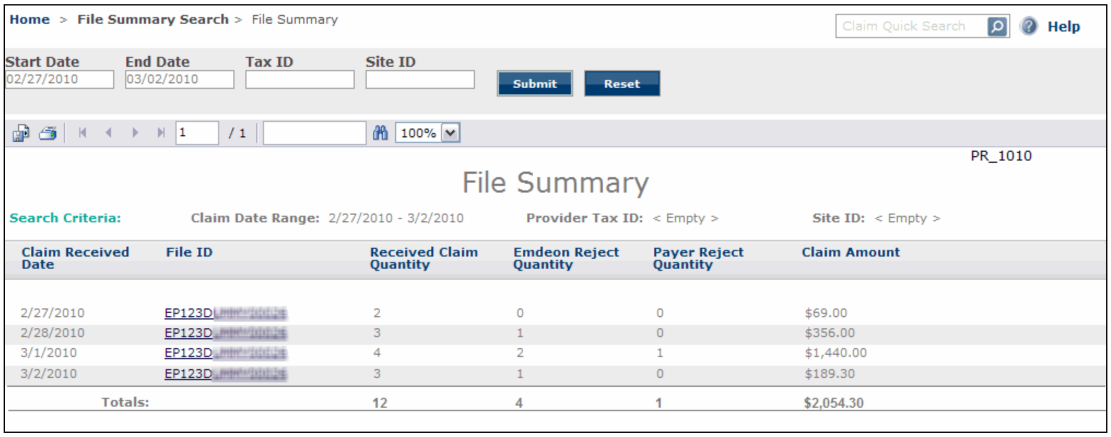
Search Criteria: **Claim Date Range:** 12/22/2010 - 12/29/2010 ▶ **Provider Tax ID :** < Empty > ▶ **Site ID :** < Empty >

Claim Received Date	ERA Received Quantity
12/22/2010	433
12/23/2010	170
12/24/2010	59
12/27/2010	1
Totals:	**663**

Click a link in the Claim Received Date column to view the Claim Summary Report for all claims with ERAs for the date listed, and then click the Emdeon Claim ID link to view the Claim Detail Report for that claim.

File Summary Report

The File Summary Report provides details on all claim batches submitted to the Emdeon clearinghouse during a specific date range. Each claim batch is identified by a File ID (Emdeon batch identifier).



Home > File Summary Search > File Summary

Start Date: 02/27/2010 End Date: 03/02/2010 Tax ID: Site ID:

PR_1010

File Summary

Search Criteria: **Claim Date Range:** 2/27/2010 - 3/2/2010 **Provider Tax ID:** < Empty > **Site ID:** < Empty >

Claim Received Date	File ID	Received Claim Quantity	Emdeon Reject Quantity	Payer Reject Quantity	Claim Amount
2/27/2010	EP123D[redacted]	2	0	0	$69.00
2/28/2010	EP123D[redacted]	3	1	0	$356.00
3/1/2010	EP123D[redacted]	4	2	1	$1,440.00
3/2/2010	EP123D[redacted]	3	1	0	$189.30
Totals:		12	4	1	$2,054.30

File Summary Column Headings

Heading	Description
Claim Received Date	Date claim was received by Emdeon
File ID	File ID assigned by Emdeon for the electronic file in which the claim was submitted
Received Claim Quantity	Total number of claims received by Emdeon
Emdeon Reject Quantity	Number of claims rejected by Emdeon
Payer Reject Quantity	Number of claims rejected by the payer
Claim Amount	Total dollar amount of all claims received (total dollar amount for total number of claims shown in the **Received Claim Quantity** column)

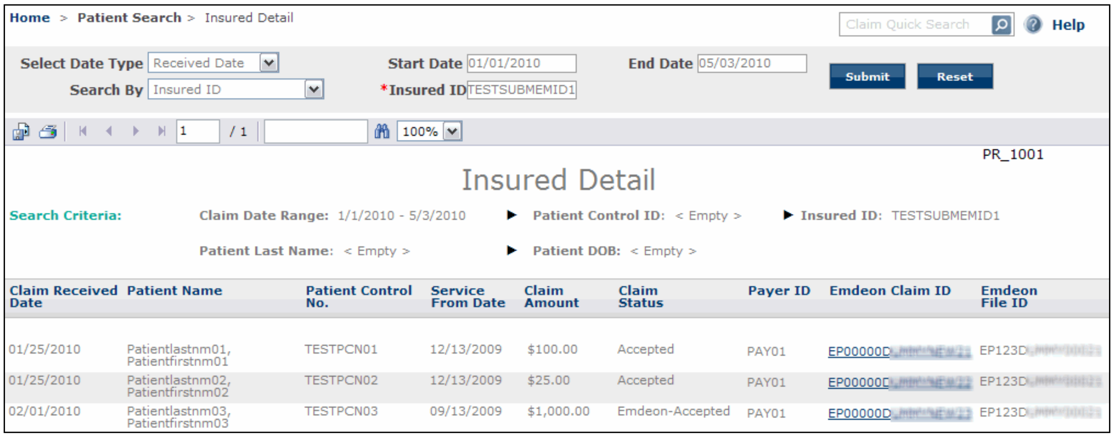
Insured Detail Report

The Insured Detail Report is displayed when you run a Patient Search.

This report provides a list of all claims for the specified patient for the date range specified in the **Claim Date Range** field.

Run a Patient Search with Insured ID

When you use Insured ID as search criteria in Patient Search the Insured Detail report displays a list of all claims for all patients (the insured party and their dependents) that are covered under the specified Insured ID (Subscriber ID) for the stated date range.



Select Date Type: Received Date
Search By: Insured ID
Start Date: 01/01/2010
End Date: 05/03/2010
*Insured ID: TESTSUBMEMID1

Insured Detail

Search Criteria: Claim Date Range: 1/1/2010 - 5/3/2010 ▶ Patient Control ID: < Empty > ▶ Insured ID: TESTSUBMEMID1
Patient Last Name: < Empty > ▶ Patient DOB: < Empty >

Claim Received Date	Patient Name	Patient Control No.	Service From Date	Claim Amount	Claim Status	Payer ID	Emdeon Claim ID	Emdeon File ID
01/25/2010	Patientlastnm01, Patientfirstnm01	TESTPCN01	12/13/2009	$100.00	Accepted	PAY01	EP00000D[redacted]	EP123D[redacted]
01/25/2010	Patientlastnm02, Patientfirstnm02	TESTPCN02	12/13/2009	$25.00	Accepted	PAY01	EP00000D[redacted]	EP123D[redacted]
02/01/2010	Patientlastnm03, Patientfirstnm03	TESTPCN03	09/13/2009	$1,000.00	Emdeon-Accepted	PAY01	EP00000D[redacted]	EP123D[redacted]

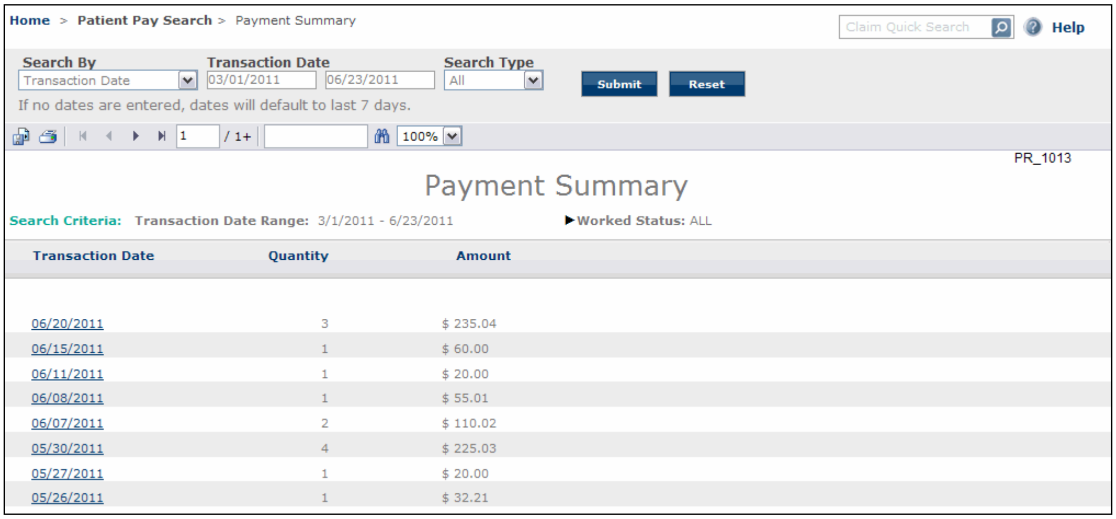
Click the highlighted “Emdeon Claim ID” to view Claim Detail report for the selected claim.

Insured Detail Column Headings

Heading	Description
Claim Received Date	Date claim was received by Emdeon or payer
Patient Name	Name of the patient submitted on the claim
Patient Control No.	Insured ID submitted on the claim
Service From Date	Date of service submitted on the claim
Claim Amount	Dollar amount of the submitted claim
Claim Status	Current claim status with Emdeon or payer
Payer ID	Payer ID submitted on the claim
Payer Name	Payer Name submitted on the claim
Emdeon Claim ID	Claim ID assigned by Emdeon for the specific claim
Emdeon File ID	File ID assigned by Emdeon for the electronic file in which the claim was submitted

Payment Summary Report

The Payment Summary Report displays when you perform a Patient Pay Search and search by transaction date. It shows patient payments made through Patient Pay Online for a specified date range and worked status. Click the date link in the Transaction Date column to display a Patient Payment Summary by Day Report for the date you selected.



Home > Patient Pay Search > Payment Summary

Search By: Transaction Date
Transaction Date: 03/01/2011 06/23/2011
Search Type: All

If no dates are entered, dates will default to last 7 days.

PR_1013

Payment Summary

Search Criteria: Transaction Date Range: 3/1/2011 - 6/23/2011 ▶Worked Status: ALL

Transaction Date	Quantity	Amount
06/20/2011	3	$ 235.04
06/15/2011	1	$ 60.00
06/11/2011	1	$ 20.00
06/08/2011	1	$ 55.01
06/07/2011	2	$ 110.02
05/30/2011	4	$ 225.03
05/27/2011	1	$ 20.00
05/26/2011	1	$ 32.21

Payment Summary Report Column Headings

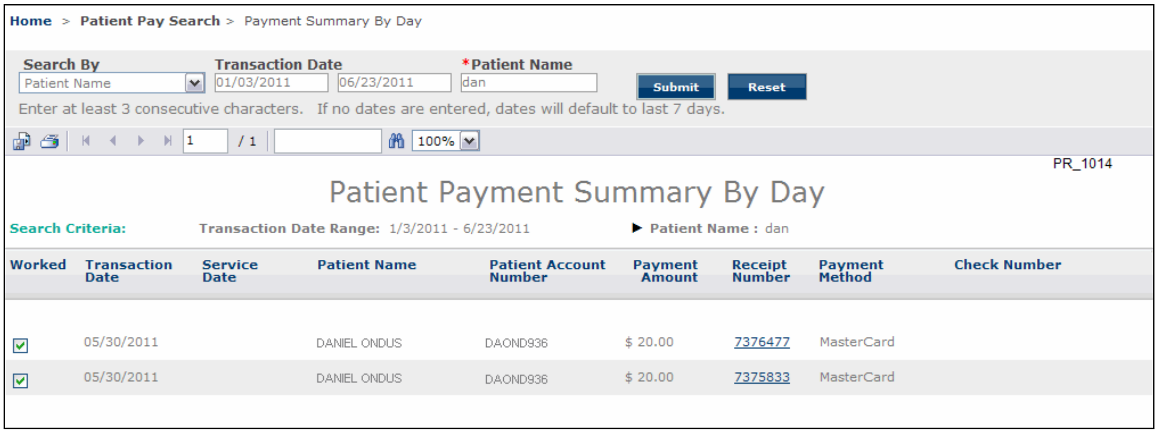
Heading	Description
Transaction Date	Date that the payment was made. Click the link to view the Payment Summary by Day Report for the date you selected.
Quantity	Number of payments made on the specified transaction date.
Amount	Total amount of all payments made on the specified transaction date.

Patient Payment Summary by Day Report

The Patient Payment Summary by Day Report displays when you perform a Patient Pay Search and search by patient name or patient account number as well as when you click a transaction date link on the Payment Summary Report.

Search by Patient Name or Patient Account Number

When you perform a Patient Pay Search and search by patient name or patient account number, the report will show the same patient name or patient account number for the transaction date range you selected.



Home > Patient Pay Search > Payment Summary By Day

Search By: Patient Name
Transaction Date: 01/03/2011 06/23/2011
*Patient Name: dan

Enter at least 3 consecutive characters. If no dates are entered, dates will default to last 7 days.

PR_1014

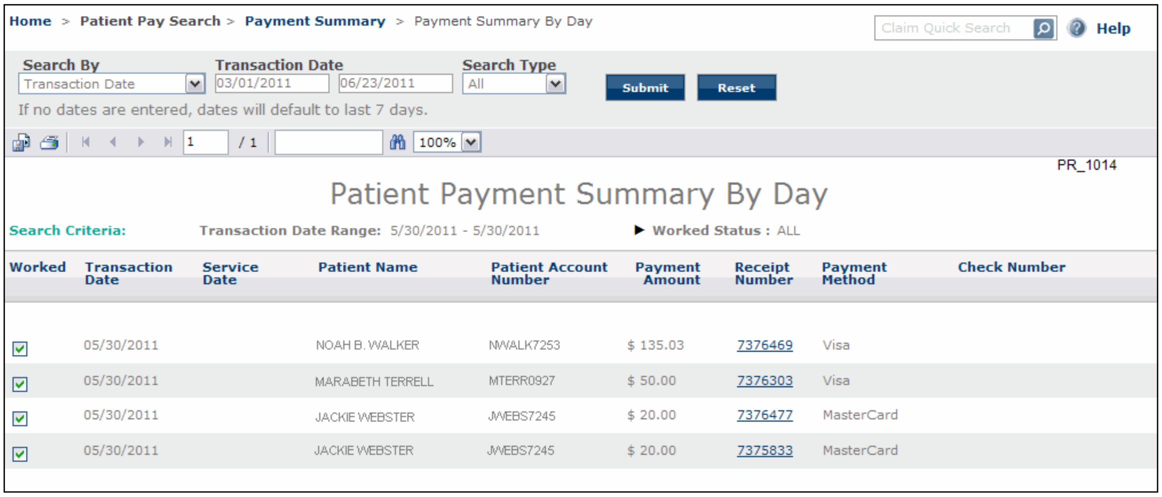
Patient Payment Summary By Day

Search Criteria: Transaction Date Range: 1/3/2011 - 6/23/2011 ▶ Patient Name : dan

Worked	Transaction Date	Service Date	Patient Name	Patient Account Number	Payment Amount	Receipt Number	Payment Method	Check Number
☑	05/30/2011		DANIEL ONDUS	DAOND936	$ 20.00	7376477	MasterCard	
☑	05/30/2011		DANIEL ONDUS	DAOND936	$ 20.00	7375833	MasterCard	

Click a Transaction Date Link

When you click a transaction date link on the Payment Summary Report, the Patient Payment Summary by Day Report shows payments for all patient names and patient account numbers for the transaction date range you selected.


Home > Patient Pay Search > Payment Summary > Payment Summary By Day
Claim Quick Search
Help
Submit
Reset
100%

Search By: Transaction Date
Transaction Date: 03/01/2011 06/23/2011
Search Type: All

If no dates are entered, dates will default to last 7 days.

1 / 1

PR_1014

Patient Payment Summary By Day

Search Criteria: Transaction Date Range: 5/30/2011 - 5/30/2011 ▶ Worked Status : ALL

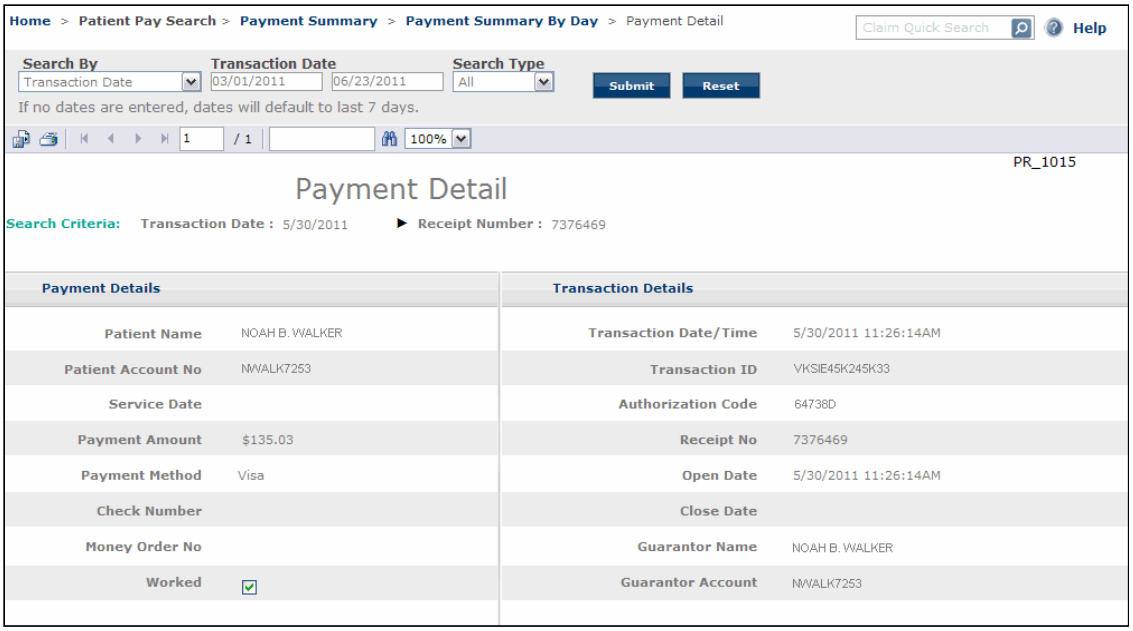
Worked	Transaction Date	Service Date	Patient Name	Patient Account Number	Payment Amount	Receipt Number	Payment Method	Check Number
☑	05/30/2011		NOAH B. WALKER	NWALK7253	$ 135.03	7376469	Visa	
☑	05/30/2011		MARABETH TERRELL	MTERR0927	$ 50.00	7376303	Visa	
☑	05/30/2011		JACKIE WEBSTER	JWEBS7245	$ 20.00	7376477	MasterCard	
☑	05/30/2011		JACKIE WEBSTER	JWEBS7245	$ 20.00	7375833	MasterCard	

Patient Payment Summary by Day Report Column Headings

Heading	Description
Worked	If there is a check in the check box, the payment is worked. If there is not a check in the check box, the payment is un-worked.
Transaction Date	Date that the payment was made
Service Date	Reserved for future use
Patient Name	Name of the patient who received the healthcare treatment the payment was made for
Patient Account Number	Provider account number for the patient
Payment Amount	Amount included in payment
Receipt Number	Unique receipt number of the transaction. Click the link to view the Payment Detail report for the specified payment.
Payment Method	Type of card used in the payment (Visa, MasterCard, Discover, or American Express)
Check Number	Reserved for future use

Payment Detail Report

The Payment Detail Report displays when you click a date link in the **Receipt Number** column on the Patient Payment Summary by Day Report. The report shows the payment and transaction details for the transaction you selected.


Home > Patient Pay Search > Payment Summary > Payment Summary By Day > Payment Detail
Claim Quick Search
Help
Submit
Reset
1
/ 1
100%

Search By: Transaction Date

Transaction Date: 03/01/2011 06/23/2011

Search Type: All

If no dates are entered, dates will default to last 7 days.

PR_1015

Payment Detail

Search Criteria: Transaction Date : 5/30/2011 ▶ Receipt Number : 7376469

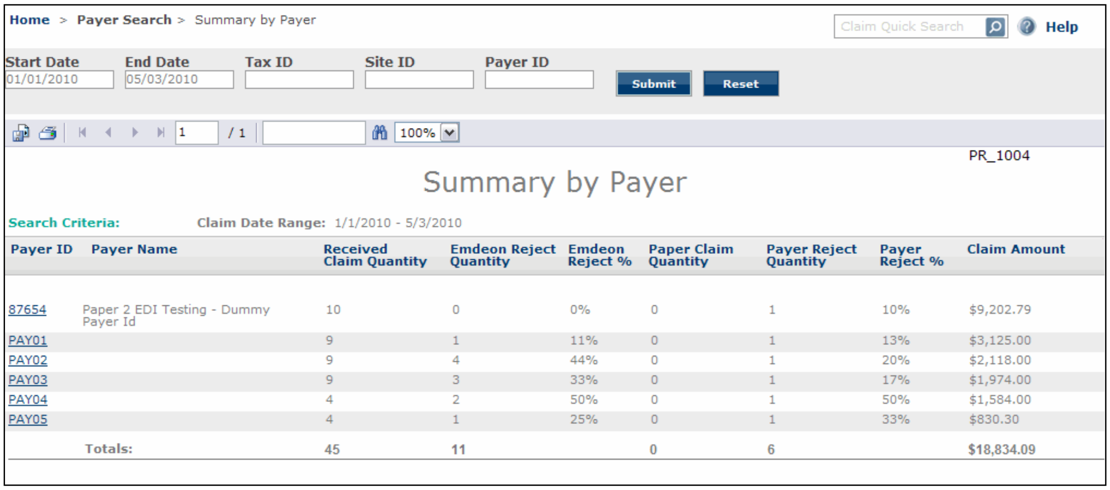
Payment Details		Transaction Details	
Patient Name	NOAH B. WALKER	Transaction Date/Time	5/30/2011 11:26:14AM
Patient Account No	NWALK7253	Transaction ID	VKSIE45K245K33
Service Date		Authorization Code	64738D
Payment Amount	$135.03	Receipt No	7376469
Payment Method	Visa	Open Date	5/30/2011 11:26:14AM
Check Number		Close Date	
Money Order No		Guarantor Name	NOAH B. WALKER
Worked	☑	Guarantor Account	NWALK7253

Payment Detail Report Rows

Heading	Description
Payment Details Column	
Patient Name	Name of the patient
Patient Account No	Provider account number for the patient
Service Date	Reserved for future use
Payment Amount	Amount of the payment
Payment Method	Type of card used in the payment
Check Number	Reserved for future use
Money Order No	Reserved for future use
Worked	If there is a check in the check box, the payment is worked. If there is not a check in the check box, the payment is un-worked.
Transaction Details Column	
Transaction Date/Time	Date and time of the payment
Transaction ID	Unique transaction identifier (assigned by system)
Authorization Code	Card authorization code (assigned by system)
Receipt No	Unique receipt number (assigned by system)
Open Date	Date and time the transaction started
Close Date	Reserved for future use
Guarantor Name	Name of the person making payment
Guarantor Account	Account number of the person making payment

Summary by Payer Report

The Summary by Payer Report is displayed when you perform a Payer Search without specifying a Payer ID. The report includes a claim summary for each payer (sorted by Payer ID).



Start Date: 01/01/2010
End Date: 05/03/2010
Tax ID:
Site ID:
Payer ID:

PR_1004

Summary by Payer

Search Criteria: Claim Date Range: 1/1/2010 - 5/3/2010

Payer ID	Payer Name	Received Claim Quantity	Emdeon Reject Quantity	Emdeon Reject %	Paper Claim Quantity	Payer Reject Quantity	Payer Reject %	Claim Amount
87654	Paper 2 EDI Testing - Dummy Payer Id	10	0	0%	0	1	10%	$9,202.79
PAY01		9	1	11%	0	1	13%	$3,125.00
PAY02		9	4	44%	0	1	20%	$2,118.00
PAY03		9	3	33%	0	1	17%	$1,974.00
PAY04		4	2	50%	0	1	50%	$1,584.00
PAY05		4	1	25%	0	1	33%	$830.30
	Totals:	45	11		0	6		$18,834.09

Summary by Payer Column Headings

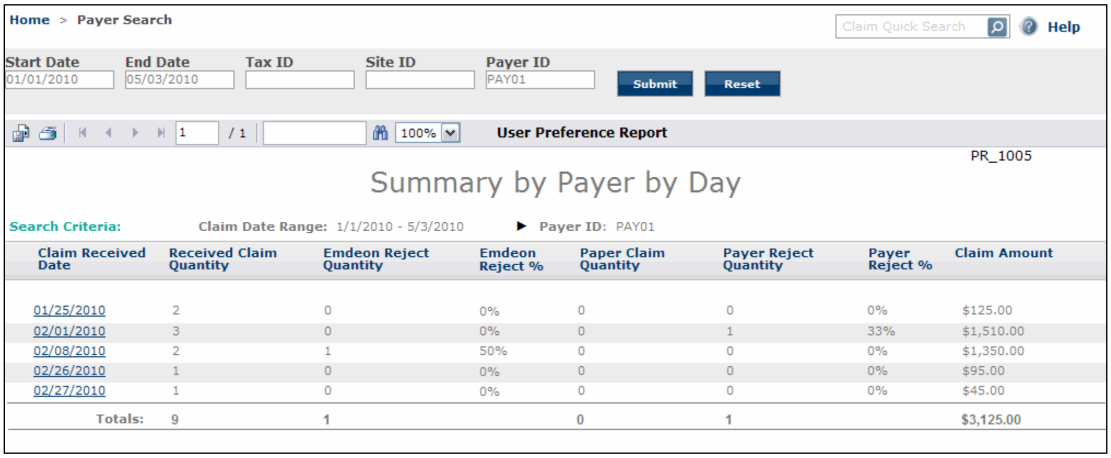
Heading	Description
Payer ID	5-character alphanumeric string; ID number of payers that had claims received by Emdeon during the specified date range. Click the highlighted date link to view the Summary by Payer by Day report for the selected Payer ID.
Payer Name	Name of payer organization
Received Claim Quantity	Total number of claims received by Emdeon. Number of claims received by Emdeon during the specified date range from the payer. Click the link in the **Payer ID** field to view details of these claims in the Summary by Payer by Day report.
Emdeon Reject Quantity	Number of claims rejected by Emdeon from the number received
Emdeon Reject %	Percentage of claims rejected by Emdeon
Paper Claim Quantity	Number of claims printed to paper by Emdeon
Payer Reject Quantity	Number of rejected claims from among those received by Emdeon during the specified date range that were rejected by the payer specified in the **Payer ID/Payer Name** fields.
Payer Reject %	Percentage of those claims received by Emdeon that were rejected by the payer.
Claim Amount	Total amount (in US dollars) of all claims received by Emdeon for the report row. This amount includes any rejected claim amounts. The Claim Amount displayed is the totality of all Emdeon claims received from the payer for the specified date range.

Summary by Payer by Day Report

The Summary by Payer by Day report can be generated in two ways:

- Perform a Payer Search with a specified Payer ID
- Click on a Payer ID link in a Summary by Payer report

The Summary by Payer by Day report displays a summary of claims for the specified Payer ID. Each row in the report shows the total quantity of claims received by the payer for the displayed date for that row. The amount in the **Claim Amount** column is the total amount in US dollars of claims (including rejected amounts) received on the specified Claim Received Date for the specified payer ID.



Start Date: 01/01/2010
End Date: 05/03/2010
Tax ID:
Site ID:
Payer ID: PAY01

PR_1005

Summary by Payer by Day

Search Criteria: Claim Date Range: 1/1/2010 - 5/3/2010 ▶ Payer ID: PAY01

Claim Received Date	Received Claim Quantity	Emdeon Reject Quantity	Emdeon Reject %	Paper Claim Quantity	Payer Reject Quantity	Payer Reject %	Claim Amount
01/25/2010	2	0	0%	0	0	0%	$125.00
02/01/2010	3	0	0%	0	1	33%	$1,510.00
02/08/2010	2	1	50%	0	0	0%	$1,350.00
02/26/2010	1	0	0%	0	0	0%	$95.00
02/27/2010	1	0	0%	0	0	0%	$45.00
Totals:	9	1		0	1		$3,125.00

Summary by Payer by Day Column Headings

Heading	Description
Claim Received Date	This report displays a summary of all those claims received on the specific date shown per report row (per specified payer). Click the highlighted date to view details for each claim received on the claim received date. That is, if the number displayed in the **Claim Received Date** column is 12, then 12 claims are displayed in the resulting report.
Received Claim Quantity	Number of claims that were received on the Claim Received Date. Note: When you click the Claim Received Date link those claims that are specified in the **Received Claim Quantity** field are displayed.
Emdeon Reject Quantity	Number of claims (from those that were received on the claim received date) that were rejected by Emdeon
Emdeon Reject %	Percentage of claims (from those that were received on the claim received date) that were rejected by Emdeon
Paper Claim Quantity	Number of claims received in paper format (rather than electronically) from among those claims in the Claim Received Date number.
Payer Reject Quantity	Number of claims rejected by the specified payer from among those claims in the Claim Received Date number.
Payer Reject %	Percentage of claims rejected by the specified payer from among those claims in the Claim Received Date number.
Claim Amount	Total amount in US dollars of claims (including rejected amounts) received on the specified Claim Received Date for the specified payer ID.

on page 143.

File Summary Search Tips

Use the (optional) "Tax ID" filter to refine your search so that only those claim batches that contain claims for the specified Tax ID are displayed.

- Tax ID format is 9-character numeric string.

Use the (optional) "Site ID" filter to refine your search so that only those claim batches that contain claims relating to the specified Site ID are displayed.

- Site ID must be a 4-character string (alpha and/or numeric).

You can also enter both optional criteria.

Patient Pay Search

Access this search by selecting **Payments** > **Patient Pay Search**. Use the Patient Pay Search to display a report that shows all patient payments made through Patient Pay Online for a specified date range.

***Note**: The Patient Pay Search is available to all Reporting & Analytics users, but the search will only yield results if your account is set up for the Patient Pay Online service.*

Patient Pay Online

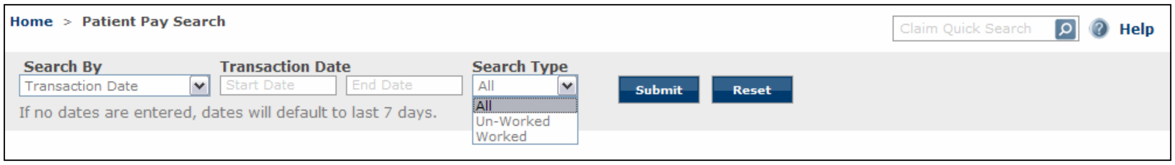
Patient Pay Online is a self-service, patient-facing application that provides comprehensive and secure online billing and payment management for healthcare bills. If your practice is set up for this online payment portal, when patients receive a healthcare bill from your practice, they can go to the web address displayed on the bill and make a secure payment with the type of cards your practice accepts. If you want the ability to collect patient payments online, contact Emdeon sales at 1-866-369-8805.

Launch a Patient Pay Search

You can search by transaction date, patient name, or patient account number.

Search by Transaction Date

If you want to search by transaction date, select “Transaction Date” in the **Search By** list, select a date range, and then select the search type. The search type choices are All, Un-Worked, and Worked. This search generates a Payment Summary Report (page 153) for the date range you selected.

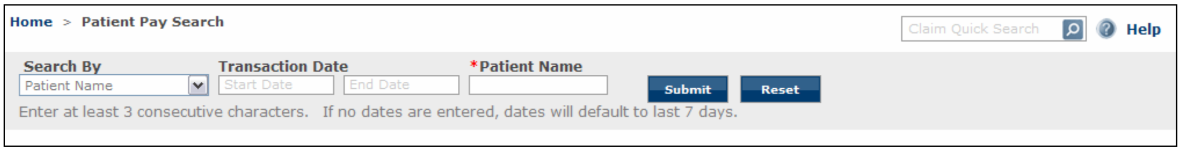

Home > Patient Pay Search

Search By: Transaction Date
Transaction Date: Start Date, End Date
Search Type: All

If no dates are entered, dates will default to last 7 days.

Search by Patient Name

If you want to search by patient name, select “Patient Name” in the **Search By** list, select the date range, and then enter part or all of the patient’s name (at least three characters). This search generates a Patient Payment Summary by Day Report (page 153) for the patient name and date range you selected.

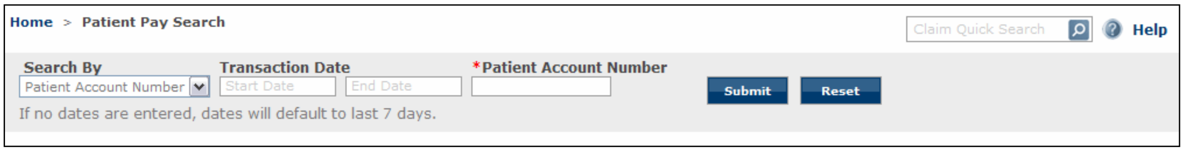

Home > Patient Pay Search

Search By: Patient Name
Transaction Date: Start Date, End Date
*Patient Name:

Enter at least 3 consecutive characters. If no dates are entered, dates will default to last 7 days.

Search by Patient Account Number

If you want to search by patient account number, select “Patient Account Number” in the Search By list, select the date range, and then enter the patient’s account number. This search generates a Patient Payment Summary by Day Report (page 153) for the patient account number and date range you selected.


Home > Patient Pay Search

Search By: Patient Account Number
Transaction Date: Start Date, End Date
*Patient Account Number:

If no dates are entered, dates will default to last 7 days.

Patient Search

Access this search by selecting **Claims** > **Patient Search**. Use the following search criteria to generate a report that lists all patient claims for a specified (or default) date range.

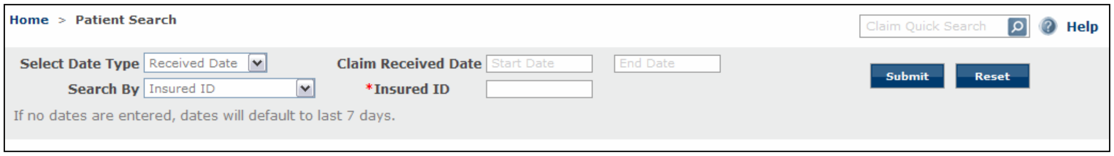
Use the **Search Date Type** list:

- Received Date
- Date of Service

Use the **Search By** list:

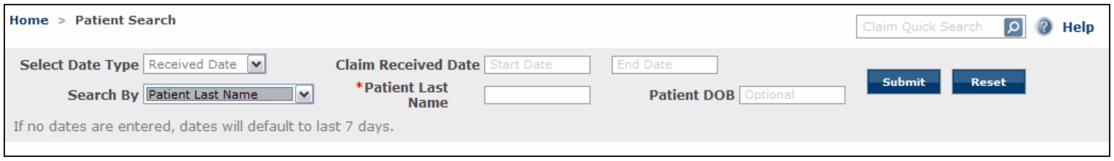
- Insured ID
- Patient Control Number (PCN)
- Patient Last Name with optional Patient DOB (Date of Birth).

- Partial last name is allowed though at least 3 consecutive characters required. For example, “Smi” will return not only those patients with the last name of “Smith”, but also “Smithson”, “Smithfield”, etc.
- Patient DOB is optional and must be in mm/dd/yyyy format. The Patient DOB data field displays only when “Patient Last Name” is your selection in the **Search By** drop-down list.



Select Date Type: Received Date
Search By: Insured ID
Claim Received Date
*Insured ID
If no dates are entered, dates will default to last 7 days.

Note that optional **Patient DOB** field is not displayed.



Select Date Type: Received Date
Search By: Patient Last Name
Claim Received Date
*Patient Last Name
Patient DOB
If no dates are entered, dates will default to last 7 days.

Patient DOB (optional field) displays only when “Patient Last Name” is selected in the **Search By** list.

Search Using Last Name Results

A successful Patient Last Name search displays the Insured Detail Report and includes a list of all claims for the specified patient (PCN) or patients.

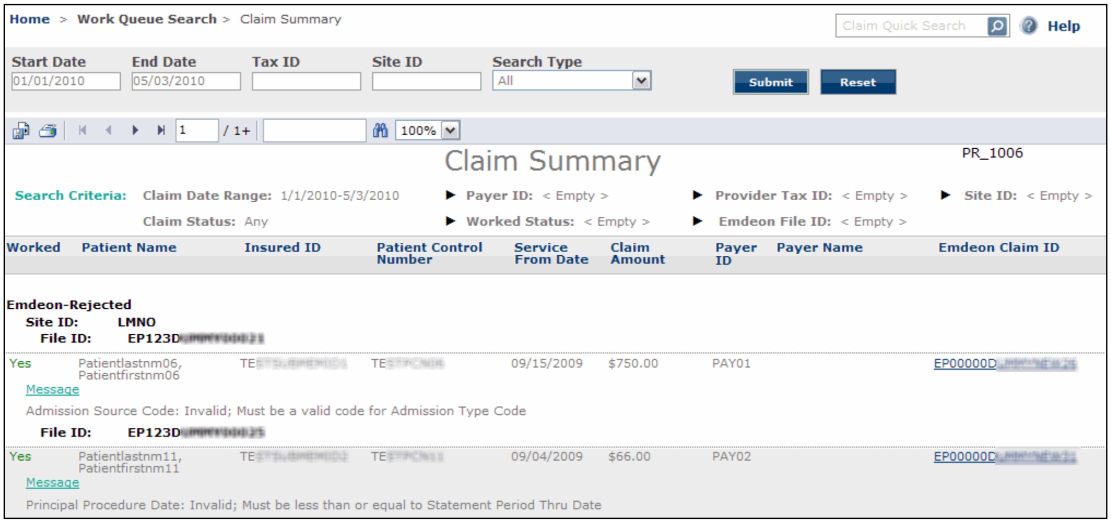
Search Using Insured ID Results

A successful Insured ID search displays the Insured Detail Report and includes a list of all claims for the primary insured party and all dependents under the Insured ID (subscriber ID) number.

For more information, see **Claim Summary Report**

The Claim Summary Report can be generated from several areas within Reporting & Analytics:

- Run a Work Queue search for any claim status.
- Click a link in the **Claim Received Date** column on the Summary by Payer by Day report.
- Run a Rejection Since Last Login search.
- Click a link in the **File ID** column of the File Summary report.
- Run a Quick search.
- Click on a pie chart slice, graph bar, or graph data point in the Dashboard view.



Start Date: 01/01/2010
End Date: 05/03/2010
Tax ID:
Site ID:
Search Type: All

Claim Summary

PR_1006

Search Criteria: Claim Date Range: 1/1/2010-5/3/2010 ▶ Payer ID: < Empty > ▶ Provider Tax ID: < Empty > ▶ Site ID: < Empty >
Claim Status: Any ▶ Worked Status: < Empty > ▶ Emdeon File ID: < Empty >

Worked	Patient Name	Insured ID	Patient Control Number	Service From Date	Claim Amount	Payer ID	Payer Name	Emdeon Claim ID
Emdeon-Rejected								
Site ID:	**LMNO**							
File ID:	**EP123D**[redacted]							
Yes	Patientlastnm06, Patientfirstnm06	TE[redacted]	TE[redacted]	09/15/2009	$750.00	PAY01		EP00000D[redacted]
Message								
Admission Source Code: Invalid; Must be a valid code for Admission Type Code								
File ID:	**EP123D**[redacted]							
Yes	Patientlastnm11, Patientfirstnm11	TE[redacted]	TE[redacted]	09/04/2009	$66.00	PAY02		EP00000D[redacted]
Message								
Principal Procedure Date: Invalid; Must be less than or equal to Statement Period Thru Date								

Claim Summary Column Headings

Heading	Description

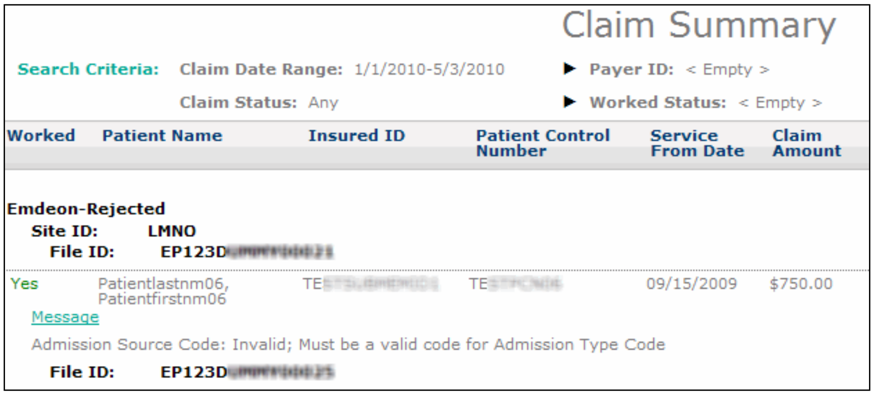
Heading	Description
Worked	"Worked" progress status; determined by the "Worked" check box in the Claim Detail report
Patient Name	Name of the patient submitted on the claim
Insured ID	Insured ID submitted on the claim
Patient Control Number	Provider's control/tracking number for patient on claim
Service From Date	Date of service
Claim Amount	Dollar amount (in US dollars) of the submitted claim
Payer ID	Payer ID submitted on the claim
Payer Name	Payer name submitted on the claim
Emdeon Claim ID	Claim ID assigned by Emdeon for the specific claim

Claim Summary Report List Order

5. Emdeon Rejected – Claims rejected by Emdeon
6. Payer Rejected – Claims rejected by the payer
7. Emdeon Accepted – Claims accepted by Emdeon but no notification from the payer received
8. Accepted – Claims accepted by payer and the claim is pending adjudication

> ***Note**: File ID is the second level of sorting That is, the first level is one of the four levels listed above, the second level sort is by File ID (File ID: includes both Site ID and Emdeon Batch File number, where applicable.)*

Layered sorting of Claim Summary results:



Claim Summary

Search Criteria: Claim Date Range: 1/1/2010-5/3/2010 ▶ Payer ID: < Empty >

Claim Status: Any ▶ Worked Status: < Empty >

Worked	Patient Name	Insured ID	Patient Control Number	Service From Date	Claim Amount
Emdeon-Rejected					
Site ID: LMNO					
File ID: EP123D[redacted]					
Yes	Patientlastnm06, Patientfirstnm06	TE[redacted]	TE[redacted]	09/15/2009	$750.00

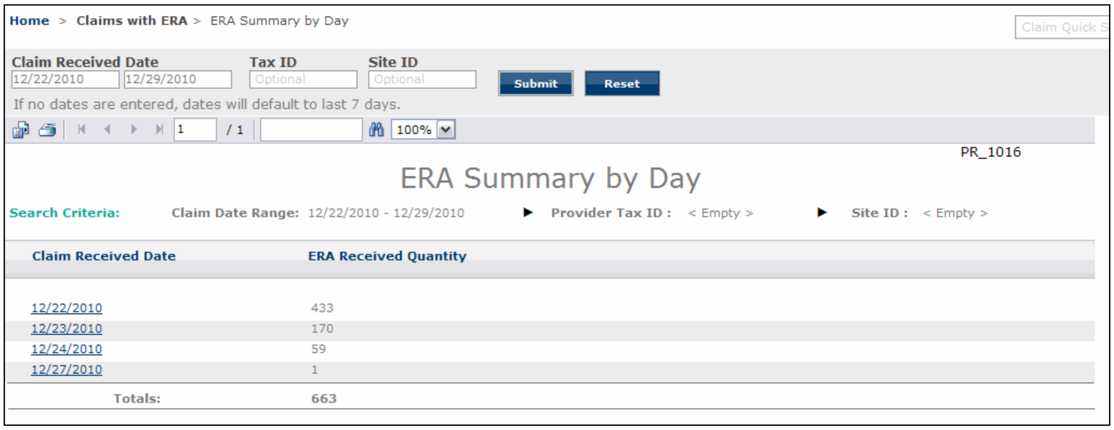
Message

Admission Source Code: Invalid; Must be a valid code for Admission Type Code

File ID: EP123D[redacted]

ERA Summary by Day Report

This report is generated from the Claims with ERA search.



Home > Claims with ERA > ERA Summary by Day

Claim Received Date: 12/22/2010 12/29/2010
Tax ID: Optional
Site ID: Optional

If no dates are entered, dates will default to last 7 days.

PR_1016

ERA Summary by Day

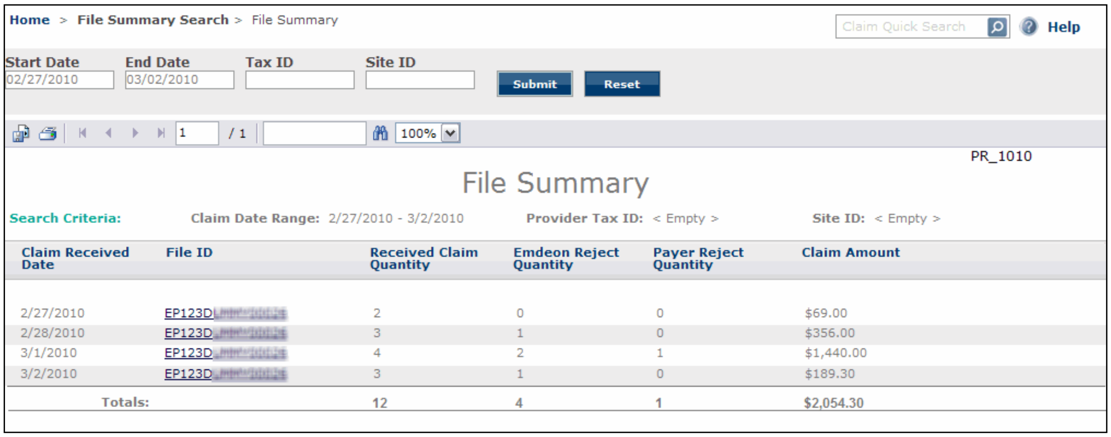
Search Criteria: Claim Date Range: 12/22/2010 - 12/29/2010 ▶ Provider Tax ID : < Empty > ▶ Site ID : < Empty >

Claim Received Date	ERA Received Quantity
12/22/2010	433
12/23/2010	170
12/24/2010	59
12/27/2010	1
Totals:	663

Click a link in the Claim Received Date column to view the Claim Summary Report for all claims with ERAs for the date listed, and then click the Emdeon Claim ID link to view the Claim Detail Report for that claim.

File Summary Report

The File Summary Report provides details on all claim batches submitted to the Emdeon clearinghouse during a specific date range. Each claim batch is identified by a File ID (Emdeon batch identifier).



Start Date: 02/27/2010
End Date: 03/02/2010
Tax ID:
Site ID:

PR_1010

File Summary

Search Criteria: Claim Date Range: 2/27/2010 - 3/2/2010 Provider Tax ID: < Empty > Site ID: < Empty >

Claim Received Date	File ID	Received Claim Quantity	Emdeon Reject Quantity	Payer Reject Quantity	Claim Amount
2/27/2010	EP123D[redacted]	2	0	0	$69.00
2/28/2010	EP123D[redacted]	3	1	0	$356.00
3/1/2010	EP123D[redacted]	4	2	1	$1,440.00
3/2/2010	EP123D[redacted]	3	1	0	$189.30
Totals:		12	4	1	$2,054.30

File Summary Column Headings

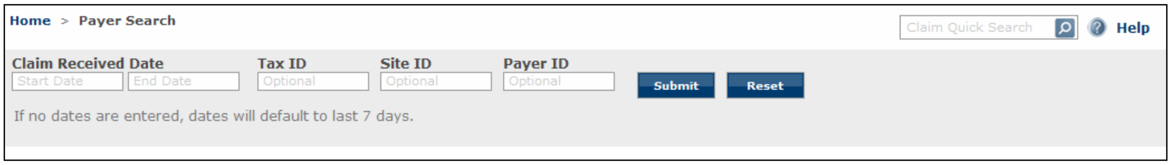
Heading	Description
Claim Received Date	Date claim was received by Emdeon
File ID	File ID assigned by Emdeon for the electronic file in which the claim was submitted
Received Claim Quantity	Total number of claims received by Emdeon
Emdeon Reject Quantity	Number of claims rejected by Emdeon
Payer Reject Quantity	Number of claims rejected by the payer
Claim Amount	Total dollar amount of all claims received (total dollar amount for total number of claims shown in the **Received Claim Quantity** column)

Insured Detail Report on page 149.

Payer Search

Access this search by selecting **Claims** > **Payer Search**. Use the Payer Search to display a report that includes all claims for a specified (or default) date range.

***Note**: The Payer ID must be a 5 character alphanumeric string.*



If no dates are entered, dates will default to last 7 days.

Search Without a Payer ID Results

A successful Payer Search without a Payer ID results in the Summary by Payer Report. For more information, see **Export and Print Reports**

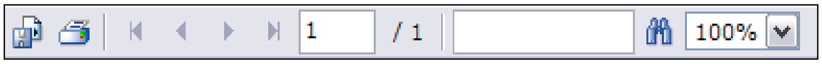
Export allows you to export a report; several file formats are available including Excel. **Print** allows you to print a report by opening the report in Adobe Viewer.

***Note**: Your browser must allow pop-up windows in order to use the Print or Export features.*

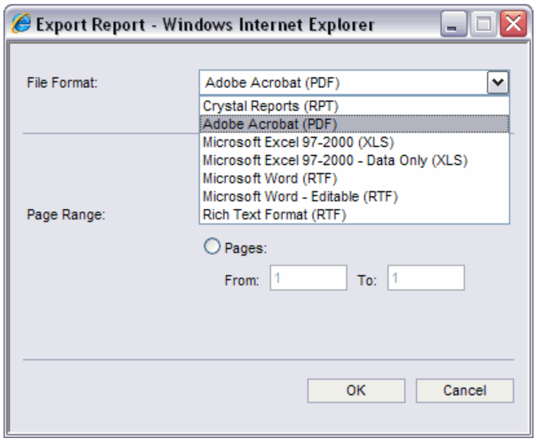
Export a Report

Export enables you to export a report from Reporting & Analytics and save it in a different format, such as Microsoft Word or Excel.

1. Click the **Export** icon.



2. Select the export format from the **File Format** list.


Export Report - Windows Internet Explorer
Crystal Reports (RPT)
Adobe Acrobat (PDF)
Microsoft Excel 97-2000 (XLS)
Microsoft Excel 97-2000 - Data Only (XLS)
Microsoft Word (RTF)
Microsoft Word - Editable (RTF)
Rich Text Format (RTF)
Page Range:
○ Pages:
OK
Cancel

File Format: Adobe Acrobat (PDF)

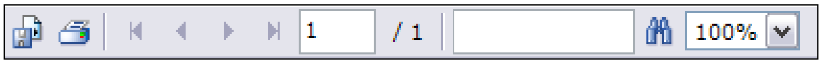
From: 1 To: 1

3. All pages will be exported unless you specify a page range. If you do not want to export the entire document, click the **Pages** option, and then enter a page range.
4. Click **OK**. The File Download window appears.
5. Click **Save**.
6. Select the target location for the file, and change the name to a more descriptive filename.
7. Click **Save**.

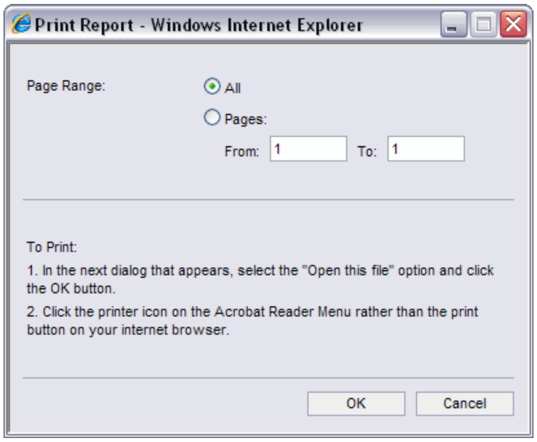
Print a Report

The **Print Report** function allows you to select print options prior to printing a report.

1. Click the **Print** icon.



2. All pages will print unless you specify a page range. If you do not want to print the entire document, click the **Pages** option, and then enter a page range.


Print Report - Windows Internet Explorer
OK
Cancel

Page Range: ● All

○ Pages:

From: 1 To: 1

To Print:

1. In the next dialog that appears, select the "Open this file" option and click the OK button.

2. Click the printer icon on the Acrobat Reader Menu rather than the print button on your internet browser.

3. Click **OK**.
4. The File Download window appears. Click **Open**.
5. The report opens in Adobe Reader (or the PDF reader that is set as the default viewer on your computer).
6. Click the **Print** icon from the Adobe Reader window, or select **File** > **Print**.

Audit History Report

> ***Note***: *This report, generated by performing an Audit History search, is different from viewing the audit history in a Claim Detail Report (see* ***View Audit History*** *on page 113).*

Data displayed in the Audit History report is sorted by Date/Time Stamp in descending order, with the most recent event at the top of the table.

- **Username**

  Reporting & Analytics user ID of the user who made the change described in the table row.

  ***Note**: The Reporting & Analytics user ID is typically the same or very similar to the Emdeon Office user ID.*

- **Action Performed**

  One of two possible actions is displayed in this field.

  - Marked claim as Worked: Specified user changed claim status to Worked.
  - Marked claim as Unworked: Specified user changed claim status to Unworked.
- **Date/Time Stamp**

  Date and time of action.

- **Emdeon Claim ID**

  Specific Emdeon Claim ID (Claim Original Reference Number) of claim.

  ***Note**: This column is not displayed if a specific Emdeon Claim ID was used in search criteria.*

on page 139.

Search With a Payer ID Results

A successful Payer Search with a Payer ID results in the Summary by Payer by Day Report. For more information, see **Summary by Payer by Day Report** on page 156.

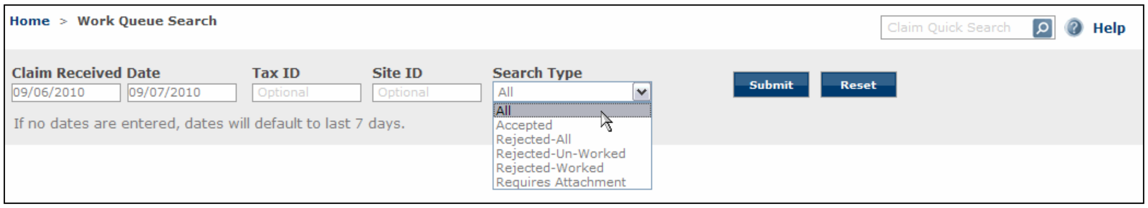
Rejection Since Last Login Search

Access this search by selecting **Claims** > **Rejection Since Last Login**. This search displays a Claim Summary report of all claims that have been rejected since you last accessed Reporting & Analytics.

***Note**: There are no search criteria associated with this report. Click **Submit** to run the search.*

Work Queue Search

Access this search by selecting **Claims** > **Work Queue Search**. Use this search to locate claims based on their "Worked" status. Use the **Search Type** list to select the claim status to be searched.



Claim Received Date: 09/06/2010 – 09/07/2010
Tax ID: Optional
Site ID: Optional
Search Type: All

If no dates are entered, dates will default to last 7 days.

Search Types – Accepted, Rejected, Requires Attachment

If you select "Rejected" status, the following additional criteria are available. Only one of the following can be selected:

- All
- Accepted
- Rejected – All
- Rejected – Un-Worked
- Rejected – Worked
- Requires Attachment

Search Criteria Formats

- "Tax ID" – 9-digit numeric string
- "Site ID" – 4-digit string (alpha and/or numeric)

"Requires Attachment" Search

All claims with status "Requires Attachment" that match all other entered search criteria for the specified date range are displayed. Claims that "require attachments" are those claims to which the payer has requested supporting documents be added.

Work Queue Search Results

- "Accepted"

  Displays only claims with an "Accepted" status.

- "All"

  Displays all claims regardless of accepted/rejected status.

- "Rejected" ("Worked" or "Un-worked")

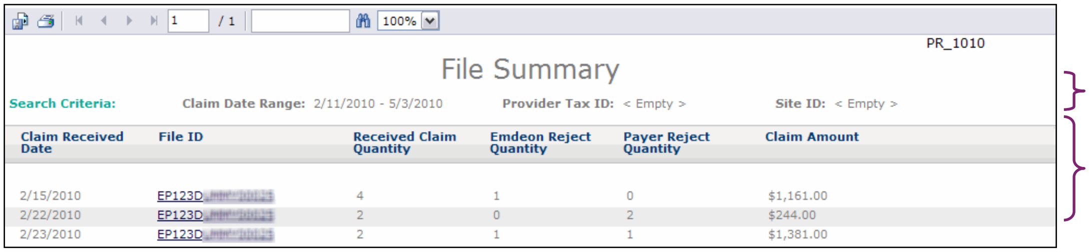
  Displays all claims that are currently identified with the selected status condition.

***Note**: For more information on how to change the status of a claim from "Un-Worked" to "Worked" please see **Descriptions and functions** of key user fields in the Claim Detail section are presented below.*

Worked Status Indicator on page 142.

Reports

Report Screen Layout



1 / 1 100%

PR_1010

File Summary

Search Criteria: **Claim Date Range:** 2/11/2010 - 5/3/2010 **Provider Tax ID:** < Empty > **Site ID:** < Empty >

Claim Received Date	File ID	Received Claim Quantity	Emdeon Reject Quantity	Payer Reject Quantity	Claim Amount
2/15/2010	EP123D[redacted]	4	1	0	$1,161.00
2/22/2010	EP123D[redacted]	2	0	2	$244.00
2/23/2010	EP123D[redacted]	2	1	1	$1,381.00

Search criteria used to generate the report

Report

Detail Links

Most reports include links that provide access to additional reports. Links are shown as underlined, dark blue text.

***Note**: Some reports are only accessed via links and are not accessible directly from the search screen.*

Search Results

Searches and their resulting reports are shown in the following table. The "↓" symbol in the **Report Result** column below indicates that further reports are available via links.

Search Type > Search Option	Report Result

Search Type > Search Option	**Report Result**
Audit History Search	Export and Print Reports

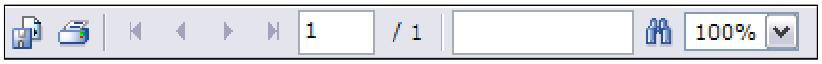
Export allows you to export a report; several file formats are available including Excel. **Print** allows you to print a report by opening the report in Adobe Viewer.

> ***Note**: Your browser must allow pop-up windows in order to use the Print or Export features.*

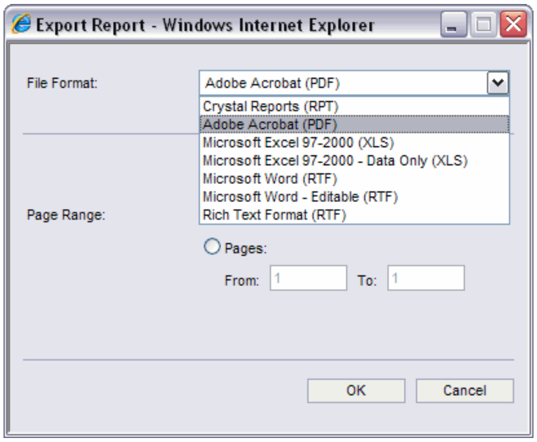
Export a Report

Export enables you to export a report from Reporting & Analytics and save it in a different format, such as Microsoft Word or Excel.

7. Click the **Export** icon.



8. Select the export format from the **File Format** list.



File Format: Adobe Acrobat (PDF)
- Crystal Reports (RPT)
- Adobe Acrobat (PDF)
- Microsoft Excel 97-2000 (XLS)
- Microsoft Excel 97-2000 - Data Only (XLS)
- Microsoft Word (RTF)
- Microsoft Word - Editable (RTF)
- Rich Text Format (RTF)

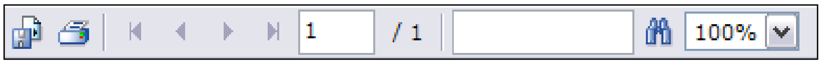
Page Range:
○ Pages:
From: 1 To: 1

9. All pages will be exported unless you specify a page range. If you do not want to export the entire document, click the **Pages** option, and then enter a page range.
10. Click **OK**. The File Download window appears.
11. Click **Save**.
12. Select the target location for the file, and change the name to a more descriptive filename.
13. Click **Save**.

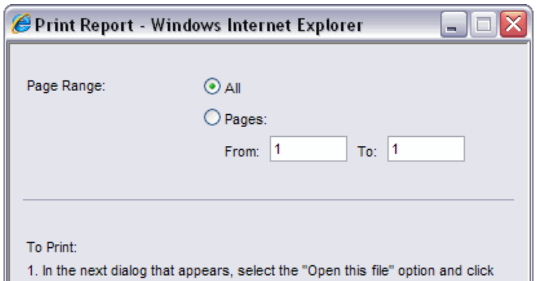
Print a Report

The **Print Report** function allows you to select print options prior to printing a report.

14. Click the **Print** icon.



15. All pages will print unless you specify a page range. If you do not want to print the entire document, click the **Pages** option, and then enter a page range.



Page Range:
● All
○ Pages:
From: 1 To: 1

To Print:
1. In the next dialog that appears, select the "Open this file" option and click

Search Type > Search Option	Report Result
Claim Quick Search	Claim Summary Report ↓ Claim Detail Report

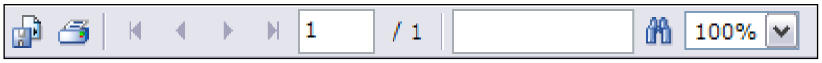
Search Type > Search Option	Report Result
Claims with ERA Search	Export and Print Reports Export allows you to export a report; several file formats are available including Excel. **Print** allows you to print a report by opening the report in Adobe Viewer.

> ***Note**: Your browser must allow pop-up windows in order to use the Print or Export features.*

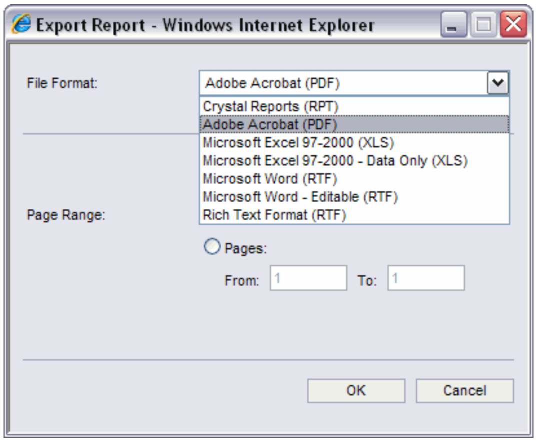
Export a Report

Export enables you to export a report from Reporting & Analytics and save it in a different format, such as Microsoft Word or Excel.

20. Click the **Export** icon.



21. Select the export format from the **File Format** list.


Export Report - Windows Internet Explorer

File Format: Adobe Acrobat (PDF)

Crystal Reports (RPT)
Adobe Acrobat (PDF)
Microsoft Excel 97-2000 (XLS)
Microsoft Excel 97-2000 - Data Only (XLS)
Microsoft Word (RTF)
Microsoft Word - Editable (RTF)
Rich Text Format (RTF)

Page Range:

○ Pages:

From: 1 To: 1

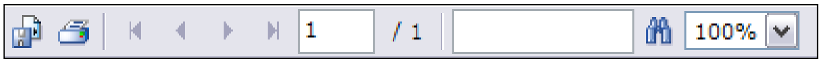
OK
Cancel

22. All pages will be exported unless you specify a page range. If you do not want to export the entire document, click the **Pages** option, and then enter a page range.
23. Click **OK**. The File Download window appears.
24. Click **Save**.
25. Select the target location for the file, and change the name to a more descriptive filename.
26. Click **Save**.

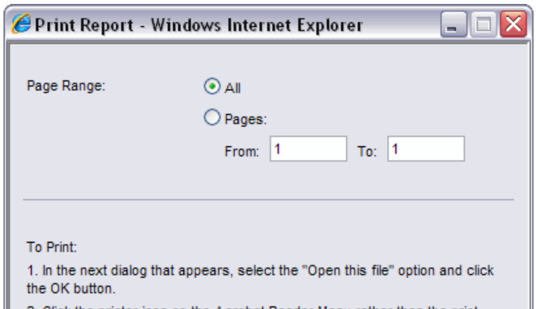
Print a Report

The **Print Report** function allows you to select print options prior to printing a report.

27. Click the **Print** icon.



28. All pages will print unless you specify a page range. If you do not want to print the entire document, click the **Pages** option, and then enter a page range.


Print Report - Windows Internet Explorer

Page Range: ● All

○ Pages:

From: 1 To: 1

To Print:

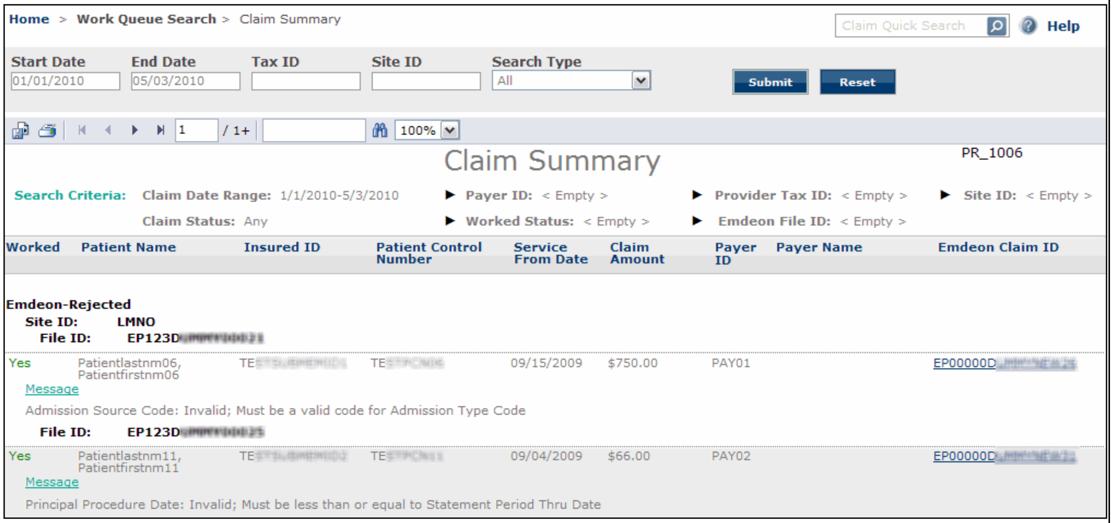
1. In the next dialog that appears, select the "Open this file" option and click the OK button.

Search Type > Search Option	Report Result
Dashboard Search • Claim Status Summary (pie chart) • Payers with Largest Rejection Dollar Amounts (bar graph) • Claim Charge Amount (line graph) For more information, see **Accessing Claim Detail through Dashboard Views** on page 101.	Claim Summary Report ↓ Claim Detail Report
File Summary Search	Claim Summary Report ↓ Claim Detail Report
Patient Pay Search > View all patient payments made through Patient Pay Online for a date range	Payment Summary Report ↓ Patient Payment Summary by Day Report ↓ Payment Detail Report
Patient Pay Search > View all patient payments made through Patient Pay Online for a patient name or patient account number	Patient Payment Summary by Day Report ↓ Payment Detail Report

Search Type > Search Option	**Report Result**
Patient Search > View all claims for a specific insured party and dependents (by Insured ID)	Claim Summary Report

The Claim Summary Report can be generated from several areas within Reporting & Analytics:

- Run a Work Queue search for any claim status.
- Click a link in the **Claim Received Date** column on the Summary by Payer by Day report.
- Run a Rejection Since Last Login search.
- Click a link in the **File ID** column of the File Summary report.
- Run a Quick search.
- Click on a pie chart slice, graph bar, or graph data point in the Dashboard view.



Start Date: 01/01/2010
End Date: 05/03/2010
Tax ID:
Site ID:
Search Type: All

Claim Summary

PR_1006

Search Criteria: Claim Date Range: 1/1/2010-5/3/2010
Claim Status: Any
Payer ID: < Empty >
Worked Status: < Empty >
Provider Tax ID: < Empty >
Emdeon File ID: < Empty >
Site ID: < Empty >

Worked	Patient Name	Insured ID	Patient Control Number	Service From Date	Claim Amount	Payer ID	Payer Name	Emdeon Claim ID
Emdeon-Rejected								
Site ID: LMNO								
File ID: EP123D[redacted]								
Yes	Patientlastnm06, Patientfirstnm06	TE[redacted]	TE[redacted]	09/15/2009	$750.00	PAY01		EP00000D[redacted]
Message Admission Source Code: Invalid; Must be a valid code for Admission Type Code								
File ID: EP123D[redacted]								
Yes	Patientlastnm11, Patientfirstnm11	TE[redacted]	TE[redacted]	09/04/2009	$66.00	PAY02		EP00000D[redacted]
Message Principal Procedure Date: Invalid; Must be less than or equal to Statement Period Thru Date								

Claim Summary Column Headings

Heading	Description
Worked	"Worked" progress status; determined by the "Worked" check box in the Detail report
Patient Name	Name of the patient submitted on the claim
Insured ID	Insured ID submitted on the claim
Patient Control Number	Provider's control/tracking number for patient on claim
Service From Date	Date of service
Claim Amount	Dollar amount (in US dollars) of the submitted claim
Payer ID	Payer ID submitted on the claim
Payer Name	Payer name submitted on the claim
Emdeon Claim ID	Claim ID assigned by Emdeon for the specific claim

Claim Summary Report List Order

33. Emdeon Rejected – Claims rejected by Emdeon
34. Payer Rejected – Claims rejected by the payer
35. Emdeon Accepted – Claims accepted by Emdeon but no notification from the payer received
36. Accepted – Claims accepted by payer and the claim is pending adjudication

> ***Note**: File ID is the second level of sorting That is, the first level is one of the four levels listed above, the second level sort is by File ID (File ID: includes both Site ID and Emdeon Batch File number, where applicable.)*

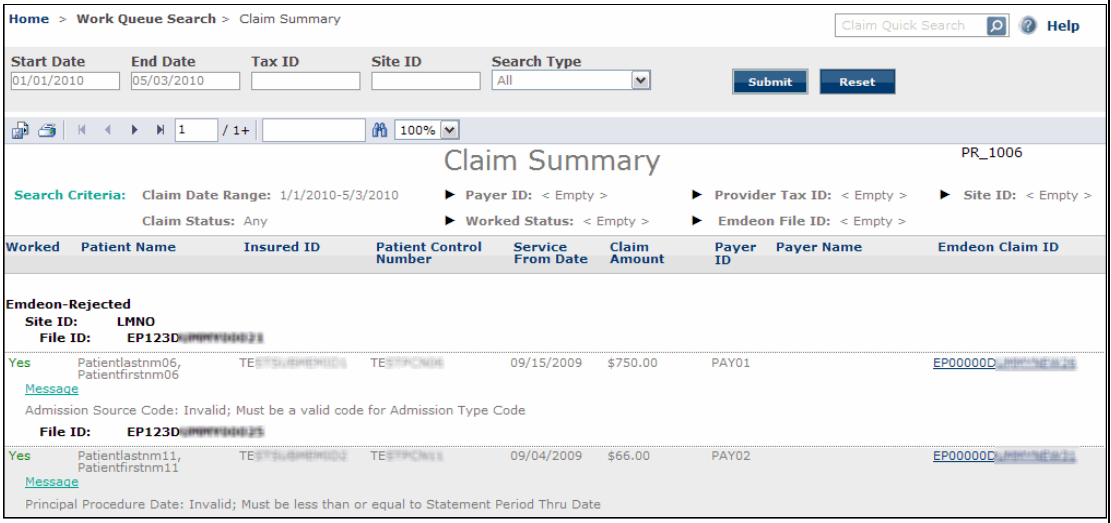
Layered sorting of Claim Summary results:

Claim Summary

Search Type > Search Option	Report Result
Patient Search > Locate all claims for a specific PCN	Claim Summary Report

The Claim Summary Report can be generated from several areas within Reporting & Analytics:

- Run a Work Queue search for any claim status.
- Click a link in the **Claim Received Date** column on the Summary by Payer by Day report.
- Run a Rejection Since Last Login search.
- Click a link in the **File ID** column of the File Summary report.
- Run a Quick search.
- Click on a pie chart slice, graph bar, or graph data point in the Dashboard view.



Start Date: 01/01/2010
End Date: 05/03/2010
Tax ID:
Site ID:
Search Type: All

Claim Summary

PR_1006

Search Criteria: Claim Date Range: 1/1/2010-5/3/2010 ▶ Payer ID: < Empty > ▶ Provider Tax ID: < Empty > ▶ Site ID: < Empty >
Claim Status: Any ▶ Worked Status: < Empty > ▶ Emdeon File ID: < Empty >

Worked	Patient Name	Insured ID	Patient Control Number	Service From Date	Claim Amount	Payer ID	Payer Name	Emdeon Claim ID
Emdeon-Rejected								
Site ID: LMNO								
File ID: EP123D[redacted]								
Yes	Patientlastnm06, Patientfirstnm06	TE[redacted]	TE[redacted]	09/15/2009	$750.00	PAY01		EP00000D[redacted]
Message Admission Source Code: Invalid; Must be a valid code for Admission Type Code								
File ID: EP123D[redacted]								
Yes	Patientlastnm11, Patientfirstnm11	TE[redacted]	TE[redacted]	09/04/2009	$66.00	PAY02		EP00000D[redacted]
Message Principal Procedure Date: Invalid; Must be less than or equal to Statement Period Thru Date								

Claim Summary Column Headings

Heading	Description
Worked	"Worked" progress status; determined by the "Worked" check box in the Detail report
Patient Name	Name of the patient submitted on the claim
Insured ID	Insured ID submitted on the claim
Patient Control Number	Provider's control/tracking number for patient on claim
Service From Date	Date of service
Claim Amount	Dollar amount (in US dollars) of the submitted claim
Payer ID	Payer ID submitted on the claim
Payer Name	Payer name submitted on the claim
Emdeon Claim ID	Claim ID assigned by Emdeon for the specific claim

Claim Summary Report List Order

37. Emdeon Rejected – Claims rejected by Emdeon
38. Payer Rejected – Claims rejected by the payer
39. Emdeon Accepted – Claims accepted by Emdeon but no notification from the payer received
40. Accepted – Claims accepted by payer and the claim is pending adjudication

> ***Note**: File ID is the second level of sorting That is, the first level is one of the four levels listed above, the second level sort is by File ID (File ID: includes both Site ID and Emdeon Batch File number, where applicable.)*

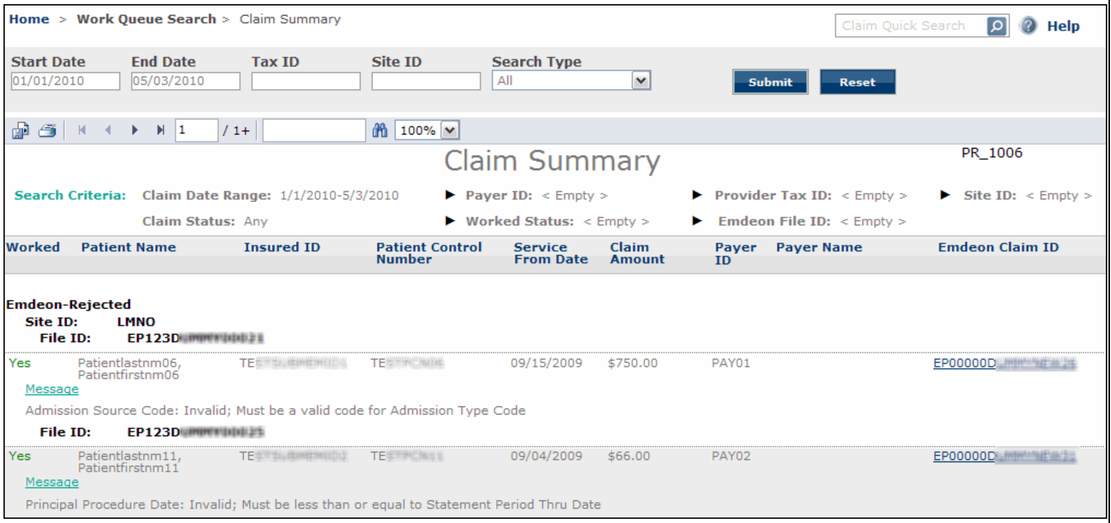
Layered sorting of Claim Summary results:

Claim Summary

Search Type > Search Option	Report Result
Patient Search > Locate all claims for a specific patient	Claim Summary Report

The Claim Summary Report can be generated from several areas within Reporting & Analytics:

- Run a Work Queue search for any claim status.
- Click a link in the **Claim Received Date** column on the Summary by Payer by Day report.
- Run a Rejection Since Last Login search.
- Click a link in the **File ID** column of the File Summary report.
- Run a Quick search.
- Click on a pie chart slice, graph bar, or graph data point in the Dashboard view.



Start Date: 01/01/2010
End Date: 05/03/2010
Tax ID:
Site ID:
Search Type: All

Claim Summary

PR_1006

Search Criteria: Claim Date Range: 1/1/2010-5/3/2010 ▶ Payer ID: < Empty > ▶ Provider Tax ID: < Empty > ▶ Site ID: < Empty >
Claim Status: Any ▶ Worked Status: < Empty > ▶ Emdeon File ID: < Empty >

Worked	Patient Name	Insured ID	Patient Control Number	Service From Date	Claim Amount	Payer ID	Payer Name	Emdeon Claim ID
Emdeon-Rejected								
Site ID: LMNO								
File ID: EP123D[redacted]								
Yes	Patientlastnm06, Patientfirstnm06	TE[redacted]	TE[redacted]	09/15/2009	$750.00	PAY01		EP00000D[redacted]
Message Admission Source Code: Invalid; Must be a valid code for Admission Type Code								
File ID: EP123D[redacted]								
Yes	Patientlastnm11, Patientfirstnm11	TE[redacted]	TE[redacted]	09/04/2009	$66.00	PAY02		EP00000D[redacted]
Message Principal Procedure Date: Invalid; Must be less than or equal to Statement Period Thru Date								

Claim Summary Column Headings

Heading	Description
Worked	"Worked" progress status; determined by the "Worked" check box in the Detail report
Patient Name	Name of the patient submitted on the claim
Insured ID	Insured ID submitted on the claim
Patient Control Number	Provider's control/tracking number for patient on claim
Service From Date	Date of service
Claim Amount	Dollar amount (in US dollars) of the submitted claim
Payer ID	Payer ID submitted on the claim
Payer Name	Payer name submitted on the claim
Emdeon Claim ID	Claim ID assigned by Emdeon for the specific claim

Claim Summary Report List Order

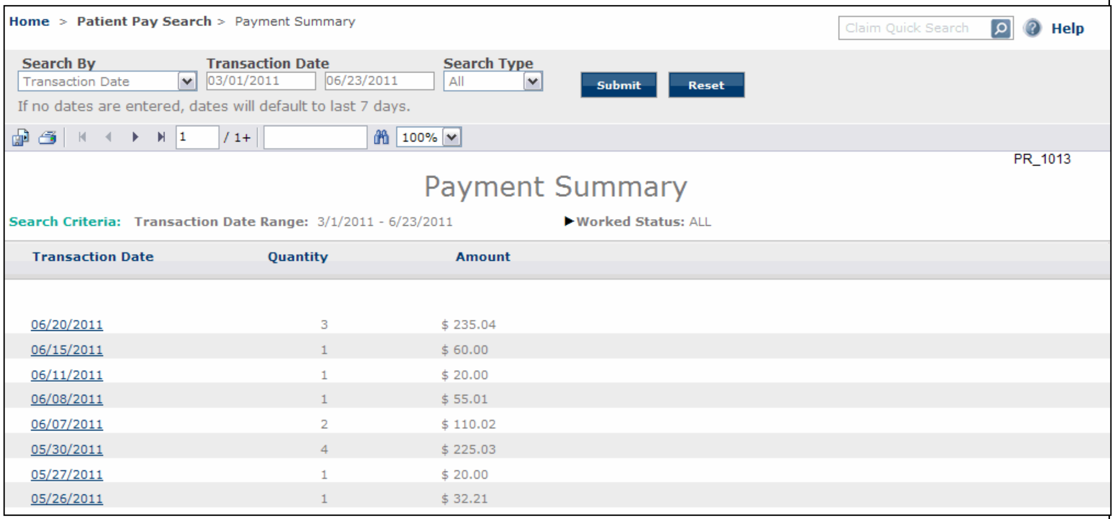
41. Emdeon Rejected – Claims rejected by Emdeon
42. Payer Rejected – Claims rejected by the payer
43. Emdeon Accepted – Claims accepted by Emdeon but no notification from the payer received
44. Accepted – Claims accepted by payer and the claim is pending adjudication

> ***Note****: File ID is the second level of sorting That is, the first level is one of the four levels listed above, the second level sort is by File ID (File ID: includes both Site ID and Emdeon Batch File number, where applicable.)*

Layered sorting of Claim Summary results:

Claim Summary

Search Type > Search Option	**Report Result**
Payer Search > Display a summary of all claims	Payment Summary Report The Payment Summary Report displays when you perform a Patient Pay Search and search by transaction date. It shows patient payments made through Patient Pay Online for a specified date range and worked status. Click the date link in the Transaction Date column to display a Patient Payment Summary by Day Report for the date you selected.



Search By: Transaction Date
Transaction Date: 03/01/2011 06/23/2011
Search Type: All
If no dates are entered, dates will default to last 7 days.

PR_1013

Payment Summary

Search Criteria: Transaction Date Range: 3/1/2011 - 6/23/2011 ▶Worked Status: ALL

Transaction Date	Quantity	Amount
06/20/2011	3	$ 235.04
06/15/2011	1	$ 60.00
06/11/2011	1	$ 20.00
06/08/2011	1	$ 55.01
06/07/2011	2	$ 110.02
05/30/2011	4	$ 225.03
05/27/2011	1	$ 20.00
05/26/2011	1	$ 32.21

Payment Summary Report Column Headings

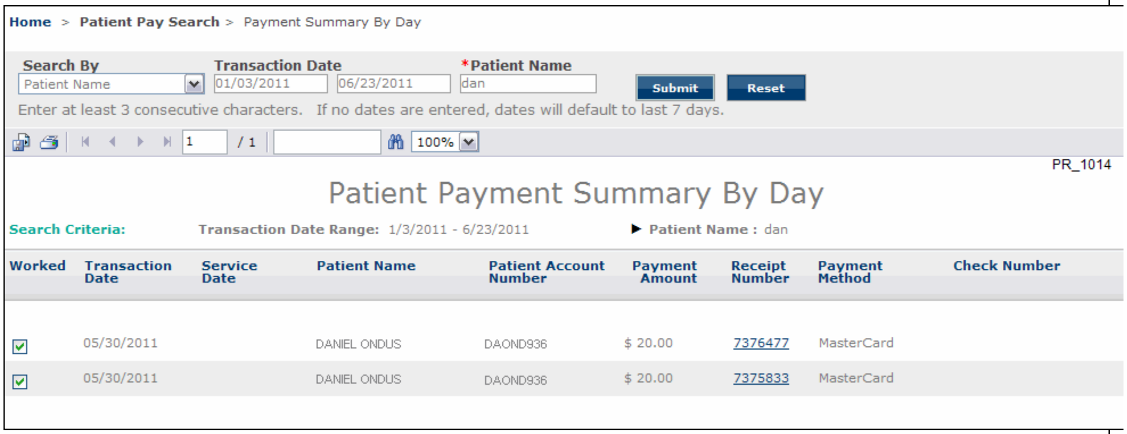
Heading	Description
Transaction Date	Date that the payment was made. Click the link to view the Payment Sum Day Report for the date you selected.
Quantity	Number of payments made on the specified transaction date.
Amount	Total amount of all payments made on the specified transaction date.

Patient Payment Summary by Day Report

The Patient Payment Summary by Day Report displays when you perform a Patient Pay Search and search by patient name or patient account number as well as when you click a transaction date link on the Payment Summary Report.

Search by Patient Name or Patient Account Number

When you perform a Patient Pay Search and search by patient name or patient account number, the report will show the same patient name or patient account number for the transaction date range you selected.



Search By: Patient Name
Transaction Date: 01/03/2011 06/23/2011
*Patient Name: dan
Enter at least 3 consecutive characters. If no dates are entered, dates will default to last 7 days.

PR_1014

Patient Payment Summary By Day

Search Criteria: Transaction Date Range: 1/3/2011 - 6/23/2011 ▶ Patient Name : dan

Worked	Transaction Date	Service Date	Patient Name	Patient Account Number	Payment Amount	Receipt Number	Payment Method	Check Number
☑	05/30/2011		DANIEL ONDUS	DAOND936	$ 20.00	7376477	MasterCard	
☑	05/30/2011		DANIEL ONDUS	DAOND936	$ 20.00	7375833	MasterCard	

Click a Transaction Date Link

When you click a transaction date link on the Payment Summary Report, the Patient

Search Type > Search Option	Report Result
Payer Search > Display a summary of all claims for a specific payer	Summary by Payer by Day Report ↓ Claim Summary Report ↓ Claim Detail Report
Rejection Since Last Login Search	Claim Summary Report ↓ Claim Detail Report
Work Queue Search > Display a summary of all claims for a specific status	Claim Summary Report (sorted by status) ↓ Claim Detail Report
Work Queue Search > Display a summary of all claims for "Rejected" claims with either "Worked" or "Un-Worked" sub-status	Claim Summary Report (for specified sub-status) ↓ Claim Detail Report

Export and Print Reports

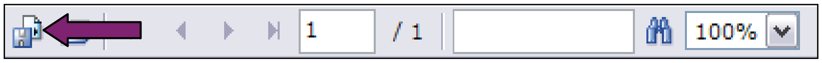
Export allows you to export a report; several file formats are available including Excel. **Print** allows you to print a report by opening the report in Adobe Viewer.

> ***Note***: *Your browser must allow pop-up windows in order to use the Print or Export features.*

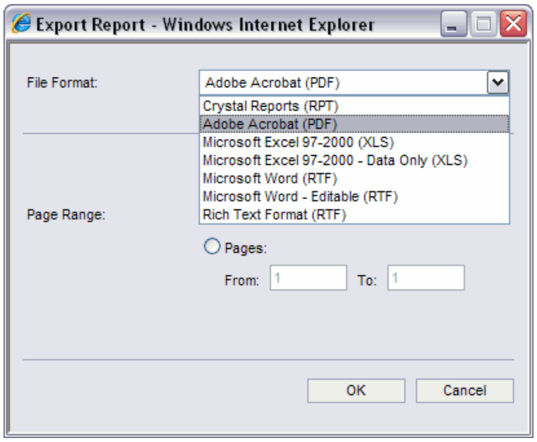
Export a Report

Export enables you to export a report from Reporting & Analytics and save it in a different format, such as Microsoft Word or Excel.

45. Click the **Export** icon.



46. Select the export format from the **File Format** list.


Export Report - Windows Internet Explorer
Crystal Reports (RPT)
Adobe Acrobat (PDF)
Microsoft Excel 97-2000 (XLS)
Microsoft Excel 97-2000 - Data Only (XLS)
Microsoft Word (RTF)
Microsoft Word - Editable (RTF)
Rich Text Format (RTF)
OK
Cancel

File Format: Adobe Acrobat (PDF)

Page Range:

○ Pages:

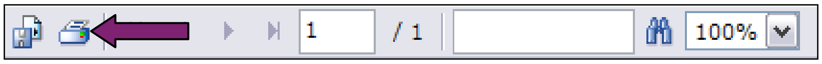
From: 1 To: 1

47. All pages will be exported unless you specify a page range. If you do not want to export the entire document, click the **Pages** option, and then enter a page range.
48. Click **OK**. The File Download window appears.
49. Click **Save**.
50. Select the target location for the file, and change the name to a more descriptive filename.
51. Click **Save**.

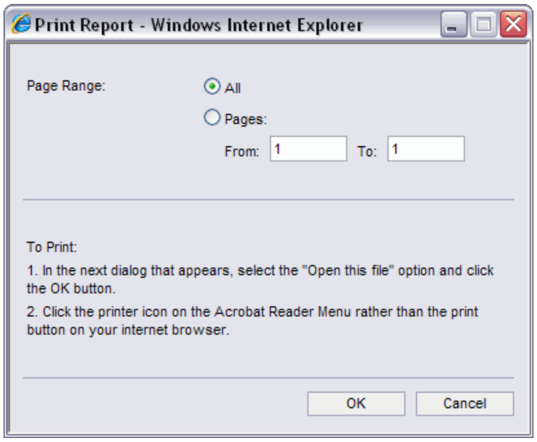
Print a Report

The **Print Report** function allows you to select print options prior to printing a report.

52. Click the **Print** icon.



53. All pages will print unless you specify a page range. If you do not want to print the entire document, click the **Pages** option, and then enter a page range.


Print Report - Windows Internet Explorer
OK
Cancel

Page Range: ● All

○ Pages:

From: 1 To: 1

To Print:

1. In the next dialog that appears, select the "Open this file" option and click the OK button.
2. Click the printer icon on the Acrobat Reader Menu rather than the print button on your internet browser.

54. Click **OK**.
55. The File Download window appears. Click **Open**.
56. The report opens in Adobe Reader (or the PDF reader that is set as the default viewer on your computer).
57. Click the **Print** icon from the Adobe Reader window, or select **File** > **Print**.

Audit History Report

***Note**: This report, generated by performing an Audit History search, is different from viewing the audit history in a Claim Detail Report (see **View Audit History** on page 144).*

Data displayed in the Audit History report is sorted by Date/Time Stamp in descending order, with the most recent event at the top of the table.

- **Username**

  Reporting & Analytics user ID of the user who made the change described in the table row.

Note: *The Reporting & Analytics user ID is typically the same or very similar to the Emdeon Office user ID.*

- **Action Performed**

  One of two possible actions is displayed in this field.

  - Marked claim as Worked: Specified user changed claim status to Worked.
  - Marked claim as Unworked: Specified user changed claim status to Unworked.
- **Date/Time Stamp**

  Date and time of action.

- **Emdeon Claim ID**

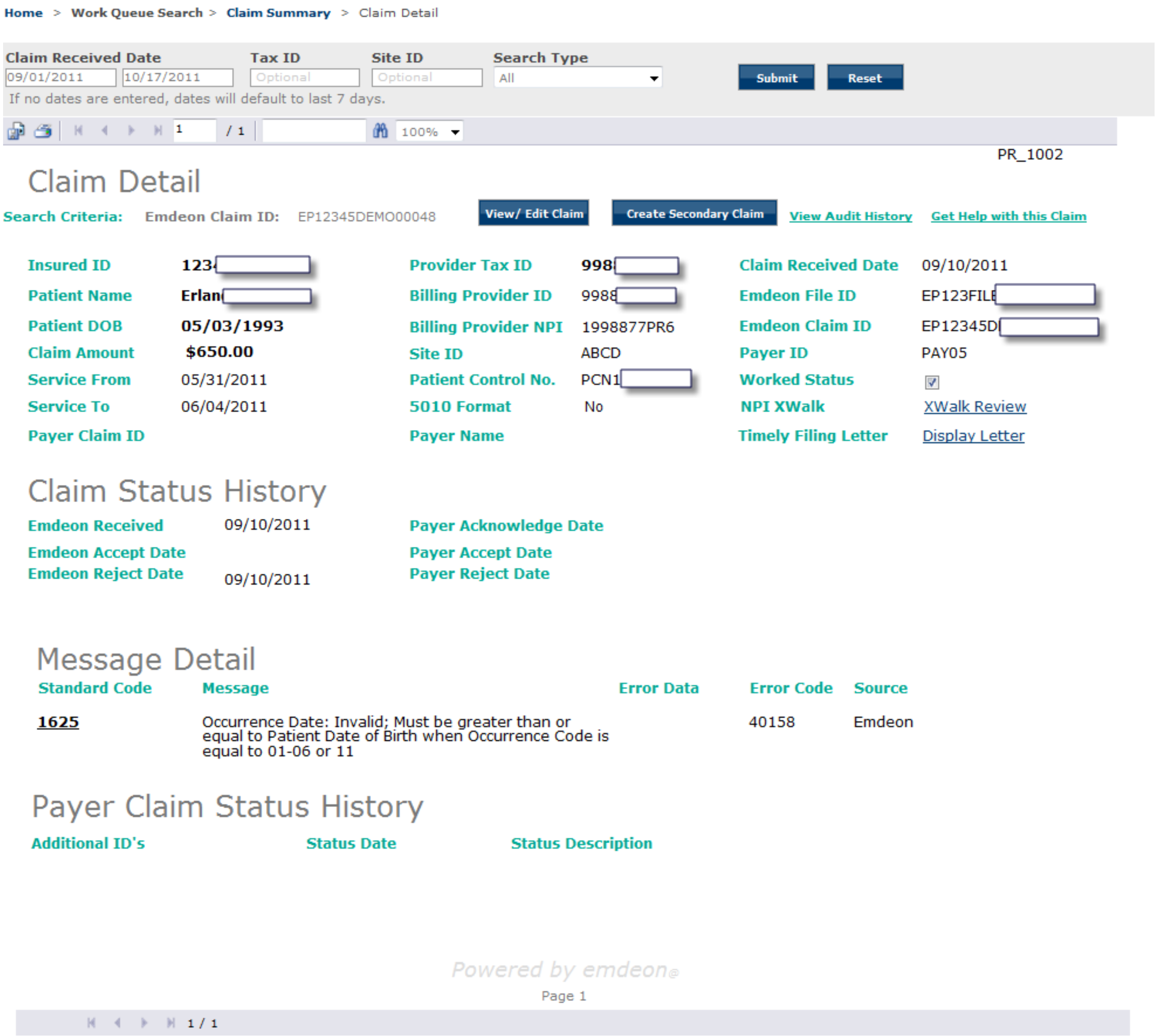
  Specific Emdeon Claim ID (Claim Original Reference Number) of claim.

Note*: This column is not displayed if a specific Emdeon Claim ID was used in search criteria.*

Claim Detail Report

You can access a Claim Detail Report in two ways.

- In an Insured Detail Report, click a link in the Claim Received Date column.
- In a Claim Summary Report, click a link in the Emdeon Claim ID column.



Home > Work Queue Search > Claim Summary > Claim Detail

Claim Received Date		Tax ID	Site ID	Search Type
09/01/2011	10/17/2011	Optional	Optional	All

If no dates are entered, dates will default to last 7 days.

PR_1002

Claim Detail

Search Criteria: Emdeon Claim ID: EP12345DEMO00048

Insured ID	123[redacted]	Provider Tax ID	998[redacted]	Claim Received Date	09/10/2011
Patient Name	Erlan[redacted]	Billing Provider ID	9988[redacted]	Emdeon File ID	EP123FIL[redacted]
Patient DOB	05/03/1993	Billing Provider NPI	1998877PR6	Emdeon Claim ID	EP12345D[redacted]
Claim Amount	$650.00	Site ID	ABCD	Payer ID	PAY05
Service From	05/31/2011	Patient Control No.	PCN1[redacted]	Worked Status	☑
Service To	06/04/2011	5010 Format	No	NPI XWalk	XWalk Review
Payer Claim ID		Payer Name		Timely Filing Letter	Display Letter

Claim Status History

Emdeon Received	09/10/2011	Payer Acknowledge Date	
Emdeon Accept Date		Payer Accept Date	
Emdeon Reject Date	09/10/2011	Payer Reject Date	

Message Detail

Standard Code	Message	Error Data	Error Code	Source
1625	Occurrence Date: Invalid; Must be greater than or equal to Patient Date of Birth when Occurrence Code is equal to 01-06 or 11		40158	Emdeon

Payer Claim Status History

Additional ID's	Status Date	Status Description

Powered by emdeon®

Page 1

Descriptions and functions of key user fields in the Claim Detail section are presented below.

Worked Status Indicator

Use the “Worked Status” check box to mark a claim as “worked.”

When the “Worked” check box is checked the claim is shown as “worked” on the Claim Summary Report. To search for “worked” claims, use the “All” or “Rejected/All” criteria in “Work Queue” search.

***Note**: The definition of "worked" is practice (or site) specific. Please be sure that all Reporting & Analytics users in your organization have a clear understanding of how your practice/site uses the "worked" feature.*

NPI XWalk

If your site has registered for the Emdeon NPI X-Walk service, the report shows if a match was found in the Emdeon Enrollment Database to perform the X-Walk, and whether the crosswalk was executed successfully. If executed successfully, the Provider NPI is inserted into the correct segment of the 837 file prior to submission to the payer. To view this information, click the "Check Claim" link.

Timely Filing Letter

Click "Display Letter" to view the Request for Claim Review Letter. The resulting screen is a printable letter that a provider can send to a payer to support assertions of proper and timely claim filing by the provider. If you are a provider you can print this letter, enter the appropriate information, attach any pertinent supporting documentation then send the letter (with attachments) to the payer.

ERA Linking in Claim Detail

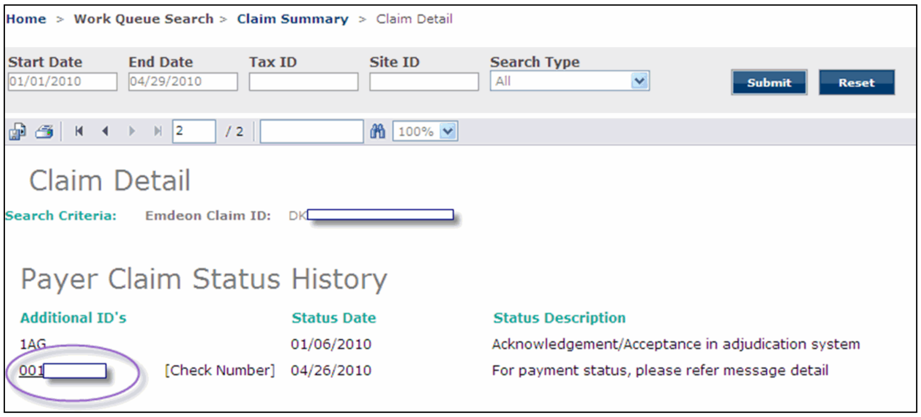
If your practice has ERA contracts with payers, ERA data is displayed in the "Payer Claim Status History" under certain conditions.

The claim has associated ERA(s).

Your practice has ERA contract with the payer on the claim.

If an ERA is associated to the claim a generic message is displayed in the **Status Description** field.

If the claim has been paid (and there is an ERA associated to the claim), the check number is displayed in the **Additional ID's** column. Click the check number to display the Payment Detail report.



Start Date: 01/01/2010
End Date: 04/29/2010
Tax ID:
Site ID:
Search Type: All

Claim Detail

Search Criteria: Emdeon Claim ID: DK[redacted]

Payer Claim Status History

Additional ID's		Status Date	Status Description
1AG		01/06/2010	Acknowledgement/Acceptance in adjudication system
001[redacted]	[Check Number]	04/26/2010	For payment status, please refer message detail

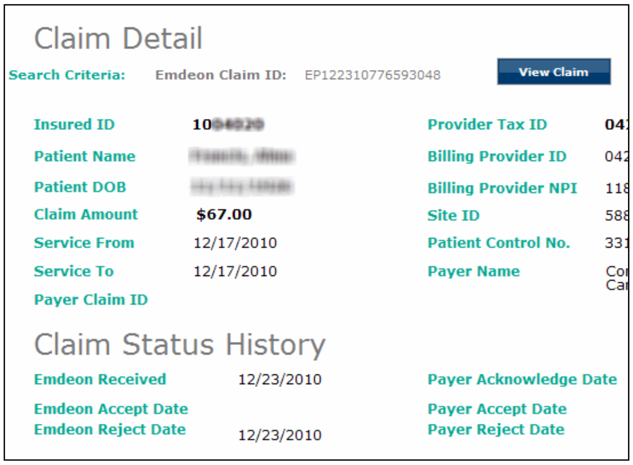
Payment Detail Report

If a linked check number is displayed in the Claim Detail Report you can access the Payment Detail report by clicking the check number.

The Payment Detail report provides key information on the claim (and the payment) including claim amount and the difference between paid amount and claim amount.

Payer Claim ID in Claim Detail Report

If the payer has received the claim and if the payer issues claim IDs to Emdeon, then the payer's claim ID appears in the **Payer Claim ID** field. However, a blank **Payer Claim ID** field does not necessarily mean that the payer has not received the claim.



Claim Detail

Search Criteria: Emdeon Claim ID: EP122310776593048

Insured ID	10[redacted]	Provider Tax ID	04
Patient Name	[redacted]	Billing Provider ID	042
Patient DOB	[redacted]	Billing Provider NPI	118
Claim Amount	$67.00	Site ID	588
Service From	12/17/2010	Patient Control No.	331
Service To	12/17/2010	Payer Name	Co Ca
Payer Claim ID			

Claim Status History

Emdeon Received	12/23/2010	Payer Acknowledge Date	
Emdeon Accept Date		Payer Accept Date	
Emdeon Reject Date	12/23/2010	Payer Reject Date	

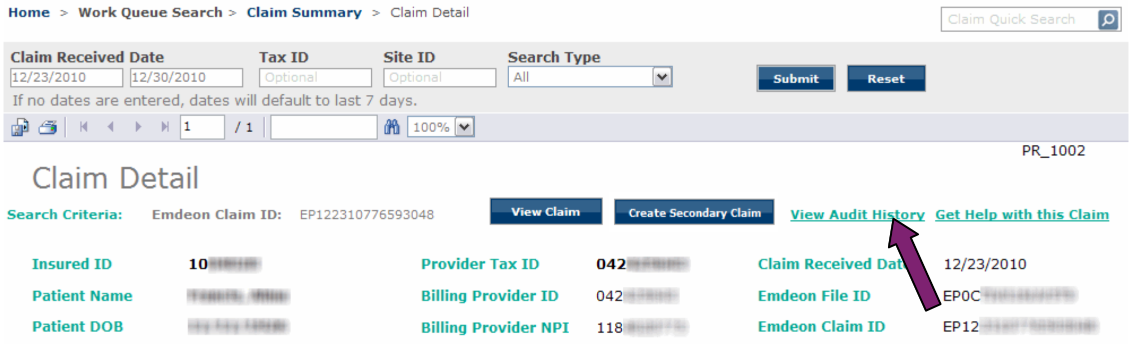
In the screen shot above, no payer claim ID appears in the Claim Detail report because the claim was rejected at Emdeon.

***Note**: While most payers do issue claim IDs upon receipt of a claim (which appear in the Claim Detail report) some payers do not.*

View Audit History

***Note**: This function, which allows you to view the audit history in a Claim Detail Report, is different from the Audit History Report which is generated by performing an Audit History search (see **Audit History Report** on p. 140).*

Click the "View Audit History" link to view the audit history of a claim.



Home > Work Queue Search > Claim Summary > Claim Detail

Claim Received Date: 12/23/2010 12/30/2010
Tax ID: Optional
Site ID: Optional
Search Type: All

If no dates are entered, dates will default to last 7 days.

Claim Detail

Search Criteria: Emdeon Claim ID: EP122310776593048

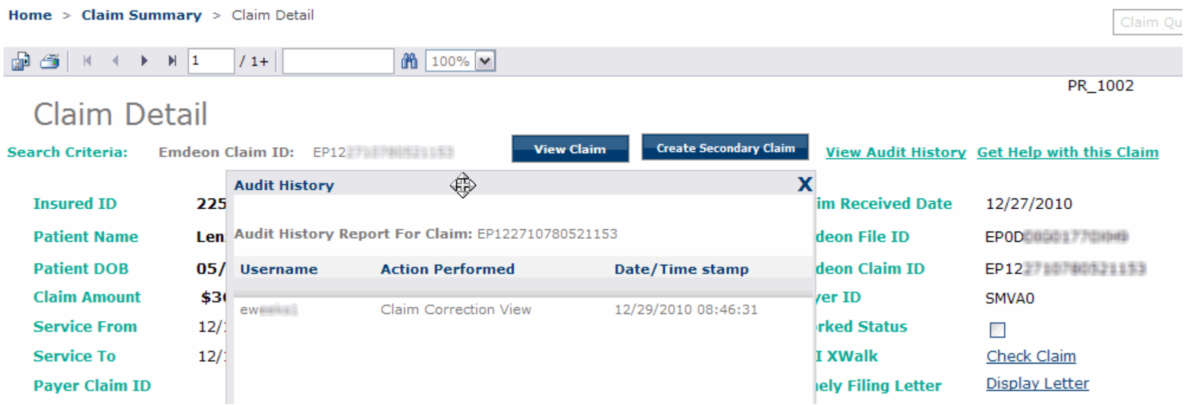
Insured ID	10[redacted]	Provider Tax ID	042[redacted]	Claim Received Dat	12/23/2010
Patient Name	[redacted]	Billing Provider ID	042[redacted]	Emdeon File ID	EP0C[redacted]
Patient DOB	[redacted]	Billing Provider NPI	118[redacted]	Emdeon Claim ID	EP12[redacted]

The following actions are tracked in Audit History:

- Click on **View Claim** button
- Click on "Eligibility" link
- Click on "Claim Status" link
- All "Worked/Unworked" status changes for the last 15 months on the claim are shown with username and date/time stamp

If the Audit History report is longer than 1,000, rows the report can be exported in Microsoft Excel format. The export will include all rows including those rows that were not displayed due to the 1,000 row display limit.

When you click the "View Audit History" link, a new window appears. The Audit History window can be moved in the same manner that the Help window can be moved (click and drag the title bar of the window).



Home > Claim Summary > Claim Detail

PR_1002

Claim Detail

Search Criteria: Emdeon Claim ID: EP12[redacted]

Audit History

Audit History Report For Claim: EP122710780521153

Username	Action Performed	Date/Time stamp
ew[redacted]	Claim Correction View	12/29/2010 08:46:31

Insured ID 225
Patient Name Len
Patient DOB 05/
Claim Amount $3
Service From 12/
Service To 12/
Payer Claim ID

im Received Date 12/27/2010
deon File ID EP0D[redacted]
deon Claim ID EP12[redacted]
yer ID SMVA0
rked Status ☐
I XWalk Check Claim
ely Filing Letter Display Letter

Workers’ Compensation Attachments

Overview

Reporting & Analytics provides you with a convenient and powerful way to manage workers’ compensation claims.

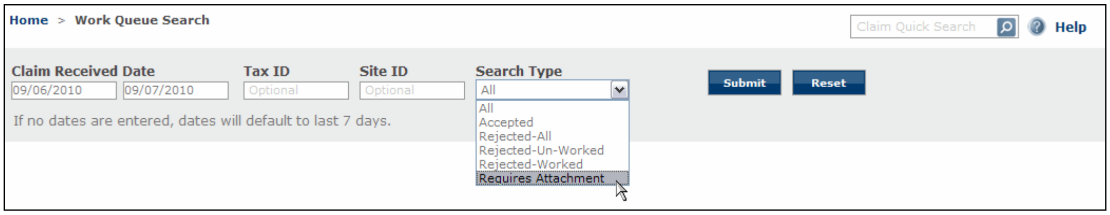
Functionality includes both claim management and the ability to respond directly to payers with requested attachments. Workers’ Compensation Attachments is available by subscription only from Reporting & Analytics.

If you have pending workers’ compensation claims, you can easily find those claims and respond to payer requests for further documentation.

Locate Claims Easily

To locate claims in Reporting & Analytics that the payer requires additional information for, begin the search by selecting **Claims** > **Work Queue Search**.

In the **Search Type** drop-down list, select “Requires Attachment”. Enter your Tax ID or Site ID for a more specific search (both fields are optional).



Home > Work Queue Search

Claim Received Date: 09/06/2010 09/07/2010
Tax ID: Optional
Site ID: Optional
Search Type: All

If no dates are entered, dates will default to last 7 days.

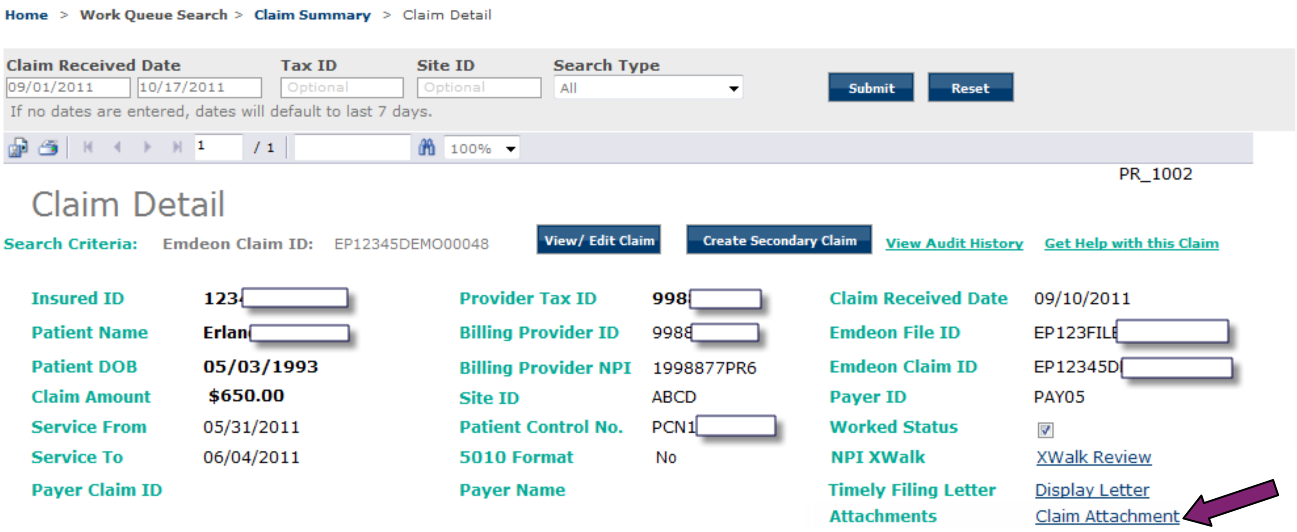
All claims that match the selected search criteria for which the payer on workers’ compensation claim(s) has requested additional documentation are shown.

Payer Allowed Response Period

On workers’ compensation claims that require attachments, payers provide a 15-day response period, during which time the provider can upload files and send them to the payer. If the provider does not respond within the 15-day response period, the claim is rejected and no longer appears in the **Work Queue Search** > “Requires Attachment” search results report.

Access Attachments Functionality

In the Claim Summary report, click the highlighted **Emdeon Claim ID** to show the Claim Detail report for the selected claim. In the far right column of the Claim Detail report, click the “Claim Attachment” link to show the workers’ compensation attachments application window.



Home > Work Queue Search > Claim Summary > Claim Detail

Claim Received Date		Tax ID	Site ID	Search Type
09/01/2011	10/17/2011	Optional	Optional	All

If no dates are entered, dates will default to last 7 days.

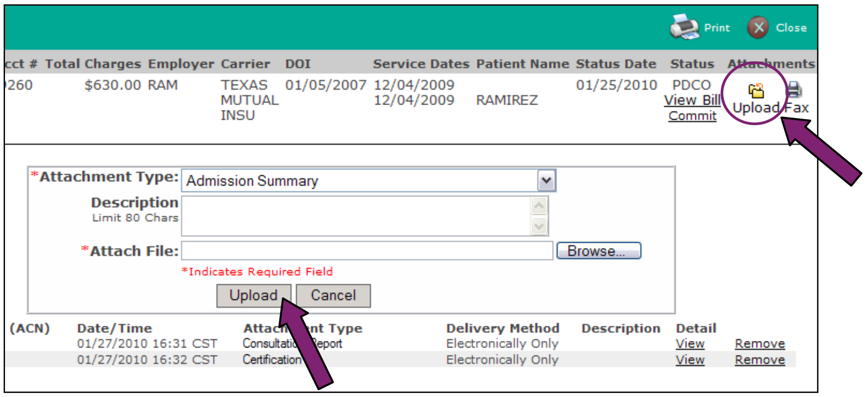
PR_1002

Claim Detail

Search Criteria: Emdeon Claim ID: EP12345DEMO00048

Insured ID	123[redacted]	**Provider Tax ID**	998[redacted]	**Claim Received Date**	09/10/2011
Patient Name	Erlan[redacted]	**Billing Provider ID**	9988[redacted]	**Emdeon File ID**	EP123FILE[redacted]
Patient DOB	05/03/1993	**Billing Provider NPI**	1998877PR6	**Emdeon Claim ID**	EP12345D[redacted]
Claim Amount	$650.00	**Site ID**	ABCD	**Payer ID**	PAY05
Service From	05/31/2011	**Patient Control No.**	PCN1[redacted]	**Worked Status**	☑
Service To	06/04/2011	**5010 Format**	No	**NPI XWalk**	XWalk Review
Payer Claim ID		**Payer Name**		**Timely Filing Letter**	Display Letter
				Attachments	Claim Attachment

Workers' compensation attachments window within Reporting & Analytics:



cct #	Total Charges	Employer	Carrier	DOI	Service Dates	Patient Name	Status Date	Status	Attachments
260	$630.00	RAM	TEXAS MUTUAL INSU	01/05/2007	12/04/2009 12/04/2009	RAMIREZ	01/25/2010	PDCO View Bill Commit	Upload Fax

*Attachment Type: Admission Summary

Description
Limit 80 Chars

*Attach File:

*Indicates Required Field

(ACN)	Date/Time	Attachment Type	Delivery Method	Description	Detail	
	01/27/2010 16:31 CST	Consultation Report	Electronically Only		View	Remove
	01/27/2010 16:32 CST	Certification	Electronically Only		View	Remove

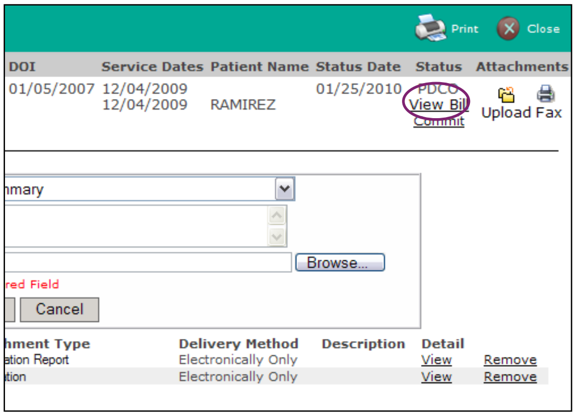
Click the **Upload** button at the upper right to show the Upload fields. Click the **Upload** button directly beneath the **Attach File** field for each attachment to add to the bill. After all files are uploaded, click the "Commit" link to send your bill and files to the payer for review.

Use the Workers' Compensation Attachments Interface

58. Click the "Claim Attachment" link in the Claim Detail report. The workers' compensation claim attachment window appears.
59. To view an attachment, click the applicable "View" link. A graphic or PDF viewer appears.
60. Click the **Print** button to print a summary view. You can print uploaded files directly from the View window.
61. Click **Upload** in the upper right corner to show the file upload window. Only PDF and TIFF format files can be uploaded.

    - Click **Browse** to locate the file to upload.
    - Select an attachment type from the **Attachment Type** drop-down list (required field).
    - Enter a description of the file (optional field).
    - Click the **Upload** button to upload the file. Repeat these four steps for each file to attach to the claim.

62. Status conditions:



DOI	Service Dates	Patient Name	Status Date	Status	Attachments
01/05/2007	12/04/2009 12/04/2009	RAMIREZ	01/25/2010	PDCO View Bill Commit	Upload Fax

mary

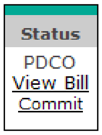
red Field

hment Type	Delivery Method	Description	Detail	
ation Report	Electronically Only		View	Remove
tion	Electronically Only		View	Remove

- PNDA – Pending Attachments. Attachments are pending to be sent to the payer.
- PDCO – Pending Commit. You can add files while bill is in this status. Click the "Commit" link to send the bill with attachments to the payer for review. Do not click "Commit" until all of your files are attached.
- PEND – All attachments and bill documents are ready to be sent to payer. This status occurs after "Commit" is clicked. This status is the condition prior to **SENT**. No action can be taken in the workers' compensation claim attachment window while in this status.
- SENT – Bill and attachments sent to payer.

***Note**: After bill and attachments are sent, the **Upload** and **Fax** buttons are removed.*

63. Fax documents so that they are correctly received by the payer.
    - If you have paper documents that you want to scan and send to the payer, click **Fax**.
    - Print the fax cover sheet, and then fax all paper documents to the payer (at the fax number shown on the fax cover sheet) with fax cover sheet as the first document in the communication. Using the fax cover sheet ensures that your faxed documents are associated to the bill.
64. You can view or remove uploaded files from the bill prior to clicking "Commit." Once committed, uploaded files cannot be removed.
65. Review the billing image created by clicking the "View Bill" link (located in the **Status** column in the upper right of the workers' compensation attachments window).



Status
PDCO View Bill Commit

66. Click "Commit" to send uploaded files to payer for review.

***Note**: You must click "Commit" to complete the bill/claim submission process. If "Commit" is not clicked, attached files are not sent to the payer, and the claim will remain in **PDCO**/Pending Commitment status.*

View and Edit Claim

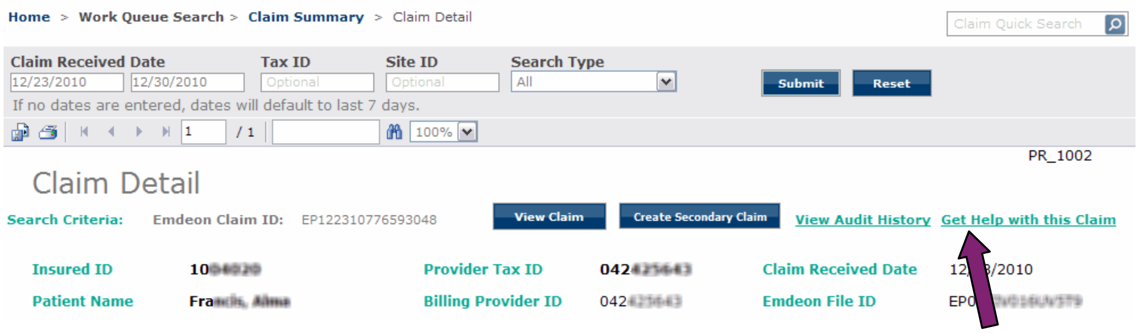
View and Edit Claims

Viewing and editing claims is a feature you can access through the Claim Detail Report. For details on how to view and edit claims, see the **View and Edit Claims** section on page 157.

"Get Help with this Claim" Link

Using the "Get Help with this Claim" link enables you to access Customer Service Alerts (CSAs) and submit a support ticket for the claim you are viewing.

67. In a Claim Detail report, click the "Get Help with this Claim" link.


Home > Work Queue Search > Claim Summary > Claim Detail
Claim Quick Search
Submit
Reset
1 / 1
100%
PR_1002
View Claim
Create Secondary Claim
View Audit History
Get Help with this Claim

Claim Received Date 12/23/2010 12/30/2010 Tax ID Optional Site ID Optional Search Type All

If no dates are entered, dates will default to last 7 days.

Claim Detail

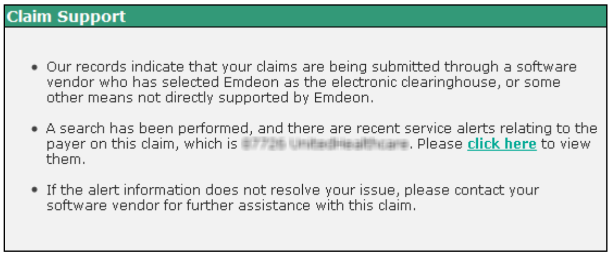
Search Criteria: Emdeon Claim ID: EP122310776593048

Insured ID	10[redacted]	Provider Tax ID	042[redacted]	Claim Received Date	12[illegible]3/2010
Patient Name	Fra[redacted]	Billing Provider ID	042[redacted]	Emdeon File ID	EP0[redacted]

68. The “Claim Support” message window appears.

    Two links may be available:

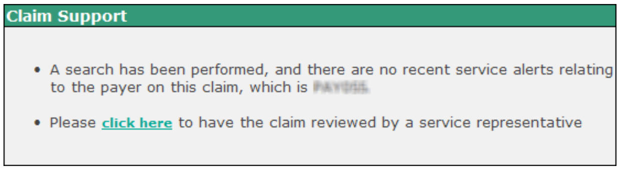
    - Customer Alerts link – If there are recent (last 30 days) Customer Service Alerts (CSAs) on the claim from the payer, a link to the CSA will appear. Hover your cursor over the CSA to view a short description. Click the link to view the CSA.



Claim Support

- Our records indicate that your claims are being submitted through a software vendor who has selected Emdeon as the electronic clearinghouse, or some other means not directly supported by Emdeon.
- A search has been performed, and there are recent service alerts relating to the payer on this claim, which is [redacted]. Please click here to view them.
- If the alert information does not resolve your issue, please contact your software vendor for further assistance with this claim.

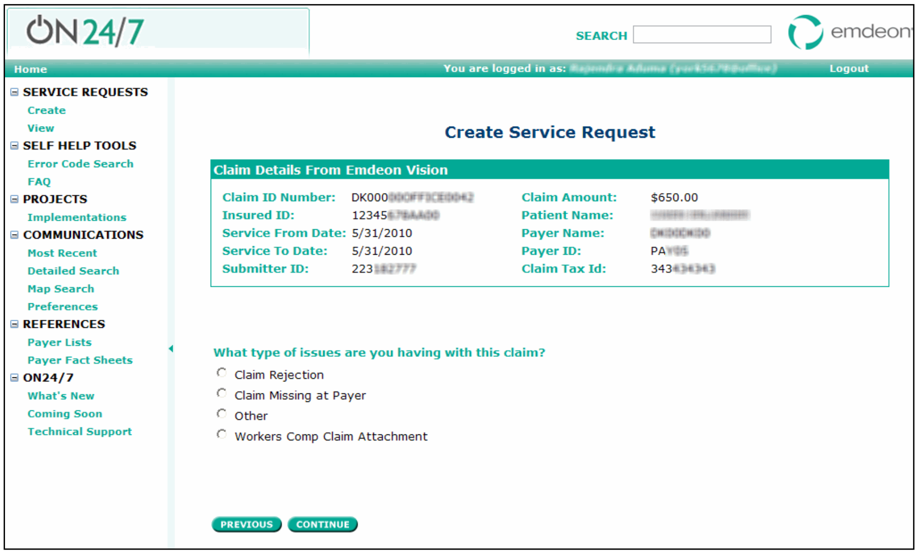
    - Service Request link – This link appears for all claims in Reporting & Analytics. Click the link to create a service request for the claim you are viewing.



Claim Support

- A search has been performed, and there are no recent service alerts relating to the payer on this claim, which is [redacted].
- Please click here to have the claim reviewed by a service representative

69. If you click the service request link, the Create Service Request form appears. The form is pre-populated with key details from the claim.


ON24/7
SEARCH
emdeon
Home
Logout
SERVICE REQUESTS
Create
View
SELF HELP TOOLS
Error Code Search
FAQ
PROJECTS
Implementations
COMMUNICATIONS
Most Recent
Detailed Search
Map Search
Preferences
REFERENCES
Payer Lists
Payer Fact Sheets
ON24/7
What's New
Coming Soon
Technical Support
PREVIOUS
CONTINUE

You are logged in as: [redacted]

Create Service Request

Claim Details From Emdeon Vision

Claim ID Number:	DK000[redacted]	Claim Amount:	$650.00
Insured ID:	12345[redacted]	Patient Name:	[redacted]
Service From Date:	5/31/2010	Payer Name:	[redacted]
Service To Date:	5/31/2010	Payer ID:	PA[redacted]
Submitter ID:	223[redacted]	Claim Tax Id:	343[redacted]

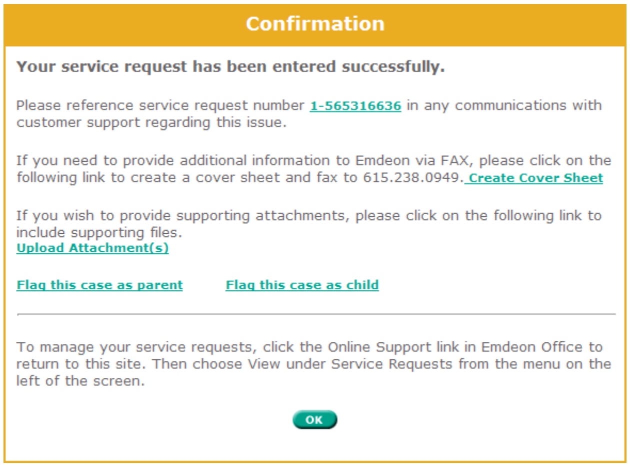
What type of issues are you having with this claim?

○ Claim Rejection
○ Claim Missing at Payer
○ Other
○ Workers Comp Claim Attachment

70. Click the option that describes the issue you are having with the claim, and then click **Continue**.
71. Enter identifying information on the pages that follow, clicking **Continue** at the bottom of each page. You will be able to review the information you entered before you submit the service request.
72. If you would like to change the information you entered, click **Start Over**.

***Note**: Clicking **Start Over** does not erase the claim information that was present when you created the service request.*

73. Click **Submit**.
74. The Confirmation window appears, where you can choose from several options or close the window by clicking **OK**.



Your service request has been entered successfully.

Please reference service request number 1-565316636 in any communications with customer support regarding this issue.

If you need to provide additional information to Emdeon via FAX, please click on the following link to create a cover sheet and fax to 615.238.0949. Create Cover Sheet

If you wish to provide supporting attachments, please click on the following link to include supporting files.
Upload Attachment(s)

Flag this case as parent   Flag this case as child

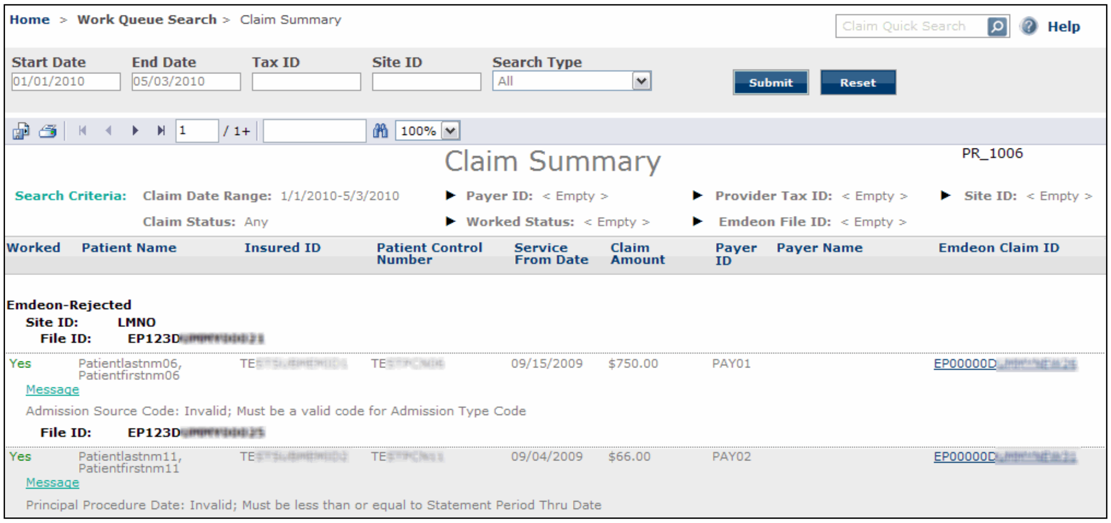
To manage your service requests, click the Online Support link in Emdeon Office to return to this site. Then choose View under Service Requests from the menu on the left of the screen.

- **Service request reference number** – Click to access details on the service request: view the request history, add a comment, add files, flag, etc.
- **Create Cover Sheet** – If you need to fax documents to Emdeon relating to the service request, click this link to open a fax cover sheet. The cover sheet is pre-populated with information that will associate the fax with the service request. Print the cover sheet and use it as the first page of the fax you send to Emdeon regarding the service request.
- **Upload Attachments** – Click to upload any standard file type up to 50 MB. You can upload only one file at a time.
- **Flag this case as parent** – If you need to link cases with related issues, click to set the service request as a parent in relation to one or more service requests. Use the search function to locate a service request, select the check box next to the service request, and then click **Save**. This will create a hierarchical linkage.
- **Flag this case as child** – If you need to link cases with related issues, click to set the service request as a child in relation to another service request. Use the search function to locate a service request, select the check box next to the service request, and then click **Save**. This will create a hierarchical linkage.

Claim Summary Report

The Claim Summary Report can be generated from several areas within Reporting & Analytics:

- Run a Work Queue search for any claim status.
- Click a link in the **Claim Received Date** column on the Summary by Payer by Day report.
- Run a Rejection Since Last Login search.
- Click a link in the **File ID** column of the File Summary report.
- Run a Quick search.
- Click on a pie chart slice, graph bar, or graph data point in the Dashboard view.



Start Date: 01/01/2010
End Date: 05/03/2010
Tax ID:
Site ID:
Search Type: All

Claim Summary

PR_1006

Search Criteria: Claim Date Range: 1/1/2010-5/3/2010 ▶ Payer ID: < Empty > ▶ Provider Tax ID: < Empty > ▶ Site ID: < Empty >
Claim Status: Any ▶ Worked Status: < Empty > ▶ Emdeon File ID: < Empty >

Worked	Patient Name	Insured ID	Patient Control Number	Service From Date	Claim Amount	Payer ID	Payer Name	Emdeon Claim ID
Emdeon-Rejected **Site ID: LMNO** **File ID: EP123D[redacted]**								
Yes	Patientlastnm06, Patientfirstnm06	TE[redacted]	TE[redacted]	09/15/2009	$750.00	PAY01		EP00000D[redacted]
Message Admission Source Code: Invalid; Must be a valid code for Admission Type Code								
File ID: EP123D[redacted]								
Yes	Patientlastnm11, Patientfirstnm11	TE[redacted]	TE[redacted]	09/04/2009	$66.00	PAY02		EP00000D[redacted]
Message Principal Procedure Date: Invalid; Must be less than or equal to Statement Period Thru Date								

Claim Summary Column Headings

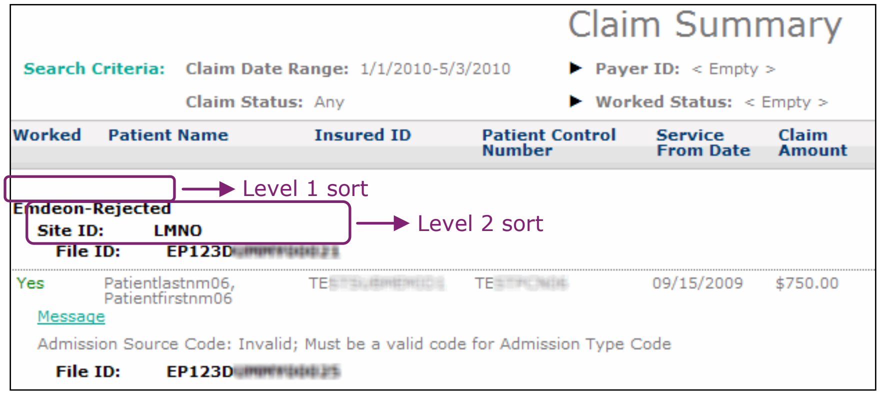
Heading	Description
Worked	"Worked" progress status; determined by the "Worked" check box in the Claim Detail report
Patient Name	Name of the patient submitted on the claim
Insured ID	Insured ID submitted on the claim
Patient Control Number	Provider's control/tracking number for patient on claim
Service From Date	Date of service
Claim Amount	Dollar amount (in US dollars) of the submitted claim
Payer ID	Payer ID submitted on the claim
Payer Name	Payer name submitted on the claim
Emdeon Claim ID	Claim ID assigned by Emdeon for the specific claim

Claim Summary Report List Order

75. Emdeon Rejected – Claims rejected by Emdeon
76. Payer Rejected – Claims rejected by the payer
77. Emdeon Accepted – Claims accepted by Emdeon but no notification from the payer received
78. Accepted – Claims accepted by payer and the claim is pending adjudication

***Note**: File ID is the second level of sorting That is, the first level is one of the four levels listed above, the second level sort is by File ID (File ID: includes both Site ID and Emdeon Batch File number, where applicable.)*

Layered sorting of Claim Summary results:



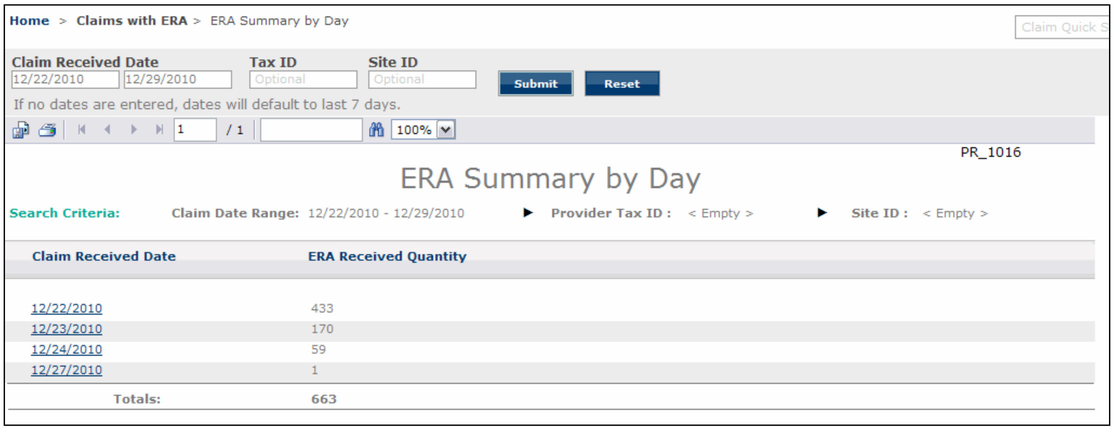
Claim Summary

Search Criteria: Claim Date Range: 1/1/2010-5/3/2010 ▶ Payer ID: < Empty >
Claim Status: Any ▶ Worked Status: < Empty >

Worked	Patient Name	Insured ID	Patient Control Number	Service From Date	Claim Amount
Emdeon-Rejected **Site ID: LMNO** **File ID: EP123D[redacted]**					
Yes	Patientlastnm06, Patientfirstnm06	TE[redacted]	TE[redacted]	09/15/2009	$750.00
Message Admission Source Code: Invalid; Must be a valid code for Admission Type Code					
File ID: EP123D[redacted]					

ERA Summary by Day Report

This report is generated from the Claims with ERA search.


Home > Claims with ERA > ERA Summary by Day
Claim Quick S
Submit
Reset
1
/ 1
100%

Claim Received Date: 12/22/2010 – 12/29/2010
Tax ID: Optional
Site ID: Optional

If no dates are entered, dates will default to last 7 days.

PR_1016

ERA Summary by Day

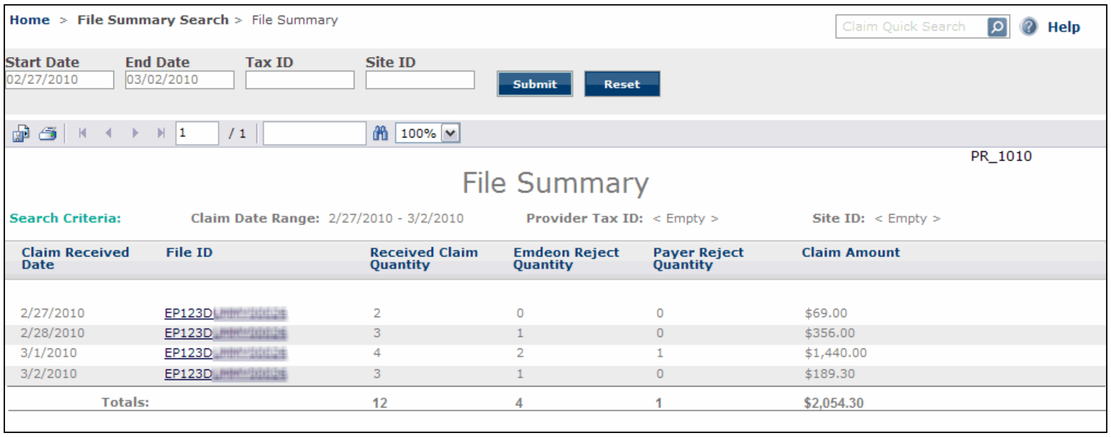
Search Criteria: **Claim Date Range:** 12/22/2010 - 12/29/2010 ► **Provider Tax ID :** < Empty > ► **Site ID :** < Empty >

Claim Received Date	ERA Received Quantity
12/22/2010	433
12/23/2010	170
12/24/2010	59
12/27/2010	1
Totals:	663

Click a link in the Claim Received Date column to view the Claim Summary Report for all claims with ERAs for the date listed, and then click the Emdeon Claim ID link to view the Claim Detail Report for that claim.

File Summary Report

The File Summary Report provides details on all claim batches submitted to the Emdeon clearinghouse during a specific date range. Each claim batch is identified by a File ID (Emdeon batch identifier).


Home > File Summary Search > File Summary
Claim Quick Search
Help
Submit
Reset
1
/ 1
100%

Start Date: 02/27/2010
End Date: 03/02/2010
Tax ID:
Site ID:

PR_1010

File Summary

Search Criteria: **Claim Date Range:** 2/27/2010 - 3/2/2010 **Provider Tax ID:** < Empty > **Site ID:** < Empty >

Claim Received Date	File ID	Received Claim Quantity	Emdeon Reject Quantity	Payer Reject Quantity	Claim Amount
2/27/2010	EP123D[redacted]	2	0	0	$69.00
2/28/2010	EP123D[redacted]	3	1	0	$356.00
3/1/2010	EP123D[redacted]	4	2	1	$1,440.00
3/2/2010	EP123D[redacted]	3	1	0	$189.30
Totals:		12	4	1	$2,054.30

File Summary Column Headings

Heading	Description
Claim Received Date	Date claim was received by Emdeon
File ID	File ID assigned by Emdeon for the electronic file in which the claim was submitted
Received Claim Quantity	Total number of claims received by Emdeon
Emdeon Reject Quantity	Number of claims rejected by Emdeon
Payer Reject Quantity	Number of claims rejected by the payer
Claim Amount	Total dollar amount of all claims received (total dollar amount for total number of claims shown in the **Received Claim Quantity** column)

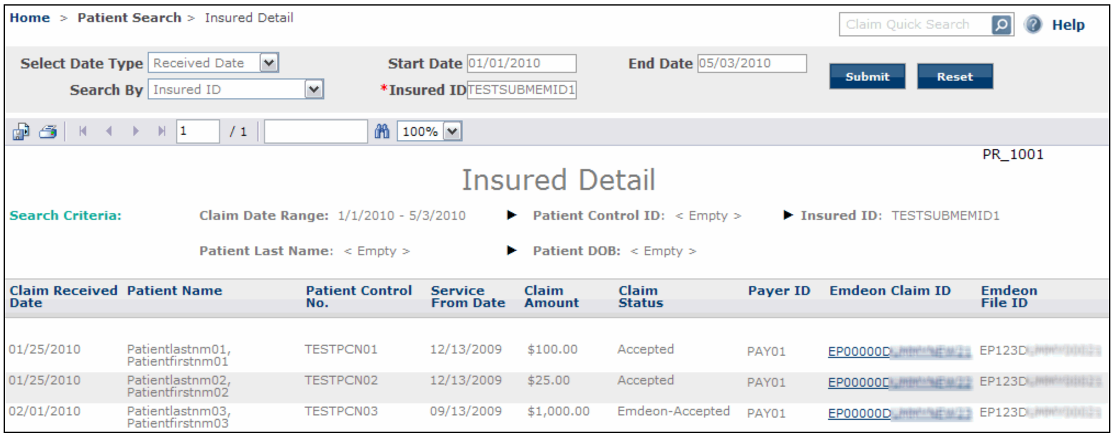
Insured Detail Report

The Insured Detail Report is displayed when you run a Patient Search.

This report provides a list of all claims for the specified patient for the date range specified in the **Claim Date Range** field.

Run a Patient Search with Insured ID

When you use Insured ID as search criteria in Patient Search the Insured Detail report displays a list of all claims for all patients (the insured party and their dependents) that are covered under the specified Insured ID (Subscriber ID) for the stated date range.



Select Date Type: Received Date
Search By: Insured ID
Start Date: 01/01/2010
End Date: 05/03/2010
*Insured ID: TESTSUBMEMID1

PR_1001

Insured Detail

Search Criteria:
Claim Date Range: 1/1/2010 - 5/3/2010
Patient Control ID: < Empty >
Insured ID: TESTSUBMEMID1
Patient Last Name: < Empty >
Patient DOB: < Empty >

Claim Received Date	Patient Name	Patient Control No.	Service From Date	Claim Amount	Claim Status	Payer ID	Emdeon Claim ID	Emdeon File ID
01/25/2010	Patientlastnm01, Patientfirstnm01	TESTPCN01	12/13/2009	$100.00	Accepted	PAY01	EP00000D[redacted]	EP123D[redacted]
01/25/2010	Patientlastnm02, Patientfirstnm02	TESTPCN02	12/13/2009	$25.00	Accepted	PAY01	EP00000D[redacted]	EP123D[redacted]
02/01/2010	Patientlastnm03, Patientfirstnm03	TESTPCN03	09/13/2009	$1,000.00	Emdeon-Accepted	PAY01	EP00000D[redacted]	EP123D[redacted]

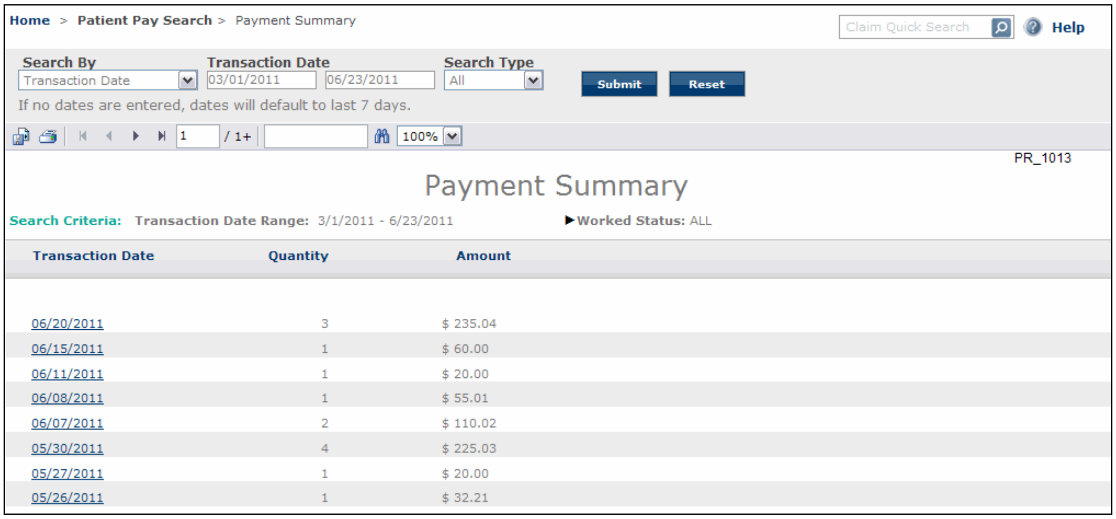
Click the highlighted “Emdeon Claim ID” to view Claim Detail report for the selected claim.

Insured Detail Column Headings

Heading	Description
Claim Received Date	Date claim was received by Emdeon or payer
Patient Name	Name of the patient submitted on the claim
Patient Control No.	Insured ID submitted on the claim
Service From Date	Date of service submitted on the claim
Claim Amount	Dollar amount of the submitted claim
Claim Status	Current claim status with Emdeon or payer
Payer ID	Payer ID submitted on the claim
Payer Name	Payer Name submitted on the claim
Emdeon Claim ID	Claim ID assigned by Emdeon for the specific claim
Emdeon File ID	File ID assigned by Emdeon for the electronic file in which the claim was submitted

Payment Summary Report

The Payment Summary Report displays when you perform a Patient Pay Search and search by transaction date. It shows patient payments made through Patient Pay Online for a specified date range and worked status. Click the date link in the Transaction Date column to display a Patient Payment Summary by Day Report for the date you selected.



Search By: Transaction Date
Transaction Date: 03/01/2011 06/23/2011
Search Type: All

If no dates are entered, dates will default to last 7 days.

1 / 1+

PR_1013

Payment Summary

Search Criteria: Transaction Date Range: 3/1/2011 - 6/23/2011 ▶Worked Status: ALL

Transaction Date	Quantity	Amount
06/20/2011	3	$ 235.04
06/15/2011	1	$ 60.00
06/11/2011	1	$ 20.00
06/08/2011	1	$ 55.01
06/07/2011	2	$ 110.02
05/30/2011	4	$ 225.03
05/27/2011	1	$ 20.00
05/26/2011	1	$ 32.21

Payment Summary Report Column Headings

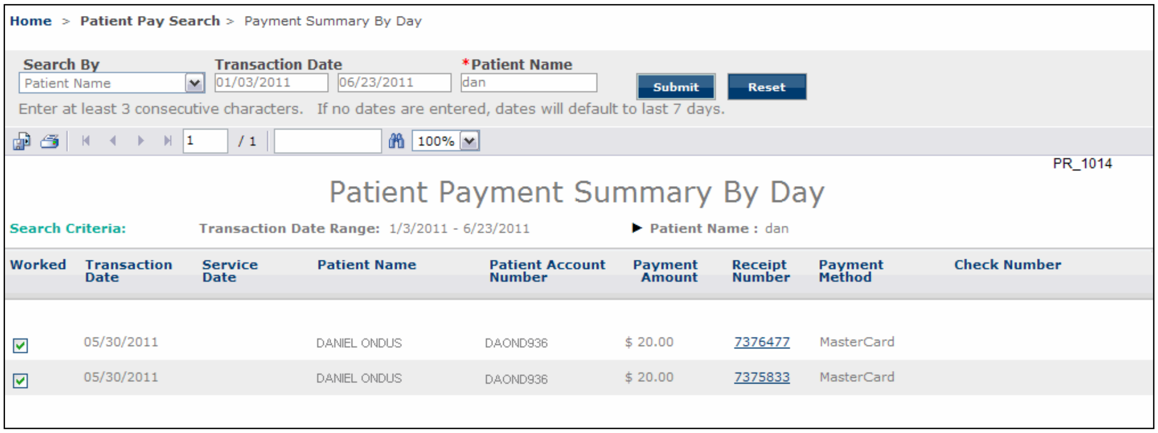
Heading	Description
Transaction Date	Date that the payment was made. Click the link to view the Payment Summary by Day Report for the date you selected.
Quantity	Number of payments made on the specified transaction date.
Amount	Total amount of all payments made on the specified transaction date.

Patient Payment Summary by Day Report

The Patient Payment Summary by Day Report displays when you perform a Patient Pay Search and search by patient name or patient account number as well as when you click a transaction date link on the Payment Summary Report.

Search by Patient Name or Patient Account Number

When you perform a Patient Pay Search and search by patient name or patient account number, the report will show the same patient name or patient account number for the transaction date range you selected.



Search By: Patient Name
Transaction Date: 01/03/2011 06/23/2011
*Patient Name: dan

Enter at least 3 consecutive characters. If no dates are entered, dates will default to last 7 days.

1 / 1

PR_1014

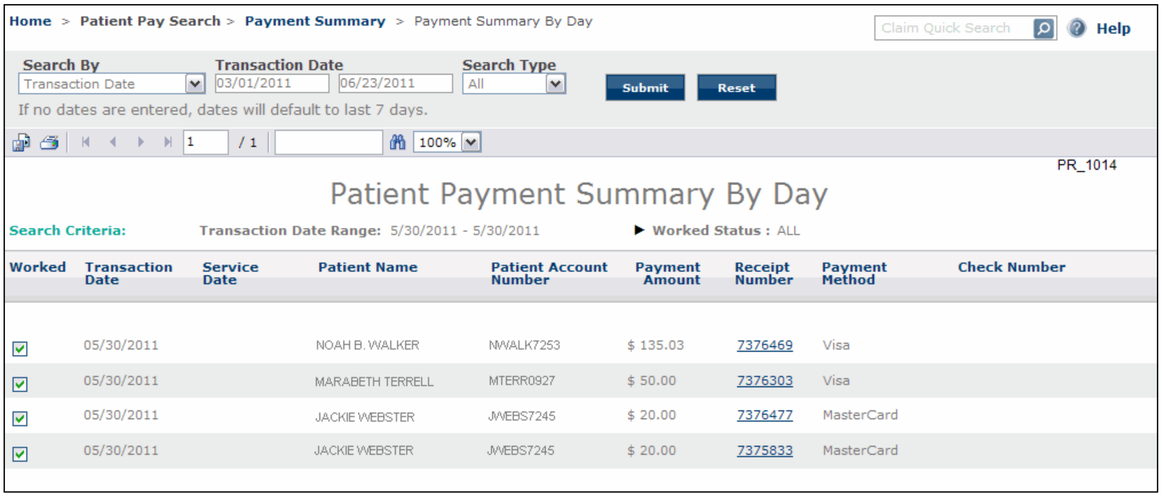
Patient Payment Summary By Day

Search Criteria: Transaction Date Range: 1/3/2011 - 6/23/2011 ▶ Patient Name : dan

Worked	Transaction Date	Service Date	Patient Name	Patient Account Number	Payment Amount	Receipt Number	Payment Method	Check Number
☑	05/30/2011		DANIEL ONDUS	DAOND936	$ 20.00	7376477	MasterCard	
☑	05/30/2011		DANIEL ONDUS	DAOND936	$ 20.00	7375833	MasterCard	

Click a Transaction Date Link

When you click a transaction date link on the Payment Summary Report, the Patient Payment Summary by Day Report shows payments for all patient names and patient account numbers for the transaction date range you selected.


Home > Patient Pay Search > Payment Summary > Payment Summary By Day
Claim Quick Search
Help
Submit
Reset
PR_1014

Search By: Transaction Date
Transaction Date: 03/01/2011 06/23/2011
Search Type: All
If no dates are entered, dates will default to last 7 days.

1 / 1 100%

Patient Payment Summary By Day

Search Criteria: Transaction Date Range: 5/30/2011 - 5/30/2011 ▶ Worked Status : ALL

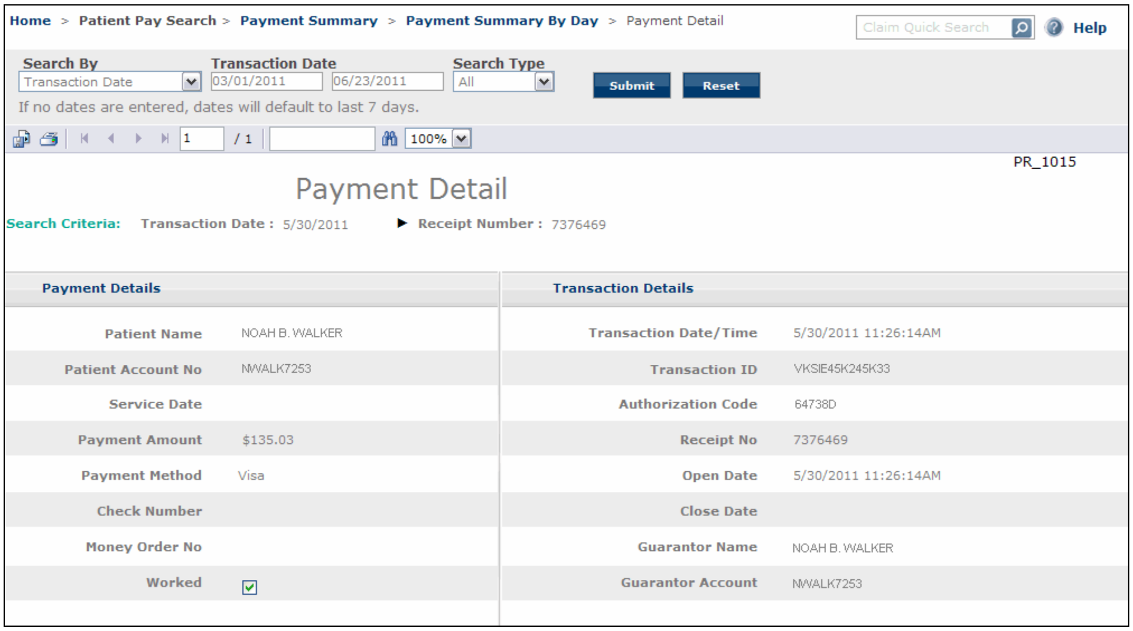
Worked	Transaction Date	Service Date	Patient Name	Patient Account Number	Payment Amount	Receipt Number	Payment Method	Check Number
☑	05/30/2011		NOAH B. WALKER	NWALK7253	$ 135.03	7376469	Visa	
☑	05/30/2011		MARABETH TERRELL	MTERR0927	$ 50.00	7376303	Visa	
☑	05/30/2011		JACKIE WEBSTER	JWEBS7245	$ 20.00	7376477	MasterCard	
☑	05/30/2011		JACKIE WEBSTER	JWEBS7245	$ 20.00	7375833	MasterCard	

Patient Payment Summary by Day Report Column Headings

Heading	Description
Worked	If there is a check in the check box, the payment is worked. If there is not a check in the check box, the payment is un-worked.
Transaction Date	Date that the payment was made
Service Date	Reserved for future use
Patient Name	Name of the patient who received the healthcare treatment the payment was made for
Patient Account Number	Provider account number for the patient
Payment Amount	Amount included in payment
Receipt Number	Unique receipt number of the transaction. Click the link to view the Payment Detail report for the specified payment.
Payment Method	Type of card used in the payment (Visa, MasterCard, Discover, or American Express)
Check Number	Reserved for future use

Payment Detail Report

The Payment Detail Report displays when you click a date link in the **Receipt Number** column on the Patient Payment Summary by Day Report. The report shows the payment and transaction details for the transaction you selected.


Home > Patient Pay Search > Payment Summary > Payment Summary By Day > Payment Detail
Claim Quick Search
Help
Submit
Reset
1 / 1
100%
PR_1015

Search By: Transaction Date
Transaction Date: 03/01/2011 06/23/2011
Search Type: All

If no dates are entered, dates will default to last 7 days.

Payment Detail

Search Criteria: Transaction Date : 5/30/2011 ▶ Receipt Number : 7376469

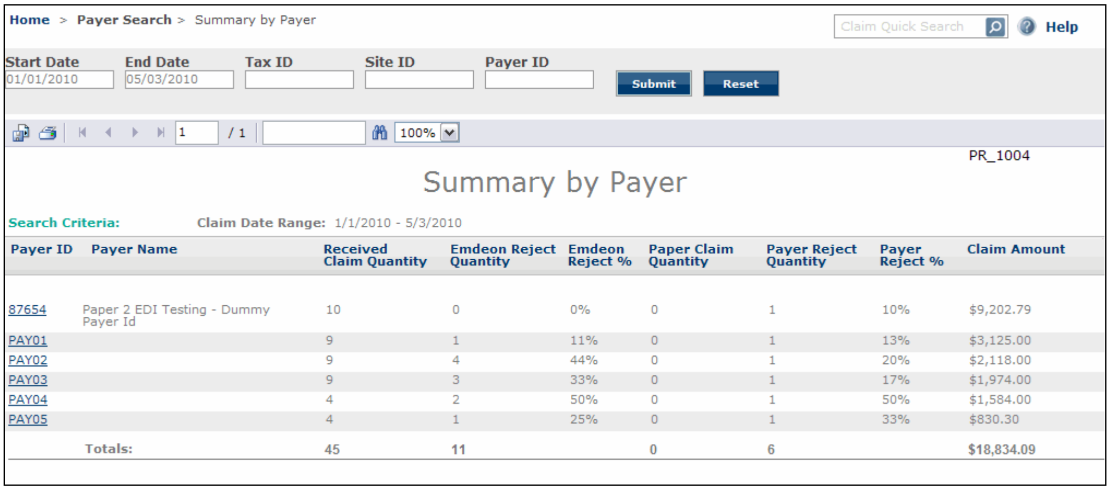
Payment Details		Transaction Details	
Patient Name	NOAH B. WALKER	Transaction Date/Time	5/30/2011 11:26:14AM
Patient Account No	NWALK7253	Transaction ID	VKSIE45K245K33
Service Date		Authorization Code	64738D
Payment Amount	$135.03	Receipt No	7376469
Payment Method	Visa	Open Date	5/30/2011 11:26:14AM
Check Number		Close Date	
Money Order No		Guarantor Name	NOAH B. WALKER
Worked	☑	Guarantor Account	NWALK7253

Payment Detail Report Rows

Heading	Description
Payment Details Column	
Patient Name	Name of the patient
Patient Account No	Provider account number for the patient
Service Date	Reserved for future use
Payment Amount	Amount of the payment
Payment Method	Type of card used in the payment
Check Number	Reserved for future use
Money Order No	Reserved for future use
Worked	If there is a check in the check box, the payment is worked. If there is not a check in the check box, the payment is un-worked.
Transaction Details Column	
Transaction Date/Time	Date and time of the payment
Transaction ID	Unique transaction identifier (assigned by system)
Authorization Code	Card authorization code (assigned by system)
Receipt No	Unique receipt number (assigned by system)
Open Date	Date and time the transaction started
Close Date	Reserved for future use
Guarantor Name	Name of the person making payment
Guarantor Account	Account number of the person making payment

Summary by Payer Report

The Summary by Payer Report is displayed when you perform a Payer Search without specifying a Payer ID. The report includes a claim summary for each payer (sorted by Payer ID).



Start Date: 01/01/2010
End Date: 05/03/2010
Tax ID:
Site ID:
Payer ID:

PR_1004

Summary by Payer

Search Criteria: Claim Date Range: 1/1/2010 - 5/3/2010

Payer ID	Payer Name	Received Claim Quantity	Emdeon Reject Quantity	Emdeon Reject %	Paper Claim Quantity	Payer Reject Quantity	Payer Reject %	Claim Amount
87654	Paper 2 EDI Testing - Dummy Payer Id	10	0	0%	0	1	10%	$9,202.79
PAY01		9	1	11%	0	1	13%	$3,125.00
PAY02		9	4	44%	0	1	20%	$2,118.00
PAY03		9	3	33%	0	1	17%	$1,974.00
PAY04		4	2	50%	0	1	50%	$1,584.00
PAY05		4	1	25%	0	1	33%	$830.30
	Totals:	45	11		0	6		$18,834.09

Summary by Payer Column Headings

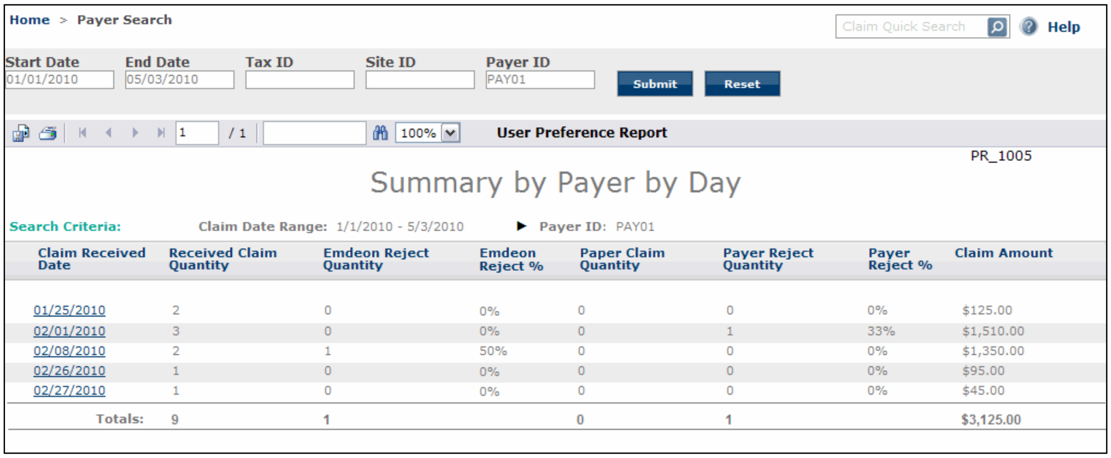
Heading	Description
Payer ID	5-character alphanumeric string; ID number of payers that had claims received by Emdeon during the specified date range. Click the highlighted date link to view the Summary by Payer by Day report for the selected Payer ID.
Payer Name	Name of payer organization
Received Claim Quantity	Total number of claims received by Emdeon. Number of claims received by Emdeon during the specified date range from the payer. Click the link in the **Payer ID** field to view details of these claims in the Summary by Payer by Day report.
Emdeon Reject Quantity	Number of claims rejected by Emdeon from the number received
Emdeon Reject %	Percentage of claims rejected by Emdeon
Paper Claim Quantity	Number of claims printed to paper by Emdeon
Payer Reject Quantity	Number of rejected claims from among those received by Emdeon during the specified date range that were rejected by the payer specified in the **Payer ID/Payer Name** fields.
Payer Reject %	Percentage of those claims received by Emdeon that were rejected by the payer.
Claim Amount	Total amount (in US dollars) of all claims received by Emdeon for the report row. This amount includes any rejected claim amounts. The Claim Amount displayed is the totality of all Emdeon claims received from the payer for the specified date range.

Summary by Payer by Day Report

The Summary by Payer by Day report can be generated in two ways:

- Perform a Payer Search with a specified Payer ID
- Click on a Payer ID link in a Summary by Payer report

The Summary by Payer by Day report displays a summary of claims for the specified Payer ID. Each row in the report shows the total quantity of claims received by the payer for the displayed date for that row. The amount in the **Claim Amount** column is the total amount in US dollars of claims (including rejected amounts) received on the specified Claim Received Date for the specified payer ID.



Start Date: 01/01/2010
End Date: 05/03/2010
Tax ID:
Site ID:
Payer ID: PAY01

PR_1005

Summary by Payer by Day

Search Criteria: Claim Date Range: 1/1/2010 - 5/3/2010 ▶ Payer ID: PAY01

Claim Received Date	Received Claim Quantity	Emdeon Reject Quantity	Emdeon Reject %	Paper Claim Quantity	Payer Reject Quantity	Payer Reject %	Claim Amount
01/25/2010	2	0	0%	0	0	0%	$125.00
02/01/2010	3	0	0%	0	1	33%	$1,510.00
02/08/2010	2	1	50%	0	0	0%	$1,350.00
02/26/2010	1	0	0%	0	0	0%	$95.00
02/27/2010	1	0	0%	0	0	0%	$45.00
Totals:	9	1		0	1		$3,125.00

Summary by Payer by Day Column Headings

Heading	Description
Claim Received Date	This report displays a summary of all those claims received on the specific date shown per report row (per specified payer). Click the highlighted date to view details for each claim received on the claim received date. That is, if the number displayed in the **Claim Received Date** column is 12, then 12 claims are displayed in the resulting report.
Received Claim Quantity	Number of claims that were received on the Claim Received Date. Note: When you click the Claim Received Date link those claims that are specified in the **Received Claim Quantity** field are displayed.
Emdeon Reject Quantity	Number of claims (from those that were received on the claim received date) that were rejected by Emdeon
Emdeon Reject %	Percentage of claims (from those that were received on the claim received date) that were rejected by Emdeon
Paper Claim Quantity	Number of claims received in paper format (rather than electronically) from among those claims in the Claim Received Date number.
Payer Reject Quantity	Number of claims rejected by the specified payer from among those claims in the Claim Received Date number.
Payer Reject %	Percentage of claims rejected by the specified payer from among those claims in the Claim Received Date number.
Claim Amount	Total amount in US dollars of claims (including rejected amounts) received on the specified Claim Received Date for the specified payer ID.

View and Edit Claims

Overview

You can correct and refile claims from within Reporting & Analytics. You can review all the fields of a primary or secondary claim, correct errors that may have caused the claim to be rejected, and re-submit the updated claim to the payer.

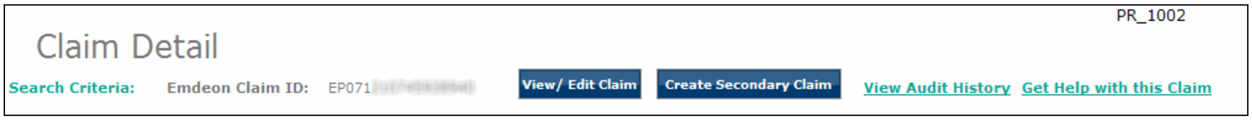
You can also create secondary claims when the primary claim has been partially paid and you want to obtain payment from an additional payer for unpaid amounts. You can only create a secondary claim from a primary claim.

Information displayed in the claim editor is always specific to the claim you access in Reporting & Analytics.

***Note**: Claim viewing and editing may not be available to all Emdeon Office users. If these services are not available to you, contact customer service for information on how to upgrade your account.*

View/Edit Permissions

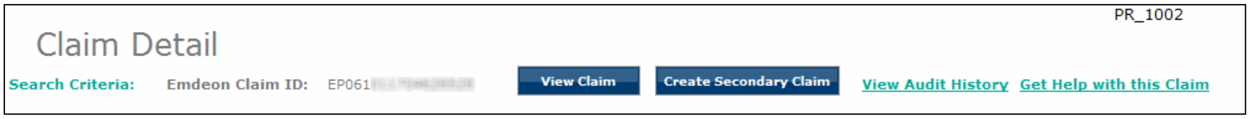
If you can see the **View/Edit Claim** button, you can view, correct, and refile claims.



Claim Detail

Search Criteria: Emdeon Claim ID: EP071[redacted]

If you can see the **View Claim** button, you can only view claims; you cannot correct or refile a claim. You must upgrade your account to be able to correct and refile claims.



Claim Detail

Search Criteria: Emdeon Claim ID: EP061[redacted]

Primary, Secondary, and Tertiary Claims

Primary Claims

You can correct and refile primary claims, and you can create a secondary claim from a primary claim.

Secondary Claims

You can correct and refile secondary claims, and you can create a secondary claim from a primary claim.

A claim is considered a secondary claim when the following conditions are true:

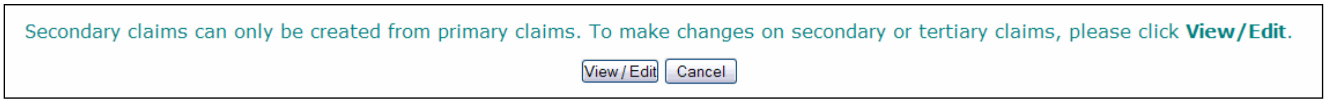
The claim has **Claim Adjudication** and **Claim Line Adjudication** tabs (see the **Secondary and Tertiary Claim** Tabs section on page 163)

and

The **Sequence** field is populated with “Secondary” on the **Payer/Billing Provider** tab in the Payer Information section.

Tertiary Claims

Currently, you can only correct and refile tertiary claims; you cannot create tertiary claims from secondary claims. If you click **Create Secondary Claim** on a secondary claim, this message appears:



Secondary claims can only be created from primary claims. To make changes on secondary or tertiary claims, please click **View/Edit**.

There is an additional limitation to tertiary claims: there is no indicator that shows whether the payer information in the **Other Insurance** tab and the claim adjudication information are from the primary or secondary claim. You can effectively view and edit only the current destination payer information.

A claim is considered a tertiary claim when the following conditions are true:

The claim has **Claim Adjudication** and **Claim Line Adjudication** tabs (see the **Secondary and Tertiary Claim** Tabs section on page 163)

and

The **Sequence** field is populated with “Tertiary” on the **Payer/Billing Provider** tab in the Payer Information section.

Limitations

Refile Date

Claims with a Receipt Date prior to 6/01/2010 are not available for viewing or correcting in Reporting & Analytics. If the claim you are trying to view in Reporting & Analytics has a Receipt Date prior to

6/01/2010, an error message appears when you click **View/Edit Claim**, **View Claim**, or **Create Secondary Claim**.

Claim Output Format

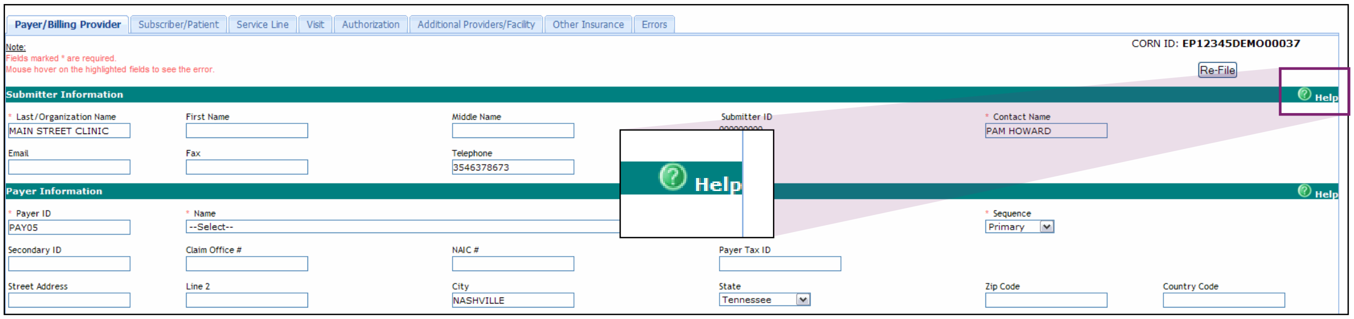
Claim viewing and editing is only available if you submit claims in ANSI X12 4010 or NSF+ output format. Many Emdeon Office users create claims in formats other than ANSI X12 4010 or NSF+ (for example, NSF2.5), but their accounts are set up so that the claims are converted to ANSI X12 4010 or NSF+; these users will be able to view and edit claims. If you do not know what the submission format of your claims is, you can find out by clicking the **View/Edit Claim**, **View Claim**, or **Create Secondary Claim** buttons on a Claim Detail Report. If a format-related error is displayed—such as "Only professional claims submitted in the ANSI 837 version 4010 format can be viewed or edited at this time"—you cannot view or edit claims. If you want to upgrade your claim format, contact customer service.

Non-Use Timeout

If you have Reporting & Analytics open but do not perform any actions for 15 minutes, your session will time out and you will lose your changes.

Context-Sensitive Help

A comprehensive, context-sensitive help reference is available for each section on all tabs. Click the "Help" link in the far right of the section header to open the Help window. Each Help window contains information specific to that section.



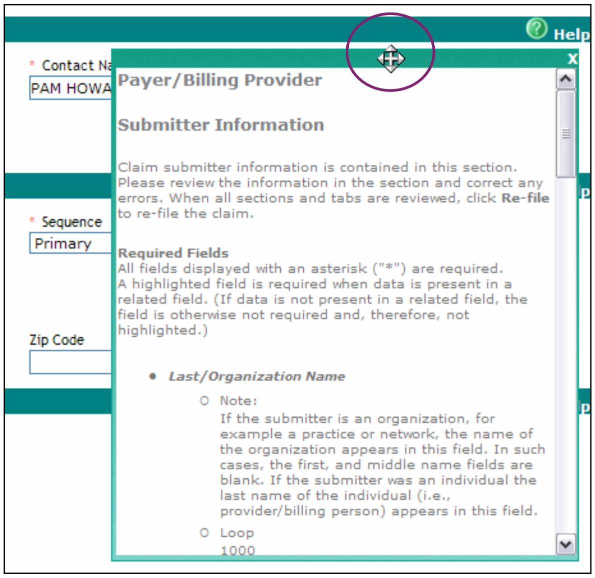
Note:
Fields marked * are required.
Mouse hover on the highlighted fields to see the error.

CORN ID: **EP12345DEMO00037**

* Last/Organization Name: MAIN STREET CLINIC
First Name:
Middle Name:
Submitter ID:
* Contact Name: PAM HOWARD
Email:
Fax:
Telephone: 3546378673

* Payer ID: PAY05
* Name: --Select--
* Sequence: Primary
Secondary ID:
Claim Office #:
NAIC #:
Payer Tax ID:
Street Address:
Line 2:
City: NASHVILLE
State: Tennessee
Zip Code:
Country Code:

To move the Help window, click and drag the header bar of the window.



Payer/Billing Provider

Submitter Information

Claim submitter information is contained in this section. Please review the information in the section and correct any errors. When all sections and tabs are reviewed, click **Re-file** to re-file the claim.

Required Fields
All fields displayed with an asterisk ("*") are required. A highlighted field is required when data is present in a related field. (If data is not present in a related field, the field is otherwise not required and, therefore, not highlighted.)

- ***Last/Organization Name***
  - Note:
    If the submitter is an organization, for example a practice or network, the name of the organization appears in this field. In such cases, the first, and middle name fields are blank. If the submitter was an individual the last name of the individual (i.e., provider/billing person) appears in this field.
  - Loop
    1000

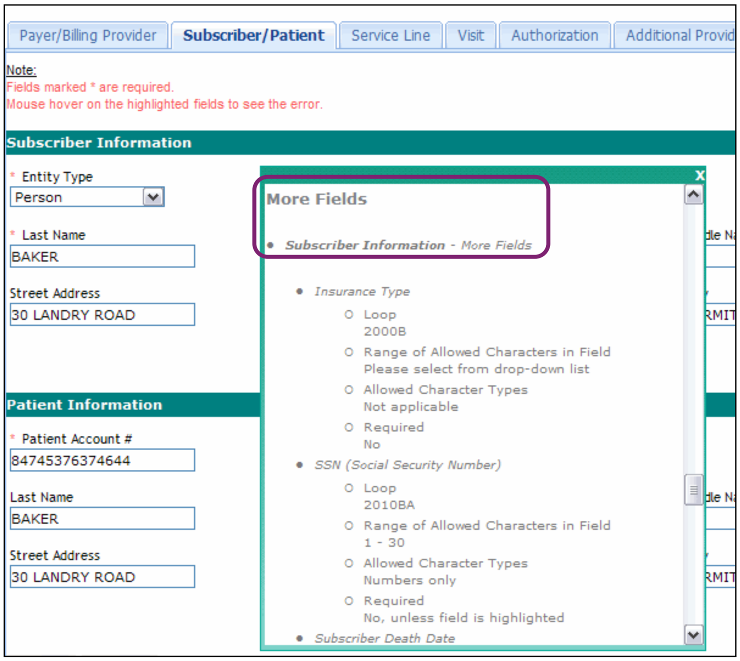
Field-Level Help

Click the "Help" link, and then scroll down to the field name. Field-level help information can include the following:

- **Note** – Any pertinent additional information about the field (for example, alternative name, situational requirements, etc.)
- **Loop** – Name and location of the ANSI X12 field that will carry this content. The loop and field names are frequently referenced in rejection and error messages.
- **Drop-down list** – List and/or description of values in the drop-down list
- **Range of Allowed Characters in Field** – Minimum/maximum number of characters allowed in the field
- **Allowed Character Types** – Type of character(s) allowed in the field (for example, letters, numbers, spaces, etc.)
- **Required** – "Yes" if the field is required; "No" if the field is not required. Situational requirements are explained if applicable.

Sub-Window Help

If the sub-window that opens when you click a **More** or **More Fields** button does not have a "Help" link, refer to the help from the section that the **More** or **More Fields** sub-window was launched from.



Note:
Fields marked * are required.
Mouse hover on the highlighted fields to see the error.

Subscriber Information

* Entity Type: Person
* Last Name: BAKER
Street Address: 30 LANDRY ROAD

Patient Information

* Patient Account #: 84745376374644
Last Name: BAKER
Street Address: 30 LANDRY ROAD

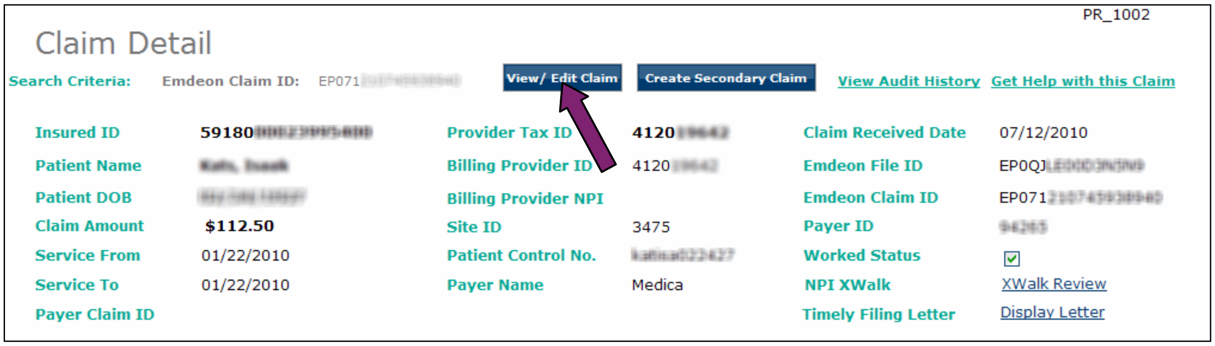
More Fields

- *Subscriber Information - More Fields*
  - *Insurance Type*
    - Loop
      2000B
    - Range of Allowed Characters in Field
      Please select from drop-down list
    - Allowed Character Types
      Not applicable
    - Required
      No
  - *SSN (Social Security Number)*
    - Loop
      2010BA
    - Range of Allowed Characters in Field
      1 - 30
    - Allowed Character Types
      Numbers only
    - Required
      No, unless field is highlighted
  - *Subscriber Death Date*

Access Claim Viewing and Editing

Follow these steps to access claim viewing and editing:

1. Select **Claims** > **Reporting & Analytics** from the main menu.
2. Search for and open the Claim Detail Report of the claim you want to use. (See the **Claim Data Searches** section on page 101 for details on search types.)
3. Click the **View/Edit Claim** button.



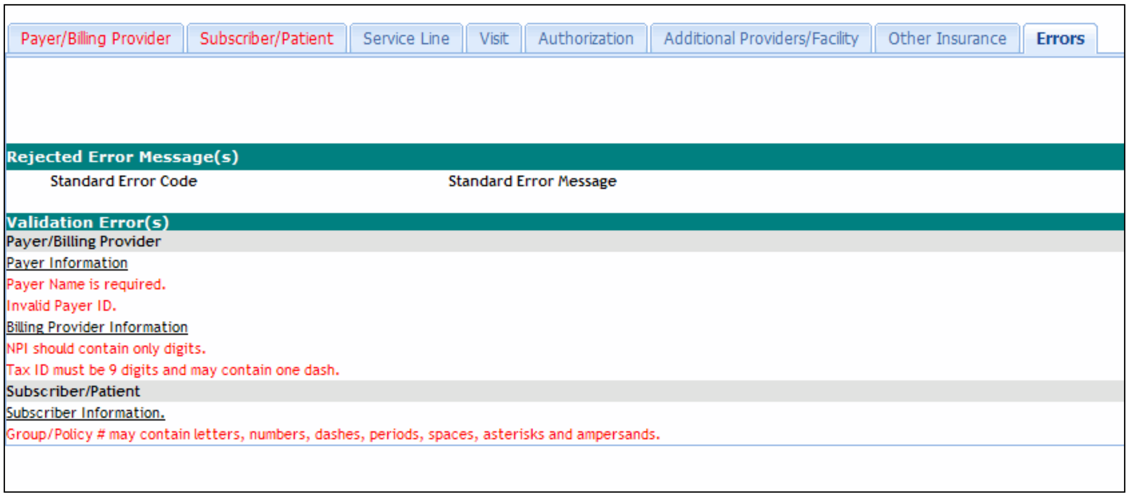
PR_1002

Claim Detail

Search Criteria: Emdeon Claim ID: EP071[redacted]

Insured ID	59180[redacted]	Provider Tax ID	4120[redacted]	Claim Received Date	07/12/2010
Patient Name	[redacted]	Billing Provider ID	4120[redacted]	Emdeon File ID	EP0QJ[redacted]
Patient DOB	[redacted]	Billing Provider NPI		Emdeon Claim ID	EP071[redacted]
Claim Amount	$112.50	Site ID	3475	Payer ID	[redacted]
Service From	01/22/2010	Patient Control No.	[redacted]	Worked Status	☑
Service To	01/22/2010	Payer Name	Medica	NPI XWalk	XWalk Review
Payer Claim ID				Timely Filing Letter	Display Letter

4. The claim opens in a new window, with the **Errors** tab selected.


Payer/Billing Provider
Subscriber/Patient
Service Line
Visit
Authorization
Additional Providers/Facility
Other Insurance
Errors

Rejected Error Message(s)

Standard Error Code	Standard Error Message

Validation Error(s)

Payer/Billing Provider

Payer Information

Payer Name is required.

Invalid Payer ID.

Billing Provider Information

NPI should contain only digits.

Tax ID must be 9 digits and may contain one dash.

Subscriber/Patient

Subscriber Information.

Group/Policy # may contain letters, numbers, dashes, periods, spaces, asterisks and ampersands.

Navigation

Tabs and Sections

Main Tabs

There are eight main tabs. Each tab is a component of the claim form. Tabs are organized into sections, and some tabs have sub-windows with additional tabs. You can view a new tab at any time by clicking the tab at the top of the window.

Payer/Billing Provider
Subscriber/Patient
Service Line
Visit
Authorization
Additional Providers/Facility
Other Insurance
Errors

Before you submit a claim, you must make all of the required changes on every tab. The changes you make on one tab will be retained when you click another tab, but there is no way to save the claim as a work in progress if you close the claim editor window or allow your session to time out.

***Note**: If you close the main window without clicking **Refile** or **Submit**, all of your changes will be lost.*

The following is a list of the main tabs and their sections:

Payer/Billing Provider

- Submitter Information
- Payer Information
- Billing Provider Information
- Pay-To Provider

Subscriber/Patient

- Subscriber Information
    - More Fields – Subscriber Information
- Patient Information
    - More Fields – Patient Information

Service Line

- Diagnosis Codes
- Claim Line Information
    - More – see
    - **Service Line Tab's Claim Line More** Button section on page 162

Visit

- Occurrence Date and Details
- Ambulance Information
- Spinal Manipulation Services
- Vision Services

Authorization

- Release Information
- Reference Information

Additional Providers/Facility

- Facility/Location Information
- Rendering Provider
- Referring Provider
- Supervising Provider
- Purchased Service Provider

Other Insurance

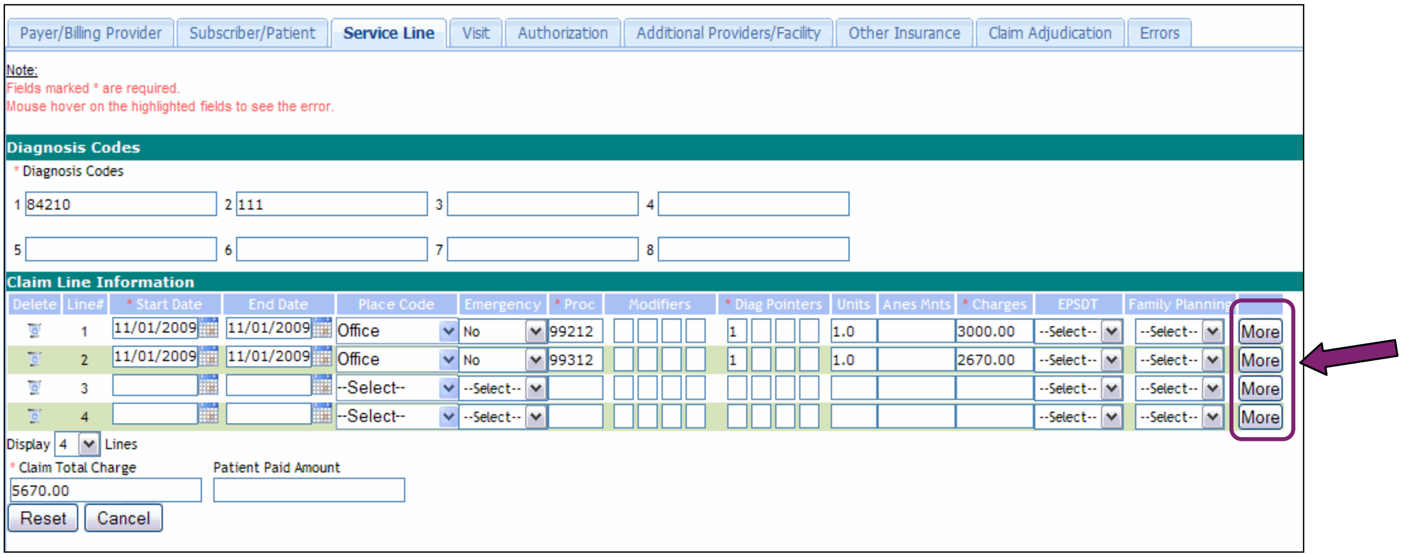
- Other Subscriber
- Other Payer Release
- Other Payer

Errors

- Rejected Error Message(s)
- Validation Errors

Service Line Tab's Claim Line More Button

The **Service Line** tab includes a **More** button for each claim line.


Payer/Billing Provider
Subscriber/Patient
Service Line
Visit
Authorization
Additional Providers/Facility
Other Insurance
Claim Adjudication
Errors
More
Reset
Cancel

Note:
Fields marked * are required.
Mouse hover on the highlighted fields to see the error.

Diagnosis Codes

* Diagnosis Codes

1 84210
2 111
3
4
5
6
7
8

Claim Line Information

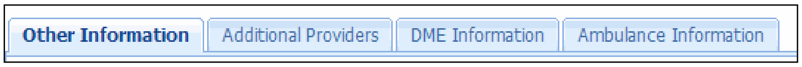
Delete	Line#	* Start Date	End Date	Place Code	Emergency	* Proc	Modifiers	* Diag Pointers	Units	Anes Mnts	* Charges	EPSDT	Family Planning	
	1	11/01/2009	11/01/2009	Office	No	99212		1	1.0		3000.00	--Select--	--Select--	More
	2	11/01/2009	11/01/2009	Office	No	99312		1	1.0		2670.00	--Select--	--Select--	More
	3			--Select--	--Select--							--Select--	--Select--	More
	4			--Select--	--Select--							--Select--	--Select--	More

Display 4 Lines

* Claim Total Charge: 5670.00

Patient Paid Amount:

Click the **More** button on each claim line that requires additional information. A separate sub-window with additional tabs opens.


Other Information
Additional Providers
DME Information
Ambulance Information

The information entered in this sub-window refers only to the specific claim line that the **More** button was clicked from.

The following is a list of the **More** Claim Line Information sub-window tabs and sections:

Other Information (Claim Line)

- Other Information
- Occurrence Dates
- Prescription and Purchase Service Details
- Line Supplemental Information

Additional Providers (Claim Line)

- Facility Information
- Referring Provider
- Rendering Provider
- Supervising Provider
- Ordering Provider
- Purchased Service Provider

DME Information (Claim Line)

- DME Information

Ambulance Information (Claim Line)

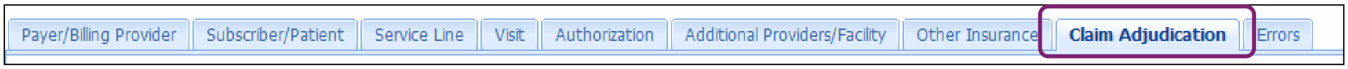
- Ambulance Information

Secondary and Tertiary Claim Tabs

A secondary or tertiary claim contains all the tabs (and data) from the primary claim, with the addition of two tabs:

Claim Adjudication

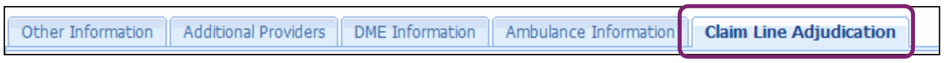
- Claim Adjudication
- Claim Adjustment
- Medicare Outpatient Adjudication
- Prior Payer Authorization
- Prior Payer Provider Identifiers


Payer/Billing Provider
Subscriber/Patient
Service Line
Visit
Authorization
Additional Providers/Facility
Other Insurance
Claim Adjudication
Errors

Claim Line Adjudication

This tab is within the **Service Line** tab. To view this tab, select the **Service Line** tab, click the **More** button, and then select the **Claim Line Adjudication** tab.

- Claim Line Adjudication
- Claim Line Adjustment


Other Information
Additional Providers
DME Information
Ambulance Information
Claim Line Adjudication

Buttons

Done

Click the **Done** button in a sub-window to save any changes that you have made in that sub-window.

Cancel

In a sub-window, click the **Cancel** button to close the sub-window without saving any changes. In a main tab, click **Cancel** to close the claim editor.

More/More Fields

Click the **More** or **More Fields** button to open a sub-window that contains additional tabs specific to a section or claim line. If you make changes in the sub-window, click **Done** to save your work.

Reset

Click the **Reset** button to remove any changes that you have made in a tab or sub-window. The fields are returned to the condition they were prior to your changes. Fields that you did not change will not be affected.

Reset does not remove any data that was in the claim when you opened the claim. **Reset** affects only the edited data in the tab or sub-window in which you click the **Reset** button.

Refile

Click the **Refile** button only after you correct as many errors as possible. Once you click **Refile**, the payer will receive the claim in one business day (if the claim is not rejected at the Emdeon clearinghouse). For information on how to correct errors before refiling, see the **Correct a Claim** section on page 164.

Submit

If you create a secondary claim from a primary claim, the **Submit** button appears instead of the **Refile** button. Click the **Submit** button only after you have supplied all the necessary information and corrected any errors that may exist. Once you click **Submit**, the payer will receive the claim in one business day (if the claim is not rejected at the Emdeon clearinghouse). For information on how to correct errors before submitting, see the **Correct a Claim** section on page 164.

Save Changes in a Sub-Window

Because changes in sub-windows are not automatically saved, click the **Done** button to save any changes that you make in a sub-window. If you close a sub-window without clicking **Done**, all of your changes will be lost.

Correct a Claim

Review and correct all errors (or as many as possible) before you refile or submit a claim. If you refile or submit a claim without correcting errors, the claim may be rejected by the payer. However, you may refile or submit a claim even if all errors have not been corrected. (Refiling or submitting a claim with errors is permitted because payers have different data requirements; some payers may disregard certain errors.)

***Note**: If you have the claim editor open but do not perform any actions for 15 minutes, your session will time out and you will lose your changes.*

Validation and Rejection

There are three distinct levels of validation that occur at different stages in the claim submission process:

1. In real time, claim fields are validated based on standard industry guidelines. For each error detected, an error is displayed in the Validation Error(s) section of the **Errors** tab. You can refile or submit a claim even if the claim has validation errors. (See the **Validation Error(s)** section on page 166.)
2. After you refile or submit a claim, the Emdeon clearinghouse validates the claim based on known payer submission requirements. The Emdeon clearinghouse can either reject the claim due to errors or pass the claim on to the payer. Errors generated by the Emdeon clearinghouse are known as

rejections, and they are listed in the Rejected Error Message(s) section of the **Errors** tab. You can refile or submit a claim even if the claim has rejection errors. (See the **Rejected Error Message(s)** section on page 165.)

3. If a claim successfully passes through the Emdeon clearinghouse to the payer, the payer processes the claim. Based on its criteria and business rules, the payer can pay a claim in full, pay a claim in part, or reject a claim. Errors generated by the payer are also known as rejections, and they are listed in the Rejection Error Message(s) section of the **Errors** tab. You can refile or submit a claim even if the claim has rejection errors from the payer. (See the **Rejected Error Message(s)** section on page 165.)

Error Indicators

These indicators help you locate errors in a claim:

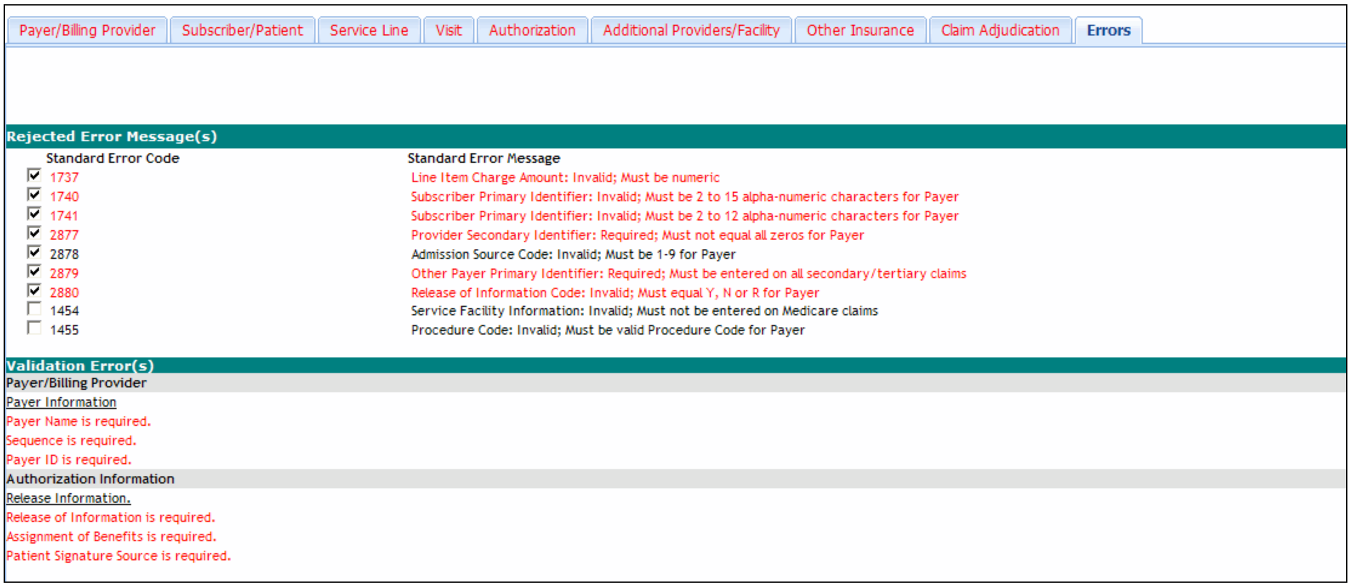
- If a tab contains errors, the tab name is in red text. If a tab does not contain errors, the tab name is in blue text.
- If a field contains an error or is required but blank, the field is highlighted yellow, and the error appears in a tooltip when you hold your cursor over the field.
- The **Errors** tab lists errors in two categories:
  - Errors detected by Emdeon or the payer when the claim was rejected
  - Validation errors based on standard industry guidelines for each field included in the claim

Use the Errors Tab

When you click the **View/Edit Claim** or **Create Secondary Claim** button in a Claim Detail Report, the claim opens in a new window with the **Errors** tab selected.

***Note**: If the claim is accepted and the claim amount paid in full, no rejection errors will appear in the **Errors** tab. Typically, there will also be no validation errors in this case, but where there are validation errors for an accepted or paid claim, you can safely disregard those errors.*

There is an upper section and a lower section in the **Errors** tab, and the sections display different types of errors.



Rejected Error Message(s)

	Standard Error Code	Standard Error Message
☑	1737	Line Item Charge Amount: Invalid; Must be numeric
☑	1740	Subscriber Primary Identifier: Invalid; Must be 2 to 15 alpha-numeric characters for Payer
☑	1741	Subscriber Primary Identifier: Invalid; Must be 2 to 12 alpha-numeric characters for Payer
☑	2877	Provider Secondary Identifier: Required; Must not equal all zeros for Payer
☑	2878	Admission Source Code: Invalid; Must be 1-9 for Payer
☑	2879	Other Payer Primary Identifier: Required; Must be entered on all secondary/tertiary claims
☑	2880	Release of Information Code: Invalid; Must equal Y, N or R for Payer
☐	1454	Service Facility Information: Invalid; Must not be entered on Medicare claims
☐	1455	Procedure Code: Invalid; Must be valid Procedure Code for Payer

Validation Error(s)

Payer/Billing Provider

Payer Information

Payer Name is required.

Sequence is required.

Payer ID is required.

Authorization Information

Release Information.

Release of Information is required.

Assignment of Benefits is required.

Patient Signature Source is required.

Rejected Error Message(s)

The upper section, Rejected Error Message(s), displays errors that were generated if the claim was rejected at the Emdeon clearinghouse or the payer. Typically, these errors are generated regarding the payer's specific requirements.

These errors are not re-evaluated as you make changes to the claim; the application will not automatically detect that you have corrected the reason for the rejection or that you have made a change that might result in a new rejection reason that was not previously in the claim. Instead, each error message in this section has a check box beside the error code. As you correct errors in the claim, you can select the corresponding check box to track your correction of the error. The check boxes will remain selected until you refile or submit the claim or close the window.

***Note**: Using the check boxes in the **Errors** tab is optional. However, if you have not selected all the check boxes when you click **Refile** or **Submit**, a confirmation window will appear that advises you to make all required changes. You can click **Cancel** to return to the claim and correct the remaining errors or click **OK** to refile or submit the claim.*

Validation Error(s)

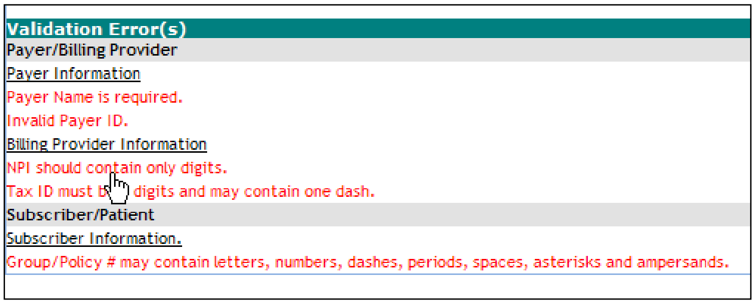
The lower section, Validation Error(s), displays errors generated in real time by comparing the data in every field on every tab to standard industry guidelines. These errors are warnings that a field's value is not valid or that a required field is blank. Some errors in this section may be duplicates of errors displayed in the upper section.

When you correct errors in the lower section, the error message is removed from the lower section automatically.

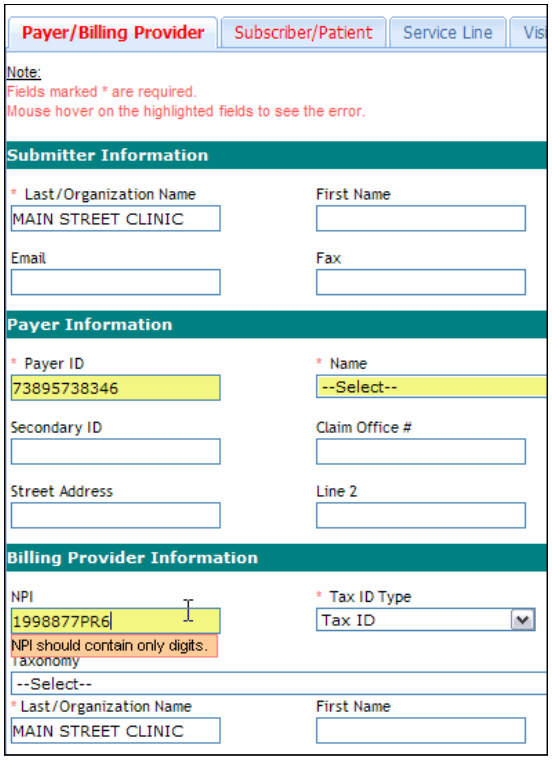
Red Error Messages

Validation and Rejection error messages that are displayed in red text are linked to the field that contains the error. Click an error message in red text to go directly to the error on the tab that it appears. The field the error appears in is highlighted yellow, and the related error message appears as a tooltip when you hold your cursor over the field.

In the example below, the error "NPI should contain only digits" is in red text and is a link. Clicking the error opens the **Payer/Billing Provider** tab, and the cursor is automatically placed in the **NPI** field, which is highlighted yellow.



Validation Error(s)
Payer/Billing Provider
Payer Information
Payer Name is required.
Invalid Payer ID.
Billing Provider Information
NPI should contain only digits.
Tax ID must b digits and may contain one dash.
Subscriber/Patient
Subscriber Information.
Group/Policy # may contain letters, numbers, dashes, periods, spaces, asterisks and ampersands.



Note:
Fields marked * are required.
Mouse hover on the highlighted fields to see the error.

Submitter Information
* Last/Organization Name: MAIN STREET CLINIC
First Name:
Email:
Fax:

Payer Information
* Payer ID: 73895738346
* Name: --Select--
Secondary ID:
Claim Office #:
Street Address:
Line 2:

Billing Provider Information
NPI: 1998877PR6
NPI should contain only digits.
* Tax ID Type: Tax ID
Taxonomy: --Select--
* Last/Organization Name: MAIN STREET CLINIC
First Name:

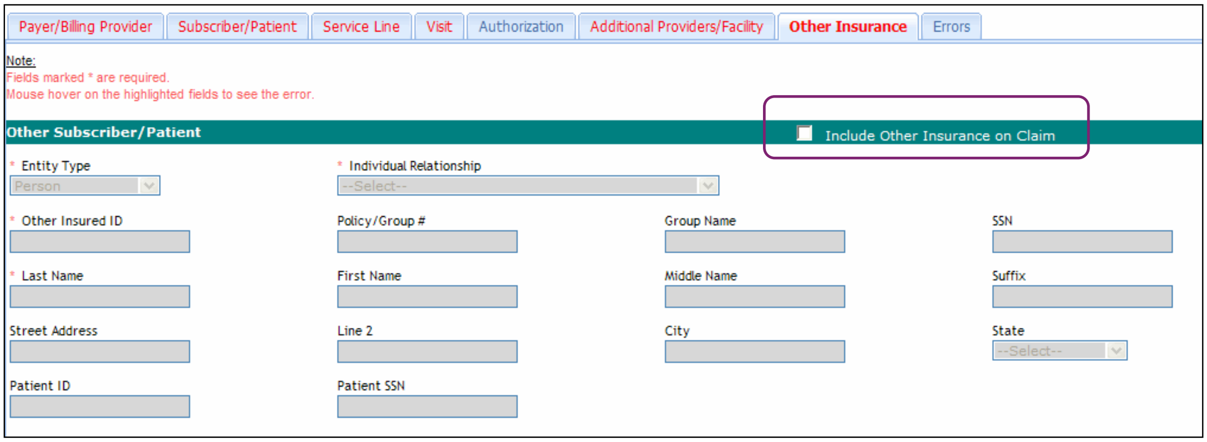
Black Error Messages

Error messages that are displayed in black text are not linked. These errors may not correspond to a particular field, or the errors may relate to a field with multiple instances and the application is unable to determine which instance of the field contains the error. For example, a rejection error message caused by an error on a claim line is likely to be shown in black text, not linked, because the rejection errors do not identify the claim line that contained the error. You will need to use your own expertise and judgment to correct these types of errors.

Enable Sections

Some sections are grayed out by default. No changes can be made to a grayed-out section. Each grayed-out section has a check box in the section header. This may happen when the original claim contained no information relevant to that section.

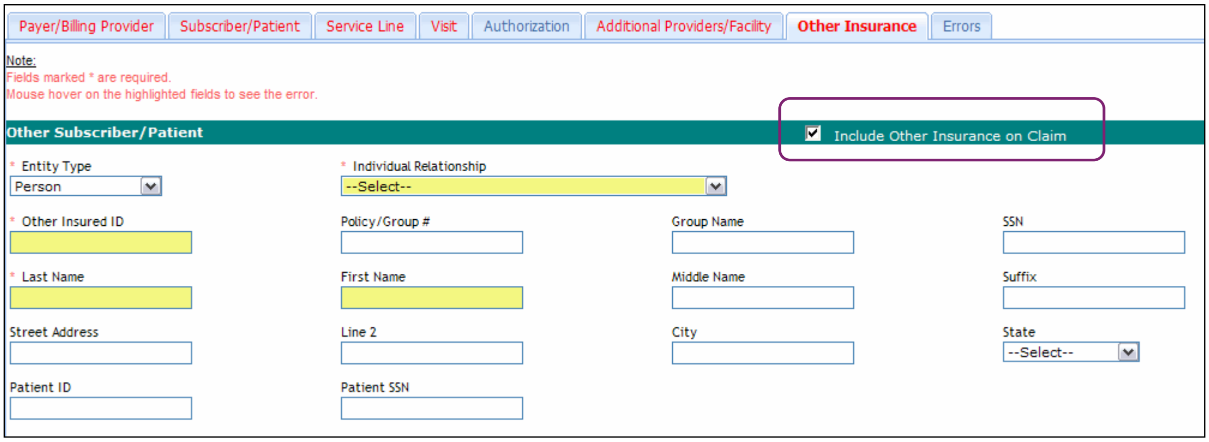
To be able to edit a grayed-out section, select the check box in that section's header. Make changes to that section if necessary. Selecting the check box indicates that you are choosing to include the section's information on the claim even though it is not included by default. Once you enable the section by selecting the check box, field requirements will apply. As shown below, the Other Subscriber/Patient section is not required, but if you select the "Include Other Insurance on Claim" check box, the **Individual Relationship**, **Other Insured ID**, **Last Name**, and **First Name** fields become required.


Payer/Billing Provider
Subscriber/Patient
Service Line
Visit
Authorization
Additional Providers/Facility
Other Insurance
Errors
Other Subscriber/Patient
Individual Relationship
Other Insured ID
Policy/Group #
Group Name
SSN
Last Name
First Name
Middle Name
Suffix
Street Address
Line 2
City
State
Patient ID
Patient SSN

Note:
Fields marked * are required.
Mouse hover on the highlighted fields to see the error.

☐ Include Other Insurance on Claim

Entity Type: Person
Individual Relationship: --Select--
State: --Select--


Payer/Billing Provider
Subscriber/Patient
Service Line
Visit
Authorization
Additional Providers/Facility
Other Insurance
Errors
Other Subscriber/Patient
Individual Relationship
Other Insured ID
Policy/Group #
Group Name
SSN
Last Name
First Name
Middle Name
Suffix
Street Address
Line 2
City
State
Patient ID
Patient SSN

Note:
Fields marked * are required.
Mouse hover on the highlighted fields to see the error.

☑ Include Other Insurance on Claim

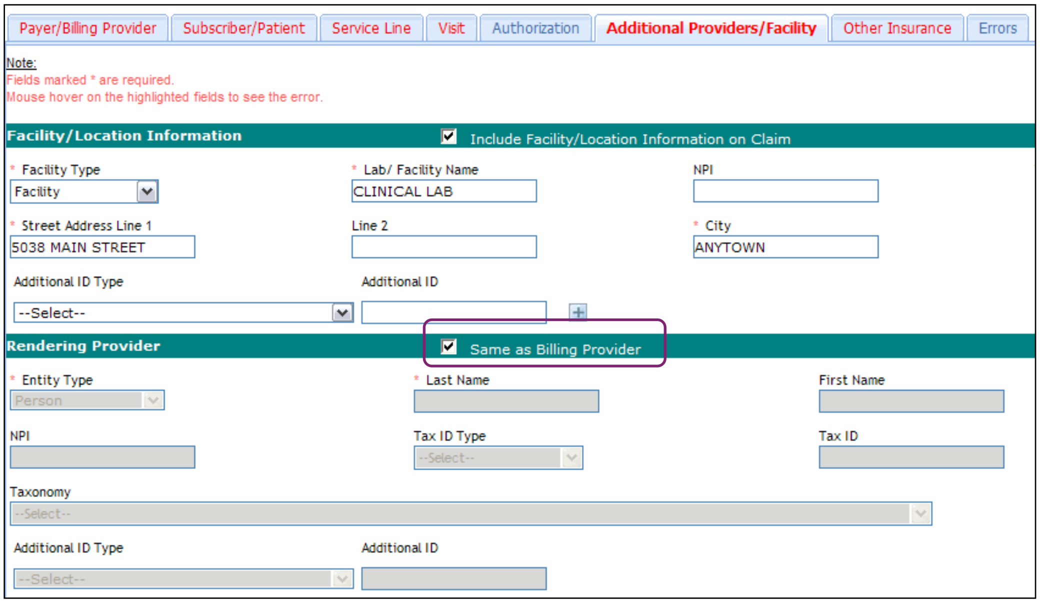
Entity Type: Person
Individual Relationship: --Select--
State: --Select--

Exception

There is one section that does not follow the pattern described above. On the **Additional Providers/Facility** tab, the Rendering Provider section is grayed out by default, but the section header check box is selected.

To be able to edit this section, clear the check box in the section header. Make changes to that section if necessary.

As shown below, clearing the check box indicates that the rendering provider is not the same as the billing provider, so the rendering provider information should be changed.


Payer/Billing Provider
Subscriber/Patient
Service Line
Visit
Authorization
Additional Providers/Facility
Other Insurance
Errors

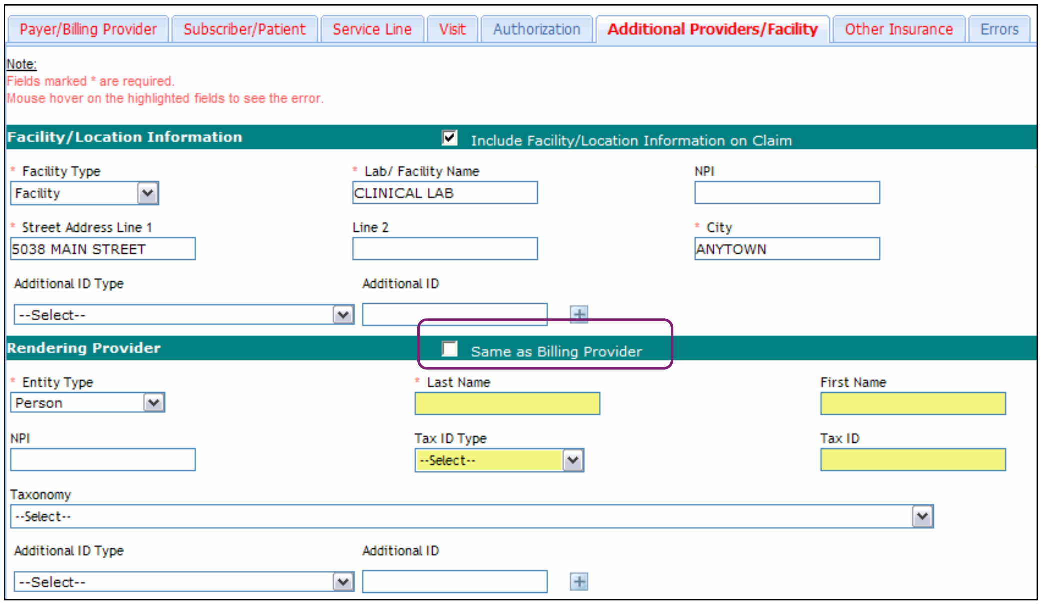
Note:
Fields marked * are required.
Mouse hover on the highlighted fields to see the error.

Facility/Location Information ☑ Include Facility/Location Information on Claim

* Facility Type: Facility
* Lab/ Facility Name: CLINICAL LAB
NPI:
* Street Address Line 1: 5038 MAIN STREET
Line 2:
* City: ANYTOWN
Additional ID Type: --Select--
Additional ID:

Rendering Provider ☑ Same as Billing Provider

* Entity Type: Person
* Last Name:
First Name:
NPI:
Tax ID Type: --Select--
Tax ID:
Taxonomy: --Select--
Additional ID Type: --Select--
Additional ID:


Payer/Billing Provider
Subscriber/Patient
Service Line
Visit
Authorization
Additional Providers/Facility
Other Insurance
Errors

Note:
Fields marked * are required.
Mouse hover on the highlighted fields to see the error.

Facility/Location Information ☑ Include Facility/Location Information on Claim

* Facility Type: Facility
* Lab/ Facility Name: CLINICAL LAB
NPI:
* Street Address Line 1: 5038 MAIN STREET
Line 2:
* City: ANYTOWN
Additional ID Type: --Select--
Additional ID:

Rendering Provider ☐ Same as Billing Provider

* Entity Type: Person
* Last Name:
First Name:
NPI:
Tax ID Type: --Select--
Tax ID:
Taxonomy: --Select--
Additional ID Type: --Select--
Additional ID:

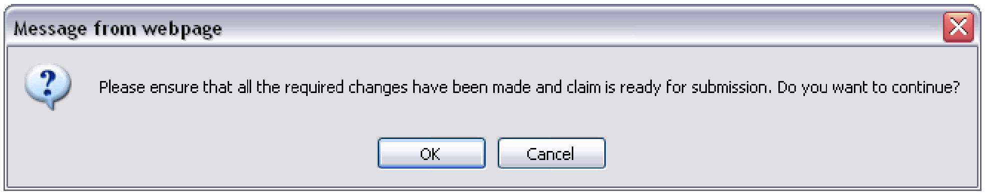
Refile a Claim

The application allows you to refile a claim whether or not all errors have been corrected. If you refile a claim that contains errors, the claim is still sent to the payer; however, the payer may reject the claim.

***Note**: It is recommended that you correct all errors if possible before you refile a claim.*

Follow these steps to refile a claim:

1. Correct as many errors as possible.
2. Click the **Refile** button.
3. If there are one or more uncorrected errors, a confirmation window appears. Click **Cancel** to return to the claim and correct the remaining error(s), or click **OK** to submit the claim with errors.



Please ensure that all the required changes have been made and claim is ready for submission. Do you want to continue?

If there are no errors, the claim is submitted to the Emdeon clearinghouse. A confirmation window appears with the message, "The claim has been successfully refiled."

If the claim is not rejected by the Emdeon clearinghouse, it is sent to the payer. The next business day, you should receive a claim confirmation report indicating whether the claim was rejected at the Emdeon clearinghouse or sent to the payer. (You will see this report in either Reporting & Analytics or your Office email depending on how your account is set up.)

Secondary Claims

When a claim is not paid in full by the payer, you can create a secondary claim from the primary claim. You can then send the secondary claim to another payer for payment of all or part of the remaining claim amount.

***Note**: The insured person on the claim must be enrolled and eligible with the payer that the secondary claim is sent to.*

When you create the secondary claim, the application automatically populates most of the fields in the secondary claim with data from the primary claim. For example, if the primary claim included information in the **Other Insurance** tab, it will be moved to the **Payer/Billing Provider** and **Subscriber/Patient** tabs as applicable in the secondary claim. For a list of the minimum required information you need to submit a secondary claim that you created from a primary claim, see the **Minimum Required Data** section on page 172.

You can create a secondary claim from a primary claim that has errors, but you should correct as many errors as possible before you submit the secondary claim. See the **Correct a Claim** section on page 164 for more information.

Secondary Claims in Office

Currently, there are two ways to create secondary claims in Office: through Reporting & Analytics and through Supplement Claims (see the **Supplement Claims** section on page 33). This section describes how to create secondary claims through Reporting & Analytics, but there are some fundamental differences between the two methods.

Feature	Secondary Claims: Reporting & Analytics	Secondary Claims: Supplement Claims
Create secondary claim	Create a secondary claim only from a primary claim that has already been submitted through the Emdeon clearinghouse to the payer. Using this method, you will upload the claim once, not twice.	Upload a primary claim for the purpose of converting it to a secondary claim to submit to another payer. Make changes needed to create the secondary claim immediately after you upload the claim. The changes you make are independent of the submission of the primary claim to the primary payer.
Change field values	Make changes to any field	Make changes only to certain fields
Submission format	Submit claims only in ANSI X12 4010 or NSF+ format	Submit claims in multiple formats

Validate Claim Charges

Because secondary claim amounts are based on the primary claim, the application validates all claim amounts at both the claim level and the service line level on secondary claims. If these amounts do not calculate correctly according to the primary claim, it will be treated as a validation error.

Claim Amount Level Validation

This level of validation ensures that the claim level payer paid amount plus all adjustment amounts entered at the claim level and line level equals the primary claim charge. If claim level payments and adjustments do not equal the primary claim charge, this error will appear on the **Errors** tab: “Claim does not balance. Adjustments and payments must equal claim total charges.”

Validation logic for claim amount field validation involves the following calculation:

> Payer paid amount (claim adjudication tab)
> +
> all the claim line adjustment amounts (claim line adjudication tab)
> +
> all the claim adjustment amounts (claim adjudication amount)
> =
> Total claim charge

Service Line Amount Level Validation

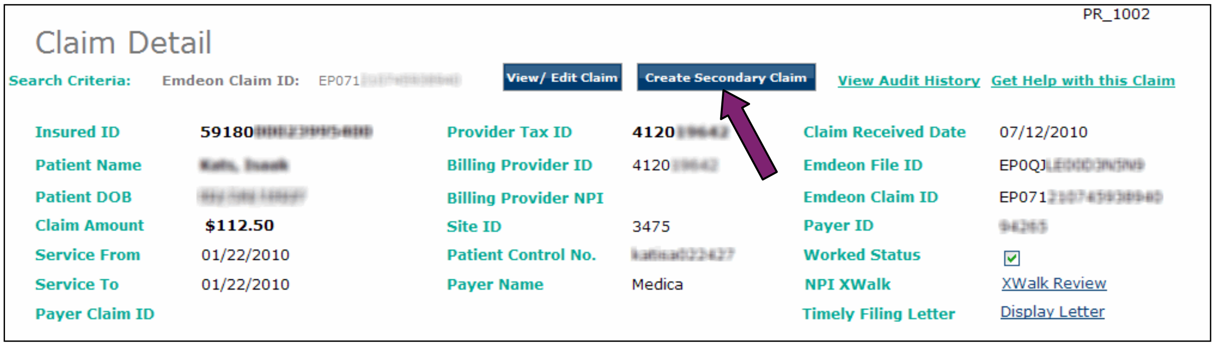
This level of validation ensures that the service line level payments and adjustments equal the primary service line charge. If service line level payments and adjustments do not equal the primary line charge, this error will appear on the **Errors** tab: “Service line <#> does not balance. Service line payment amount and adjustment amounts must equal original line charge.”

Service line level validation logic involves the following calculation:

> Service line payer paid amount
> +
> All claim line adjustment amounts
> =
> Total line charge

Create a Secondary Claim from a Primary Claim

1. Select **Claims** > **Reporting & Analytics** from the main menu.
2. Search for and open the Claim Detail Report of the primary claim you want create a secondary claim for. (See the **Claim Data Searches** section on page 101 for details on search types.)
3. Click the **Create Secondary Claim** button.

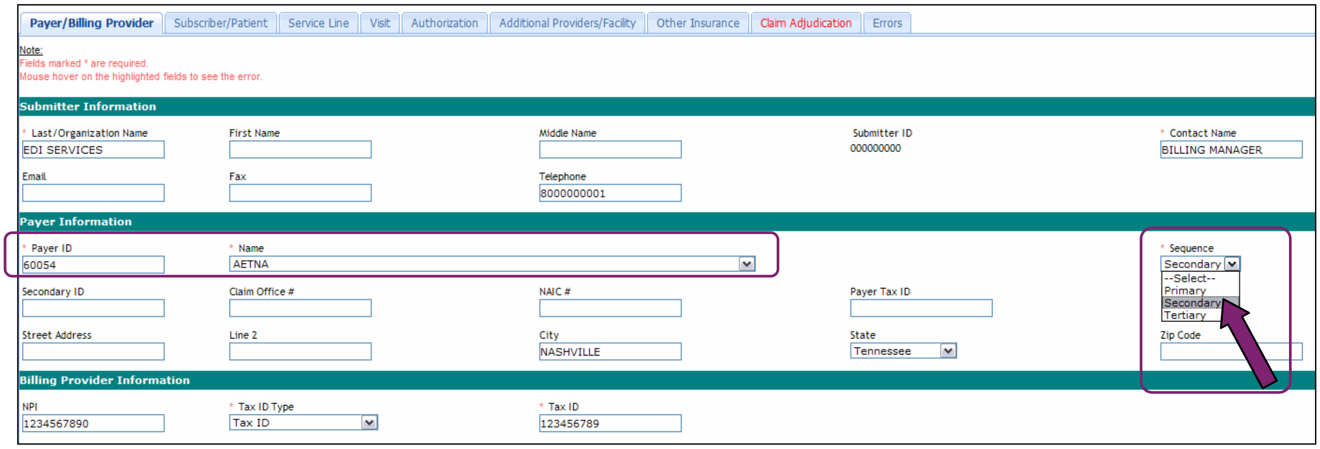


Claim Detail

Search Criteria: Emdeon Claim ID: EP071[redacted]

Insured ID	59180[redacted]	**Provider Tax ID**	4120[redacted]	**Claim Received Date**	07/12/2010
Patient Name	[redacted]	**Billing Provider ID**	4120[redacted]	**Emdeon File ID**	EP0QJ[redacted]
Patient DOB	[redacted]	**Billing Provider NPI**		**Emdeon Claim ID**	EP071[redacted]
Claim Amount	$112.50	**Site ID**	3475	**Payer ID**	[redacted]
Service From	01/22/2010	**Patient Control No.**	[redacted]	**Worked Status**	☑
Service To	01/22/2010	**Payer Name**	Medica	**NPI XWalk**	XWalk Review
Payer Claim ID				**Timely Filing Letter**	Display Letter

4. On the **Payer/Billing Provider** tab, enter the **Payer ID** and **Name**, and for the **Sequence** field, select “Secondary”.



Note:
Fields marked * are required.
Mouse hover on the highlighted fields to see the error.

Submitter Information

* Last/Organization Name: EDI SERVICES
First Name:
Middle Name:
Submitter ID: 000000000
* Contact Name: BILLING MANAGER
Email:
Fax:
Telephone: 8000000001

Payer Information

* Payer ID: 60054
* Name: AETNA
* Sequence: Secondary
Secondary ID:
Claim Office #:
NAIC #:
Payer Tax ID:
Street Address:
Line 2:
City: NASHVILLE
State: Tennessee
Zip Code:

Billing Provider Information

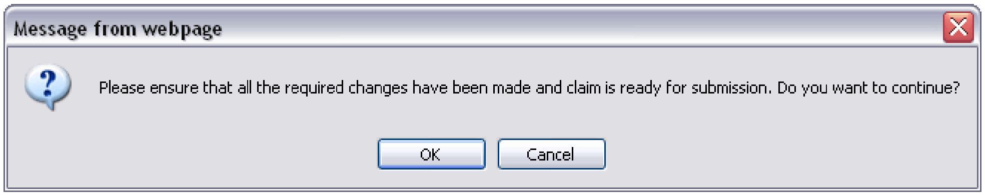
NPI: 1234567890
* Tax ID Type: Tax ID
* Tax ID: 123456789

***Note**: Some fields may already be pre-populated with data from the primary claim. See the **Minimum Required Data** section on page 172 for more information.*

5. On the **Subscriber/Patient** tab, enter information about the subscriber/patient.
6. On the **Authorization** tab, select the correct values in the **Release Information** section.
7. On the **Other Insurance** tab, enter required information in the **Other Payer** section.
8. On the **Claim Adjudication** tab, enter the **Adjudication/Payment Date** and **Payer Paid Amount** concerning the payment made on the primary claim.

   If you want to include line level information on the claim, select the **Service Line** tab, click the **More** button, select the **Claim Line Adjudication** tab, and then enter additional information relating to a specific line. (If the section you want to edit is grayed out, select the check box in the section header to enable the section for editing. See the **Enable Sections** section on page 167 for more information.)

9. On the **Errors** tab, review the information and correct as many errors as possible. (See the **Correct a Claim** section on page 164 for more information.)
10. Click **Submit**.
11. If there are one or more uncorrected errors, a confirmation window appears. Click **Cancel** to return to the claim and correct the remaining error(s), or click **OK** to submit the claim with errors.


Message from webpage

Please ensure that all the required changes have been made and claim is ready for submission. Do you want to continue?

If there are no errors, the claim is submitted to the Emdeon clearinghouse. A confirmation window appears with the message, "The claim has been successfully submitted."

If the claim is not rejected by the Emdeon clearinghouse, it is sent to the payer. The next business day, you should receive a claim confirmation report indicating whether the claim was rejected at the Emdeon clearinghouse or sent to the payer. (You will see this report in either Reporting & Analytics or your Office email depending on how your account is set up.)

Minimum Required Data

The table below lists the minimum required data you will need to enter to submit a secondary claim. Other required data will automatically appear on the secondary claim because it will have been pre-populated from the primary claim.

Tab	Section	Field	Note
Payer/Billing Provider	Payer Information	Payer ID (which populates Name)	If the **Other Payer ID** and **Other Payer Name** fields from the **Other Insurance** tab on the primary claim were populated, those values will pre-populate the **Payer ID** and **Name** fields on the secondary claim. If the values did not pre-populate, complete these fields.
		Sequence	Select "Secondary"
Subscriber/Patient	Subscriber Information	Entity Type	If the Entity Type, Individual Relationship, Other Insured ID, Last Name, and First Name fields from the **Other Insurance** tab on the primary claim were populated, those values will pre-populate these fields on the secondary claim. If the values did not pre-populate, complete these fields.
		Patient Relationship to Insured	
		Subscriber ID	
		Last Name	
		First Name	
Authorization	Release Information	Release of Information	These fields are claim-specific and cannot be assumed or pre-populated from the primary claim. Complete these fields.
		Patient Signature Source	
		Assignment of Benefits	
Other Insurance	Other Payer	Claim Filing Indicator	These fields do not appear on the primary claim, so they will not be pre-populated. Complete these fields.
		Insurance Type	
Claim Adjudication	Claim Adjudication	Adjudication/Payment Date	If the payer amount paid differs from the claim total charges, adjustments will be required to offset the difference. These adjustments can be entered at the claim level, line level, or both. See the **Claim Amount Level Validation** section on page 170 for calculation specifications.
		Payer Paid Amount	
	Claim Adjustment	Claim Adjustment Group	These fields are required if you select the "Include Claim Adjustments on Claim" check box.
		Claim Adjustment Reason	
		Adjustment Amount	
Claim Line Adjudication (Select Service Line tab, click More button, and select Claim Line Adjudication tab)	Claim Line Adjudication	Service Line Paid Amount	This field is required if you select the "Include Claim Line Adjudication on Claim" check box. The other relevant fields in the Claim Line Adjudication section are pre-populated from the primary claim line detail but can be changed if they are reported back differently on the ERA.
	Claim Line Adjustment	Claim Adjustment Group Code	These fields are required if you select the "Include Claim Line Adjudication on Claim" check box. See the Service Line Amount Level Validation section for calculation specifications.
		Claim Adjustment Reason Code	
		Adjustment Amount	
Note: All of the other amount fields on the Claim Adjustment and Claim Line Adjustment sections are only required when they are reported on the primary claim payer's ERA.			

Emdeon is a leading provider of revenue and payment cycle solutions that connect payers, providers, and patients to improve the healthcare business processes.

To learn more about our company, our services, and our commitment to improving healthcare, visit our website at **www.emdeon.com**.

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