Job Aid:
Provider Portal Claims

Overview

The Vaya Health (Vaya) Provider Portal includes a section for claims information and a search functionality that allows providers to view their claims history or search by claim type. Additionally, the Provider Portal offers a submission section for both Professional and Institutional claim types.

The purpose of this job aid is to detail the process by which providers may access and navigate claims information in the Provider Portal.

Click any section below for details:

Section 1: Getting Started

Step 1

Select **Claims** from the left side menu of the Provider Portal homepage.

Note: Your access level will determine the type of information you are able to view in the **Claims** section.

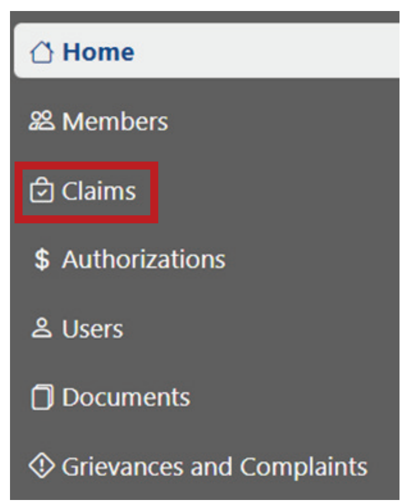

Figure 1: Claims Selection

Step 2

Upon accessing the **Claims** homepage, you will see several terms that may require definition, including:

- **Portal ID** – This is the claim's ID in the Provider Portal prior to submission to Health Solutions Plus (HSP).
- **Member ID** – This is the member or recipient's identification number issued by Vaya.
- **HSP ID** – This is the claim ID that is assigned once the claim is processed in HSP.

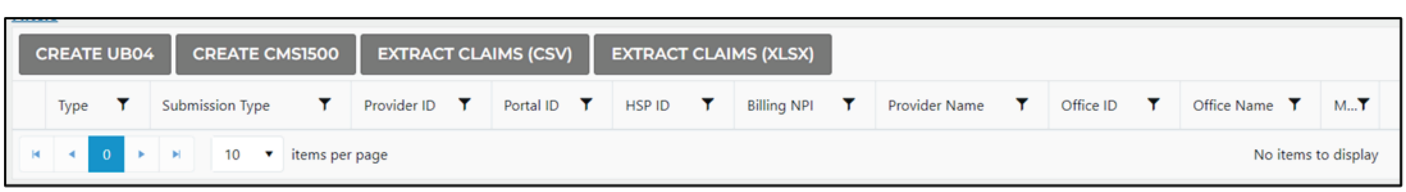

Figure 2: Claims Homepage Options

Step 3

Review the submission and status categories. The **Submitted?** column will display true next to a claim if it has been submitted and false if it has not been submitted.

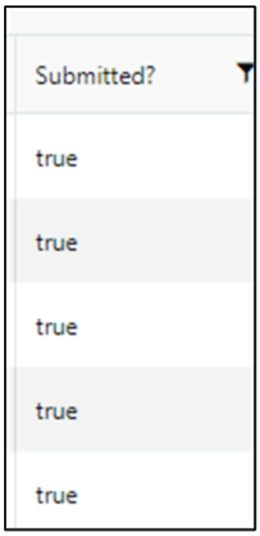

Figure 3: Submitted? Column

The **Status** column identifies the claim's status as one of the following:

- **Pended** – This indicates that the claim is pended in HSP and is awaiting manual review by Vaya's Business Services team.
- **Completed** – This indicates that at least one line of the claim has been approved.
- **Denied** – This indicates that the claim has been denied.
- **TBD** – This acronym indicates that the status is to be determined (TBD).

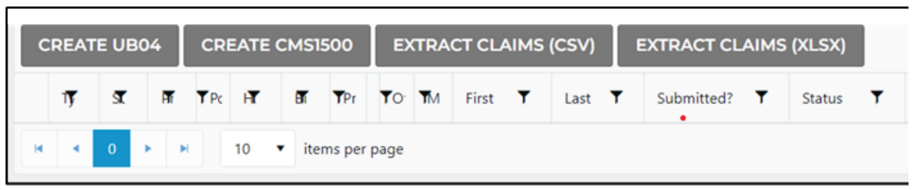

Figure 4: Claim Status

Note: To view additional details about a claim on the **Claims** homepage, select the arrow button next to the claim.

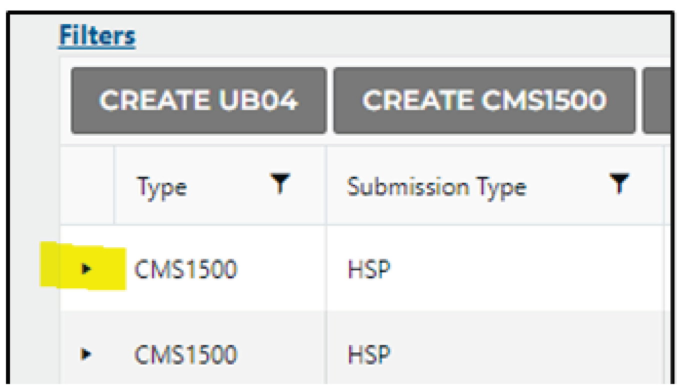

Figure 5: Claim Details Expansion Option

Section 2: Searching for a Claim

Searching for a Specific Claim or Type of Claim

Step 1

Enter the relevant search information under any of the column headings and/or by using the dropdown menus for the claims **Start Date**, **End Date**, **Claim Source**, and/or **Type**.

Step 2

Select **Filter**.

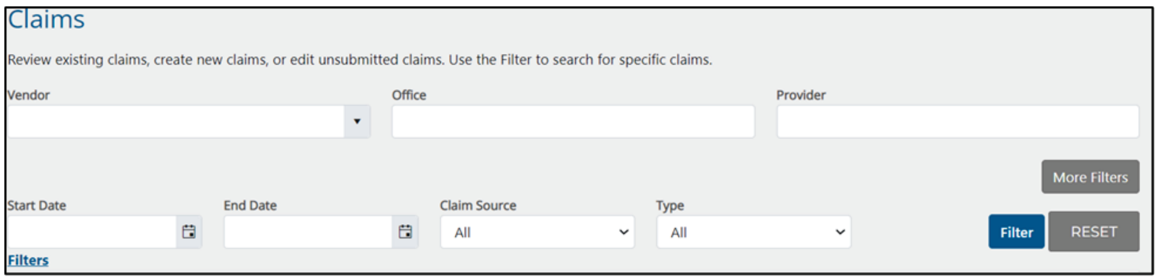

Figure 6: Claims Dropdown Selections

Conducting a Historical Search for Claims Older Than 90 Days

Step 1

Select **More Filters**.
The **Search for Historical Values** section will appear in the middle of the page.

Step 2

The search will set the **Claim Source** dropdown over the grid to filter for historical claims.

Note: Historical searches look for archived records within the specified date range.
If the date range is not provided, the search will display results from the last two years.
Results for this type of search are limited to 100 rows.

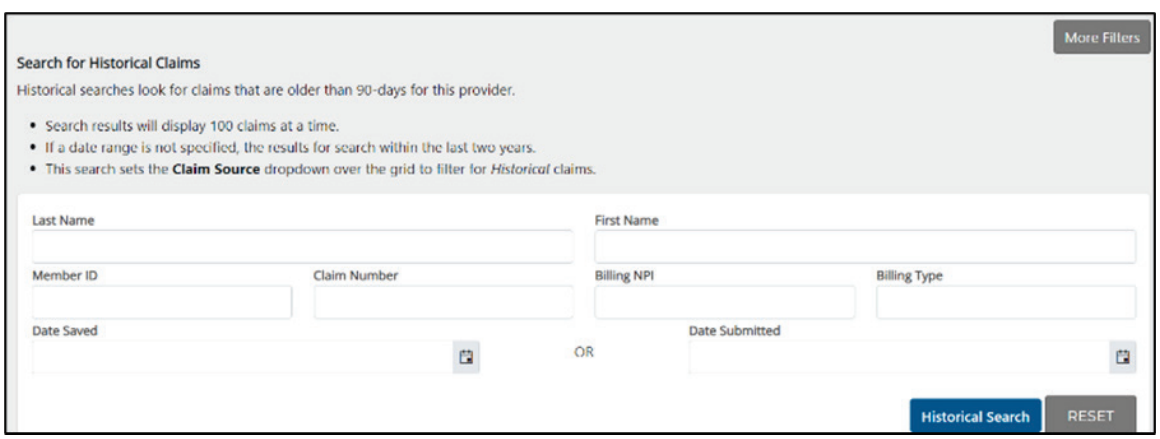

Figure 7: Historical Claims Search

Using Additional Filters

Step 1

Select the word Filter displayed in blue text from the left side of the page to access the filter search on the **Claims Home** page.

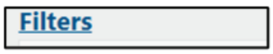

Figure 8: Filters Selection

Step 2

Review the quick search options. which include

- **Portal ID** (the claim number in the portal),
- **HSP ID** (the ID provided in HSP), and
- **Name**.

Step 3

Enter claim filters and select **Filter**.

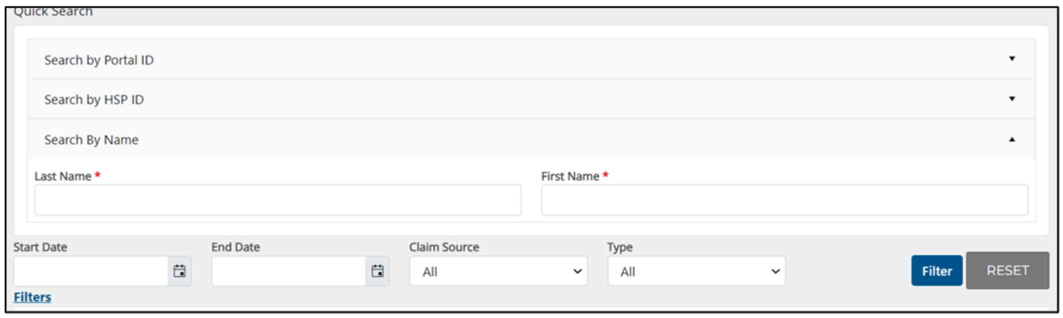

Figure 9: Claim Filters

Section 3: Editing and Copying Claims

You can enter claims either through the Provider Portal or electronically via 837 files. While you may edit a claim entered through the Provider Portal until it is submitted for payment, claims submitted electronically via 837 files cannot be edited.

Note: For more information about 837 claims, please reference the Vaya Health Provider Operations Manual.

Editing a Claim Submitted Through the Provider Portal

Step 1

Locate the claim from the Claims homepage and select **Edit**. The claim details will display.

Step 2

Edit the claim information and select **Save**.

Step 3

Select the blue **Validate Claim** button from the lower middle section of the screen to ensure the information is accurate.

Step 4

Select Submit Claim from the right corner of the page after validating the information is correct. Once the claim has been submitted, the claim type and number will display at the top of the screen.

Copying a Claim Saved in or Submitted via the Provider Portal

Step 1

Locate the claim from the Claims homepage and select **Copy**. The claim details will display.

Step 2

Change the desired claim information and select **Save**.

Step 3

Select the blue **Validate Claim** button from the lower middle section of the screen to ensure the information is accurate.

Step 4

Select **Submit Claim** from the right corner of the page after validating the information is correct. Once the claim has been submitted, the claim type and number will display at the top of the screen.

Section 4: Uploading and Downloading 837 Claims

Step 1

Navigate to the **Quick Access** section from the Provider Portal resource page to submit or download an 837 claim.

Step 2

Select [Upload or review your EDI transactions](). A new window will open with the CrushFTP application.

Step 3

Log in and upload 837 files to the **Upload** folder or access response files via the **Download** folder.

Note: Folder names may vary.

Section 5: Creating a Claim

Step 1

Using the dropdown menu on the Claims homepage to select the correct vendor, office, and provider in the order they appear on the screen.

- For **Vendor**, select the National Provider Identifier (NPI).
- For **Office**, select the specific location or office.
- For **Provider**, select the person performing the service.

After you select these options, some fields will automatically populate.

Step 2

Choose the type of claim you would like to create by selecting one of the options displayed in the middle of the page, either **CMS UB04/Institutional Claim** or **CMS 1500/Professional Claim**.

The **Create a Claim** page will open.

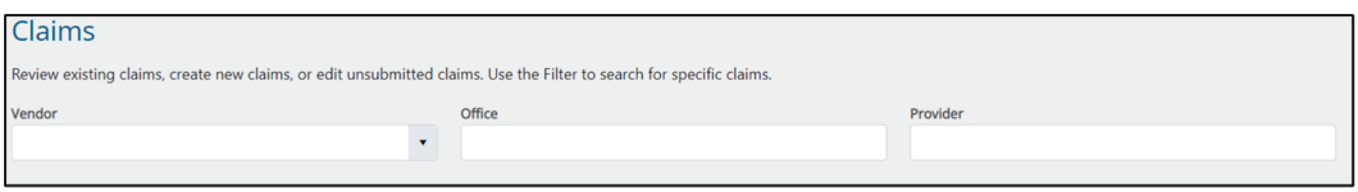

Figure 10: Claims Homepage

Step 3

Complete the claim.

Note: Fields marked with an asterisk (*) in the Provider Portal are required. Complete all dropdown boxes and text fields to ensure you submit a clean claim.

<table>
<tr><th>CMS UB04/Institutional Claims</th><th>CMS 1500/Professional Claims</th></tr>
<tr><td>
To create and submit a CMS UB04/Institutional claim, use the dropdown menu to select rendering provider and office.

Enter the patient’s first name, last name, and date of birth; select Search, and provide the following information:

Demographics/patient information
(should autofill from a member search):
First and last name
Date of birth
SSN
Gender
Address
Billing provider’s information
and pay-to information:
Office name
Address
Telephone
Patient control number and MRN
Bill type (required)
Federal tax ID number
Statement covers period from/through
Patient identifier and name:
First name
Last name
Patient address
Birth date
Gender
Admission information:
Date
Time
Type
Source

</td><td>
To create and submit a CMS 1500/Professional claim, use the dropdown menu to select rendering provider, taxonomy, and office.

Enter the patient’s first and last name, select Search, and provide the following information:

Demographics/patient information
(should autofill from a member search):
First and last name
Date of birth
SSN
Gender
Address
Insurance information:
Insurer’s ID number
Patient name:
First name
Last name
Patient demographics:
Patient birth date
Patient gender
Insured name:
First name
Last name
Patient contact details:
Patient address
Telephone
Patient relationship to insured:
Relationship
Insured contact details:
Address
Patient contact condition related to:
Employment
Auto accident

</td></tr>
</table>

Job Aid:

Provider Portal Claims

CMS UB04/Institutional Claims

- Discharge information:
  - Hour
  - Status
- Condition codes
- Accident state
- Occurrence code and date
- Occurrence span:
  - Code
  - Date
- Responsible party:
  - Name
  - Address
- Value codes:
  - Code
  - Amount
- Service lines – Select **Expand Editor**
  - Fill in all information that pertains to the service being billed
  - Add in total charges and non-covered charges
- Payor information:
  - Payer identification (enter the payor name and the code will automatically populate)
  - Health plan ID (this field will automatically populate based on the information in the payor identification field)
  - Rel info (options are Y or I – provider has informed consent to release medical information)
  - Asg. Benefits (options are Y, N, or W – not applicable)
  - Prior payments
  - Est. amount due
- Insured information:
  - Insured name
  - Relationship type
  - Unique ID
  - Group name
  - Group number
  - Precedence (Options include primary, secondary, and tertiary)

CMS 1500/Professional Claims

  - Auto accident state
- Insured information:
  - Insured policy group or FECA number
  - Birth date
  - Gender
  - Insurance plan name
  - Another health benefit plan
- Patient signature values
  - Signed (options include Y – signature on file, N – no signature on file, I – provider has informed consent to release medical information)
  - Date
- Insured or authorized person's signature:
  - Signature values (options include yes or no)
  - Signed and date
- Date of current illness:
  - Date
  - Qualifier
- Other date:
  - Other date
  - Qualifier
- Date patient unable to work in current occupation:
  - From date
  - To date
- Name of referring provider or other source:
  - Name
  - Qualifier
  - Other ID
  - Other ID qualifier
  - NPI number
- Hospitalization dates related to current services:
  - From date
  - To date
- Additional claim information
- Outside lab charges:
  - Outside lab
  - Charges
- Diagnosis, nature of illness, or injury code

CMS UB04/Institutional Claims	CMS 1500/Professional Claims

• Authorization number
• Original claim number
• Diagnosis code:
  ○ Diagnosis
  ○ Present on Admission (POA) indicator (physical health claims)
• DX and ECI codes:
  ○ Admitting code
  ○ Patient reason for visit code
  ○ PPS code
  ○ ECI code
• Procedure codes and dates:
  ○ Procedure
  ○ Code
  ○ Date
• Attending provider details:
  ○ First and last
  ○ Name
  ○ NPI
  ○ Qualifier
  ○ Taxonomy
• Operating provider:
  ○ First and last name
  ○ NPI
  ○ Qualifier
  ○ Taxonomy
• Remarks
• Codes – Code A (Taxonomy)
	• Resubmission code:
	  ○ Value
	  ○ Original claim number
	• Prior authorization number
	• Service lines – Select “**Expand Editor**”
	  ○ Fill in all information that pertains to the service that is being billed.
	  ○ Please see **DME Billing With Local W Codes** for additional information.
	• Federal tax ID number:
	  ○ Tax ID number
	  ○ Is it EIN?
	• Prior account number
	• Accept assignment
	• Total charges
	• Total COB amount paid
	• Physician signature (If the service is clinician-based, enter the clinician signature. If the service is not clinician-based, enter the organization name):
	  ○ Signed
	  ○ Date
	• Name and address of facility where services were rendered (if other than home or office):
	  ○ Facility name
	  ○ Address
	  ○ Telephone
	  ○ Facility ID
	• Physician’s or supplier’s billing address:
	  ○ First and last name
	  ○ Address
	  ○ Telephone

Section 6: Saving, Validating, and Submitting a Claim

Step 1

Navigate to the **Create a Claim** page to save, validate, and submit claims.

Step 2

To save a claim to complete in the future, select **Save** from the left side at the bottom of the page.

Note: If a claim is in Saved status, Vaya will not process it.

Step 3

To validate all information included with a claim is accurately entered, select **Validate Claim** from the middle section at the bottom of the page.

Step 4

To submit a claim after validation, select **Submit Claim** from the right side at the bottom of the page.

Note: Submitted claims may not be edited upon retrieval. To edit a submitted claim, you must copy the existing claim and submit a replacement with the necessary changes.

Figure 11: Create a Claim Page – Claim Options

Section 7: Claims and Remittance Advice Reports

Step 1

Select **RA Reports** from the left side of the Claims Homepage to access Remittance Advice (RA) reports and review claims payments.

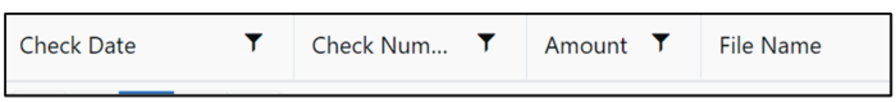

Figure 13: Example RA Report

Step 2

Select the **Claim Extract** button and choose the desired format to run a report of claims

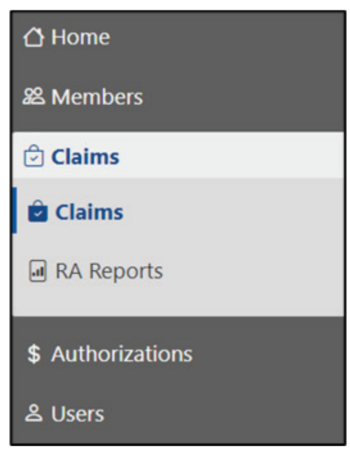

Figure 12: RA Reports Selection

Job Aid:

Provider Portal Claims

Section 8: Claims Attachments and DME Billing with Local W Code

Select attachments can be submitted via a 275 claim attachment format or in an 837 file, allowing the provider to link the separately received attachment to the claim for processing. These attachments can be submitted via the Provider Portal in the attachments section that appears at the bottom of a claim form after the provider saves the claim.

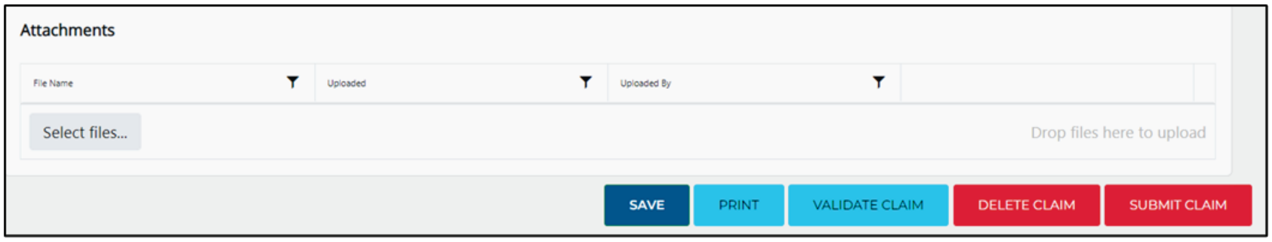

Figure 14: Claims Attachments

Attachments are required for the following:

- Consent forms (for example, sterilization forms)
- Certificate of medical necessity (CMN)
- Invoices
- Discharge summaries
- Operative report
- Child medical exam checklist

DME Billing with Local W Codes

Note: For service lines, select Expand Editor and populate all information that pertains to the service being billed.

- Claims for DME/POS services must include both the National DME Miscellaneous and corresponding local W codes to be eligible for reimbursement
- Per NCDHHS billing requirements, Vaya has updated the Provider Portal to capture the local W codes when processing claims for DME/POS Miscellaneous services. Follow the steps below when submitting DME/POS Miscellaneous services claims:

Step 1

Select **Expand Editor** for field **24. Service Lines** within the Provider Portal.

Figure 15: Service Lines – Expand Editor

Step 2

Use field **24d. Service Code Description** to select the appropriate local code.

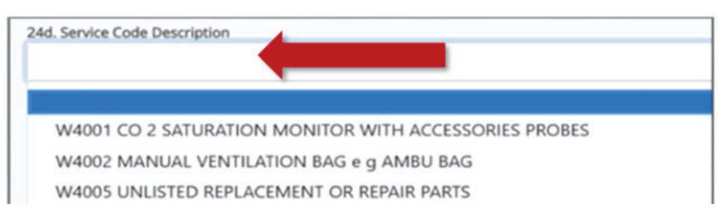

Figure 16: Service Code Description Field