Provider Portal User Guide

For Chorus Community Health Plans – Individual and Family Plan network providers

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Introduction

Provider OnLine (POL) was created to provide online tools that allow providers to access patient's medical history, benefit and eligibility information and communicate with Chorus Community Health Plans. Providers can access valuable information 24/7 including:

- Member eligibility search
- Claims submission
- Claims Search
- Online chat
- Secure messaging
- Document Repository
- Online security management

Users can navigate POL by following the instructions listed in the User Guide.

Main Menu

After logging in, the user can navigate through POL. The left-hand navigation menu appears on all POL screens. From this menu, the user can access the following features:

- User Guide
- Eligibility
- Claims Inquiry
- Enter Claims
- Create Batches
- Messages
- Documents
- Contact Us
- Chat with a Provider Services representative

The user should select the appropriate hyperlink to access the desired function or information.

Eligibility

The Eligibility link takes the user to a section of POL where the user is able to confirm the eligibility of Health Plan members as well as member PCP and benefit information.

The user is able to access/view specific member information by clicking on the Eligibility link on the left hand navigation menu. The Eligibility screen is displayed below.

The user can search for a member by using either the members id or complete a search by name.

By selecting the Submit button, the members plan information is presented.

Name: **Member Number:**

Current Plan: 4/1/2024 - Open

Primary Member: **Pharmacy Copay:** 10/$20/$60**/$250**

Employer: Chorus Silver
Plan Name: Xaei7-Silver EPO
Plan Type: Individual Product
Plan Status: Active
Plan Period: 4/1/2024 - Open
Plan Year: 1/1/2024 - Open
Group Number: EXD002
Subscriber Number:

Plan Period = Enrolled member's span of eligibility
Plan Year = Organizations (Employer Group, Govt Pgm, etc) Contract Span

Member Details

Member Name **Phone:**
Gender: **Address:**
Date of Birth:
Relationship to Subscriber:
ID Card Number:

View/Print Member ID Card for Active Plan

Physician Details

Physician Name: Not Selected
Practice Name: Not Selected **Address:**
Phone:
Fax:

Plan Documents

Schedule of Benefits Certificate of Coverage

Plans

Name	Plan Start	Plan End	Plan Year Start	Plan Year End	Group-Division
Xaei7-Silver EPO	4/1/2024	Open	1/1/2024	Open	EXD002-966

Utilization for Plan XAEI7

Spending Summary information is not available.

Go to Extended

The following information can be viewed on the Member Eligibility Detail Screen.

- Current plan information of the member – Primary member, plan name, deductible and copayment information
- Plan documents – Links to PDFs of the member's schedule of benefits and other plan riders
- Plan information – Includes current start and end dates and previously held plans
- Utilization information – Included deductible information for the member

Claim Inquiry

The user can search for a general list of all claims with their POL account by selecting the Claims Inquiry menu option.

The user can search for claims by Member Last Name and/or Member ID Number. The search criteria that can be used to retrieve a claim is:

- Claim Type
  - Encounters (HCFA)
  - Institutional (UB)
- Patient account number
- Date range

The user can search for claims from an appropriate facility by clicking on the drop-down label for "**Select Security Setting**." The values in this drop-down box are configured by the user's security and access settings.

The user will need to define the date range for the claims search.

- **From Date** - can be set to any date in the past
- **To Date** – cannot be greater than current date

Users can search for any claim filed for the provider.

If the search results are on multiple pages, there will be hyperlinked page numbers at the top and the bottom of the search.

Claim details can be accessed by clicking on the hyperlink of the date of a particular claim.

Enter Claims

The Claims Prelog screen has many fields of entry. Below are a few reminders before getting started:

- **Tab key** = Move field to field.
- **Shift + Tab** = Go back a field.
- **Decimal points** are used for dollar amounts and diagnosis codes.
- Fields marked with a red asterisk (*) are system-required fields of entry.
- Binoculars indicate a search field to aid in selecting or completing information. To display a search window, the cursor must be in the selected search field.
- Upon completion of a claim, a pop-up box stating the claim was submitted successfully will appear.

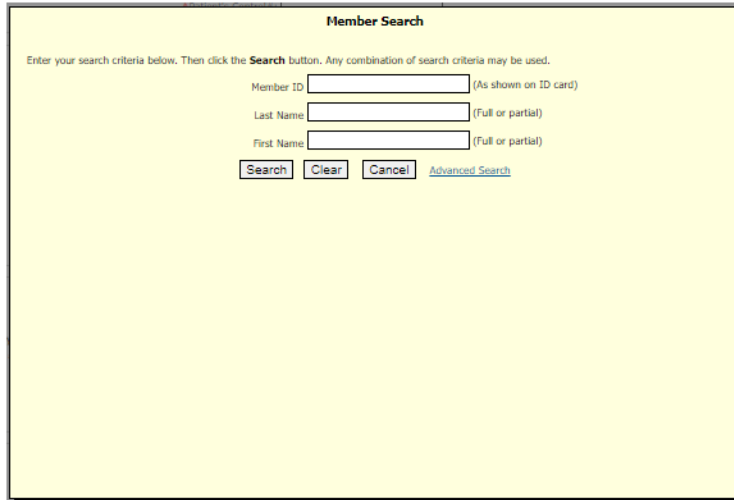
HCFA Claims

The HCFA form is a standardized form designed to contain all information necessary for billing and/or claim payment. The HCFA form is used primarily by individual providers/groups for outpatient services.

After clicking on **Enter Claims** from the sidebar menu option, select the type of claim to be entered.

1. **HCFA** — Select **HCFA** to present the HCFA claim form.
2. **Select Security Setting** - will default to the entity assigned by the OAA
3. ***Insured ID** — Enter the member's ID number
   a. Member's name**,** date of birth and gender are presented.

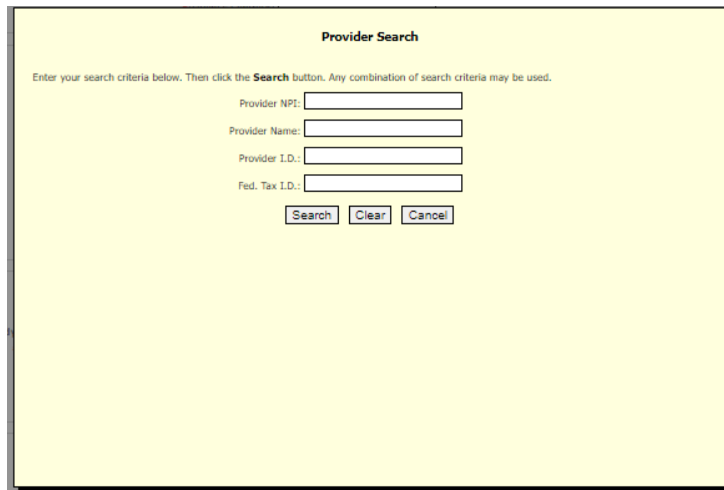
b. Click on the binoculars to access the Member Search screen if a search is needed.



4. ***Patient Control #*** — Enter the internal patient account number the provider assigns for identification.
5. ***Billing Provider ID*** —Billing Provider ID auto-populates based on the entity populated in the "Select Security Setting" field
6. ***Servicing Provider ID*** — The individual provider who rendered the service. Identified in Prelog with a 6-digit provider number.
   a. Click on the binoculars to access the Provider Search screen.
7. **Ordering/Prescribing/Referring Physician ID** — Click on to access the Provider Directory Search screen. This area is required for Ordering, Rendering, and Prescribing Providers.

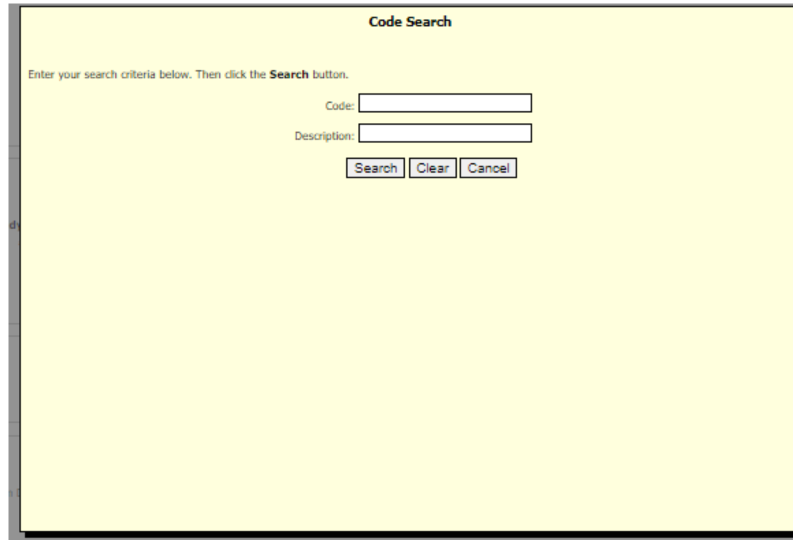
Search will allow the user to find the Provider ID by NPI, Provider Name, Provider ID, or Federal Tax ID.

- Prelog is configured to return **ONLY** the providers listed under the selected Vendors Tax ID #.



The NPI will prepopulate for the Provider Id entered.

8. ***From Date**— Enter the initial date of service.
9. ***Through Date** — Enter the final date of service.
10. **Diagnosis** — Enter the first diagnosis on the claim.
    a. repeat process to enter additional diagnoses.
    b. **Note:** To ensure a correct Diagnosis code is used**:**
        - Enter decimal point after 3rd character
        - Be as specific as possible.
        - Click on the binoculars to access the Code Search screen.



11. ***Total Amount Billed** — Enter the total amount of the entire claim, including the decimal point.
12. **Claim Paper Work —** Only used when billing corrected HCFA claims. **CC** for Corrected Claim/**CV** for Claim Void (if service never took place).
13. **Notes** — Select Add to present an open text field. The original form number is required for corrected claims, then click save.
14. ***From Date of Service**— Enter the initial date of service.
15. ***To Date of Service** — Enter the date of service.
16. ***Place of Service** — Enter the place of service code.
17. ***Type of Service** — The system will auto-populate with 01
    a. Type numeric "01" is always used.
18. ***Diagnosis Reference** — Enter the number of the diagnosis code linked to the service line.
    a. Please use a comma to separate entries. Example: 1,2,3
19. ***CPT/HCPCS** — Enter the five (5) character CPT or HCPCS code.

Note: The user must bill with the correct codes and/or modifiers according to the provider contract(s).

- Click on the binoculars to access the Code Search screen.

19. **1st Modifier** – Enter the 1st modifier if applicable.
20. **2nd, 3rd, 4th, Modifier** — Enter 2nd, 3rd, 4th modifier if applicable, press [TAB] after each.
21. ***Amount Billed** — Enter the total amount billed for the service line. Enter decimal point, press [TAB].
22. ***Days or Units** — The system will default to 1. Enter the number of units billed for the service line if different, press [TAB].
23. **OIC Allowed** – Not used at this time.
24. **OIC Paid** – Not used at this time.
25. **OIC Deductible** – Not used at this time.
26. **OIC Co-Ins** – Not used at this time.
27. **OIC Not Covered** – Not used at this time.
28. **OIC Carrier Group** – Not used at this time.

* Denotes a required field.

Adding/Finalizing a Service Line

23. After the appropriate units are entered, click “Add Detail Line”. This will add the service line to Prelog.
24. After the service line has been entered and added, there will be a service line summary at the bottom of the page.
25. Once a service is added, only the Amt. Billed and Qty (Units) fields can be edited in the summary lines.

Deleting a Service Line

26. If the service line needs to be deleted permanently or deleted and re-entered, the user will have the option to delete the line.
    a. To delete the service line, select the “X” icon

Finalizing a Claim

27. Once all the data has been entered on the claim:
    a. On the last service line entry, press or click on “Add” to add the service line.
    b. If all the services have been entered, click on the “Save Claim” button at the bottom of the screen.

28. After the form (claim) has been saved and cleared, the following message appears: “Save Complete: Claim has been saved!”
    a. Press Enter or click on OK to accept.

UB Claims

The UB form is a standardized form designed to contain all information necessary for billing and/or claim payment. The UB form is used primarily by hospitals and other hospital-type facilities for inpatient and outpatient billing that require Revenue Codes only.

After clicking on **Enter Claims** from the sidebar menu option, the type of claim to be entered for the entity is required.

1. **UB** — Select **UB** to present the UB claim form.
2. **Select Security Setting** - will default to the entity assigned by the OAA
3. ***Insured ID** — Enter the member’s #, including either an ALDA digit number or 10-digit Medicaid number.
    a. Member’s name**,** date of birth and gender are presented.
    b. Click on the binoculars to access the Member Search screen if a search is needed.

Member Search

Enter your search criteria below. Then click the **Search** button. Any combination of search criteria may be used.

Member ID (As shown on ID card)
Last Name (Full or partial)
First Name (Full or partial)
Search Clear Cancel Advanced Search

4. ***Patient Control #** — Enter the internal patient account number the provider assigns for identification.
5. ***Billing Provider ID** —Billing Provider ID auto-populates based on the entity populated in the “Select Security Setting” field
6. ***Servicing Provider ID** — The individual provider who rendered the service. Identified in Prelog with a 6-digit provider number.
    a. Click on the binoculars to access the Provider Search screen.
7. ***Attending Physician ID** — The physician responsible for all patient care. Identified in Prelog with a 6-digit provider number.
    a. Click on the binoculars to access the Provider Search screen.

8. ***Admitting Physician ID** – The physician responsible for documenting the day of admission and diagnosis while admitting the patient to the hospital.
    a. Click on the binoculars to access the Provider Search screen.
9. ***Facility ID** – A health related facility designed to provide care for individuals.
    a. Click on the binoculars to access the Provider Search screen.

Search will allow the user to find the Provider ID by NPI, Provider Name, Provider ID, or Federal Tax ID.

- Prelog is configured to return **ONLY** the providers listed under the Vendors Tax ID # selected.

Provider Search

Enter your search criteria below. Then click the **Search** button. Any combination of search criteria may be used.

Provider NPI:
Provider Name:
Provider I.D.:
Fed. Tax I.D.:

Search Clear Cancel

The NPI will prepopulate for the Provider Id entered.

10. ***From Date**— Enter the initial date of service.
11. ***Through Date** — Enter the final date of service.
12. ***Admission Type** — Enter admission type, system defaults to 01.
    a. Click on the binoculars to access the Code Search screen.
13. ***Admit Date** — Enter the admission date for the claim.
14. **Admission Hour** — Enter admission hour, system defaults to 01.
15. **Admission Source** — Enter admission source.
16. ***Discharge Date** — Enter the date of discharge for the claim.
17. ***Discharge Status** — Enter discharge status.
18. ***Bill Type** — Enter bill type.
    a. Click on the binoculars to access the Code Search screen.
19. ***Total Amount Billed** — Enter the total amount of the entire claim. Enter decimal point, press [TAB].

20. **Total OIC Allowed** – Not used at this time.
21. **Total OIC Paid** – Not used at this time.
22. **Condition Selection** – Not used at this time.
23. **Occurrence Code** — Not used at this time.
24. *** Principal Diagnosis Code** — Enter the principal diagnosis code billed on the claim.
    a. Enter decimal point after 3rd character.
    b. repeat process to enter additional diagnoses.
        - Click on the binoculars to access the Code Search screen.
25. **Admitting Diagnosis Code** — Enter the admitting diagnosis code billed on the claim.
    a. Enter decimal point after 3rd character.
    b. repeat process to enter additional diagnoses.
        - Click on the binoculars to access the Code Search screen.

26. **E Code** – E-Codes billed identify conditions related to poisoning and external causes of adverse effects of drugs and other chemical substances. Decimal point is required after the 4th character.
27. **Procedure Section** – Not used at this time.
28. **Value Section** — Enter value codes if applicable. Repeat the process for multiple codes.
    a. Click on the binoculars to access the Code Search screen.
29. **Claim Paperwork** — Not used at this time.
30. **Claim Note 1 through 4** — Not used at this time.
31. ***Revenue Code** — Enter the Revenue code for service line.
    a. Click on the binoculars to access the Code Search screen.
32. **HCPCS Code** — If applicable, enter the (5) character HCPCS/CPT code.
    a. Click on the binoculars to access the Code Search screen.
33. ***Date of Service** — Enter the service date for the service line.
34. ***Days or Units** — Enter the number of units for the service line; system will default to 1, press [TAB].
35. **1st Modifier** — Enter if applicable for the service line.
    a. Click on the binoculars to access the Code Search screen.

36. ***Amount Billed** — Enter the total amount billed for the service line. Decimal point required.
37. **OIC Allowed** – Not used at this time.
38. **OIC Paid** – Not used at this time.
39. **OIC Deductible** – Not used at this time.
40. **OIC Co-Ins** – Not used at this time.
41. **OIC Not Covered** – Not used at this time.
42. **OIC Carrier Group** – Not used at this time.

* Denotes a required field.

Adding/Finalizing a Service Line

29. After the appropriate units are entered, click "Add Detail Line". This will add the service line to Prelog.
30. After the service line has been entered and added, there will be a service line summary at the bottom of the page.
31. Once a service is added, only the Amt. Billed and Qty (Units) fields can be edited in the summary lines.

Deleting a Service Line

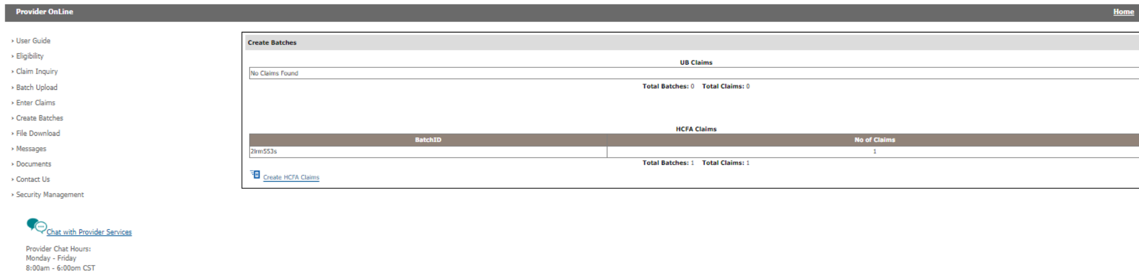
32. If the service line needs to be deleted permanently or deleted and re-entered, the user will have the option to delete the line.
    a. To delete the service line, select the "X" icon

Finalizing a Claim

33. Once all the data has been entered on the claim:
    a. On the last service line entry, press or click on "**Add**" to add the service line.
    b. If all the services have been entered, click on the "**Save Claim**" button at the bottom of the screen.
34. After the form has been saved and cleared, the following message appears: "Save Complete: Claim has been saved!"
    a. Press **Enter** or click on **OK** to accept.

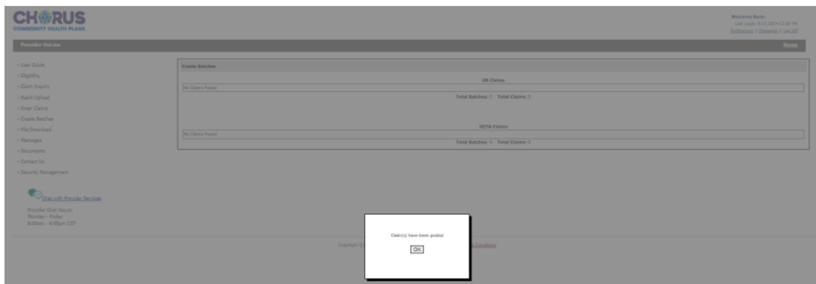
Create Batches

When the Prelog claims are *saved*, the claims sit in the Prelog Claims table. The **Create Batches** function begins the editing process by consolidating all the Prelog Batches physically entered into one electronic batch number and automatically assigns an Internal Batch ID number and an Extended Batch ID.



Next, click on either **Create UB Claims** or **Create HCFA Claims**, or both, if claims were entered under each form type. The claims are combined into one electronic claims batch, creating a new batch number record, and are automatically submitted for editing.

After clicking on **Create UB Claims** and/or **Create HCFA Claims**, notification is returned that "Claim(s) have been posted"



Chat

Providers can chat with Provider Services representatives on an assortment of topics.

To initiate a chat, users should follow the steps below:

1. Click on the Chat with Provider Services link or the Callout icon. The Select a topic for your chat is presented.
2. If applicable type the Member ID in the Member ID field
3. Select a topic and select Start Chat Session. A live chat session will be presented.

LIVE CHAT

End Chat Session

Before beginning your chat session, please select a topic from the list below that best describes your question, concern, or comment (one may already have been selected).

For fastest handling of all claim inquiries, use the compose feature when viewing the claim online.

Member's ID: (Numbers only) (if applicable)

My preferred security setting is:

I would like to chat with a provider services representative about:

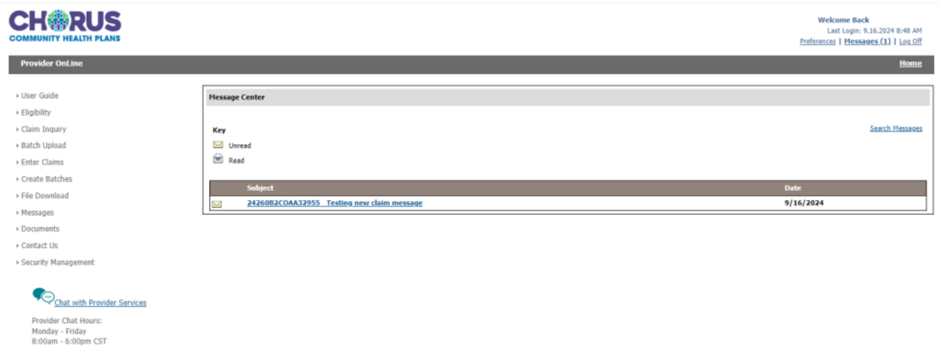
- a member's eligibility
- coverage for a procedure code
- authorization requirements
- locating a provider or facility
- durable medical equipment (DME)
- vision/dental/behavioral benefits
- chiropractic benefits
- home health benefits
- an Explanation of Payment
- the status of an appeal
- a topic that is not listed here

Start Chat Session ›

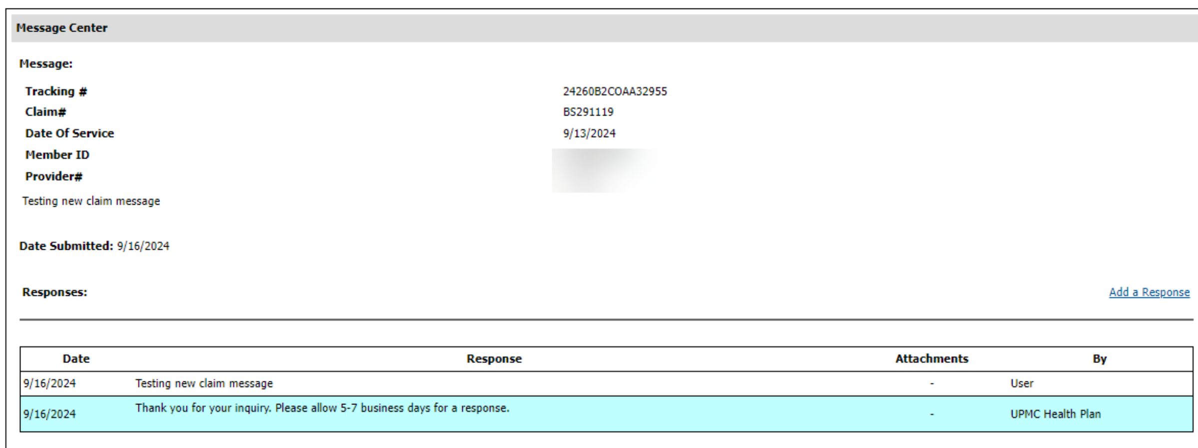
Messages

The user is able to access secure messages by clicking on the Messages link in the menu bar as well as the left navigation. If the user has unread messages, the number of unread messages is listed in parenthesis to the right of messages.

The screen below is the main screen for the Message Center. There is a key to indicate read messages and unread messages.



The user can access the details of a message by clicking on the hyperlink for the respective message's subject.



Preferences

A user can update their name, email and telephone number by selecting Preferences in the top menu bar.

The users demographic details and their Online Account Administrator information is presented.

Security Management

The OnLine account administrator is the individual within a practice who manages all Provider OnLine security and access.

OAA's can access their security management settings by clicking the Security Management link on the left-hand navigation. Here, OAA's have the following options:

- Add New User Account
- Manage Pending Users
- Modify User Permissions
- View Clinical Applications
- Add Account Administrators
- Remove Account Administrators

Add New User Account

To add a user, OAA's should click on the **Add New User Account** link. That will take the OAA to the **Add User** page.

Add User

Search for an Existing Provider OnLine Account
using any available information

First Name: John

Last Name: Doe

Search Clear

This search returns the first 100 records found. If you cannot find what you are looking for, please refine your search.

The OAA should type in the first and last name of the person they are adding. They should then click on the **Search** button to continue. This will generate the search results.

Add User

Search for an Existing Provider OnLine Account
using any available information

First Name: John

Last Name: Doe

Search Clear

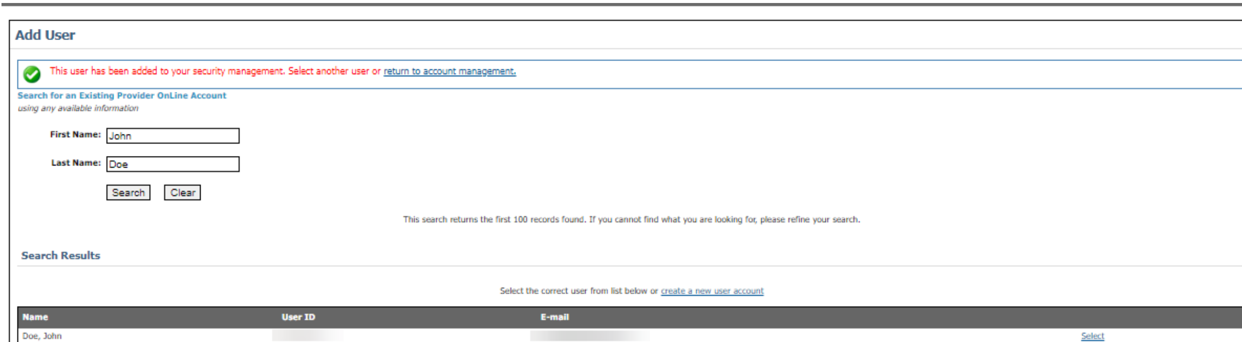
This search returns the first 100 records found. If you cannot find what you are looking for, please refine your search.

Search Results

Select the correct user from list below or create a new user account

Name	User ID	E-mail	
Doe, John			Select

Once the correct user is found in the search results, the OAA should click on the **Select** link. This will add the user to your security management.



The OAA can then return to the account management section by clicking on the **return to account management** link.

If no users appear in the Search Results, the OAA will need to create a user. To do so, the OAA should:

1. Click on the **create a new user account**

This will take the user to the **Create New Account for Provider OnLine** webpage.

2. Fill in the user and office information
3. Fill in the New Login Information (new user ID and temporary password)

4. Click on the **Submit** button to create the user account or **Clear** to clear the fields

Create New Account for Provider OnLine

User Information

First Name: Jane
Last Name: Doe
E-mail: janedoe@test.com
Confirm E-mail: janedoe@test.com

Office Information

Office Address 1: 1234 Main Street
Office Address 2:
City: Hometown
State: WA
Zip: 1111
Work Phone: 111-111-11111
xxx-xxx-xxxx

Submit | Clear

The user will receive an invitation to select their user id and password.

Manage Pending Users

To assign permissions for the newly created user, return to security management and select Manage Pending Users. All users that have received the invitation but have yet to establish the account will appear on the Manager Pending Users page. Invitations are good for 72 hours from receipt.

Users will appear in Manage Pending Users will display all users that have not registered for an account for 7 days from the creation date.

CHORUS COMMUNITY HEALTH PLANS

Welcome Back:
Last Login: 9.13.2024 12:00 PM
Preferences | Messages | Log Off

Provider OnLine | Home

- User Guide
- Eligibility
- Claim Inquiry
- Batch Upload
- Enter Claims
- Create Batches
- File Download
- Messages
- Documents
- Contact Us
- Security Management

Manage Pending Users

Return to Security Management

For security purposes, new user invites are valid for 72 hours. If users do not register within 72 hours, you can resend their invitation below. If you no longer wish to create a new user, simply cancel their invitation. If users do not register within 7 days of their last invite, you will need to re-register them under the Add New Users tab.

Show 10 records

Last Name	First Name	Created Date/Time	Expires at Date/Time	Action
DOE	JANE	9/13/2024 4:47:15 PM	9/13/2024 4:57:15 PM	Resend Invitation / Cancel Invitation / Edit Permission

- Resend Invitation will send the invitation to the email address for the newly created user.
- Cancel Invitation will remove the ability for the user to set up an id and password.
- Edit Permissions will allow the OAA to add access to the new user.
  - **NOTE:** All users are automatically granted the following permissions upon account creation:
    - View member eligibility information
    - Search for codes
    - Access to document library
    - Online Chat

After the OAA selects the applicable permissions, selection of click **Next** will navigate to the **Assign Medical Claims Submission Types** screen. The OAA will then have to select the type of medical claims submission access (PRE-HCFA and/or PRE-UB) they wish to grant the user.

Next, the OAA will Assign Vcode Access to the new user. The OAA will have three options to choose from when granting access: None, Group Access, or Individual Provider Access.

The OAA will then review the access has given to the user and then click **save.**

CHORUS
COMMUNITY HEALTH PLANS

Welcome Back: GINA WOODS
Last Login: 9.13.2024 12:00 PM
Preferences | Messages | Log Off

Provider OnLine | Home

- User Guide
- Eligibility
- Claim Inquiry
- Batch Upload
- Enter Claims
- Create Batches
- File Download
- Messages
- Documents
- Contact Us
- Security Management

Chat with Provider Services

Provider Chat Hours:
Monday - Friday
8:00am - 6:00pm CST

Modify User Permission & Access

Please review the access you have selected for this user.

VCODE Identifiers for selected application(s)
Provider
V10902 - All

Medical Claims View

Explanation of Payment

Medical Claims Submission
Requested Submission Types
PRE-HCFA
PRE-UB

Cancel Save

Modify User Permissions

Selection of Modify User Permissions allows the Online Account Administrator (OAA) to edit the existing users permissions. The steps to update the users permissions are the same as outlined in the Manage Pending User steps.

Add Online Account Administrators

The **Add Online Account Administrators** link allows the OAA to designate (two including yourself) Online Account Administrators. To do so, the OAA should:

1. Click **Select** next to the User ID they choose to designate an OAA.

Manage Online Account Administrators

Select the active user you wish to delegate online account administrator privileges to.

Name	User ID	
B2c Cchp	B2CCCHP	Select
B2c Claims	BC2TESTCLAIMS	Select
John Doe	JDOECCHP1	Select
Cchp Mfa	CCHPMFA	Select
Cchp Newuser	CCHPNEWUSER	Select
Cchp Newuser	CCHPNEWUSER1	Select
Edi Testing	EDITESTINGFORCLAIMS123456789	Select
	B2COAA	current

Cancel

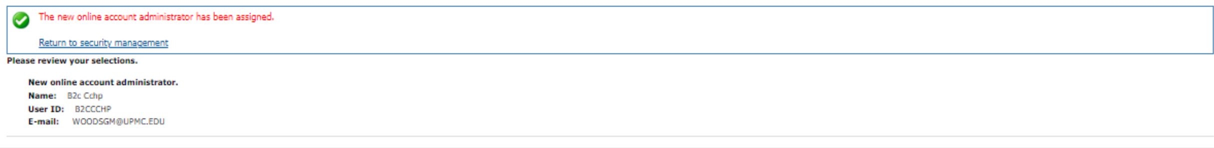
2. Review & save your selection.

Manage Online Account Administrators

Please review your selections.

New online account administrator.
Name: B2c Cchp
User ID: B2CCCHP
E-mail: WOODSGM@UPMC.EDU

Cancel Save



NOTE: When changing your OAA designation, the user will have to remove a current OAA before they proceed to the review section.

Manage Online Account Administrators

You must have two online account administrators at this time. Please select the one you wish to remove.

Name	
	Select
B2c Cchp	Select

Cancel