

PROVIDER PORTAL USER GUIDE



Children’s Community Health Plan Provider Portal

The secure Children’s Community Health Plan Provider Portal allows users 24/7 access to resources and self-service applications to simplify everyday tasks, promote efficiencies in business, and streamline electronic transactions.

This Children’s Community Health Plan Provider Portal User Guide details how to use the self-service applications available in the Portal once a Provider Portal account is created. If an account has not been established, refer to the Children’s Community Health Plan Provider Portal Registration Guide for the registration process to create individual and organization Provider Portal accounts.

Google Chrome is recommended for optimum performance when using the Provider Portal.

Access the Children’s Community Health Plan Provider Claims Portal directly:

<https://providerauth.cchpservices.com/>

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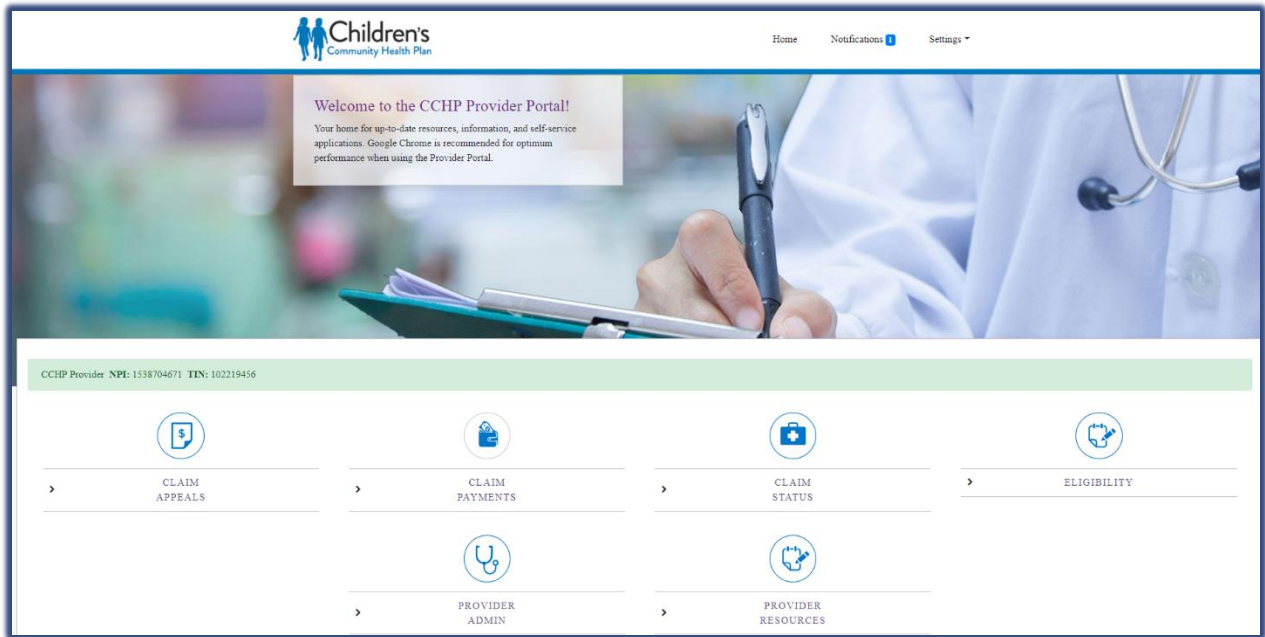
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A. Home Page

The Children’s Community Health Plan Provider Portal Home Page offers users access to:

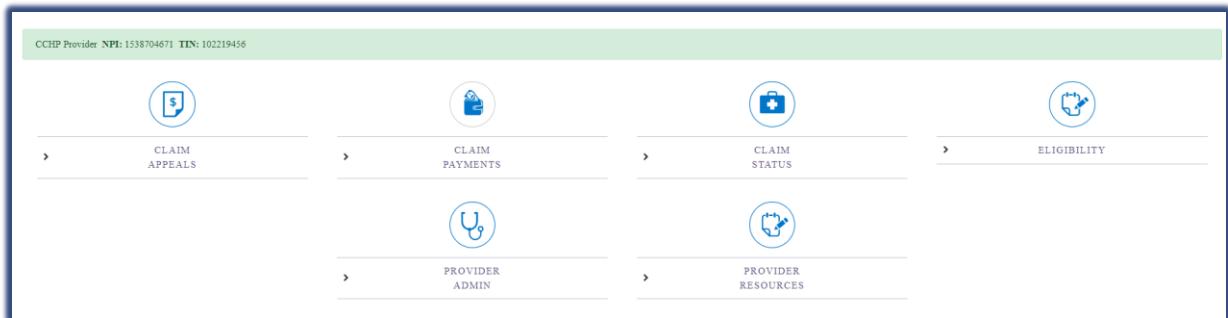
- Self-service claims and authorization applications
- Secure Notifications
- Change Provider ID

Whenever present, clicking the  logo located at the top of the page will return users to the Provider Portal Home Page.



Applications

Each user will only have access to the application(s) assigned to them by the Site Administrator for their organization. Available applications will be displayed on the Home Page, and can be updated by the Site Administrator at any time. The Provider Admin application is reserved for Site Administrators only.



Notifications

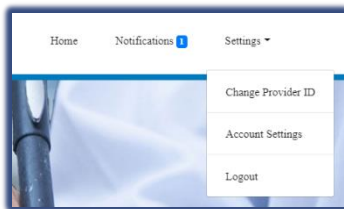
The Notifications page stores all notifications that are delivered through the Provider Portal, including:

- Flash Messages
- Account Profile Updates
- New User Registration
- Claim Appeal Receipt Notice
- Claim Appeal Decision Notice

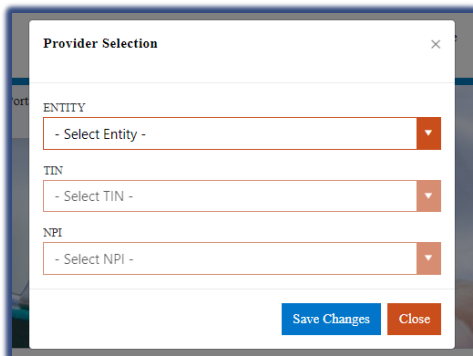


Change Provider ID

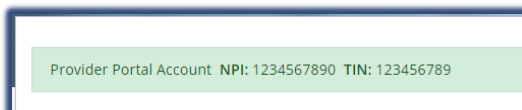
Users who have access to multiple Organization accounts can change their access without logging out. This can be done by selecting the Settings dropdown at the top, -and click **Change Provider ID**.



The Organization Details box will appear. Select the Entity you would like to work under from the **Entity** dropdown. Then select the applicable Tax Identification Number (TIN) and National Provider Identifier (NPI) from the dropdowns and click **Save Changes**. Users will only be able to select a TIN and NPI that is registered under the Entity that is first selected, and will only have access to information available on that account.



The selected Organization information will appear in the green panel above the application tiles.

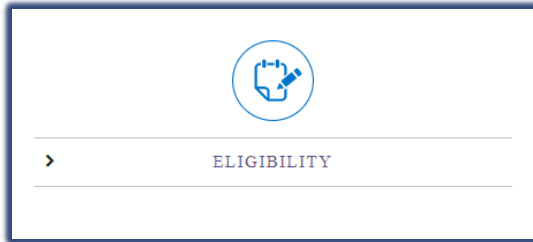


B. Eligibility

This application provides human readable real-time EDI 270/271 transactions. The information includes detail regarding Dean Health Plan eligibility and benefit plan coverage, co-payments, and deductibles. It also provides the member's primary health insurance carriers name, if applicable.

a. Access Eligibility

After logging into the Provider Portal select the **Eligibility** application located on Home Page.



b. Submit Real-Time 270 Eligibility Transaction

Users are taken to the **New Eligibility Inquiry** page

A screenshot of the "New Eligibility Inquiry" page. The title "New Eligibility Inquiry" is at the top left. Below it is a form box with the heading "Member Information". The form contains several input fields: "Last Name", "First Name", "Middle Initial", "*Date of Birth" (with a placeholder "mm/dd/yyyy"), "Member ID", and "Date of Service" (with a placeholder "08/29/2019"). A blue "SUBMIT REQUEST" button is located at the bottom right of the form box.

In order to successfully submit a 270 Eligibility Inquiry, the following fields must be filled:

- Date of Service (this will be pre-populated with the current date)
- Member's Date of Birth
- Either the member's First and Last Name or the Member ID

The Date of service will default to the current date. Maximum eligibility lookup is 12 months.

Tip

Eligibility Inquiries can be submitted by searching by the member DOB and either their full name of their member ID.

c. Eligibility Inquiry Response

Eligibility Inquiry Results

Member Name:	MEMBER, SAMPLE
Member ID:	12345678901
Date of Birth:	01/01/2000
Group Number:	123ABCD (EXCHANGE INDIVIDUAL)
Plan Network Identification Number:	DHP EXCHANGE IND
Plan Begin Date:	01/01/2020
Plan End Date:	12/31/9999

SUBMIT NEW INQUIRY

The member’s policy information will appear in the top, left portion of the screen. Verify that the correct member is showing on the screen.

Other Primary Policy

Other health insurance (Primary) information will be returned:

- If the health insurance is listed as the primary payer
- As the subscriber level (Loop 2120C)
- If the other health insurance is effective at the requested Plan Date in the 270 eligibility request (DTP*291), and will only return the Organization Name (NM103)

Coverage

The table will display member benefit information for the policy year that was searched.

Each column can be filtered alphabetically or numerically by selecting the arrows in the top row of each column.

There is a **Search** field located in the upper right corner of the page next to the table. Enter a keyword or dollar value into this field to filter results to only show fields that contain those keywords or values.

▲	Eligibility Information Code	Plan Description	Coverage Level Code	Service Type Code	Insurance Type Code	Network Indicator	Amount	Percentage	Benefit Dates	Time Period
	Active Coverage	DEAN HEALTH PLAN ACA		Health Benefit Plan Coverage	Exclusive Provider Organization					
+	Deductible		Individual	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	\$750.00			Service Year
	Deductible		Individual	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	\$750.00			Year to Date
	Deductible		Individual	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	\$0.00			Remaining
	Deductible		Family	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	\$1500.00			Service Year
	Deductible		Family	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	\$750.00			Year to Date
	Deductible		Family	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	\$750.00			Remaining

Additional details may apply to specific benefits. These details are denoted by a box with a “+” in the left column of the table. Please select this box to review additional details that apply to this benefit.

▲	Eligibility Information Code ▼
+	Non-Covered

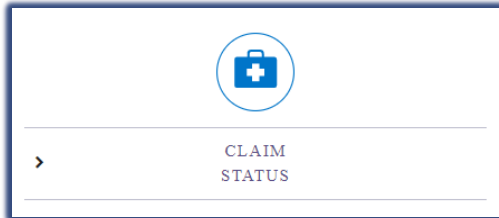
Message THOSE SERVICES AS REQUIRED BY STATE/FEDERAL MANDATES ARE COVERED. SUBMIT PRESCRIPTION COVERAGE REQUESTS TO THE PATIENT'S PBM.

Once benefits have been verified, users can submit a new inquiry by selecting the **Submit New Inquiry** under the member policy information. Click the Dean Health Plan banner at the top of the screen to return to the Home Page, or close the tab to exit entirely.

C. Claim Status

The Claim Status application provides human readable real time EDI (Electronic Data Interchange) 276/277 Claim Status Request and Response transactions that enables users to check the status of their submitted claims.

After logging into the Provider Portal click the **Claim Status** application located on Home Page.



Tip

Maximum claim status lookup is 12 months.

Users will be taken to the **New Claim Status Inquiry** page.

a. Submit Real-Time 276 Claim Status Transaction

Select the Billing ID (NPI) from the Provider Billing ID dropdown. This should be the billing NPI that the claim(s) was submitted under. Enter information into all required fields denoted by (*):

- Member Last Name
- Member First Name
- Date of Birth
- Member ID
- Date of Service Start Date (If the start date is the not the exact date of service, the end date must also be entered.)

Once all required fields and desired optional fields have been filled, click **Submit Request**.

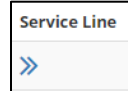
b. 277 Claim Status Response

All claims that meet the search criteria will be returned in the results.

Claim Status Inquiry Results						
Member ID:		00012345601				
Member Name:		MEMBER, SAMPLE				
SUBMIT NEW INQUIRY						
Control Number	Dates of Service	Claim Charges	Claim Paid Amount	Adjudication Date	Status	Service Line
20000000H111111	10/01/2018 - 10/31/2018	\$ 10.00	10.00	11/18/2018	Finalized - The claim/encounter has completed the adjudication cycle and no more action will be taken. Claim/line has been paid	»

Tip

For additional details relating to each service line, click the double arrow to the right of the record under **Service Line**. This will display each service line individually.



The claim header will show:

- Children’s Community Health Plan claim number
- Dates of Service
- Claim Charges
- Claim Paid Amount
- Adjudication Date
- Status (Pending or Finalized)

For additional details relating to each service line, select the double arrow on the right of the record under **Service Line**. This will display each service line individually.

Control Number	Dates of Service	Claim Charges	Claim Paid Amount	Adjudication Date	Status	Service Line
20000000H111111	10/01/2018 - 10/31/2018	\$ 10.00	\$ 10.00	11/18/2018	Finalized - The claim/encounter has completed the adjudication cycle and no more action will be taken. Claim/line has been paid	»
Service Line Information						
Rev Code:						
Procedure:	E0570					
Mod:	RR					
Svc Units:	31					
Date:	10/01/2018 - 10/31/2018					
Charge:	\$ 10.00					
Paid:	\$ 10.00					
As of:	08/13/2019					
Finalized - The claim/encounter has completed the adjudication cycle and no more action will be taken.				Claim/line has been paid		

The Service Line Information will display the following information:

- Revenue Code
- Service Units
- Modifier (if applicable)
- Date of Service
- Billed Charges
- Paid Amount
- Final Review Date
- Status

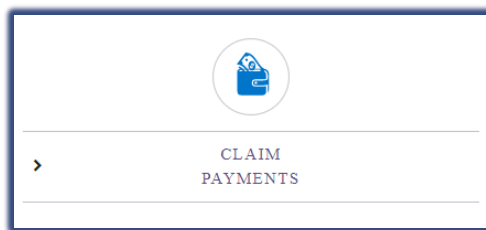
Click **Submit New Inquiry** to review additional claims, or select the Dean Health Plan banner to return to the Home Page.

D. Claim Payments

The Claim Payments application provides access to claim payment information online and allows Dean Health Plan to deliver Electronic Remittance Advice (ERAs) or “remits” to providers online rather than mailing these documents. ERAs are statements from Children’s Community Health Plan documenting payments of claims.

a. Access Claim Payments

After logging into the Provider Portal select the **Claim Payments** application located on Home Page.



Tip

It is recommended that date and patient information both be entered to return the most accurate search results.

Tip

Remits from the past 180 days can be reviewed.

Remits

Use the **Remit Search** on the left side to filter for specific claim payments. If no search filters are selected, the report will default to payment information from the last 30 days.

Date Submitted	Payer	Patient Name	Check Number	Check Date	Patient Account Number	Paid Amount	Action
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	333	6565.00	» 📄 🖨️
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	111	15.81	» 📄 🖨️
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	222	0.00	» 📄 🖨️
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	555	0.00	» 📄 🖨️
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	555	0.00	» 📄 🖨️
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	555	2417.73	» 📄 🖨️

Search Options:

- **Date** – select the check date (if known) by entering a specific date or date range
- **Patient** – enter member ID to name to search for a claim for a specific member’s remits
- **Keyword** – enter information related to a claim. Can include claim number, check number, servicing provider NPI1, servicing provider name, etc.

Claim results will display as search criteria is entered. Continue entering search criteria until desired results are achieved.

Remits

This page allows you to manage remits from the past two weeks (180 days when filtering). You can view remit files using the buttons(s) below.

Use the search box to search for specific remits, or use the filters to view remits for specific payers and/or patients. By clicking the Download CSV link under Payments, you can download a payment report that is restricted to your filtered search results. If no filters are selected, the report will download the payment information from the last 30 days.

Remit Search

Keyword
SEARCH

Filter

Date

Patient

Clear Filters

Date Submitted	Payer	Patient Name	Check Number	Check Date	Patient Account Number	Paid Amount	Action
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	333	6565.00	> 📄 🖼️
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	111	15.81	>> 📄 🖼️
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	222	0.00	>> 📄 🖼️
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	555	0.00	>> 📄 🖼️
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	555	0.00	>> 📄 🖼️
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	555	2417.73	>> 📄 🖼️

More Details

EOP Image

General claim information is available on this screen, but additional details are available through the **Action** items on the far right column of each record. Available **Actions** include:

- Show details
- Add notes
- View Image

Show Details

Select the double-arrow **Action** to expand the header line to view additional payment details including:

- Provider Information
- Payment Information
- EDI transactions

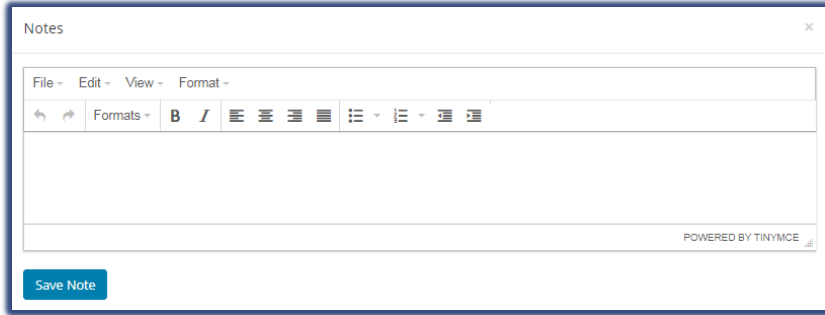
Show 10 entries

Date Submitted	Payer	Patient Name	Check Number	Check Date	Patient Account Number	Paid Amount	Action
2019-07-22 11:37 AM						0.00	>> 📄 🖼️

Claim Information	Payment Information	Additional Actions
Patient Name : Member Id : Payer Claim Number : Patient Account Number : Total Charge :	Payer Name : Provider Name : Check Number : Check Date : Paid Amount :	<div style="border: 1px solid #0070C0; padding: 2px; display: inline-block;">☰ View EDI</div>

Add Notes

Select the clipboard and paper icon to enter payment specific notes that are viewable for all users with access to the same account.



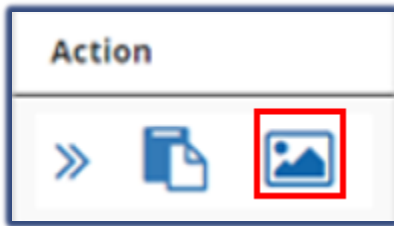
EOP

Tip

Once a note has been added to a payment, the note icon will turn green

Image

Select the picture icon to view the EOP. This is a sample only, and should not be used for business purposes.

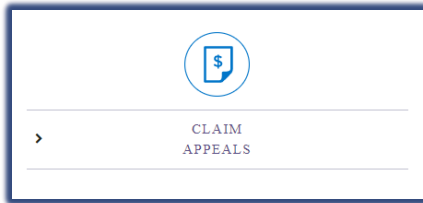


E. Claim Appeals

Claims that have finished processing and are in a finalized status (paid/denied) can be appealed directly through the Provider Portal.

a. Access Claim Appeals

After logging into the Provider Portal select the **Claim Appeal** application



Tip

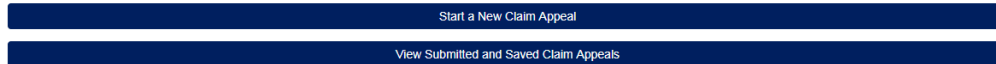
Corrected claims cannot be submitted via the Provider Portal.

The Claim Appeal feature has two options:

- **Start a New Claim Appeal** – allows the submission of a new Claim Appeal
- **View Submitted and Saved Claim Appeals** – allows the search for claim appeals that may have been started and saved or claim appeals that were submitted.

Note: Up to 500 submitted claim appeals within a six month period will be available to view.

Choose an action below:



b. Start a New Claim Appeal

To start a new claim select the **Start a New Claim Appeal** action to prompt the **Select Claim Appeal Type** form to display. Select the radio button for the applicable claim appeal type and click **Select Form**.

Appeal Type	Description
<input type="radio"/> COB	Use this form to request a reconsideration of a coordination of benefits (COB) denial. The primary payor's EOP is required if not submitted with the original claim.
<input type="radio"/> Additional Payment	Use this form to request a reconsideration of a payment. Include both the amount originally paid as well as the expected payment amount. A brief statement explaining why the original payment is incorrect, is also required.
<input type="radio"/> Recoup	Use this form to request a recoupment or refund. Include both the amount originally billed as well as the recoupment/refund amount. The reason for the recoupment/refund is also required.
<input type="radio"/> Timely Filing	Use this form to request a reconsideration of a timely-filing denial. Providers are required to file claims in a timely manner. All claims must be submitted in accordance with the claim filing limit stipulated in your Provider Agreement/Contract. Documentation to support the timely-filing waiver will be required.
<input type="radio"/> Code Review Request	Use this form to request a reconsideration of a claims-edit denial. For example, denials due to frequency/maximum units, code bundling, inappropriate modifier, global surgery, diagnosis etc. A brief statement explaining why the claim edit should be overturned, and corresponding supporting documentation will be required.
<input type="radio"/> Authorization	Use this form to request a reconsideration of a failure-to-pre-authorize denial.
<input type="radio"/> Medical Necessity	Use this form to request a reconsideration of a medical-necessity denial. A brief statement explaining why the denial should be overturned and corresponding supporting documentation will be required.
<input type="radio"/> Unlisted Codes	Use this form to request a reconsideration of an unlisted code denial. A description of the unlisted procedure, a brief statement explaining why the unlisted code denial should be overturned, and supporting documentation will be required.
<input type="radio"/> Duplicate Denial	Use this form if you believe your claim denied as a duplicate in error.

Validate Claim

After selecting the applicable Claim Appeal Type, a validation form will be prompted. Validate the claim by entering the Claim Number and Member Number and click **Validate Claim**. Once validated, additional appeal fields will populate.

Although there is an option to Submit the appeal at the bottom of the page, claim appeals cannot be submitted until all required with a red asterisk "*" have been completed. Required Fields include:

- Member Name
- Date of Services
- First Time Review
- Selecting Claim Lines
- Comments
- Attach Supporting Documents

First Time Review

After entering the member name and date of services, select the appropriate radial button under First Time Review. If **No** is selected, you will be prompted to complete two additional fields – **Reason for Resubmission** and **Original Claim Appeal Submission Date**.

First Time Review? *

Yes No

Reason for Resubmission *

Please explain the reason for resubmitting the appeal

Original Claim Appeal Submission Date *

Enter the date of original submission (MM/DD/YYYY)

Appeal All Claim Lines

If the **Appeal All Claim Lines** box is selected, all data entry fields except for **CARC** (Claim Adjustment Reason Code) will be grayed out.

Note: Although there is not a red asterisk “*” by the **CARC** code data field, it is always required.

Appeal All Claim Lines?

CARC code is always required. If you do not choose "All Claim Lines", Service Line and Amount Charged are also required.

Service Line	CARC	RARC	Amount Charged	Remove
Enter the Service Line Code	Enter the CARC Code	Enter the RARC Code	\$ Enter the amount charged	<input type="checkbox"/>

+ Add Line

If you are not appealing all claim lines, all fields in the section must be completed.

Additional claim lines may be added by selecting **(+Add Line)** at the bottom of this section. These additional lines can also be removed by selecting the (x) box on the right.

Appeal All Claim Lines?

CARC code is always required. If you do not choose "All Claim Lines", Service Line and Amount Charged are also required.

Service Line	CARC	RARC	Amount Charged	Remove
Enter the Service Line Code	Enter the CARC Code	Enter the RARC Code	\$ Enter the amount charged	<input type="checkbox"/>
Enter the Service Line Code	Enter the CARC Code	Enter the RARC Code	\$ 0.00	<input type="checkbox"/>
Enter the Service Line Code	Enter the CARC Code	Enter the RARC Code	\$ 0.00	<input type="checkbox"/>

+ Add Line

Comments

In the **Comments Field**, include a brief but detailed explanation as to why the claim is being appealed. The explanation should include information related to the appeal and should support why the original decision should be overturned. Be as detailed as necessary and include call reference numbers, if applicable.

Attach Supporting Documents

- Attach only the documents that are applicable and will support the medical necessity. Required information must be legible and clearly marked. Do not use highlight markers as they do not always show up on scanned images.
- In adherence to the HIPAA Privacy Rule, only the minimum necessary documentation needed for review should be submitted. The member's entire record should not be submitted unless it can be specifically justified as needed for that purpose.
- Appropriate file types include .jpg, .pdf, .png, .docx, .xlsx, and .msg.

Drag and drop supporting documents directly into the appeal. The drop box will turn green when the documentation is in the appropriate location to be released.

Once the documents are attached, they will appear in the Attach Supporting Documents section. Attachments can be deleted by clicking the "X" in the red box.

Add Claim Appeal

Multiple claim appeals can be added for the same claim type, such as COB, Timely Filing, Authorization, etc., by clicking the **+ Add Claim Appeal**. Clicking the **+ Add Claim Appeal** will prompt the process to start over with completing the validation and claim appeal form.

After completion of the Claim Appeal form, there are three options located at the bottom of the form:

- **Cancel Request** – Choosing this option will prompt the message, “Are you sure?” If you cancel the request, entered data will be lost. This will also remove the request if it was previously saved.
- **Save Request** – Choosing this option will prompt the message, “Appeal request has been saved.”
- **Submit** – Choosing this option will prompt the message, “Your claim appeal has been submitted successfully.”

Your claim appeal has been submitted successfully.

You will receive a confirmation email shortly.

Back to Menu
Exit

Once the appeal has been submitted, a Claim Appeal Acknowledgement will be sent through Notifications. Click **Notifications** on the Home Page to access this Acknowledgement.

HOME >
NOTIFICATIONS 76 >
SETTINGS ▾

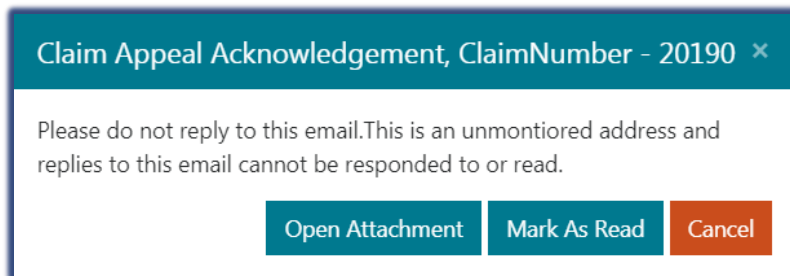
Tip

The number of unread Notifications are displayed in the Notifications field.

The most recent Notifications will be displayed at the top of the list and can be filtered by column. Look under the **Subject** column to find the **Claim Appeal Acknowledgement** with the applicable claim number identified and click **Read** to view the notification.

Read Flag	Read Date	Received Date	Subject	Action
		12/9/2019	Claim Appeal Acknowledgement, ClaimNumber - 20190628EDW0001	Read
		12/5/2019	Claim Appeal Acknowledgement, ClaimNumber - 20190628EDW0001	Read
		12/4/2019	Claim Appeal Acknowledgement, ClaimNumber - 20190628EDW0001	Read
✓	2/5/2020	12/3/2019	Claim Appeal Acknowledgement, ClaimNumber - 20190628EDW0001	Read
		11/29/2019	Claim Appeal Acknowledgement, ClaimNumber - 20190628EDW0001	Read
		11/29/2019	Claim Appeal Acknowledgement, ClaimNumber - 20190628EDW0001	Read

Click **Open Attachment** to download the Acknowledgement, and click on the pdf that appears at the bottom of the screen to view the Acknowledgement Letter.



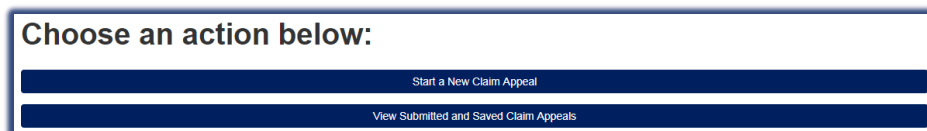
Once the appeal has been reviewed by the Health Plan, a **Determination Letter** will be sent through Notifications. This letter will indicate the review of the claim appeal was completed and the decision that was made.

Note: Claim appeal denial decisions can be re-appealed through online claim appeal submission. Denials should not be re-appealed if there is no new or supporting information to be reviewed.

c. View Submitted and Saved Claim Appeals

This feature enables the user to search for claim appeals that may have been started and saved, or active claim appeals that have been submitted.

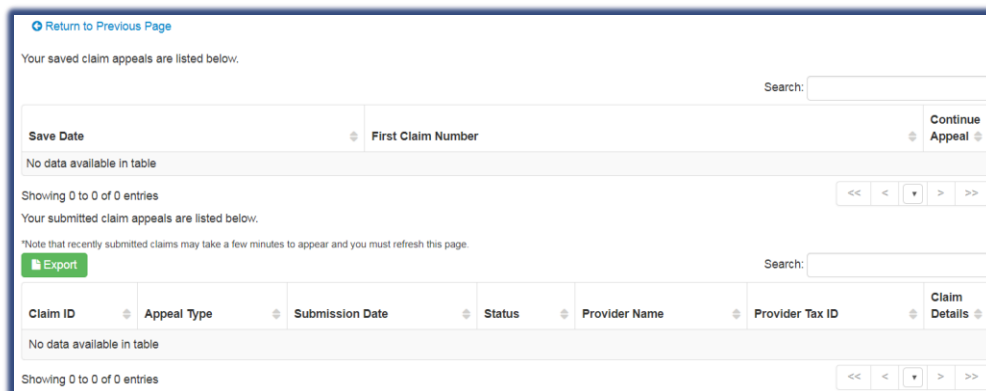
Select **View Submitted and Saved Claim Appeals** action.



Tip

Up to 500 submitted claim appeals within a six month period will be available to view.

After selecting the **View submitted and Saved Claim Appeals** action the following screen will be prompted.



Saved Claim Appeals

Saved claim appeals are located at the top section. If a claim appeal is started but not submitted, a user can resume the process by clicking **Continue Appeal** at the end of the saved claim appeal record.

Your saved claim appeals are listed below.

Search:

Save Date	First Claim Number	Continue Appeal
Tue Sep 10 2019 08:30:40 GMT-0500 (Central Daylight Time)	COB	Continue Appeal

Showing 1 to 1 of 1 entries

<< < 1 > >>

Submitted Claim Appeals

Submitted claim appeals are located at the bottom section. To view a submitted claim appeal select the **View Appeal** button located at the end of the submitted claim appeal record.

Claim ID	Appeal Type	Submission Date	Status	Provider Name	Provider Tax ID	Claim Details	User ID
20170101ZZ00000	Recoup	03/30/2018	Completed	DORY MAKEUP	333333221	View Appeal	sshoe11

View Appeal

Select **View Appeal** to view the details of the claim appeal submitted.

Claim ID	Appeal Type	Submission Date	Status	Provider Name	Provider Tax ID	Claim Details	User ID
20170101ZZ00000	Recoup	03/30/2018	Completed	DORY MAKEUP	333333221	View Appeal	sshoe11

After selecting to view appeal the Appeal Details will be displayed.

Appeal Details Print

Provider Tax ID 333333221	Contact Phone Number <input type="text"/>
Member ID 000111222301	Claim ID 20160101ZZ00000
Member Last Name SUNSHINE	Date of Service 01/01/2016
Member First Name SALLY	First Time Review? <input checked="" type="radio"/> Yes <input type="radio"/> No

Service Line	CARC	RARC	Amount Charged
3	110		1423

Showing 1 to 1 of 1 entries

Explanation
Testing 123

Attach Supporting Documents

Name