# Table of Contents

**Chapter 1: INTRODUCTION**
- About HMSA e-Claim ........................................................................................................... 2
- Accessing HMSA e-Claim System ......................................................................................... 3

**Chapter 2: DASHBOARD**
- HMSA e-Claim Dashboard ..................................................................................................... 4
- Generate Claim ......................................................................................................................... 5
- Professional Form Billing - CMS-1500 .................................................................................. 6
  (includes CMS-1500 New User Setup)
- Institutional Form Billing - UB-04 ........................................................................................ 17
- Manage Claims - Claim Correction ........................................................................................ 18

**Chapter 3: INQUIRIES - Search and view individual e-claims online**
- View Claims (claim level detail) ........................................................................................... 21
- View Claim Rejects .................................................................................................................. 23
- Received Remittance Detail .................................................................................................... 25

**Chapter 4: REPORTS**
- Reports .................................................................................................................................... 27

**Chapter 5: SUPPORT**
- Report a Problem ................................................................................................................... 29

**Appendix 1: HMSA Membership Numbers** ...................................................................... 30

**Appendix 2: QUEST EPSDT Claim Requirements** ............................................................. 32

**Appendix 3: National Drug Codes (NDC)** ....................................................................... 33

**Appendix 4: Warning Messages** ........................................................................................ 34
Chapter 1: INTRODUCTION

About HMSA e-Claim

To help streamline claims submission, HMSA offers its provider network an e-claim system that can be accessed via Internet Explorer, version 7 or above. HMSA e-Claim makes it easy for you to securely submit claims, access detailed reports, and manage claims submitted to the system. There is no charge for HMSA participating providers to use the HMSA e-Claim system.

HMSA e-Claim benefits include:

- No cost for providers.
- No billing software required.
- Connects to HMSA’s EDI system.
- Allows online submission and status checks of e-claims.
- Easy to edit rejected e-claims.
Accessing HMSA e-Claim System

Open Internet Explorer, version 7 or above and go to http://hhin.hmsa.com. Enter your HHIN User ID and Password.

Click on “HMSA e-Claims,” located at the top of the HHIN Home Page

Support: If you have questions about the HMSA e-Claim system, please call the HMSA EDI Help Desk at 948-6355 on Oahu or 1 (800) 377-4672 toll-free on the Neighbor Islands.
Chapter 2: DASHBOARD

My Portal - HMSA e-Claim Dashboard

Following login, My Portal gives you options to manage your data, reporting, and inquiry needs, as well as a dashboard that allows easy access to your Daily/Weekly/Monthly billing activity. The dashboard displays the following information.

- **Submitted Claim File Status**
  Claim files submitted within the last 30 days. Change the date range by clicking on the calendar icon.

- **Claim Reject Inventory (not reviewed)**
  Claims rejected and not reviewed by the end user. See page 23 to learn how to change each claim’s review status.

- **Claim Processing Status**
  Claims received but not processed. A yellow warning flag indicates claims have not been processed within three to five days. A red alert flag indicates unprocessed claims older than six days. Monitor the information and call us at 948-6355 on Oahu if you have questions.

Click on My Portal in the upper left corner to get back to this page.
Generate (Direct Data Entry) Claim

Generate Claim (or e-Claim) lets providers submit claims electronically to HMSA by keying the claim information via our standard template forms (CMS-1500 or UB-04). From My Portal, click **Generate DDE Claim** under Data Management.
Professional Form Billing CMS-1500

If billing on the **CMS-1500** form, please select (CMS-1500) from the Claim Type dropdown, and complete the rest of the dropdown selections.

- Claim Type = (CMS-1500) or (UB-04)
- Payer Resp = Primary
- Sender Trade Partner = Provider sending the claim
- Received Trade Partner = HMSA
New User CMS-1500 Setup - Setting up Boxes 31, 32, 33, and 36

Please do not enter asterisks (*), equal signs (=), pound signs (#), caret symbols (^), hypens (-), apostrophes ('), underscores (_), periods (.), or percentages (%). (For example, street number, suite, ZIP code).

Box 31: Name of Physician or Supplier

The provider who renders the service is only required when the name and NPI is different from the Billing Provider NPI in Box 33A. If the name and NPI are the same, do not enter the information in Box 31 and 24J.

If the provider rendering the service and NPI are not the same as in Box 33 and 33A, click on Select in Box 31 and the screen below will be displayed. Click Yes when asked Do you want to add a new Physician?

Your search did not find any Physicians ", "

Do you want to add a new Physician?

Yes  No

Complete the fields below and click Yes from the Default dropdown.
Click **Add** to save the information. The provider information will now appear every time you access the CMS-1500 form in Box 31.

Box 32: Name and Address of Facility Where Services Were Rendered is not mandatory unless services were rendered outside the home or office.

Box 33: Physician’s Supplier’s Billing Name and information

To save billing physician information in Box 33, click **Save/Look up Provider Info**, then click **Yes** when asked Do you want to add a new Billing?

---

**Your search did not find any Billing ****

**Do you want to add a new Billing?**

- **Yes**
- **No**
1. If your practice has a group name, it should be entered in the last name field. Do not use the first and middle name fields in that case.

2. Enter the street address only in Box 33—no P.O. Box. P.O. Box goes in Box 36.

3. A nine-digit ZIP code is required. Exclude special characters (hyphens).

Select Yes from the Default dropdown, and then click Add to save the information. The billing provider information will now appear every time you access the CMS-1500 form.

Box 36: Pay to Provider Address
The Pay to Provider Address is only required when the address where the payment goes is different from the billing physician’s address in Box 33 (e.g., a P.O. Box). If the address is the same, do not fill out Box 36.

The new user setup is now complete. Proceed with the Professional Claim Form (CMS-1500) as directed below.
Completing the CMS-1500 Form (after one-time setup of Boxes 31, 32, 33, and 36)

Please do not enter asterisks (*), equal signs (=), pound signs (#), caret symbols (^), hyphens (-), apostrophes (’), underscores (_), periods (.) or percentages (%). (For example, tax IDs, diagnosis codes, phone numbers, etc.)

* Fields with a red asterisk are required. See icon below.
* Fields with an S indicate that you can search for a value in a table.

- When moving between fields, use the TAB key or the mouse. Pressing the ENTER key may cancel entry, and you will need to re-enter the claim. If you get this message and would like to continue entering the claim, click OK.

- It’s best to use the scroll bar on the right side of your screen instead of the mouse wheel.

- The Claim Number and DCN fields are pre-filled with a system-assigned claim number. Also, the Claim option to the right is the default—do NOT change it to Encounter.

Box 1: Use BL for HMSA plans and Blue Cross/Blue Shield for Blue Card members, FI for the Federal Employees Program, or MC for the QUEST plan.

Box 1A: Click on Save/Look up – Member Info to search for or add subscriber/member information. Note: You must use the Save/Look up function to auto-populate these fields. If you type insured and patient information directly into Boxes 1a, 4, 5, 7, and 11 you will get an error when the system creates the e-claim.
1) Adding a patient who is the insured member

   A. Click Add Insured from the Member Search box.
B. Errors entering the format of the Subscriber ID are common. The format of HMSA Plan is 13 characters, QUEST is 10 numeric characters, BCBS Federal Employees Health Benefits Plan is nine characters, and for BlueCard plans use the exact number as shown on the card. Refer to Appendix 1 for more information.

Please note that the Insured Member box must be completed to save your subscriber information.

C. You will then see the following: Click on the option button (orange arrow below) for the insured.

D. The message box below will appear. Click Yes if the insured member is also the patient. The data entered in the Insured Member screen is now populated into the CMS-1500 form. If your patient is not the insured, but is a dependent of an insured member, use the following instructions.

2) Adding a dependent of the Insured Member
   A. Follow instructions in step 1) A through B.
B. At the bottom of the box that appears, click **Yes** to the question Do you want to add a new Patient Member? See image above.

C. Complete the Patient Member box and click **Add**.
D. You will then see the following.

E. Click on the option button (see orange arrow above) for the patient. The dependent’s data is populated in box 5, the insured’s data in box 7.

3) Searching for a previously entered patient

Once you have added all of your patients in the Insured Member screen, you will be able to search for the insured member in the Member Search screen below.

You can search by subscriber ID, insured’s last name and first name, or by clicking Search. If you search by subscriber ID, the insured member and dependents (if applicable) will be displayed.

A. If your patient is the insured member, select the insured member by clicking on the option button (see orange arrow below).

Then, click Yes to the following question.

B. If your patient is the dependent of the insured, click on the dependent's option button (see orange arrow on the next page).
C. The dependent's data is populated in boxes 2, 3, 5, and 6; the insured's data in boxes 4, 7, and 11 (shown below).
When the form is complete, select **Submit** or **Submit and Add Another**.

**Important Notes about CMS-1500 form:**

Box 9: If Box 11d is Yes, also complete Box 9. Enter **HMSA** in the Insurance Plan Name or Program Name box.

Box 14 Date of Current Illness/Injury/Pregnancy: Do not enter a date in Box 14 if this date is the same as the date of service in box 24A.

Box 17 Name of Referring Physician: If a referring physician name is required for the type of claim you are submitting, enter the last and first name.

Box 17B: At least one Referring Physician identifier is required in an e-claim. You can search the NPI Registry at https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do.

Boxes 19-22: You can resubmit a corrected claim and void a previously submitted claim electronically. The following must be completed to avoid a duplicate claim:

- Box 19: Reason for claim resubmission or void.
- Box 22: Medicaid Resubmission Code. Select code = 7 (Replacement) or 8 (Void).
- Box 22: The original Ref. No. must contain Original HMSA Claim ID.

Boxes 24D CPT/HCPCS code: If you include a tax CPT code S9999, enter only one tax S9999 in on e-claim. Multiple S9999s in an e-claim will be rejected by the HMSA EDI system.
Institutional Form Billing - UB-04

If billing on the UB-04 form, please refer to page 7. Select the appropriate form from the Claim Type dropdown.

- FL1 complete the Billing Provider information. Refer to pages 8 and 9, Box 33 in the CMS-1500, for instructions.
- FL2 complete the Pay to Provider information. Refer to page 9, Box 36 in the CMS-1500, for instructions.
- Go to FL 60 to look up or add new insured member and patient information. Refer to pages 11 to 15 for instructions.

* Fields with red asterisks are required. See icon below

Please do not enter asterisks (*), equal signs (=), pound signs (#), caret symbols (^), hyphens (-), apostrophes (‘), underscores (_), periods (.), or percentages (%) in any of the fields (e.g., tax IDs, diagnosis codes, phone numbers, etc.).

- Fields with S indicate that you can search for a value in a table.
- When moving between fields, use the TAB key or the mouse. Pressing the ENTER key may cancel entry, and you will need to re-enter the claim. If you get this message and would like to continue entering the claim, click OK.

- It’s best to use the scroll bar on the right side of your screen instead of the mouse wheel.
- The Claim Number and DCN fields are pre-filled with a system-assigned claim number. Also, the Claim option to the right is the default-do NOT change it to Encounter.
Manage Claims - Claim Correction

With a few keystrokes, HMSA e-Claim let’s providers correct claims that have just been entered or have been rejected by the edits in the e-claim or the HMSA EDI systems.

From My Portal, click DDE under Data Management.

When you first access Manage DDE Claims, click Search to view all rejected and/or recently entered claims. Claims that have not yet been processed (T-Txn Loaded) and claims that have been rejected (E-Reject/Error) will be displayed. Use % to perform wildcard searches.
• Edit claims with the (T-Txn Loaded) status by clicking the DCN number assigned to each claim and then clicking Edit.

After clicking the DCN number, you can click Do Not Resubmit for a claim you do not want the e-claim system to process.

The status of Do Not Resubmit claim is N and can be viewed in View Claims under the Inquiries section. Click on My Portal to return to Inquiries. Use the dropdown option of Claim Status and select N.

Printer Friendly lets you print the claims in status T-Txn Loaded and/or E-Reject/Error.

• Correct a claim with an E-Reject/Error status by clicking on the DCN number assigned to the claim and then clicking on Edit.

Click Reject/Error to see a Claim Status Information box that will reveal the reason for the rejection. In the example below, the subscriber’s member ID is not in the correct format.
Call HMSA support staff at 948-6355 on Oahu if you have questions about how to correct the rejection.

A. If the information about the insured and/or patient is incorrect, click on Save/Look up – Member Info in Box 1a in the CMS-1500 claim form (or Box 60 in the UB04 claim form).

B. The following screen will appear:
C. If the information about the insured member is incorrect, click on **Edit** next to the SubId under Insured (R000098765432 in example above). Let’s say the subscriber number is incorrect. Make the appropriate change (i.e., make sure there is a total of 13 characters) and click **Update**. (Refer to Appendix 1 for the correct Insured Member number format.) Click on the option button to the left of Edit. The revision made for the insured member will now populate the CMS-1500 (or UB04) claim.

D. If the information about the patient is incorrect, click **Edit** next to the SubId under Patient. Let’s say that the date of birth is incorrect. Make the appropriate change and click **Update**. Click on the option button to the left of Edit. The revision made for the patient will now populate the CMS-1500 (or UB04) claim.

E. After editing the claim, click **Submit**.
Chapter 3: INQUIRIES - Search and view individual e-claims online

View Claims - Claim Level Detail

View Claims under Inquiries will allow you to manually search/view claims.

From My Portal click View Claims from the Inquiries section. Search for claims based on a variety of search criteria. Use % to perform wildcard searches. The following criteria, alone or in combination, are commonly used.

1. Processed Date From/Processed Date To.
2. Member Last Name/Member First Name.
3. Member ID Number.
4. Patient Account Number.

△ To Generate Listing: Select Parameters, Then Click Search
The following are descriptions of claim statuses.

**T-Txn Loaded:**
- Claim(s) have been loaded in the e-claim system but await processing.

<table>
<thead>
<tr>
<th>Status</th>
<th>Submitted Date</th>
<th>Extract Date</th>
<th>Date of Service</th>
<th>DCN</th>
<th>Claim Type</th>
<th>Company</th>
<th>Member Num</th>
<th>Provider ID</th>
<th>Payer Account Number</th>
<th>Member Last Name</th>
<th>Member First Name</th>
<th>Provider Tax ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>T-Txn Loaded</td>
<td>02/29/2011</td>
<td>03/29/2011</td>
<td></td>
<td>11032690000017</td>
<td>Prof</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**X-Extracted to Payer/HMSA EDI System**
- Claim(s) have been processed and sent to the HMSA EDI system.

<table>
<thead>
<tr>
<th>Status</th>
<th>Submitted Date</th>
<th>Extract Date</th>
<th>Date of Service</th>
<th>DCN</th>
<th>Claim Type</th>
<th>Company</th>
<th>Member Num</th>
<th>Provider ID</th>
<th>Payer Account Number</th>
<th>Member Last Name</th>
<th>Member First Name</th>
<th>Provider Tax ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-Extracted to Payer</td>
<td>02/29/2011</td>
<td>03/30/2011</td>
<td>08/29/2011</td>
<td>10032900000016</td>
<td>Prof</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**A-Accepted by Payer/HMSA EDI System**
- Claim(s) have been accepted/acknowledged by the HMSA EDI system.

<table>
<thead>
<tr>
<th>Status</th>
<th>Submitted Date</th>
<th>Extract Date</th>
<th>Date of Service</th>
<th>DCN</th>
<th>Claim Type</th>
<th>Company</th>
<th>Member Num</th>
<th>Provider ID</th>
<th>Payer Account Number</th>
<th>Member Last Name</th>
<th>Member First Name</th>
<th>Provider Tax ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-Accepted by Payer</td>
<td>03/22/2011</td>
<td>03/26/2011</td>
<td>03/17/2011</td>
<td>1003220000004</td>
<td>Prof</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**E-Reject/Error**
- The HMSA EDI system has rejected this claim.
  Go to Manage Claims shown on page 18 for instructions to fix the claims rejected by HMSA’s EDI system.

<table>
<thead>
<tr>
<th>Status</th>
<th>Submitted Date</th>
<th>Extract Date</th>
<th>Date of Service</th>
<th>DCN</th>
<th>Claim Type</th>
<th>Company</th>
<th>Member Num</th>
<th>Provider ID</th>
<th>Payer Account Number</th>
<th>Member Last Name</th>
<th>Member First Name</th>
<th>Provider Tax ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-Reject/Error</td>
<td>03/21/2011</td>
<td>03/20/2011</td>
<td>03/21/2011</td>
<td>1106210000002</td>
<td>Prof</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**N-Not Submitted**
- Results from clicking Do Not Resubmit via the Edit function under Manage Claims (page 19).
  Show Search at the upper lefthand corner of the list of claims will reveal your search criteria. Conversely, Hide Search will hide them.
View Claim Rejects

View Claim Rejects under Inquiries shows a complete history of all reject/error claims. From My Portal, click View Claim Rejects from the Inquiries section.

In addition to seeing rejected claim detail, you can change the Review Status from Not Reviewed to Reviewed or vice versa. To do this, click on the DCN claim number to view the detail of the claim.
Then select the Toggle Reviewed button under Claim Info. This will allow you to reconcile or check off the rejected claims you have already reviewed and will update the dashboard to only show rejected claims that are still Not Reviewed.

Notes about Inquiry

- The above screen is shown in all inquiry reports.
- Click X to close the page.
- Printer Friendly option can be practical if you would like to print out the claim.
- On the right panel, Status will give you the reason(s) for the e-status/rejection error. Call the HMSA EDI Help Desk at 948-6355 on Oahu if you have questions about how to correct the rejection (this error in the Status tab only applies for claims in e-status).
- The Attachments and Repricing Information tabs do not apply to the HMSA e-Claim system.
Received Remittance Detail

Remittance under Inquiries provides e-claim users with the ability to view remittance information at the claim level.

From My Portal, click **Received Remittance Detail**.

Search for remittance checks based on the following criteria.

List of remittances for HMSA, QUEST, Senior, and BlueCard plans.
Summary of remittance check down to the patient level (total charge, total paid, and total remaining).

Click on the patient control number to display the detail of the claim.

From My Portal, select View Claims by Status D – Paid by Payor, Patient Account Number, or Patient Name.
Chapter 4: REPORTS

Reports

Generate reports for printout or monitor claims’ progress in the system.

To generate a report, click **Submitted DOE Claims** under Reports.

Then select a date range from the Submitted Date From and Submitted Date To fields and click **Search**.
• You can confirm the week’s transmission to HMSA, predict cash flow based on the number of claims submitted, or reconcile problems.

• In the example above, it shows nine claims were accepted by the HMSA EDI system with status (Accepted), 1 claim rejected as shown by Status Error and a Status N not submitted by the user.

• You can download this report to an Excel or a PDF file.
Chapter 5: SUPPORT
Report a Problem

For support, please call the HMSA EDI Help Desk at 948-6355 on Oahu or 1 (800) 377-4672 toll-free on the Neighbor Islands or email edisupport@hmsa.com.
Appendix 1: HMSA Subscriber Numbers

The format of the HMSA Subscriber Number is a common rejection error (Status E claims). Use the following guidelines:

**HMSA Private Business**

The subscriber number is 16 characters and has the following format:

\[ XLaannnnnnnnnc \]

Where “a” represents an alpha character.
Where “n” represents a numeric character.
Where “c” represents a check digit.

**The first three characters** should not be reported for claims filing purposes. **The member number filed should have 13 characters.**

**HMSA Akamai Advantage**

The subscriber number is 16 characters and has the following format:

\[ XLaadnnnnnnndc \]

Where the first “a” represents an alpha character L or M.
Where the second “a” represents an alpha character.
Where “n” represents a numeric character.
Where “d” can be an alpha or numeric character.
Where “c” represents a check digit.

**The first three characters** should not be reported for claims filing purposes. **The member number filed should have 13 characters.**

**HMSA QUEST**

**The first three characters** should not be reported for claims filing purposes. **The QUEST subscriber number has 10 numeric characters.**
Blue Cross/Blue Shield Federal Employee Program (FEP).

For FEP members, the member ID card normally looks like the image below.

![Member ID Card](image)

The member ID should be entered exactly as shown on the card (with R + eight digits), without adding any zeroes.

**Blue Card (BC) - ITS**

The subscriber number has up to 17 characters and the first three digits are alpha.

For filing purposes, it has up to 17 characters. The first three characters have to be alpha and the other 13 or 14 can be either alpha or numeric. Positions 1 and 2 are not XL. Positions 1 through 4 are not “AFHC.”

**Away from Home Care - AFHC**

The subscriber number has up to 21 characters, and the first four are always AFHC.

For filing purposes, it has up to 21 characters, and the first four are always AFHC. The others can be alpha or numeric.
Appendix 2: QUEST Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Claim Requirements

Requirements for e-claim:

1) HMSA should receive the Department of Human Services (DHS) forms three to four business days before the e-claim arrives at HMSA. This will allow HMSA enough time to route the DHS forms to the right area in the QUEST department.
   a. Please note that the original DHS form is sent to Med-QUEST. A copy is held for about a week in anticipation of the arrival of an e-claim.
      Mail the DHS forms to:
      HMSA QUEST Operations
      P.O. Box 3520
      Honolulu, HI 96811-3520
   b. The copy of the DHS form will not be retained for more than one week so the timing of the e-claim and the DHS form is important.

2) Complete Box 1 in e-claim with MC Program.

3) Complete Box 24H in e-claim with Y, assuming you are using an age-appropriate preventative CPT code.

4) The date of service in the e-claim must be the same screening date indicated on the DHS Form.
Appendix 3: National Drug codes (NDCs)

The NDC was introduced in 1972 as a 10-character code with a “4-4-2” configuration to identify the labeler, product, and package segment, respectively. Later, the FDA expanded the labeler segment to five digits, with two configurations (“5-4-1” and “5-3-2”). All of these configurations used dashes as delimiters to distinguish the three segments.

Today, most users convert the historic codes to an 11-digit format. In this format the first five digits represent the labeler segment, the next four digits are the product, and the last two digits are the package. To convert a historic NDC to this newer 5-4-2 configuration, add a leading zero either to a three-digit product segment or to a one-digit package segment. The 11-digit format includes no dashes. The 11-digit format is the only one permitted in NCPDP messages, and HIPAA regulations mandate this 11-digit format for all HIPAA transactions.

***Information shows hyphens in NDC number, but the hyphen should NOT be used in e-claim.

This is the formula to change a 10-digit NDC to an 11-digit code. Examples of segment packets are shown in the first column.

<table>
<thead>
<tr>
<th>NDC segments</th>
<th>10 digit NDCs</th>
<th>Change to 11 digits</th>
<th><strong>In e-claim, do not include hyphens</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>4-4-2</td>
<td>1234-5678-90</td>
<td>01234-5678-90</td>
<td>Add zero before first segment</td>
</tr>
<tr>
<td>5-3-2</td>
<td>12345-678-90</td>
<td>12345-0678-90</td>
<td>Add zero before second segment</td>
</tr>
<tr>
<td>5-4-1</td>
<td>12345-6789-1</td>
<td>12345-6789-01</td>
<td>Add zero before third segment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NDC segments</th>
<th>11 digit NDCs</th>
<th>11 digits</th>
<th><strong>In e-claim, do not include hyphens</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>5-4-2</td>
<td>12345-6789-01</td>
<td>12345-6789-01</td>
<td>This format is perfect, no change required</td>
</tr>
</tbody>
</table>

See [www.ncbi.nlm.nih.gov/pmc/articles/PMC2965522/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2965522/) for more information.
Appendix 4: Warning Messages

The e-claim system displays warning messages to help you improve the accuracy of a claim. The edits will also warn you that the claim contains invalid data or will not allow you to submit an incomplete claim. The following are a few examples.

1) Skipped diagnosis code entry in the first field and instead entered it in the second field. Enter the diagnosis code in the first field and delete the diagnosis code in the second field.

2) Two diagnosis codes entered sequentially. Service line 2 pointed to diagnosis 3 when third diagnosis code was not present. Correct the value in Box 24E to 1 and/or 2.
3. Service Date entered is 01/17/2012 (should be 01/17/2013). Warning gives biller a chance to correct Date of Service when it’s 180 days before current date. Correct the year in the message box and click OK. You’ll do this multiple times for each service from and to date.

4. Enter negative charge. Warning focuses biller on row 1 in Box 24. Delete the hyphen before the charge in Box 24F.

5. DOB year is 1962 but entered 1862. Enter the correct value and click OK.
6. Warning that a patient record for a subscriber number is already in the database

Windows Internet Explorer

⚠️ Payor: 990040115 and Sub Id r0000123456789 has already been taken.

OK