

**Show Me Healthy Kids**

MANAGED BY HOME STATE HEALTH



**home state  
health**

# Show Me Healthy Kids Claim Support and Portal Training

# How Do I Submit Claims?

## Portal Submission – Used When Credentialing is *Completed*

### Submit Claims Electronically through your Preferred Clearinghouse:

- Emdeon
- SSI
- Trizetto Provider Solutions
- Availity

Behavioral and Medical Claims are Processed through Home State Health, but on Separate Platforms with Different Payer ID's:

**Home State's *Medical Payer ID* is 68069**

**Home State's *BH Medical Payer ID* is 68068**

For more information please visit:

[Electronic Transactions | Home State Health](#)

## Provider Portal

- **Group NPI must be registered with MMAC before gaining access to the secure portal.**
- To register, please go directly to <https://www.homestatehealth.com/login.html>, register for a username and password, then select the “Claims Role Access” module.

Once you have access to the secure portal\* you may file first-time claims individually or submit first time batch claims. You will also have the capability to find, view, and correct any previously processed claims. Supporting documentation can also be uploaded via the secure provider portal.

\*All submissions sent through the portal allow for real-time tracking of Claim Status.\*

# PaySpan® Payment and Remittance Advice

Show Me Healthy Kids

MANAGED BY HOME STATE HEALTH

- Home State and **PaySpan** Health have partnered to provide **Electronic Fund Transfer (EFT)** and **Electronic Remittance Advice (ERA)** services
- This service is FREE
- **ERA's** can be imported directly into Practice Management systems
- Once contracted, **PaySpan** will issue a registration code and the online enrollment process takes 5 to 10 minutes to complete.
- To obtain a unique registration code contact PaySpan Provider Services at: **877-331-7154 (Option 1)**
- Contact Provider Services for more information or visit [www.PaySpan.com](http://www.PaySpan.com)



# What Information Does A Claim Contain?

## Claim Header:

- National Provider Identifier (NPI) for the attending physician and the service facility
- Primary diagnosis code
- Inpatient procedure, if applicable
- Diagnosis-related group (DRG)
- Name of the patient's insurance company, and
- Overall charge for the claim

## Claim Detail:

- Date of service
- Procedure code
- Corresponding diagnosis code
- National Drug Code (NDC), if applicable
- Attending physician's NPI number, and
- Charge for the service

For additional details on claim submission please see Provider Manual Billing and Claims Submission section here: [https://www.homestatehealth.com/content/dam/centene/home-state-health/pdfs/HSH\\_SMHK%20Provider%20Manual%20508%20Compliant%2012272022.pdf](https://www.homestatehealth.com/content/dam/centene/home-state-health/pdfs/HSH_SMHK%20Provider%20Manual%20508%20Compliant%2012272022.pdf)

# Completing a CMS 1500 Claim Form

Home State Health has a step-by-step billing guide located in the Provider Manual starting on page 81 on the pdf link below.

[Provider Manual Link](#)

- Required (R) fields must be completed on all claims.
  - Any required fields that are missing – claims will be rejected.
- Conditional (C) fields must be completed if the information applies to the situation, or the service provided.

Please see the example from Provider Manual:

Field #	Field Description	Instruction or Comments	Required (R) or Conditional (C)
1	INSURANCE PROGRAM IDENTIFICATION	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. Enter "X" in the box noted Medicaid (Medicaid #).	R
1a	INSURED I.D. NUMBER	The 8-digit Medicaid identification number on the member's Home State Health I.D. card.	R
2	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's Home State Health I.D. card. Do not use nicknames.	R
3	PATIENT'S BIRTH DATE / SEX	Enter the patient's 8-digit date of (MM/DD/YYYY) and mark the appropriate box to indicate the patient's sex/gender.	R
4	INSURED'S NAME	Enter the patient's name as it appears on the member's Home State Health I.D. card.	C



Note: Therapy and Professional services are billed on the 1500 claim form.

# Primary Diagnosis

## What is a Primary Diagnosis?

The primary diagnosis refers to the patient condition that demands the most provider resources during the patient's stay. There is often confusion surrounding primary and principal diagnoses and, consequently, the terms are commonly used interchangeably. While these can be (and frequently are) the same diagnosis in practice, their definitions are distinct. While a principal diagnosis is the underlying cause of patient symptoms, the primary diagnosis is used for healthcare billing purposes.

## Why are Primary Diagnoses Important in Healthcare?

Primary diagnoses play an important function in how providers are reimbursed for healthcare services. Whether it is diagnosis-related grouping (DRG) or ICD-10 coding, the primary diagnosis is used to inform the payer how much the provider is owed after a medical claim is submitted.

# What Is An ICD-10 Code

The ICD-10 is a code system that contains codes for diseases, signs and symptoms, abnormal findings, circumstances and external causes of diseases or injury.

## Mental, Behavioral and Neurodevelopmental Disorders F01-F99

### What does an ICD-10 code look like?

- ICD-10-CM Diagnoses Codes are 3–7-character codes
  - Character 1 is alphabetic
  - Character 2 is numeric
  - Characters 3–7 are alphabetic or numeric, with a decimal after 3<sup>rd</sup> digit
    - Example: Generalized anxiety disorder- F41.1

### Basic Intro to ICD-10 Code: [Training Link ICD -10 Codes](#)



Note: Have you signed up for MO Healthnet News?  
<https://dss.mo.gov/mhd/providers/index.htm#GD-snippet-form>  
Provider Bulletins can assist with Coding and Fee Schedules  
<https://dss.mo.gov/mhd/providers/pages/bulletins.htm>

# What Is A HCPCS Code?

## HCPCS: Healthcare Common Procedure Coding System

- A HCPCS code (pronounced hicks-picks) is a five-digit code containing 1 letter and 4 numeric characters. (example: K0108, E0630)
- There are 2 levels of HCPCS
  - Level I codes are based on CPT codes. They're used for services and procedures offered by healthcare providers.
  - Level II codes cover health care services and procedures that aren't performed by healthcare providers. Examples of items billed with level II codes are medical equipment, supplies, and ambulance services.

HCPCS level II code lists can be found on the [CMS website](#). Level I codes, however, are copyrighted by the AMA just like CPTs. ([CPT Codes: Format, Categories, and Uses verywellhealth.com](#))

# What Is A CPT Code

*CPT code is a code billed to insurer to indicate the services rendered to a patient.*

## CPT: Current Procedural Terminology

- A CPT code is a five-digit numeric code (example: 99214, 99306)

## Matching CPT Codes to Services rendered:

- Complete a CPT code search on the [American Medical Association website](#). You will have to register (for free). You are limited to five searches per day. You can search by a CPT code or use a keyword to see what the code for a service might be. ([CPT Codes: Format, Categories, and Uses \(verywellhealth.com\)](#))
- Please use our Prior Authorization tool located on our website under Provider Resources to validate if that is a covered benefit or if prior authorization is required.  
<https://www.homestatehealth.com/providers/pre-auth-needed/medicaid-pre-auth.html>

## Covered Services 7/1

### Psychiatric Residential Treatment Facility (PRTF)

- As of July 1, 2022, MHD managed care plans began covering **PRTF** services for their members.
- Providers must bill HCPCS code H2013
- Please see for reference: <https://dss.mo.gov/mhd/providers/pdf/bulletin44-32.pdf>
- Providers must submit claims for other behavioral health services (e.g., **individual, family, and group psychotherapy**) to Home State Health for SMHK members rather than to MHD. In order to ensure continuity of care, Home State Health will cover out of network providers who are already serving this population for a period of six months.
- The vast majority of COA 4 participants will be covered by SMHK/Home State Health, but children and youth who have opted out of managed care will be covered through fee-for-service.

# Residential CCS Services

Providers must bill HCPCS code H0019 and the appropriate modifier for facility type and treatment level

## Qualified Residential Treatment Program

Facility Type	Level 2	Level 3	Level 4
QRTP	H0019 HK	H0019 HK TF	H0019 HK TG
Non-QRTP	H0019 HA	H0019 HA TF	H0019 HA TG

Procedure Code	HCPCS Standard Description
H0019	Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem

[PRTF Bulletin Billing draft \(mo.gov\)](#)

[SMHK Residential Codes and Rates Bulletin Final \(mo.gov\)](#)

[PRTF Bulletin Billing \(mo.gov\)](#)

# Covered Services 10/1/2022

## PHASED IMPLEMENTATION SMHK went live on July 1, 2022

- In order to allow adequate time for provider training, credentialing, and system changes, coverage of residential and treatment foster care (TFC) services by the specialty plan will not be implemented until October 1, 2022.
- The services below are covered only for participants with the following medical eligibility codes: (Children's Division: 07, 08, 37, 38, 66, 0F; Adoption/Guardianship Subsidy: 36, 56, 57, 5A). **CD will continue to pay room and board to residential facilities for individuals receiving services through MHD fee-for service and for individuals receiving services through SMHK/Home State Health.**

# Treatment Foster Care & Transition Treatment Foster Care

- Providers must bill for TFC with HCPCS codes H2020. Modifiers are not required for this service.
- Providers must bill for Transition TFC with HCPCS code H2022 and modifier HE.

<b>Provider</b>	<b>Service</b>	<b>Proc code / Mod</b>	<b>HCPCS Description</b>
TFC	TFC	H2020	Therapeutic behavioral health services, per diem
TFC	Transition TFC	H2022 HE	Community based wrap-around services, per diem

[PRTF Bulletin Billing draft \(mo.gov\)](#)

[SMHK Residential Codes and Rates Bulletin Final \(mo.gov\)](#)

[PRTF Bulletin Billing \(mo.gov\)](#)

# Residential Aftercare

Providers must bill for aftercare services with HCPCS code H2022 and the appropriate modifier for facility type

Facility Type	Procedure code / modifier
QRTP	H2022 HK
Non-QRTP	H2022 HA

Procedure Code	HCPCS Standard Description
H2022	Community based wrap-around services, per diem

[PRTF Bulletin Billing draft \(mo.gov\)](#)

[SMHK Residential Codes and Rates Bulletin Final \(mo.gov\)](#)

[PRTF Bulletin Billing \(mo.gov\)](#)

# What Happens When Claim is Submitted

## When claim submitted on paper

- Once received a clean claim processes within 30 - 45 days.
- There are 180 days to submit a claim for timely filing.
- Validate claim status by contacting Provider Services at 1-877-236-1020.
- Rejected claims will be followed up with a letter of notification.

## When submitted electronic

- Once received a clean claim processes within 30 - 45 days.
- There are 180 days to submit a claim for timely filing.
- Pending, paid, and denied status with reason codes appear on provider portal once clean claim is received in system.
- Rejected claims will not enter our pre-adjudication process. Please work with your clearinghouse to identify and resubmit claim for processing.

# Avoid Claim Denials

Most common claim denials:

- Incorrect Diagnosis Code Used
- Incorrect Claim Form (CMS 1500 must be used)
- Member Ineligible for Home State Health Services
  - *Always check MO HealthNet [www.emomed.com](http://www.emomed.com)*
  - *Call Provider Services at 1-877-236-1020*
- Incorrect Payer ID Used (Behavioral vs. Medical)
- Form was Signed!
- Black/White Form Submitted
- Handwritten Forms Submitted

# Claims Support

Contact Home State Health's **Provider Services** Team, Monday through Friday from 8AM – 5PM, 1-877-236-1020

Submission	Address
First Time Claims and Corrected Claims:	Home State Health Plan Claim Processing Department P. O. Box 4050 Farmington, MO 63640- 3829 Home State Health Behavioral Health Attn: Claims PO Box 7400 Farmington, MO 63640-3827
Claim Reconsiderations:	Home State Health Plan Attn: Claim Reconsideration P. O. Box 4050 Farmington, MO 63640- 3829
Claim Appeals:	Home State Health Plan Attn: Claim Appeal P. O. Box 4050 Farmington, MO 63640-3829

Note: You must obtain a Provider Services Reference Number First Before Escalating Issues To a Provider Network Specialist



# Claims Escalation Process

- Call Provider Services per Applicable Line of Business (number on the back of ID card) to Inquire About Claim. (Obtain Representative's Name and Reference Number)
- Submit Claim Reconsideration
  - Provider Portal <https://www.homestatehealth.com/login.html>  
(Obtain Reference Number)
  - Mail Paper Reconsideration if Portal isn't Functioning Properly or Claim Number can't be Located. (Forms are Located on Website per Line of Business).
- If you have called Provider Services and/or sent in a Claim Reconsideration, and there are more than 10 claims, please complete Claim Escalation Excel Spreadsheet and email to our Claims Integrity Department, [MO\\_Claims\\_Integrity@homestatehealth.com](mailto:MO_Claims_Integrity@homestatehealth.com).  
(Ensure Original Provider Services Reference Number is Noted on Spreadsheet)
- Submit Claim Appeal. (Forms are Located on Website per Line of Business).

## Provider Representative Specialists Assist with:

- Appeal and claim reconsideration guidance
- Member benefits and eligibility
- Our Find a Provider online directory
- Authorization requirements
- Claim submission requirements
- Evidence of payment (EOP)/remittance advice support
- PaySpan (EFT/ERA) assistance
- Provider data review
- Payment and clinical policy questions
- Website/portal questions, including password reset

# Provider Engagement Administrator

## Provider Engagement Administrators Assist with:

- Product education
- Sharing provider resources/tools
- Policy and procedure protocols
- Use of the secure provider portal
- Core business functions
- Access and availability oversight
- Quality and credentialing site visits

## Helpful Links:

Show Me Healthy Kids

MANAGED BY HOME STATE HEALTH

Home State Health Provider Resources	<a href="#">Missouri Provider Resources   Home State Health</a>
Basic Intro to ICD-10 Codes	<a href="#">ICD-10 Codes Link</a>
American Medical Association	<a href="#">American Medical Association Link</a>
Home State Health Show Me Healthy Kids	<a href="#">Show Me Healthy Kids (homestatehealth.com)</a>
PaySpan (Electronic Funds Transfer)	<a href="#">Payspan   Login Page (payspanhealth.com)</a>
Home State Secured Provider Portal	<a href="#">Log In (entrykeyid.com)</a>

# Portal Overview

# Secure Provider Portal Introduction

The Provider Portal allows providers to:

- Check eligibility
- Submit, correct, and check claim status
- Submit and view prior authorizations
- View patient care gaps
- And much more

Home State Health's secure portal : <https://www.homestatehealth.com/login.html>

All at no charge....*FREE!*

# Portal Registration and Login

**Tip:** When a tax identification number operates in more than one state, the portal user can register for each health plan's portal with the same username (e-mail) and password.



## Log In

Username (Email)

LOG IN

[Create New Account](#)



[Help](#) [Privacy Policy](#) [Terms of Use](#) © 2021 Centene

# Account Manager

- A Portal Account Manager is a role assigned to a primary contact within a provider organization
- The Account Manager is responsible for the day-to-day support of all Secure Provider Portal user accounts that are registered under the same tax identification number. Some account manager tasks include:
  - Approving access for new secure portal users
  - Assigning permissions for users based on job responsibilities
  - Regularly adjusting permissions when roles change
  - Terminating users who no longer work at the practice.

# Account Management User



Eligibility Patients Authorizations Claims Messaging Help

Viewing For: [Dropdown] Medicaid [GO]

Account Details  
User Management

### Search for User

Email: [Text] Last Name: [Text] Status: [Dropdown]

Verification Pending

**Go!** **Clear**

### Invite a User

Email Address: [Text]

**Send Invitation**

[Account Manager User Guide](#)

Email Address ↑	Last Name ↑	First Name ↑	TIN ↑	Telephone Number ↑	Status ↑	
[Blurred]	[Blurred]	[Blurred]	[Blurred]	[Blurred]	Active	<b>Verify Account / Update User</b>
[Blurred]	[Blurred]	[Blurred]	[Blurred]	[Blurred]	Active	<b>Verify Account / Update User</b>
[Blurred]	[Blurred]	[Blurred]	[Blurred]	[Blurred]	Active	<b>Verify Account / Update User</b>
[Blurred]	[Blurred]	[Blurred]	[Blurred]	[Blurred]	Active	<b>Verify Account / Update User</b>
[Blurred]	[Blurred]	[Blurred]	[Blurred]	[Blurred]	Active	<b>Verify Account / Update User</b>

24 items found, displaying 1 to 10. Page 1/3 1,2,3 [Next](#) [Last](#)

Portal Account Managers, can click here to access the **Account Manager User Guide**



[Blurred]	[Blurred]	[Blurred]	[Blurred]	[Blurred]	Active	Account Manager Access	<b>Update User</b>
[Blurred]	[Blurred]	[Blurred]	[Blurred]	[Blurred]	PasswordExpired		<b>Update User</b>
[Blurred]	[Blurred]	[Blurred]	[Blurred]	[Blurred]	Active	Account Manager Access	<b>Update User</b>
[Blurred]	[Blurred]	[Blurred]	[Blurred]	[Blurred]	PasswordExpired		<b>Update User</b>
[Blurred]	[Blurred]	[Blurred]	[Blurred]	[Blurred]	Active		<b>Update User</b>

# Portal Account Details

The screenshot shows a web portal interface for account management. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this is a dropdown menu for 'Go to Dashboard For:' with 'Medicaid' selected and a 'GO' button. A red box highlights the 'Account Details' link in the top right corner. The main content area is divided into two sections: 'Account Details' and 'Add a TIN'. The 'Account Details' section contains a form with fields for Name, User Name (Email), Password, Telephone Number, Fax Number, and three Secret Questions. A red arrow points to an 'Update Account' button with the text 'Click Update Account, to change account details'. The 'Add a TIN' section includes a note about validation, a form with 'Name TIN' (with a red box around the 'Enter Name' field) and 'Tax ID' (with '123456789' entered), and an 'Add TIN' button. Below these sections is the 'Your TINs' section, which has a 'Provider Demographic Update Instructions' link and a table of TINs. The table has columns for 'TIN' and 'Product'. The first row is 'Allwell', the second is 'Ambetter', the third is 'Behavioral Health', and the fourth is 'Medicaid' (marked as 'Current Primary'). Red arrows point to the 'Mark as Primary' button for 'Allwell' with the text 'Click Mark as Primary, to change TIN and Product login default'. Red arrows point to the 'X' icons for 'Ambetter' and 'Medicaid' with the text 'Click X to remove a TIN'. A red arrow points to the 'Provider Demographic Update Instructions' link with the text 'Click Provider Demographic Update Instructions to access instructions'. A red arrow points to the 'Medicaid' entry with the text 'Click TIN / Product to view / update Provider Demographics'.

Your TINs, list the TIN(s) you added to your portal account

Use **Add a TIN**, to associate additional TIN(s) to your portal account

Click **Provider Demographic Update Instructions** to access instructions

Click **X** to remove a TIN

Click **TIN / Product** to view / update Provider Demographics

Click **Mark as Primary**, to change TIN and Product login default

# Who is Eligible?

## Show Me Healthy Kids (SMHK)

- Children in the care and custody of the Missouri Department of Social Services
- Children or youth in alternative care
- Children receiving adoption or legal guardianship subsidy
- Former foster care youth under the age of 26, who were in foster care on their 18th birthday and covered by Medicaid from another state, and who are not currently eligible for Medicaid coverage under another program
- Former foster care youth under the age of 26, who were in foster care on their 18th birthday and covered by MO HealthNet (Missouri Medicaid), and who meet other eligibility criteria

## Home State Health

- Women aged 18-55 with no health insurance
- Children under age 19
- Adult age 19-64
- Senior 65 and older
- Parents or Caretakers of children
- Pregnant women and Unborn child

# Medical Eligibility (ME) Codes SMHK

Verify ME Codes for Show Me Healthy Kids via eMOMED at [www.emomed.com](http://www.emomed.com)

ME Code	ME Code Description
<b>DSS Division of Family Services</b>	
07	Foster Care – IV – E
37	Title XIX-FFP/HDN
38	Independent Foster Care Children – Ages 18 to age 26
08	CWS-FC
66	Child Welfare – HIF
0F	Subset of participants currently under ME 07 and ME 38. ME 0F will model ME 08 eligibility, claims processing, and financial coding.
<b>Adoption Subsidy</b>	
56	Adoption Subsidy – IV – E Eligible - 5A
36	Adoption Subsidy– FFP
57	Adoption Subsidy – CWS
5A	Subset of participants currently under ME 56. ME 5A will model ME 57 eligibility, claims processing, and financial coding.
<b>DSS Division of Youth Services</b>	
29	Division of Youth Services – FYS-FC
52	DYS – GR
50	DYS – Poverty
68	DYS - HIF

# Checking Eligibility

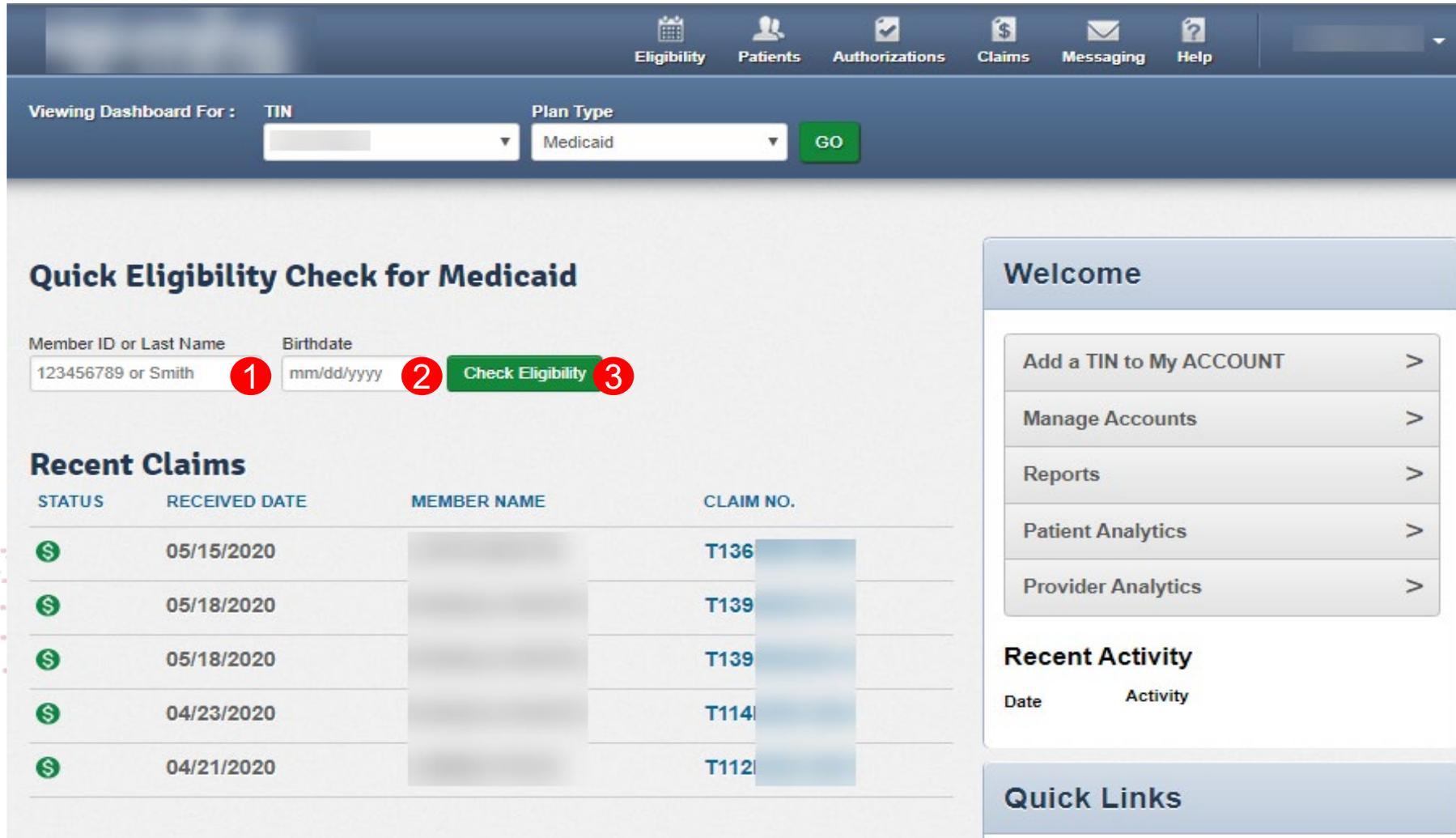
## Why is it important to check eligibility?

Once the provider determines the participant may have or has MO HealthNet eligibility, it is the provider's responsibility to check the participant's eligibility. **This must be done before every visit. Eligibility is updated daily. The participant must be eligible on the date of service or claims will deny.**

## Eligibility Tips:

- When checking eligibility, if the member does not pull up, verify data entered
- If Member ID + DOB does not pull up the member, try Member Last Name + DOB
- Check for other insurance-Coordination of Benefits (COB) **MO HealthNet is the payer of last resort. Providers must bill all other payers as primary.**
- As best practice, always check member eligibility prior to and the day of appointment

# Eligibility Check, option 1



The screenshot shows a web application interface for Home State Health. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this is a header section for 'Viewing Dashboard For' with dropdown menus for 'TIN' and 'Plan Type' (set to Medicaid) and a 'GO' button. The main content area is divided into three sections: 'Quick Eligibility Check for Medicaid', 'Recent Claims', and a right-hand sidebar. The 'Quick Eligibility Check' section has input fields for 'Member ID or Last Name' (with '123456789 or Smith' and a red '1' in a circle) and 'Birthdate' (with 'mm/dd/yyyy' and a red '2' in a circle), followed by a green 'Check Eligibility' button with a red '3' in a circle. The 'Recent Claims' section is a table with columns for STATUS, RECEIVED DATE, MEMBER NAME, and CLAIM NO., listing five claims with green dollar signs and dates from 04/21/2020 to 05/15/2020. The sidebar contains a 'Welcome' section with a list of menu items (Add a TIN to My ACCOUNT, Manage Accounts, Reports, Patient Analytics, Provider Analytics) and a 'Recent Activity' section with columns for Date and Activity. A 'Quick Links' section is at the bottom of the sidebar.

Viewing Dashboard For : TIN [dropdown] Plan Type [dropdown] Medicaid [dropdown] GO

### Quick Eligibility Check for Medicaid

Member ID or Last Name: 123456789 or Smith **1** Birthdate: mm/dd/yyyy **2** **Check Eligibility** **3**

### Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
\$	05/15/2020	[blurred]	T136
\$	05/18/2020	[blurred]	T139
\$	05/18/2020	[blurred]	T139
\$	04/23/2020	[blurred]	T114
\$	04/21/2020	[blurred]	T112

### Welcome

- Add a TIN to My ACCOUNT >
- Manage Accounts >
- Reports >
- Patient Analytics >
- Provider Analytics >

### Recent Activity

Date	Activity
------	----------

### Quick Links

# Eligibility Check, option 2



1 Eligibility Patients Authorizations Claims Messaging

Viewing Eligibility For : TIN [ ] Plan Type Medicaid GO

### Eligibility Check

Date of Service 05/27/2020 Member ID or Last Name 123456789 or Smith 2 DOB mm/dd/yyyy 3 **Check Eligibility** 4 Print

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	PRODUCT	CARE GAPS	LOG ER VISIT
	05/27/2020	[ ] <a href="#">View details</a> 5	05/27/2020	Medicaid LTC Non-Dual	Non-compliant for annual well visit.	ER Visit? Remove

If Eligibility Check is for an ER visit, click **ER Visit?**

# Patient Overview

**Overview**

Cost Sharing

Assessments

Health Record

ADT

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

 This patient is eligible as of today, Jan 24, 2023

[Print Eligibility Overview](#)

**VIEW CARE TEAM CONTACTS**

**Patient Information**

Name

Gender

Birthdate

Age

Member #

Address

**PCP Information**

UNASSIGNED PCP

[View PCP History](#)

**EPSDT**

[Care Gaps](#)

Patient due for dental check-up.

No flu vaccine in past 12 months.

[Allergies](#)

None On File

**Eligibility History**

Start Date	End Date	Product Name
Jul 1, 2022	Ongoing	Home State Health Plan - Show Me Healthy Kids
Sep 9, 2021	Jun 30, 2022	Home State Health Plan - Foster Care

[more](#)

[View Clinical Information](#)

# Patient Overview



Eligibility Patients Authorizations Claims Messaging

Viewing Eligibility For : [ ] Medicaid GO

Back to Eligibility Check

**Overview**

- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations
- Referrals
- Coordination of Benefits
- Claims
- Document Resource Center
- Notes

**Overview**

👍 This patient is eligible as of today, Nov 19, 2019.

[Print Eligibility Overview](#)

**Patient Information**

Name [ ]  
Gender M  
Birthdate [ ]  
Age [ ]  
Member # [ ]  
Address [ ]

**PCP Information**

Name TERRIE [ ]  
Address [ ]  
Practice Type [ ] MEDICINE  
Phone Number [ ]

[View PCP History](#)

[EPSDT](#)

[Care Gaps](#)

Risk Category Alerts: COPD/Asthma

[Allergies](#)

None On File

[View Clinical Information](#)

**Eligibility History**

Start Date	End Date	Product Name
Dec 1, 2018	Ongoing	SSI Non-Dual
May 1, 2018	Nov 30, 2018	TANF

[more](#)

# Patient Overview continued



[View Clinical Information](#)

## Three Most Recent ER Visits

Primary Diagnosis	Date	Facility/Provider
<a href="#">EPISTAXIS</a>	10/29/2019	MEDICAL CENTER INC...
<a href="#">EPISTAXIS</a>	08/28/2018	MEDICAL CENTER INC...
<a href="#">PNEUMONIA UNSPECIFIED ORGANISM</a>	07/20/2018	MEDICAL CENTER INC...

## Three Most Recent Inpatient Admissions

Primary Diagnosis	Date	Facility/Provider
<a href="#">HYPERTROPHY TONSILS W/HYP ADENOIDS</a>	06/10/2019	MEDICAL CENTER INC...
<a href="#">MOD PERSIST ASTHMA ACUTE EXACERBAT</a>	04/30/2019	MEDICAL CENTER INC...

## Three Most Recent Office Visits

Primary Diagnosis	Date	Facility/Provider
<a href="#">HYPERTROPHY TONSILS W/HYP ADENOIDS</a>	11/13/2019	
<a href="#">HYPERTROPHY TONSILS W/HYP ADENOIDS</a>	10/30/2019	
<a href="#">DELAYED MILESTONE IN CHILDHOOD</a>	10/03/2019	

## Top 5 Most Occurring Diagnosis

- MIX RECEPTIVE-EXPRESSV LANGUAGE D/O
- DELAYED MILESTONE IN CHILDHOOD
- SHORT STATURE CHILD
- MOD PERSIST ASTHMA ACUTE EXACERBAT
- HYPERTROPHY TONSILS W/HYP ADENOIDS

## Recent Pharmacy Activity

- FLOVENT HFA AER 44MCG
- MUPIROCIN OIN 2%
- CEFDINIR SUS 250/5ML

# Patient Overview - Assessments



[Back to Eligibility Check](#)

**Overview**

**Cost Sharing**

**Assessments**

**Health Record**

**Care Plan**

**Authorizations**

**Referrals**

**Coordination of Benefits**

**Claims**

**Document Resource Center**

**Notes**

---

**Please tell us about your patient's health**

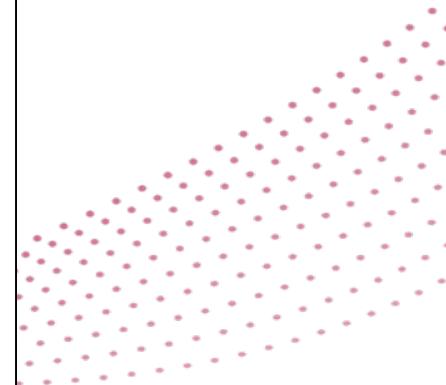
**Child Welfare Referral Assessment**  
A Child Welfare Referral helps determine why a member is being referred to case management. [Fill Out Now!](#)

**Person Centered Service Plan (PCSP) Signature Addendum**  
Please take a few minutes to fill out the form below. [Fill Out Now!](#)

**Previous Assessments**

You have not told us about anything yet. Please fill out a form.

If notice of pregnancy (NOP) were applicable for the member, it would be available.



# Patient Overview- Health Record



Back to Authorizations

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**Health Record**

Care Plan

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Power Account Service Estimate

Document Resource Center

Notes

Visits Medications Immunizations Labs Allergies

Information displaying on the members health record is based on submitted claims.

Primary Diagnosis	Date	Visit Type	Claim Type	Facility/Provider
<a href="#">Low Back Pain</a>	01/08/2020 - 01/08/2020	Home	Medical	
<a href="#">Low Back Pain</a>	12/05/2019 - 12/05/2019	Home	Medical	
<a href="#">Low Back Pain</a>	11/07/2019 - 11/07/2019	Home	Medical	
<a href="#">Htn Heart Disease W/Heart Fail</a>	11/01/2019 - 11/01/2019	Inpatient Hospital	Medical	
<a href="#">Cellulitis Of Right Lower Limb</a>	10/31/2019 - 11/01/2019	Inpatient Hospital	Medical	
<a href="#">Cellulitis Of Right Lower Limb</a>	10/30/2019 - 10/30/2019	Inpatient Hospital	Medical	
<a href="#">Primary Osteoarthritis Rt Shoulder</a>	10/30/2019 - 10/30/2019	Inpatient Hospital	Medical	
<a href="#">Oth Nonspecific Abn Find Lng Field</a>	10/30/2019 - 10/30/2019	Outpatient Hospital	Medical	

# Patient Overview – Care Plan



[Back to Authorizations](#)

Care Plans come from the clinical system.  
These care plans are setup with the case manager(s) for the patient.

Overview

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This member's care plan to treat:

Case Worker

## Integrated Care

05/12/2020 - OPEN

### Member is hospitalized

Goal: **Member will transition from hospital to home setting with appropriate support in place. by 2020-06-16**

**Member is a young adult and may still be dependent on older adults/ family members to successfully n may be a barrier to success**

### What we're doing:

- 2020-06-16 CM will communicate with member/member family &/or inpatient case management/discharge planning and assist with member's transition to home setting as needed.
- 2020-06-16 Member/ member family will communicate with inpatient case management/discharge planning/ CM regarding status of ongoing home health needs and preferences

# Patient Overview - Authorizations



[Back to Authorizations](#)

When viewing a member's authorizations, the list will display the last 18 months, regardless of the submitting provider.

Overview	Authorizations							
Cost Sharing	STATUS	AUTH NBR	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE	
Assessments	APPROVE	IP190	02/04/2020	12/31/9999	E87.6	INPATIENT	Medical	
Health Record	APPROVE	IP179	10/29/2019	11/01/2019	I50.9	INPATIENT	Medical	
Care Plan	APPROVE	IP167	07/19/2019	07/22/2019	L03.115	INPATIENT	Medical	
<b>Authorizations</b>	APPROVE	OP16	07/09/2019	09/06/2019	Z48.01	OUTPATIENT	Home Health	
Referrals	PARTIAL_APPROVE	IP162	06/08/2019	06/25/2019	L03.90	INPATIENT	Medical	
Coordination of Benefits	APPROVE	IP161	05/21/2019	05/24/2019	L03.90	INPATIENT	Medical	
Claims	APPROVE	IP158	04/24/2019	04/29/2019	I50.9	INPATIENT	Medical	
Power Account Service Estimate	<a href="#">Create a New Authorization</a>							
Document Resource Center								
Notes								

Click an Auth NBR to view the authorization details

Click **Create a New Authorization**, to submit a web authorization request for the member



# Patient Overview - Referrals



[Back to Authorizations](#) **XXXXXX-XXXXXX**

- Overview
- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations
- Referrals**
- Coordination of Benefits
- Claims
- Power Account Service Estimate
- Document Resource Center
- Notes

\*Source:

\*Date:

Last Name, First Name:

Phone Number, Extension:

Additional Comments:

Utilizing Referrals, allows providers to submit a member for assistance from child welfare services, behavioral or case management (options may vary by state).

# Patient Overview – Coordination of Benefits



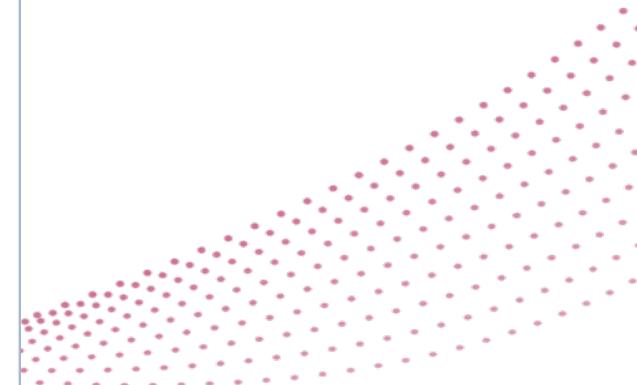
[Back to Authorizations](#)

**Overview** [Print Coordination of Benefits](#)

Effective Date	Term Date	Policy Number	Group Number	Carrier Name	Coverage
07/01/2016	12/31/9999			BC BS	MEDICAL AND HOSPITAL MO

Coordination of Benefits (COB) information on file for the member displays here.

- Overview
- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations
- Referrals
- Coordination of Benefits**
- Claims
- Document Resource Center
- Notes



# Patient Overview - Claims



[Back to Eligibility Check](#)

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Coordination of Benefits

**Claims**

Document Resource Center

Notes

## Claims: Recent

Click **Create a New Claim**, to submit a web claim for the member.

[Create a New Claim](#)

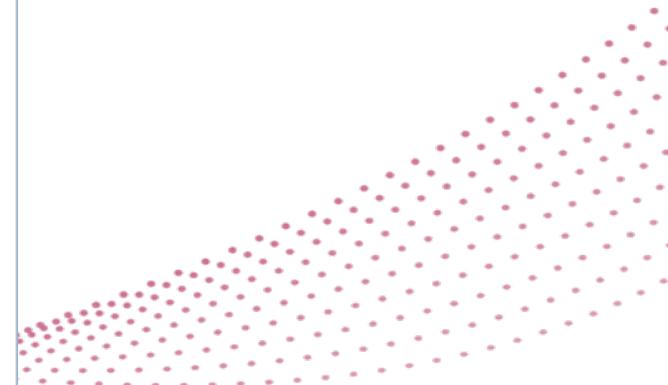
The last one month of claims for this member are displayed below. To view more claims for this member, [visit the Claims page](#).

Show claims for    [View most recent month](#)

CLAIM NO. ↑	REF/ACCT NO. ↑	DOS RANGE ↑	PAYMENT DATE ↑	RECEIVED DATE ↑	BILLED/PAID ↑	STATUS ↑
<a href="#">T148</a>		05/22/2020 - 05/22/2020	06/04/2020	05/27/2020	\$643.00 / \$1	PAID
<a href="#">T150</a>		05/22/2020 - 05/22/2020	06/04/2020	05/29/2020	\$75.00 / \$2	PAID
<a href="#">T153</a>		05/22/2020 - 05/22/2020		06/01/2020	\$145.00 / \$9	PAID

3 items found, displaying all items. Page 1/1 1

Click **Claim Number**, to view the claims details



# Patient Overview – Document Resource Center



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**Document Resource Center**

Notes

## Document Upload

## Document Review

1.

Document Category:

Please Select a Category

Please Select a Category

Medical Necessity

Quality Management

2.

Document Type:

3.

Upload File:

Choose File

No file chosen

4.

Submit



**Tips:** The 1<sup>st</sup> page of the document, should include:

- Reason for upload (i.e. Requested clinical documents, etc.)
- Authorization #, if applicable

# Patient Overview – Notes



[Back to Authorizations](#)

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**Notes**

## Notes

### Create a New Note

General Note

[Write Note](#)

### Previous Notes

### Date

[General Note](#)

Oct 15, 2019

[General Note](#)

Jan 29, 2020

Allows portal users to create and view notes regarding the member.



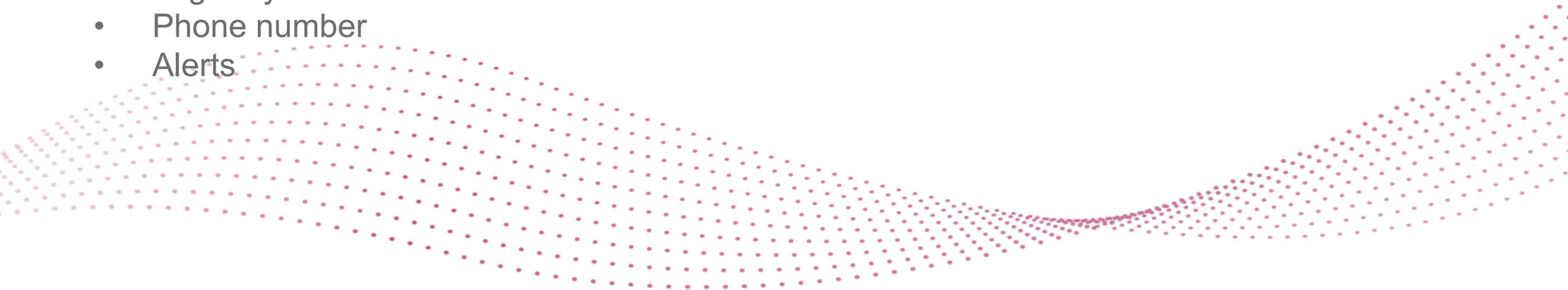
# Patient Lists



Primary Care Providers can view and download a list of their assigned members.

The Patient List displays:

- Member Name
- Member ID #
- DOB
- Preferred language
- Eligibility status
- Phone number
- Alerts



# Patient Lists



Eligibility **Patients** Authorizations Claims Messaging

Viewing Patients For : TIN 1799 Plan Type Medicaid GO Find Patient

Patient List as of 07/31/2020 Download Filter

This is only a list of your patients, please check eligibility to confirm the effective date and benefits for this member.

Eligible	Preferred Language ↑	Member Name ↑	Member ID ↑	Date of Birth ↑	Phone Number ↑	ALERTS
👍						No HRA
👍						CG No HRA
👍						No HRA
👍						CG No HRA
👍						CG No HRA
👍						NM No HRA
👍						NM No HRA
👍						NM No HRA
👍						NM No HRA
👍						No HRA

2,146 items found, displaying 1 to 10. Page 1/215 1 2 3 4 5 6 7 8 Next Last

Click **Download** to export the Patient List into Excel.

Click **Filter** to access filter options.

Filter By:

Provider NPI Provider Medicaid Number

Member Last Name

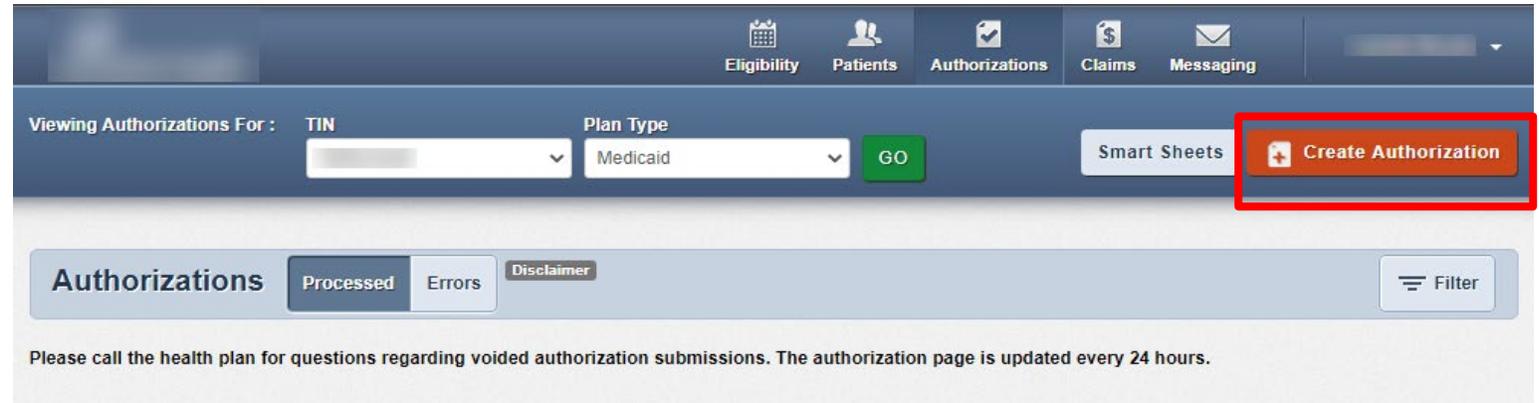
- Care Gaps
- Case Management
- Emergency Department
- Special Needs
- Preferred Language
- Disease Management
- New Member
- No HRA

Go! Clear

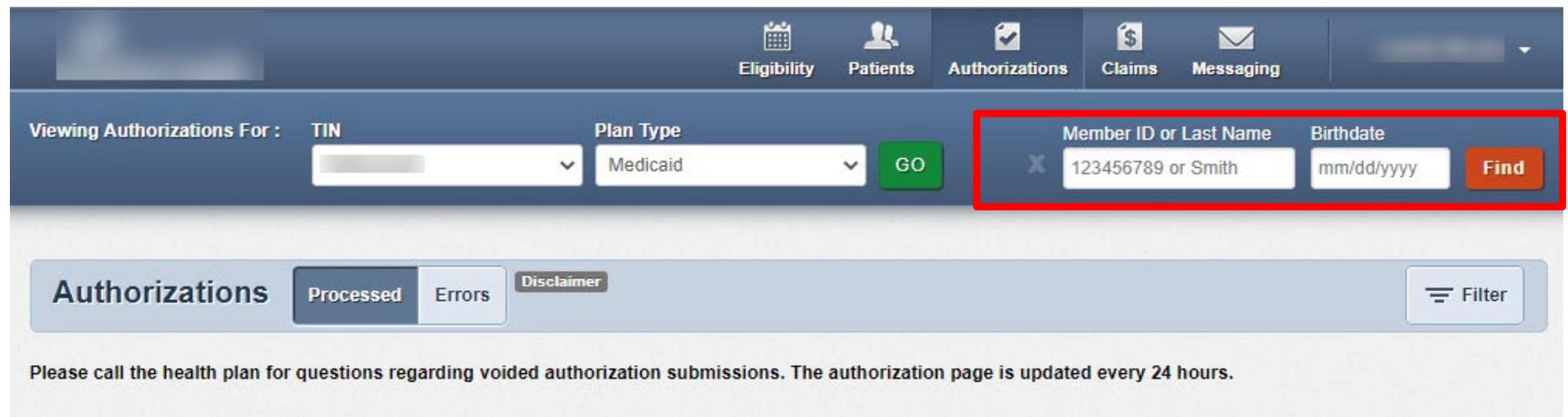
# Create Authorization (Web Authorization Request)

To begin a web authorization request:

1. Click **Create Authorization**
2. Enter **Member ID or Last Name**
3. Enter Member's **Birthdate**
4. Click **Find**



This screenshot shows the top navigation bar with 'Eligibility', 'Patients', 'Authorizations', 'Claims', and 'Messaging' tabs. Below the navigation bar, there are filters for 'Viewing Authorizations For : TIN' and 'Plan Type' (Medicaid), with a 'GO' button. A 'Smart Sheets' button is also visible. The 'Create Authorization' button is highlighted with a red box.



This screenshot shows the same interface as the previous one, but with the 'Member ID or Last Name' and 'Birthdate' fields filled in. The 'Member ID or Last Name' field contains '123456789 or Smith' and the 'Birthdate' field contains 'mm/dd/yyyy'. The 'Find' button is highlighted with a red box.



**Tip:** You cannot create a web authorization on an ineligible member.

# Create Authorization (Web Authorization Request)

Eligibility Patients Authorizations Claims Messaging

Viewing Patients For : TIN [ ] Plan Type Medicaid [ ] GO

Smart Sheets Create Authorization

1

2

### Authorization For

DOB: [ ] MEDICAID NBR: [ ]

After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 866-246-4358 for after-hours urgent admission, inpatient notifications or requests.

Please select Service Type.

**Tip:** Use the **Tab** key (on your keyboard) to move to fields in a web authorization request.

### Enter Authorization

1. PROVIDER REQUEST

Select a Service Type [ ]

NEXT >

2. SERVICE LINE

3. FINISH UP

# Criteria

## Finish Up, continued

Completed Service Lines will display:

- **Auth Req'd**
  - Yes
  - Not Required, or
  - Vendor
- **Review Needed**
  - No, or
  - **Complete Now**

The screenshot shows a web interface for entering authorization. It is divided into two main sections: 'Authorization For' and 'Enter Authorization'.

**Authorization For:** This section contains fields for 'DOB' and 'MEDICAID NBR'. Below these are two main sections: 'PROVIDER REQUEST' and 'SERVICE LINES'. The 'PROVIDER REQUEST' section includes a plus icon, a blurred name, and fields for 'Primary Diagnosis: J03.91: ACUTE RECURRENT TONSILLITIS UNS', 'NPI', 'TIN', and 'Phone'. The 'SERVICE LINES' section includes a plus icon, a blurred name, and fields for 'Dates: 08/06/2020 - 08/08/2020', 'NPI', 'TIN: \*\*\*\*\*3493', 'Participating: Yes', and 'Phone'. At the bottom of this section is a table with a red border:

Procedure Code	Service Type	Auth Req'd?	Review Needed?	Review Completed?
42825	Surgical	Yes	<b>Complete Now</b>	No

**Enter Authorization:** This section has a progress indicator with three steps: '1. PROVIDER REQUEST', '2. SERVICE LINE', and '3. FINISH UP'. Below this are fields for 'CONTACT IQC', 'Phone', 'Fax', and 'Email'. There is an 'Add Comments' button and an 'Attachment' section with a file upload button and the text 'No file chosen'.

**Residential Prior Authorization** <https://www.homestatehealth.com/content/dam/centene/home-state-health/pdfs/HSH-MO-SMHK-Resi-PA-Proces.pdf>

**Residential Criteria-** <https://www.homestatehealth.com/content/dam/centene/home-state-health/pdfs/HSH-MO-SMHK-Criteria-CHKLST.pdf>

# Accessing Authorizations

To access, create, or submit a web authorization request, click **Authorizations**.

Providers can use the portal to submit web authorization requests and view 18 months of authorization history.

**Tip:** The member drives your Plan Type selection. For example, an Ambetter member will not pull up under Medicaid.

The screenshot displays a healthcare provider portal dashboard. At the top, there is a navigation bar with icons and labels for 'Eligibility', 'Patients', 'Authorizations', 'Claims', 'Messaging', and 'Help'. Below this, a filter section shows 'Viewing Dashboard For : TIN' and 'Plan Type' set to 'Medicaid', with a 'GO' button. The main content area is divided into three sections: 'Quick Eligibility Check for Medicaid' with input fields for 'Member ID or Last Name' (123456789 or Smith) and 'Birthdate' (mm/dd/yyyy), and a 'Check Eligibility' button; 'Recent Claims' table; and a 'Welcome' sidebar with a menu of options.

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
Ⓢ	05/15/2020	[REDACTED]	T136
Ⓢ	05/18/2020	[REDACTED]	T139
Ⓢ	05/18/2020	[REDACTED]	T139
Ⓢ	05/18/2020	[REDACTED]	T139

**Welcome**

- Add a TIN to My ACCOUNT >
- Manage Accounts >
- Reports >
- Patient Analytics >
- Provider Analytics >

**Recent Activity**

Date	Activity
------	----------

# Authorization Summary

The screenshot shows a web application interface for managing authorizations. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations (highlighted with a red box), Claims, Messaging, and Help. Below this, a filter section allows users to view authorizations for a specific TIN and Plan Type (Medicaid), with a 'GO' button and a 'Create Authorization' button. A 'Filter' button is also present. A callout box explains that the data displays authorizations submitted under the selected TIN for the last 90 days. Below the callout is a table of authorization records with columns for Status, Auth ID, Member, From Date, To Date, Diagnosis, Auth Type, and Service. A red arrow points to the 'Auth ID' column, and another red arrow points to the 'Filter' button.

Displays authorizations submitted under TIN, for the last 90 days, regardless how they were submitted.

Click **Filter** to access filter options

Click an **Auth ID** to view authorization details

STATUS	AUTH ID	MEMBER	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	IP186		05/12/2020	12/31/9999	M16.11	INPATIENT	Surgical
APPROVE	IP190		02/28/2020	12/31/9999	Z79.2	INPATIENT	Skilled Nursing
APPROVE	OP18		02/27/2020	03/27/2020	M21.961	OUTPATIENT	Outpatient Surgery
APPROVE	OP18		02/19/2020	03/21/2020	S83.512A	OUTPATIENT	Outpatient Surgery
APPROVE	IP187		02/17/2020	12/31/9999	R10.2	INPATIENT	Surgical
PEND	IP190		02/11/2020	12/31/9999	D57.00	INPATIENT	Medical
APPROVE	IP190		02/08/2020	12/31/9999	J18.9	INPATIENT	Medical
APPROVE	OP19		02/07/2020	05/07/2020	E66.01	OUTPATIENT	Outpatient Services
APPROVE	IP190		02/07/2020	02/11/2020	J10.1	INPATIENT	Medical

# Authorization Details

[Back to Authorizations](#)

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**Cost Sharing**

**Assessments**

**Health Record**

**Care Plan**

**Authorizations**

**Referrals**

**Coordination of Benefits**

**Claims**

**Document Resource Center**

**Notes**

**Auth Status:** APPROVE  
**Auth Nbr:** IP19[REDACTED]  
**Admit Date:** 05/12/2020  
**Provider of Service(s):** [REDACTED]

**Explanation:** Pay  
**Auth Type:** INPATIENT  
**Service:** Surgical  
**Discharge Date:** 05/20/2020  
**Procedure Code(s):** 99221

**Diagnosis Code(s):** T21.31XA

**Notes & Attachments:** [View](#)

Line Item	Service type	From Date	To Date	Stay Level	Location	Status	Medical Necessity	Decision Date
1	Medical	05/12/2020	05/13/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/13/2020
2	Medical	05/13/2020	05/14/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/14/2020
3	Medical	05/14/2020	05/15/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/15/2020
4	Medical	05/15/2020	05/18/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/18/2020
5	Surgical	05/18/2020	05/19/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/19/2020
6	Surgical	05/19/2020	05/20/2020	Med/Surg	Inpatient Hospital	APPROVE	Met as requested	05/20/2020

[Back to Authorization List](#)

# Authorization Details Links and Pop-Up

[Back to Authorizations](#)

**Overview**  
Auth Status: APPROVE  
Auth Nbr: IP195  
Admit Date: 05/12/2020  
Provider of Service(s): HOSPITAL

**Cost Sharing**

**Assessments**

**Health Record**

**Care Plan**

**Authorizations**

**Referrals**

**Coordination of Benefits**

**Claims**

Explanation: Pay  
Auth Type: INPATIENT  
Service: Surgical  
Discharge Date: 05/20/2020  
[Procedure Code\(s\):](#) 99221  
99231  
Notes & Attachments: [View](#)

**Diagnosis Code(s):** T21.31XA  
R69  
T21.11XA

Click hyperlink(s) to view additional codes

Hover your mouse over a Line Item to view the CPT, REV or HCPC code associated with it

Line Item	Service type	From Date	Medical Necessity	Decision Date
1	Medical	05/12/2020	Met as requested	05/13/2020
2	Medical	05/13/2020	Met as requested	05/14/2020
3	Medical	05/14/2020	Met as requested	05/15/2020
4	Medical	05/15/2020	Met as requested	05/18/2020

**Diagnosis and Procedure Codes**

Primary Diagnosis Code: T21.31XA  
Additional Diagnosis Codes: R69 T21.11XA  
Primary Procedure Code: 99221  
Additional Procedure Codes: 99221

# Authorization Tips

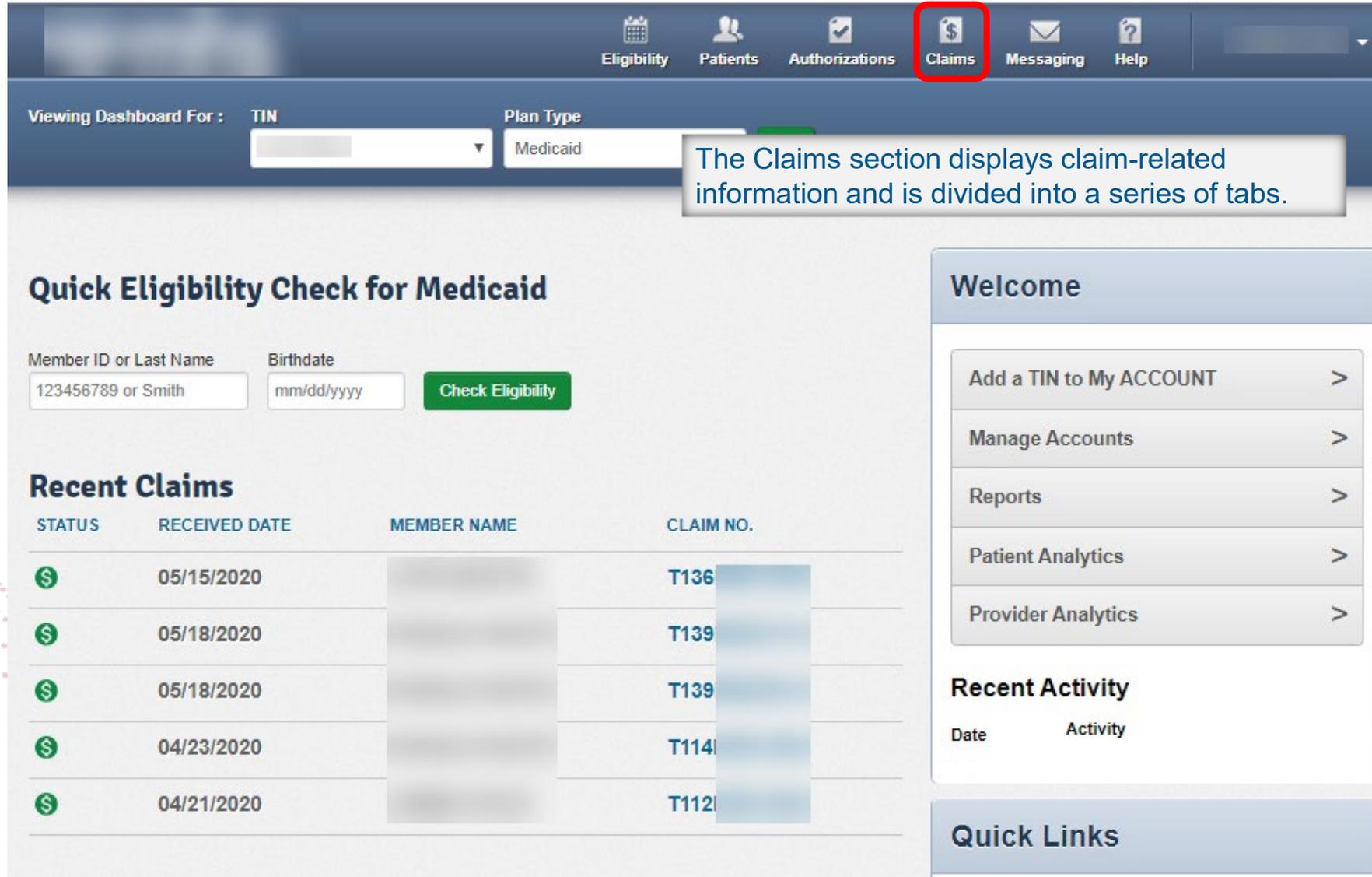
---

- Always check the member's eligibility before submitting an authorization request
  - A web authorization **cannot** be submitted on an ineligible member
- Web authorizations generally load in processing queue within seconds of submission
- Up to five (5) separate documents can be attached to a web authorization request
- Always use the confirmation number to check the status of the request

If an error is encountered the web authorization request will not load, and thereby will not be processed

**Authorization submissions are required through the portal as of January/2021**

# Claims



Eligibility Patients Authorizations **Claims** Messaging Help

Viewing Dashboard For : TIN [ ] Plan Type Medicaid

The Claims section displays claim-related information and is divided into a series of tabs.

### Quick Eligibility Check for Medicaid

Member ID or Last Name: 123456789 or Smith Birthdate: mm/dd/yyyy [Check Eligibility](#)

### Recent Claims

STATUS	RECEIVED DATE	MEMBER NAME	CLAIM NO.
\$	05/15/2020	[REDACTED]	T136
\$	05/18/2020	[REDACTED]	T139
\$	05/18/2020	[REDACTED]	T139
\$	04/23/2020	[REDACTED]	T114
\$	04/21/2020	[REDACTED]	T112

### Welcome

- [Add a TIN to My ACCOUNT](#) >
- [Manage Accounts](#) >
- [Reports](#) >
- [Patient Analytics](#) >
- [Provider Analytics](#) >

### Recent Activity

Date	Activity
------	----------

### Quick Links

# Claim Submission – Create a new Claim (Individual Web Claim)



To begin an individual web claim:

1. Click **Create Claim**
2. Enter **Member ID or Last Name**
3. Enter Member's **Birthdate**
4. Click **Find**

This screenshot shows the top navigation bar of the Home State Health claims management system. The navigation bar includes icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below the navigation bar, there are two dropdown menus: "Viewing Claims For : TIN" and "Plan Type" (set to Medicaid). A green "GO" button is next to the Plan Type dropdown. To the right, there is an "Upload EDI" button and a red-bordered "Create Claim" button. Below this, there is a "Claims" section with a menu icon and several tabs: Individual, Saved, Submitted, Batch, Recurring, Payment History, My Downloads, and Claims Audit Tool.This screenshot shows the search section of the Home State Health claims management system. It features the same navigation bar as the previous screenshot. Below the navigation bar, there are two dropdown menus: "Viewing Claims For : TIN" and "Plan Type" (set to Medicaid). A green "GO" button is next to the Plan Type dropdown. To the right, there are two input fields: "Member ID or Last Name" (containing the text "123456789 or Smith") and "Birthdate" (containing the text "mm/dd/yyyy"). A red-bordered "Find" button is located to the right of these input fields.

For additional details on claim submission please see Provider Manual Billing and Claims Submission section here:

[https://www.homestatehealth.com/content/dam/centene/home-state-health/pdfs/HSH\\_SMHK%20Provider%20Manual%20508%20Compliant%2012272022.pdf](https://www.homestatehealth.com/content/dam/centene/home-state-health/pdfs/HSH_SMHK%20Provider%20Manual%20508%20Compliant%2012272022.pdf)

# Create new Claim – Submission Confirmation



The screenshot shows a web application interface with a dark blue header. The header contains navigation tabs: Eligibility, Patients, Authorizations, Claims, and Messaging. Below the header is a search bar labeled "Viewing Claims For:" with two dropdown menus and a green "GO" button. To the right of the search bar are two buttons: "Upload EDI" and "Create Claim".

Below the search bar, the page displays a success message:

THIS SECTION:  
**Success** Congratulations!

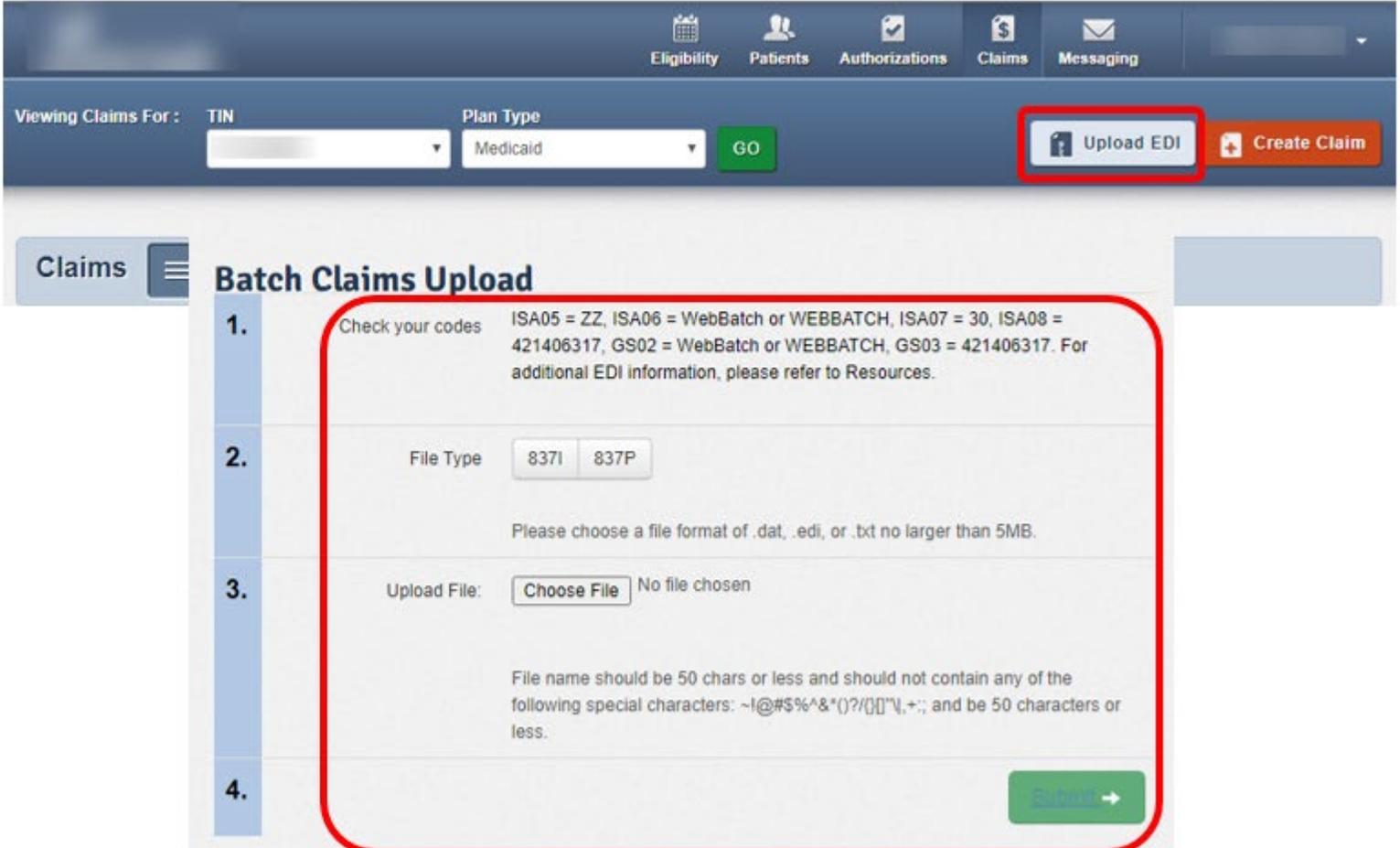
**Your claim has been submitted**  
**Your confirmation ID is 800225232**

A callout box on the right side of the page contains the text: "The Success page displays the web claim submission confirmation ID. This ID can be used to search for the claim on the Submitted tab."

# Claim Submission – Upload Electronic Data Interchange (EDI)

Click **Upload EDI** to upload an EDI Batch (837I / 837P).

1. Check the codes in your file.
  - Ensure file name is less than 50 characters and does not contain special characters
2. Select **File Type**.
3. Click **Choose File**. A separate window will display.
4. Select file from your computer directory.
5. Click **Open**.
6. Click **Submit**.



The screenshot shows the Home State Health claims management interface. At the top, there are navigation tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. Below these, there are filters for 'Viewing Claims For : TIN' and 'Plan Type' (Medicaid), with a 'GO' button. A red box highlights the 'Upload EDI' button. The main content area is titled 'Batch Claims Upload' and contains a numbered list of instructions:

1. Check your codes: ISA05 = ZZ, ISA06 = WebBatch or WEBBATCH, ISA07 = 30, ISA08 = 421406317, GS02 = WebBatch or WEBBATCH, GS03 = 421406317. For additional EDI information, please refer to Resources.
2. File Type: 837I 837P. Please choose a file format of .dat, .edi, or .txt no larger than 5MB.
3. Upload File: Choose File No file chosen. File name should be 50 chars or less and should not contain any of the following special characters: ~!@#\$\$%^&\*(){}|'";, and be 50 characters or less.
4. Submit →

# Viewing Claims

Eligibility Patients Authorizations Claims Messaging

Viewing Claims For : TIN Plan Type

The Individual tab displays claims on file under the TIN, regardless of how they were submitted. [GO](#) [Upload EDI](#) [Create Claim](#)

Claims **Individual** Saved Submitted Batch Recurring Payment History My Downloads Claims Audit Tool

Claims: Recent

Search: Date Range : 04/28/2020 to 05/28/2020 [Change dates](#) [Filter](#) [Search](#)

CLAIM NO. ↑	CLAIM TYPE ↓	MEMBER NAME ↓	SERVICE DATE(S) ↓	BILLED/ PAID ↓	CLAIM STATUS ↓
<a href="#">T147</a>	CMS-1500		05/22/2020 - 05/22/2020	\$38.00 / \$0.00	Pending
<a href="#">T147</a>	CMS-1500		05/22/2020 - 05/22/2020	\$75.00 / \$0.00	Pending
<a href="#">T147</a>	CMS-1500		05/22/2020 - 05/22/2020	\$38.00 / \$0.00	Pending
<a href="#">T147</a>	CMS-1500		05/22/2020 - 05/22/2020	\$480.00 / \$0.00	Pending
<a href="#">T148</a>	CMS-1500		05/22/2020 - 05/22/2020	\$247.00 / \$0.00	Pending
<a href="#">T142</a>	CMS-1500		05/20/2020 - 05/20/2020	\$494.00 / \$0.00	Pending
<a href="#">T142</a>	CMS-1500		05/18/2020 - 05/18/2020	\$458.00 / \$0.00	Pending

Click Claim Number to view claim details

Click **Change Dates** to search up to 24 months

Click **Filter** and/or **Search** for additional options

# Benefits of Portal Utilization



- Portal available 24/7
- Cost savings, portal free to submit claims and authorizations
- Better management of patient's care, i.e., care gaps
- Efficiency of electronic authorizations and claim submissions
- Ability to view patient eligibility
- Ability to view both patient and provider history/data
- Ability to correct claims

Questions?

Show Me Healthy Kids

MANAGED BY HOME STATE HEALTH

