

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

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- 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

CMS 1500 Form

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While waiting for group NPI registration with MMAC, you may submit paper claims on a CMS 1500. CMS 1500 form contains unique medical codes detailing the care administered during the member's visit.

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. ☐ MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA ☐ OTHER ☐ (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No. Street)

8. CITY STATE ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐ b. AUTO ACCIDENT? YES ☐ NO ☐ c. OTHER ACCIDENT? YES ☐ NO ☐

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

13. OTHER CLAIM ID (Designated by NUCC)

14. INSURANCE PLAN NAME OR PROGRAM NAME

15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, complete items 9, 10, and 11

16. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

17. SIGNED DATE

18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

20. OUTSIDE LAB? YES ☐ NO ☐ \$ CHARGES

21. DISBURSEMENT CODE ORIGINAL REF. NO.

22. PRIOR AUTHORIZATION NUMBER

23. DATE(S) OF SERVICE From MM DD YY To MM DD YY

24. PROCEDURE(S), SERVICE(S), OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS I MODIFIER

25. DIAGNOSIS CODE(S) ICD-10

26. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including Degree(s) or Credentials) (I certify that the information on this form applies to this bill and are made a part thereof.)

27. SERVICE FACILITY LOCATION INFORMATION

28. TOTAL CHARGE \$

29. AMOUNT PAID \$

30. Paid for NUCC Use

31. BILLING PROVIDER INFO & PII # ()

SIGNED DATE NPI #

DI PAGE PRINTED TYPE APPROVED 04/03/11/07 FORM 1500 (02-12)

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/HSB_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.

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 looks 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 3rd 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.

Provider	Service	Proc code / Mod	HCPCS Description
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

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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
 - 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

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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.
(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

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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

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

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

Account Details

User Management

Viewing For : Medicaid

GO

Search for User

Email

Last Name

Status

Email

Last Name

Status...

Verification Pending

Go!

Clear

Invite a User

Email Address

name@domain.com

Send Invitation

Account Manager User Guide

Email Address ↑	Last Name ↑	First Name ↑	TIN ↑	Telephone Number ↑	Status ↑	
					Active	Verify Account / Update User
					Active	Verify Account / Update User
					Active	Verify Account / Update User
					Active	Verify Account / Update User
					Active	Verify Account / Update User

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

					Active	Account Manager Access	<div>Update User</div>
					PasswordExpired		<div>Update User</div>
					Active	Account Manager Access	<div>Update User</div>
					PasswordExpired		<div>Update User</div>
					Active		<div>Update User</div>

24 items found, displaying 1 to 10. Page 1/3 1,2,3 Next Last

Portal Account Details

The screenshot shows the 'Account Details' page of a portal. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this is a 'Go to Dashboard For:' section with a dropdown menu set to 'Medicaid' and a 'GO' button. A red box highlights the 'Account Details' link in the top right corner, with a red arrow pointing to it from the text 'Click Update Account, to change account details'. The main content area is divided into two sections. The left section, titled 'Account Details', contains fields for Name, User Name (Email), Password, Telephone Number, Fax Number, and three Secret Questions. The right section, titled 'Add a TIN', contains a text area for 'Name TIN' and a 'Tax ID' field with the value '123456789'. A red box highlights the 'Add TIN' button. Below these sections is the 'Your TINs' section, which has a 'Provider Demographic Update Instructions' link. It contains a table with four rows: 'Allwell', 'Ambetter', 'Behavioral Health', and 'Medicaid'. Each row has a 'Mark as Primary' button and a delete 'X' button. A red box highlights the 'Mark as Primary' button for the 'Medicaid' row, with a red arrow pointing to it from the text 'Click Mark as Primary, to change TIN and Product login default'. Another red box highlights the 'X' button for the 'Ambetter' row, with a red arrow pointing to it from the text 'Click X to remove a TIN'. A third red box highlights the 'TIN / Product' column header, with a red arrow pointing to it from the text 'Click TIN / Product to view / update Provider Demographics'.

Click **Update Account**, to change account details

Account Details

Name

User Name (Email)

Password

Telephone Number

Fax Number

Secret Question What is your favorite pet's name?

Secret Question What city were you born in?

Secret Question What is your mother's maiden name?

Update Account

Add a TIN

Please note, provider services will need to validate any additional TINs, which could take several days. You will be notified by email when verification is complete.

Name TIN

Enter Name

Tax ID

123456789

Add TIN

Your TINs [Provider Demographic Update Instructions](#)

TIN

★ Mark as Primary	Allwell	X
★ Mark as Primary	Ambetter	X
★ Mark as Primary	Behavioral Health	X
★ Current Primary	Medicaid	X

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

ME Code	ME Code Description
DSS Division of Family Services	
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.
Adoption Subsidy	
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.
DSS Division of Youth Services	
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



Eligibility

Patients

Authorizations

Claims

Messaging

Help

Viewing Dashboard For :

TIN

Plan Type

Medicaid

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		T136
\$	05/18/2020		T139
\$	05/18/2020		T139
\$	04/23/2020		T114
\$	04/21/2020		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

Eligibility Check

Date of Service

Member ID or Last Name 2

DOB 3

4

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	PRODUCT	CARE GAPS	LOG ER VISIT
	05/27/2020	<input type="text"/> 5 View details	05/27/2020	Medicaid LTC Non-Dual	Non-compliant for annual well visit.	<input type="button" value="ER Visit?"/> <input type="button" value="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

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

34

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

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

Print Eligibility Overview

Patient Information

PCP Information

Name

Gender

Birthdate

Age

Member #

Address

Name

Address

Practice Type

Phone Number

View PCP History

EPSDT

Care Gaps

Risk Category Alerts: COPD/Asthma

Allergies

None On File

Eligibility History

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

more

View Clinical Information

Patient Overview continued



[View Clinical Information](#)

Three Most Recent ER Visits

Primary Diagnosis	Date	Facility/Provider
EPISTAXIS	10/29/2019	MEDICAL CENTER INC...
EPISTAXIS	08/28/2018	MEDICAL CENTER INC...
PNEUMONIA UNSPECIFIED ORGANISM	07/20/2018	MEDICAL CENTER INC...

Three Most Recent Inpatient Admissions

Primary Diagnosis	Date	Facility/Provider
HYPERTROPHY TONSILS W/HYP ADENOIDS	06/10/2019	MEDICAL CENTER INC...
MOD PERSIST ASTHMA ACUTE EXACERBAT	04/30/2019	MEDICAL CENTER INC...

Three Most Recent Office Visits

Primary Diagnosis	Date	Facility/Provider
HYPERTROPHY TONSILS W/HYP ADENOIDS	11/13/2019	
HYPERTROPHY TONSILS W/HYP ADENOIDS	10/30/2019	
DELAYED MILESTONE IN CHILDHOOD	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](#)

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

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
Low Back Pain	01/08/2020 - 01/08/2020	Home	Medical	
Low Back Pain	12/05/2019 - 12/05/2019	Home	Medical	
Low Back Pain	11/07/2019 - 11/07/2019	Home	Medical	
Htn Heart Disease W/Heart Fail	11/01/2019 - 11/01/2019	Inpatient Hospital	Medical	
Cellulitis Of Right Lower Limb	10/31/2019 - 11/01/2019	Inpatient Hospital	Medical	
Cellulitis Of Right Lower Limb	10/30/2019 - 10/30/2019	Inpatient Hospital	Medical	
Primary Osteoarthritis Rt Shoulder	10/30/2019 - 10/30/2019	Inpatient Hospital	Medical	
Oth Nonspecific Abn Find Lng Field	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

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

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

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Power Account Service Estimate

Document Resource Center

Notes

Authorizations

STATUS	AUTH NBR	FROM DATE	TO DATE	DIAGNOSIS	AUTH TYPE	SERVICE
APPROVE	IP190	02/04/2020	12/31/9999	E87.6	INPATIENT	Medical
APPROVE	IP179	10/29/2019	11/01/2019	I50.9	INPATIENT	Medical
APPROVE	IP167	07/19/2019	07/22/2019	L03.115	INPATIENT	Medical
APPROVE	OP16	07/09/2019	09/06/2019	Z48.01	OUTPATIENT	Home Health
PARTIAL_APPROVE	IP162	06/08/2019	06/25/2019	L03.90	INPATIENT	Medical
APPROVE	IP161	05/21/2019	05/24/2019	L03.90	INPATIENT	Medical
APPROVE	IP158	04/24/2019	04/29/2019	I50.9	INPATIENT	Medical

Create a New Authorization

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

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](#)

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Power Account Service Estimate

Document Resource Center

Notes

*Source

Please select Source

*Date

02/13/2020

2

57

PM

Last Name, First Name

Phone Number, Extension

Additional Comments

Submit

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

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

Notes

Effective Date

07/01/2016

Term Date

12/31/9999

Policy Number

Group Number

Carrier Name

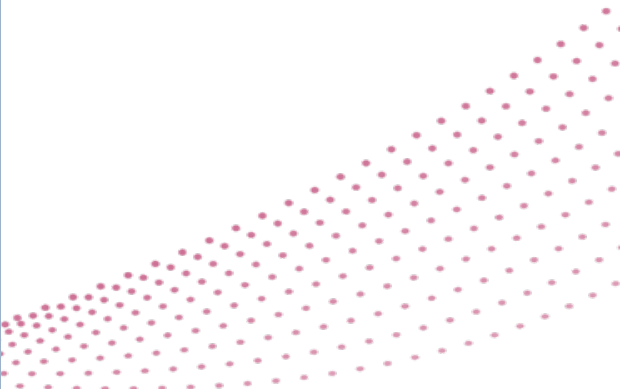
BC BS

Coverage

MEDICAL AND HOSPITAL MO

Print Coordination of Benefits

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



Patient Overview - Claims



[Back to Eligibility Check](#)

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

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 ↑
T148		05/22/2020 - 05/22/2020	06/04/2020	05/27/2020	\$643.00 / \$1	PAID
T150		05/22/2020 - 05/22/2020	06/04/2020	05/29/2020	\$75.00 / \$2	PAID
T153		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



[Back to Eligibility Check](#)

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

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 1st page of the document, should include:
- Reason for upload (i.e. Requested clinical documents, etc.)
 - Authorization #, if applicable

Patient Overview – Notes



[Back to Authorizations](#)

Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Document Resource Center

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

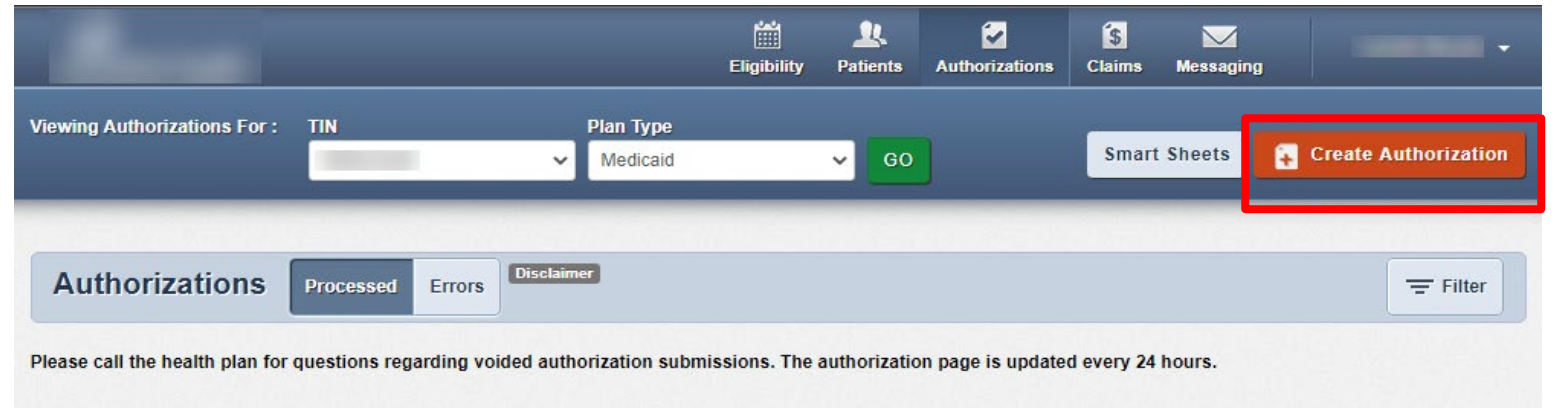
Go!

Clear

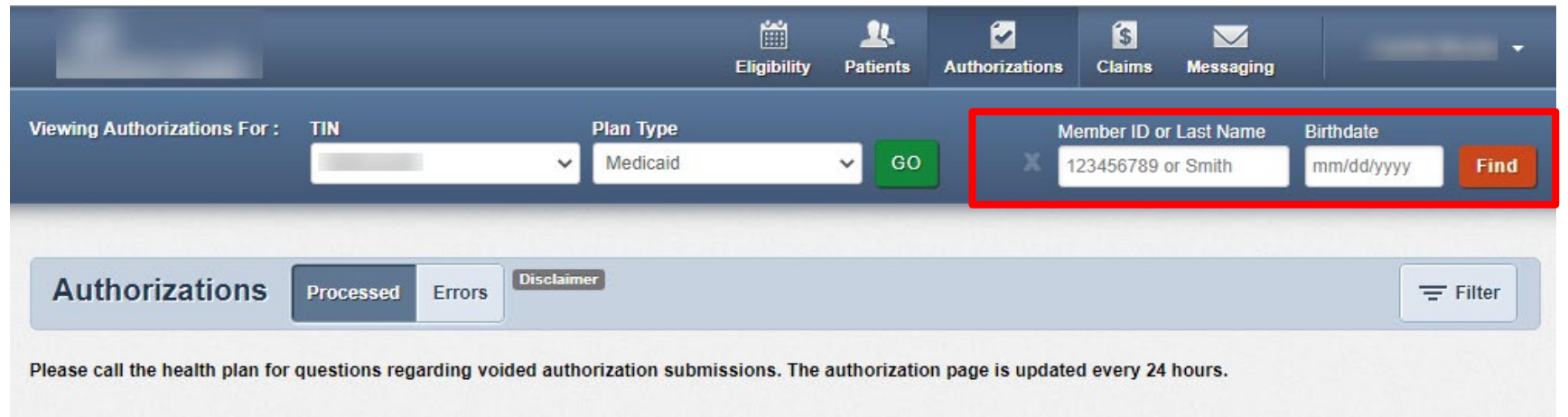
Create Authorization (Web Authorization Request)

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 tabs for Eligibility, Patients, Authorizations, Claims, and Messaging. Below the navigation bar, there are filters for 'Viewing Authorizations For : TIN' and 'Plan Type' (Medicaid), with a 'GO' button. To the right of these filters is a 'Smart Sheets' button and a red-bordered button labeled 'Create Authorization' with a plus icon.



This screenshot shows the same interface as the previous one, but with the 'Find' button highlighted in red. The 'Find' button is located to the right of the 'Member ID or Last Name' and 'Birthdate' input fields. The 'Member ID or Last Name' field contains the text '123456789 or Smith' and the 'Birthdate' field contains the placeholder 'mm/dd/yyyy'.



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

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**

Authorization For

DOB: MEDICAID NBR:

PROVIDER REQUEST

+

Primary Diagnosis: J03.91: ACUTE RECURRENT TONSILLITIS UNS
NPI:
TIN:
Phone:

SERVICE LINES

Service Line 1

+

Dates: 08/06/2020 - 08/08/2020
NPI:
TIN: *****3493
Participating: Yes
Phone:

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

Enter Authorization

1. PROVIDER REQUEST

EDIT

2. SERVICE LINE

EDIT

3. FINISH UP

CONTACT IQC

Phone

Fax

Email

+

 Add Comments

Attachment:
Upload any relevant attachments. (5Mb limit)
Attachment name cannot contain any spaces or special characters.

Choose File

 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-Critria-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.

Eligibility

Patients

Authorizations

Claims

Messaging

Help

Viewing Dashboard For :

TIN

Plan Type

Medicaid

GO

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		T136
\$	05/18/2020		T139
\$	05/18/2020		T139
\$	05/18/2020		T139

Welcome

Add a TIN to My ACCOUNT

Manage Accounts

Reports

Patient Analytics

Provider Analytics

Recent Activity

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

Authorization Summary

Eligibility

Patients

Authorizations

Claims

Messaging

Help

Viewing Authorizations For :

TIN

Plan Type

Medicaid

GO

Create Authorization

Authorizations

Processed

Errors

Disclaimer

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

Filter

Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours.

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

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

Click **Filter** to access filter options

Authorization Details

[Back to Authorizations](#)

Overview

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]
[Diagnosis Code\(s\)](#): T21.31XA

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

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

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Referrals

Coordination of Benefits

Claims

Auth Status: APPROVE
Auth Nbr: IP195
Admit Date: 05/12/2020
Provider of Service(s): HOSPITAL
[Diagnosis Code\(s\):](#) T21.31XA
R69
T21.11XA

Click hyperlink(s) to view additional codes

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

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

Line Item	Service type	From Date	Diagnosis and Procedure Codes				Medical Necessity	Decision Date
1	Medical	05/12/2020	Primary Diagnosis Code: T21.31XA Additional Diagnosis Codes: R69 T21.11XA Primary Procedure Code: 99221 Additional Procedure Codes: 99221				Met as requested	05/13/2020
2	Medical	05/13/2020					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	APPROVE	Met as requested	05/18/2020

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		T136
\$	05/18/2020		T139
\$	05/18/2020		T139
\$	04/23/2020		T114
\$	04/21/2020		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 portal with icons for Eligibility, Patients, Authorizations, Claims, and Messaging. Below the navigation bar, there are filters for "Viewing Claims For : TIN" and "Plan Type" (set to Medicaid), with a "GO" button. To the right of these filters is an "Upload EDI" button and a red-bordered "Create Claim" button. Below the filters is a "Claims" section with tabs for Individual, Saved, Submitted, Batch, Recurring, Payment History, My Downloads, and Claims Audit Tool.This screenshot shows the same interface as the previous one, but with the search fields highlighted by a red border. The "Viewing Claims For : TIN" and "Plan Type" (Medicaid) filters are still present. The "GO" button is to the right of the "Plan Type" dropdown. To the right of the "GO" button are two input fields: "Member ID or Last Name" (containing the placeholder text "123456789 or Smith") and "Birthdate" (containing the placeholder text "mm/dd/yyyy"). To the right of these fields is a red-bordered "Find" button.

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/HSB_SMHK%20Provider%20Manual%20508%20Compliant%2012272022.pdf

Create new Claim – Submission Confirmation



Eligibility

Patients

Authorizations

Claims

Messaging

Viewing Claims For :

GO

Upload EDI

Create Claim

THIS SECTION:

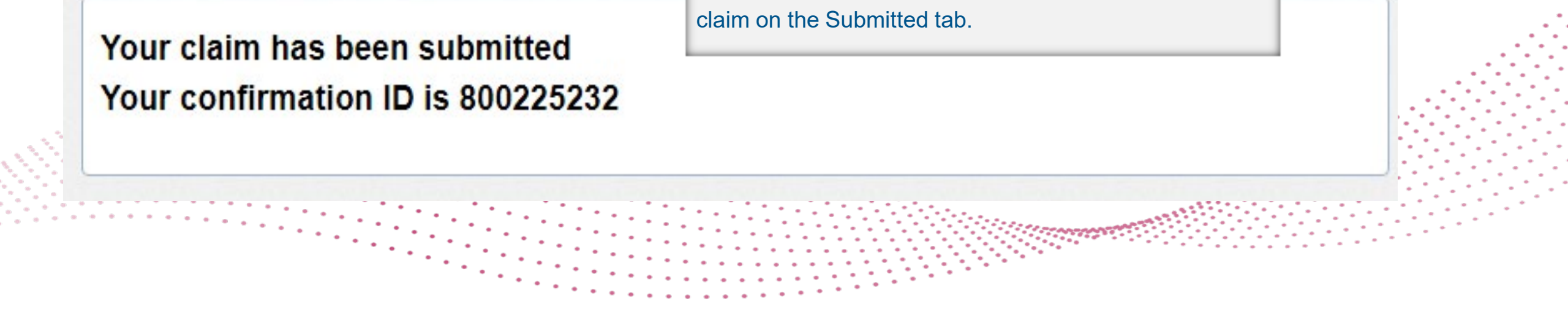
Success

Congratulations!

Your claim has been submitted

Your confirmation ID is 800225232

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**.

A screenshot of the Home State Health Claims portal. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, and Messaging. Below this, 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. A red box highlights the entire form area, which includes: 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) with a note: "Please choose a file format of .dat, .edi, or .txt no larger than 5MB." 3. Upload File: Choose File (No file chosen) with a note: "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. A green "Submit" button with a right arrow.

Viewing Claims

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 ↑
T147	CMS-1500		05/22/2020 - 05/22/2020	\$38.00 / \$0.00	Pending
T147	CMS-1500		05/22/2020 - 05/22/2020	\$75.00 / \$0.00	Pending
T147	CMS-1500		05/22/2020 - 05/22/2020	\$38.00 / \$0.00	Pending
T147	CMS-1500		05/22/2020 - 05/22/2020	\$480.00 / \$0.00	Pending
T148	CMS-1500		05/22/2020 - 05/22/2020	\$247.00 / \$0.00	Pending
T142	CMS-1500		05/20/2020 - 05/20/2020	\$494.00 / \$0.00	Pending
T142	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

