Chapter 3. Claims

The Nevada Medicaid and Nevada Check Up Provider Web Portal (PWP) allows providers, or their delegates, to create/submit, adjust and copy claims online. Providers, or their delegates, can also use the PWP to verify claim status.

For provider specific billing information refer to the Billing Guidelines (by Provider Type).

3.1 Submit Claim

The Claims tab provides the ability to submit dental, institutional, and professional claims. To begin the claim submission process select one of the submit claim options from the Claims submenu, or click on the Claims tab to be directed to the claims landing page.

Claims submenu options:

<table>
<thead>
<tr>
<th>My Home</th>
<th>Eligibility</th>
<th>Claims</th>
<th>Care Management</th>
<th>File Exchange</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Search Claims</td>
<td>Submit Claim Dental</td>
<td>Submit Claim Inst</td>
<td>Submit Claim Prof</td>
<td>Search Payment History</td>
<td>Treatment History</td>
</tr>
</tbody>
</table>

Claims landing page:
Navigation Notes

Do not use the links that appear at the top of the page to navigate between steps of the claims submission process. This could cause data to be lost. Always use the Back to Step buttons at the bottom of the pages to move between steps. If you have successfully updated any information on a step and return to the previous step, your information is not lost.

Example:

You completed Step 1 and continued to Step 2, where you successfully added or updated the diagnosis code information. You return to Step 1 to indicate that the claim is the result of an accident. When you return to Step 2, the diagnosis information you added previously still appears.

If you add or modify information on a step and click “Continue” button without saving the information, a warning message will display.

Example:

You added a diagnosis code, but did not click Add. You click Continue to proceed to Step 3. You are prompted with a warning that you will lose unsaved data by navigating away from the page.

3.1.1 Submit Claim Dental

Select Submit Claim Dental to create and submit a dental claim.

Claim submission is a three step process, click on the “Continue” button at the bottom of each page to continue on to the next step. Click on the “Cancel” button to cancel the creation of the claim.

- Step 1-Provider, Patient and Claim Information
- Step 2-Diagnosis Codes and Other Insurance Details
- Step 3-Service Details and Attachments
Submit Dental Claim: Step 1

* Indicates a required field.

Provider Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Provider ID</td>
<td>1215</td>
</tr>
<tr>
<td>*Billing Provider Service Location</td>
<td>22-DENTAL CENTER-321 N MALL OR STE P101, LAS VEGAS, NEVADA, 89130</td>
</tr>
<tr>
<td>Rendering Provider ID</td>
<td>1230</td>
</tr>
<tr>
<td>*Rendering Provider Service Location</td>
<td>22-DENTAL CENTER-321 N MALL OR STE P101, LAS VEGAS, NEVADA, 89130</td>
</tr>
<tr>
<td>Referring Provider ID</td>
<td>1169</td>
</tr>
<tr>
<td>Service Facility Location ID</td>
<td>1205</td>
</tr>
</tbody>
</table>

Patient Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Recipient ID</td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td>First Name</td>
<td></td>
</tr>
<tr>
<td>Birth Date</td>
<td></td>
</tr>
</tbody>
</table>

Claim Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident Related</td>
<td></td>
</tr>
<tr>
<td>*Place of Treatment</td>
<td>11-Physician's Office</td>
</tr>
<tr>
<td>*Patient Number</td>
<td></td>
</tr>
<tr>
<td>Authorization Number</td>
<td></td>
</tr>
<tr>
<td>Include Other Insurance</td>
<td>[ ]</td>
</tr>
<tr>
<td>Total Charged Amount</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

All of the fields marked with a red asterisk (*) are required fields.

**Provider Information**

The Billing Provider Information is automatically populated with the Billing Provider ID and ID Type of the provider that the signed-in user is associated with.

The following fields can be completed as follows:

- Billing Provider Service Location – Select the appropriate provider type/service location for the type of service being billed
- Rendering Provider ID – If applicable enter the rendering provider NPI
  - ID Type – Select NPI from the drop-down list
- Rendering Provider Service Location – If a rendering provider ID is entered, a rendering provider service location is required; Select the appropriate provider type/service location for rendering provider
- Referring Provider ID – If applicable enter the referring provider NPI
  - ID Type – Select NPI from the drop-down list
- Service Facility Location ID – If applicable enter the service facility NPI
  - ID Type – Select NPI from the drop-down list
**Patient Information**

Enter the 11-digit recipient ID in the Recipient ID field. The Last Name, First Name, and Birth Date will be automatically populated based for the recipient ID that is entered.

<table>
<thead>
<tr>
<th>Patient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient ID</td>
</tr>
<tr>
<td>Last Name</td>
</tr>
<tr>
<td>First Name</td>
</tr>
<tr>
<td>Birth Date</td>
</tr>
</tbody>
</table>

**Claim Information**

<table>
<thead>
<tr>
<th>Claim Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident Related</td>
</tr>
<tr>
<td>Accident Date</td>
</tr>
<tr>
<td>Accident State</td>
</tr>
<tr>
<td>Place of Treatment</td>
</tr>
<tr>
<td>Patient Number</td>
</tr>
<tr>
<td>Authorization Number</td>
</tr>
<tr>
<td>Include Other Insurance</td>
</tr>
<tr>
<td>Total Charged Amount</td>
</tr>
</tbody>
</table>

The following fields can be completed as follows:

- **Accident Related** – If the claim is related to accident, select the accident type from the drop-down list
- **Accident Date** – Enter the date of the accident
- **Accident State** – Displays if Auto Accident is selected in the Accident Related drop-down list
- **Accident Country** – Displays if Auto Accident is selected in the Accident Related drop-down list
- **Place of Treatment** – Select the place of treatment from the drop-down list
- **Patient Number** – Enter a patient number
- **Authorization Number** – If applicable, enter the prior authorization number for the service(s) being billed on the claim
- **Include Other Insurance** – If the recipient has other insurance that paid as primary, check this box; When this box is checked the Other Insurance Information panel will appear on the Submit Dental Claim: Step 2
- **Total Charged Amount** – Read only and displays the total charge amount associated with the claim
Submit Dental Claim: Step 2
When the Submit Dental Claim: Step 2 page is first displayed all of the panels are expanded. Click “Collapse All” to close all panels, or click minus icons on each panel to close only that panel.

<table>
<thead>
<tr>
<th>#</th>
<th>Diagnosis Type</th>
<th>Diagnosis Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>*Diagnosis Type</td>
<td>ICD-10-CM vx</td>
<td>Add</td>
</tr>
</tbody>
</table>

Diagnosis Codes
Select the row number to edit the row, Click the Remove link to remove the entire row. Please note that the 1st diagnosis entered is considered to be the principal (primary) Diagnosis Code.

Other Insurance Details
Enter the carrier and policy holder information below. Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the Remove link to remove the entire row.

Other Insurance Details
Back to Step 1  Continue  Cancel

Click “Expand All” to expand all panels, or click plus icons on each panel to open only that panel.
**Diagnosis Codes**

The first diagnosis entered is considered to be the principal or primary diagnosis code.

- The PWP allows for up to 8 diagnosis codes
- Diagnosis codes are searchable
  - Enter the first three letters or the first three numbers of the code to use the predictive search
- Click the “Add” button to add each diagnosis code
- Click the “Remove” link to remove any diagnosis codes added to the claim in error

All of the fields marked with a red asterisk (*) are required fields.
Other Insurance Details
If the recipient has other insurance carrier information on file with Nevada Medicaid, the policy information will auto populate in the Other Insurance Details panel. Other Insurance Details fields are required only if you are adding other insurance payment information.

- Click “Add Adjustment” button to add claim adjustment details to the other insurance details line.
- Click “Cancel Adjustment” button to cancel any updates to the claims adjustment details
- Click “Save Insurance” button to save the information to the other insurance details line.
- Click “Cancel Insurance” button to cancel any updates to the other insurance details line.
- Click the “Remove” link to remove any other insurance details added to the claim in error.
- Click “Continue” button to complete Submit Dental Claim: Step 3.
If the recipient does not have other insurance carrier information on file with Nevada Medicaid, the policy information will not auto populate in the Other Insurance Details panel. Other Insurance Details can be added by completing the following fields:

- **Carrier Name** – Enter the other insurance carrier name
- **Carrier ID** – Enter the other insurance carrier ID
- **Policy Holder Last Name** – Enter the last name of the policy holder
- **First Name** – Enter the first name of the policy holder
- **MI** – Enter the middle initial of the policy holder
- **Policy ID** – Enter the policy ID
- **Insurance Type** – Select the insurance type from the drop-down list
- **Responsibility** – Select the responsibility type from the drop-down list
- **Patient Relationship to Insured** – Select the patient relationship to insured from the drop-down list
- **Payer Paid Amount** – Enter the amount paid by the other insurance
- **Paid Date** – Enter the date the other insurance paid
- **Remaining Patient Liability** – Enter the remaining patient liability
- **Claim Filing Indicator** – Select the claim filing indicator from the drop-down list.

All of the fields marked with a red asterisk (*) are required fields.

Click “Add Insurance” button to add the Other Insurance Details to the claim.
Updating Other Insurance Details
Select the sequence number of any other insurance line item to update details such as the allowed amount, paid amount, paid date and adjustment codes for the specific other insurance carrier.

- Click “Add Adjustment” button to add claim adjustment details to the other insurance details line
- Click “Cancel Adjustment” button to cancel any updates to the claims adjustment details
- Click “Save Insurance” button to save the information to the other insurance details line
- Click “Cancel Insurance” button to cancel any updates to the other insurance details
- Click the “Remove” link to remove any other insurance details added to the claim in error

Click “Continue” button to complete Submit Dental Claim: Step 3.
Submit Dental Claim: Step 3
When the Submit Dental Claim: Step 3 page is first displayed not all of the panels are expanded.

- Click “Expand All” to expand all panels, or click plus icons on each panel to open only that panel.
- Click “Collapse All” to close all panels, or click minus icons on each panel to close only that panel.

All of the fields marked with a red asterisk (*) are required fields.

## Service Details

- Up to 50 service details to be added to a dental claim
- Procedure codes are searchable
  - Enter the first three letters or the first three numbers of the code to use the predictive search
- Modifiers are searchable
Enter the first 3 letters of the description or the first 2 number or letters of the modifier to use the predictive search

- Click the “Add” button to add each service detail
- Click the “Remove” link to remove any service detail added to the claim in error

All of the fields marked with a red asterisk (*) are required fields.

### Updating Service Details
Select the sequence number of any service detail line item to update details such as the service date, procedure code, units or charge amount.

- Click the “Save” button to save the changes
- Click the “Reset” button to clear any of the changes to the service detail
- Click on the “Cancel” button to cancel any updates and close the service detail

### Adding Other Insurance Details on Service Detail line
Select the sequence number of any service detail line item to add other insurance details and claim adjustment details.
1. Add Other Insurance Details first and click Add Insurance button.
2. Click the sequence number in the Other Insurance for Service Detail panel to add the Adjustment Details.
3. Enter the Claim Adjustment Details and click the Add Adjustment button to add adjustment information for the other insurance.

4. Click the Save Insurance button to save the other insurance information with the claim adjustment details.
5. Click Save button to save the updates to the Service Detail Line.

Attachments
To include attachments electronically with a claim:

- Transmission Method – FT - File Transfer is selected by default
- Upload file – click “Browse” button and locate the file on your computer to be attached
- Attachment Type – select the type of attachment from the drop-down list
- A description of the attachment can be entered, but it is not required
- Click “Add” button to attach the file
- Repeat for additional attachments if needed up to 10 attachments can be added per claim (Note: the combined size of all attachments cannot exceed 4MB)
- To remove any attachments that were attached incorrectly, use the “Remove” link
- Click on the “Cancel” button to cancel and close the attachment line
All of the fields marked with a red asterisk (*) are required fields.

Claim Submission
Click the “Submit” button to complete the claim creation process.

Confirm Dental Claim
After clicking the “Submit” button, the Confirm Dental Claim page will display with the claim details to review before submission.

- Click the “Confirm” button to submit the claim
- Click the “Print Preview” button to print a copy of the Confirm Dental Claim page
- Click on the “Cancel” button to cancel the claim submission
Submit Dental Claim: Confirmation
The Submit Dental Claim: Confirmation will appear after the claim has been submitted. It will display the claim status and Claim ID.

Submit Dental Claim: Confirmation

Dental Claim Receipt

Your Dental Claim was successfully submitted. The claim status is Finalized Payment.
The Claim ID is 2218172000009.

Click Print Preview to view the claim details as they have been saved on the payer's system.
Click Copy to copy member or claim data.
Click Adjust to resubmit the claim.
Click New to submit a new claim.
Click View to view the details of the submitted claim.

- Click “Print Preview” button to view the claim details
- Click “Copy” button to copy claim data
- Click “Adjust” button to resubmit the claim
- Click “New” button to submit a new claim
- Click “View” button to view the details of the submitted claim

3.1.2 Submit Claim Inst

Select Submit Claim Inst to create and submit an Institutional claim.
Claim submission is a three step process, click on the “Continue” button at the bottom of each page to continue on to the next step. Click on the “Cancel” button to cancel the creation of the claim.

- Step 1-Provider, Patient and Claim Information
- Step 2-Diagnosis Codes and Other Insurance Details
- Step 3-Service Details and Attachments
Submit Inst Claim: Step 1

All of the fields marked with a red asterisk (*) are required fields.

**Claim Type**
Use the Claim Type drop-down to indicated the type of institutional claim.
Provider Information

The Billing Provider Information is automatically populated with the Billing Provider ID and ID Type of the provider that the signed-in user is associated with.

<table>
<thead>
<tr>
<th>Provider Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Billing Provider Service Location</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Institutional Provider ID</strong></td>
<td>12345</td>
</tr>
<tr>
<td><strong>Billing Provider ID</strong></td>
<td>12345</td>
</tr>
<tr>
<td><strong>Attending Provider ID</strong></td>
<td>12345</td>
</tr>
<tr>
<td><strong>Operating Provider ID</strong></td>
<td>12345</td>
</tr>
</tbody>
</table>

All of the fields marked with a red asterisk (*) are required fields.

The following fields can be completed as follows:

- Billing Provider Service Location – Select the appropriate provider type/service location for the type of service being billed
- Institutional Provider ID – If applicable enter the institutional provider NPI
  - ID Type – Select NPI from the drop-down list
- Attending Provider ID – If applicable enter the attending provider NPI
  - ID Type – Select NPI from the drop-down list
- Operating Provider ID – If applicable enter the operating provider NPI
  - ID Type – Select NPI from the drop-down list

Patient Information

Enter the 11-digit recipient ID in the Recipient ID field. The Last Name, First Name, and Birth Date will be automatically populated based on the recipient ID that is entered.

<table>
<thead>
<tr>
<th>Patient Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recipient ID</strong></td>
<td>12345678901</td>
</tr>
<tr>
<td>Last Name</td>
<td>ISAAC</td>
</tr>
<tr>
<td>Birth Date</td>
<td>01/01/1999</td>
</tr>
</tbody>
</table>

All of the fields marked with a red asterisk (*) are required fields.

Claim Information

The required information in the Claims Information panel depends on the type of institutional claim that is being created.
Admission Type, Admission Source, Admitting Diagnosis, and Patient Status are searchable. Enter the first three letters or the first numbers of the code to use the predictive search.

For example:

<table>
<thead>
<tr>
<th>Admission Source</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Reserved for assignment by the NUBC. (Discontinued effective 10/1/07)</td>
</tr>
<tr>
<td>7</td>
<td>Reserved for assignment by the NUBC. (Discontinued effective 7/1/10)</td>
</tr>
<tr>
<td>A</td>
<td>Reserved for assignment by the NUBC. (Discontinued effective 10/1/07)</td>
</tr>
<tr>
<td>B</td>
<td>Reserved for assignment by the NUBC. (Discontinued effective 7/1/10)</td>
</tr>
<tr>
<td>C</td>
<td>Reserved for assignment by the NUBC. (Discontinued effective 7/1/10)</td>
</tr>
</tbody>
</table>

Claim Information panel for Inpatient, Inpatient Crossover and Long Term Care claims

<table>
<thead>
<tr>
<th>Claim Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Covered Dates</em></td>
</tr>
<tr>
<td><em>Admission Date/Time</em></td>
</tr>
<tr>
<td><em>Admission Type</em></td>
</tr>
<tr>
<td><em>Admitting Diagnosis Type</em></td>
</tr>
<tr>
<td><em>Patient Status</em></td>
</tr>
<tr>
<td><em>Patient Number</em></td>
</tr>
<tr>
<td>Include Other Insurance</td>
</tr>
<tr>
<td>Discharge Date/Time</td>
</tr>
<tr>
<td><em>Admission Source</em></td>
</tr>
<tr>
<td><em>Admitting Diagnosis</em></td>
</tr>
<tr>
<td><em>Facility Type Code</em></td>
</tr>
<tr>
<td>Authorization Number</td>
</tr>
<tr>
<td>Total Charged Amount</td>
</tr>
</tbody>
</table>

All of the fields marked with a red asterisk (*) are required fields

Claim Information panel for Outpatient and Outpatient Crossover claims

<table>
<thead>
<tr>
<th>Claim Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Covered Dates</em></td>
</tr>
<tr>
<td><em>Admission Date/Time</em></td>
</tr>
<tr>
<td><em>Admission Type</em></td>
</tr>
<tr>
<td><em>Admitting Diagnosis Type</em></td>
</tr>
<tr>
<td><em>Patient Status</em></td>
</tr>
<tr>
<td><em>Patient Number</em></td>
</tr>
<tr>
<td>Include Other Insurance</td>
</tr>
<tr>
<td>Discharge Date/Time</td>
</tr>
<tr>
<td><em>Admission Source</em></td>
</tr>
<tr>
<td><em>Admitting Diagnosis</em></td>
</tr>
<tr>
<td><em>Facility Type Code</em></td>
</tr>
<tr>
<td>Authorization Number</td>
</tr>
<tr>
<td>Total Charged Amount</td>
</tr>
</tbody>
</table>

All of the fields marked with a red asterisk (*) are required fields

The following fields can be completed as follows:

- **Covered Dates** – Enter the covered dates of service for the claim
- **Admission Date/Hour** – Enter the date and time of admission
- **Discharge Hour** – Enter the time the recipient was discharged from care
- **Admission Type** – Enter a patient number
- **Admission Source** – Enter the source of admission
- **Admitting Diagnosis Type** – ICD-10-CM is selected by default, ICD-9-CM can also be selected if applicable
• Admitting Diagnosis – Enter the diagnosis code for the diagnosis that was present at time of admission

• Patient Status – Enter the patient status

• Facility Type Code – Select the correct facility type code from the drop-down list

• Patient Number – Enter patient number

• Authorization Number – If applicable, enter the prior authorization number for the service(s) being billed on the claim

• Include Other Insurance – If the recipient has other insurance that paid as primary, check this box; When this box is checked the Other Insurance Information panel will appear on the Submit Institutional Claim: Step 2

• Total Charged Amount – Read only and displays the total charge amount associated with the claim

**Medicare Crossover Details**
The Medicare Crossover Details panel will display when Crossover Inpatient or Crossover Outpatient is selected as the claim type.

<table>
<thead>
<tr>
<th>Medicare Crossover Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Amount</td>
</tr>
<tr>
<td>Blood Deductible Amount</td>
</tr>
<tr>
<td>Medicare Payment Amount</td>
</tr>
<tr>
<td>Co-insurance Amount</td>
</tr>
<tr>
<td>Medicare Payment Date(s)</td>
</tr>
</tbody>
</table>

Use the Medicare Explanation of Benefits to complete the following fields as applicable:

• Deductible Amount

• Co-insurance Amount

• Blood Deductible Amount

• Medicare Payment Date

• Medicare Payment Amount

**Submit Institutional Claim: Step 2**
When the Submit Institutional Claim: Step 2 page is first displayed all of the panels except for diagnosis are collapsed. Click “Expand All” to open all panels, or click plus icons on each panel to open only that panel.
Click “Collapse All” to close all panels, or click minus icons on each panel to close only that panel.
### Value Codes

Select the row number to edit the row. Click the Remove link to remove the entire row.

<table>
<thead>
<tr>
<th>#</th>
<th>Value Code</th>
<th>Amount</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Value Code*  *Amount*

**Add**  **Reset**

### Surgical Procedures

Operating Provider is required to be entered back on Step 1 to allow for entry of surgical procedure codes within this panel.

[Back to Step 1]  [Continue]  [Cancel]
**Diagnosis Codes**

The first diagnosis entered is considered to be the principal or primary diagnosis code.

- The PWP allows for up to 8 diagnosis codes
- Diagnosis codes are searchable
  - Enter the first three letters or the first three numbers of the code to use the predictive search
- Click the “Add” button to add each diagnosis code
- Click the “Remove” link to remove any diagnosis codes added to the claim in error

<table>
<thead>
<tr>
<th>#</th>
<th>Diagnosis Type</th>
<th>Diagnosis Code</th>
<th>POA</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ICD-10-CM</td>
<td>R4920-Unspecified coma</td>
<td>Yes</td>
<td>Remove</td>
</tr>
<tr>
<td>2</td>
<td>*Diagnosis Type</td>
<td>*Diagnosis Code</td>
<td>Present on Admission</td>
<td>No</td>
</tr>
</tbody>
</table>

All of the fields marked with a red asterisk (*) are required fields.

**External Cause of Injury Diagnosis Codes**

If applicable enter the external cause of injury diagnosis codes.

- Diagnosis codes are searchable
  - Enter the first three letters or the first three numbers of the code to use the predictive search
- Click the “Add” button to add each diagnosis code
- Click the “Remove” link to remove any diagnosis codes added to the claim in error

<table>
<thead>
<tr>
<th>#</th>
<th>Diagnosis Type</th>
<th>External Cause of Injury Diagnosis Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ICD-10-CM</td>
<td>R4920-Unspecified coma</td>
<td>Remove</td>
</tr>
<tr>
<td>2</td>
<td>*Diagnosis Type</td>
<td>*External Cause of Injury Diagnosis Code</td>
<td></td>
</tr>
</tbody>
</table>

**Patient Reason for Visit Diagnosis Codes**

The patient reason for visit diagnosis codes only displays on institutional claims with an outpatient claim type. If applicable enter the patient reason for visit diagnosis codes.

- Diagnosis codes are searchable
  - Enter the first three letters or the first three numbers of the code to use the predictive search
- Click the “Add” button to add each diagnosis code
- Click the “Remove” link to remove any diagnosis codes added to the claim in error

<table>
<thead>
<tr>
<th></th>
<th>Diagnosis Type</th>
<th>Patient Reason for Visit Diagnosis Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ICD-10-CM</td>
<td>D009-0th viral infections with skin and mucous membrane lesions</td>
<td>Remove</td>
</tr>
<tr>
<td>2</td>
<td>*Diagnosis Type</td>
<td><a href="#">ICD-10-CM</a> <em>Patient Reason for Visit Diagnosis Code:</em></td>
<td>Add</td>
</tr>
</tbody>
</table>
Other Insurance Details

If the recipient has other insurance carrier information on file with Nevada Medicaid, the policy information will auto populate in the Other Insurance Details panel. Other Insurance Details fields are required only if you are adding other insurance payment information.

- Click “Add Adjustment” to add claim adjustment details to the other insurance details line
- Click “Save Insurance” to save the information to the other insurance details line
- Click “Cancel Adjustment” to cancel any updates to the claims adjustment details
- Click “Cancel Insurance” to cancel any updates to the other insurance details
- Click the “Remove” link to remove any other insurance details added to the claim in error

If the recipient does not have other insurance carrier information on file with Nevada Medicaid, the policy information will not auto populate in the Other Insurance Details panel. Other Insurance Details can be added by completing the following fields:

- Carrier Name – Enter the other insurance carrier name
- Carrier ID – Enter the other insurance carrier ID
• Policy Holder Last Name – Enter the last name of the policy holder
• First Name – Enter the first name of the policy holder
• MI – Enter the middle initial of the policy holder
• Policy ID – Enter the policy ID
• Insurance Type – Select the insurance type from the drop-down list
• Responsibility – Select the responsibility type from the drop-down list
• Patient Relationship to Insured – Select the patient relationship to insured from the drop-down list
• Payer Paid Amount – Enter the amount paid by the other insurance
• Paid Date – Enter the paid the other insurance paid
• Remaining Patient Liability – Enter the remaining patient liability
• Claim Filing Indicator – Select the claim filing indicator from the drop-down list.

All of the fields marked with a red asterisk (*) are required fields.
Click “Add Insurance” to add the Other Insurance Details to the claim.
Updating Other Insurance Details
Click the sequence number of any other insurance line item to update details such as the allowed amount, paid amount, paid date and adjustment codes for the specific other insurance carrier.

- Click “Add Adjustment” to add claim adjustment details to the other insurance details line
- Click “Save Insurance” to save the information to the other insurance details line
- Click “Cancel Adjustment” to cancel any updates to the claims adjustment details
- Click “Cancel Insurance” to cancel any updates to the other insurance details
- Click the “Remove” link to remove any other insurance details added to the claim in error

Condition Codes
If applicable enter condition codes for the claim.
- The PWP allows for up to 24 condition codes
- Condition codes are searchable
  - Enter the first three letters or the first two numbers of the code to use the predictive search
• Click the “Add” button to add each condition code
• Click the “Remove” link to remove any condition codes added to the claim in error

### Occurrence Codes
If applicable enter occurrence codes for the claim.

- The PWP allows for up to 24 occurrence codes
- Occurrence codes are searchable
  - Enter the first three letters or the first two numbers of the code to use the predictive search
- Click the “Add” button to add each occurrence code
- Click the “Remove” link to remove any occurrence codes added to the claim in error

### Value Codes
If applicable enter value codes for the claim.

- The PWP allows for up to 24 value codes
- Value codes are searchable
  - Enter the first three letters or the first two numbers of the code to use the predictive search
- Value code amounts are displayed as a decimal. The amount can either be a number, such as days, or a dollar amount.
  - For value codes 80 – Covered Days and 81 – Non Covered Days enter the number of days.
- Click the “Add” button to add each value code
- Click the “Remove” link to remove any value codes added to the claim in error
Surgical Procedures
In order to add surgical procedure codes to the claim, an operating provider needs to be entered on Submit Institutional Claim: Step 1.

- The PWP allows for up to 24 surgical procedures
- The first surgical procedure code entered is considered to be the principal surgical procedure code
- Surgical procedures are searchable
  - Enter the first three letters or the first two numbers of the code to use the predictive search
- Click the “Add” button to add each surgical procedure
- Click the “Remove” link to remove any surgical procedures added to the claim in error

Submit Institutional Claim: Step 3
When the Submit Institutional Claim: Step 3 page is first displayed not all of the panels are expanded.

- Click “Expand All” to expand all panels, or click plus icons on each panel to open only that panel.
- Click “Collapse All” to close all panels, or click minus icons on each panel to close only that panel.
All of the fields marked with a red asterisk (*) are required fields.

**Service Details Inpatient Claim Types**

- Up to 50 service details to be added to an institutional claim
- Revenue Codes are searchable
  - Enter the first three letters or the first three numbers of the code to use the predictive search
- HCPCS/Proc codes are searchable
  - Enter the first three letters or the first three numbers of the code to use the predictive search
- Modifiers are searchable
Service Details

Select the row number to add the row. Click the Remove link to remove the entire row.

<table>
<thead>
<tr>
<th>Row</th>
<th>Revenue Code</th>
<th>HCPCS/Proc Code</th>
<th>From Date</th>
<th>To Date</th>
<th>Units</th>
<th>Charge Amount</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0121-Non-2 Bed-Med-Surg-Gyn</td>
<td>05/01/2018</td>
<td>05/10/2018</td>
<td>10.00 Days</td>
<td>$1,000.00</td>
<td>Remove</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.000</td>
<td></td>
</tr>
</tbody>
</table>

All of the fields marked with a red asterisk (*) are required fields.

Service Details Outpatient Claim Types

- Up to 50 service details to be added to an institutional claim
- Revenue Codes are searchable
  - Enter the first three letters or the first three numbers of the code to use the predictive search
- HCPCS/Proc codes are searchable
  - Enter the first three letters or the first three numbers of the code to use the predictive search
- Modifiers are searchable
  - Enter the first 3 letters of the description or the first 2 number or letters of the modifier to use the predictive search
- Click the “Add” button to add each service detail
- Click the “Remove” link to remove any service detail added to the claim in error

<table>
<thead>
<tr>
<th>Row</th>
<th>Revenue Code</th>
<th>HCPCS/Proc Code</th>
<th>From Date</th>
<th>To Date</th>
<th>Units</th>
<th>Charge Amount</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.000</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><em>Revenue Code</em></td>
<td><em>HCPCS/Proc Code</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Remove</td>
</tr>
</tbody>
</table>

Add | Reset

EVS User Manual, Chapter 3
Updated 03/20/2019 (pv 12/28/2018) MODERNIZATION
Adding NDC information for Physician-Administered Drugs

Nevada Medicaid requires a National Drug Code (NDC) and an NDC quantity for each claim line with a physician administered drug. To add NDC information to the service line, expand the NDCs for Svc section by clicking on the plus icon. The HCPCS/Proc Code and NDC are both required for Physician-Administered Drugs.

Updating Service Details

Select the sequence number of any service detail line item to update details such as the service date, procedure code, units or charge amount.

- Click the “Save” button to save the changes
- Click the “Reset” button to clear any of the changes to the service detail
- Click on the “Cancel” button to cancel any updates and close the service detail
Adding Other Insurance Details on Service Detail line

Select the sequence number of any service detail line item to add other insurance details and claim adjustment details.

1. Add Other Insurance Details first and click Add Insurance button.
2. Click the sequence number in the Other Insurance for Service Detail panel to add the Adjustment Details.
3. Enter the Claim Adjustment Details and click Add Adjustment button to add adjustment information for the other insurance.
4. Click Save Insurance button to save the other insurance information with the claim adjustment details.

5. Click Save button to save the updates to the Service Detail Line.
Attachments
To include attachments electronically with a claim:

- Transmission Method – FT - File Transfer is selected by default
- Upload file – click “Browse” button and locate the file on your computer to be attached
- Attachment Type – select the type of attachment from the drop-down list
- A description of the attachment can be entered, but it is not required
- Click “Add” button to attach the file
- Repeat for additional attachments if needed up to 10 attachments can be added per claim (Note: the combined size of all attachments cannot exceed 4MB)
- To remove any attachments that were attached incorrectly, use the “Remove” link
- Click on the “Cancel” button to cancel and close the attachment line

All of the fields marked with a red asterisk (*) are required fields.
Claim Submission
Click the “Submit” button to complete the claim creation process.

Confirm Institutional Claim
After clicking the “Submit” button, the Confirm Institutional Claim page will display with the claim details to review before submission.

### Claim Information

<table>
<thead>
<tr>
<th>Covered Dates</th>
<th>Admission Date/Time</th>
<th>Admission Source</th>
<th>Discharge Date</th>
<th>Facility Type Code</th>
<th>Authorization Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/01/2018</td>
<td>05/01/2018</td>
<td>2</td>
<td>05/01/2018</td>
<td>131</td>
<td>123456789011234567</td>
</tr>
<tr>
<td>Emergency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
</tr>
</tbody>
</table>

| Patient Number | 12345 |

<table>
<thead>
<tr>
<th>Previous Claim ID</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Total Charged Amount | $250.00 |

### Diagnosis Codes

### External Cause of Injury Diagnosis Codes

### Patient Reason for Visit Diagnosis Codes

### Other Insurance Details

<table>
<thead>
<tr>
<th>#</th>
<th>Carrier Name</th>
<th>Carrier ID</th>
<th>Policy ID</th>
<th>Payor Paid Amount</th>
<th>Paid Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Blue Shield</td>
<td>09001</td>
<td>0000000001</td>
<td>$100.00</td>
<td>05/01/2018</td>
</tr>
</tbody>
</table>

### Condition Codes

### Occurrence Codes

### Value Codes

### Surgical Procedures

### Service Details

<table>
<thead>
<tr>
<th>Svc. #</th>
<th>Revenue Code</th>
<th>CPT Code</th>
<th>Mod</th>
<th>From Date</th>
<th>To Date</th>
<th>Units/Type</th>
<th>Charge Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0450</td>
<td>77012</td>
<td>TC</td>
<td>05/01/2018</td>
<td>05/01/2018</td>
<td>1,000 Unit</td>
<td>$250.00</td>
</tr>
</tbody>
</table>

### Attachments
- Click the “Confirm” button to submit the claim
- Click the “Print Preview” button to print a copy of the Confirm Institutional Claim page
- Click on the “Cancel” button to cancel the claim submission

**Submit Institutional Claim: Confirmation**

The Submit Institutional Claim: Confirmation will appear after the claim has been submitted. It will display the claim status and Claim ID.

- Click “Print Preview” button to view the claim details
- Click “Copy” button to copy claim data
- Click “Adjust” button to resubmit the claim
- Click “New” button to submit a new claim
- Click “View” button to view the details of the submitted claim
3.1.3 Submit Claim Prof

Select **Submit Claim Prof** to create and submit a professional claim. Claim submission is a three step process, click on the “Continue” button at the bottom of each page to continue on to the next step. Click on the “Cancel” button to cancel the creation of the claim.

- Step 1-Provider, Patient and Claim Information
- Step 2-Diagnosis Codes and Other Insurance Details
- Step 3-Service Details and Attachments

Submit Professional Claim: Step 1

![Submit Professional Claim: Step 1 form](image)

All of the fields marked with a red asterisk (*) are required fields.

**Provider Information**

The Billing Provider Information is automatically populated with the Billing Provider ID and ID Type of the provider that the signed-in user is associated with.

![Provider Information table](image)
The following fields can be completed as follows:

- **Billing Provider Service Location** – Select the appropriate provider type/service location for the type of service being billed
- **Rendering Provider ID** – If applicable enter the rendering provider NPI
  - ID Type – Select NPI from the drop-down list
- **Rendering Provider Service Location** – If a rendering provider ID is entered, a rendering provider service location is required; Select the appropriate provider type/service location for rendering provider
- **Referring Provider ID** – If applicable enter the referring provider NPI
  - ID Type – Select NPI from the drop-down list
- **Service Facility Location ID** – If applicable enter the service facility NPI
  - ID Type – Select NPI from the drop-down list

### Patient Information

Enter the 11-digit recipient ID in the Recipient ID field. The Last Name, First Name, and Birth Date will be automatically populated based on the recipient ID that is entered.

<table>
<thead>
<tr>
<th>Patient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recipient ID</strong></td>
</tr>
<tr>
<td><strong>Last Name</strong></td>
</tr>
<tr>
<td><strong>Birth Date</strong></td>
</tr>
<tr>
<td><strong>First Name</strong></td>
</tr>
</tbody>
</table>

### Claim Information

Please select at least one option from the Accident State or Accident Country dropdowns below.

<table>
<thead>
<tr>
<th>Claim Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date Type</strong></td>
</tr>
<tr>
<td><strong>Accident Related</strong></td>
</tr>
<tr>
<td><strong>Accident State</strong></td>
</tr>
<tr>
<td><strong>Patient Number</strong></td>
</tr>
<tr>
<td><strong>Date of Currents</strong></td>
</tr>
<tr>
<td><strong>Admission Dates</strong></td>
</tr>
<tr>
<td><strong>Accident Country</strong></td>
</tr>
<tr>
<td><strong>Transport Certification</strong></td>
</tr>
<tr>
<td><strong>Certification Condition Indicator</strong></td>
</tr>
<tr>
<td><strong>Condition Indicator</strong></td>
</tr>
<tr>
<td><strong>Transport Distance</strong></td>
</tr>
<tr>
<td><strong>Ambulance Transport Reason</strong></td>
</tr>
<tr>
<td><strong>Does the provider have a signature on file?</strong></td>
</tr>
<tr>
<td><strong>Include Other Insurance</strong></td>
</tr>
<tr>
<td><strong>Total Charged Amount</strong></td>
</tr>
</tbody>
</table>

All of the fields marked with a red asterisk (*) are required fields.

The following fields can be completed as follows:

- **Date Type** – Select illness, injury or pregnancy from the drop-down list if
• Date of Current – Enter the start date of the illness, injury, or pregnancy that is related to this claim
• Accident Related – If the claim is related to accident, select the accident type from the drop-down list
• Admission Date – Enter the admission date if this claim is related to a hospital admission
• Accident State – Displays if Auto Accident is selected in the Accident Related drop-down list
• Accident Country – Displays if Auto Accident is selected in the Accident Related drop-down list
• Patient Number – Enter a patient number
• Authorization Number – If applicable, enter the prior authorization number for the service(s) being billed on the claim
• Transport Certification – Select yes or no
• Certification Condition Indicator – This question displays and is required if yes is marked for Transport Certification; Select yes or no
• Condition Indicator – These fields appear and are required if yes is marked for Transport Certification; select the correct value from the drop-down list
• Transport Distance – This field displays and is required if yes is marked for Transport Certification; enter the number of miles patient was transported
• Ambulance Transport Reason – This field displays and is required if yes is marked for Transport Certification; Select the ambulance transport reason from the drop-down list
• Does the provider have a signature on file? – Select yes or no
• Include Other Insurance – If the recipient has other insurance that paid as primary, check this box; When this box is checked the Other Insurance Information panel will appear on the Submit Dental Claim: Step 2
• Total Charged Amount – Read only and displays the total charge amount associated with the claim
Submit Professional Claim: Step 2
When the Submit Prof Claim: Step 2 is first displayed all of the panels are expanded. Click “Collapse All” to close all panels, or click minus icons on each panel to close only that panel.

Click “Expand All” to expand all panels, or click plus icons on each panel to open only that panel.
Diagnosis Codes

The first diagnosis entered is considered to be the principal or primary diagnosis code.

- The PWP allows for up to 8 diagnosis codes
- Diagnosis codes are searchable
  - Enter the first three letters or the first three numbers of the code to use the predictive search
- Click the “Add” button to add each diagnosis code
- Click the “Remove” link to remove any diagnosis codes added to the claim in error

All of the fields marked with a red asterisk (*) are required fields.
Other Insurance Details

If the recipient has other insurance carrier information on file with Nevada Medicaid, the policy information will auto populate in the Other Insurance Details panel. Other Insurance Details fields are required only if you are adding other insurance payment information.

- Click “Add Adjustment” to add claim adjustment details to the other insurance details line
- Click “Save Insurance” to save the information to the other insurance details line
- Click “Cancel Adjustment” to cancel any updates to the claims adjustment details
- Click “Cancel Insurance” to cancel any updates to the other insurance details
- Click the “Remove” link to remove any other insurance details added to the claim in error
- Click “Continue” button to complete Submit Professional Claim: Step 3.
If the recipient does not have other insurance carrier information on file with Nevada Medicaid, the policy information will not auto populate in the Other Insurance Details panel. Other Insurance Details can be added by completing the following fields:

- **Carrier Name** – Enter the other insurance carrier name
- **Carrier ID** – Enter the other insurance carrier ID
- **Policy Holder Last Name** – Enter the last name of the policy holder
- **First Name** – Enter the first name of the policy holder
- **MI** – Enter the middle initial of the policy holder
- **Policy ID** – Enter the policy ID
- **Insurance Type** – Select the insurance type from the drop-down list
- **Responsibility** – Select the responsibility type from the drop-down list
- **Patient Relationship to Insured** – Select the patient relationship to insured from the drop-down list
- **Payer Paid Amount** – Enter the amount paid by the other insurance
- **Paid Date** – Enter the paid the other insurance paid
- **Remaining Patient Liability** – Enter the remaining patient liability
- **Claim Filing Indicator** – Select the claim filing indicator from the drop-down list.

All of the fields marked with a red asterisk (*) are required fields.

Click “Add Insurance” to add the Other Insurance Details to the claim.
Updating Other Insurance Details
Select the sequence number of any other insurance line item to update details such as the allowed amount, paid amount, paid date and adjustment codes for the specific other insurance carrier.

- Click “Add Adjustment” to add claim adjustment details to the other insurance details line
- Click “Save Insurance” to save the information to the other insurance details line
- Click “Cancel Adjustment” to cancel any updates to the claims adjustment details
- Click “Cancel Insurance” to cancel any updates to the other insurance details
- Click the “Remove” link to remove any other insurance details added to the claim in error

Click “Continue” button to complete Submit Professional Claim: Step 3.
Submit Professional Claim: Step 3
When the Submit Professional Claim: Step 3 is first displayed not all of the panels are expanded.

- Click “Expand All” to expand all panels, or click plus icons on each panel to open only that panel.
- Click “Collapse All” to close all panels, or click minus icons on each panel to close only that panel.

<table>
<thead>
<tr>
<th>Submit Professional Claim: Step 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claim Type</strong></td>
</tr>
</tbody>
</table>

**Provider Information**

- **Billing Provider ID**: 1312
- **ID Type**: NPI

**Patient and Claim Information**

- **Recipient ID**: 00000000001
- **Recipient**: ISAAC T CLARIZZ
- **Gender**: Male
- **Birth Date**: 01/01/1999
- **Total Charged Amount**: $0.00

**Diagnosis Codes**

**Other Insurance Details**

<table>
<thead>
<tr>
<th>#</th>
<th>Carrier Name</th>
<th>Carrier ID</th>
<th>Policy ID</th>
<th>Payor Paid Amount</th>
<th>Paid Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Blue Shield</td>
<td>BS001</td>
<td>0000000001</td>
<td>$15.00</td>
<td>06/01/2018</td>
</tr>
</tbody>
</table>

**Service Details**

Select the row number to edit the row. Click the Remove link to remove the entire row.

<table>
<thead>
<tr>
<th>Ser. #</th>
<th>From Date</th>
<th>To Date</th>
<th>Place of Service</th>
<th>Procedure Code</th>
<th>Charge Amount</th>
<th>Units</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>Place of Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Procedure Code**: EMG
- **Charge Amount**: 0.000
- **Units**: 0.000

**NDCs for Ser. # 1**

- **Add**
- **Reset**

**Attachments**

Click the Remove link to remove the entire row.

<table>
<thead>
<tr>
<th>#</th>
<th>Transmission Method</th>
<th>File</th>
<th>Control #</th>
<th>Attachment Type</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Click to add attachment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All of the fields marked with a red asterisk (*) are required fields.
Service Details

- Up to 50 service details to be added to a professional claim
- Procedure codes are searchable
  - Enter the first three letters or the first three numbers of the code to use the predictive search
- Modifiers are searchable
  - Enter the first 3 letters of the description or the first 2 number or letters of the modifier to use the predictive search
- Click the “Add” button to add each service detail
- Click the “Reset” button to clear all of the information that has been entered
- Click the “Remove” link to remove any service detail added to the claim in error

All of the fields marked with a red asterisk (*) are required fields.

Adding NDC information for Physician-Administered Drugs

Nevada Medicaid requires a National Drug Code (NDC) and an NDC quantity for each claim line with a physician-administered drug. To add NDC information to the service line, expand the NDCs for Svc section by clicking on the plus icon. The HCPCS/Proc Code and NDC are both required for physician-administered drugs.
Updating Service Details
Select the sequence number of any service detail line item to update details such as the service date, procedure code, units or charge amount.

- Click the “Save” button to save the changes
- Click the “Reset” button to clear any of the changes to the service detail
- Click on the “Cancel” button to cancel any updates and close the service detail
Adding Other Insurance Details on Service Detail line
Select the sequence number of any service detail line item to add other insurance details and claim adjustment details.

1. Add Other Insurance Details and click Add Insurance button.

![Service Details Table](image)

<table>
<thead>
<tr>
<th>Svc #</th>
<th>From Date</th>
<th>To Date</th>
<th>Place of Service</th>
<th>Procedure Code</th>
<th>Charge Amount</th>
<th>Units</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>07/01/2018</td>
<td>07/01/2018</td>
<td>11-Office</td>
<td>99214-OUTPATIENT VISIT BST</td>
<td>0150.00</td>
<td>1.000 Unit</td>
<td>Remove</td>
</tr>
</tbody>
</table>

**Other Insurance for Service Detail**
Click the row number to edit the row. Click the Remove link to remove the entire row.

<table>
<thead>
<tr>
<th>#</th>
<th>Carrier ID</th>
<th>Procedure Code</th>
<th>Modifiers</th>
<th>Payer Paid Amount</th>
<th>Paid Date</th>
<th>Paid Units</th>
<th>Remaining Patient Liability</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>07829-Cigna</td>
<td>99214</td>
<td></td>
<td>90.00</td>
<td>08/01/2018</td>
<td>1.00</td>
<td></td>
<td>Add Insurance</td>
</tr>
</tbody>
</table>
2. Click the sequence number in the Other Insurance for Service Detail panel to add the Adjustment Details.

<table>
<thead>
<tr>
<th>Service Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>From Date</strong></td>
</tr>
<tr>
<td>07/01/2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Insurance for Service Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Carrier ID</strong></td>
</tr>
<tr>
<td>07/022</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim Adjustment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claim Adjustment Group Code</strong></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Click to collapse.

Add Adjustment | Cancel Adjustment

Save Insurance | Cancel Insurance

Click to add a new other insurance.
3. Enter the Claim Adjustment Details and click Add Adjustment button to add adjustment information for the other insurance.

4. Click Save Insurance button to save the other insurance information with the claim adjustment details.
5. Click Save button to save the updates to the Service Detail Line.

### Service Details

<table>
<thead>
<tr>
<th>Svc #</th>
<th>From Date</th>
<th>To Date</th>
<th>Place of Service</th>
<th>Procedure Code</th>
<th>Charge Amount</th>
<th>Units</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>07/01/2018</td>
<td>07/01/2018</td>
<td>11-Office</td>
<td>99214-OFFICE/OUTPATIENT VISIT EST</td>
<td>$156.00</td>
<td>1,000 Unit</td>
<td>Remove</td>
</tr>
</tbody>
</table>

### Other Insurance for Service Detail

<table>
<thead>
<tr>
<th>#</th>
<th>Carrier ID</th>
<th>Procedure Code</th>
<th>Payer Paid Amount</th>
<th>Paid Date</th>
<th>Paid Units</th>
<th>Remaining Patient Liability</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>07826</td>
<td>99214-OFFICE/OUTPATIENT VISIT EST</td>
<td>$10.00</td>
<td>08/01/2018</td>
<td>1.00</td>
<td>$50.00</td>
<td>Remove</td>
</tr>
</tbody>
</table>

Click to add a new other insurance.
Attachments
To include attachments electronically with a claim:

- Transmission Method – FT - File Transfer is selected by default
- Upload file – click “Browse” button and locate the file on your computer to be attached
- Attachment Type – select the type of attachment from the drop-down list
- A description of the attachment can be entered, but it is not required
- Click “Add” button to attach the file
- Repeat for additional attachments if needed up to 10 attachments can be added per claim (Note: the combined size of all attachments cannot exceed 4MB)
- To remove any attachments that were attached incorrectly, use the “Remove” link
- Click on the “Cancel” button to cancel and close the attachment line

All of the fields marked with a red asterisk (*) are required fields.
Claim Submission
Click the “Submit” button to complete the claim creation process.

Confirm Professional Claim
After clicking the “Submit” button, the Confirm Professional Claim page will display with the claim details to review before submission.

- Click the “Confirm” button to submit the claim
- Click the “Print Preview” button to print a copy of the Confirm Professional Claim page
- Click on the “Cancel” button to cancel the claim submission
Submit Professional Claim: Confirmation
The Submit Professional Claim: Confirmation will appear after the claim has been submitted. It will display the claim status and Claim ID.

Submit Professional Claim: Confirmation

Your Professional Claim was successfully submitted. The claim status is Finalized Payment.
The Claim ID is 23180178000001.

Click Print Preview to view the claim details as they have been saved on the payer’s system.
Click Copy to copy member or claim data.
Click Adjust to resubmit the claim.
Click New to submit a new claim.
Click View to view the details of the submitted claim.

- Click “Print Preview” button to view the claim details
- Click “Copy” button to copy claim data
- Click “Adjust” button to resubmit the claim
- Click “New” button to submit a new claim
- Click “View” button to view the details of the submitted claim

3.1.4 Submit a claim for exception batch processing

Exception batch processing claims should be submitted electronically using the PWP. Use the attachments panel to attach the batch processing letter. The attachment description must start with capital EXCP for the claim to be processed correctly.
3.2 View a Claim

Once a claim has been submitted, the claim can be viewed by selecting the “View” button on the Submit Receipt page or selecting the ICN from the Search Results grid.

Submit Receipt page

Viewing the claim displays a summary of the claim that was submitted, with the first panel expanded. Select “Expand All” to expand all panels, or select plus icons on each panel to open only that panel.

Search Results grid

Viewing the claim displays a summary of the claim that was submitted, with the first panel expanded. Select “Expand All” to expand all panels, or select plus icons on each panel to open only that panel.
### View Institutional Claim - ID 2218170609021

#### Claim Information

<table>
<thead>
<tr>
<th>Claim Status</th>
<th>Finalized Denied</th>
<th>Admission Date/Time</th>
<th>06/30/2018 12:00</th>
<th>Admission Source</th>
<th>E-Transfer from Ambulatory Surgery Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Dates</td>
<td>06/01/2018</td>
<td>Admission Diagnosis Type</td>
<td>ID-10-CM</td>
<td>Facility Type Code</td>
<td>115 Hospital Inpatient (Including Medicare Part A) Late Charge(s) Only</td>
</tr>
<tr>
<td>Admission Type</td>
<td>Emergency</td>
<td>Discharge Date</td>
<td></td>
<td>Authorization Number</td>
<td>_</td>
</tr>
<tr>
<td>Admitting Diagnosis</td>
<td>84200</td>
<td>Patient Status</td>
<td>Discharged to Home or Self Care (Routine Discharge)</td>
<td>Related Claim ICN</td>
<td>_</td>
</tr>
<tr>
<td>Patient Number</td>
<td>1234</td>
<td>Note</td>
<td>_</td>
<td>Total Allowed Amount</td>
<td>$1,050.00</td>
</tr>
<tr>
<td>Previous Claim ICN</td>
<td>_</td>
<td>Total Co-pay Amount</td>
<td>$0.00</td>
<td>Total Paid Amount</td>
<td>$0.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Service Details

<table>
<thead>
<tr>
<th>Seq #</th>
<th>Revenue Code</th>
<th>HCPCS/Proc Code</th>
<th>Mod</th>
<th>From Date</th>
<th>To Date</th>
<th>Units/Type</th>
<th>Charge Amount</th>
<th>Allowed Amount</th>
<th>Co-pay Amount</th>
<th>Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0121-355-2</td>
<td>End-Med-Surg-Gyn</td>
<td></td>
<td>06/01/2018</td>
<td>06/01/2018</td>
<td>1,000 Days</td>
<td>$1,050.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

---

No External Cause of Injury Diagnoses Codes exist for this claim.

No Other Insurance Details exist for this claim.

No Condition Codes exist for this claim.

No Occurrence Codes exist for this claim.

No Value Codes exist for this claim.

No Surgical Procedures exist for this claim.

No Attachments exist for this claim.
3.3 Adjust a Claim

Once a claim has been processed and paid, an adjustment can be submitted to correct data entry or billing errors. To begin the claim adjustment process select the “Adjust” button on the Submit Receipt page, or View claims page.

Submit Receipt page

<table>
<thead>
<tr>
<th>Submit Professional Claim Confirmation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Claim Receipt</td>
<td></td>
</tr>
<tr>
<td>Your Professional Claim was successfully submitted. The claim status is finalized Payment.</td>
<td></td>
</tr>
<tr>
<td>The Claim ID is 233011780000001.</td>
<td></td>
</tr>
<tr>
<td>Click [Print Preview] to view the claim details as they have been saved on the payer’s system.</td>
<td></td>
</tr>
<tr>
<td>Click [Copy] to copy member or claim data.</td>
<td></td>
</tr>
<tr>
<td>Click [Adjust] to resubmit the claim.</td>
<td></td>
</tr>
<tr>
<td>Click [New] to submit a new claim.</td>
<td></td>
</tr>
<tr>
<td>Click [View] to view the details of the submitted claim.</td>
<td></td>
</tr>
</tbody>
</table>
View page

Clicking the “Adjust” button reopens the claim so corrections can be made and the claim resubmitted for processing. Claim adjustment is a three-step process.

The adjudication details will display on Resubmit Claim: Step 1.

Click on the “Continue” button at the bottom of each page to continue on to the next step.

Click on the “Cancel” button to cancel the adjustment.
Beneath Institutional Claim ID 2016105000012: Step 1

* Indicates a required field.

Claim Type: Outpatient

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID: 3338
*Billing Provider Service Location: 341 MEDICAL CENTER-1303 N MAIN ST, LAS VEGAS, NEVADA 89119

Institutional Provider ID: 1801
Attending Provider ID: 1801
Operating Provider ID: 1801
Other Operating Provider ID: 1801
Referring Provider ID: 1801155276

Patient Information

*Recipient ID: 054567
Last Name: MDKDOZSC
First Name: YDVE
Birth Date: 04/29/1940

Claim Information

Claim Status: Finalized Payment
*Covered Dates: 02/07/2018 - 02/08/2018
Admission Date/Time: 02/07/2018 12:00 (hr:min)
*Admission Type: Emergency
Admitting Diagnosis: 01-Discharged to Home or Self Care
*Patient Status: 01-Discharged to Home or Self Care
*Patient Number: TBB-CL8M
Include Other Insurance: 

Adjudication Errors

Claim / Service # | HIPAA Adj | Description | EOB
---|---|---|---
Claim | 202 | COVERED DAYS HESSING | 1050
Claim | 7499 | CLAIM PROCESSED BY CLINICAL CLAIM EDITOR | 7499
Service # 2 | 3080 | NO REINS BILL FOR RVN CODE | 1178

Total Charged Amount: $800.00

Continue  Cancel

EVS User Manual, Chapter 3
Updated 03/20/2019 (pv 12/28/2018) MODERNIZATION
Navigate through each step of the claim and make any necessary updates. Select “Resubmit” button the Resubmit Claim: Step 3 to display the Confirm page.

**Resubmit Claim: Step 3**

Click “Confirm” button on the Confirm page to submit the adjustment claim.
### Confirmation page

#### Confirm Institutional Claim - ID 2018105000012

Select Print Preview before you confirm if you want to ensure you view the claim as you entered it. After confirmation, Print Preview may reflect changes as the claim has been saved on the payer system.

**Claim Type**: Outpatient

**Provider Information**

- **Billing Provider ID**: 16381
- **ID Type**: NPI
- **Institutional Provider ID**: 11 - MEDICAL CENTER - 1300 N MAIN ST, LAS VEGAS, NEVADA, 89119
- **ID Type**: NPI
- **Attending Provider ID**: 1801
- **ID Type**: NPI
- **Operating Provider ID**: 1801
- **ID Type**: NPI
- **Operating Provider Service Location**: 

**Patient Information**

- **Recipient ID**: 3545636
- **Recipient Name**: YOYE I HOKO2SC
- **Gender**: Male
- **Birth Date**: 01/20/1940

**Claim Information**

- **Claim Status**: Finalized Payment
- **Covered Dates**: 02/07/2018 - 02/08/2018
- **Admission Type**: 1-Emergency
- **Admitting Diagnosis Type**: 
- **Admitting Diagnosis**: 
- **Patient Status**: 01
- **Patient Number**: TTR-CLAIM
- **Previous Claim ID**: 2018105000012
- **Note**: 

**Adjudication Errors**

#### Diagnosis Codes

#### External Cause of Injury Diagnostic Codes

#### Patient Reason for Visit Diagnostic Codes

#### Condition Codes

#### Occurrence Codes

#### Value Codes

**Service Details**

<table>
<thead>
<tr>
<th>Serv #</th>
<th>Revenue Code</th>
<th>HCPCS/Proc Code</th>
<th>Mod</th>
<th>From Date</th>
<th>To Date</th>
<th>Units/Type</th>
<th>Charge Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0112-RAB-Pvt-Diabetic</td>
<td>46560-Repair lip</td>
<td></td>
<td>02/07/2018</td>
<td>02/08/2018</td>
<td>1.00 Unit</td>
<td>$400.00</td>
</tr>
<tr>
<td>2</td>
<td>0110-RAB-Semi-Pvt-2 Bed-General</td>
<td></td>
<td></td>
<td>02/08/2018</td>
<td>02/09/2018</td>
<td>1.00 Unit</td>
<td>$400.00</td>
</tr>
</tbody>
</table>

**No Other Insurance Details exist for this claim**

**No Surgical Procedures exist for this claim**

**No Attachments exist for this claim**

[Back to Step 1]  [Back to Step 2]  [Back to Step 3]  [Print Preview]  [Confirm]  [Cancel]
Resubmit Claim: Confirmation

The Resubmit Claim: Confirmation will appear after the claim has been submitted. It will display the claim status and Claim ID.

<table>
<thead>
<tr>
<th>Resubmit Outpatient Claim Confirmation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Claim Receipt</td>
<td></td>
</tr>
<tr>
<td>Your Outpatient Claim was successfully resubmitted. The claim status is Finalized Payment. The Claim ID is 98181780000001.</td>
<td></td>
</tr>
<tr>
<td>Click Print Preview to view the claim details as they have been saved on the payer’s system. Click Copy to copy member or claim data. Click Adjust to resubmit the claim. Click View to view the details of the submitted claim.</td>
<td></td>
</tr>
</tbody>
</table>

3.4 Void a Claim

Once a claim has been processed and paid, a void can be submitted to void the payment. To begin the claim void process select the “Void” button on the View claims page. To access the View claims page, search for the claim that needs to be voided, and select the Claim ID in the search results grid.

Search claims response with Search Results grid.

<table>
<thead>
<tr>
<th>Search Claims</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A minimum one field is required. Recipient ID, Service From and To Date are required fields for the search when Claim ID is not entered.</td>
<td></td>
</tr>
<tr>
<td>Claim searches are limited to a maximum range of 45 days.</td>
<td></td>
</tr>
<tr>
<td>Claim ID</td>
<td>[blank]</td>
</tr>
<tr>
<td>Recipient ID</td>
<td>[234567890123]</td>
</tr>
<tr>
<td>Rendering Provider ID</td>
<td></td>
</tr>
<tr>
<td>Service From</td>
<td>02/01/2018</td>
</tr>
<tr>
<td>To</td>
<td>02/28/2018</td>
</tr>
<tr>
<td>ID Type</td>
<td></td>
</tr>
<tr>
<td>Claim Type</td>
<td></td>
</tr>
<tr>
<td>Claim Status</td>
<td></td>
</tr>
<tr>
<td>Search</td>
<td></td>
</tr>
<tr>
<td>Reset</td>
<td></td>
</tr>
</tbody>
</table>

Search Results:

To see service line information, or to view the remittance advice, click on the “+” next to the claims ID.

<table>
<thead>
<tr>
<th>Total Records: 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim ID</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>E00181478000006</td>
</tr>
</tbody>
</table>
## View claims page

**Claims > Search Claims > View Institutional Claim**

### View Institutional Claim - ID 2218178960008

**Claim Type**: Outpatient

**Provider Information**

- **Billing Provider ID**: 1538178801
- **ID Type**: NPI
- **Billing Provider Service Location**: 10 VALLEY VIEW MEDICAL CENTER: 1303 N MAIN ST, CEDAR CITY, UTAH, 84721-9746
- **Institutional Provider ID**: __
- **ID Type**: __
- **Attending Provider ID**: 1750632404
- **ID Type**: NPI
- **Operating Provider ID**: __
- **ID Type**: __
- **Other Operating Provider ID**: __
- **ID Type**: __
- **Referring Provider ID**: __
- **ID Type**: __

**Patient Information**

- **Recipient ID**: 294567890123
- **Recipient Name**: DEF ABC
- **Gender**: Female
- **Birth Date**: 06/29/1990

**Claim Information**

- **Claim Status**: Finalized Payment
- **Covered Dates**: 02/28/2018
- **Admission Date/Hour**: 02/28/2018 - 01:00
- **Admission Source**: 2-Clinic or Physician’s Office
- **Discharge Date**: __
- **Discharge Hour**: __
- **Facility Type Code**: 131-Hospital Outpatient: Admit through ED Discharge Claim
- **Patient Status**: 61-Discharged to Home or Self Care (Routine Discharge)
- **Authorization Number**: 45810000063
- **Patient Number**: 234567890123
- **Related Claim ICN**: __
- **Previous Claim ICN**: __
- **Note**: __
- **Total Allowed Amount**: $100.00
- **Total Co-pay Amount**: $0.00
- **Total Charged Amount**: $100.00
- **Total Paid Amount**: $100.00

### Error Codes

- **Diagnosis Codes**
- **Condition Codes**
- **Occurrence Codes**
- **Value Codes**

### Service Details

<table>
<thead>
<tr>
<th>Doc #</th>
<th>Revenue Code</th>
<th>HCPCS/Proc Code</th>
<th>Modifier</th>
<th>From Date</th>
<th>To Date</th>
<th>Units/Type</th>
<th>Charge Amount</th>
<th>Allowed Amount</th>
<th>Co-pay Amount</th>
<th>Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0100-All Inclusive Rate (R&amp;B + Anesthesia)</td>
<td>56674-LAPSER ABORT UTERINE FIBRIDS</td>
<td>02/28/2018</td>
<td>02/28/2018</td>
<td>1.000 UNIT</td>
<td>$100.00</td>
<td>$100.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
</tbody>
</table>

No External Cause of Injury Diagnosis Codes exist for this claim

No Other Insurance Details exist for this claim

No Surgical Procedures exist for this claim

No Attachments exist for this claim

A Confirmation message will appear to confirm that the user wants to void the claim.
After selecting OK, the user will be returned back to the search claims page and a confirmation message will appear indicating that the Claim ID was successfully voided.
3.5 Copy a Claim

Once a claim has been submitted, the details can be copied to quickly enter a new claim. To copy a claim, select the “Copy” button on the Submit Receipt page, or View claims page.

Submit Receipt page

<table>
<thead>
<tr>
<th>Professional Claim Receipt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Professional Claim was successfully submitted. The claim status is finalized payment. The Claim ID is 23101780000001.</td>
</tr>
<tr>
<td>Click Print Preview to view the claim details as they have been saved on the owner’s system. Click Copy to copy member or claim data. Click Adjust to resubmit the claim. Click New to submit a new claim. Click View to view the details of the submitted claim.</td>
</tr>
</tbody>
</table>

Print Preview  Copy  Adjust  New  View
Copy Claim Information

- Select the information you would like to copy to a new claim.
- Click “Copy” button to copy the selected information into a new claim. The Submit Claim: Step 1 page appears where you can continue entering the claim information.
3.6 Appeal a Claim

Once a claim has been processed and denied, an appeal can be submitted online using Secure Correspondence. Secure Correspondence is for authenticated (logged in) users to submit appeals, questions, comments or request technical assistance related to EVS functions in a secure environment and receive answers through the website. For more information on Secure Correspondence, refer to EVS User Manual Chapter 1.

Providers have the right to appeal a claim that has been denied. If your appeal is rejected (e.g., for incomplete information), there is no extension to the original 30 calendar days. Per Medicaid Services Manual (MSM) Chapter 100, Section 105.2C titled Disputed Payment, appeal requests for subsequent same service claim submissions will not be considered. That is, if a provider resubmits a claim that has already been denied and another denial is received, the provider does not have another 30-day window in which to submit an appeal. Such appeal requests will be rejected.

How to file a claim appeal

To submit a claim appeal, include each component listed below:
A completed form FA-90 (Formal Claim Appeal Request) that contains all of the following:
- Reason for the appeal.
- Provider name and NPI/API.
- The claim’s ICN (claim number).
- Name and phone number of the person Nevada Medicaid can contact regarding the appeal.
- Documentation to support the issue, when applicable, e.g., physician’s notes, emergency room reports.
1. From the My Home page, click **Secure Correspondence**.

2. From the Secure Correspondence Message Box screen, click **Create New Message**.

From the Create Message screen, enter in information. All fields with a red asterisk (*) are required.
3. Enter in a Subject for the appeal.

4. Select Claims Appeals from the Message Category drop-down box.

5. Select by phone or email from the Preferred Method of Communication drop-down box.

6. Enter the Claim ID for the claim that is being appealed.

7. Enter the Service Provider NPI in the Service Provider ID field. If there is more than one service location, select the correct service location from the Service Provider Location drop-down box.

8. Select NPI from the NPI drop-down box.

9. Enter the denial reason in the Denial Reason field.

10. Enter comments limited to 1,000 characters.

11. Upload the supporting documentation for the appeal using the Upload File field. Note: multiple attachments can be submitted.

12. Select FA-90-Claim Appeal Request Form as the Attachment Type. Note: Select this
for each attachment, if multiple attachments are being submitted.

13. Click Add button to add the attachments to the appeal.

14. Click **Send**.

The Confirmation screen box displays stating the secure message was successfully sent.

15. Click **OK**.

An email response will be sent to your email address that was entered during registration unless you requested to be contacted by another means, such as by phone or alternate email address. All appeal responses will be paperless and will be sent through EVS Secure Correspondence.

**How to download a claim appeal letter**

The Report Download page allows users to download Provider Letters. The Report Download page can be accessed under Resources.

Select Claims Appeal Letters as the Report Category. To search for appeal letters, enter either of the following:

- From Date, To Date and Recipient ID.
- Contact Tracking Number (CTN) - The CTN can be found in the Secure Correspondence Message Box.
3.7 Verifying claim status

The Search Claims tab provides the ability to search and view a list of claims for recipients which the provider billed. The list can be filtered to search by various methods such as by claim or by recipient.

By clicking on the Claims tab, you will see two links that allow you to either search claims or to search your payment history.

3.7.1 Availability

The status of a direct data entry claim submitted using the PWP is usually available on the same day of submission.

3.7.2 Accessing the claim status request

To view claims status, select Search Claims from the Claims submenu, or click on the Claims tab to be directed to the claims landing page.
3.7.3 Verifying claim status

To verify claim status, the user has the option to search by the following:

- Claim Information
- Recipient Information
- Service Information
### Claim Status field requirements

<table>
<thead>
<tr>
<th>Field</th>
<th>Format</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claim Information</strong></td>
<td></td>
</tr>
<tr>
<td>Claim ID</td>
<td>Optional field. Must enter in 16-digit Internal Claim Number (ICN). If ICN is not used, must enter recipient ID and service dates. If incorrect ICN is entered, will receive message: “There are no claims to show based on the search criteria selected.”</td>
</tr>
<tr>
<td><strong>Recipient Information</strong></td>
<td></td>
</tr>
<tr>
<td>Recipient ID</td>
<td>Optional field. Required field if no ICN is entered. Must enter 11-digit recipient ID. If the incorrect ID is entered or no claims found, will receive message: “There are no claims to show based on the search criteria selected.”</td>
</tr>
<tr>
<td><strong>Service Information</strong></td>
<td></td>
</tr>
<tr>
<td>Rendering Provider ID</td>
<td>Optional field. Must enter provider 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API). Claims are only shown when paid to the logged in provider, but the rendering provider on the claim can be different and used as search criteria. Provider ID Type is required if Rendering Provider ID is entered. You have the ability to search for providers by clicking on the magnifying glass icon. If the incorrect ID is entered or no claims found, will receive message: “There are no claims to show based on the search criteria selected.”</td>
</tr>
<tr>
<td>ID Type</td>
<td>Must select the Provider ID Type in this field if searching by rendering provider.</td>
</tr>
<tr>
<td>Claim Type</td>
<td>Optional field. Drop-down menu defaults to “ALL.” If no claims found, will receive message: “There are no claims to show based on the search criteria selected.”</td>
</tr>
<tr>
<td>Service From</td>
<td>Optional field. Required field if no Claim ID entered. Service date searches cannot span more than 45 days or include future dates. If claim status is for one date of service, the From date must be the same as the To date. Must be entered in MMDDCCYY format. If no claims are found, will receive message: “There are no claims to show based on the search criteria selected.”</td>
</tr>
<tr>
<td>Service To</td>
<td>Optional field. Required field if no Claim ID entered. Service date searches cannot span more than 45 days or include future dates. If claim status is for one date of service, the From date must be the same as the To date. Must be entered in MMDDCCYY format. If no claims are found, will receive message: “There are no claims to show based on the search criteria selected.”</td>
</tr>
<tr>
<td>Claim Status</td>
<td>Optional field. Drop-down menu defaults to “ALL.” If no claims found, will receive message: “There are no claims to show based on the search criteria selected.”</td>
</tr>
</tbody>
</table>

A minimum of one field (claim ID or ICN) is required for searches. If the ICN is unknown, you can request a claim search by recipient ID and service date range. If the servicing/rendering provider is different than the billing provider, you should include the rendering Provider ID and Provider ID Type.
To search claims:

1. Enter information in the appropriate fields.

2. Click “Search” button.

A successful response to the claim status inquiry when searching by recipient ID and Service From and To date is shown below.

To view more information about the claim, click on the expand all “+” symbol located to the left of the Claim ID column to view the claim information page.
The claim information displays the services billed in more detail.

- **Service** – Service line
- **Service Date** – Date of service
- **Line Status** – Claim line status
- **Reason Code** – Codes for claim status
- **Units** – Units billed
- **Revenue** – Revenue code if applicable
- **Procedure/Modifiers** – Services billed with modifiers if applicable
- **Charge** – Charges billed
- **Paid** – Payment received

For claims that are finalized, the user will have the ability to click **RA Copy (PDF)** where a new window will open to gain access to a copy of the remittance advice. The user can then print or save the RA to his/her computer.
To view the claim click on the Claim ID in the search results grid.

The View claims page will display.
### View Institutional Claim - ID 221817800008

#### Claim Information
- **Claim Type**: Outpatient
- **Provider Information**
  - **Billing Provider ID**: NPI
  - **Institutional Provider ID**: NPI
  - **Operating Provider ID**: NPI
  - **Other Operating Provider ID**: NPI
  - **Referring Provider ID**: NPI
- **Patient Information**
  - **Recipient ID**: N/A
  - **Recipient Name**: Condor
  - **Gender**: Female
- **Claim Status**: Finalized Payment
- **Covered Dates**: 02/28/2018 - 01/00
- **Admission Type**: Urgent
- **Admitting Diagnosis**: Discharged from Home or Self Care (Routine Discharge)
- **Facility Type Code**: 131 (Hospital Outpatient: Admit through Discharge Claim)
- **Admission Date/Time**: 02/28/2018, 01:00
- **Admission Source**: 2-Clinic or Physician’s Office
- **Discharge Hour**: N/A
- **Authorization Number**: 131 (Hospital Outpatient: Admit through Discharge Claim)
- **Related Claim ICN**: N/A
- **Total Allowed Amount**: $100.00
- **Total Copayment**: $0.00
- **Total Paid Amount**: $100.00

#### Adjudication Errors
- No External Cause of Injury Diagnosis Codes exist for this claim
- No Other Insurance Details exist for this claim
- No Surgical Procedures exist for this claim
- No Attachments exist for this claim

#### Service Details

<table>
<thead>
<tr>
<th>_svc #</th>
<th>Revenue Code</th>
<th>HCPCS/Proc Code</th>
<th>Mod</th>
<th>From Date</th>
<th>To Date</th>
<th>Units/Type</th>
<th>Charge Amount</th>
<th>Allowed Amount</th>
<th>Copay Amount</th>
<th>Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0100-All Inclusive Rate (R&amp;B + Aniary)</td>
<td>68624-LAPS ABILITI UTERINE FEBRICIDS</td>
<td></td>
<td>02/28/2018</td>
<td>02/28/2018</td>
<td>1.000 UNT</td>
<td>$100.00</td>
<td>$100.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

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4. To clear the screen and access claim status on another claim, click the **Reset** button found on the search claims section of the page.

![Search Claims](image)

3.7.4 Verifying claim status through member focused viewing

The **Member Focused Viewing** link allows you to view a summary of all members’ information on one page, based on the last 10 members previously viewed in EVS. When you search for other members in EVS, the **Member Focused Viewing** page remains available, so you do not have to repeat searches.

To check on claim status in Member Focus Viewing, click **Member Focused Viewing** from the **My Home page**.
The Member Focus Search page appears. This page displays two tabs. If the user has previously viewed members, the Last Member Viewed tab displays up to the last 10 searches. If no members have been previously viewed, then only the Search tab displays. Selection of an individual member from either tab displays the Member In Focus bar at the top of the page and summary information below, including their recent activity.

Click the name that is listed on the Member Focus Search page. The Member Details page appears.

The member details displays showing:

- Member Details
- Coverage Details
• Claims information
• Authorization information

Note: At the top of the page, the member will remain in focus even if the user navigates away from the Member Details page. Click “Close Member Focus” link to close the member in focus.
Any recent claims billed for the Member in Focus will display under the heading **Your Member Claims**.

To search for more claims, click on the **View More Claims for This Member** link. This will take the user to the **Search Claims** page. The Recipient ID field will be pre-populated with the recipient ID. The Service From and To fields will also be pre-populated with a 30 days search range using the date of the search as the To date.

If there are any claims that match the search criteria they will be listed under the **Search Results**. The message “There are no claims to show based on the search criteria selected.” will display if, there are no claims that match the search criteria.
1. To check claim status on another claim for the same member, fill in the **From** and **To** dates and click **Search**.

2. To check claim status for another member, click **Reset** and fill in the member’s information, then click **Search**. Even if another member’s information is displayed, the previous member will still remain in focus.

3. To go back to the previous members detail page, click **Return to Member Focus**.

4. To change the member in focus, click **Change** next to the name in the Member in Focus. This will take you back to the **Member in Focus** page. You can then select from the other members on the list.

5. To remove the member in focus while checking claim status on another member, click **Close Member Focus** or click on the “[X]” icon. The **Claim Status** page will now be in view and the user will no longer be in Member Focus Viewing.