

Payerpath UB-04 Training



Nevada Medicaid Provider Training



What will be covered...

- **Benefits of electronic claim submission**
- **Required enrollment forms**
- **Submission contact information**
- **Signing on to Allscripts-Payerpath**
- **Creating and viewing claims**
- **Submitting a UB-04 claim form**
- **Copy claims feature**
- **View the remittance advice**



Electronic Data Interchange (EDI)

- **Eliminates supply costs**
 - Preprinted forms
 - Envelopes and postage
 - Allscripts-Payerpath claim submission is free
- **Eliminates time-consuming processes and reduces claim errors**
 - Document sorting and filing
 - Built-in validation checks
- **Quicker processing and notification**
 - Check claim status within 48 hours of submission

EDI Enrollment Documents

www.medicaid.nv.gov

Scroll down to EDI Enrollment Forms



Nevada Departments of
Health and Human Services
Division of Health Care Financing and Policy Provider Portal

[Contact Us](#) [DHCFP Home](#)

[Home](#) [Providers](#) [EVS](#) [Pharmacy](#) [Prior Authorization](#) [Quick Links](#) [Calendar](#)

- Announcements **Latest News**
- [Web Announcement 1258](#)
Reminders for Provider Types 64 and 65 Regarding Hospice Forms
 - [Web Announcement 1257](#)
Outpatient Physician-Administered Drug Claims That Denied or Voided with Edit Code 0162 to be Reprocessed
 - [Web Announcement 1256](#)
Attention All Providers: New Form for Requesting Termination of Service with Existing Provider
 - [Web Announcement 1255](#)
Payerpath Claim Submission Training for November 2016
 - [Web Announcement 1254](#)
2016 Annual Medicaid Conference Presentations and Survey
- [View All Web Announcements](#)

- Featured Links**
- [Authorization Criteria](#)
 - [DHCFP Home](#)
 - [EDI Enrollment Forms and Information](#)
 - [EVS User Manual](#)
 - [Online Provider Enrollment](#)
 - [Provider Login \(EVS\)](#)

Electronic Claims / EDI

Electronic billing (also called Electronic Data Interchange or "EDI") speeds payment and eliminates costs associated with paper claims. You can submit electronic claims through a clearinghouse or through your existing, HIPAA-compliant business management software.

If you have any questions, please contact our EDI Coordinator at:
Telephone: (877) 638-3472
Fax: (775) 335-8502

EDI Enrollment Forms

EDI enrollment forms are for completion and submission by active or enrolling Nevada Medicaid and Nevada Check Up providers only.

Form Number	Title
FA-35	Electronic Transaction Agreement for Service Centers
FA-36	Service Center Operational Information
FA-37	Service Center Authorization
FA-39	Payerpath Enrollment

EDI Announcements

Title	Date
Payerpath Claim Submission Training for November 2016	Oct. 24, 2016
Payerpath Claim Submission Training for October 2016	Sept. 29, 2016
Payerpath Claim Submission Training for September 2016	Sept. 1, 2016
Payerpath Claim Submission Training for August 2016	July 19, 2016
Payerpath Claim Submission Training for July 2016	June 24, 2016

Notifications

[Enrollment Termination](#)
[Frequently Asked Questions \(FAQs\)](#) [\[Review\]](#)

If you are a Medicaid provider whose revalidation application has not been processed by your termination due date, you will not have access to the Provider Web Portal the day after your termination date. This will prevent any prior authorizations (PAs) from being submitted for approval. Please ensure that you have submitted your revalidation application to Hewlett Packard Enterprise at least 10 business days prior to your termination date to ensure that your application is processed on time.

Provider Links

- [Billing Information](#)
- [E-Prescribing Forms](#)
- [Provider Enrollment](#)
- [Provider Newsletters](#)
- [Provider Training](#)



Allscripts-Payerpath Enrollment Documents

- Enrolled providers may submit electronic Nevada Medicaid and Nevada Check Up claims free of charge through Allscripts-Payerpath.
- Simply complete Service Center Authorization form (FA-37) and the Allscripts-Payerpath Enrollment form (FA-39) located on the Electronic Claims/EDI webpage and submit your documents for processing.



Required Registration Forms

- Enrollment forms for Allscripts-Payerpath: www.medicaid.nv.gov
- Send in one FA-37 (Service Center Authorization) form for each Group National Provider Identifier/Atypical Provider Identifier (NPI/API) unless billing each rendering provider as an individual

AND

- Send in one FA-39 (Payerpath Enrollment) form and include the names of all those who will be using this Payerpath account



Form Submission and Contact Information

- Completed registration forms are to be mailed to:
Nevada Medicaid
P.O. Box 30042
Reno, Nevada 89520-3042
- Faxed to: 775-335-8502
- Emailed to: NVMMIS.EDIsupport@dxc.com
- Upload forms to: www.medicaid.nv.gov then login to Electronic Verification System (EVS) website to upload documents
- For assistance, call 1-877-638-3472, option 2, select then option 0 and then select option 3 to speak with an EDI Coordinator



Getting Started

Accessing Payerpath

On the Electronic Claims/EDI webpage, scroll down to the Allscripts-Payerpath link.

PayerPath Claim Submission Training for August 2014(Updated August 26, 2014)	July 25, 2014
PayerPath Claim Submission Training	July 10, 2014
EDI Announcement: Dual Use for 4010/5010 Formats Ends June 30, 2012	June 5, 2012
Anesthesia Services Claims Submitted Electronically (Updated May 31, 2012)	May 4, 2012
EDI Announcement: Nevada Medicaid Version 5010 Solution Limits Diagnosis Codes on 837P Transactions.	April 10, 2012
EDI Announcement: Prepare for March 31, 2012, End Date for Dual Use of 5010 and D.0 Formats	January 15, 2012
Instructions for EDI Enrollment	December 2011

Payerpath

Enrolled providers may submit electronic Nevada Medicaid and Nevada Check Up claims free of charge through [Allscripts-Payerpath](#).

Service Center Directory

The Service Center Directory is a list of commercial clearinghouses currently registered with Hewlett Packard Enterprise. The list contains links to each clearinghouse's web site.

[Service Center Directory](#)

Provider Billing Manual: EDI Chapter

The EDI chapter in the Provider Billing Manual provides answers to commonly asked EDI questions.

[Read the chapter...](#)

Service Center User Manual

The Service Center User Manual contains technical instructions for submitting and retrieving electronic transactions. This includes SFTP guidelines, transaction testing and handling login problems. EDI registration instructions are also included.

[Service Center User Manual](#)

EDI Companion Guides

Title	Date
Transaction 270/271 - Health Care Eligibility Inquiry and Response	February 2015
Transaction 271U - Unsolicited Transaction - HIPAA Version 5010	February 2013
Transaction 277U - Unsolicited 277 Claims Status Response - HIPAA Version 5010	October 2012
Transaction 820 - Health Care Premium Payment - HIPAA Version 5010	October 2012
Transaction 834 - Benefit Enrollment and Maintenance - HIPAA Version 5010	October 2012
Transaction 835 - Health Care Payment/Advice	February 2015

Payerpath Login Screen

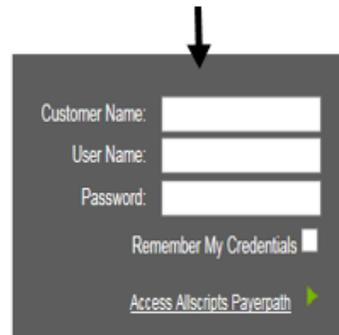


Contact Sales	
	Sales 1-800-334-8534
	Inside Sales 1-800-877-5678 (opt. 4, opt. 4)

www.payerpath.com
Select Payerpath Login

Login Page

Allscripts Allscripts Payerpath Login



Customer Name:

User Name:

Password:

Remember My Credentials

[Access Allscripts Payerpath](#) ▶

- ▶ [Page Help](#)
- ▶ [Forgot your Password?](#)
- ▶ [Forgot your Username?](#)
- ▶ [Change your Password.](#)

Enter Customer Name
Enter User Name
Enter Password

Welcome Page



Welcome

Claims Patients Reports Maintenance Help Tools

Resources

Knowledge Center

Select New Messages

Quick Links



New Messages



Payer Reports



Remit Reports

Select New Remit Reports

My Filters

Claims Filters

You have not set up any Claims filters.

Create Filter

Welcome Page



Welcome

Claims

Patients

Reports

Maintenance

Help

Tools

Resources

Knowledge Center

Quick Links



New Messages



Payer Reports



Remit Reports

My Filters

Claims Filters

You have not set up any Claims filters.

Create Filter

Please select Knowledge Center.

Knowledge Center

The screenshot shows the Allscripts Knowledge Center interface. At the top left is the Allscripts logo. To its right is a green header bar with the text "Knowledge Center". Below this header is a navigation bar with the following items: Claims, Patients, Reports, Maintenance, Help, and Tools. On the left side, there is a "Categories" sidebar with a green header. The sidebar contains four items: "Training Materials - Claims" (with a downward arrow), "General Information", "ANSI Code Sets", and "Miscellaneous". The main content area on the right contains the following text:

Welcome to the all-new Knowledge Center

Here, you will find resources designed to help you fully utilize this web portal. All documentation can be found divided into categories via the navigation bar to the left.

This is the Knowledge Center.
Please select General Information.

Training Materials Claims



Knowledge Center

Claims Patients Reports Maintenance Help Tools

Categories

Training Materials -
Claims

General Information

ANSI Code Sets

Miscellaneous

General Information

NV Medicaid Dental Claim Field Values

NV Medicaid Institutional Claim Field Values

NV Medicaid Professional Claim Field Values

ADA2002 Claim Field Values

Report Enhancements

Payerpath ICD-10 Ready_Set_Go

Payerpath Changes in 4.11

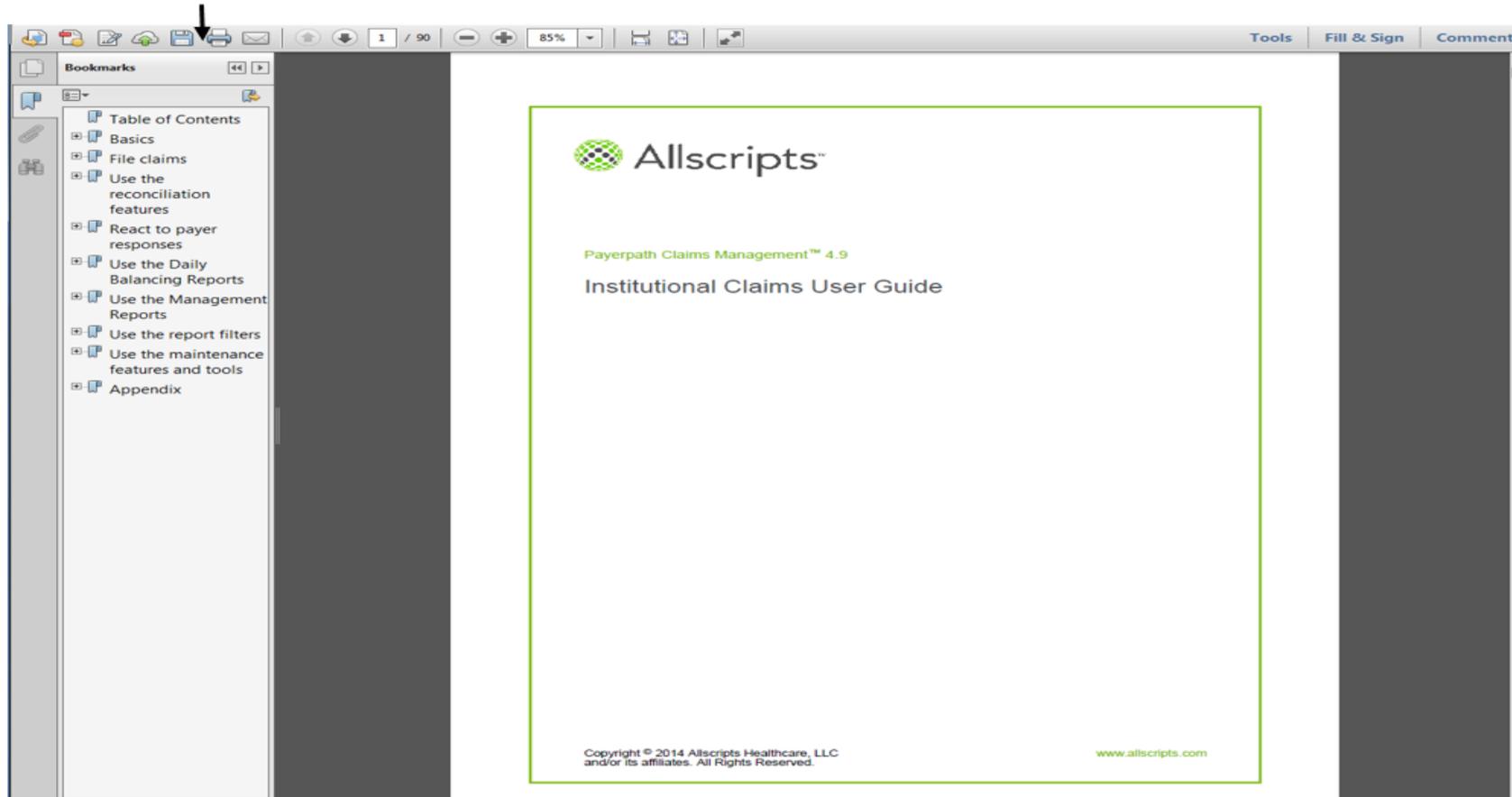
Professional User Manual

Institutional User Manual

Dental User Guide

This is the General Information.
Please select Institutional User Manual.

Payerpath Institutional Claims User Guide



This is the Institutional Claims User Guide.
Please select the Save icon or Print icon in the top left corner.



Learning Check

- 1. What is the website address you would use to directly login to Allscripts-Payerpath?**
- 2. What is one of the first things you should do when getting started with Allscripts-Payerpath?**
 - a. Print your remittance advice
 - b. Submit a claim
 - c. Copy a claim
 - d. Visit the Knowledge Center
- 3. Which documents should you review and/or print?**
 - a. Payerpath Institutional UB COB Instructions
 - b. Payerpath Institutional User Guide
 - c. All of the above



UB-04 Claim Form Submission

Submitting Institutional Claim Form

The screenshot shows the Allscripts 'Welcome' page. At the top left is the Allscripts logo. A green header bar contains the word 'Welcome'. Below this is a navigation bar with tabs for 'Claims', 'Patients', 'Reports', 'Maintenance', 'Help', and 'Tools'. The 'Claims' tab is selected, and a dropdown menu is open, showing 'View Claims'. A teal callout box with white text points to this 'View Claims' option. The callout text reads: 'From the Welcome Page, select Claims then scroll down to the View Claims options'. The main content area includes a 'News' section with 'OPR Information! Please Read!' and a 'View' button, a 'Quick Links' section with 'New Messages' (4) and 'Payer', and a 'My Filters' section with the text 'You have not set up' and a 'Create' button.

Customer Support

Call 877-638-3472, option 2, then option 0, then option 3 | Mon-Fri 8 a.m. to 5 p.m. PT | Email: nvmmis.edisupport@dxc.com

Claims List Filter



Select Institutional

Choose from Untransmitted (claims not yet sent) or Transmitted (claims that have been sent)

My Claim Filters

Select: ▼

Name: Save Manage My Filters

Selection Criteria

Form Type: ▼

Payer Group:
NV Medicaid Institutional

Payer Name:

Billing Provider: ▲ ▼

Claim Status:

Untransmitted
Deleted
Failed
Warning

Transmitted

Service Type: Inpatient Outpatient Other

Bill Type:

Claim Type: Primary Secondary Both

From	Through
Create Date: <input type="text"/>	<input type="text"/>
Date Of Service: <input type="text"/>	<input type="text"/>
Procedure Code: <input type="text"/>	<input type="text"/>
Patient Account #: <input type="text"/>	<input type="text"/>
Patient Last Name: <input type="text"/>	<input type="text"/>

Select Apply Filter

Apply Filter

Untransmitted Claims List



Untransmitted Claims List

Claims Patients Reports Maintenance Help Tools

Sorted By: (x)Pat Name ▲ ? Filtered

0 selected

	Status	Location	Pat Name	Pat Acct	Payer	NPI	Created	Sent	Ack	Rcvd	Remitted	Charges	Paid	
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/12/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/05/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	03/16/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	02/17/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	02/09/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	02/02/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	F	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	01/20/16					\$0.00	\$0.00	V H
<input type="checkbox"/>	P	NV TRAINING		CLAIM TEMF NV MEDIC	100100100	100100100	04/05/16					\$535.00	\$0.00	V H

Jump To: 1 - 2016-04-16 Displaying items 1 - 15 of 26

Previously entered claims will be displayed on the Untransmitted Claims List. Claims must be in a "P" (Passed) status before they can be sent.

Select "V" for View

Claims not modified within 90 days will be deleted
Claims in Blue are assigned to Print Mail or Unassigned Payer

Untransmitted claims are retained in the system for 90 days.

How to Create a Claim Template



UB04 Institutional - NV Medicaid Institutional

Claims Patients Reports Maintenance Help Tools

Back To List Form Fields (20) Electronic Fields (1)

1. Provider Name
BILLING SERVICE
Provider Address
100 1ST ST
RENO NV 895020000
Provider Phone 7753358501 Fax Country Code

2. Pay to Name
Pay to Address

3a. Patient Control Number
b. Medical Record Number

4. Type of Bill

5. Federal Tax Number 000000000

6. Statement Covers Period (From - Through)

7.

8a. Patient Identifier
b. Patient Name (Last Name, First Name, Middle Initial)

8b. Patient Address
c. Patient City
d. Patient Zip
e. Country Code

10. Patient Birth Date
11. SEX
12. Admission
13. Admission Hour
14. Priority (Type) of Admission or Visit
15. Point of Origin for Admission or Visit
16. Discharge Hour
17. Patient Discharge Status
18. Condition Codes
19. Condition Codes
20. Condition Codes
21. Condition Codes
22. Condition Codes
23. Condition Codes
24. Condition Codes
25. Condition Codes
26. Condition Codes
27. Condition Codes
28. Condition Codes
29. Accident State
30.

31. Occurrence Code Date
32. Occurrence Code Date
33. Occurrence Code Date
34. Occurrence Code Date
35. Occurrence Span Code From Through
36. Occurrence Span Code From Through
37.

38. Responsible Party Name (Last, First, MI)
Responsible Party Address

39. Value Codes
Code Amount
a
b
c
d

40. Value Codes
Code Amount
a
b
c
d

41. Value Codes
Code Amount
a
b
c
d

42. Revenue Codes	43. Revenue Description/IDE Number/Medicaid Drug Rebate	44. HCPCS/Accommodation Rates/HIPPS Rate Codes				45. Service Date	46. Service Units	47. Total Charges	48. Non-Covered Charges	49. DEL

Scroll down to the bottom of the page and select Copy

Patient Name: Account: Select Edit

Claim 1 of 24

New Copy Hold Inbound View Print Undo Changes Save & Run Edits

How to Create a Claim Template



UB04 Institutional - NV Medicaid Institutional

Claims Patients Reports Maintenance Help Tools

Back To List Form Fields (20) Electronic Fields (1)

1. Provider Name
BILLING SERVICE
Provider Address
100 1ST ST
RENO NV 895020000
Provider Phone 7753358501 Fac Country Code

2. Pay to Name
Pay to Address

3a. Patient Control Number
b. Medical Record Number

4. Type of Bill

5. Federal Tax Number 000000000

6. Statement Covers Period (From - Through)

7.

8a. Patient Identifier
b. Patient Name (Last Name, First Name, Middle Initial)

8b. Patient Address
b. Patient City c. Patient State d. Patient

10. Patient Birth Date 11. SEX
M F U

12. Admission
13. Admission
14. Priority
15. Point of
16. Discharge
17. Patient

31. Occurrence
Code Date
32. Occurrence
Code Date
33. Occurrence
Code Date

36. Responsible Party Name (Last, First, MI)
Responsible Party Address

38. Occurrence Span
Code From Through

37.

41. Value Codes
Code Amount
a
b
c
d

42. Revenue Codes	43. Revenue Description/IDE Number/Medicaid Drug Rebate	44. HCPCS/Accommodation Rates/HIPPS Rate Codes	45. Service Date	45. Service Units	47. Total Charges	48. Non-Covered Charges	49. DEL

Message from webpage
Are you sure you want to copy the current claim?
OK Cancel

Select OK

Patient Name: Account: Select Edit



How to Create a Claim



UB04 Institutional - NV Medicaid Institutional

Claims Patients Reports Maintenance Help Tools

Back To List		Form Fields (20)				Electronic Fields (1)																	
1. Provider Name BILLING SERVICE		2. Pay to Name		3a. Patient Control Number		4. Type of Bill																	
Provider Address 100 1ST ST		Pay to Address		b. Medical Record Number																			
RENO NV 895020000				5. Federal Tax Number 000000000		6. Statement Covers Period (From - Through)																	
Provider Phone 7753358501						7.																	
8a. Patient Identifier				8b. Patient Address																			
b. Patient Name (Last Name, First Name, Middle Initial)				b. Patient City		c. Patient State		d. Patient Zip		e. Country Code													
10. Patient Birth Date		11. SEX		12. Admission		13. Admission Hour		14. Priority (Type) of Admission or Visit		15. Point of Origin for Admission or Visit		16. Discharge Hour		17. Patient Discharge Status		Condition Codes				29. Accident State		30.	
		M F U																					
31. Occurrence Code Date		32. Occurrence Code Date		33. Occurrence Code Date		34. Occurrence Code Date		35. Occurrence Span Code From Through		36. Occurrence Span Code From Through		37.											
38. Responsible Party Name (Last, First, MI)				39. Value Codes				40. Value Codes				41. Value Codes											
Responsible Party Address				Code Amount				Code Amount				Code Amount											
				a b c d				a b c d				a b c d											

Key in all of the Red highlighted sections on the UB-04 claim form

How to Create a Claim



UB04 Institutional - NV Medicaid Institutional

Claims Patients Reports Maintenance Help Tools

Back To List Form Fields (20) Electronic Fields (1)

1. Provider Name BILLING SERVICE Provider Address 100 1ST ST RENO NV 895020000 Provider Phone 7753358601		2. Pay to Name Pay to Address		3a. Patient Control Number 010101 b. Medical Record Number		4. Type of Bill 111																	
5. Federal Tax Number 000000000		6. Statement Covers Period (From - Through) 04/01/2016 04/05/2016		7.																			
8a. Patient Identifier				9a. Patient Address 1 FIRST STREET																			
b. Patient Name (Last Name, First Name, Middle Initial) ALE GINER				b. Patient City RENO		c. Patient State NV		d. Patient Zip 89602		e. Country Code													
10. Patient Birth Date 01/01/1960		11. SEX M		12. Admission		13. Admission Hour		14. Priority (Type) of Admission or Visit		15. Point of Origin for Admission or Visit		16. Discharge Hour		17. Patient Discharge Status 30		Condition Codes 18-28				29. Accident State		30.	
31. Occurrence Code Date		32. Occurrence Code Date		33. Occurrence Code Date		34. Occurrence Code Date		35. Occurrence Span Code From Through		36. Occurrence Span Code From Through		37.											
38. Responsible Party Name (Last, First, MI)				39. Value Codes Code Amount				40. Value Codes Code Amount				41. Value Codes Code Amount											
42. Revenue Codes				43. Revenue Description/ICE Number/Medicaid Drug Rebate				44. HCPCS/Accommodation Rates/HPPS Rate Codes				45. Service Date		46. Service Units		47. Total Charges		48. Non-Covered Charges		49. DEL			

Scroll down to the bottom of the page and select Save & Run Edits to save all changes

Patient Name: Account Select Edit

Claim 1 of 24

New Copy Hold Inbound View Print Undo Changes **Save & Run Edits**

How to Create a Claim



UB04 Institutional - NV Medicaid Institutional

Claims Patients Reports Maintenance Help Tools

Field 6 will be highlighted until all data is completed on the UB-04 claim form

All the updates will be saved to the document and will no longer be highlighted in Red

Any new edits will be highlighted in Red

Enter new requirements on UB-04 form

Patient Name: ALE, GINER Account: 010101

Select Edit

Claim 1 of 25



How to Create a Claim



UB04 Institutional - NV Medicaid Institutional

Claims Patients Reports Maintenance Help Tools

Back To List Form Fields (12) Electronic Fields (1)

1. Provider Name: BILLING SERVICE
 Provider Address: 100 1ST ST
 RENO NV 895020000
 Provider Phone: 7753358501

2. Pay to Name: [Empty]
 Pay to Address: [Empty]

3a. Patient Control Number: 010101
 b. Medical Record Number: [Empty]

4. Type of Bill: 111

5. Federal Tax Number: 000000000
 6. Statement Covers Period (From - Through): 04/01/2016 - 04/05/2016

7. [Empty]

8a. Patient Identifier: [Empty]
 b. Patient Name (Last Name, First Name, Middle Initial): ALE GINER
 8b. Patient Address: 1 FIRST STREET
 RENO NV 89502

10. Patient Birth Date: 01/01/1960
 11. SEX: M F U
 12. Admission: 04/01/2016
 13. Admission Hour: 12
 14. Priority (Type) of Admission or Visit: 1
 15. Point of Origin for Admission or Visit: [Empty]
 16. Discharge Hour: [Empty]
 17. Patient Discharge Status: 30
 18-28. Condition Codes: [Empty]

29. Accident State: [Empty]
 30. [Empty]

31. Occurrence Code Date: [Empty]
 32. Occurrence Code Date: [Empty]
 33. Occurrence Code Date: [Empty]
 34. Occurrence Code Date: [Empty]
 35. Occurrence Span Code From Through: [Empty]
 36. Occurrence Span Code From Through: [Empty]
 37. [Empty]

38. Responsible Party Name (Last, First, MI): [Empty]
 Responsible Party Address: [Empty]

39. Value Codes
 a. Code Amount
 b. Code Amount
 c. Code Amount
 d. Code Amount

40. Value Codes
 a. Code Amount
 b. Code Amount
 c. Code Amount
 d. Code Amount

41. Value Codes
 a. Code Amount
 b. Code Amount
 c. Code Amount
 d. Code Amount

42. Revenue Codes	43. Revenue Description/IDE Number/Medicaid Drug Rebate	44. HCPCS/Accommodation Rates/HPPS Rate Codes	45. Service Date	46. Service Units	47. Total Charges	48. Non-Covered Charges	49. DEL
0120					\$5000.00		

Key in all of the Red highlighted sections on the UB-04 claim form

Scroll down to the bottom of the page and select Save & Run Edits to save all changes

Patient Name: ALE, GINER Account: 010101
 Select Edit
 Claim 1 of 25

New Copy Hold Inbound View Print Undo Changes **Save & Run Edits**

How to Create a Claim



UB04 Institutional - NV Medicaid Institutional

Claims Patients Reports Maintenance Help Tools

Back To List Form Fields (12) Electronic Fields (1)

1. Provider Name: BILLING SERVICE
Provider Address: 100 1ST ST
RENO NV 895020000
Provider Phone: 7753358501

2. Pay to Name: [Empty]
Pay to Address: [Empty]

3a. Patient Control Number: 010101
b. Medical Record Number: [Empty]

4. Type of Bill: 111

5. Federal Tax Number: 000000000
6. Statement Covers Period (From - Through): 04/01/2016 - 04/05/2016

7. [Empty]

8a. Patient Identifier: [Empty]
b. Patient Name (Last Name, First Name, Middle Initial): ALE GINER
9a. Patient Address: 1 FIRST STREET
b. Patient City: RENO c. Patient State: NV d. Patient Zip: 89502 e. Country Code: [Empty]

10. Patient Birth Date: [Empty] 11. SEX: [Empty] 12. Admission: 04/01/2016
13. Admission Hour: [Empty] 14. Priority (Type) of [Empty] 15. Point of Origin for [Empty] 16. Discharge Hour: [Empty] 17. Patient Discharge: [Empty]

22. 23. 24. 25. 26. 27. 28. Condition Codes: [Empty]

29. Accident State: [Empty] 30. [Empty]

31. Occurrence Code Date: [Empty] 32. Occurrence Code Date: [Empty] 33. Occurrence Code Date: [Empty]

34. Occurrence Code Date: [Empty] 35. Occurrence Code Date: [Empty]

36. Occurrence Span Code From: [Empty] Through: [Empty]

37. [Empty]

38. Responsible Party Name (Last, First, MI): [Empty]
Responsible Party Address: [Empty]

41. Value Codes
Code Amount
a [Empty] [Empty]
b [Empty] [Empty]
c [Empty] [Empty]
d [Empty] [Empty]

42. Revenue Codes	43. Revenue Description/IDE Number/Medicaid Drug Rebate	44. HCPCS/Accommodation Rates/IFPPS Rate Codes	45. Service Date	46. Service Units	47. Total Charges	48. Non-Covered Charges	49. DEL
0120					\$5000.00		

Message from webpage
Total ChargeLine with Revenue Code 001 or 0001 is required.
OK

A pop up message will advise Total ChargeLine with Revenue Code 001 or 0001 is required

After your last revenue line please enter 001 in Field 42 and total Charges in field 47

How to Create a Claim



UB04 Institutional - NV Medicaid Institutional

Claims Patients Reports Maintenance Help Tools

Back To List Form Fields (12) Electronic Fields (1)

1. Provider Name: BILLING SERVICE
 Provider Address: 100 1ST ST
 RENO, NV 895020000
 Provider Phone: 7753358501

2. Pay to Name: [Empty]
 Pay to Address: [Empty]

3a. Patient Control Number: 010101
 b. Medical Record Number: [Empty]

4. Type of Bill: 111

5. Federal Tax Number: 000000000
 6. Statement Covers Period (From - Through): 04/01/2016 - 04/05/2016

7. [Empty]

8a. Patient Identifier: [Empty]
 b. Patient Name (Last Name, First Name, Middle Initial): ALE GINER
 8b. Patient Address: 1 FIRST STREET
 c. Patient City: RENO
 d. Patient State: NV
 e. Patient Zip: 89502
 f. Country Code: [Empty]

10. Patient Birth Date: 01/01/1960
 11. SEX: M [] F [] U [] O []
 12. Admission Date: 04/01/2016
 13. Admission Hour: 12
 14. Priority (Type) of Admission or Visit: 1
 15. Point of Origin for Admission or Visit: [Empty]
 16. Discharge Hour: [Empty]
 17. Patient Discharge Status: 30
 18-28. Condition Codes: [Empty]

29. Accident State: [Empty]

30. [Empty]

31. Occurrence Code Date: [Empty]
 32. Occurrence Code Date: [Empty]
 33. Occurrence Code Date: [Empty]
 34. Occurrence Code Date: [Empty]
 35. Occurrence Span Code From Through: [Empty]
 36. Occurrence Span Code From Through: [Empty]

37. [Empty]

38. Responsible Party Name (Last, First, MI): [Empty]
 Responsible Party Address: [Empty]

39. Value Codes (a-d): [Empty]
 40. Value Codes (a-d): [Empty]
 41. Value Codes (a-d): [Empty]

42. Revenue Codes	43. Revenue Description/IDE Number/Medicaid Drug Rebate	44. HCPCS/Accommodation Rates/HIPPS Rate Codes	45. Service Date	46. Service Units	47. Total Charges	48. Non-Covered Charges	49. DEL
0120					\$5000.00		<input type="checkbox"/>
001					\$5000.00		<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>

Key in the last revenue line
 Enter 001 in Field 42 and total Charges in field 47

Scroll down to the bottom of the page and select Save & Run Edits to save all changes

Patient Name: ALE, GINER Account: 010101
 Select Edit
 Claim 1 of 25

New Copy Hold Inbound View Print Undo Changes **Save & Run Edits**

How to Create a Claim



UB04 Institutional - NV Medicaid Institutional

Claims Patients Reports Maintenance Help Tools

Back To List Form Fields (7) Electronic Fields (1)

1. Provider Name: BILLING SERVICE
 Provider Address: 100 1ST ST
 RENO NV 895020000
 Provider Phone: 7753358501

2. Pay to Name: [Empty]
 Pay to Address: [Empty]

3a. Patient Control Number: 010101
 b. Medical Record Number: [Empty]

4. Type of Bill: 111

5. Federal Tax Number: 000000000
 6. Statement Covers Period (From - Through): 04/01/2016 - 04/05/2016

7. [Empty]

8a. Patient Identifier: [Empty]
 b. Patient Name (Last Name, First Name, Middle Initial): ALE GINER

9a. Patient Address: 1 FIRST STREET
 b. Patient City: RENO c. Patient State: NV d. Patient Zip: 89502 e. Country Code: [Empty]

10. Patient Birth Date: 01/01/1960
 11. SEX: M F U
 12. Admission: 04/01/2016
 13. Admission Hour: 12
 14. Priority (Type) of Admission or Visit: 1
 15. Point of Origin for Admission or Visit: [Empty]
 16. Discharge Hour: [Empty]
 17. Patient Discharge Status: 30
 18-28. Condition Codes: [Empty]

29. Accident State: [Empty]
 30. [Empty]

31. Occurrence Code Date: [Empty]
 32. Occurrence Code Date: [Empty]
 33. Occurrence Code Date: [Empty]
 34. Occurrence Code Date: [Empty]
 35. Occurrence Span Code From Through: [Empty]
 36. Occurrence Span Code From Through: [Empty]
 37. [Empty]

38. Responsible Party Name (Last, First, MI): [Empty]
 Responsible Party Address: [Empty]

39. Value Codes
 a. Code Amount
 b. Code Amount
 c. Code Amount
 d. Code Amount

40. Value Codes
 a. Code Amount
 b. Code Amount
 c. Code Amount
 d. Code Amount

41. Value Codes
 a. Code Amount
 b. Code Amount
 c. Code Amount
 d. Code Amount

42. Revenue Codes	43. Revenue Description/IDE Number/Medicaid Drug Rebate	44. HCPCS/Accommodation Rates/HIPPS Rate Codes	45. Service Date	46. Service Units	47. Total Charges	48. Non-Covered Charges	49. DEL
1 0120				[Red]	\$5000.00		<input type="checkbox"/>
2 001					\$5000.00		<input type="checkbox"/>
							<input type="checkbox"/>
							<input type="checkbox"/>

Any new edits will be highlighted in Red

Enter new requirements on the UB-04 form

Enter Service Units in Field 46

How to Create a Claim



UB04 Institutional - NV Medicaid Institutional

Claims Patients Reports Maintenance Help Tools

Back To List Form Fields (7) Electronic Fields (1)

1. Provider Name: BILLING SERVICE
 Provider Address: 100 1ST ST
 RENO NV 895020000
 Provider Phone: 7753358501

2. Pay to Name
 Pay to Address

3a. Patient Control Number: 010101
 b. Medical Record Number

4. Type of Bill: 111

5. Federal Tax Number: 000000000
 6. Statement Covers Period (From - Through): 04/01/2016 - 04/05/2016

7.

8a. Patient Identifier
 b. Patient Name (Last Name, First Name, Middle Initial): ALE GINER
 c. Patient City: RENO
 d. Patient State: NV
 e. Patient Zip: 89502
 f. Country Code

9a. Patient Address: 1 FIRST STREET

10. Patient Birth Date: 01/01/1960
 11. SEX: M
 12. Admission: 04/01/2016
 13. Admission Hour: 12
 14. Priority (Type) of Admission or Visit: 1
 15. Point of Origin for Admission or Visit
 16. Discharge Hour
 17. Patient Discharge Status: 30
 Condition Codes: 18-28
 29. Accident State
 30.

31. Occurrence Code Date
 32. Occurrence Code Date
 33. Occurrence Code Date
 34. Occurrence Code Date
 35. Occurrence Span Code From Through
 36. Occurrence Span Code From Through
 37.

38. Responsible Party Name (Last, First, MI)
 Responsible Party Address

39. Value Codes
 Code Amount
 a
 b
 c
 d

40. Value Codes
 Code Amount
 a
 b
 c
 d

41. Value Codes
 Code Amount
 a
 b
 c
 d

42. Revenue Codes	43. Revenue Description/IDE Number/Medicaid Drug Rebate	44. HCPCS/Accommodation Rates/HIPPS Rate Codes	45. Service Date	46. Service Units	47. Total Charges	48. Non-Covered Charges	49. DEL
1 0120				5	\$5000.00		
2 001					\$5000.00		

Any new edits will be highlighted in Red

Enter new requirements on the UB-04 form

Enter Service units in Field 46

Scroll down to the bottom of the page and select Save & Run Edits to save all changes

← Patient Name: ALE, GINER Account: 010101
 Select Edit
 Claim 2 of 26

New Copy Hold Inbound View Print Undo Change **Save & Run Edits**

How to Create a Claim



UB04 Institutional - NV Medicaid Institutional

Claims Patients Reports Maintenance Help Tools

Back To List Form Fields (6) Electronic Fields (1)

1. Provider Name: BILLING SERVICE
 Provider Address: 100 1ST ST
 RENO NV 895020000
 Provider Phone: 7753358501

2. Pay to Name
 Pay to Address

3a. Patient Control Number: 010101
 b. Medical Record Number

4. Type of Bill: 111

5. Federal Tax Number: 000000000
 6. Statement Covers Period (From - Through): 04/01/2016 - 04/05/2016

7.

8a. Patient Identifier
 b. Patient Name (Last Name, First Name, Middle Initial): ALE GINER
 8b. Patient Address: 1 FIRST STREET
 c. Patient State: NV
 d. Patient Zip: 89502
 e. Country Code

10. Patient Birth Date: 01/01/1960
 11. SEX: M F U
 12. Admission: 04/01/2016
 13. Admission Hour: 12
 14. Priority (Type) of Admission or Visit: 1
 15. Point of Origin for Admission or Visit
 16. Discharge Hour: 30
 17. Patient Discharge Status
 Condition Codes: 18-28
 29. Accident State
 30.

Code Date Code Date Code Date Code Date Code From Through Code From Through

35. Responsible Party Name (Last, First, MI)
 Responsible Party Address

39. Value Codes Amount
 a b c d

40. Value Codes Amount
 a b c d

41. Value Codes Amount
 a b c d

42. Revenue Codes	43. Revenue Description/IDE Number/Medicaid Drug Rebate	44. HCPCS/Accommodation Rates/HIPPS Rate Codes	45. Service Date	46. Service Units	47. Total Charges	48. Non-Covered Charges	49. DEL
1	0120			5	\$5000.00		
2	001				\$5000.00		

All the updates will be saved to the document and will no longer be highlighted in Red

Scroll down to the next Red highlighted fields

How to Create a Claim



UB04 Institutional - NV Medicaid Institutional

Claims Patients Reports Maintenance Help Tools

50. Payer Name a. <input type="radio"/> NV MEDICAID b. <input type="radio"/> c. <input type="radio"/>		51. Health Plan Identification Number a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	52. Release of Information Certification Indicator a. <input type="radio"/> Y b. <input type="radio"/> c. <input type="radio"/>	53. Assignment of Benefits Certification Indicator a. <input type="radio"/> Y b. <input type="radio"/> c. <input type="radio"/>	54. Prior Payments - Payer a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	55. Estimated Amount Due - Payer a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	56. National Provider Identifier - Billing Provider 1001001001	57. Coverage Indicator a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	
58. Insured's Name a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>		59. Patient's Relationship to Insured a. 18 b. <input type="text"/> c. <input type="text"/>	60. Insured's Unique Identifier a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	61. Insured's Group Number a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>		62. Insured's Group Number a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>			
63. Authorization Code/Referral Number a. ENTER PA b. <input type="text"/> c. <input type="text"/>			64. Document Control Number (DCN) a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>		65. Employer Name (of the insured) a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>				
67. Principal Diagnosis Code and Present on Admission Indicator ICD-10 <input type="text"/>	67 a. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 b. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 c. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 d. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 e. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 f. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 g. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 h. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	68. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>
67 i. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 j. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 k. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 l. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 m. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 n. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 o. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 p. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 q. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	68. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>
69. Admitting Diagnosis Code <input type="text"/>	70. Patient's Reason for Visit a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>		71. Prospective Payment System (PPS) Code <input type="text"/>		72. External Cause of Injury (ECI) Code and Present on Admission Indicator a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>			73. External Cause of Injury (ECI) Code and Present on Admission Indicator a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	
74. Principal Procedure Code and Date <input type="text"/>	74 a. Other Procedure Codes and Dates <input type="text"/>	74 b. Other Procedure Codes and Dates <input type="text"/>	74 c. Other Procedure Codes and Dates <input type="text"/>	74 d. Other Procedure Codes and Dates <input type="text"/>	74 e. Other Procedure Codes and Dates <input type="text"/>	75. Attending Provider Name and Identifiers NPI <input type="text"/> QIAL <input type="text"/> LAST NAME <input type="text"/> FIRST NAME <input type="text"/>			
76. Operating Name and Identifiers NPI <input type="text"/> QIAL <input type="text"/> LAST <input type="text"/> FIRST <input type="text"/>						77. Other Provider Name and Identifiers NPI <input type="text"/> QIAL <input type="text"/> LAST <input type="text"/> FIRST <input type="text"/>			
78. Other Provider (Individual) Names and Identifiers NPI <input type="text"/> QIAL <input type="text"/> LAST <input type="text"/> FIRST <input type="text"/>						79. Other Provider (Individual) Names and Identifiers NPI <input type="text"/> QIAL <input type="text"/> LAST <input type="text"/> FIRST <input type="text"/>			
80. Remarks <input type="text"/>									

Enter the Estimated Amount Due - Payer

Key in all of the Red highlighted sections on the UB-04 claim form

How to Create a Claim



UB04 Institutional - NV Medicaid Institutional

Claims	Patients	Reports	Maintenance	Help	Tools					
Active Payer	50. Payer Name a. <input type="radio"/> NV/MEDICAID b. <input type="radio"/> c. <input type="radio"/>	51. Health Plan Identification Number a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	52. Release of Information Certification Indicator a. <input type="radio"/> Y b. <input type="radio"/> c. <input type="radio"/>	53. Assignment of Benefits Certification Indicator a. <input type="radio"/> Y b. <input type="radio"/> c. <input type="radio"/>	54. Prior Payments - Payer a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	55. Estimated Amount Due - Payer a. \$5000.00 b. <input type="text"/> c. <input type="text"/>	56. National Provider Identifier - Billing Provider 1001001001 57. Other (Billing) Provider Identifier a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>			
58. Insured's Name a. ALE b. <input type="text"/> c. <input type="text"/>		59. Patient's Relationship to Insured GINER a. 18 b. <input type="text"/> c. <input type="text"/>		60. Insured's Unique Identifier a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>		61. Insured's Group Name a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>		62. Insured's Group Number a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>		
63. Authorization Code/Referral Number a. 0000000000 b. <input type="text"/> c. <input type="text"/>			64. Document Control Number (DCN) a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>			65. Employer Name (of the Insured) a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>				
66. Diagnosis and Procedure Code Qualifier (ICD Version Indicator) ICD-10	67. Principal Diagnosis Code and Present on Admission Indicator Z741	67 a. Other Diagnosis Code and Present on Admission Indicator Z742	67 b. Other Diagnosis Code and Present on Admission Indicator Z743	67 c. Other Diagnosis Code and Present on Admission Indicator Z748	67 d. Other Diagnosis Code and Present on Admission Indicator Z749	67 e. Other Diagnosis Code and Present on Admission Indicator	67 f. Other Diagnosis Code and Present on Admission Indicator	67 g. Other Diagnosis Code and Present on Admission Indicator	67 h. Other Diagnosis Code and Present on Admission Indicator	68.
67 i. Other Diagnosis Code and Present on Admission Indicator	67 j. Other Diagnosis Code and Present on Admission Indicator	67 k. Other Diagnosis Code and Present on Admission Indicator	67 l. Other Diagnosis Code and Present on Admission Indicator	67 m. Other Diagnosis Code and Present on Admission Indicator	67 n. Other Diagnosis Code and Present on Admission Indicator	67 o. Other Diagnosis Code and Present on Admission Indicator	67 p. Other Diagnosis Code and Present on Admission Indicator	67 q. Other Diagnosis Code and Present on Admission Indicator	67 r. Other Diagnosis Code and Present on Admission Indicator	
69. Admitting Diagnosis Code Z741	70. Patient's Reason for Visit a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>			71. Prospective Payment System (PPS) Code <input type="text"/>	72. External Cause of Injury (EC) Code and Present on Admission Indicator a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>			73.		
74. Principal Procedure Code and Date <input type="text"/>	74 a. Other Procedure Codes and Dates <input type="text"/>		74 b. Other Procedure Codes and Dates <input type="text"/>		74 c. Other Procedure Codes and Dates <input type="text"/>		74 d. Other Procedure Codes and Dates <input type="text"/>		74 e. Other Procedure Codes and Dates <input type="text"/>	
75. 76. Attending Provider Name and Identifiers NPI 1001001001 QUAL <input type="text"/> LAST SMITH FIRST JOHN										
77. Operating Name and Identifiers NPI <input type="text"/> QUAL <input type="text"/> LAST <input type="text"/> FIRST <input type="text"/>										
78. Other Provider Name and Identifiers NPI <input type="text"/> QUAL <input type="text"/> LAST <input type="text"/> FIRST <input type="text"/>										
79. Other Provider (Individual) Names and Identifiers NPI <input type="text"/> QUAL <input type="text"/> LAST <input type="text"/> FIRST <input type="text"/>										
80. Remarks <input type="text"/>										

Scroll down to the bottom of the page and select Save & Run Edits to save all changes

Patient Name: ALE, GINER Account: 010101
Select Edit
Claim 1 of 36

New Copy Hold Inbound View Print Undo Change **Save & Run Edits**

How to Create a Claim



UB04 Institutional - NV Medicaid Institutional

Any new edits will be highlighted in Red

Enter new requirements on the UB-04 form

Enter Service Medicaid ID number in Field 60

Patient Name: ALE, GINER Account: 010101

Select Edit

Claim 1 of 26

How to Create a Claim



UB04 Institutional - NV Medicaid Institutional

Claims	Patients	Reports	Maintenance	Help	Tools																							
Active Payer	50. Payer Name a. <input checked="" type="radio"/> NV MEDICAID b. <input type="radio"/> c. <input type="radio"/>	51. Health Plan Identification Number a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	52. Release of Information Certification Indicator a. <input checked="" type="radio"/> Y b. <input type="radio"/> c. <input type="radio"/>	53. Assignment of Benefits Certification Indicator a. <input checked="" type="radio"/> Y b. <input type="radio"/> c. <input type="radio"/>	54. Prior Payments - Payer a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	55. Estimated Amount Due - Payer a. \$5000.00 b. <input type="text"/> c. <input type="text"/>	56. National Provider Identifier - Billing Provider 1001001001 57. Other (Billing) Provider Identifier a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>																					
58. Insured's Name a. ALE b. <input type="text"/> c. <input type="text"/>	GINER <input type="text"/> <input type="text"/>	59. Patients Relationship to Insured a. 18 b. <input type="text"/> c. <input type="text"/>	60. Insured's Unique Identifier a. 00000000001 b. <input type="text"/> c. <input type="text"/>	61. Insured's Group Name a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	62. Insured's Group Number a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	63. Authorization Code/Referral Number a. 0000000000 b. <input type="text"/> c. <input type="text"/>	64. Document Control Number (DCN) a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	65. Employer Name (if the Insured) a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	66. Diagnosis and Procedure Code Qualifier (ICD Version Indicator) 100-10	67. Principal Diagnosis Code and Present on Admission Indicator Z741	67 a. Other Diagnosis Code and Present on Admission Indicator Z742	67 b. Other Diagnosis Code and Present on Admission Indicator Z743	67 c. Other Diagnosis Code and Present on Admission Indicator Z748	67 d. Other Diagnosis Code and Present on Admission Indicator Z749	67 e. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 f. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 g. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 h. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 i. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 j. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 k. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 l. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 m. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 n. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 o. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 p. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 q. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	68. <input type="text"/>
69. Admitting Diagnosis Code Z741	70. Patient's Reason for Visit a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	71. Prospective Payment System (PPS) Code <input type="text"/>	72. External Cause of Injury (ECI) Code and Present on Admission Indicator a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	73. <input type="text"/>	74. Principal Procedure Code and Date <input type="text"/>	74 a. Other Procedure Codes and Dates <input type="text"/>	74 b. Other Procedure Codes and Dates <input type="text"/>	74 c. Other Procedure Codes and Dates <input type="text"/>	74 d. Other Procedure Codes and Dates <input type="text"/>	74 e. Other Procedure Codes and Dates <input type="text"/>	75. 76. Attending Provider Name and Identifiers NPI: 1001001001 QUAL: <input type="text"/> LAST: SMITH FIRST: JOHN	77. Operating Name and Identifiers NPI: <input type="text"/> QUAL: <input type="text"/> LAST: <input type="text"/> FIRST: <input type="text"/>	78. Other Provider Name and Identifiers NPI: <input type="text"/> QUAL: <input type="text"/> LAST: <input type="text"/> FIRST: <input type="text"/>	79. Other Provider (Individual) Names and Identifiers NPI: <input type="text"/> QUAL: <input type="text"/>														
80. Remarks <input type="text"/>																												

Scroll down to the bottom of the page and select Save & Run Edits to save all changes

Patient Name: ALE, GINER Account: 010101
Select Edit

New Copy Hold Inbound View Print Undo Changes **Save & Run Edits**

How to Create a Claim



UB04 Institutional - NV Medicaid Institutional

Claims Patients Reports Maintenance Help Tools

50. Payer Name a. <input type="radio"/> NV MEDICAID b. <input type="radio"/> c. <input type="radio"/>	51. Health Plan Identification Number a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	52. Release of Information Certification Indicator a. <input type="radio"/> Y b. <input type="radio"/> c. <input type="radio"/>	53. Assignment of Benefits Certification Indicator a. <input type="radio"/> Y b. <input type="radio"/> c. <input type="radio"/>	54. Prior Payments - Payer a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>	55. Estimated Amount Due - Payer a. \$5000.00 b. <input type="text"/> c. <input type="text"/>	56. National Provider Identifier - Billing Provider 1001001001	57. Other (Billing) Provider Identifier a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>												
58. Insured's Name a. ALE GINER b. <input type="text"/> c. <input type="text"/>		59. Patient's Relationship to Insured a. 18 b. <input type="text"/> c. <input type="text"/>	60. Insured's Unique Identifier a. 00000000001 b. <input type="text"/> c. <input type="text"/>	61. Insured's Group Name a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>		62. Insured's Group Number a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>													
63. Authorization Code/Referral Number a. 0000000000 b. <input type="text"/> c. <input type="text"/>			64. Document Control Number (DCN) a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>		65. Employer Name (of the Insured) a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>														
66. Diagnosis and Procedure Code Qualifier (ICD Version Indicator) ICD-10	67. Principal Diagnosis Code and Present on Admission Indicator Z741	67 a. Other Diagnosis Code and Present on Admission Indicator Z742	67 b. Other Diagnosis Code and Present on Admission Indicator Z743	67 c. Other Diagnosis Code and Present on Admission Indicator Z748	67 d. Other Diagnosis Code and Present on Admission Indicator Z749	67 e. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 f. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 g. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 h. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 i. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 j. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 k. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 l. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 m. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 n. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 o. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 p. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 q. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>	67 r. Other Diagnosis Code and Present on Admission Indicator <input type="text"/>
69. Admitting Diagnosis Code Z741	70. Patient's Reason for Visit a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>			71. Prospective Payment System (PPS) Code <input type="text"/>		72. External Cause of Injury (ECI) Code and Present on Admission Indicator a. <input type="text"/> b. <input type="text"/> c. <input type="text"/>			73. <input type="text"/>										
74. Principal Procedure Code and Date <input type="text"/>		74 a. Other Procedure Codes and Dates <input type="text"/>		74 b. Other Procedure Codes and Dates <input type="text"/>		74 c. Other Procedure Codes and Dates <input type="text"/>		74 d. Other Procedure Codes and Dates <input type="text"/>		74 e. Other Procedure Codes and Dates <input type="text"/>		75. Attending Provider Name and Identifiers NPI: 1001001001 QUAL: <input type="text"/> LAST: SMITH FIRST: JOHN							
80. Remarks <input type="text"/>												77. Operating Name and Identifiers NPI: <input type="text"/> QUAL: <input type="text"/> LAST: <input type="text"/> FIRST: <input type="text"/>							
												78. Other Provider Name and Identifiers NPI: <input type="text"/> QUAL: <input type="text"/> LAST: <input type="text"/> FIRST: <input type="text"/>							
												79. Other Provider (Individual) Names and Identifiers NPI: <input type="text"/> QUAL: <input type="text"/>							

Once the page is saved, please scroll up to the top of the page and look for the tab that reads Electronic Fields

Patient Name: ALE, GINER Account: 010101
Select Edit



How to Create a Claim



Back To List Form Fields **Electronic Fields (1)**

1. Provider Name
BILLING SERVICE
Provider Address
100 1ST ST
RENO NV 895020000
Provider Phone 7753358501 Fax Country Code

2. Pay to Name
Pay to Address

3a. Patient Control Number 010101
b. Medical Record Number

4. Type of Bill 111

5. Federal Tax Number 000000000
6. Statement Covers Period (From - Through) 04/01/2016 04/05/2016

7.

8a. Patient Identifier
b. Patient Name (Last Name, First Name, Middle Initial) ALE GINER
9a. Patient Address 1 FIRST STREET
b. Patient City RENO c. Patient State NV d. Patient Zip 89502 e. Country Code

10. Patient Birth Date 01/01/1960 11. SEX M F U
12. Admission 04/01/2016

23. 24. 25. 26. 27. 28. 29. Accident State 30.

31. Occurrence Code Date 32. Occurrence Code Date 33. Occurrence Code Date
36. Occurrence Span Code From Through 37.

38. Responsible Party Name (Last, First, MI)
Responsible Party Address

41. Value Codes
Code Amount
a b c d

	42. Revenue Codes	43. Revenue Description/ICD Number/Medicaid Drug Rebate	44. HCPCS/Accommodation Rates/HIPPS Rate Codes	45. Service Date	46. Service Units	47. Total Charges	48. Non-Covered Charges	49.	DEL
1	0120				5	\$5000.00			
2	001					\$5000.00			

Click on the Electronic Fields tab at the top of the page to enter the Insured's Date of Birth

How to Create a Claim



Categories	Back To List	Form Fields	Electronic Fields (1)
Payer A (1)			
Additional Provider			
Attending Provider			
Billing Provider			
Charge Reports			
Claim Pricing Repricing			
Codes			
Coordination of Benefits - Payer A			
Coordination of Benefits - Payer B			
Coordination of Benefits - Payer C			
Coordination of Benefits Additional Adjustments A			
Coordination of Benefits Additional Adjustments B			

Payer A
Insurance Type Code A: <input type="text"/>
Source of Payment Code A: <input type="text" value="MC-Medicaid"/>
Payer Subidentification Number: <input type="text"/>
Insured Date Of Birth: <input type="text" value=""/>
Insured Sex: <input type="text"/>
Patient Signature Source: <input type="text"/>
Covered Days: <input type="text"/>
Noncovered Days: <input type="text"/>
Coinurance Days: <input type="text"/>
Insured Employment Status Code: <input type="text"/>
Form Locator 2 (upper line): <input type="text"/>

Enter Insured's Date of Birth

How to Create a Claim

Allscripts UB04 Institutional - NV Medicaid Institutional

Claims Patients Reports Maintenance Help Tools

Categories

- Payer A (1)
- Additional Provider
- Attending Provider
- Billing Provider
- Charge Reports
- Claim Pricing Repricing
- Codes
- Coordination of Benefits - Payer A
- Coordination of Benefits - Payer B
- Coordination of Benefits - Payer C
- Coordination of Benefits Additional Adjustments A
- Coordination of Benefits Additional Adjustments B

Back To List **Form Fields** **Electronic Fields (1)**

Payer A

Insurance Type Code A:

Source of Payment Code A: MC-Medicaid

Payer Subidentification Number:

Insured Date Of Birth: 01/01/1960

Insured Sex:

Patient Signature Source:

Covered Days:

Noncovered Days:

Coinsurance Days:

Insured Employment Status Code:

Form Locator 2 (upper line):

Scroll down to the bottom of the page and select Save & Run Edits to save all changes

Patient Name: ALE, GINER Account: 010101

Select Edit

Claim 1 of 27

New Copy Hold Inbound View Print Undo Changes **Save & Run Edits**

How to Print & Save Your Claim



UB04 Institutional - NV Medicaid Institutional

Claims Patients Reports Maintenance Help Tools

Categories	Back To List	Form Fields	Electronic Fields
Payer A	Payer A		
Additional Provider	Insurance Type Code A:	<input type="text"/>	
Attending Provider	Source of Payment Code A:	MC-Medicaid	
Billing Provider	Payer Subidentification Number:	<input type="text"/>	
Charge Reports	Insured Date Of Birth:	01/01/1960	
Claim Pricing Repricing	Insured Sex:	<input type="text"/>	
Codes	Patient Signature Source:	<input type="text"/>	
Coordination of Benefits - Payer A	Covered Days:	<input type="text"/>	
Coordination of Benefits - Payer B	Noncovered Days:	<input type="text"/>	
Coordination of Benefits - Payer C	Coinurance Days:	<input type="text"/>	
Coordination of Benefits Additional Adjustments A	Insured Employment Status Code:	<input type="text"/>	
Coordination of Benefits Additional Adjustments B	Form Locator 2 (upper line):	<input type="text"/>	

Scroll down to the bottom of the page and select the Print button to print a copy of the claim form

How to Print & Save Your Claim

Allscripts UB04 Institutional - NV Medicaid Institutional

Categories

- Payer A
- Additional Provider
- Attending Provider
- Billing Provider
- Charge Reports
- Claim Pricing Repricing
- Codes
- Coordination of Benefits - Payer A
- Coordination of Benefits - Payer B
- Coordination of Benefits - Payer C
- Coordination of Benefits Additional Adjustments A
- Coordination of Benefits Additional Adjustments B

Tools

UB04 Form (ICD10) - With Form

UB04 Form (ICD10) - Without Form

Print Cancel

A pop up window will appear. Select the UB-04 Form (ICD-10)-With Form, then select the Print button.

Patient Name: ALE. GINER Account: 010101
No Errors
Claim 1 of 27

How to Print & Save Your Claim

https://www.payerpath.com/?USERGUID={9bc3c36d-abac-420c-8a14-925278501fe4}&ReportName=FormUB04& - Internet Explorer

TOC Page 1 of 1 Sort By Select Format Download **Preview** Print Help

BILLING SERVICE 2 3a PAT CNTL # 010101
100 1ST ST
RENO, NV 895020000
775 335 - 8501
4b MED REC #
5 FED TAX NO 000000000 8 STATEMENT COVERS PERIOD FROM 040116 THROUGH 040516

8 PATIENT NAME
9 PATIENT ADDRESS # 1 FIRST STREET
10 ALE, GINER 11 RENO NV 89502

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION	13 ICD	14 TYPE	15 SRC	16 DNR	17 STAT	18	19	20	21	CONDITION CODES	22	23	24	25	26	27	28	29 ACCT	30 STATE
01011960	F	040116	12	1				30														

31 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	36 OCCURRENCE DATE	37

38	39 CODE	VALUE CODES	40 CODE	VALUE CODES	41 CODE	VALUE CODES
		AMOUNT		AMOUNT		AMOUNT

42 REV CD	43 DESCRIPTION	44 HCPCS / NDC / ICD-9 CODE	45 SERV SPTS	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0120				5	5000.00		

125%

A pop up window will show the UB-04 Form (ICD-10)-With Form in a Report Viewer, then select the Preview button

How to Print & Save Your Claim

The screenshot shows a web browser window displaying a UB-04 form. The browser's address bar shows the URL: <https://www.payerpath.com/Reporting/PrintReport.aspx?Rptname=FormUB04>. The browser's toolbar includes icons for Save and Print, which are highlighted with a green box. A green callout box points to these icons with the text: "A pop up window will show the UB-04 Form (ICD-10)- With Form in a PDF document, then select the Save button or the Print button".

The form itself is a UB-04 form with the following data:

BILLING SERVICE										3a PAT. CNTRL # 010101										4 TYPE OF BILL 0111																																																																																																																																																																																													
100 1ST ST										5 MED. REC. #																																																																																																																																																																																																							
RENO, NV 895020000										6 FED. TAX NO. 000000000										8 STATEMENT COVERS PERIOD FROM 040116 THROUGH 040516																																																																																																																																																																																													
775 335 - 8501										1 FIRST STREET																																																																																																																																																																																																							
9 PATIENT NAME										c NV										e 89502																																																																																																																																																																																													
10 BIRTHDATE 01011960										11 SEX F										12 DATE 040116										13 HR 12										14 TYPE 1										15 SRC										16 DHR										17 STAT 30										18										19										20										21										22										23										24										25										26										27										28										29 ACCT STATE										30									
31 OCCURRENCE CODE										32 OCCURRENCE DATE										33 OCCURRENCE CODE										34 OCCURRENCE DATE										35 OCCURRENCE SPAN CODE										36 OCCURRENCE SPAN FROM										37 OCCURRENCE SPAN THROUGH																																																																																																																																																					
38										39 CODE										40 CODE										41 CODE																																																																																																																																																																																			
										VALUE CODES AMOUNT										VALUE CODES AMOUNT										VALUE CODES AMOUNT																																																																																																																																																																																			
42 REY. CD. 0120										43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE										45 SERV. DATE										46 SERV. UNITS 5										47 TOTAL CHARGES 5000.00										48 NON-COVERED CHARGES										49																																																																																																																																											

8.50 x 11.00 in

Done

How to Print & Save Your Claim

https://www.payerpath.com/Reporting/PrintReport.aspx?Rptname=FormUB04 - Internet Explorer

Tools Fill & Sign Comment

1 / 1 141%

BILLING SERVICE
100 1ST ST
RENO, NV 895020000
775 335 - 8501

3a PAT. CNTL # 010101
b MED REC #
5 FED TAX NO 000000000
8 STATEMENT COV FROM 040116

9 PATIENT NAME
a ALE, GINER
9 PATIENT ADDRESS
a 1 FIRST STREET
b RENO
c NV

10 BIRTHDATE 01011960
11 SEX F
12 DATE 040116
13 HR 12
14 TYPE 1
15 SRC
16 DHR
17 STAT 30

ADMISSION
13 HR 14 TYPE 15 SRC 16 DHR

CONDITION CODES
17 STAT 18 19 20 21 22 23 24 25 26 27 28 29 AC STA

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN FROM THROUGH
36 OCCURRENCE SPAN FROM THROUGH

39 CODE VALUE CODES AMOUNT
40 CODE VALUE CODES AMOUNT
41 CODE VALUE CODES AMOUNT

42 REV CD 0120
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV DATE
46 SERV UNITS 5
47 TOTAL CHARGES 5000.00
48 NON COVERED CHARGES
49

8.50 x 11.00 in

Done

To close the pop up window for the PDF document, select the Red X in the right hand corner of the window

How to Print & Save Your Claim

https://www.payerpath.com/?USERGUID=[9bc3c36d-abac-420c-8a14-925278501fe4]&ReportName=FormUB04& - Internet Explorer

TOC Page 1 of 1 Sort By Select Format Download Preview Print Help

BILLING SERVICE
100 1ST ST
RENO, NV 895020000
775 335 - 8501

36 PAT CNTL # 010101
5 MED REC # 0111
6 FED TAX NO. 000000000
8 STATEMENT COVERS PERIOD FROM 040116 THROUGH 040516

8 PATIENT NAME ALE, GINER
9 PATIENT ADDRESS 1 FIRST STREET
10 RENO NV 89502

10 BIRTHDATE	11 SEX	12 DATE	13 HR	14 TYPE	15 SRC	16 DNR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE	30
01011960	F	040116	12	1			30													

31 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	34 OCCURRENCE DATE	35 CODE	36 OCCURRENCE SPAN FROM	37 THROUGH	38 CODE	39 OCCURRENCE SPAN FROM	40 THROUGH	41 CODE	42 AMOUNT

42 ICD CODE	43 DESCRIPTION	44 HCPCS / RATE / WPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON COVERED CHARGES	49
0120				5	5000.00		

125%

To close the pop up window for the Report Viewer document, select the Red X in the right hand corner of the window

Untransmitted Claims List



Untransmitted Claims List

Claims Patients Reports Maintenance Help Tools

Sorted By: (x)Created ▾ 7 Filtered

▾ Actions ▾ 1 selected

	Status	Location	Pat Name	Pat Acct	Payer	NPI	Created	Sent	Ack	Rcvd	Remitted	Charges	Paid		
<input checked="" type="checkbox"/>	P	NV TRAINING ALE, GINER		010101	NV MEDIC	100100100	04/23/16					\$5,000.00	\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINING ,			NV MEDIC	100100100	04/23/16					\$0.00	\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINING ,			NV MEDIC	100100100	04/23/16					\$0.00	\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINING ,			NV MEDIC	100100100	04/15/16						\$0.00	Y	H
<input type="checkbox"/>	P	NV TRAINING HILL, THOMA:		100200300	NV MEDIC	100100100	02/10/16					\$2,000.00	\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINING ,			NV MEDIC	100100100	02/10/16						\$0.00	Y	H
<input type="checkbox"/>	P	NV TRAINING HILL, THOMA:		100200300	NV MEDIC	100100100	02/10/16					\$2,000.00	\$0.00	Y	H
<input type="checkbox"/>	P	NV TRAINING HILL, THOMA:		100200300	NV MEDIC	100100100	02/10/16					\$2,000.00	\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINING ,			NV MEDIC	100100100	02/10/16						\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINING ,			NV MEDIC	100100100	02/10/16						\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINING ,			NV MEDIC	100100100	02/10/16						\$0.00	Y	H
<input type="checkbox"/>	P	NV TRAINING HILL, THOMA:		100200300	NV MEDIC	100100100	02/10/16					\$5,000.00	\$0.00	Y	H
<input type="checkbox"/>	P	NV TRAINING HILL, THOMA:		100200300	NV MEDIC	100100100	02/10/16					\$2,000.00	\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINING ,			NV MEDIC	100100100	02/10/16						\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINING ,			NV MEDIC	100100100	02/10/16						\$0.00	Y	H

Jump To: 1 - 04/23/16 ▾ Displaying items 1 - 15 of 27

Other options available from the Untransmitted Claims List include selecting any claims in a Passed Status to Print or mark for Send

Claims not modified within 90 days will be deleted
 Claims in Blue are assigned to Print Mail or Unassigned Payer

Untransmitted Claims List



Untransmitted Claims List

Claims Patients Reports Maintenance Help Tools

Sorted By: (x)Created ▾ ? Filtered

3 selected

Selected	Status	Location	Acct	Payer	NPI	Created	Sent	Ack	Rcvd	Remitted	Charges	Paid		
<input type="checkbox"/>	P	NV TRAINIK	0101	NV MEDIC	100100100	04/23/16					\$5,000.00	\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINIK		NV MEDIC	100100100	04/23/16					\$0.00	\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINIK		NV MEDIC	100100100	04/23/16					\$0.00	\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINIK		NV MEDIC	100100100	04/15/16					\$0.00	\$0.00	Y	H
<input type="checkbox"/>	P	NV TRAINIK	0200300	NV MEDIC	100100100	02/10/16					\$2,000.00	\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINIK		NV MEDIC	100100100	02/10/16					\$0.00	\$0.00	Y	H
<input checked="" type="checkbox"/>	P	NV TRAINIK	2003								\$2,000.00	\$0.00	Y	H
<input checked="" type="checkbox"/>	P	NV TRAINIK HILL, THOMA									\$2,000.00	\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINIK									\$0.00	\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINIK									\$0.00	\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINIK									\$0.00	\$0.00	Y	H
<input type="checkbox"/>	P	NV TRAINIK HILL, THOMA: 1002003									\$5,000.00	\$0.00	Y	H
<input type="checkbox"/>	P	NV TRAINIK HILL, THOMA: 1002003									\$2,000.00	\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINIK		NV MEDIC	100100100	02/10/16					\$0.00	\$0.00	Y	H
<input type="checkbox"/>	F	NV TRAINIK		NV MEDIC	100100100	02/10/16					\$0.00	\$0.00	Y	H

Jump To: 1 - 04/23/16 ▾ Displaying items 1 - 15 of 27

Other options available from the Untransmitted Claims List include selecting any claims to Print

Actions

- Show Summary
- Assign
- Hold
- New
- Remove Hold
- Send

Other options available from the Untransmitted Claims List include selecting any claims in a Passed Status to Print or mark for Send

Claims not modified within 90 days will be deleted
 Claims in Blue are assigned to Print Mail or Unassigned Payer



Viewing Remittance Advice

Remittance Detail

The screenshot displays the Allscripts web application interface. At the top left is the Allscripts logo. A green header bar contains the text "Welcome". Below this is a navigation menu with tabs for "Claims", "Patients", "Reports", "Maintenance", "Help", and "Tools". The "Reports" tab is highlighted with a green box, and a callout box labeled "Select Reports" points to it. A dropdown menu is open under "Reports", listing "Billing Summary", "Payer", "Remittance", "Payer Rejects", "Transmitted Claim", and "Payer Report Filter". The "Remittance" option is highlighted with a green box, and a callout box labeled "Select Remittance" points to it. On the left side, there is a "Resources" section with a "Knowledge Center" link. Below the navigation is a "Quick Links" section with three icons: "New Messages" (0), "Payer Reports" (0), and "Remit Reports" (0). At the bottom is a "My Filters" section with a "Claims Filters" dropdown menu and a message: "You have not set up any Claims filters." with a "Create Filter" button.

Remittance Report Filter

Remittance Report Filter

Claims

Patients

Reports

Maintenance

Help

Tools

Select Report Dates

Select Criteria	
<input checked="" type="radio"/> 0-90 Days <input type="radio"/> 91+ Days	
From	Through
Report Date: 04/16/2016	04/23/2016
Payer: All Payers	
NPI:	
View: <input checked="" type="checkbox"/> Read <input checked="" type="checkbox"/> Unread <input type="checkbox"/> Deleted	
<input type="checkbox"/> Display Downloadable Reports Only	
From	Through
Check Amount:	
Check Number:	
Check Date:	

Back To List

Apply Filter

Select Apply Filter

Remittance Detail List



Remittance Detail List

Claims Patients Reports Maintenance Help Tools

Check Data will be listed: Payer, NPI, Check No, Check Amount, Check Date, Received Date and Status

Export to CSV

	Payer	NPI	Check No	Check Amt	Check Date	Received Date	Status			
<input type="checkbox"/>	NV Medicaid Professional		210002480194059	\$5,290.08	07/19/2013	7/14/2013 4:50:53 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480191411	\$5,744.88	07/12/2013	7/7/2013 5:03:00 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480188786	\$4,909.39	07/05/2013	6/30/2013 5:04:37 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480186066	\$4,660.83	06/28/2013	6/23/2013 4:56:53 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480183559	\$9,760.75	06/21/2013	6/16/2013 4:37:07 PM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480178481	\$4,435.92	06/07/2013	6/2/2013 4:51:43 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480175928	\$7,708.32	05/31/2013	5/26/2013 5:03:05 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480173295	\$2,000.59	05/24/2013	5/19/2013 4:55:41 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480170713	\$3,781.44	05/17/2013	5/12/2013 4:56:36 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480168121	\$1,599.84	05/10/2013	5/5/2013 4:56:22 AM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480165439	\$4,435.92	05/03/2013	4/28/2013 4:27:37 PM	R			View
<input type="checkbox"/>	NV Medicaid Professional		210002480162845	\$2,181.60	04/26/2013	4/21/2013 4:54:13 AM	R			View

Displaying items 1 - 12 of 12

Select View

Filter List

Remittance Advice



NV Medicaid - 835 Remittances

Customer Name:

Claim Detail													
Patient Demographics				Claim Information									
Name:				Claim Status: 1				Total Billed:		\$145.44			
Pat Acct: CLAIM TEMPLET				Claim Num/ ICN: 2013193701488301				Total Prov Paid:		\$145.44			
Ins Id:													
Rend Prov	Service Date	Proc	Mods	Rmrk Cd	Billed	Allowed	Deduct	Colns	Grp / Rc / Qty /	Adj Amt	Prov Adj Cd/ Amt	Prov Paid	Pat Bal Due
	05 Jul - 06 Jul 2013	H2014			\$145.44							\$145.44	\$0.00
					\$145.44	\$0.00	\$0.00	\$0.00		\$0.00	\$0.00	\$145.44	\$0.00
Name:				Claim Status: 1				Total Billed:		\$363.60			
Pat Acct: CLAIM TEMPLET				Claim Num/ ICN: 2013193701488302				Total Prov Paid:		\$363.60			
Ins Id:													
Rend Prov	Service Date	Proc	Mods	Rmrk Cd	Billed	Allowed	Deduct	Colns	Grp / Rc / Qty /	Adj Amt	Prov Adj Cd/ Amt	Prov Paid	Pat Bal Due
	07 Jul - 11 Jul 2013	H2014			\$363.60							\$363.60	\$0.00
					\$363.60	\$0.00	\$0.00	\$0.00		\$0.00	\$0.00	\$363.60	\$0.00
Name:				Claim Status: 1				Total Billed:		\$145.44			
Pat Acct: CLAIM TEMPLET				Claim Num/ ICN: 2013193701489201				Total Prov Paid:		\$145.44			
Ins Id:													
Rend Prov	Service Date	Proc	Mods	Rmrk Cd	Billed	Allowed	Deduct	Colns	Grp / Rc / Qty /	Adj Amt	Prov Adj Cd/ Amt	Prov Paid	Pat Bal Due
	05 Jul - 06 Jul 2013	H2014			\$145.44							\$145.44	\$0.00
					\$145.44	\$0.00	\$0.00	\$0.00		\$0.00	\$0.00	\$145.44	\$0.00
Name:				Claim Status: 1				Total Billed:		\$363.60			
Pat Acct: CLAIM TEMPLET				Claim Num/ ICN: 2013193701489202				Total Prov Paid:		\$363.60			
Ins Id:													
Rend Prov	Service Date	Proc	Mods	Rmrk Cd	Billed	Allowed	Deduct	Colns	Grp / Rc / Qty /	Adj Amt	Prov Adj Cd/ Amt	Prov Paid	Pat Bal Due
	07 Jul - 11 Jul 2013	H2014			\$363.60							\$363.60	\$0.00
					\$363.60	\$0.00	\$0.00	\$0.00		\$0.00	\$0.00	\$363.60	\$0.00
Name:				Claim Status: 1				Total Billed:		\$145.44			
Pat Acct: CLAIM TEMPLET				Claim Num/ ICN: 2013193701489401				Total Prov Paid:		\$145.44			
Ins Id:													
Rend Prov	Service Date	Proc	Mods	Rmrk Cd	Billed	Allowed	Deduct	Colns	Grp / Rc / Qty /	Adj Amt	Prov Adj Cd/ Amt	Prov Paid	Pat Bal Due
	05 Jul - 06 Jul 2013	H2014			\$145.44							\$145.44	\$0.00
					\$145.44	\$0.00	\$0.00	\$0.00		\$0.00	\$0.00	\$145.44	\$0.00

Name of Insured
Pat Account
Insurance ID Number
Service Date
Procedure Code

Claim Number/ICN

Total Billed Amount
Total Provider Paid Amount



Learning Check

1. You should always copy the template before entering claim information?
 - a. Yes
 - b. No
2. From the Welcome page, where do you go to start your submission of a claim?
 - a. Tools
 - b. Reports
 - c. Claims
 - d. Help
3. Will your claim be automatically submitted once it's in a passed status?
 - a. Yes
 - b. No



Nevada Medicaid Contact Information

EDI Help Desk

Phone: (877) 638-3472 (select option 2, then select option 0, then select 3)

Email NVMMIS.EDIsupport@dxc.com

Mailing Address

Nevada Medicaid

EDI Coordinator

P.O. Box 30042

Reno, NV 89520-3042

Nevada Provider Training

Email NevadaProviderTraining@dxc.com



Thank you