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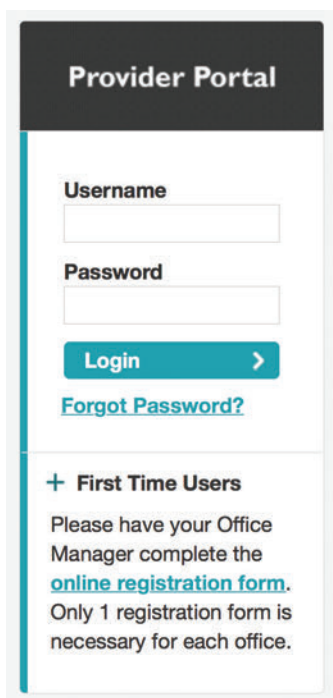
Registration

Registering for the Texas Children's® Health Plan (The Health Plan) Provider Portal is convenient. New physicians, office managers, or administrators can **register online** by following these simple steps.

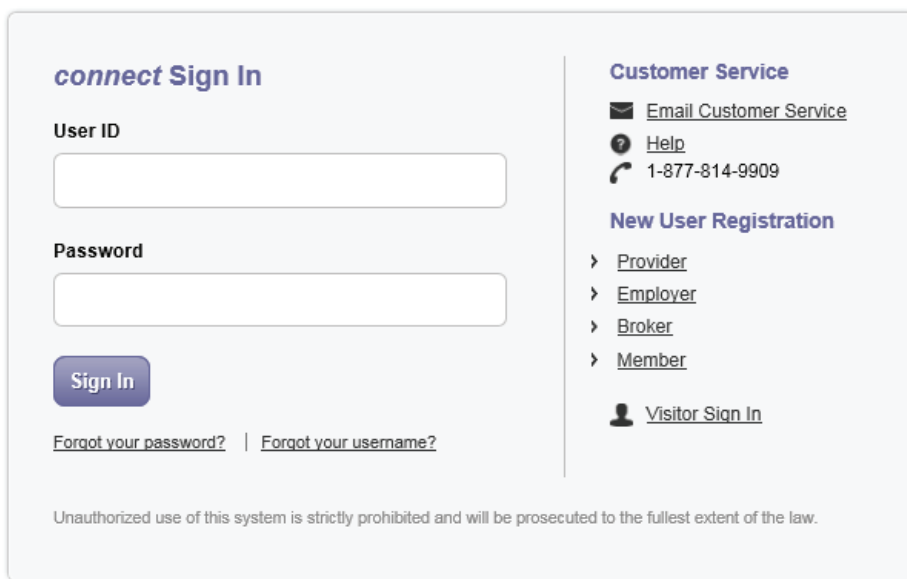
Step 1

Go to **<https://www.texaschildrenshealthplan.org/for-providers>**.

Click on the **First Time Users** link under the Login box.



The screenshot shows the 'Provider Portal' login interface. It features a dark header with the text 'Provider Portal'. Below the header, there are two input fields labeled 'Username' and 'Password'. A teal 'Login' button with a right-pointing arrow is positioned below the password field. A link for 'Forgot Password?' is located below the login button. On the left side, there is a section titled '+ First Time Users' which contains the text: 'Please have your Office Manager complete the [online registration form](#). Only 1 registration form is necessary for each office.'



The screenshot shows the 'connect Sign In' page. It has a light blue background. The main section is titled 'connect Sign In' and contains two input fields for 'User ID' and 'Password'. A purple 'Sign In' button is below the password field. Below the button are two links: 'Forgot your password?' and 'Forgot your username?'. On the right side, there is a 'Customer Service' section with links for 'Email Customer Service', 'Help', and a phone number '1-877-814-9909'. Below that is a 'New User Registration' section with expandable links for 'Provider', 'Employer', 'Broker', and 'Member'. At the bottom right of this section is a 'Visitor Sign In' link with a person icon. A disclaimer at the bottom states: 'Unauthorized use of this system is strictly prohibited and will be prosecuted to the fullest extent of the law.'

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[VPAT](#) | [Privacy Policy](#) | [System Requirements](#)



Step 2

Before you enter your **User Information**, please check to see if your office is already registered. They can simply add you with their access. Fields with a red asterisk are required.

User Information

If you are an existing user of the Connect system please login [Click here to start your session.](#)

First Name *	<input type="text"/>
Middle Initial	<input type="text"/>
Last Name *	<input type="text"/>
Title *	<input type="text"/>
E-Mail *	<input type="text"/>
Confirm E-Mail *	<input type="text"/>
Office Phone *	<input type="text"/> <small>Example: (555) 555-5555</small>
Extension #	<input type="text"/> <small>Example: 123456</small>
Office Fax *	<input type="text"/> <small>Example: (555) 555-5555</small>
User Name *	<input type="text"/>
Password *	<input type="password"/>
Confirm Password *	<input type="password"/>
Security Question 1 *	<input type="text"/> ▼
Security Answer 1 *	<input type="text"/> <small>Your answer may not contain your username.</small>
Security Question 2 *	<input type="text"/> ▼
Security Answer 2 *	<input type="text"/> <small>Your answer may not contain your username.</small>
Security Question 3 *	<input type="text"/> ▼
Security Answer 3 *	<input type="text"/> <small>Your answer may not contain your username.</small>
Local Admin	<input checked="" type="checkbox"/> As the primary registrant, you are automatically a local admin

Click the **Next** button.

Step 3

Enter your Office Information. All fields are required.

Office Information

Enter the name and address of your office.

Organization Name *	<input type="text"/>
Tax ID *	<input type="text"/>
Address *	<input type="text"/>
City *	<input type="text"/>
State *	<input type="text"/>
Zip Code *	<input type="text"/>

Cancel

Back

Next

Click the **Next** button.

Please choose the Health Plan you are registering a provider for.

Health Plan

Next

Please choose the Health Plan you are registering a provider for.

Health Plan	<div> <div>Select a Health Plan</div> <div> <div>AVMED</div> <div>Blue Cross & Blue Shield of Rhode Island</div> <div>Blue Cross and Blue Shield of Vermont</div> <div>Boston Medical Center HealthNet Plan</div> <div>Capital Health Plan</div> <div>CareOregon, Inc.</div> <div>Colorado Access</div> <div>DSRIP</div> <div>Family Health Network</div> <div>Florida Health Care Plans</div> <div>Harvard Pilgrim Health Care</div> <div>HealthEdge</div> <div>Health Plan of San Mateo</div> <div>HealthTrio Health Plan</div> <div>HPHC Subscriber DB</div> <div>Humana Puerto Rico</div> <div>Independent Health</div> <div>Johns Hopkins HealthCare LLC</div> <div>Martins Point Health Care, Inc.</div> <div>Pacific Medical Center</div> <div>PaySpan Inc.</div> <div>Rocky Mountain Health Plans</div> <div>San Francisco Health Plan</div> <div>TakeCare</div> <div>Texas Childrens Health Plan</div> <div>The University of Arizona Health Plans</div> <div>Total EHR</div> <div>Total Health Care</div> <div>Tufts Health Public Plans (MA)</div> </div> </div>
-------------	---

Please choose the Health Plan you are registering a provider for.

Health Plan

Texas Childrens Health Plan

Next

User Information

If you are an existing user of the Connect system please login [Click here to start your session.](#)

First Name *

Middle Initial

Last Name *

Title *

E-Mail *

Confirm E-Mail *

Office Phone *

Example: (555) 555-5555

Extension #

Example: 123456

Office Fax *

Example: (555) 555-5555

User Name *

Password *

Confirm Password *

Security Question 1 *

Security Answer 1 *

Your answer may not contain your username.

Security Question 2 *

Security Answer 2 *

Your answer may not contain your username.

Security Question 3 *

Security Answer 3 *

Your answer may not contain your username.

Local Admin

☒

As the primary registrant, you are automatically a local admin

Cancel

Back

Next

Search for your provider office

Search For

Search By

Search Text

Search

Cancel

Back

Next

Search for your provider office

Search For

Search By

Search Text

Search

Provider Office Search Results

Name	Office Address
<input type="radio"/> TCP - After Hours The Woodlands	1011 Medical Plaza Dr #220, The Woodlands, TX 77380
<input type="radio"/> TCP - Barker Cypress	9925 Barker Cypress Road, Ste. 200, None, Cypress, TX 77433
<input type="radio"/> TCP - Barker Cypress	9925 Barker Cypress Road, Ste. 200, None, Cypress, TX 77433
<input type="radio"/> TCP - Behavioral Wellness	7515 S Main St #220, None, Houston, TX 77030
<input type="radio"/> TCP - Cypress	13203 Fry Rd #600, None, Cypress, TX 77433
<input type="radio"/> TCP - Cypress	13203 Fry Rd #600, None, Cypress, TX 77433
<input type="radio"/> TCP - Dr. Leass	1011 Medical Plaza Drive, Ste. 100, None, Spring, TX 77380
<input type="radio"/> TCP - Dr. Leass	1011 Medical Plaza Drive, Ste. 100, None, Spring, TX 77380
<input type="radio"/> TCP - East	13018 Woodforest Blvd., Ste. A, None, Houston, TX 77015
<input type="radio"/> TCP - East	13018 Woodforest Blvd., Ste. A, None, Houston, TX 77015
1 - 10 of 209 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 ≥	

☐ My office is not listed *

Cancel

Back

Next

Adding additional users

Step 1

Once you complete your registration, you can register additional users. If you are going to add additional users, click **Yes**, then click the **Next** button. If not, click **No** and click the **Next** button.

Register Additional Users

Would you like to add additional users to your registration?

Yes *

☐

No *

☐

Cancel

Back

Next

Step 2

Once you complete the form for additional users, click **Local Admin** if you want a user to have the same administrative rights to add or delete users and manage roles. Click **Add User**. If you want to continue to add users, repeat this step. Once you have added all additional users, click the **Next** button.

Additional User Information

First Name *

Middle Initial

Last Name *

Title *

E-Mail *

Confirm E-Mail *

Office Phone *

Example: (555) 555-5555

Extension #

Example: 123456

Office Fax *

Example: (555) 555-5555

Clear

Add User

Cancel

Back

Next

Additional User Information

First Name *	<input type="text"/>
Middle Initial	<input type="text"/>
Last Name *	<input type="text"/>
Title *	<input type="text"/>
E-Mail *	<input type="text"/>
Confirm E-Mail *	<input type="text"/>
Office Phone *	<input type="text"/> <small>Example: (555) 555-5555</small>
Extension #	<input type="text"/> <small>Example: 123456</small>
Office Fax *	<input type="text"/> <small>Example: (555) 555-5555</small>

[Clear](#)[Add User](#)

New Additional Users:

[▶ Test3. Provider](#)[\[edit , delete \]](#)[Cancel](#)[Back](#)[Next](#)

After adding additional users, the registration process confirms the additional users by displaying their names under the Additional Users section.

*NOTE: Local administrators can select their username/password.
All other users are assigned system-generated usernames and temporary passwords.*

Step 3

Once you have completed entering additional users, you will receive a Registration Summary. If any information is incorrect, click the **Back** or **Cancel** button. If all the information is correct, click the **Finish** button.

Registration Summary

Office Contact Info:

[edit]

▶ [TCP - Behavioral Wellness](#)

Practices Represented:

[edit]

▶ [TCP - Behavioral Wellness](#)

User Information:

[edit]

▶ [Test, Provider](#)

Cancel

Back

Finish

You will receive **User IDs** and **User Types** for each added user. Click **Next**.

Registration Created

Below are the users that have been created for your registration. Please take note of the User IDs since they will be needed to log into the application.

Name	User ID	User Type
Test, Provider	pctest1	Provider Contact

Next

Registration Complete

Thank you. Your registration with Texas Children's Health Plan is now complete.

Are there any additional health plans that you would like to register for?

Yes ☐

No ☐

Next

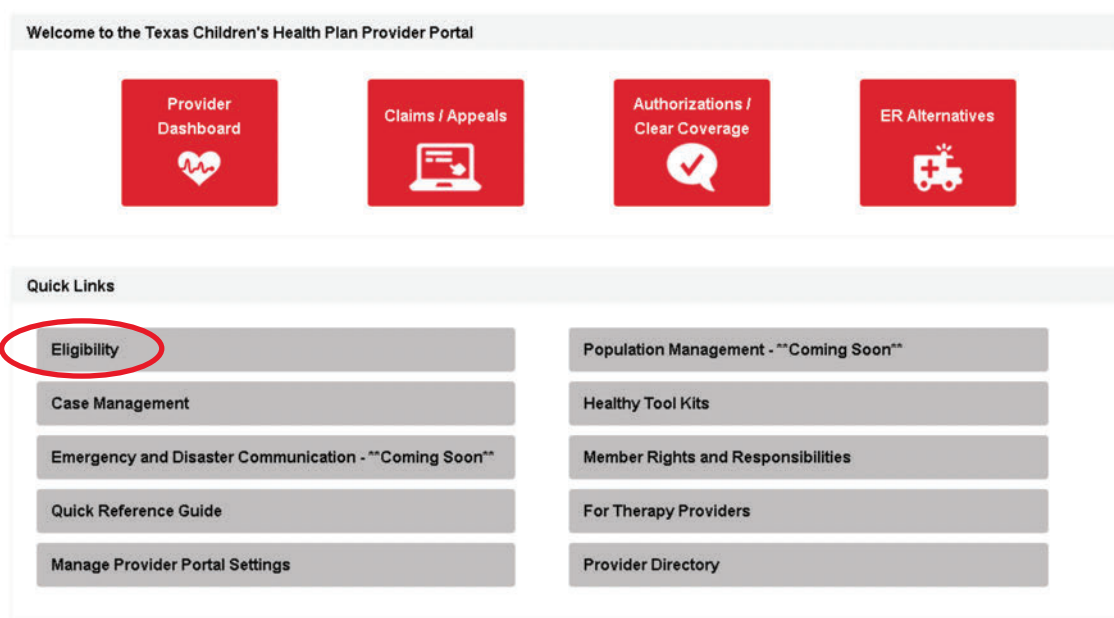
Once registration is complete, you will receive a confirmation e-mail. The Health Plan will approve registrations as soon as possible. You will then need to login to the Provider Portal using your username and temporary password assigned by The Health Plan. You will be prompted to create a new password.

Eligibility

The Provider Portal allows you to verify eligibility and copay information for your Texas Children's Health Plan patients. Below are some simple steps to get you started.

Step 1

Click on the **Eligibility** button under the *Quick Links* section of Provider Portal Homepage.



The eligibility search feature allows you to search for a patient by any of the following:

- Last name, member ID or SSN (required)
- Date of birth (required)
- PCP
- Effective “as of”
- Gender
- Age

Step 2

Complete the fields and then click the **Search** button. The eligibility search results screen displays the member name, gender, effective dates, date of birth, member ID, if an EPSDT is needed, and PCP. (For best results, use only the Last Name, Member ID or Social Security Number and the Birth Date).

Eligibility Search

Conduct Eligibility Search

☐ Last Name
 ☒ Member ID
 ☐ Social Security Number

Patient

(ID Example - HP555555,HP444444)

PCP

Search Filters

As of 

Birth Date

(MM/DD/YYYY)

Gender

Age

NOTE: You must enter a date of birth using one of the following examples: 05/25/2008, or 05/25/08. Last name search can be partial (at least first 2 letters of last name), while the SSN and member ID must be exact. To view newborn eligibility, enter the member's ID number and type "NB" after the number.

Eligibility Search Results

	Name	Sex	Effective Dates	Birth Date	Member ID	Primary Care Provider	EPSDT
<input type="button" value="Select"/>	██████████	M	1 Nov 2018- 31 Dec 2078	██████	██████	██████	

Step 3

For eligibility detail, click on the member name.

The **Eligibility Detail** screen will display The Health Plan member information including name, date of birth, sex, member ID, PCP, address, and phone number. Benefit copay information will also be displayed. If the effective date is red, the member is inactive.

STAR Kids members also have their MDCP waiver information populated when you click on the members name to display the eligibility detail. MDCP waiver information is located under Benefit Plan Information.

You can click on the **Print** icon to print the eligibility detail. Benefit information will display copays. The Coordination of Benefits (COB) will be listed under the **Additional Information** link.

Click **Back to Search** to return to the **Eligibility Detail** page.

You can click on the **View History** icon to see all previous eligibility segments.

Eligibility History For [REDACTED] (820524734)

Effective Dates	PCP	Product
01 Nov 2018 - 31 Dec 2078	[REDACTED]	CHIP
01 Nov 2017 - 30 Sep 2018	[REDACTED]	STAR
01 Jan 2017 - 30 Sep 2017	[REDACTED]	CHIP
01 May 2015 - 29 Feb 2016	[REDACTED]	STAR
01 Dec 2011 - 28 Feb 2013	[REDACTED]	STAR
01 Nov 2010 - 31 Aug 2011	[REDACTED]	STAR
01 Jun 2009 - 31 Aug 2010	[REDACTED]	STAR
01 Dec 2008 - 28 Feb 2009	[REDACTED]	STAR

EPSDT visit alert

We have a feature that alerts you when a member's EPSDT visit is due. The EPSDT alert is shown on the **Eligibility Detail** page.

ALERT EPSDT - NEW 90 DAY VISIT DUE

 [Print](#)  [View History](#)

[Help](#) 

Eligibility Detail as of 16 Jul 2019

Patient Information

Name

Sex Male

Member ID

Address

[Map](#) ----> [Driving Directions](#)

Birth Date

PCP CHRISTUS FAMILY PRACTICE CENTER-JASPER

Phone

Benefit Information

Benefit Description	Copay
Emergency Room	\$0.00
Inpatient Visit	\$0.00
Office Visit	\$0.00

Locating a STAR Kids Service Coordinator

STAR Kids members are assigned a Service Coordinator to assist in coordination of care. To locate the Service Coordinator, begin by clicking on the **Eligibility** screen.

Step 1

Enter the **Member ID** and the **Birth Date** using the format of MM/DD/YYYY. The member eligibility will be shown. Click on the **Member Name**.

Step 2

Scroll to the bottom of the eligibility information. Under **Additional Information**, the Service Coordinator's name and phone number will be listed.

Additional Information

Service Coordinator Name: - MSW, Phone Number: or - is the alternate insurance carrier on record.

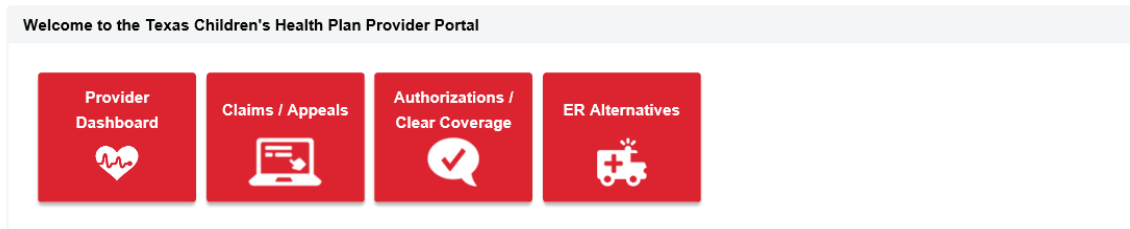
[Select](#)

Claims

Checking the status of a claim has never been easier. Follow the steps below to get started.

Step 1

Click on the **Claims/Appeals** button.



You will see three tabs on the Claims/Appeals screen: **Claims Status Search**, **Remittance Advice Search** and **Add Claim for Single Claim Submission**.

Under the **Claims Status** tab, you can search for a claim by any of the following:

- Claim number (partial search)
- Date of service
- Patient information
 - Last name (partial search)
 - Member ID
 - SSN
 - Patient account number
- Provider information
 - Last name (partial search)
 - Tax ID
 - NPI
- Bill type
- Status (Paid, Pending, Denied)

Claim Status Search

Claim Number

Date of Service To

☒ Last Name
 ☐ Member ID
 ☐ Social Security Number
 ☐ Patient Account Number

(Patient List)

Patient (Last Name Example - Smith, John)
 (ID Example - HP5555555,HP4444444)
 (SSN Example - 555-55-5555, 444-44-444)
 (Medicaid ID Example - AA55555,AA44444)
 (Medicare ID Example - 5555555,4444444)

☒ Last Name
 ☐ Provider Tax ID
 ☐ Provider NPI

Provider

NOTE: A patient's account number will only be searchable if submitted on the claim. User can only view claims for providers associated with the Tax ID based on the user's access list.

Step 2

Complete the fields and click the **Search** button. A **Claim Status Search Results** screen will appear. You will see a link for the claim numbers, status, patient name, patient account number, DOS, provider name, total charged, and total paid.

Provider

Bill Type

☐ Status
 ☒ Paid
 ☒ Pended
 ☒ Denied
 ☒ Submitted

► Indicates non-standard HIPAA data element

Step 3

Click on the claim number to see the Claim Status details.

Claim Status Detail for 19128E19289

Claim Level Information

Provider	Blue Cross of Texas	Practice	Blue Cross of Texas
Patient	19128E19289	Patient Account No.	19128E19289
Bill Type	001		
► Ref/Auth Number	1846341		
► Referring Provider			
► Diagnosis			

Service Line Information

Line	Status	Check/EFT Number	Payment Date	DOS	Procedure	Modifier	Units	Billed Amount	► Allowed Amount	► Co-Payment
001	Finalized/Payment	1846341	9 May 2019	3 May 2019	0431	GO XE U5	2	\$108.00	\$57.38	\$0.00
Totals								\$108.00	\$57.38	\$0.00

NOTE: Clicking on the Check/EFT Number will open the Remittance Advice tab.

Claims Remittance

Step 1

To search for a claim remittance, click on the **Claims** button under the **Office Management** section of the Provider Portal or the **View My Claims** link on the homepage. You will see two tabs on the **Claims** screen: one for **Claims Status** search and one for **Remittance Advice** search.

Claim Status
Remittance Advice
Add Claim

Remittance Advice

By Provider

Select Provider ▼

By Tax ID

By Patient

SELECT PATIENT

By Patient Account Number

By Remittance Advice

Check Number ▼

By Date

Check Date ▼

From:

To:

Search

Clear

Under the **Remittance Advice** tab, you can search by any of the following:

- Provider information
 - Last name (partial search)
 - Tax ID/TIN
 - NPI
- Patient information
 - Last name (partial search)
 - SSN
 - Member ID
 - Patient account number
- Check number
- Claim number
- Check date
- Date of service

Step 2

Complete the fields and then click the **Search** button. The **Remittance Advice Search Results** screen will appear.

Step 3

Click on the check. The **Remittance Advice Detail** screen will appear. This screen consists of two sections: the **Check Detail** section and the **Claims Detail** section.

Claim Status

Remittance Advice

Add Claim

Remittance Advice Detail for Check Number 1846341. Total Claims Paid: 10

Check Date	Total Paid	Payor	Vendor Name	Vendor Address	Tax ID	Vendor NPI
9 May 2019	\$1137.41	Texas Children's Health Plan	TEXAS CHILDREN'S HEALTH PLAN	1500 PRAIRIE AVENUE, FLOOR 100 HOUSTON, TX 77030	76001234	1234567890

Send X12-835 to Document Manager

RA Report

Selected Claim Number **19128E19289**

Provider	Patient	Patient Account Number	Member ID Number
TEXAS CHILDREN'S HEALTH PLAN	1234567890	1234567890	1234567890

Code Lookup

The Code Lookup feature allows you to enter a code and view code explanations.

Step 1

Click on the **Claims/Appeals** button then **Code Lookup** button.

Step 2

Enter a Diagnosis Code, Procedure Code, or Modifier Code. You will receive an explanation for the code you entered.

Code Search

Search ☒ Diagnosis ☐ Procedure ☐ Modifier

Diagnosis Code Search

Search ☒ Diagnosis ☐ Procedure ☐ Modifier

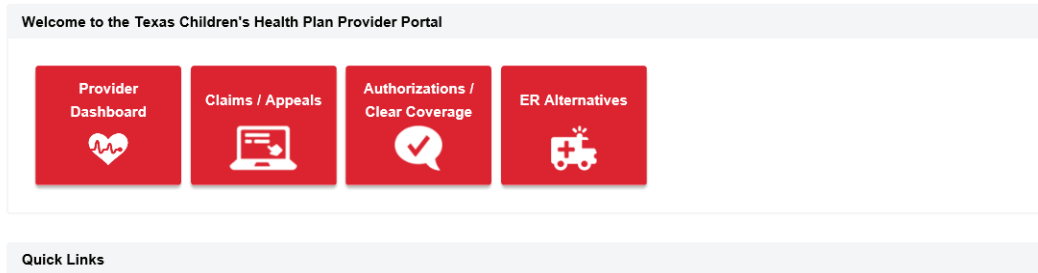
Search Results

Code Set	Code	Description
ICD-10-CM	V34.0	Driver of three-wheeled motor vehicle injured in collision with heavy transport vehicle or bus in nontraffic accident
ICD-10-CM	V34.0XXA	Driver of three-wheeled motor vehicle injured in collision with heavy transport vehicle or bus in nontraffic accident, initial encounter
ICD-10-CM	V34.0XXS	Driver of three-wheeled motor vehicle injured in collision with heavy transport vehicle or bus in nontraffic accident, sequela
ICD-10-CM	V34.0XXD	Driver of three-wheeled motor vehicle injured in collision with heavy transport vehicle or bus in nontraffic accident, subsequent encounter

Individual Claim Submission

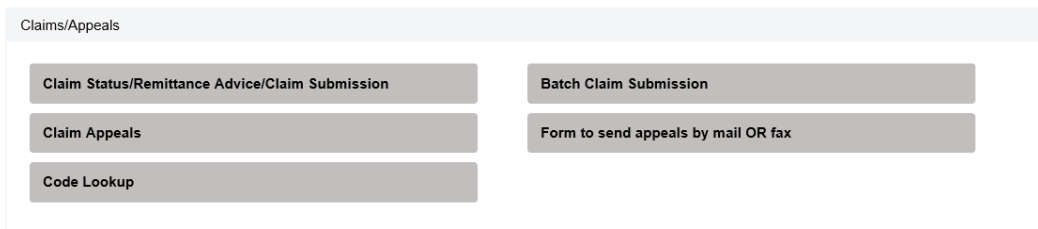
Step 1

Click on the **Claims/Appeals** menu under the *Quick Links* menu.



Step 2

To enter a new individual claim, click on the **Claim Status/Remittance Advice/Claim Submission** button. Select **Claim Submission**.



Step 3

Search for the patient by Last Name, Member ID, or Medicaid ID. Click the **Select** button (circled below in red) to begin entering an individual claim.

If the effective dates appear in red, the member is
terminated.

Eligibility information is updated every 15 minutes
from 7 a.m. to 7 p.m. Monday to Friday

[Return to Previous Page](#)

Pages: (1) Results: 1

Eligibility Search Results

[Help](#) 

Name	Sex	Effective Dates	Birth Date	Member ID	Primary Care Provider	EPSDT
Select						

Step 4

Create **Professional Services Claim**: Enter information into all required fields.

Create Professional Services Claim

[Help](#)

Patient Information

Patient Name	<input type="text"/>	Patient Account	<input type="text"/>
Relationship	<input type="text"/>	Member ID	<input type="text"/>
Address	<input type="text"/>	City	<input type="text"/>
State, Zip	<input type="text"/>	Home Phone	<input type="text"/>
Date of Birth	<input type="text"/>	Gender	<input type="text"/>
Release of Information	<input type="text" value="-Select-"/>	Amount Paid by Patient	<input type="text"/>

Patient Condition Related To

Related Causes ☐ Auto Accident ☐ Employment ☐ Other

Accident Location -or-

Date of Current Illness or LMP

Accident Date

Admit Date

Discharge Date

EPSDT Referral

EPSDT Condition Indicator ☐ AV ☐ ST ☐ S2

Rendering Provider

☒ Name ☐ Provider NPI

Rendering Provider

Rendering Provider Tax ID

Practice Name

Billing Provider

Billing Provider Tax ID

Provider Taxonomy Code

Provider Signature on File

Provider Accept Assignment



DIAGNOSIS: Enter at least two characters to populate a list of DX Codes.
Dx Code format: **xxx.xxxx**.

CLAIM NOTE: Any claims information The Health Plan should be aware of can be entered by the Provider.

21

Step 5

Once all the required fields are entered, click **Add Services** (circled below in red).

Claim Note

Claim Note

Services

Add Services

Indicates required field

Step 6

If all required fields are not entered, you will get the following error message detailing the missing fields. Select the **Return** button to return to the previous page to add the missing required information.

Return

Error

Form Error

Pt. Account is a required field.
 Amount Paid by Patient is a required field.
 Provider Name is a required field.
 Rendering Provider Tax ID is a required field.
 Rendering Provider Practice Name is a required field.
 Provider Signature on File is a required field.
 Provider Accepts Assignment is a required field.
 Benefits Assigned is a required field.
 Release of Information is a required field.
 DX Codes is a required field.
 Date of Current Illness or LMP is a required field.
 Billing Provider does not have address information.
 Provider Taxonomy Code must be 10 characters.

Step 7

You will now be allowed to proceed to the next step in Single Claim Submission.

Claim Status **Remittance Advice** **Add Claim**

[Return to Previous Page](#) [Help](#)

Add Service

Patient Information

Patient Name Patient Account No.

Provider Practice

Services

Start Date End Date

Place of Service

Service Facility Location ☐ Name ☐ Provider NPI

Search

Enter at least two characters

Procedure Code

Diagnosis Codes ☐ 1. J00 Acute nasopharyngitis [common cold]

Units Charge

Emergency

Procedure Line Note

NDC Data

[Add](#) [Clear](#)

Indicates required field

Services

Start	End	POS	TOS	Proc	Mod1	Mod2	Mod3	Mod4	Dx	Emergency	Units	Charge
No Services Added.												

[Cancel](#)

[Return to Previous Page](#)

Step 8

Procedure Code Search: Enter at least two characters to populate a list of procedure codes.

Enter at least two characters

Procedure Code

99391 | CPT | Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the

Diagnosis Codes ☐

Units Charge

Emergency

Procedure Line Note

NDC Data

[Add](#) [Clear](#)

Indicates required field

Services

Start	End	POS	TOS	Proc	Mod1	Mod2	Mod3	Mod4	Dx	Emergency	Units	Charge
No Services Added.												

[Cancel](#)

[Return to Previous Page](#)

Step 9

After selection of **Procedure Code**, click on the **Find Modifiers** button.

Step 10

Select from the list of appropriate modifiers. There can be a maximum of 4 modifiers per line item. Please select Modifiers in the correct order for the line item being billed. Click the **Add Modifiers** button (circled below in red) to populate modifiers.

Modifier List

<input type="checkbox"/> 21 Prolonged Evaluation and Management Services CPT_M	<input type="checkbox"/> 23 Unusual Anesthesia CPT_M	<input type="checkbox"/> 24 Unrelated Evaluation and Management Service by Same Physician During a Postoperative Period
<input checked="" type="checkbox"/> 25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service CPT_M	<input type="checkbox"/> 26 Professional Component CPT_M	<input type="checkbox"/> 25 FLT3 (Acute myelogenous leukemia)
<input type="checkbox"/> 32 Mandated Services CPT_M	<input type="checkbox"/> 33 Preventive Service CPT_M	<input type="checkbox"/> 50 Bilateral Procedure
<input type="checkbox"/> 52 Reduced Services CPT_M	<input type="checkbox"/> 79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period CPT_M	<input type="checkbox"/> 95 Synchronous Telemedicine Service Rendered via Time Interactive Audio and Video Telecommunication
<input type="checkbox"/> 99 Multiple Modifiers CPT_M	<input type="checkbox"/> AF Specialty Physician CPT_M	<input type="checkbox"/> AG Primary Physician

Currently Selected Modifiers

25 - Significant, Separ... X

Add Modifiers CANCEL

NDC DATA: Must be submitted in the following format:

N4 | <NDC Code> | <Quantity> | <2 digit unit of measure code> |

Procedure Line Note

NDC Data X

Add **Clear**

Indicates required field

Services

Start	End	POS	TOS	Proc	Mod1	Mod2	Mod3	Mod4	Dx	Emergency	Units	Charge
No Services Added.												

Cancel

[Return to Previous Page](#)

Step 11

Review Claims Detail for final submission. Click **Next** (circled below in red) to proceed.

Services

	Start	End	POS	TOS	Proc	Mod1	Mod2	Mod3	Mod4	Dx	Emergency	Units	Charge
Edit Remove	6/5/2019		49		99391	25				1	N	1 Units	
Edit Remove	6/5/2019		49		90700					1	N	1 Units	
Edit Remove	6/5/2019		49		90460					1	N	1 Units	
Edit Remove	6/5/2019		49		90461					1	N	1 Units	
Edit Remove	6/5/2019		49		90713					1	N	1 Units	
Edit Remove	6/5/2019		49		90460					1	N	1 Units	
Edit Remove	6/5/2019		49		90744					1	N	1 Units	
Next Cancel													

[Return to Previous Page](#)

Step 12

Enter **Patient Information**.

Claim Summary

[Help](#)

Patient Information

Patient Name	<input type="text"/>	Patient Account	<input type="text"/>
Relationship	Self	Member ID	<input type="text"/>
Address	<input type="text"/>	City	<input type="text"/>
State, Zip	<input type="text"/>	Home Phone	<input type="text"/>
Date of Birth	<input type="text"/>	Gender	F
Release of Information	Signed statement/Claims	Amount Paid by Patient	<input type="text"/>

Patient Condition Related To

Related Causes	Accident Location
Accident Date	Date of Current Illness or LMP 5/1/2019
Admit Date	Discharge Date
EPSDT Referral -Select-	EPSDT Condition Indicator

Rendering Provider

Provider Tax ID

Practice Name

Billing Provider Billing Provider Tax ID

Provider Taxonomy Code

Provider Signature on File Yes Provider Accept Assignment Assigned

Benefits Assigned Not Applicable

Pay To Address

Entity Type

Referral and Authorization Information

Prior Auth. No. Referring Physician

Diagnoses

Dx Codes 1. J00 Acute nasopharyngitis [common cold]

Additional Information

[Link Documents](#)

Services

Start	End	POS	TOS	Proc	Mod1	Mod2	Mod3	Mod4	Dx	Emergency	Units	Charge
6/5/2019		49		99391	25				1	N	1 Units	
6/5/2019		49		90700					1	N	1 Units	
National Drug Code Data: N4[58160081052].5[ML]												
6/5/2019		49		90460					1	N	1 Units	
6/5/2019		49		90744					1	N	1 Units	
National Drug Code Data: N4[58160081052].5[ML]												

Total Charges

Submit

Cancel

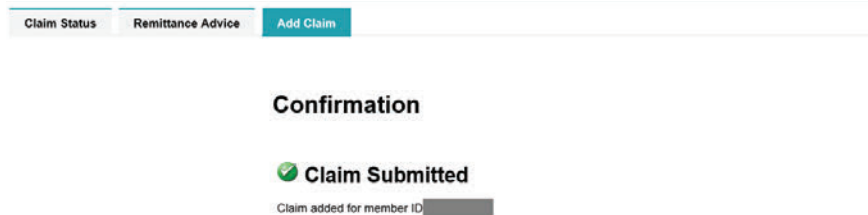
► Indicates non-standard HIPAA data element

Step 12

Submit claim by clicking the **Submit** button.

Step 13

The **Claim Submitted Confirmation** screen will be displayed.



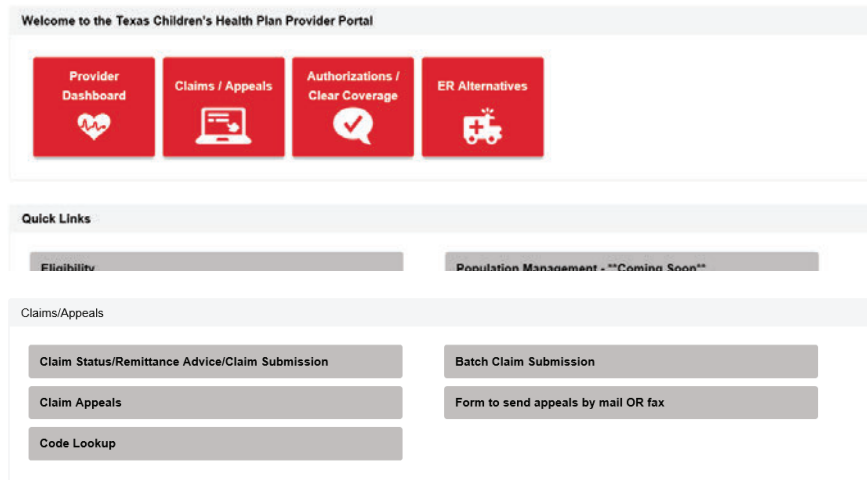
Batch Claims Submittal

Step 1

Perform an export of the claims to be submitted from your Claims Billing System. The accepted file formats are “837 Institutional” or “837 Professional”. Please save the file to your computer or on your computer network. The file name and its location is required for Step 4.

Step 2

Select the **Batch Claims Submission** menu option from the **Claims/Appeals** menu.



Batch Claims Submittal

The Batch Claims Submission process allows providers to submit standard 837 professional and institutional files, exported from their claims billing systems, to TCHP for processing. Only standard 837 professional and institutional files will be accepted. To submit a batch of claims, use the fields and buttons below. First, choose the appropriate claim type of institutional or Professional extension from the "Select" dropdown. Then click the "Choose File" or "Browse" button and find the file you wish to upload. Once you found your file, select it and click the "Open" button. Repeat the process for each file. Once you've selected all the files you wish to upload, click on the "Upload" button.

If further information is needed, please use the following links for assistance:

- [Institutional Companion Guide](#)
- [Professional Companion Guide](#)

Please note, that even though the claims submitted to TCHP will be loaded the next business day, it may take up to 48 hours before the claims status is viewable in Provider TouchPoint.

Step 3

Select the appropriate **Claim Type** for each file to be uploaded. Each file can only contain one type of claim.

Batch Claims Submittal

The Batch Claims Submission process allows providers to submit standard 837 professional and institutional files, exported from their claims billing systems, to TCHP for processing. Only standard 837 professional and institutional files will be accepted. To submit a batch of claims, use the fields and buttons below. First, choose the appropriate claim type of Institutional or Professional extension from the "Select" dropdown. Then click the "Choose File" or "Browse" button and find the file you wish to upload. Once you found your file, select it and click the "Open" button. Repeat the process for each file. Once you've selected all the files you wish to upload, click on the "Upload" button.

If further information is needed, please use the following links for assistance:

- [Institutional Companion Guide](#)
- [Professional Companion Guide](#)

Please note, that even though the claims submitted to TCHP will be loaded the next business day, it may take up to 48 hours before the claims status is viewable in Provider TouCHPoint.

* Required

Claim Type	Select a file
Attachment 1	<div> <div> --Select-- Institutional Professional </div> <div> Browse... </div> </div>
Attachment 2	<div> <div> --Select-- </div> <div> Browse... </div> </div>
Attachment 3	<div> <div> --Select-- </div> <div> Browse... </div> </div>
Attachment 4	<div> <div> --Select-- </div> <div> Browse... </div> </div>
Attachment 5	<div> <div> --Select-- </div> <div> Browse... </div> </div>

Step 4

Click the **Choose File** or **Browse** button (depending on your browser), and browse to the location of where the exported claim files were saved (from Step 1). Institutional and professional claims can be uploaded in separate files, but as part of the same upload.

Batch Claims Submittal

The Batch Claims Submission process allows providers to submit standard 837 professional and institutional files, exported from their claims billing systems, to TCHP for processing. Only standard 837 professional and institutional files will be accepted. To submit a batch of claims, use the fields and buttons below. First, choose the appropriate claim type of Institutional or Professional extension from the "Select" dropdown. Then click the "Choose File" or "Browse" button and find the file you wish to upload. Once you found your file, select it and click the "Open" button. Repeat the process for each file. Once you've selected all the files you wish to upload, click on the "Upload" button.

If further information is needed, please use the following links for assistance:

- [Institutional Companion Guide](#)
- [Professional Companion Guide](#)

Please note, that even though the claims submitted to TCHP will be loaded the next business day, it may take up to 48 hours before the claims status is viewable in Provider TouCHPoint.

* Required

Claim Type	Select a file
Attachment 1	<div> <div> Professional </div> <div> C:\Users\... Browse... </div> </div>
Attachment 2	<div> <div> --Select-- </div> <div> Browse... </div> </div>
Attachment 3	<div> <div> --Select-- </div> <div> Browse... </div> </div>
Attachment 4	<div> <div> --Select-- </div> <div> Browse... </div> </div>
Attachment 5	<div> <div> --Select-- </div> <div> Browse... </div> </div>

Step 5

Clicking the **Upload** button will upload the claims. Successful uploads will result in a message stating the number of files uploaded successfully, and the current date.

Batch Claims Submittal

The Batch Claims Submission process allows providers to submit standard 837 professional and institutional files, exported from their claims billing systems, to TCHP for processing. Only standard 837 professional and institutional files will be accepted. To submit a batch of claims, use the fields and buttons below. First, choose the appropriate claim type of institutional or Professional extension from the "Select" dropdown. Then click the "Choose File" or "Browse" button and find the file you wish to upload. Once you found your file, select it and click the "Open" button. Repeat the process for each file. Once you've selected all the files you wish to upload, click on the "Upload" button.

If further information is needed, please use the following links for assistance:

- [Institutional Companion Guide](#)
- [Professional Companion Guide](#)

Please note, that even though the claims submitted to TCHP will be loaded the next business day, it may take up to 48 hours before the claims status is viewable in Provider TouchPoint.

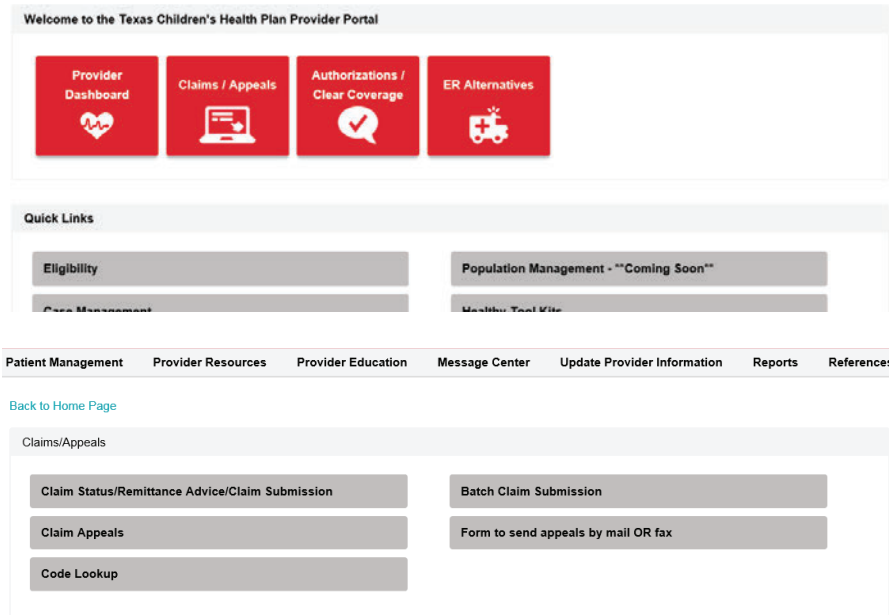
* Required
1 file(s) uploaded successfully on 06/07/2019.
0 file(s) failed to upload.

Claim Type	Select a file
* Attachment 1	<div> <div>---Select---</div> <div>Browse...</div> </div>
Attachment 2	<div> <div>---Select---</div> <div>Browse...</div> </div>
Attachment 3	<div> <div>---Select---</div> <div>Browse...</div> </div>
Attachment 4	<div> <div>---Select---</div> <div>Browse...</div> </div>

Claim Appeals

Step 1

Click on the **Claims/Appeals** menu to enter a Claim Appeal.



Welcome to the Texas Children's Health Plan Provider Portal

Provider Dashboard | Claims / Appeals | Authorizations / Clear Coverage | ER Alternatives

Quick Links

Eligibility | Population Management - **Coming Soon**

Patient Management | Provider Resources | Provider Education | Message Center | Update Provider Information | Reports | References

[Back to Home Page](#)

Claims/Appeals

Claim Status/Remittance Advice/Claim Submission | Batch Claim Submission

Claim Appeals | Form to send appeals by mail OR fax

Code Lookup

Step 2

Enter the **Claim ID**, **Member ID**, and **National Provider ID** associated with the claim being appealed.

Claims Appeals

To submit the appeal, use the fields and buttons below. First, enter the Claim ID into the Claim ID field and tab out of the claim field. The NPI and Member ID will auto-populate into their corresponding fields. The Provider Name, Member Name and Member's DOB will appear.

At least one reason for appeal must be selected.

For any supporting documents you wish to upload, click the "Choose File" or "Browse" button and find the file. Once you have found your file, select it and click the "Open" button. Repeat the process for each file. Once you've selected all the files you wish to upload and filled in the Required fields, click on the "Submit" button.

To view the statuses of your appeals, please click the following [Provider Claims Appeal Report](#)

Please ensure the supporting documentation is attached.

Please allow 15 minutes for the appeal to be submitted to TCHP.

* Required

* Claim ID

* Member ID

* National Provider ID

* Reason for Appeal 1

Reason for Appeal 2

Reason for Appeal 3

Please allow 15 minutes for the appeal to be submitted to TCHP.

* Required

* Claim ID

* Member ID

* National Provider ID

* Reason for Appeal 1

Reason for Appeal 2

Reason for Appeal 3

Please ensure the supporting documentation is attached.

Attachment 1

Attachment 2

Attachment 3

Comment

300 character(s) left.

* Required

* Claim ID

Valid Claim ID.

* Member ID

* National Provider ID

* Reason for Appeal 1

Reason for Appeal 2

Reason for Appeal 3

Please ensure the supporting documentation is attached.

Attachment 1

Attachment 2

Attachment 3

Comment

300 character(s) left.

* Required

* Claim ID

* Member ID

* National Provider ID

* Reason for Appeal 1
--- Select ---

Reason for Appeal 2
▼

Reason for Appeal 3
▼

Please ensure the supporting documentation is attached.

Attachment 1
 Browse...

Attachment 2
 Browse...

Attachment 3
 Browse...

Comment

300 character(s) left.

Please ensure that the NPI, Member ID and Claim ID fields are filled out.

Submit

Step 3

Click the **Validate** button to display the Provider Name, Member Name, and date of birth.

* Required

* Claim ID

The Claim ID you entered could not be found.

* Member ID

The Member ID you entered could not be found.

* National Provider ID

* Reason for Appeal 1
--- Select ---

Reason for Appeal 2
▼

Reason for Appeal 3
▼

Please ensure the supporting documentation is attached.

Attachment 1
 Browse...

Attachment 2
 Browse...

Attachment 3
 Browse...

Comment

300 character(s) left.

Step 4

User can add an attachment or include information related to the appeal in the comment field. There is a 300 character limit. An attachment is not required to submit an appeal.

Claims Appeals

To submit the appeal, use the fields and buttons below. First, enter the Claim ID into the Claim ID field and tab out of the claim field. The NPI and Member ID will auto-populate into their corresponding fields. The Provider Name, Member Name and Member's DOB will appear.

At least one reason for appeal must be selected.

For any supporting documents you wish to upload, click the "Choose File" or "Browse" button and find the file. Once you have found your file, select it and click the "Open" button. Repeat the process for each file. Once you've selected all the files you wish to upload and filled in the Required fields, click on the "Submit" button.

To view the statuses of your appeals, please click the following [Provider Claims Appeal Report](#)

Please ensure the supporting documentation is attached.

Please allow 15 minutes for the appeal to be submitted to TCHP.

* Required

* Claim ID

* Member ID

* National Provider ID

* Reason for Appeal 1

Reason for Appeal 2

Reason for Appeal 3

Please allow 15 minutes for the appeal to be submitted to TCHP.

* Required

* Claim ID

* Member ID

* National Provider ID

* Reason for Appeal 1

Reason for Appeal 2

Reason for Appeal 3

Please ensure the supporting documentation is attached.

Attachment 1

Attachment 2

Attachment 3

Comment

300 character(s) left.

Submit

Step 5

Once all the required fields are entered, clicking the **Submit** button will confirm the Claim Appeal has been submitted and you will receive a Claim Appeal tracking number that begins with the prefix CA_.

You may now enter the next Claim Appeal.

* Required

* Claim ID

* Member ID

* National Provider ID

* Reason for Appeal 1
--- Select ---

Reason for Appeal 2
▼

Reason for Appeal 3
▼

Please ensure the supporting documentation is attached.

Attachment 1 Browse...

Attachment 2 Browse...

Attachment 3 Browse...

Comment

300 character(s) left.

Please ensure that the NPI, Member ID and Claim ID fields are filled out.

Submit

* Reason for Appeal 1
--- Select ---

Reason for Appeal 2
▼

Reason for Appeal 3
▼

Please ensure the supporting documentation is attached.

Attachment 1 Browse...

Attachment 2 Browse...

Attachment 3 Browse...

Comment

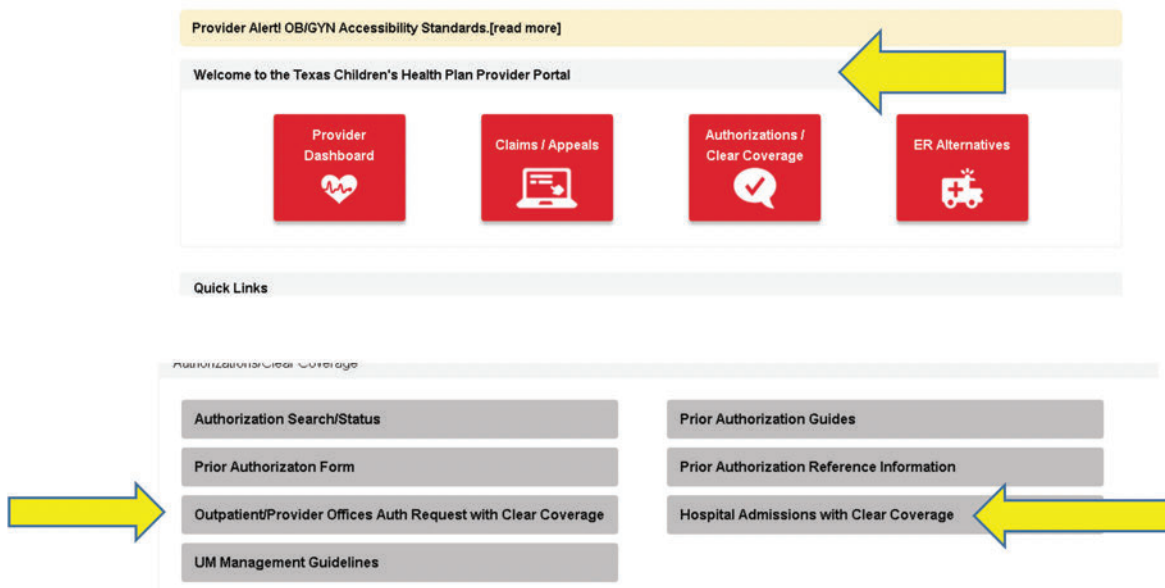
300 character(s) left.

→ Your Claim Appeal has been successfully submitted for Claim ID Your Claim Appeal Tracking Number is CA_36953383558861562

Submit

Authorizations

Authorizations may be requested by Clear Coverage™, which is located in the **Authorizations/Clear Coverage** menu. **Inpatient Hospital Admissions** and **Outpatient/Provider** offices are listed separately.



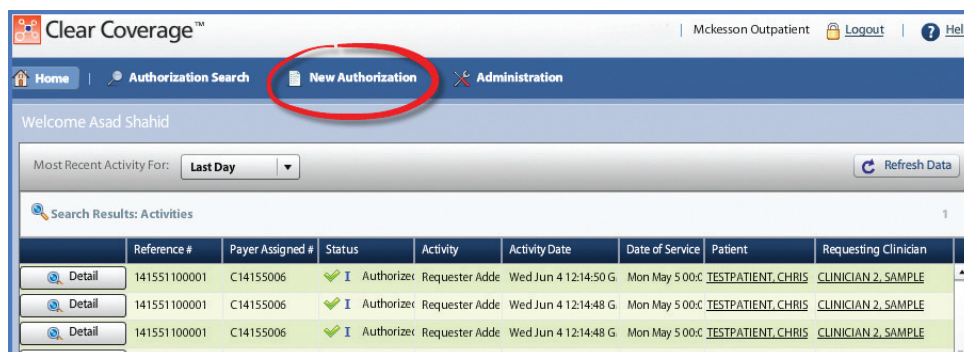


Creating an Outpatient Authorization Request

Authorization Request Workflow

Steps	Description
1. Find the Patient	Identifies the patient that requires this service.
2. Select the Requesting Clinician	Identifies the provider requesting this service.
3. Add Diagnosis (ICD-10) code(s)	Indicates the primary diagnosis(es) for this patient.
4. Select the procedure or service	Indicates which service(s) the patient needs (for example, Genetic Testing, Bariatric Surgery, Wheelchair).
5. Add Service Information	Provides information such as answers to questions that determine medical necessity of the service and indicates the facility where this service will be performed.
6. Add Additional Notes	Provides additional information about the case.

Click **New Authorization** to access the authorization workflow.



MCKESSON

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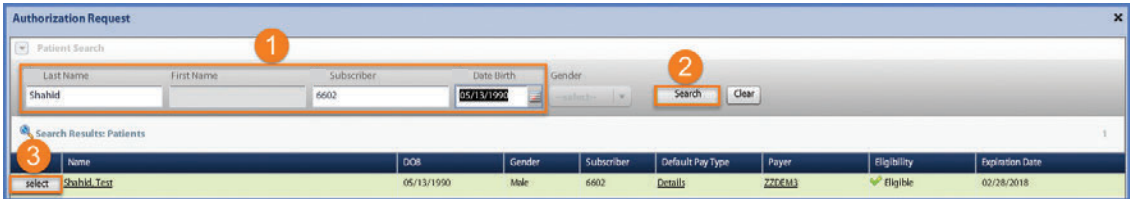
Creating an Outpatient Authorization Request

Step 1: Find the Patient

Creating an **Authorization Request** starts with finding the patient.

You find a patient by entering information such as the subscriber ID or the patient's first and last name in the search fields.

1. Enter search criteria in the required fields.
2. Click **Search** or press the Enter key.
3. Click **Select** next to the patient name.

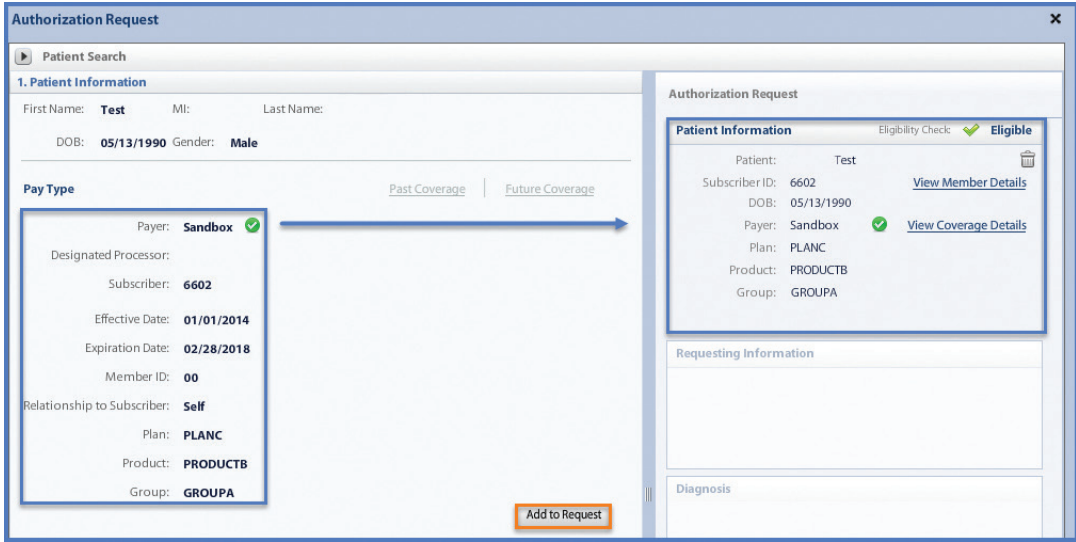


Name	DOB	Gender	Subscriber	Default Pay Type	Payer	Eligibility	Expiration Date
Shahid, Test	05/13/1990	Male	6602	Details	ZZZ(EM)	✓ Eligible	02/28/2018

Verify the Patient Information

1. Verify the patient's health plan information, then click **Add to Request**.

The Patient Information is added to the Authorization Request summary, and Clear Coverage™ advances to the Requesting Information accordion.



1. Patient Information

First Name: **Test** MI: Last Name:

DOB: **05/13/1990** Gender: **Male**

Pay Type

Payer: **Sandbox** ✓

Designated Processor:

Subscriber: **6602**

Effective Date: **01/01/2014**

Expiration Date: **02/28/2018**

Member ID: **00**

Relationship to Subscriber: **Self**

Plan: **PLANC**

Product: **PRODUCTB**

Group: **GROUPA**

Add to Request

Authorization Request

Patient Information Eligibility Check: ✓ **Eligible**

Patient: **Test** [View Member Details](#)

Subscriber ID: **6602**

DOB: **05/13/1990**

Payer: **Sandbox** ✓ [View Coverage Details](#)

Plan: **PLANC**

Product: **PRODUCTB**

Group: **GROUPA**

Requesting Information

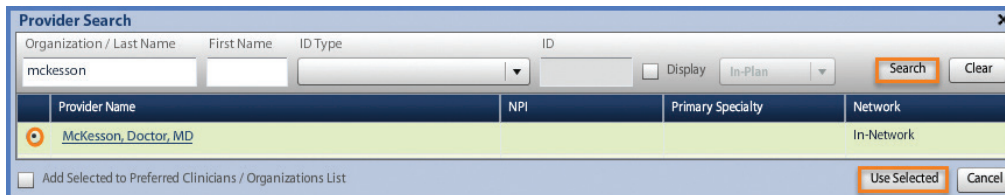
Diagnosis

Creating an Outpatient Authorization Request

Step 2: Select a Requesting Provider/PCP

1. Enter the **Date of Service** by clicking the calendar icon and selecting a date.
2. The **Facility Name** automatically defaults to the facility you are logged into.
3. Click the **Requesting Clinician** drop-down list and select the provider requesting the Authorization.
 - a. If the Requesting Clinician drop-down list is blank or if you want to select a different provider, click **Select Other Clinician**. In the Provider Search, enter a name in the Last Name field and click **Search**. Once you locate the provider, click **Use Selected** (as shown below).
 - b. You have the option to select the Add Selected to Preferred Clinicians/Organizations List check box to add the selected provider to the Requesting Clinician drop-down list for future authorizations.
4. Click **Add to Request**.

The Requesting Information is added to the Authorization Request summary and Clear Coverage advances to the Diagnosis accordion.



The Provider Search dialog box contains the following fields and controls:

- Organization / Last Name: mckesson
- First Name: (empty)
- ID Type: (dropdown menu)
- ID: (empty)
- Display: (checkbox)
- In-Plan: (dropdown menu)
- Search: (button)
- Clear: (button)

Provider Name	NPI	Primary Specialty	Network
McKesson, Doctor, MD			In-Network

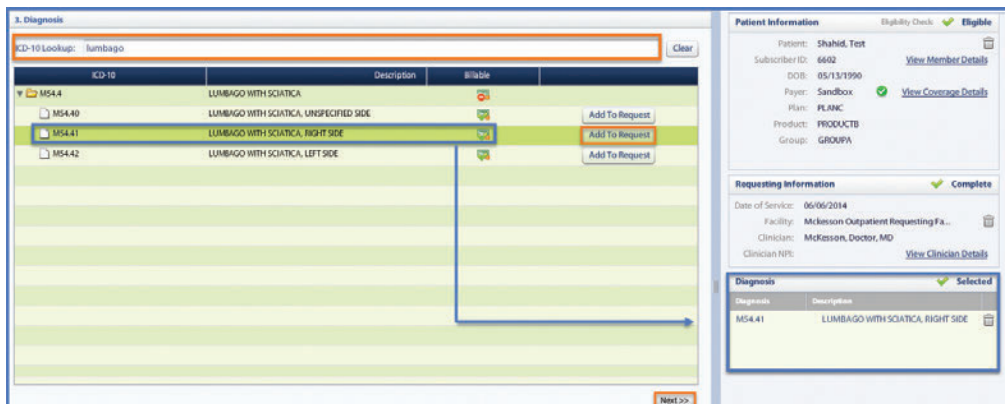
At the bottom, there is a checkbox for "Add Selected to Preferred Clinicians / Organizations List" and buttons for "Use Selected" and "Cancel".

Step 3: Select a Diagnosis

The Diagnosis accordion enables you to choose one or more diagnoses that are appropriate for the service for which you are requesting authorization.

1. Search for the diagnosis by entering one of the following in the ICD Lookup:
 - a. Part of the clinical diagnosis description (for example, "lumbago")
 - b. ICD-10 code (for example, "M54.41" for lumbago)
2. When you find the appropriate diagnosis code, click **Add to Request** next to the diagnosis.
3. Repeat steps 1-2 to include additional diagnoses, if necessary.
4. Click **Next**.

The Diagnosis(es) is added to the Authorization Request summary and Clear Coverage advances to the Service accordion.



The interface shows the "3. Diagnosis" section with an "ICD-10 Lookup" field containing "lumbago". Below the search bar is a table of results:

ICD-10	Description	Billable	Add To Request
M54.4	LUMBAGO WITH SCIATICA		
M54.40	LUMBAGO WITH SCIATICA, UNSPECIFIED SIDE		Add To Request
M54.41	LUMBAGO WITH SCIATICA, RIGHT SIDE		Add To Request
M54.42	LUMBAGO WITH SCIATICA, LEFT SIDE		Add To Request

On the right, the "Patient Information" section shows details for Shahid, Tera, including Subscriber ID, DOB, Payer, Plan, Product, and Group. Below this, the "Requesting Information" section shows the Date of Service (06/06/2014), Facility (McKesson Outpatient Requesting Fa...), and Clinician (McKesson, Doctor, MD). At the bottom, the "Diagnosis" section shows the selected diagnosis: M54.41 LUMBAGO WITH SCIATICA, RIGHT SIDE.

Creating an Outpatient Authorization Request

Step 4: Select a Service

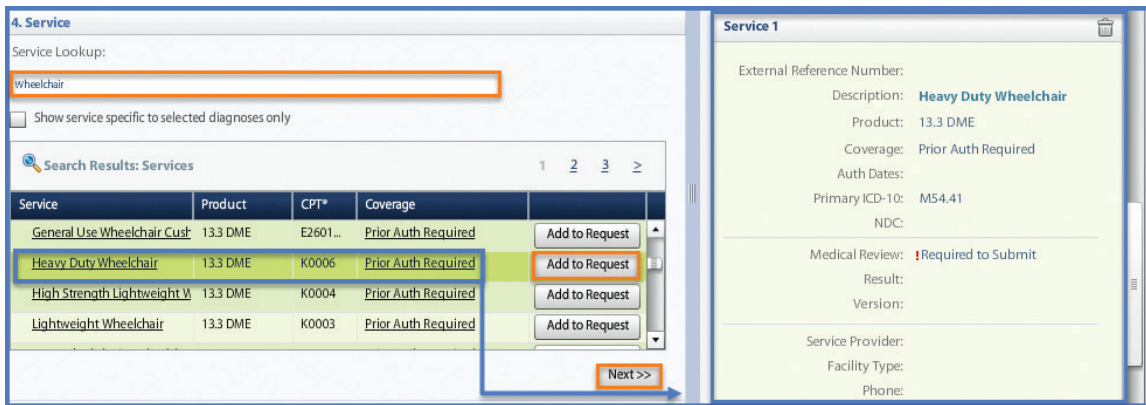
The Service accordion enables you to select the service for which you are requesting authorization.

1. Search for a service by entering one of the following in the Service Lookup:
 - a. Enter a complete CPT®/HCPCS code" (for example, "K0006")
 - b. Enter a portion of the service name (for example, "Wheelchair")

The **Coverage** column in the list of services indicates whether a certain procedure or service can be Auto-Authorized. The coverage labels can be customized by the payer.

If you select the wrong service, click the trash can icon next to the service to delete it from your list and then choose again.

2. Repeat steps 1-2 until you have added all of the services you need authorized for this patient.
3. Click **Next**.



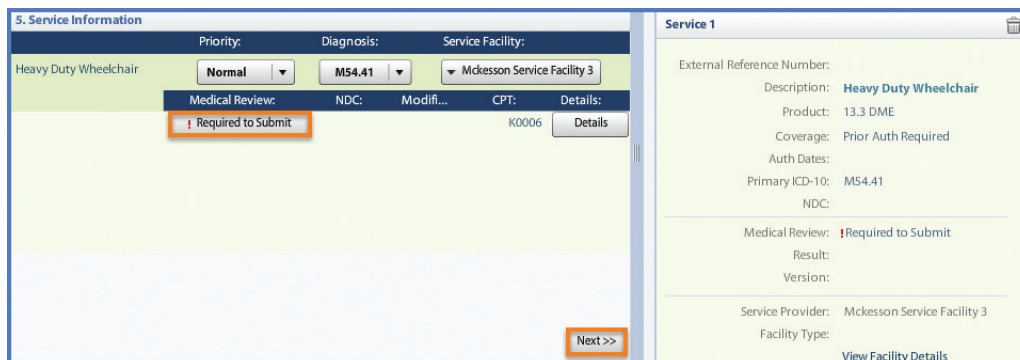
Service	Product	CPT®	Coverage	
General Use Wheelchair Cust	13.3 DME	E2601...	Prior Auth Required	Add to Request
Heavy Duty Wheelchair	13.3 DME	K0006	Prior Auth Required	Add to Request
High Strength Lightweight W	13.3 DME	K0004	Prior Auth Required	Add to Request
Lightweight Wheelchair	13.3 DME	K0003	Prior Auth Required	Add to Request

Step 5: Enter Service Information

Clear Coverage uses a question and answer workflow to assess the medical necessity of the requested service. The Medical Review information is addressed below. Additional fields like Diagnosis, Service Facility, Modifiers, and so on may be required to complete prior to submission. Required information will be marked with a red exclamation point (!).

Note: Not all services will require a Medical Review, but those that do will have the red exclamation point icon (!), then:

1. Click **Required to Submit** in the Service Information accordion.

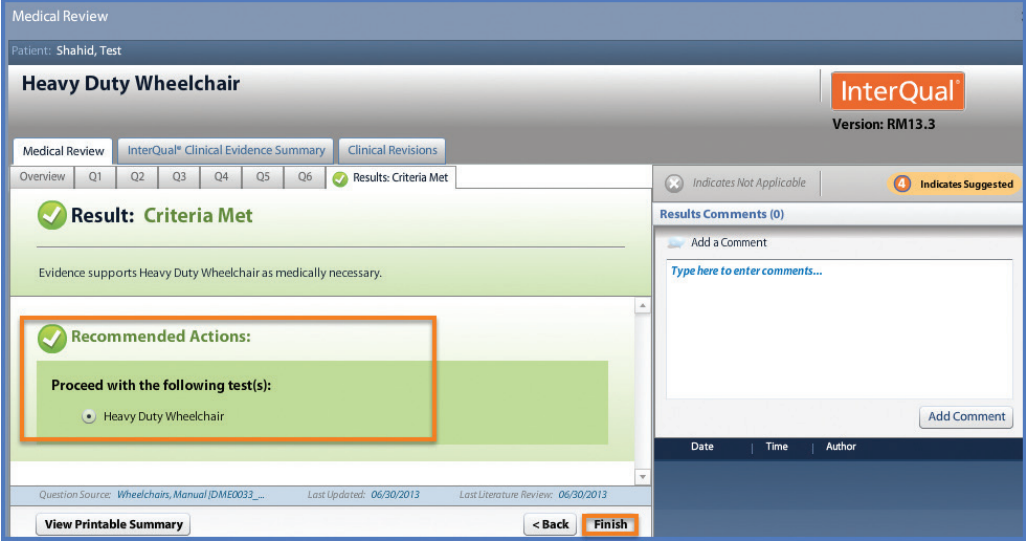


Priority:	Diagnosis:	Service Facility:
Normal	M54.41	Mckesson Service Facility 3

Medical Review:	NDC:	Modifi...	CPT:	Details:
! Required to Submit			K0006	Details


Creating an Outpatient Authorization Request

2. Answer each question, as appropriate, for the patient and their medical condition. Upon completion of the Medical Review Q&A, you will receive a recommendation on the medical appropriateness of the service based on the best current evidence available.



There may be alternate actions suggested, such as switching to a more appropriate service or removing the service you requested.

3. Click **Finish**.

Notice that under Medical Review in the Authorization Request the Required to Submit label has changed to  with the result of the Medical Review.

Note: If a Medical Review is not required or if the Medical Review result was "Criteria Not Met," then attach clinicals for nurse review.

Step 6: Adding a Note or Attaching a Document

The Additional Notes accordion enables you to provide additional notes to support your Authorization Request.

1. Click in the Additional Notes text field and type any additional information that supports the request. Add the Requesting PCP/Provider's fax number as a note.

Note: You may copy and paste information from the EMR to support the request. There is a 4,000 character limit in this text field.

2. Click **Browse** to locate a document that you would like to attach.

Note: You may attach one or more files up to 5MB in size.

3. Click the **Add Note/Attachments** to add the notes to the request.

Creating an Outpatient Authorization Request

4. If necessary, review the request to be sure that you have added all information, then click **Submit**.



After submission, you will receive an immediate response to the request with the following information:

- Service (Name of the service)
- Reference #
- Payer Authorization
- Request Status
- Expires

If approved, you will also receive a **Payer Authorization** number. This is your **Authorization**.

5. Create another authorization request.

- Click **No** to return to the Authorization Search.
- Click **Yes** to create another authorization request for the same patient, provider, and diagnosis (if you leave those check boxes selected).



Group	Service	Reference #	Payer Authorization#	Request Status	Expires
	Heavy Duty Wheelchair	141570900013	C14157002	✓ Auto Author	09/04/2014

[View Request \(PDF\) >>](#)

Would you like to create another Authorization Request?

☐ Include Requesting Information

☐ Include Diagnoses

☒ I have read the disclaimer on the authorization request PDF

Yes No

Start by logging into Clear Coverage Outpatient / Provider Offices.

1. After logging in, click **New Authorization** at the top of the main screen.
2. In the Patient Search accordion, search for a patient by entering information, then click **Search**.

3. In the Search Results, click **Select** next to the patient's name.

Name	DOB	Gender	Subscriber	Card #	Default Pay Type	Carrier	Eligibility
TESTPATENT, JIM	01/01/1979	Male	SUBSCRIBER		Details	SCS	✓ Display

4. Verify the patient's information, and then click **Add to Request**.

5. In the Requesting Information accordion, select the **Date of Service** and then select the **Requesting Clinician** from your preferred clinician list. Alternatively, choose a provider from the **Select Other Clinician** link. Click **Add to Request**.

6. In the Diagnosis accordion, search for a specific billable diagnosis, click **Add to Request**, and then click **Next**. Search by entering a diagnosis description or ICD-10 may be entered.

7. In the Service accordion, search for the **Service/Test**, click **Add to Request**, and then click **Next**. Search by entering a service/test description or CPT®/HCPCS code.

8. In the Service Information accordion, complete the required information, and then click **Next**. Note: Required fields have a red exclamation mark (!).

- A. **Priority** – Defaults to Normal.
- B. **Diagnosis** – If you selected multiple diagnosis codes, you should select the primary diagnosis from this drop-down list.
- C. **Service Facility** – Select the appropriate servicing Facility or Provider.
- D. **Medical Review** – An (!) appears only if a Medical Review is required.
- E. **Modifiers** – Appears only if a modifier is required. Click to select a modifier.
- F. **CPT** – You may be required to select a primary CPT code.
- G. **Details** – Enables you to specify details such as: Pay-To-Provider, Place of Service, Units/Duration. Enter this information as required.

9. In the **Additional Notes** accordion, attach a clinical document file to the authorization request if a Medical Review is not required or if the Medical Review result is "Criteria Not Met" and service is "Not Recommended" or "Requires Health Plan Review".

10. Verify the **Authorization Request** details are correct in the right pane.

11. Click **Submit** in the lower right pane. If **Submit** is not active, move the pointer over it to see the information that's missing.

12. Clear Coverage creates a request confirmation for each service/test.

13. **Print** the authorization request by selecting the **View Request PDF** link. Then, click **YES** to create another authorization for the same patient or **NO** to go back to the main screen to create an authorization for a new patient.

You can find more detailed information and reference guides in the Help section by clicking the **Help** button in the top right hand corner of the screen.

Inpatient Hospital Admissions

The **Inpatient Authorization Request** through Clear Coverage™ connects payors and hospitals to improve the efficiency of conducting an Authorization. There are three (3) functions within the Authorization Service.

- Search Authorization Requests
- Create a New Authorization Request
- Administration

What is Auto-Authorization?

Clear Coverage offers the ability to submit an Authorization Request for a hospital admission, as well as receive an immediate, real-time response to that request. The Clear Coverage Auto-Authorization Service combines critical components required to carry out an Authorization: an Eligibility check and a Medical Appropriateness check. Additional Clear Coverage help is located on the home page.

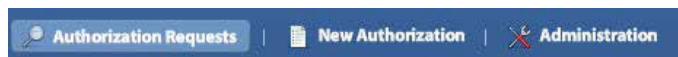
New Authorization Request Workflow

There are **6 steps** in creating a new Authorization Request:

Steps/Accordion	Information
1. Select the Patient	Who is the patient who requires this admission?
2. Select the Admitting Physician/ Facility	Who/Which is the physician/facility requesting the admission?
3. Select Diagnosis (ICD-10) code(s)	What are the primary diagnosis(s) for this admission for this patient?
4. Select the Admission Criteria	Which admission criteria is applicable?
5. Perform the Medical Review	Provide answers to questions to determine medical necessity of the admission.
6. Add Additional Notes/Documentation	Additional information about the admission.

Clear Coverage Tabs

Once logged on, various tabs will appear on the top window. Below is a sample of tabs that will appear:

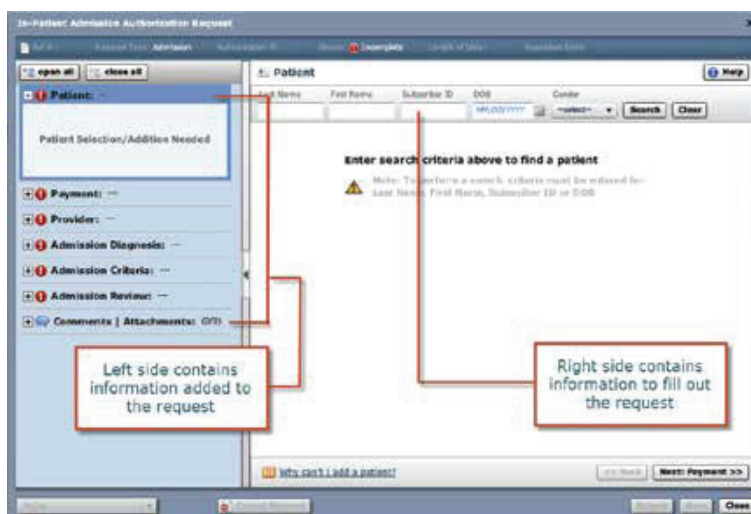


- Search Authorization Requests
- New Authorization Requests
- Administration

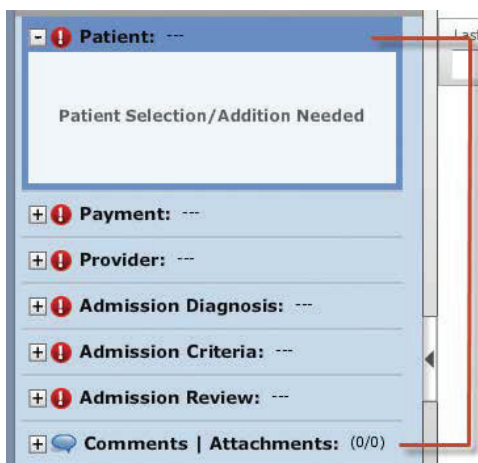
New Authorization Request Overview

The **"New Authorization"** Tab consists of 2 sides:

- The **left side** contains the information that has been added to the authorization request.
- The **right side** contains information to search for patients, providers, and diagnoses.



Click on the Accordion Headers on the left to switch from area to area.



Creating a New Authorization Request

Click on the "New Authorization" tab to open the workflow available on this tab.

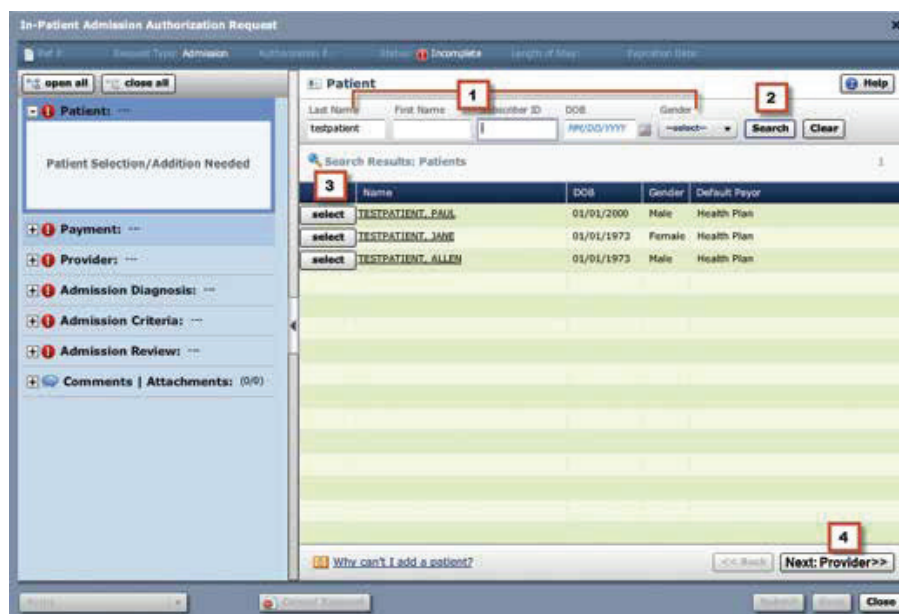


Step 1: Patient Search

Creating an authorization request starts with selecting the Patient.

Using the Search function, a Patient can be found with a few letters of their first or last name. If you have the member or subscriber ID of the patient, you can use that as well. The same search criteria options that are used for Outpatient also apply to Inpatient.

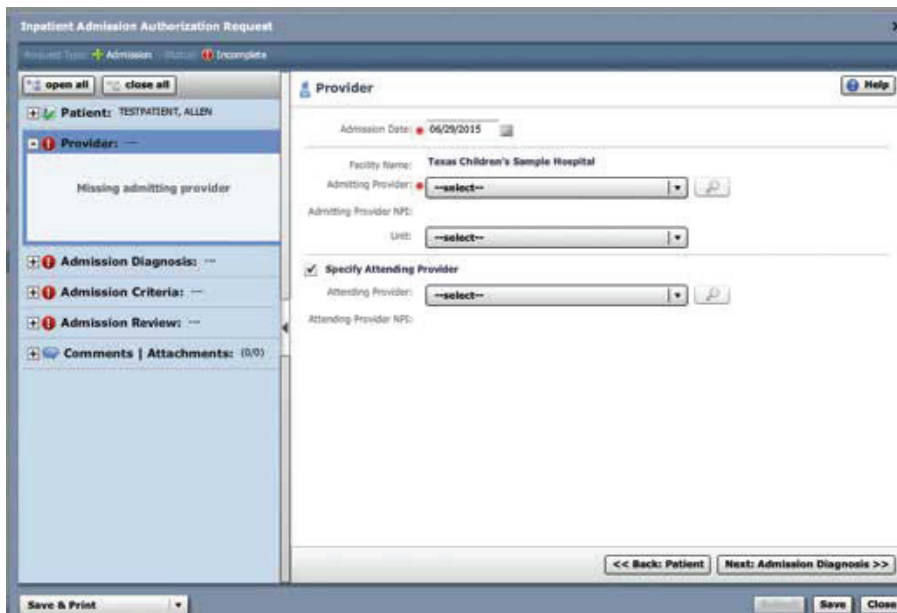
1. Enter search criteria.
2. Click on the "Search" button.
3. Click the "Select" button on the patient for whom the admission being requested.
 - a. The selected patient's information is added to the authorization request on the left side of the window.
 - b. Verify the patient information, eligibility, or search for another patient.
4. Click on the "Next: Provider" button.



Name	DOB	Gender	Default Payer
TESTPATIENT_PAUL	01/01/2000	Male	Health Plan
TESTPATIENT_JANE	01/01/1973	Female	Health Plan
TESTPATIENT_ALLEN	01/01/1973	Male	Health Plan

Step 2: Provider Information

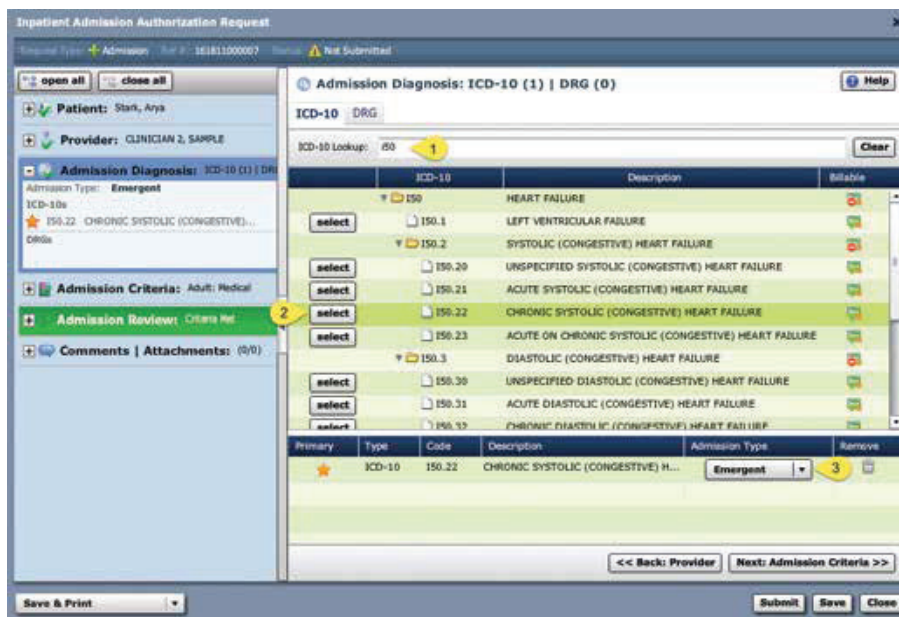
1. Enter the **Admission Date** - **Note:** You can click on the Calendar icon adjacent to the field and click on a date or enter the date in the format MM/DD/YYYY, e.g. 09/15/2010.
2. The **Facility Name** will automatically default to the facility the user is assigned too.
3. Click on the **Admitting Provider** drop-down menu and select the Facility requesting the Authorization.
(The "**Admitting Provider ID**" will automatically populate once the "**Admitting Provider**" is selected).
4. If Admitting Provider drop-down is blank or to add another Facility click the **search icon**. In the Provider Search enter Facility Name or an ID Type, click **Search** and once located you can "**Add Selected to Preferred Clinician List**".
5. Select the unit from the **Unit** drop-down, if applicable.
6. Click the "**Specify Attending Provider**" check box to select an attending provider, if applicable.
7. Select the Attending Provider from the drop-down or use the search button to search.
8. Click on the "**Next: Admission Diagnosis**" button.
9. (This moves the Provider Information into the Authorization Request and moves you to the next accordion — Admission Diagnosis).



Step 3: Admission Diagnosis

The **Diagnosis** accordion allows you to choose one or more admission diagnoses for the requesting Authorization. The diagnosis can be identified by searching in the **"Diagnosis Lookup"** field, listing any results matching the keywords.

1. Search for the diagnosis using one of the following methods:
 - a. Part of the clinical diagnosis description (e.g. "Heart Failure")
 - b. ICD-10 or DRG code (e.g. "I50.22")
2. When you find the appropriate diagnosis code, click the **"Select"** button next to the diagnosis. (The Diagnosis is added into the Authorization Request on the left-hand side).
3. Select the Admission Type by using the **"Admission Type"** drop-down.
4. Repeat Procedure Steps 1-3 to include additional diagnoses if desired.
5. Click the **"Next: Admission Criteria"** button to move to the next accordion.



Inpatient Admission Authorization Request

Request Type: Admission Ref # 161811000007 Status: Not Submitted

open all close all

Patient: Stark, Anya

Provider: CLINICIAN 2, SAMPLE

Admission Diagnosis: ICD-10 (1) | DRG (0)

Admission Type: Emergent

ICD-10s: I50.22 CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE

Criteria:

Admission Criteria: Adult: Medical

Admission Review: Criteria Met

Comments | Attachments: (0/0)

Admission Diagnosis: ICD-10 (1) | DRG (0)

ICD-10 DRG

ICD-10 Lookup: I50

ICD-10	Description	Billable
I50	HEART FAILURE	
I50.1	LEFT VENTRICULAR FAILURE	
I50.2	SYSTOLIC (CONGESTIVE) HEART FAILURE	
I50.20	UNSPECIFIED SYSTOLIC (CONGESTIVE) HEART FAILURE	
I50.21	ACUTE SYSTOLIC (CONGESTIVE) HEART FAILURE	
I50.22	CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE	
I50.23	ACUTE ON CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE	
I50.3	DIASTOLIC (CONGESTIVE) HEART FAILURE	
I50.30	UNSPECIFIED DIASTOLIC (CONGESTIVE) HEART FAILURE	
I50.31	ACUTE DIASTOLIC (CONGESTIVE) HEART FAILURE	
I50.32	CHRONIC DIASTOLIC (CONGESTIVE) HEART FAILURE	

Primary	Type	Code	Description	Admission Type	Remove
★	ICD-10	I50.22	CHRONIC SYSTOLIC (CONGESTIVE) H...	Emergent	

<< Back: Provider Next: Admission Criteria >>

Save & Print Submit Save Close

Step 4: Admission Criteria

The **Admission Criteria** accordion allows you to select the criteria for the admission event for which you are submitting an Authorization Request.

1. Select the criteria for your review. **Note:** If the criteria are not mapped to the diagnosis code, it may not be able to be selected for use.
 - a. You can select the category if you want to use condition-specific, acute, critical, or intermediate level of care criteria.
2. The **"Coverage"** column displays whether a certain admission criteria can be Auto-Authorized.
3. Click **"Select"** next to the admission criteria to add it to the Authorization Request.
 - a. If you select the wrong admission criteria, click **"Change Selected Criteria"** to delete the selection from your request and choose again.

The screenshot shows the 'Inpatient Admission Authorization Request' form. The 'Admission Criteria' section is active, displaying a list of criteria. The 'Coverage' column is highlighted with a red circle. The 'select' button next to the 'General Surgical' criteria is also highlighted with a red circle. The 'Criteria Selection Needed' message is visible in the left sidebar.

4. The Coverage column for your admission criteria will determine what the next step is to take.

	Notes	Description	Product	Coverage
select	N	Cardiovascular / Peripheral Vascu	Acute	Medical Review Required
select	N	CNS / Musculoskeletal (Acute)	Acute	Medical Review Required
select	N	Endocrine / Metabolic (Acute)	Acute	Medical Review Required

5. Information about the selected admission criteria will be displayed. Click **"Next: Admission Review"** to begin the medical review.

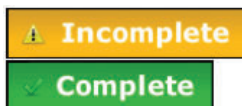
Coverage	Meaning/Action to take
"Covered"	This admission does not require pre-authorization and cannot be added to an Authorization Request. ACTION: You do not need to submit an authorization request and can stop this process.
"Not Covered"	This admission is not a covered service. ACTION: You do not need to submit an authorization request and can stop this process.
"Medical Review Required"	This admission can be Auto-Authorized if the admission is recommended based on Medical Review. ACTION: Select the Criteria and Perform Medical Review.
"Authorized Instantly"	This admission will be Auto-Authorized regardless of the outcome of the Medical Review. ACTION: Select the Criteria and Perform Medical Review.
"Authorization Required"	This admission cannot be Auto-Authorized, but Medical Review is required. The request will be evaluated by the Payer's Utilization Management team. Proceed with the authorization. ACTION: Select the criteria and Perform Medical Review.
"Notification Required"	This admission indicates that the patient's health plan must be notified of the admission. ACTION: Select the criteria and Perform Medical Review.

Step 5: Perform Medical Review

Clear Coverage will access the Medical Necessity of the Authorization Request.

If in the previous step, the **"Coverage"** of your test was either **"Medical Review Required"**, **Authorized Instantly**, or **"Authorization Required"**, you need to perform Medical Review in order for the request to Auto-Authorize and give you an immediate authorization. If you do not perform medical review in those cases, you will NOT be eligible to receive an Auto-Authorization, and the case will require manual review.

1. Click on the **"Launch Medical Review"** button to launch the Medical Review.
2. Provide the appropriate responses for your specific patient and clinical situation.
3. Upon completion of the Medical Review, you will receive an outcome on the medical appropriateness of the admission based on the best current evidence available.



4. Click **Save**.
 - a. Notice that under Medical Review in the Authorization Request the **"Not Started"** status has changed to **"Complete"** or **"Incomplete"** based on the result of the Medical Review.

The screenshot shows the 'Inpatient Admission Authorization Request' window. The 'Admission Review (Required)' section is active, displaying 'Heart Failure' and 'Observation Criteria Met'. Below this, a list of 'Episode Day' entries is shown, with 'Episode Day 1' marked as 'Observation' and 'Criteria Met', while 'Episode Day 2' through 'Episode Day 6' are marked as 'Not Started'. The left sidebar shows patient information: Patient: Stark, Anya; Provider: CLINICIAN 2, SAMPLE; Admission Diagnosis: ICD-98 (1) | DM; Admission Criteria: Adult: Medical; and Admission Review: Criteria Met. The bottom of the window has buttons for 'Save & Print', 'Submit', 'Save', and 'Close'.

Step 6: Adding a Comment or Document

The **Comments | Attachments** section allows you to provide any additional notes to support your Authorization Request.

1. Add any additional notes to support the request (additional medical evidence, etc.)

Note: You may copy and paste areas from your EMR to support your request in this area if needed.

2. Click the **"Add Comment"** button to attach comments to the authorization request.

3. Click the **"Browse"** button to attach a file.

Note: Add notes and attach supporting clinical documentation when a "Criteria Not Met" and/or a "Pending" status is received.

The screenshot shows the 'Inpatient Admission Authorization Request' window with the 'Comments | Attachments: (0/0)' section active. It features a table with columns for Date, Time, Author, Comment, and Attachments. Below the table is an 'Add Comment / Attachment' section with a 'Browse' button for attachments and a text area for comments. The bottom of the window includes an 'Add Comment' button, a character count '14 of 4000', and navigation buttons for '<< Back: Admission Review' and 'Next: Comments | Attachments >>'. The left sidebar shows the same patient information as the previous screenshot, but the 'Admission Review' status is now 'Criteria Met'.

"Save" or "Submit" an Authorization

1. Verify all **6 Sections/Accordions** of the Authorization Request are filled out and complete.
2. Is **Medical Review** complete? Make sure you have performed the Medical Review questions if your admission coverage was "Medical Review Required", "Authorized Instantly", or "Authorization Required".
3. If you need to come back to Medical Review or if you are not sure about information within the authorization Click on the **"Save"** button.
4. If you are confident in the authorization information Click on the **"Submit"** button.
 - a. You will be asked to enter your contact information if this option is turned on.

Contact details are required for all submitted authorizations. Please provide contact details (a name and a phone number) below and press submit to finish the request.

First Name: Last Name:

Phone Number: e.g. (555) 555-1212
() - Ext

- b. You will then be asked to input an estimated length of stay if you have this option turned on.

Estimated Length Of Stay

Payor requires all in-patient authorization requests to have an estimated length of stay from the requesting office. Please provide the estimated length of stay for this request.

Estimated Length Of Stay in days

- c. Click **"Submit"**.

d. You will then receive an Automatic response to the request:

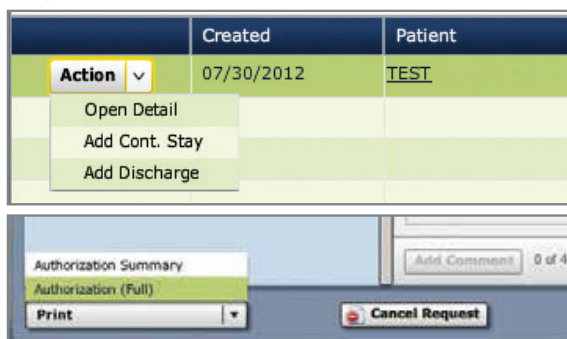
- i. Your request will be **Approved** (Auto-Authorized).
- ii. Clear Coverage will record the Request with an **Internal Reference #**, a 12 digit number (Ex. "012345678901").
- iii. If approved, you will also receive a certification number, a 10 character code starting with a "C" (Ex. "C12345ABCD"). This is your **Authorization Number**.
- iv. If the authorization status is "Pending", find the member from the home page, click on "Action" button next to desired patient, select "Open Detail", then add the clinical attachment and notes. Refer to Step/Accordion 6 for instructions on adding notes and attachments

Note: If the Submit button is not enabled, hover over the submit button to determine what information is missing from your request.



ADM Reference #:	123121100016
Payer Certification #:	C12312028
Authorization Status:	Authorized
Admission Date:	07/30/2012
Category:	Adult : Condition Specific
Criteria:	Heart Failure
Length of Stay:	2 days
Repeated Length of Stay:	2 days
Expiration Date:	08/01/2012

5. To review authorization submitted by the provider you are logged in as, click the Search Authorization Requests tab. For a copy of the authorization, click the "**Open Detail**" button, then click **Print Authorization** Full or Summary. This will open a pdf that can be printed or saved.



	Created	Patient
Action ▼	07/30/2012	TEST
Open Detail		
Add Cont. Stay		
Add Discharge		

Search Results: Authorization Results

	Created	Patient	Payer	Admit Date
Action ▼	10/21/2013	TESTPATIENT, ALLEN	Sandbox	10/21/2013
Open Detail	11/20/2013	TESTPATIENT, ALLEN	Sandbox	11/20/2013
Add Cont. Stay	10/11/2013	TESTPATIENT, ALLEN	Sandbox	10/11/2013
Add Discharge	10/11/2013	TESTPATIENT, ALLEN	Sandbox	10/11/2013
Action ▼	10/11/2013	TESTPATIENT, ALLEN	Sandbox	10/11/2013
Action ▼	10/10/2013	TESTPATIENT, ALLEN	Sandbox	10/10/2013

The **Action** drop-down will allow you to:

- View the request: "**Open Detail**"
- Add a Continued Stay
- Add a Discharge

Creating a Continued Stay Review

To create a Continued Stay:

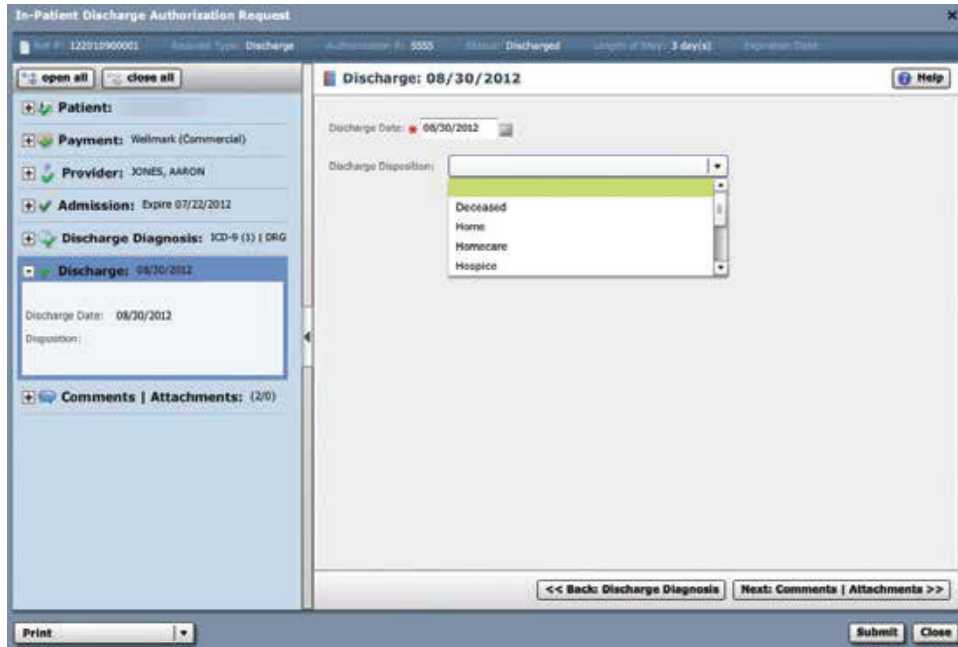
1. Locate the patient on the **"Authorization Request"** tab.
2. Click the **"Action"** button next to the patient and select **"Add Cont. Stay"** from the drop-down menu.
3. Enter a new Diagnosis if different from the original or continue on to the Cont. Stay Criteria.
4. You may or may not be required to complete the Continued Stay review.
5. Add any comments/attachments.
6. Click **"Submit"**.

Multiple Continued Stays can be performed.

Creating a Discharge

To create a Discharge:

1. Locate the patient on the **"Authorization Request"** tab.
2. Click the **"Action"** button next to the patient and select **"Add Discharge"** from the drop-down menu.
3. Enter the **"Discharge Date"**.
4. Use the drop-down menu to select the **"Discharge Deposition"** if this option is turned on.
5. Click **"Submit"**.



In-Patient Discharge Authorization Request

Ref # 12201900001 | Patient Type: Discharge | Authorization #: 5055 | Status: Discharged | Length of Stay: 3 day(s) | Expiration Date

open all | close all

Patient:

Payment: Wellmark (Commercial)

Provider: JONES, AARON

Admission: Expire 07/22/2012

Discharge Diagnosis: ICD-9 (3) | DRG

Discharge: 08/30/2012

Discharge Date: 08/30/2012

Disposition:

Discharge Disposition:

- Deceased
- Home
- Homecare
- Hospice

Comments | Attachments: (2/0)

<< Back: Discharge Diagnosis | Next: Comments | Attachments >>

Print | Submit | Close

Start by logging into Clear Coverage.

1. After logging in, click **New Authorization** at the top of the main screen.
2. In the Patient Search accordion, search for a patient by entering information, then click **Search**. Note that fields with a red asterisk (*), if noted, are required.
3. In the Search Results, click Select Next to the patient's name.
4. Verify the patient's information, click Next: Provider.

5. In the Provider accordion, select the **Admission Date** followed by the **Admitting Provider** (Facility) from your preferred clinician list. You may also choose a facility by clicking on the icon. Click **Next: Admission Diagnosis**.

6. In the Admission Diagnosis accordion, search for a specific billable diagnosis, click **Select**, and then select an **Admission Type**. Click **Next: Admission Criteria**.

7. In the Admission Criteria accordion, start by selecting the category of your admission criteria. Click **Select** next to the appropriate service and then click **Next: Admission Review**.

8. After the medical review has been completed, click **Next: Comments/Attachments**.

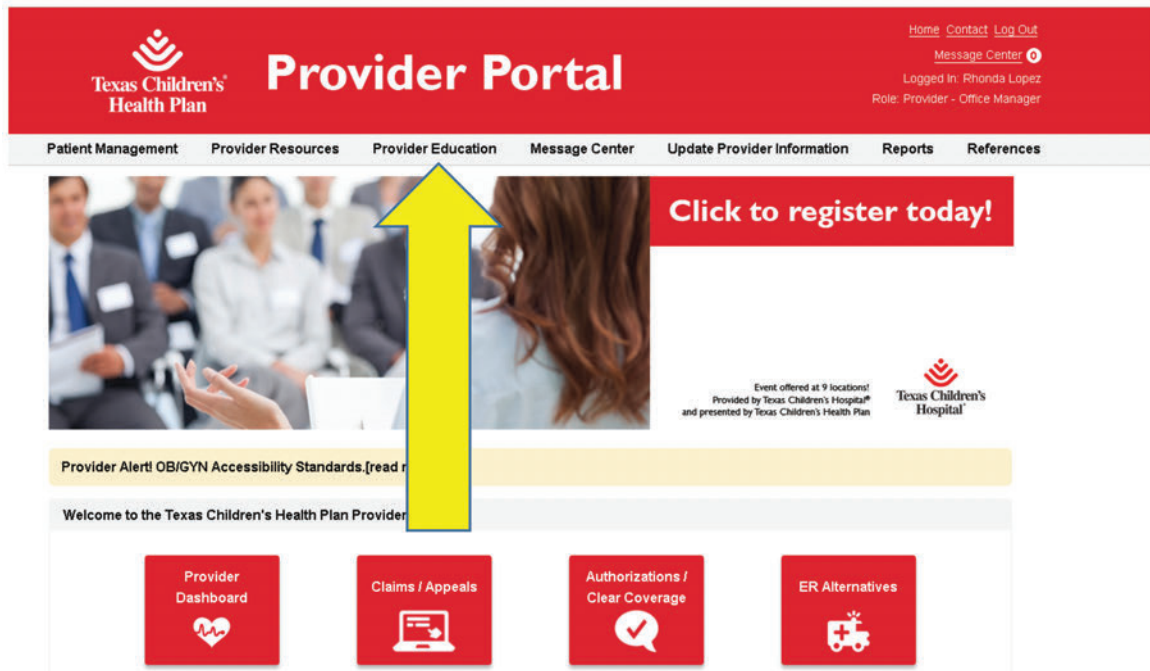
9. In the **Comments/Attachments** accordion, add notes and attach supporting clinical documentation when a "Criteria Not Met" and/or a "Pending" status is received. Reference page 11, "iv. If authorization status is "Pending"...from the Clear Coverage Inpatient Training Guide.
10. Verify the **Authorization Request** details are correct in the right pane.
11. Click **Submit** in the lower right pane. If **Submit** is not active, move the pointer over it to see the information that's missing.
12. A request confirmation is created for each service/test.



You can find more detailed information and reference guides in the **Help** section by clicking the **Help** button in the top right hand corner of the screen.

13. Print the authorization request by selecting the **View Request (PDF)** link.

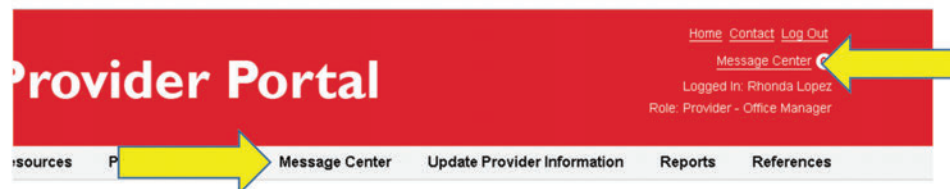
Additional Clear Coverage help is located under the **Provider Education** menu.



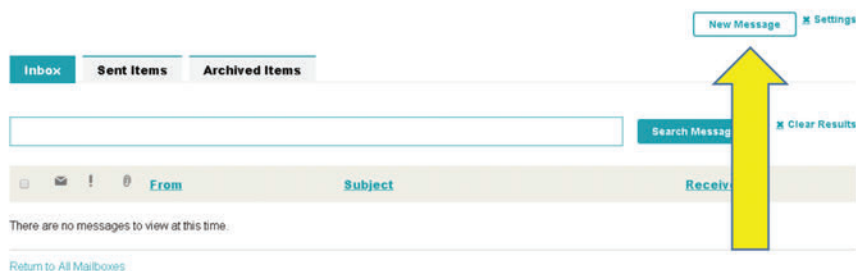
Secure Messaging

Every Provider Portal user receives a secure messaging e-mail account. Your **Message Center** is located in the top menu and just below the red banner. Using the Message Center, you can:

- Add and edit mailboxes
- Send messages to The Health Plan staff
- Receive and manage messages
- Add or send documents



Inbox Messages for 180 MEDICAL INC



Compose Message for 180 MEDICAL INC

From: 180 MEDICAL INC

To:

Subject:

Mark urgent ☐

Attachments [Attach a file](#)

[ADD RECIPIENTS](#) [Add CC](#)

Add Recipients

Department

1 - 6 of 6

Name	Category	
Authorization Questions	Department	Add
Claims Supporting Documentation	Department	Add
Eligibility Questions	Department	Add
Provider Relations - Claims Que.	Department	Add
Provider Relations - General Co.	Department	Add
Provider Relations - Issues With	Department	Add

To

Authorization Questions

Add Recipients CANCEL

Secure Messaging

To send a message, follow the steps below:

Step 1

Click on the **New Message** button. The **Compose Message** form will appear.

Step 2

Select **Add Recipient(s)**.

Step 3

Select a recipient from the list below by clicking the **Add** button to the right, then clicking **Add Recipients** at the bottom:

- Provider Relations – General comments
- Provider Relations – Claims questions
- Provider Relations – Issues with portal
- Utilization Management – Authorization questions
- Member Services – Eligibility questions

Compose Message for 180 MEDICAL INC

From: 180 MEDICAL INC

To: [Add CC](#)

Subject:

Mark urgent ☐

Attachments [Attach a file](#)

Step 4

Type in your subject and content. You can also attach documents and check the **Mark Urgent** box for your message. When finished, click the **Send** button.

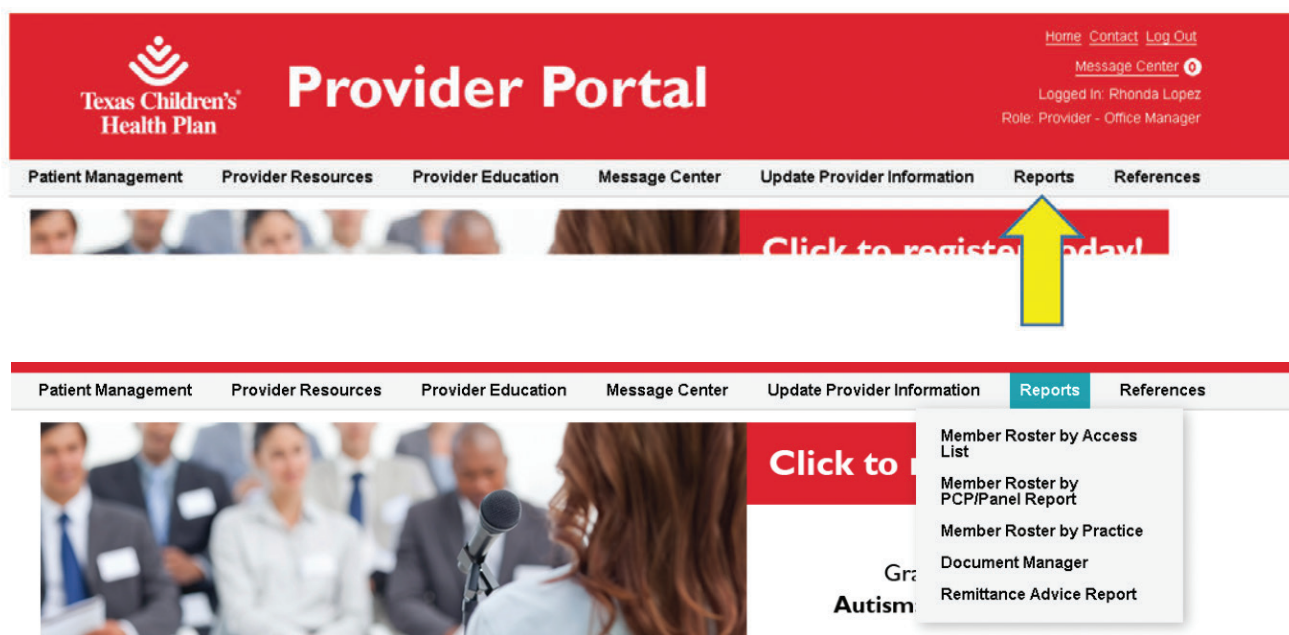
You will receive a confirmation that your message was sent. You can return to your inbox or do another task. You will be able to see your sent mail by clicking on the **Sent Items** tab. When a response is received, the **Message Center** in the top right of the Portal Homepage will display the number of items in your inbox.

Reports

You can access reports online through **The Provider Portal**. This feature allows you to generate your own PCP panel reports.

Step 1

Click on the **Reports** button at the top of the portal home page. A list of available reports will appear.



Step 2

Click on the report name you would like to generate.

Member Roster by PCP

Select Type of Members

Active Members As of 05/23/2019

Please select a provider to narrow the search. If one is not selected no results will be returned.

Provider

Select Provider

Subscriber Section

A check in the box means the member is the primary subscriber.

Filter By

Subscribers Only

Step 3

Select your Provider Name or your Provider ID and click **Search**.

Step 4

Select provider by clicking the **Add** link to the right then click **Continue**.

Step 5


Select the type of report format you want:

- CVSPDF
- Excel
- CVS

Step 6

Click the **Submit** button.

NOTE: If your panel report has more than 2,000 members, your report will be sent to the Document Manager.



Provider Portal

[Home](#)
[Contact](#)
[Log Out](#)

[Message Center](#)

 Logged In: Rhonda Lopez
 Role: Provider - Office Manager

[Patient Management](#)
[Provider Resources](#)
[Provider Education](#)
[Message Center](#)
[Update Provider Information](#)
[Reports](#)
[References](#)

Member Roster by PCP

Select Type of Members

Active Members
 As of
 05/23/2019

Please select a provider to narrow the search. If one is not selected no results will be returned.

Provider

Select Provider

Subscriber Section

A check in the box means the member is the primary subscriber.

Filter By

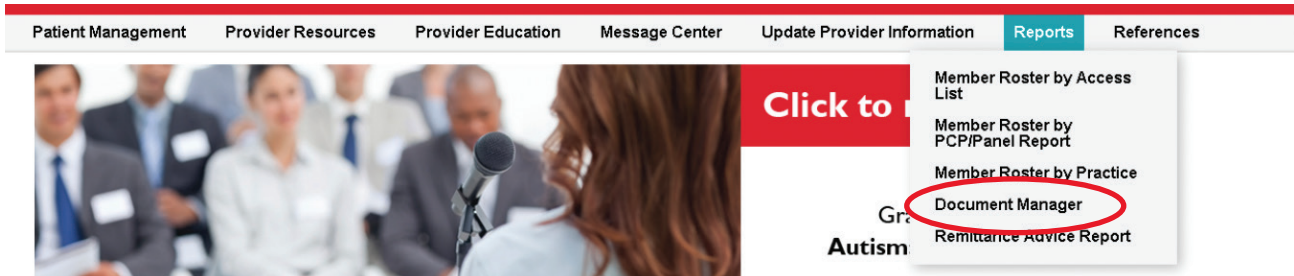
☐
 Subscribers Only

Document Manager

The Health Plan will send reports and documents to providers using the **Document Manager**. You will receive files in your Message Center inbox. When the file is downloaded, it will move from the Message Center inbox to the inbox tab in Document Manager. To access the Document Manager, follow the steps below.

Step 1

Click on the **Document Manager** link under the **Reports Menu** on the top right of the home page.



Step 2

Click on the **Download** link and save the report to your computer.

My Documents

[EDI Upload](#)
[Add Document](#)

[Current Documents](#)
[Archived Documents](#)

Name:

Category:

Date Range: to

Owner:

Status:

Member:

[Search](#)
[CLEAR](#)

Sorted By:

Per Page:

Member Roster by PCP_

.csv (627 KB)

Uploaded: 05/15/2019

Expires: 2019-08-13

Step 3

Click on the **Open** or **Save** button. The document will move from your **Inbox** tab to the **Downloaded** tab of the **Document Manager**. The selected format will open in the bottom left side of your screen.

Sorted By: Newest ▾

Per Page 25 ▾

[837_5010_Wed Jul 17 00:30:44 GMT-06:00 2019 \(2 KB\)](#)

Owned By: Texas Children's Health Plan Member:

Received

Uploaded: 07/17/2019

Expires: 2019-10-15 00:30:44 GMT-06:00

Permanently Delete

[tchp-valence-data-2019-07-16.csv \(14 KB\)](#)

Owned By: Member:

Received

Uploaded: 07/16/2019

Expires: 2020-07-16

Permanently Delete

[201907162240000_TCHP_Payor_Admin_Provider_Report.csv \(799 KB\)](#)

Owned By: Member:

Received

Uploaded: 07/16/2019

Expires: 2020-07-16

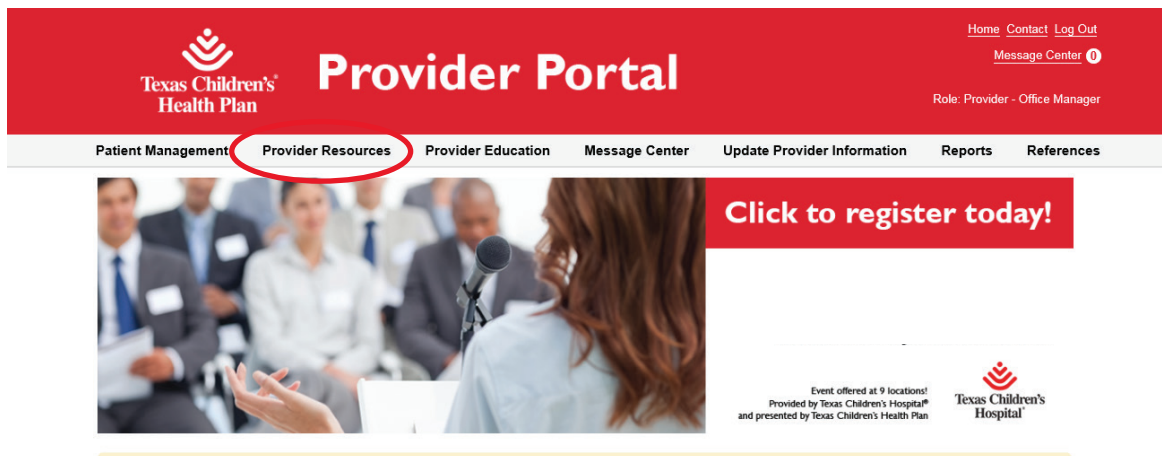
Permanently Delete

[201907162237000_TCHP_Payor_Admin_Member_Report.csv \(154 KB\)](#)

Uploaded: 07/16/2019

Provider Complaint

The **Provider Complaint** form is available under the **Provider Resources** menu on the portal homepage. Complete the form and provide details in the Note section. When complete click **Save**. A Texas Children's Health Plan employee will be in contact with you or the practice in an effort to resolve the complaint.

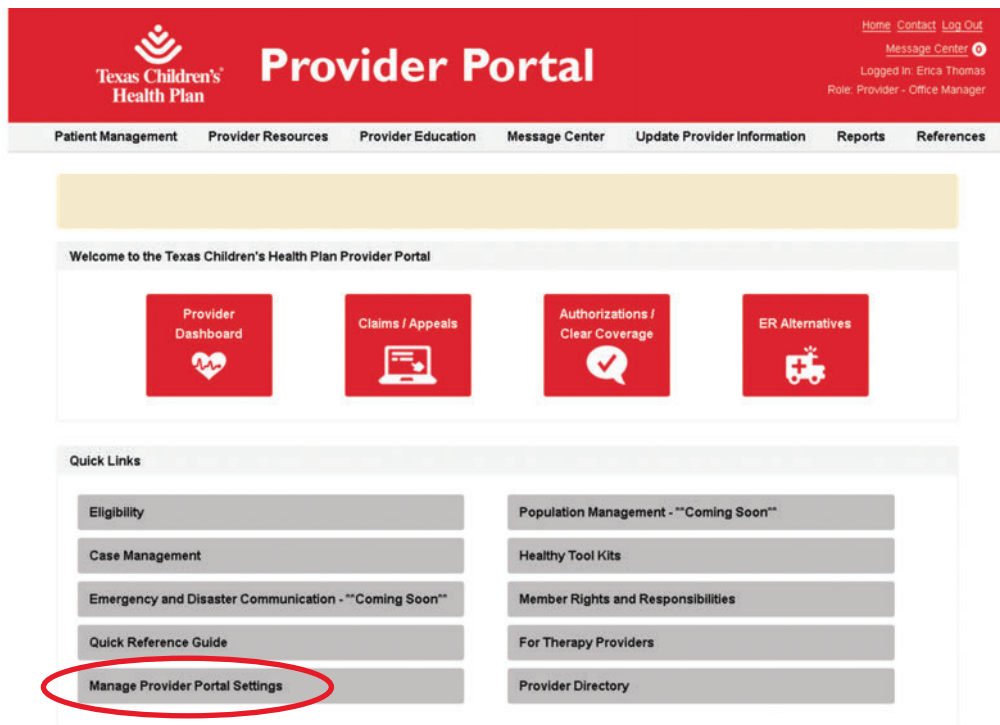


Adding or Removing a User

If you need to add or remove a user, you can use the **System Administration/ User Maintenance** feature.

Step 1

Click on the **Manage Provider Portal Settings**.



Step 2

To add a user, click the **Add User** button.

User Maintenance

<input type="checkbox"/>	User Name	Office Security	Company Name	Company ID Number	Company Status	TIN	User ID	Last Login	Validated Thru
<input type="checkbox"/>	Testorman, BABY Q	User	TEXAS PRIMARY CARE SPECIALIST PLLC	173902	Expired		BATes3		02/20/2018
<input type="checkbox"/>	Testorman, CSM1-9706e Q	Main Office Contact	TEXAS PRIMARY CARE SPECIALIST PLLC	173902	Expired		CSM1-9706e	02/20/2018	02/20/2018
<input type="checkbox"/>		Main Office Contact	TEXAS PRIMARY CARE SPECIALIST PLLC	173902	Expired			07/18/2019	02/20/2018

[Add User](#)

Step 3

Enter the new user information and click the **Submit** button.

Add User

First Name

Middle Initial

Last Name

E-mail Address

Confirm E-mail Address

Title
e.g., Office Manager

Office Phone

Phone Ext.

Office Fax

☐ Local Administrator

Step 4

You can then select a user role and access list from the pull down menu. Once you complete your user selections, click the **Select Role** button.

User Role Selection

Roles:

Entity Lists:

The user status will show “Pending” until The Health Plan confirms the user change.

User Role Maintenance

Texas Children's Health Plan

Texas Children's Health Plan - Provider Portal

Role	Entity List Name	Registration Status
<input type="checkbox"/> Provider - Office Staff	TEXAS PRIMARY CARE SPECIALIST PLLC	Pending

Step 5

Once The Health Plan confirms, the user status will change from “Pending” to “Confirmed.” The office administrator will receive an email with the user’s temporary password. The office administrator must forward the user name (found in User Maintenance) and temporary password for the initial login.

Changing a user role or access list

Step 1

To change a user’s role or access list, click on the user’s name.

Step 2

Click the **Add** button.

User Role Maintenance

Texas Children's Health Plan

Texas Children's Health Plan - Provider Portal

Role	Entity List Name	Registration Status
<input type="checkbox"/> Provider - Office Manager	TEXAS PRIMARY CARE SPECIALIST PLLC	Confirmed
<input type="checkbox"/> Provider - Office Staff	TEXAS PRIMARY CARE SPECIALIST PLLC	Confirmed
<div> <div>Add</div> <div>Remove</div> </div>		

Step 3

Select a different role or access list.

Step 4

Click the **Select Role** button.

User Role Selection

Roles

Provider - Provider - CBO

Entity Lists

Texas Childrens Health Plan 04

Select Role

Cancel

Step 5

Click on the button next to the old role.

Step 6

Click on the **Remove** button.

Under the **User Role Maintenance** section, you will see the user role change confirmed.

User Role Maintenance

Texas Children's Health Plan

Texas Children's Health Plan - Provider Portal

Role	Entity List Name	Registration Status
<input type="checkbox"/> Provider - Office Manager	TEXAS PRIMARY CARE SPECIALIST PLLC	Confirmed

Add Remove

Removing a User Role

Step 1

To change a user's role, click on the user's name.

Step 2

Click on the box next to the role.

Step 3

Click the **Remove** button.

User Role Maintenance

Texas Children's Health Plan

Texas Children's Health Plan - Provider Portal

Role	Entity List Name	Registration Status
<input type="checkbox"/> Provider - Office Manager	TEXAS PRIMARY CARE SPECIALIST PLLC	Confirmed
<input type="checkbox"/> Provider - Office Staff	TEXAS PRIMARY CARE SPECIALIST PLLC	Confirmed

Add Remove

NOTE: You must have one role for the user or the user will be deleted.


Step 4

Enter the reason for removing user.

Step 5

Click the **Yes** button.

Verification

 **Are you sure you wish to
remove this user?**

This action cannot be undone.
Removing the selected roles will remove the user's registration
with Texas Children's Health Plan.
A reason must be entered for this action.
Click the Yes button to continue.

» Reason:

ended employment 

» Indicates required field

Yes

No

You will then return to the **User Maintenance** screen.