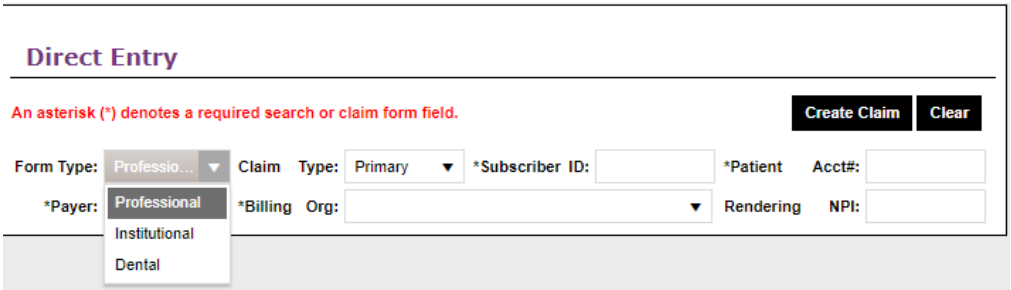
Claim Direct Entry

Create a Direct Entry Claim

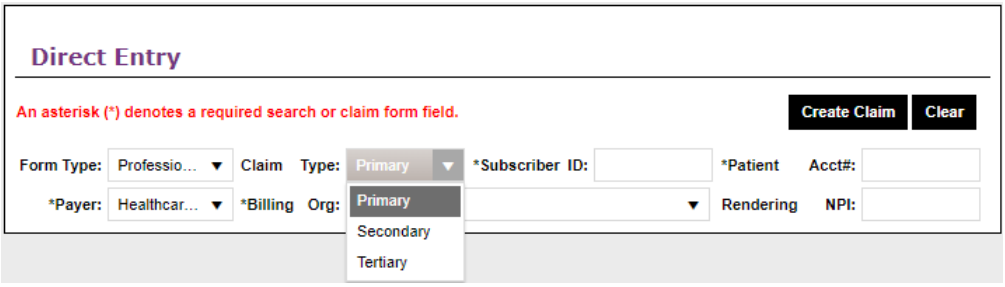
The Direct Entry module allows users to enter claims directly into the portal, eliminating paper submissions, minimizing turnaround time, and enhancing visibility throughout the claim adjudication process.

Before beginning claim entry, gather the necessary information available. While the module is designed with maximum flexibility to create a claim even if required components are missing, you will avoid rejections and delays in processing if you have a few key elements. For example, Payer IDs and prior payment details are required on Secondary and Tertiary claims.

1. From **Claim Center**, select **Options > Direct Entry**.
2. Select the appropriate Form Type from the drop-down menu. This selection dictates the display fields, entry requirements, and validation rules.

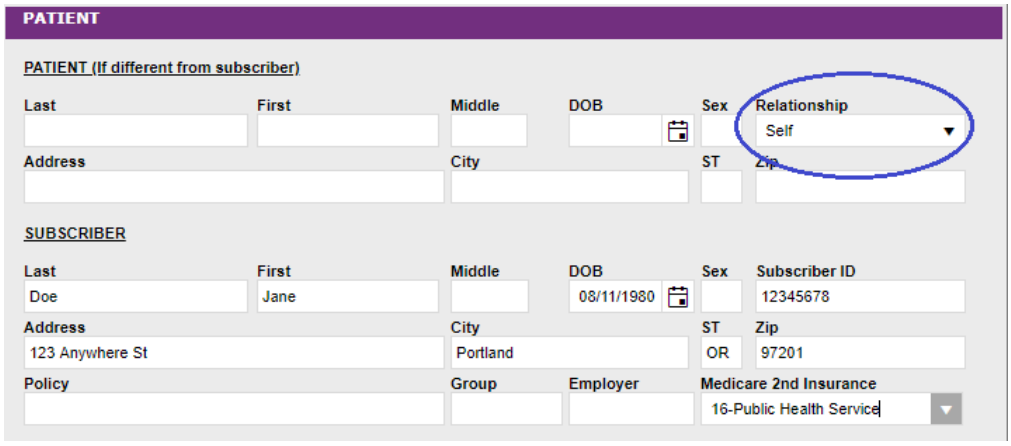


3. Select the Claim Type. If iCircle is the secondary or tertiary payer, you will need to have the other Payer name, Payer ID, and plan specific Subscriber ID available to you.

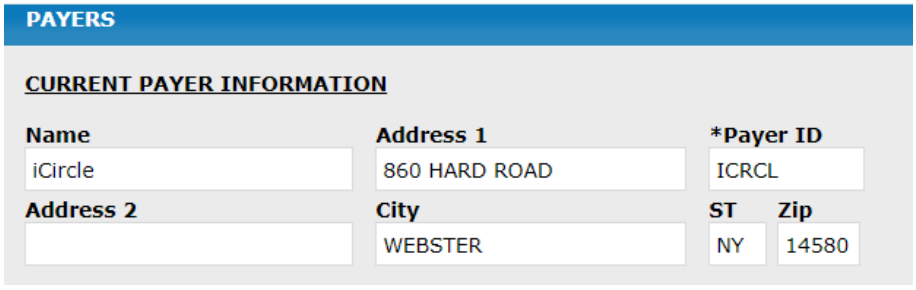


4. Enter additional required fields:
    - Subscriber ID
    - Patient Acct# (Your patient reference number)
    - Billing Org. If you are linked to multiple provider organizations, you may select from the drop-down menu. Otherwise, this field will pre-populate.

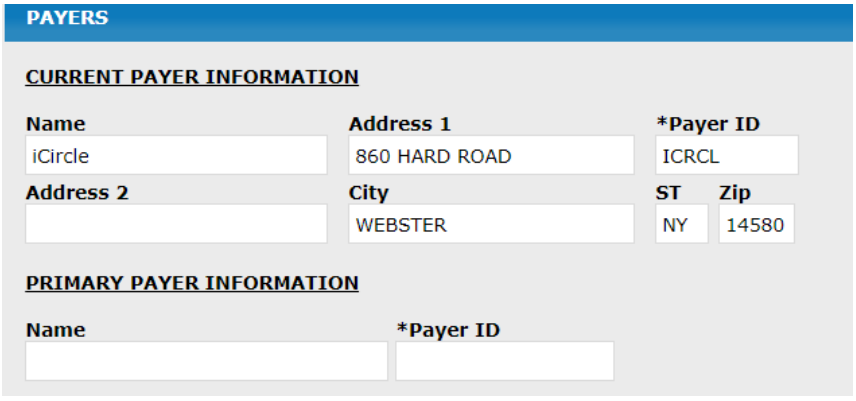
5. Click Create Claim.
6. In the **Patient** section, if the Subscriber and Patient are the same, select 'Self' from the Relationship field in The Patient sub-section, then key in the following in the Subscriber sub-section: Last name, First name, DOB, Sex, Address/City/State/Zip, and then select the Medicare 2nd Insurance from the drop-down menu.



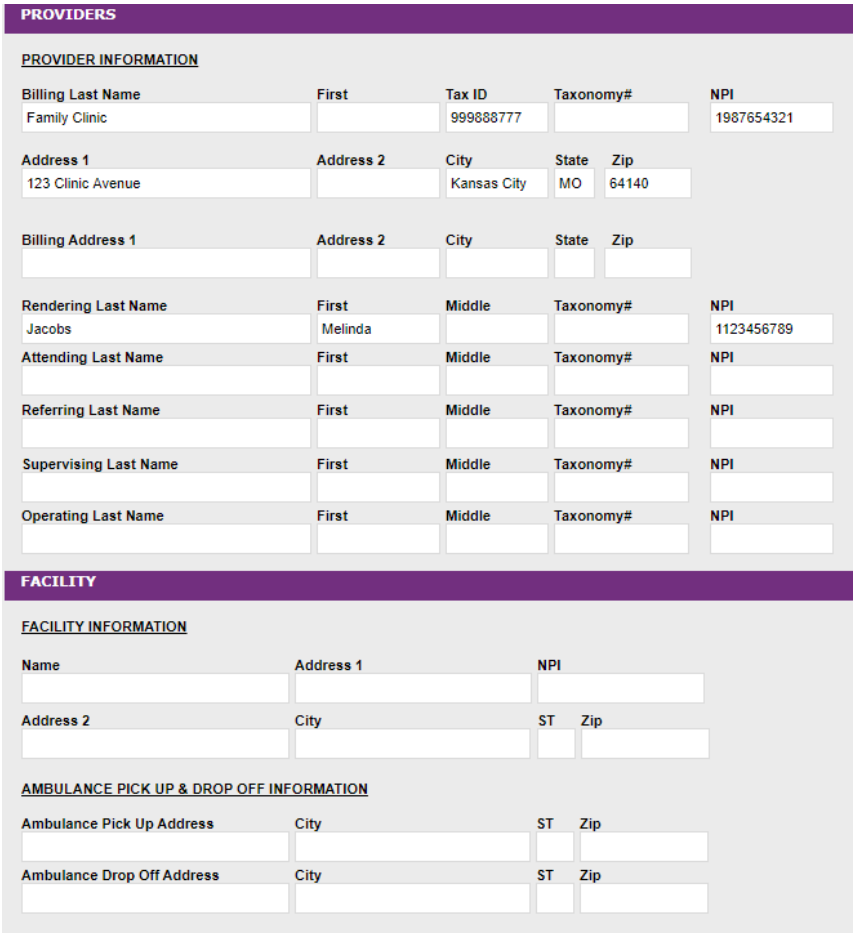
7. Fill out any necessary fields in the Payers section.
   a) For Primary Payer claims, the single payer information will auto-populate. You can move on to the next section.



   b) For Secondary and Tertiary claims, enter additional **Payer Names** and associated **Payer IDs**, then key in Subscriber information, this time entering the Subscriber ID and the Group/Policy number for each payer. Select the appropriate **Filing Code**.



8. Some of the fields in the **Providers** section will auto-populate based on the record the plan has on file. Key in all other pertinent **Provider** and **Facility** information required for the type of claim you are submitting, just as you would on a HCFA-1500 or UB-04.



PROVIDERS

PROVIDER INFORMATION

Billing Last Name	First	Tax ID	Taxonomy#	NPI
Family Clinic		999888777		1987654321

Address 1	Address 2	City	State	Zip
123 Clinic Avenue		Kansas City	MO	64140

Billing Address 1	Address 2	City	State	Zip

Rendering Last Name	First	Middle	Taxonomy#	NPI
Jacobs	Melinda			1123456789

Attending Last Name	First	Middle	Taxonomy#	NPI

Referring Last Name	First	Middle	Taxonomy#	NPI

Supervising Last Name	First	Middle	Taxonomy#	NPI

Operating Last Name	First	Middle	Taxonomy#	NPI

FACILITY

FACILITY INFORMATION

Name	Address 1	NPI

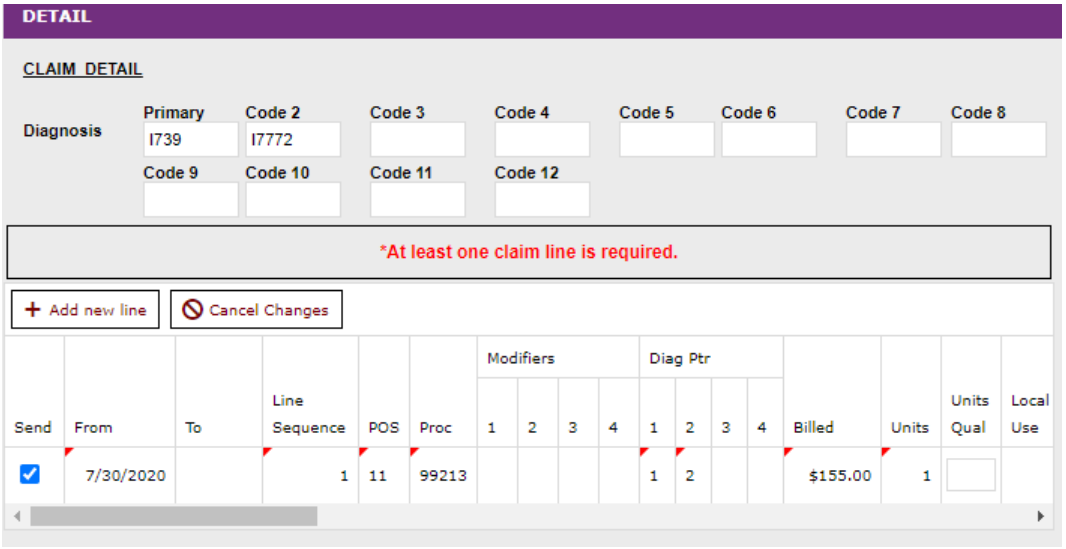
Address 2	City	ST	Zip

AMBULANCE PICK UP & DROP OFF INFORMATION

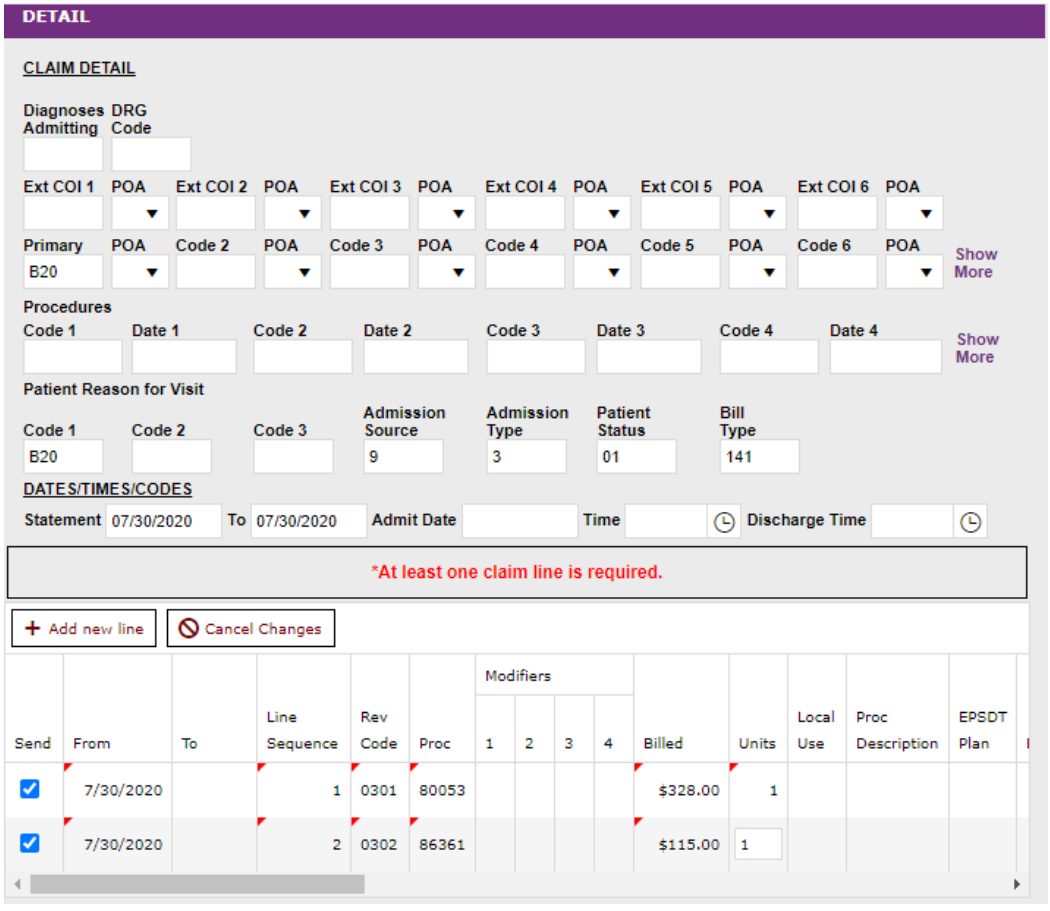
Ambulance Pick Up Address	City	ST	Zip

Ambulance Drop Off Address	City	ST	Zip

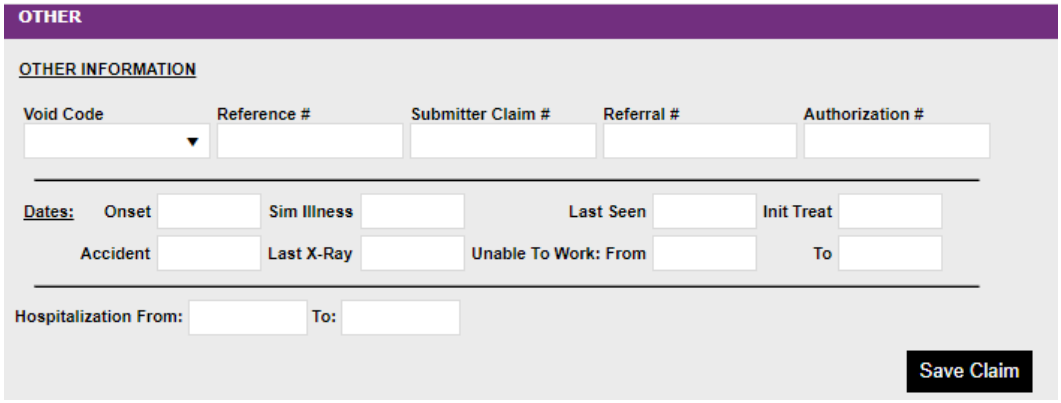
9. In the **Detail** section, enter Diagnosis Codes, then click 'Add new line'. Key in all pertinent information, scrolling to the right to access additional fields as necessary. Repeat these steps until all lines are added.



For Institutional claims, the **Detail** section will display additional fields applicable to hospital claims, as shown in the screenshot below.

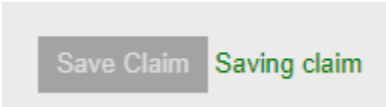


10. Key any pertinent information into the **Other** section. If the claim type or payer requires Referral or Authorization #s, be sure to add them here.



11. **Save** the claim.

    a) For **Primary Payer** claims, click **Save Claim**. If successful, the 'Saving claim' message will appear briefly before you are returned to the Direct Entry home screen.

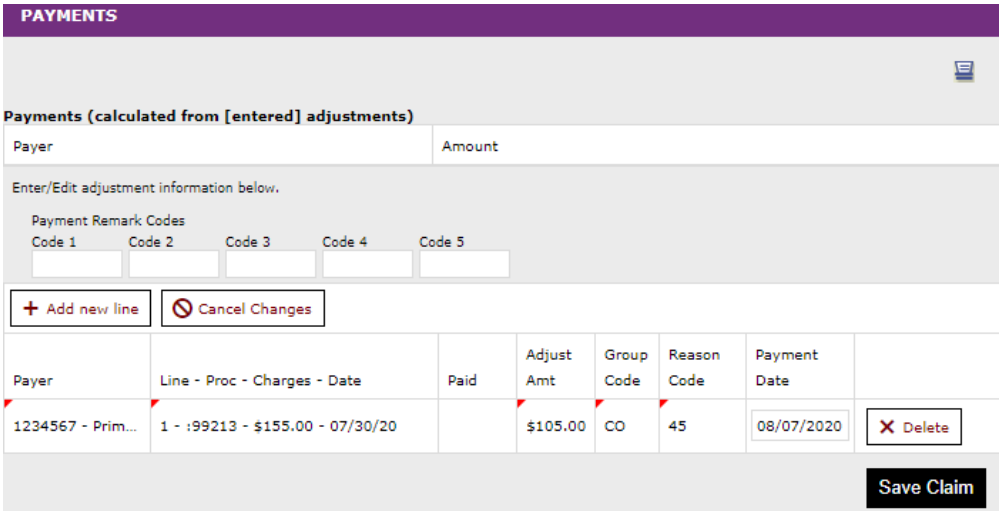


Note the green text confirming your claim was saved successfully.

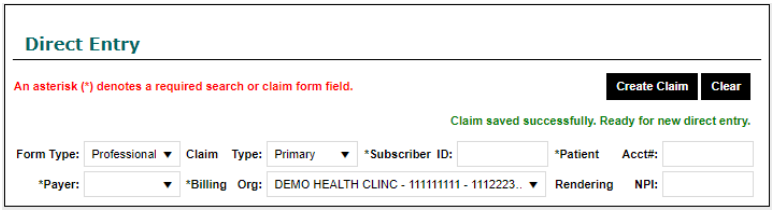
    b) For Secondary and Tertiary claims, click **Save & Continue**, then complete the **Payments** portion of the claim:

- Click **Add New Line**, then select from the choices in the **Payer** drop-down menu.
- In the **Line – Proc – Charges – Date** column, select a line to enter a line-level adjustment, or select Claim Header to enter a single claim-level adjustment.
- Click in the **Adjust Amt** field, then enter the adjustment amount (billed charges minus write-off and paid amount). You do not need to enter anything into the 'Paid' field.
- Any lines not paid in full will require the adjustment Group and Reason Codes provided by the previous payer.

- Repeat for any additional adjustments, then Click **Save Claim.**



12. Once the claim is saved, you will be returned to the Direct Entry screen to begin a new claim.



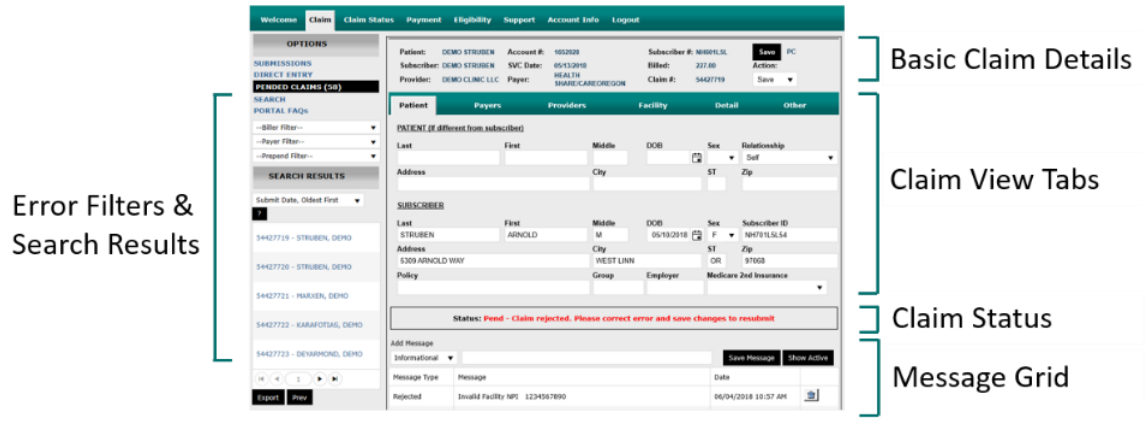
Note: Return to the portal later to review the status of claims entered.

- If the claim is pended, review pend messages, make necessary changes, and then click the Save icon in the upper right corner of the window.
- If the claim is in received status, it has not completed processing. Check the claim again later.
- If the claim is in validated status, the claim will be routed to the payer.

View and Resolve Pended Claims

View and resolve pended claims on the Pended Claims page. You can also view past claim file submissions. Pended claims should be resolved daily.

To access Pended Claims, in the **Claim Center** select **Options > Pended Claims**. All pended claims will appear in the search results.

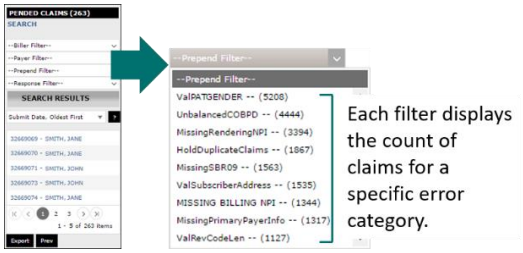


To resolve pended claims, review messages within the grid with the 'Rejected' Message Type, make the necessary changes to the claim, and save. If it is not clear to you what needs to be corrected, refer to industry standard billing guidelines and billing instructions provided by the payer.

Error Filters & Search Results

Use the Error Filters to narrow pended claims. Each filter displays the count of claims in each pend bucket based on any other filter criteria already in place (such as a specific payer).

Claims may have more than one error. Reference the Message Grid to ensure all errors have been corrected before saving and resubmitting a claim.



Filter Option	Description
Biller Filter	Filter by a specific plan.
Filter by Payer	Filter by a specific destination.
Prepend Filter	Displays pends resulting from a preset business rule. These pended claims have not been sent to the destination.
Response Filter	Displays messages provided by the destination on claims sent to them. These messages can communicate acceptance or rejection.