

Claim Direct Entry

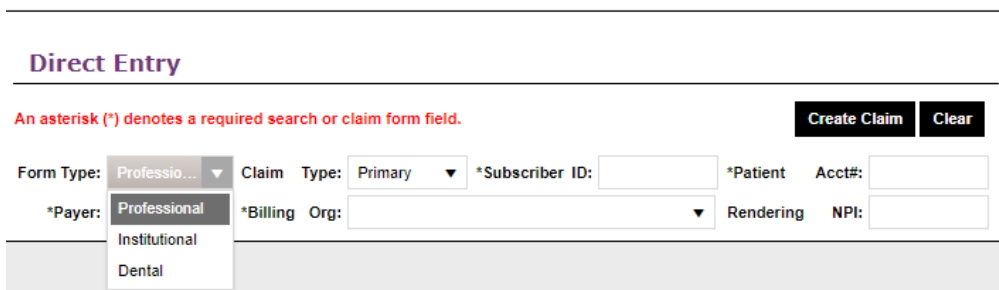


Create a Direct Entry Claim

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.



Direct Entry

An asterisk (*) denotes a required search or claim form field.

Create Claim **Clear**

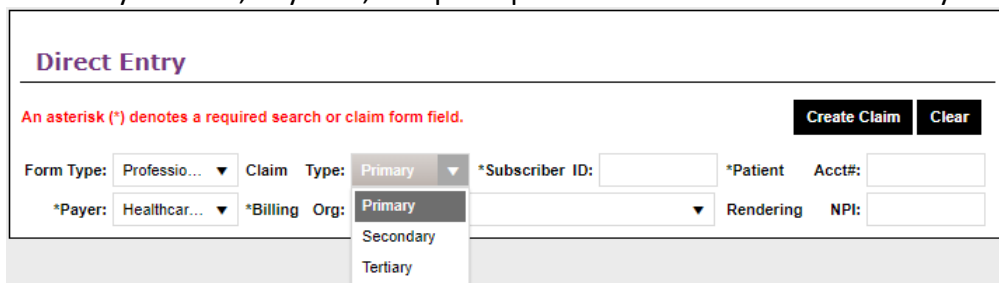
Form Type: Professional... ▼ Claim Type: Primary ▼ *Subscriber ID: *Patient Acct#:

*Payer: Professional ▼ *Billing Org: Rendering NPI:

Institutional

Dental

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.



Direct Entry

An asterisk (*) denotes a required search or claim form field.

Create Claim **Clear**

Form Type: Professional... ▼ Claim Type: Primary ▼ *Subscriber ID: *Patient Acct#:

*Payer: Healthcar... ▼ *Billing Org: Primary ▼ Rendering NPI:

Secondary

Tertiary

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.

PATIENT						
<u>PATIENT (If different from subscriber)</u>						
Last	First	Middle	DOB	Sex	Relationship	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Self	
Address		City	ST	Zip		
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>		
<u>SUBSCRIBER</u>						
Last	First	Middle	DOB	Sex	Subscriber ID	
Doe	Jane	<input type="text"/>	08/11/1980	<input type="text"/>	12345678	
Address		City	ST	Zip		
123 Anywhere St		Portland	OR	97201		
Policy	Group	Employer	Medicare 2nd Insurance			
<input type="text"/>	<input type="text"/>	<input type="text"/>	16-Public Health Service			

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.

PAYERS				
<u>CURRENT PAYER INFORMATION</u>				
Name	Address 1	*Payer ID		
iCircle	860 HARD ROAD	ICRCL		
Address 2	City	ST	Zip	
<input type="text"/>	WEBSTER	NY	14580	

- 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**.

PAYERS				
<u>CURRENT PAYER INFORMATION</u>				
Name	Address 1	*Payer ID		
iCircle	860 HARD ROAD	ICRCL		
Address 2	City	ST	Zip	
<input type="text"/>	WEBSTER	NY	14580	
<u>PRIMARY PAYER INFORMATION</u>				
Name	*Payer ID			
<input type="text"/>	<input type="text"/>			



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				
<u>PROVIDER INFORMATION</u>				
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				
<u>FACILITY INFORMATION</u>				
Name	Address 1	NPI		
Address 2	City	ST	Zip	
<u>AMBULANCE PICK UP & DROP OFF INFORMATION</u>				
Ambulance Pick Up Address	City	ST	Zip	
Ambulance Drop Off Address	City	ST	Zip	

- 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.

DETAIL

CLAIM DETAIL

Diagnosis Primary Code 2 Code 3 Code 4 Code 5 Code 6 Code 7 Code 8
 I739 I7772
 Code 9 Code 10 Code 11 Code 12

*At least one claim line is required.

Send	From	To	Line Sequence	POS	Proc	Modifiers				Diag Ptr				Billed	Units	Units Qual	Local Use
						1	2	3	4	1	2	3	4				
<input checked="" type="checkbox"/>	7/30/2020		1	11	99213					1	2			\$155.00	1		

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

DETAIL

CLAIM DETAIL

Diagnoses DRG
 Admitting Code

Ext COI 1 POA Ext COI 2 POA Ext COI 3 POA Ext COI 4 POA Ext COI 5 POA Ext COI 6 POA

Primary POA Code 2 POA Code 3 POA Code 4 POA Code 5 POA Code 6 POA [Show More](#)

Procedures
 Code 1 Date 1 Code 2 Date 2 Code 3 Date 3 Code 4 Date 4 [Show More](#)

Patient Reason for Visit
 Code 1 Code 2 Code 3 Admission Source Admission Type Patient Status Bill Type
 B20 9 3 01 141

DATES/TIMES/CODES
 Statement 07/30/2020 To 07/30/2020 Admit Date Time Discharge Time

*At least one claim line is required.

Send	From	To	Line Sequence	Rev Code	Proc	Modifiers				Billed	Units	Local Use	Proc Description	EPSDT Plan
						1	2	3	4					
<input checked="" type="checkbox"/>	7/30/2020		1	0301	80053					\$328.00	1			
<input checked="" type="checkbox"/>	7/30/2020		2	0302	86361					\$115.00	1			

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.

OTHER

OTHER INFORMATION

Void Code	Reference #	Submitter Claim #	Referral #	Authorization #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Dates:

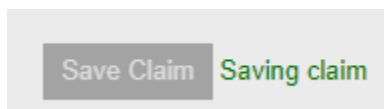
Onset	<input type="text"/>	Sim Illness	<input type="text"/>	Last Seen	<input type="text"/>	Init Treat	<input type="text"/>
Accident	<input type="text"/>	Last X-Ray	<input type="text"/>	Unable To Work: From	<input type="text"/>	To	<input type="text"/>

Hospitalization From: To:

Save Claim

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.

Direct Entry

An asterisk (*) denotes a required search or claim form field.

Create Claim **Clear**

Claim saved successfully. Ready for new direct entry.

Form Type: <input type="text" value="Professio..."/>	Claim Type: <input type="text" value="Primary"/>	*Subscriber ID: <input type="text"/>	*Patient Acct#: <input type="text"/>
*Payer: <input type="text" value="Healthcar..."/>	*Billing Org: <input type="text"/>	Rendering NPI: <input type="text"/>	

- 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**.

PAYMENTS

Payments (calculated from [entered] adjustments)

Payer	Amount
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Enter/Edit adjustment information below.

Payment Remark Codes

Code 1	Code 2	Code 3	Code 4	Code 5
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

+ Add new line
⊘ Cancel Changes

Payer	Line - Proc - Charges - Date	Paid	Adjust Amt	Group Code	Reason Code	Payment Date	
1234567 - Prim...	1 - :99213 - \$155.00 - 07/30/20		\$105.00	CO	45	08/07/2020	X Delete

Save Claim

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

Direct Entry

An asterisk (*) denotes a required search or claim form field.

Create Claim
Clear

Claim saved successfully. Ready for new direct entry.

Form Type: Professional ▾	Claim Type: Primary ▾	*Subscriber ID: <input style="width: 80%;" type="text"/>	*Patient Acct#: <input style="width: 80%;" type="text"/>
*Payer: <input style="width: 80%;" type="text"/>	*Billing Org: DEMO HEALTH CLINC - 111111111 - 1112223.. ▾	Rendering	NPI: <input style="width: 80%;" type="text"/>

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.

The screenshot shows the iCircle Care web application interface for Pended Claims. On the left, there is a sidebar with 'Error Filters & Search Results' including filters for 'Submit Date, Oldest First' and a list of search results. The main content area is divided into several sections: 'Basic Claim Details' at the top with patient and subscriber information; 'Claim View Tabs' below that with tabs for Patient, Payers, Providers, Facility, Detail, and Other; 'Claim Status' showing a red error message: 'Status: Pend - Claim rejected. Please correct error and save changes to resubmit.'; and 'Message Grid' at the bottom with a table of messages.

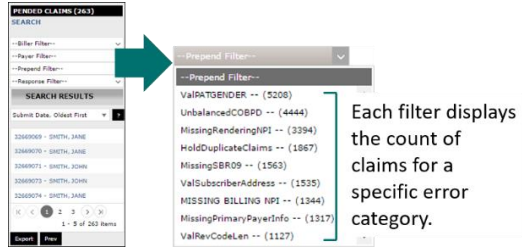
Message Type	Message	Date
Rejected	Invalid Facility NPI: 1234567890	06/04/2018 10:07 AM

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.