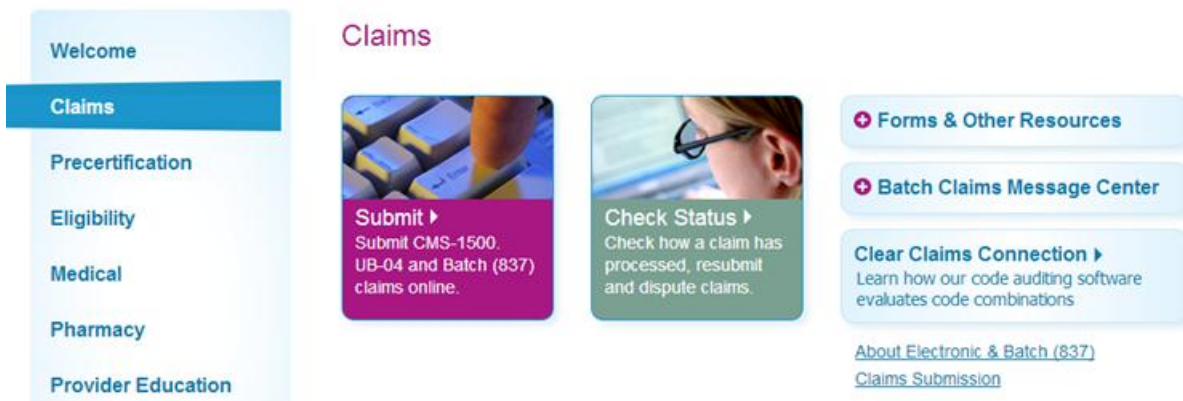


## Website User Guide: Claims Transaction Tools

The claims transaction tools on this site, allow you to:

- Submit claims
- Verify the status of one or several claims
- Use ClearClaimConnection to verify code combinations
- View Anthem HealthKeepers Plus reimbursement policies
- Obtain instructions to submit claims using Electronic Data Interchange (EDI).
- Download documents

To access the claims transaction tools, click on the claims tab on the homepage.



This guide will give you steps to:

- Submit claims
- View claim status
- Use ClearClaimConnection

## Submitting Claims on the Portal

1. Select **Claims** on the menu then click **Submit**.
2. Click **SUBMIT CLAIMS**.
3. Select the appropriate form per your contract (e.g., **CMS 1500**, **UB-04**, or **Batch 837**). **Please note** that submitting claims via Batch 837 requires you to complete the 837 Trading Partner Agreement.
4. Select your TIN in the drop-down menu then select your provider number.
5. Select the correct address.
6. Select the market for the claim in the drop-down menu.

The online forms display in the same order as the actual paper form. The menu on the left side of the page tells you where you are in the submission process. The page displayed to the right is the Patient's Information page. If you omit required information, the system will highlight those fields. You cannot go to the next page until all required information is entered. When you finish submitting the claim, print the confirmation page so you have a record of the transaction number in the event that you have a question or an issue.

CMS 1500 Form

The screenshot shows a form titled "Select TIN and then select Provider ID". It features a TIN dropdown menu with "62186" selected. Below this is a table of Provider IDs:

Provider Number	Provider Name
Select 01040	Chesapeake, Kevin A.
Select 01041	Chesapeake, David A.
Select 01044	Chesapeake, John M.
Select 01058	Chesapeake, Gordon L.
Select 01066	HealthTrust, Steven N.

Below the table is another form section for address selection:

Provider ID	Address 1	Address 2	Address 3	City	State	Zip Code
Select 01040	1224	Trotwood	Ave	Chattanooga	TN	37421

UB 04 Form

The screenshot shows the "UB 04 Form" with a left-hand navigation menu. The "Patient's Information" section is active. Fields include:

- Claim Type: [dropdown]
- 3a. Patient Control No.: [text]
- 4. Type Of Bill: [text]
- 5. Fed. Tax No.: 237133975
- Billing Facility Name: Chesapeake General Hospital
- Address: PO Box 41220, City: Phoenix, State: AZ, Zip Code: 850801220
- 6. Statement Covers Period: From [text] Through [text]
- Insurance Unique ID: ANTHEM Member ID [dropdown]
- Member ANTHEM ID: [text]
- Patient Information: 8. First Name, Last Name, Middle Initial, 9. Address, City, State, Zip Code, 10. Birth Date, 11. Sex (Male, Female, Unknown), Marital Status
- Admission: 12. Date, 13. HR, 14. Type, 15. SRC, 16. Discharge Hour, 17. Discharge Status, Medical Record Number

Buttons for "Next" and "Cancel" are visible at the bottom right.

CMS 1500 Form

The screenshot shows the "CMS 1500 Form" with a left-hand navigation menu. The "Insurance Information" section is active. Fields include:

- Member ANTHEM ID [dropdown]
- Insured ID Number: [text]
- Member ANTHEM ID: [text]
- Last Name: [text]
- First Name: [text], Middle Initial: [text]
- Address (No., Street): [text]
- City: [text], State: [text], Zip Code: [text]
- Telephone (include Area Code): [text], Birth Date: [text]
- Sex: [radio] Male [radio] Female [radio] Unknown
- Patient Marital Status: [text]
- Patient Relation To Insured: [radio] Self [radio] Spouse [radio] Child [radio] Other
- Patient Employment Status: [radio] Employed [radio] Full Time Student [radio] Part Time Student
- Clear employed / student status [button]
- Is Patient's Condition Related To:
  - a. Employment?: [radio] Yes [radio] No
  - b. Auto Accident?: [radio] Yes [radio] No State: [dropdown]
  - c. Other Accident?: [radio] Yes [radio] No

Buttons for "Next" and "Cancel" are visible at the bottom right.

## View Claim Status

Select **Claims** on the menu, and then **Check Status**. The **Claim Status Tool** page displays with the user's provider ID in the **Provider ID** drop-down menu.

### Claim Status

Claim(s) search is based on the Initial Date of Service.  
 Fields marked with an asterisk ( \* ) are required.

**Please note:** If there are several providers under the same TIN and you want to view claim status for each, make sure that all providers are activated under your user name. Otherwise, you will only be able to see claims for the one provider.

#### To view the status of an individual claim:

1. Enter the start date or date of service
2. Select the member ID number type from the drop-down menu (optional)
3. Enter the member ID number and click **Search**. All claim(s) for the selected date and member will display (optional)

To view more details on an individual claim, click the corresponding link in the status column below.

<< < Page 1 > >> Results per page 10

Status	Member #	Claim #	Date Of Service	Amount Charged	Amount Paid
<a href="#">PENDING</a>	xxxxxx	xxxxxx	10/1/2013	\$5,399.29	\$0.00
<a href="#">PENDING</a>	xxxxxx	xxxxxx	10/2/2013	\$49,191.51	\$0.00
<a href="#">PENDING</a>	xxxxxx	xxxxxx	10/11/2013	\$5,125.54	\$0.00

<< < Page 1 > >> Results per page 10

#### To view the status of several claims:

1. Enter the start date of the dates of service then enter the desired end date. The date range cannot exceed 30 days.

2. Click **Search**. Multiple claims will display for the selected date range. Click on the status of any claim line to view more details about that claim.

### Claim Details

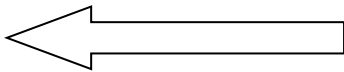
Claim Number 116546048100  
 Member Sale, Travis (714270820)  
 Date of Service 6/1/2013  
 Amount Charged \$857.00  
 Amount Paid \$0.00  
 Check Amount \$0.00  
 Check Number  
 Process Date 8/3/2013  
 Insurance Type MEDICAID  
 Claim Status Denied

CLAIM #	SERVICE DETAIL	CPT CODE	REASON
116546048100	01	99236	Termination - Member not eligible for Benefits

[Return to Results](#)

Use the buttons at the bottom of the window to take further action on the claim, including submitting an appeal.

[Resubmit CMS-1500](#) [Appeal Claim](#) [New Search](#)

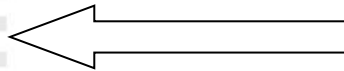


### Claim Appeals

#### Claim Details

Provider ID: xxxxxx  
 Provider Name: xxxxxx  
 Provider Address: xxxxxx  
 Provider City: Fredericksburg  
 Provider State: VA  
 Provider Zip: 224087762  
 Member ID: xxxxxx  
 Member Last Name: xxxxxx  
 Member First Name: xxxxxx  
 Member Address: xxxxxx  
 Member City: xxxxxx  
 Member State: VA  
 Member Zip: 225429073  
 Member DOB: 8/13/2006  
 Date Of Service From: 6/1/2013  
 Date Of Service To: 6/1/2013  
 Claim Type: HCFA

When you click Appeal Claim, you will see additional claims detail.



Please describe the reason for this appeal below

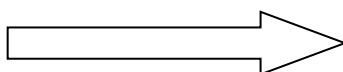
Summary of Appeal: \*

#### Claim Appeal Contact Information

First Name: \*   
 Last Name: \*   
 Street Address: \*   
 City: \*   
 State: \*   
 Zip: \*   
 Phone - enter exactly 10 numbers, no symbols: \*   
 Fax - enter exactly 10 numbers, no symbols: \*   
 Agency:   
 Email:   
 Preferred method of contact: \*

Supporting Files (25 MB Maximum, tif, tiff, pdf, xls, doc, docx Format Only)

1.    
 2.    
 3.    
 4.    
 5.

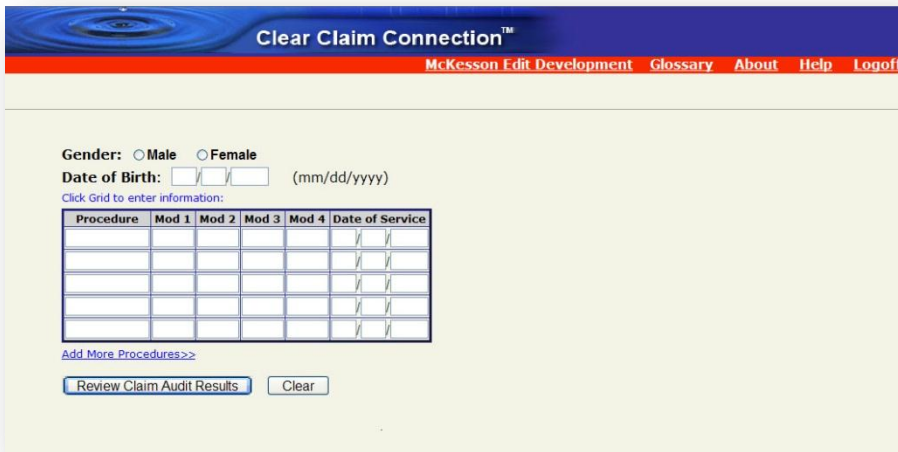


Complete the appeal contact information and attach any supporting document. Then, click Submit Appeal.

## ClearClaimConnection

HealthKeepers, Inc. offers a web-based code auditing reference tool for claims called ClearClaimConnection (C3). C3 mirrors how our current code auditing software evaluates code combinations during the adjudication of a claim. This tool allows you to access our claim auditing rules and clinical rationale built into the code auditing software.

1. Select **Claims** on the menu, then select **Clear Claim Connection**.
2. Choose your provider type and click the check box **I agree to the Terms & Conditions** to proceed. If you do not agree to the terms, you cannot use this tool.
3. Enter the member's information, the procedure codes, modifiers (if any) and the date of service.
4. Click **Review Claim Audit Results**.



The screenshot shows the Clear Claim Connection web application. At the top, there is a blue header with the text "Clear Claim Connection™" and a red navigation bar with links for "McKesson Edit Development", "Glossary", "About", "Help", and "Logoff". Below the header, the form includes a "Gender" section with radio buttons for "Male" and "Female". The "Date of Birth" section has a date input field with a placeholder "(mm/dd/yyyy)". A link "Click Grid to enter information:" is positioned above a table. The table has columns for "Procedure", "Mod 1", "Mod 2", "Mod 3", "Mod 4", and "Date of Service". Below the table is a link "Add More Procedures>>". At the bottom of the form are two buttons: "Review Claim Audit Results" and "Clear".

Procedure	Mod 1	Mod 2	Mod 3	Mod 4	Date of Service
					/ /
					/ /
					/ /
					/ /

**Remember: This tool does not guarantee payment. It explains our code edit logic on claims.**

## How to Submit Corrected Claims Electronically

### Definitions

- **Rejected claim:** A claim that was received by HealthKeepers, Inc. and deemed unclear. The claim is never loaded to the adjudication system. The claim is returned along with the reason for rejection back to the provider.
- **Accepted claim:** A claim that was received by HealthKeepers, Inc. and passed all front-end edits. The claim was successfully loaded to the adjudication system where a final determination of paid or denied is achieved.
- **Corrected claim:** Represents a claim that was accepted and finalized by HealthKeepers, Inc. The claim is updated with additional information that will potentially impact the payment of the claim (e.g., *Initial claim submission is accepted and contains a single service line. The provider realizes the lab charges were left off of the original claim and submits a corrected claim which contains the original services that were billed, plus the new service lines containing the lab charges.*)
- **Resubmission claim:** Represents a claim that was initially rejected by HealthKeepers, Inc. due to invalid or missing data. Once the appropriate changes are made to the claim in order to make the claim clean, the claim is resubmitted to HealthKeepers, Inc. for consideration.

**Note: A claim that is resubmitted is always considered and treated as a new claim.**

### Process Steps

1. **EDI Professional Claim (837P):** Providers should use one of the following frequency codes to indicate a correction was made to a previously submitted and adjudicated claim.
  - 7 – Replacement of prior claim
  - 8 – Void/cancel prior claim

*Note: Visit the NUBC website at [nubc.org](http://nubc.org) and select Resources for a full definition of each code and to confirm use of these codes on a professional claim*
2. **Indicator Placement:**
  - Loop: 2300 (Claim information)
  - Segment: CLM 05-03 (Claim frequency type code)
  - Value: 7, 8
3. **EDI Claim Institutional (837I):** Providers should use one of the following Bill Type frequency codes in order to indicate a correction was made to a previous submitted and adjudicated claim.
  - 0XX5 – Late charges only claim
  - 0XX7 – Replacement of prior claim
  - 0XX8 – Void/cancel prior claim

*Note: A full definition of each code can be referenced in a UB-04 Billing Manual.*

**4. Indicator Placement:**

- Loop: 2300 (Claim information)
- Segment: CLM 05-03 (Claim frequency type code)
- Value: 5, 7, 8

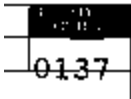
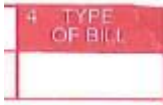
**5. Paper Claim (UB04):** Providers should use one of the following bill type frequency codes in order to indicate a correction was made to a previously submitted and adjudicated claim, or the provider may physically stamp a claim as being a corrected claim:

- 0XX5 – Late charges only claim
- 0XX7 – Replacement of prior claim
- 0XX8 – Void/cancel prior claim

*Note: A full definition of each code can be referenced on Pages II-111 through II-114 of the Ingenix UB-04 Billing Manual.*

**6. Indicator Placement:**

Field Number 4 (Type of Bill)



OR

Stamped or Handwritten:

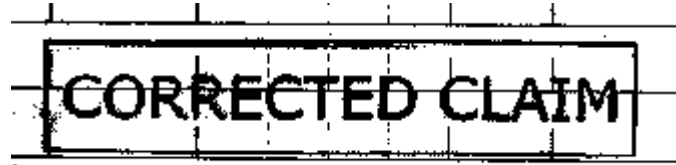


**7. Paper Claim (CMS 1500):** Providers should stamp or handwrite on the claim “CORRECTED” or “CORRECTED CLAIM” to indicate a correction was made to a previously submitted and adjudicated claim, or the provider may physically stamp a claim as being a corrected claim. The original reference number located in Field 22 can be used to report the original claim ID assigned by HealthKeepers, Inc.; however, it is not required.

- 0XX5 – Late charges only claim
- 0XX7 – Replacement of prior claim
- 0XX8 – Void/cancel prior claim

*Note: A full definition of each code can be referenced in a UB-04 Billing Manual.*

8. Indicator Placement: Stamped or Handwritten indicator: CORRECTED CLAIM



Corrected Claim

19. RESERVED FOR LOCAL USE	2ND Submission Corrected Claim	2
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Item 1, 2, 3 or 4 to Item 21E by Line)		2

20. OUTSIDE LAB?	\$ CHARGES
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO. 999999999999

**1500** Corrected Claim  
**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05  
PICA

PO BOX 62469  
VIRGINIA BEACH VA 23466

CORRECTED CLAIM PICA

CARRI

**1500** Corrected Claim #999999999999  
**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05  
PICA

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GR
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2	Corrected Claim clm #999999999999
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## **Internal Handling Procedure**

Paper claims that are stamped or contain a handwritten indicator of corrected or corrected claim are scanned and worked manually.

Electronic and web claims that contain the appropriate frequency codes are suspended for manual adjudication. Web-corrected claims submitted using the resubmit button on the portal will open a blank claim form, if the original claim was submitted via EDI, or paper. A previously submitted claim will open with the claim fields prepopulated with the original data. Once the claim is submitted through the portal, the claim is suspended and is worked manually.

In all cases stated above, if a corrected claim is determined to be a new claim and a pre-existing claim does not exist in the adjudication system, the claim is manually entered and adjudicated. If the claim is truly a corrected claim, the analyst will reopen the original claim, adjust and make any necessary changes to the claim based on the latest claim submission and adjudicate as necessary.