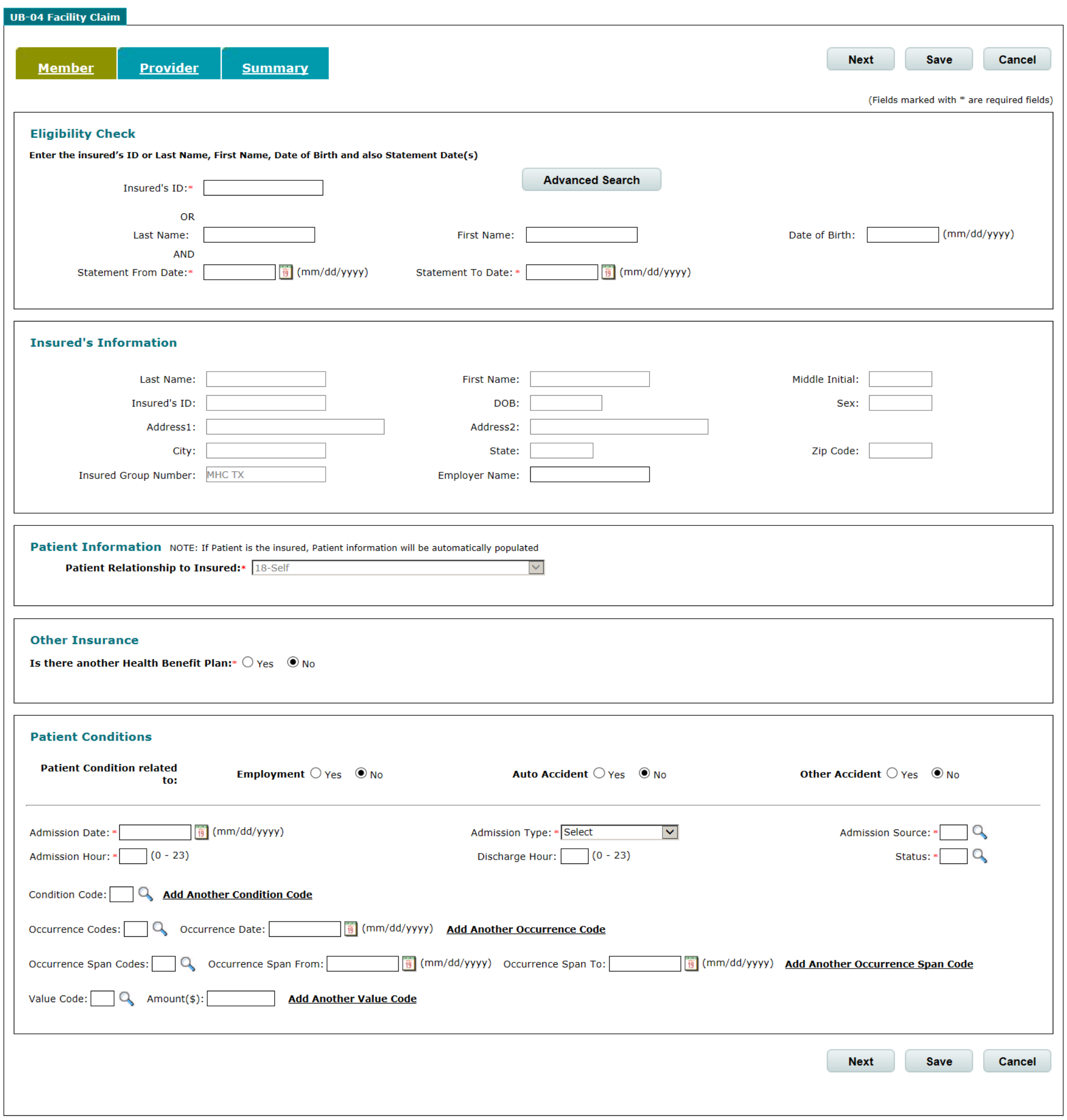
Creating Institutional Claim

This functionality enables the registered provider to submit an Institutional Claim (UB04) through the Web Portal. An encounter or zero-pay claim cannot be submitted through the Web Portal at this time. These types of submissions should continue through the existing process.

The following are the steps to submit an Institutional Claim. To fill out an Institutional Claim form (UB04) you must fill out the Member Tab and the Provider Tab. Once everything is filled out it will appear in the Summary Tab prior to submission.

Member Tab



UB-04 Facility Claim

Member | Provider | Summary

Next | Save | Cancel

(Fields marked with * are required fields)

Eligibility Check

Enter the insured's ID or Last Name, First Name, Date of Birth and also Statement Date(s)

Insured's ID:* | Advanced Search

OR

Last Name: | First Name: | Date of Birth: (mm/dd/yyyy)

AND

Statement From Date:* (mm/dd/yyyy) | Statement To Date:* (mm/dd/yyyy)

Insured's Information

Last Name: | First Name: | Middle Initial:

Insured's ID: | DOB: | Sex:

Address1: | Address2:

City: | State: | Zip Code:

Insured Group Number: MHC TX | Employer Name:

Patient Information NOTE: If Patient is the insured, Patient information will be automatically populated

Patient Relationship to Insured:* 18-Self

Other Insurance

Is there another Health Benefit Plan:* Yes No

Patient Conditions

Patient Condition related to: Employment Yes No | Auto Accident Yes No | Other Accident Yes No

Admission Date:* (mm/dd/yyyy) | Admission Type:* Select | Admission Source:*

Admission Hour:* (0 - 23) | Discharge Hour: (0 - 23) | Status:*

Condition Code: Add Another Condition Code

Occurrence Codes: Occurrence Date: (mm/dd/yyyy) Add Another Occurrence Code

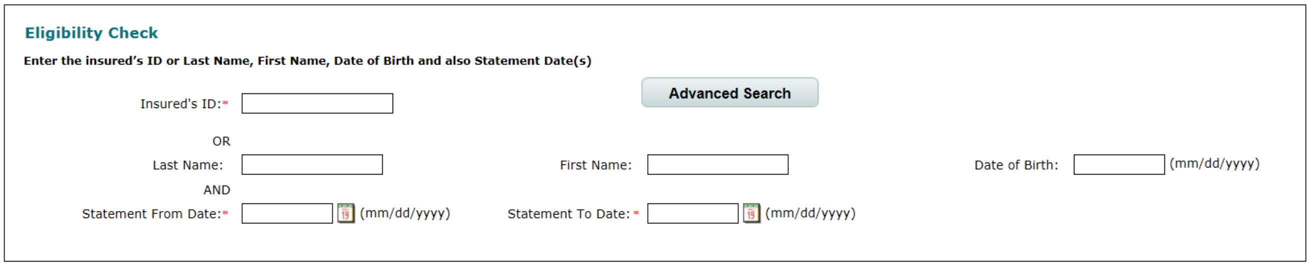
Occurrence Span Codes: Occurrence Span From: (mm/dd/yyyy) Occurrence Span To: (mm/dd/yyyy) Add Another Occurrence Span Code

Value Code: Amount($): Add Another Value Code

Next | Save | Cancel

Member Tab - Insured Information Section

The Eligibility Check section validates that the member entered is a Molina member and is eligible on the dates of service entered.


Eligibility Check

Enter the insured's ID or Last Name, First Name, Date of Birth and also Statement Date(s)

Insured's ID:*

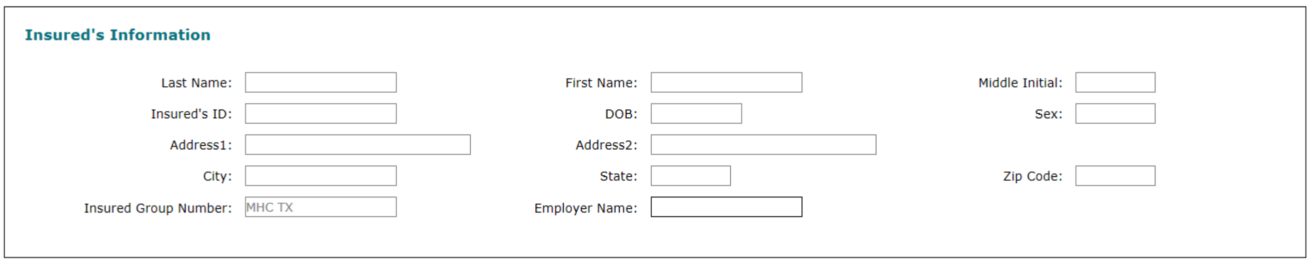
Advanced Search

OR

Last Name: First Name: Date of Birth: (mm/dd/yyyy)

AND

Statement From Date:* (mm/dd/yyyy) Statement To Date:* (mm/dd/yyyy)


Insured's Information

Last Name: First Name: Middle Initial:

Insured's ID: DOB: Sex:

Address1: Address2:

City: State: Zip Code:

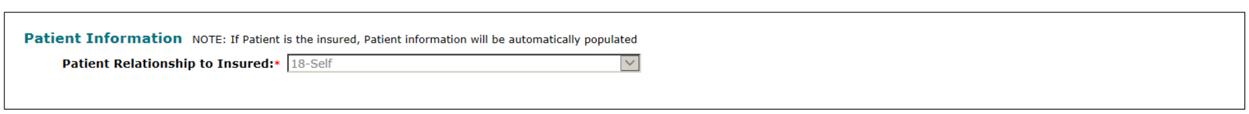
Insured Group Number: MHC TX Employer Name:

1. Enter the Insured's ID from their ID card or their Last Name, First Name and Date of Birth.
2. You must enter a Service From Date and a Service To Date

On successful validation against the dates of service entered, the Insured's information will populate. This information is not editable. If you do not know the Insured's ID number, select the Advance Search button to locate the member using the Member Eligibility Inquiry tool.

Note: Submitting claims from the Member Eligibility Inquiry or Member Roster will validate the member eligibility against a date of service of today. If the claim is not for this date of service, enter the correct dates and the member will be revalidated and the Insured's Information section will populate.

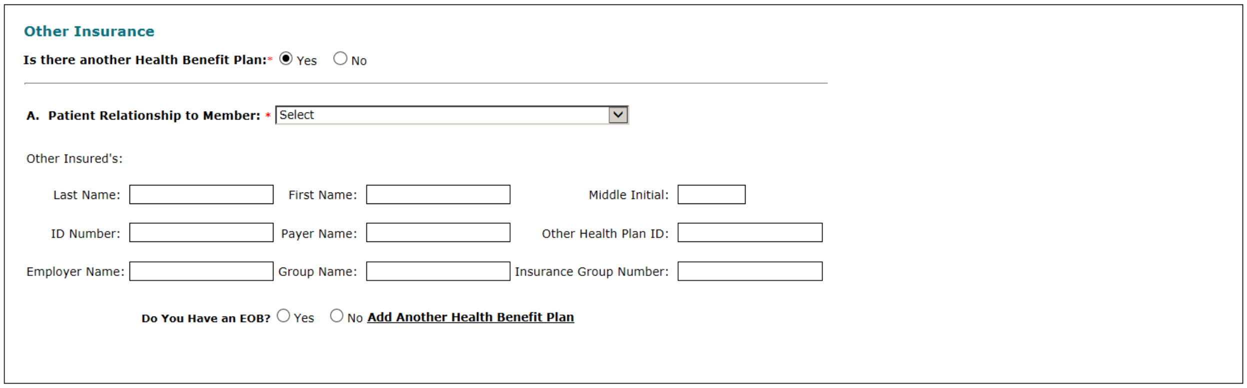
Member Tab - Patient Information Section


Patient Information NOTE: If Patient is the insured, Patient information will be automatically populated

Patient Relationship to Insured:* 18-Self

For most coverage, Patient Relationship to Insured defaults to "Self". For Marketplace coverage select the appropriate relationship and patient name. Information known in our system will automatically populate. When known, fill in any additional information as appropriate.

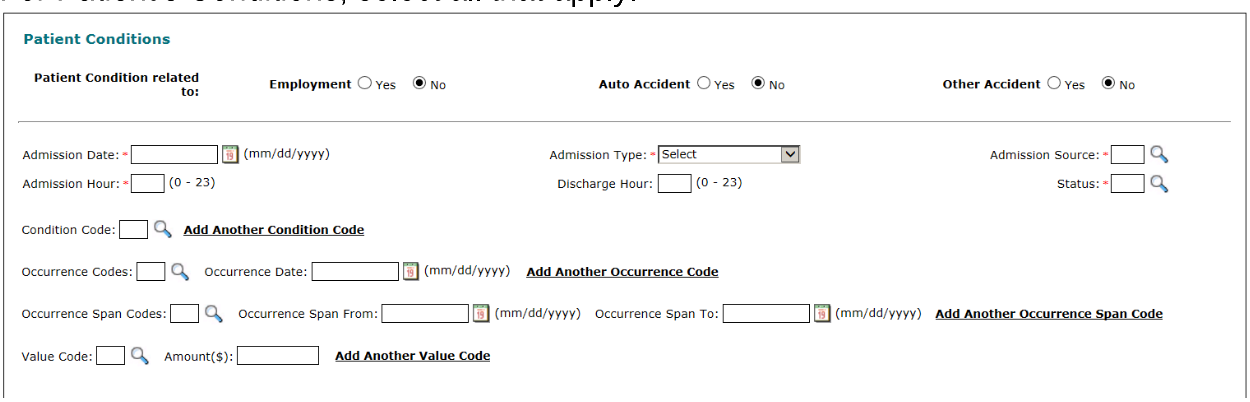
Member Tab - Other Insurance Section



If the user has another benefit plan, select YES. The fields will be enabled to enter information for the other benefit plan. Clicking yes for the question "Do you have an EOB?" will enable where you will enter additional information in the Explanation of Benefits section located in the Provider Tab.

Member Tab - Patient Condition Section

For Patient's Conditions, select all that apply.



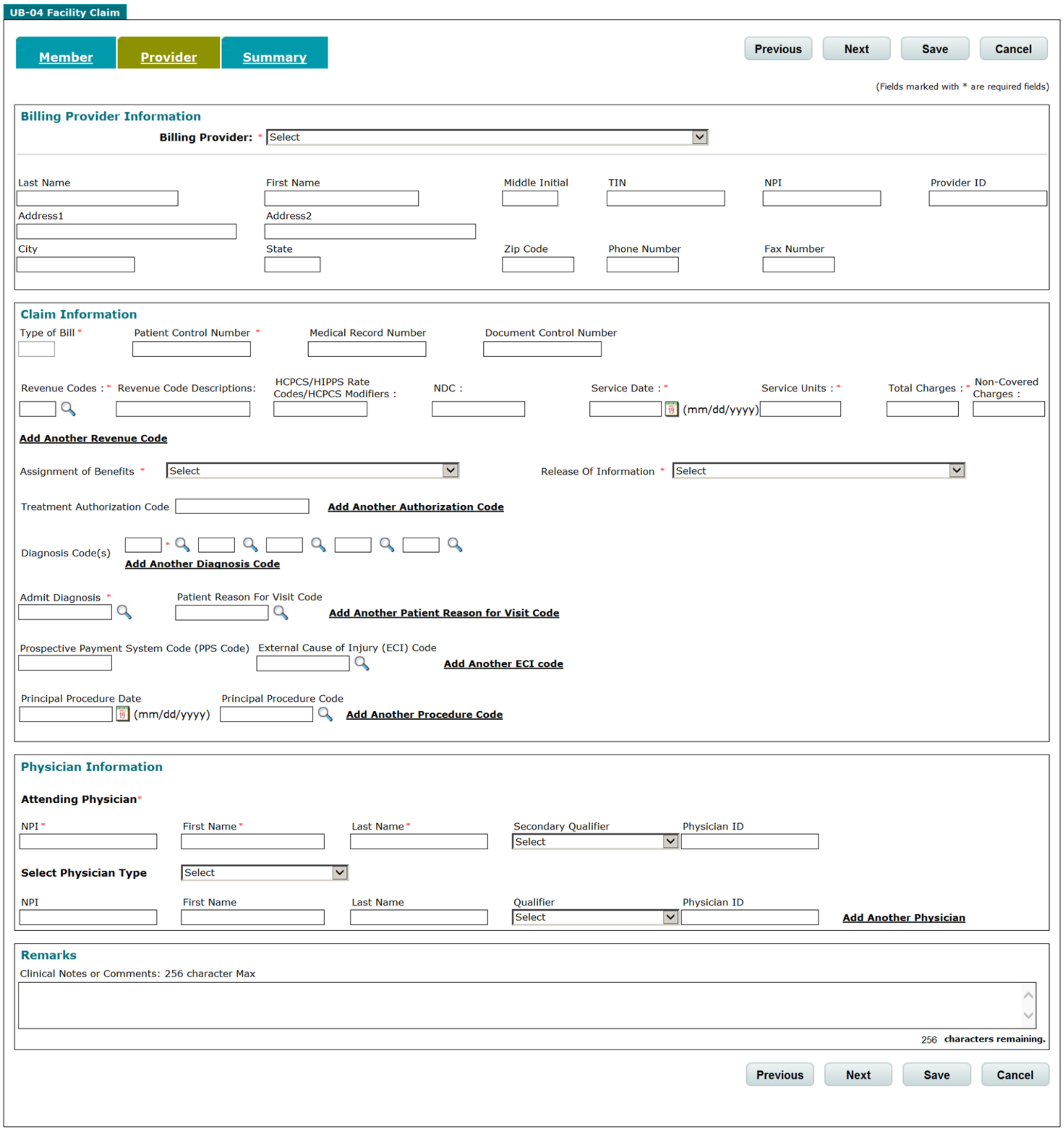
If there are any other dates known or related to the patient's condition, enter them as appropriate. Enter all required admission information for the institution Enter, search and add Condition Codes, Occurrence Span Code and dates, and Value Code.

Note: Click on the "Add another code" links and add as appropriate the necessary codes and dates needed.

If there are any other dates related to the patient's condition, those must be entered as well.

Click **Next** once all required fields have been entered/selected to move to the Provider Tab or you can save and continued at a later time by clicking on the **Save for Later** button. You will be provided a reference number and be able to retrieve the saved claim from the Incomplete Claims menu item.

Provider Tab


UB-04 Facility Claim

Member | Provider | Summary

Previous | Next | Save | Cancel

(Fields marked with * are required fields)

Billing Provider Information

Billing Provider: * Select

Last Name | First Name | Middle Initial | TIN | NPI | Provider ID

Address1 | Address2

City | State | Zip Code | Phone Number | Fax Number

Claim Information

Type of Bill * | Patient Control Number * | Medical Record Number | Document Control Number

Revenue Codes : * | Revenue Code Descriptions: | HCPCS/HIPPS Rate Codes/HCPCS Modifiers : | NDC : | Service Date : * (mm/dd/yyyy) | Service Units : * | Total Charges : * | Non-Covered Charges :

Add Another Revenue Code

Assignment of Benefits * Select | Release Of Information * Select

Treatment Authorization Code | Add Another Authorization Code

Diagnosis Code(s) *

Add Another Diagnosis Code

Admit Diagnosis * | Patient Reason For Visit Code | Add Another Patient Reason for Visit Code

Prospective Payment System Code (PPS Code) | External Cause of Injury (ECI) Code | Add Another ECI code

Principal Procedure Date (mm/dd/yyyy) | Principal Procedure Code | Add Another Procedure Code

Physician Information

Attending Physician*

NPI * | First Name * | Last Name * | Secondary Qualifier Select | Physician ID

Select Physician Type Select

NPI | First Name | Last Name | Qualifier Select | Physician ID | Add Another Physician

Remarks

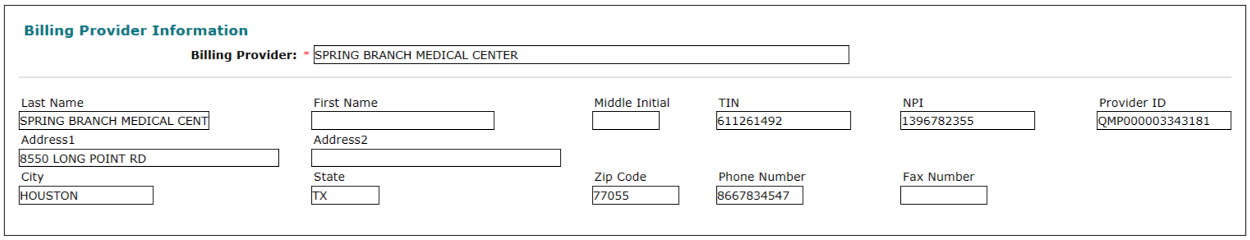
Clinical Notes or Comments: 256 character Max

256 characters remaining.

Previous | Next | Save | Cancel

Provider Tab - Billing Provider Information

The Billing Provider Information is automatically populated based on the user Web Portal account information; if more than one billing provider is associated with the user account, all billing providers will be shown. Just select the correct one from the Billing Provider drop down and the system will populate the required fields.


Billing Provider Information
Billing Provider: * SPRING BRANCH MEDICAL CENTER

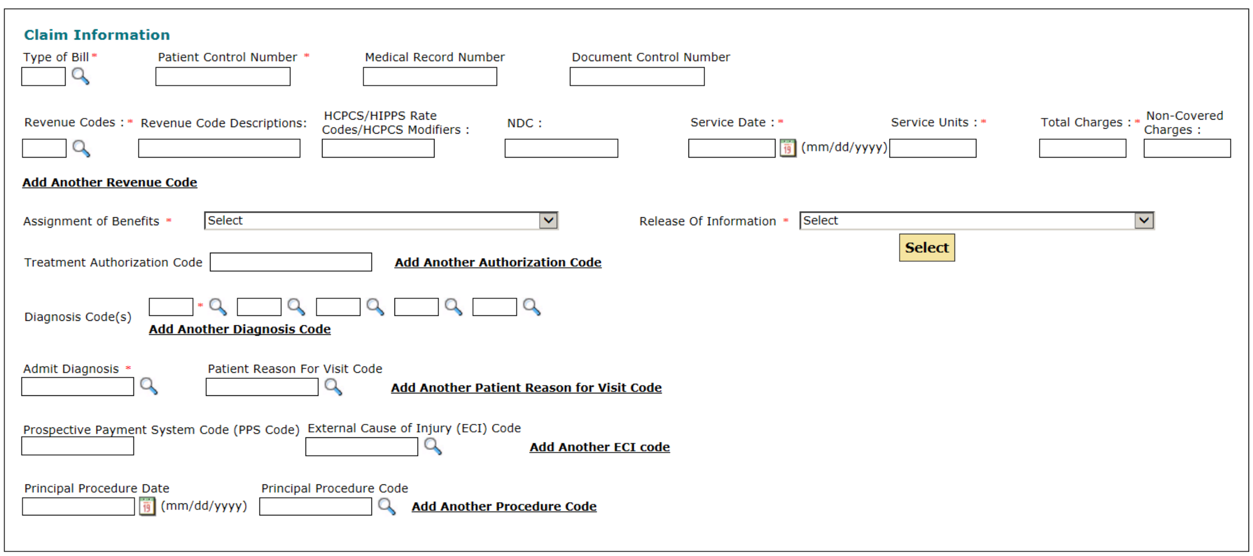
Last Name	First Name	Middle Initial	TIN	NPI	Provider ID
SPRING BRANCH MEDICAL CENT			611261492	1396782355	QMP000003343181

Address1	Address2
8550 LONG POINT RD	

City	State	Zip Code	Phone Number	Fax Number
HOUSTON	TX	77055	8667834547	

Note: The Billing Provider information is not editable and must be in our system to submit a claim online. If you have questions about the Billing Provider information, please call your Provider Services representative.

Provider Tab - Claim Information

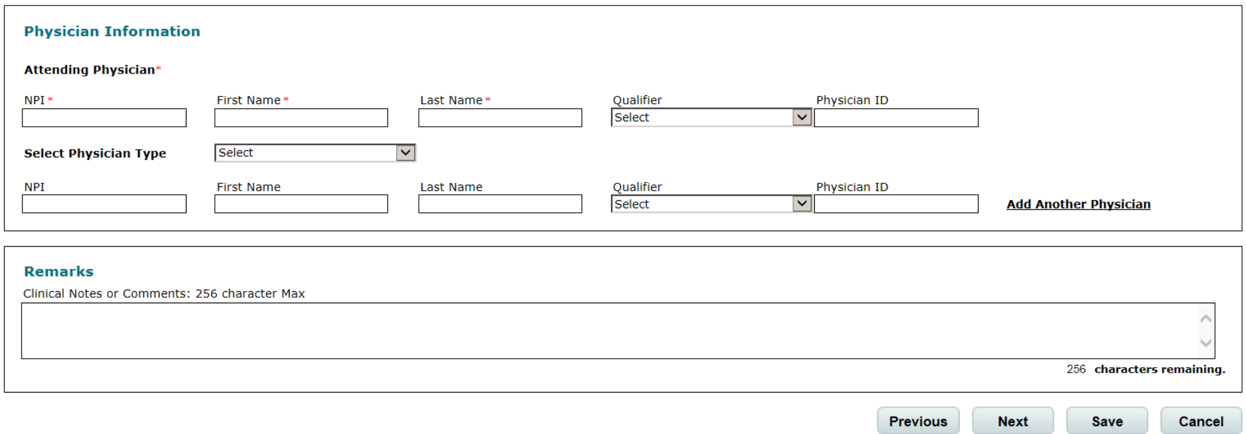


Enter all mandatory fields denoted by the red asterisks. Use the magnifying glass next to the field to search when item is not known. Example of mandatory fields includes: Type of Bill, Patient Control Number, Revenue Codes, Service Dates, Service Units, Total Charges, Assignment of Benefits, Release of Information and Diagnosis Codes where applicable.

- Add additional lines/information as needed using the provided links to create additional field/lines, such as add another Claim Line by clicking the "Add Another Revenue Code" link.
- Select an option from drop down for Assignment of Benefits and Release of Information.
- Enter Treatment authorization code if applicable and add another field as necessary.

- Enter the “Diagnosis Code”, “Admit Diagnosis”, “Patient Reason for Visit”, “PPS Code”, “External Cause of Injury code”, and “Principal Procedure Date and Code” wherever appropriate.

Physician Information and Remarks

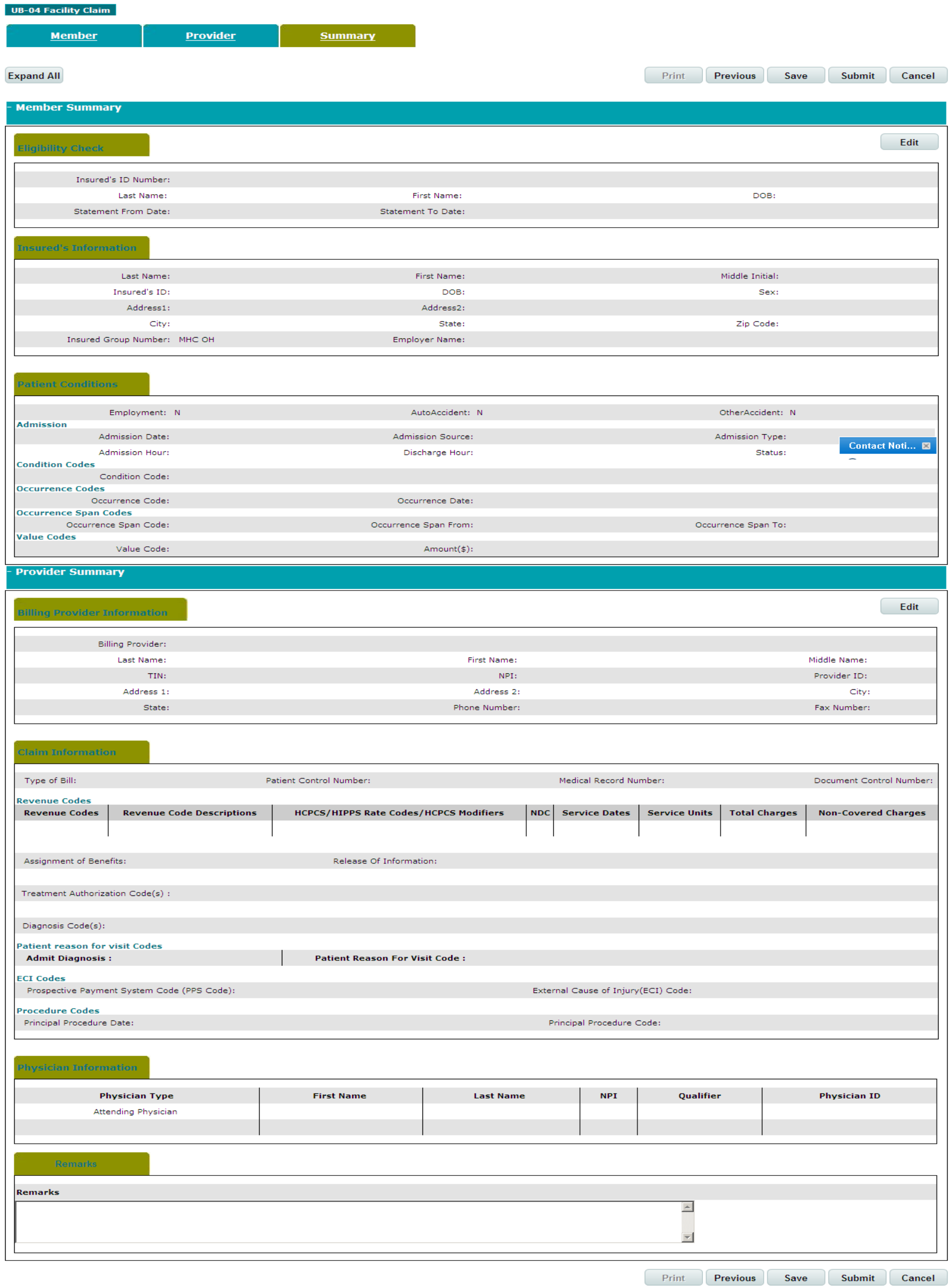


Enter Attending Physician Information in the fields provided. You also have the option to add additional physician types by using the add physician link as appropriate, such as Admitting, Operating, etc. and enter the information corresponding to each line.

In the Remarks section add comments up to 256 characters as needed.

After entering all the required and applicable fields in the Provider Tab, click on the Next button. This will navigate to the Summary Tab.

Summary Page



UB-04 Facility Claim

Member | Provider | Summary

Expand All

Print | Previous | Save | Submit | Cancel

Member Summary

Eligibility Check Edit

Insured's ID Number:
Last Name: First Name: DOB:
Statement From Date: Statement To Date:

Insured's Information

Last Name: First Name: Middle Initial:
Insured's ID: DOB: Sex:
Address1: Address2:
City: State: Zip Code:
Insured Group Number: MHC OH Employer Name:

Patient Conditions

Employment: N AutoAccident: N OtherAccident: N

Admission

Admission Date: Admission Source: Admission Type:
Admission Hour: Discharge Hour: Status:

Contact Noti...

Condition Codes

Condition Code:

Occurrence Codes

Occurrence Code: Occurrence Date:

Occurrence Span Codes

Occurrence Span Code: Occurrence Span From: Occurrence Span To:

Value Codes

Value Code: Amount($):

Provider Summary

Billing Provider Information Edit

Billing Provider:
Last Name: First Name: Middle Name:
TIN: NPI: Provider ID:
Address 1: Address 2: City:
State: Phone Number: Fax Number:

Claim Information

Type of Bill: Patient Control Number: Medical Record Number: Document Control Number:

Revenue Codes

Revenue Codes	Revenue Code Descriptions	HCPCS/HIPPS Rate Codes/HCPCS Modifiers	NDC	Service Dates	Service Units	Total Charges	Non-Covered Charges

Assignment of Benefits: Release Of Information:

Treatment Authorization Code(s) :

Diagnosis Code(s):

Patient reason for visit Codes

Admit Diagnosis : Patient Reason For Visit Code :

ECI Codes

Prospective Payment System Code (PPS Code): External Cause of Injury(ECI) Code:

Procedure Codes

Principal Procedure Date: Principal Procedure Code:

Physician Information

Physician Type	First Name	Last Name	NPI	Qualifier	Physician ID
Attending Physician					

Remarks

Remarks

Print | Previous | Save | Submit | Cancel

Summary Page - Summary Tab

The Summary Tab is where users will see all the information entered in the Member and Provider Tab. Here you can review or edit information to correct any mistakes. If everything appears correct, then the next step is to click the Submit button.

The system will validate to insure all required fields are completed and will notify the user on where to go to fix any issues. If submitted successfully, there will be a Reference Number at the top of the page. This number is used for future reference. You will also receive an email to the email address on file from your account profile notifying you where you will have the claim number for future reference