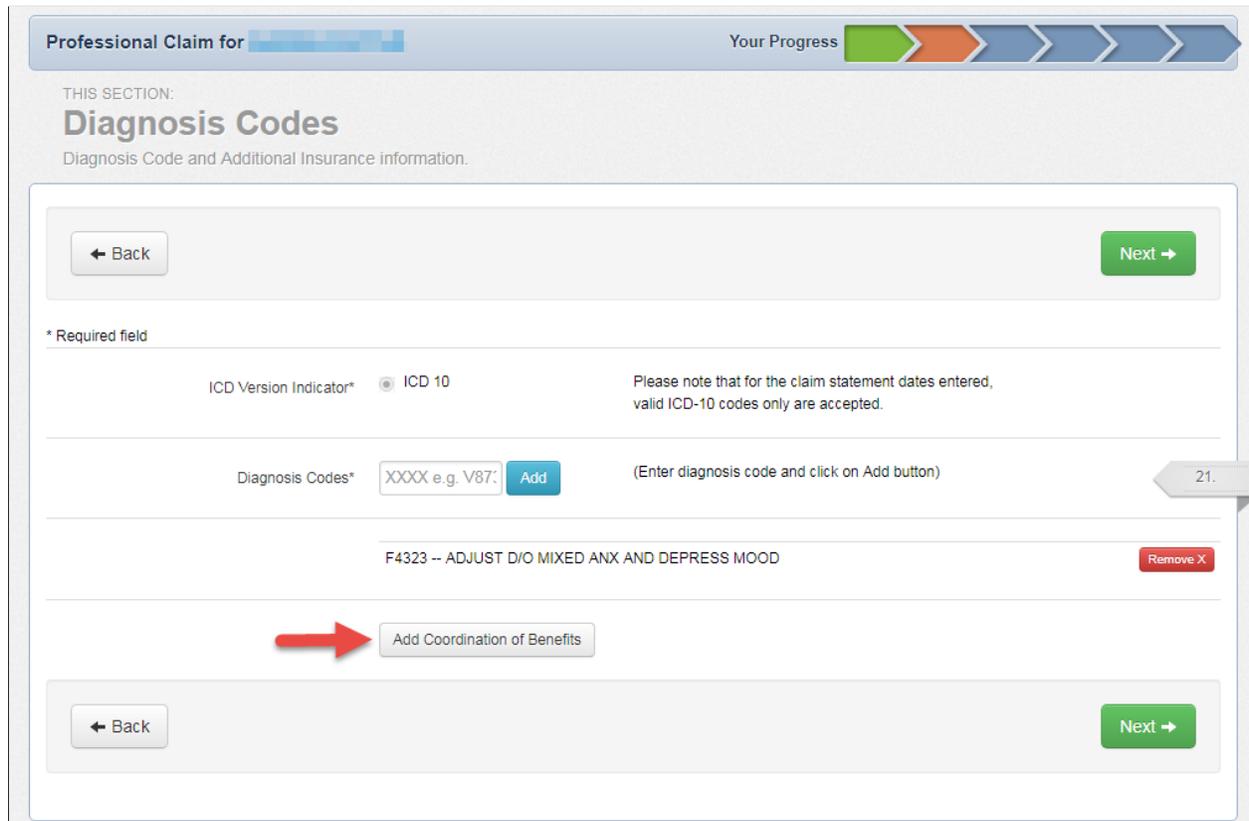


Coordination of Benefits Entry Walkthrough

This guide serves as a walkthrough for entering Coordination of Benefits (COB) information on professional claims submitted via the Secure Provider Portal.

Step 1

On the Diagnosis Codes page, click **Add Coordination of Benefits**.



Professional Claim for [REDACTED] Your Progress 

THIS SECTION:
Diagnosis Codes
Diagnosis Code and Additional Insurance information.

[← Back](#) [Next →](#)

* Required field

ICD Version Indicator* ICD 10 Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.

Diagnosis Codes* [Add](#) (Enter diagnosis code and click on Add button)

F4323 -- ADJUST D/O MIXED ANX AND DEPRESS MOOD [Remove X](#)

 [Add Coordination of Benefits](#)

[← Back](#) [Next →](#)

Step 2

Click **Carrier Type** drop-down to select the applicable carrier type and then enter the policy number. Once completed, click **Next**.

The screenshot shows the 'Primary Insurance' section of a form. At the top, there is a title 'Primary Insurance' with a red 'x Remove' button. Below it is a notice: 'Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.' The form contains two main input fields: 'Carrier Type*' and 'Policy Number*'. The 'Carrier Type*' dropdown menu is open, showing a list of options: 'Select...', '16 -- C50M - Medicare HMO', 'AM -- C50M - Automobile', 'WC -- C50M - Workmans comp', 'MB -- M5ED - Medicare Part B', 'CI -- C50M - Commercial', and 'MA -- M5ED - Medicare Part A'. A red arrow points to the 'Carrier Type*' label. Another red arrow points to the 'Policy Number*' label. At the bottom left is a 'Back' button, and at the bottom right is a 'Next' button with a red arrow pointing to it. On the right side of the form, there are two tabs labeled '9d' and '9a'.

Fill out Service Line information as per normal procedure. Then scroll down to complete the Primary Insurance fields.

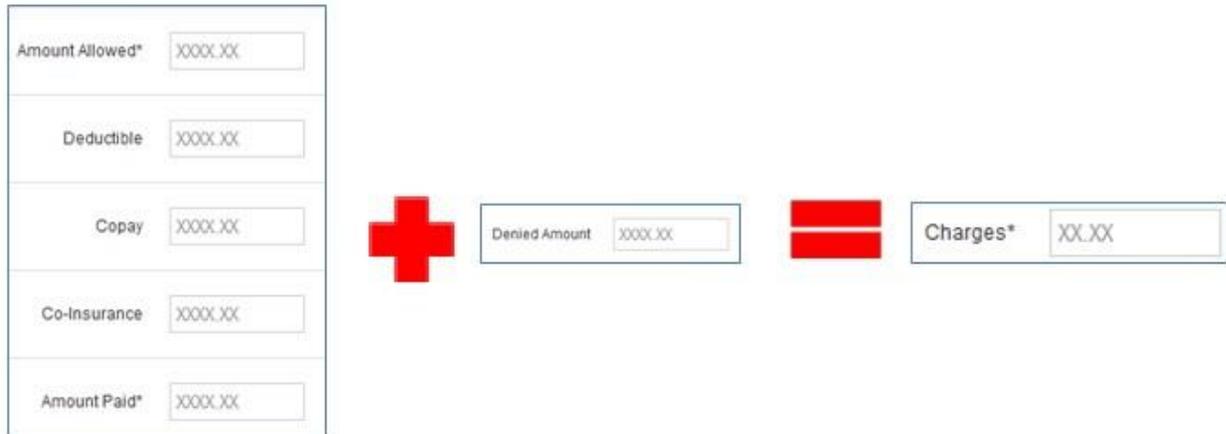
The screenshot shows the 'Service Lines' section of a form. At the top, there is a header 'Professional Claim for [redacted]' and a progress indicator 'Your Progress' with a series of colored arrows. Below the header, it says 'THIS SECTION: Service Lines' and 'Enter maximum of 50 service lines.' The form has a 'Back' button on the left and a 'Next' button on the right. A summary box on the left shows 'Total: \$73.32' and a '+ New Service Line' button. The main area is titled 'Now Viewing Line 1: T1017 / \$73.32' and contains several fields: 'Dates of Service*' (From: 07/06/2017, To: 07/06/2017), 'Place of Service*' (11 - PROVIDERS OFFICE), 'Procedure Code*' (T1017), 'Modifiers' (XX, Add button, HR, Remove X button), 'Diagnosis Code(s)*' (F4323 - ADJUST D/O MIXED ANX AND DEPRESS MOOD), 'Charges*' (73.32), 'Units / Days*' (4.0, Type: UN - Units), 'Family Planning' (Yes, No, EPSDT: Select...), 'NDC' (NDC), and 'Supplemental Information' (Supplemental Information). On the right side of the form, there are several tabs labeled '24.a' through '24.h'. At the top right of the form, there are 'Delete' and 'Save / Update' buttons.

Step 4

Enter the line items on the primary insurance in accordance with the rules of the section.

COB entry rules: The amount charged for services (entered by provider on line 24f) must equal the total of the line items from the **Primary Insurance** fields and the **Service Line Denial Reason** section. So the following must be true before moving forward:

Total of the **Primary Insurance** fields + **Denied Amount** = **Total Charges**



Another way to display the equation is:

Charges - Total of Primary Insurance Fields = Denied Amount



There are a number of scenarios that may be encountered when entering this information. Please review the following examples for more information.

Example 1

Total Charges on line 24f = \$100

Amount Allowed by primary = \$60

Amount Paid by primary = \$60

In this example, the provider is charging \$100 and the primary paid \$60. This leaves a remainder of \$40, which should be entered in the Denied Amount field and a Denied Category must be selected.

Primary Insurance	
<small>Notice: If the Member has more than one primary insurance (Medicaid would be th</small>	
Amount Allowed*	<input type="text" value="60"/>
Deductible	<input type="text" value="XXXX.XX"/>
Copay	<input type="text" value="XXXX.XX"/>
Co-Insurance	<input type="text" value="XXXX.XX"/>
Amount Paid*	<input type="text" value="60"/>
Service Line Denial Reasons	
Denied Category	<input type="text" value="Over Allowable"/> ▼
Denied Amount	<input type="text" value="40"/>

Example 2

Total charges on line 24f = \$100

Amount Allowed by primary = \$50

Member responsibility is a copay = \$20

Amount Paid by primary = \$30

In this example, the total charges are \$100. The primary Amount Allowed is \$50 and the member had a co-pay responsibility of \$20. Therefore, the primary paid the remaining \$30. (i.e. Amount Allowed (\$50) – Copay (\$20) = Amount Paid (\$30)).

The amount received from the primary (\$30) and member (\$20) totals \$50. This leaves a remainder of \$50, which should be entered in the Denied Amount field and a Denied Category must be selected.

Primary Insurance	
<small>Notice: If the Member has more than one primary insurance (Medicaid would be the</small>	
Amount Allowed*	<input type="text" value="50"/>
Deductible	<input type="text" value="XXXX.XX"/>
Copay	<input type="text" value="20"/>
Co-Insurance	<input type="text" value="0"/>
Amount Paid*	<input type="text" value="30"/>
Service Line Denial Reasons	
Denied Category	<input type="text" value="Over Allowable"/> ▼
Denied Amount	<input type="text" value="50"/>

Step 6

Click **Add Denied Reason**, to add the EOB information entered to the Service Line. Once clicked, the denied amount and category will appear below the button.

Service Line Denial Reasons
Select denied category, enter amount and click "Add Denied Reason" to add a denied amount to your claim.

Denied Category

Denied Amount



\$ 50.00 Over Allowable

Step 7

Click the **Save/Update**.

If everything was entered correctly, then there will be no error messages and you can continue on.

Please Note: Steps 4 – 7 must be completed for each Service Line on the web claim.

Step 8

After entering the Provider Details on step 3 of claim submission, proceed forward to step 4 - Attachments. It is **not a requirement** to include a copy of the explanation of Benefits received from the primary payer. We offer this as an optional feature.

Note: If the EOB is from Medicare and includes the EOB information for several other claims, this does not present a problem. You can attach the entire image.

Professional Claim for [REDACTED] Your Progress

THIS SECTION:
Attachments
Add attachments to the claim (5MB limit). Supported types are .jpg, .tif, .pdf and .tiff

← BackIf there are no attachments, click Next.Next →

Attachments

**Do NOT send password protected files. You must click ATTACH for each file being submitted.*

File* No file chosen Attachment Type*

There are no attached files.

← BackIf there are no attachments, click Next.Next →