User Guide

ForwardHealth Provider Portal Professional Claims

December 15, 2025

WISCONSIN DEPARTMENT
of HEALTH SERVICES

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1 Introduction

Providers may submit professional claims directly to ForwardHealth using Direct Data Entry, an online application, available through their secure ForwardHealth Provider Portal.

2 Access the Claims Page

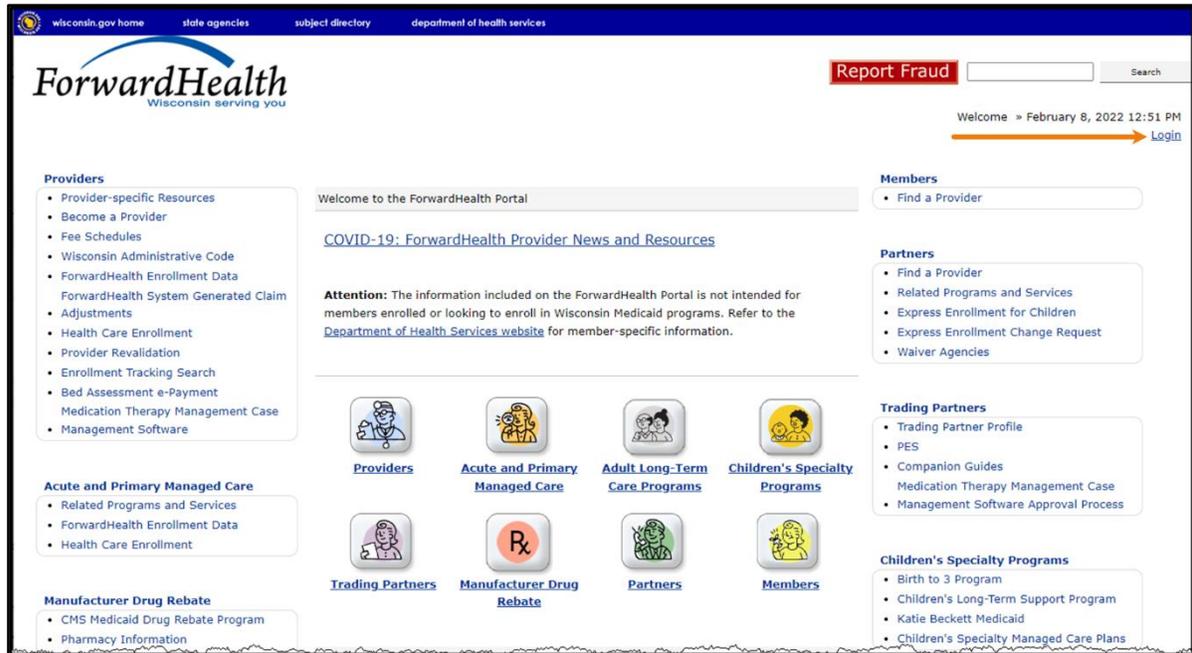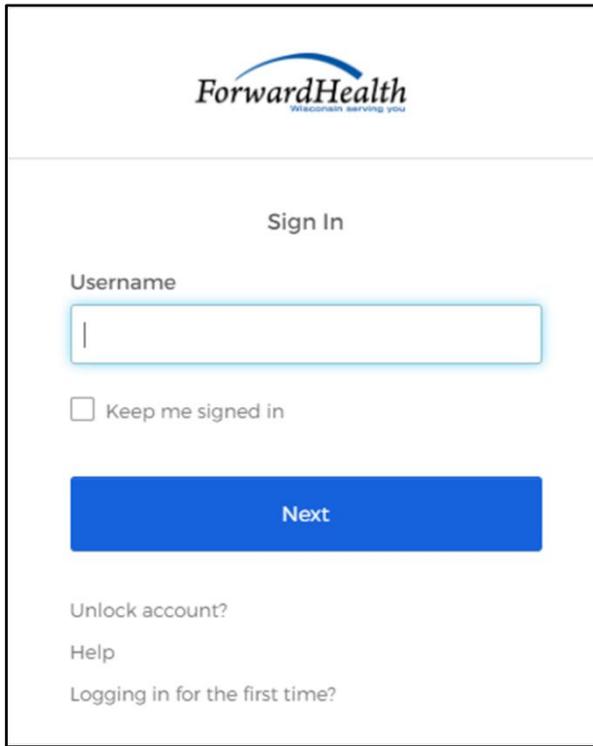1. Access the ForwardHealth Portal (the Portal) at forwardhealth.wi.gov/.

Figure 1 ForwardHealth Portal Homepage

2. Click **Login**. A Sign In box will be displayed.

Figure 2 Sign In Box

3. Enter the user's username.

4. Click **Next**. A Verify with your password box will be displayed.
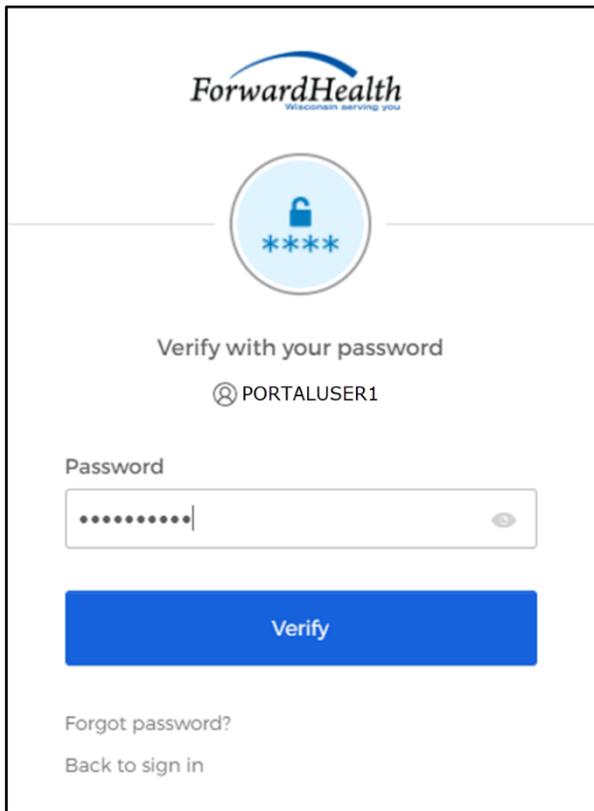

Figure 3 Verify With Your Password Box

5. Enter the user's password.

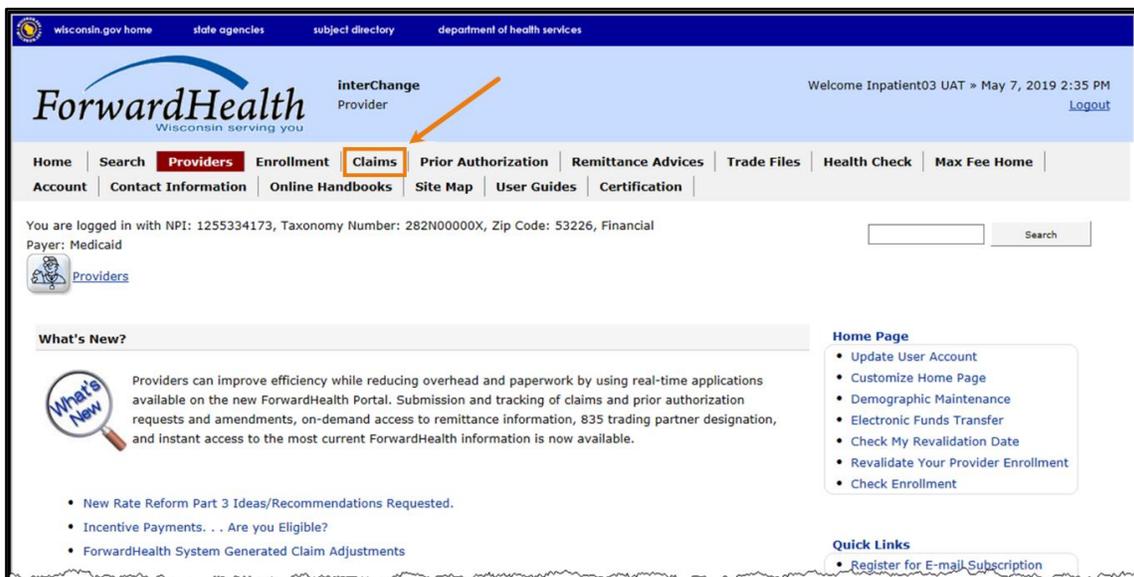6. Click **Verify**. The user's secure provider page will be displayed.

Figure 4 Secure Provider Page

7. Click **Claims** on the main menu at the top of the page. The Claims page will be displayed.

Claims

User Guides
• Portal User Guides

Claims Submission Options
Providers may submit claims to ForwardHealth electronically or on paper. Providers are encouraged to submit claims electronically as it improves efficiency, reduces billing and processing errors, and allows for the timely processing of payments.

Providers may begin the claim processing function by clicking on the following options.

What would you like to do?

• Claim search
• Claims Submission Report
• Submit Dental Claim
• Submit Institutional Claim
• Submit Compound/Noncompound Claim
• Submit Professional Claim
• Upload Claim Attachments
• WWWP Reporting Form Search
• Submit WWWP Breast Cancer Diagnostic and Follow Up Report
• Submit WWWP Cervical Cancer Diagnostic and Follow Up Report
• Submit WWWP Breast and Cervical Cancer Screening Activity Report
• Private Duty Nursing - Prior Authorization Claims Report

Providers having difficulties determining which method to use when submitting a claim, or in submitting a claim through the Portal, may call provider services at 800-947-9627.

Figure 5 Claims Page

All claim type submission options are available from this page.

Children's Long-Term Support Program (CLTS) providers will see the followings options on their Claims page.

• Claim search

• Claims Submission Report

• Submit Institutional Claim

• Submit Professional Claim

• Upload Claim Attachments

• Create a Claim From Prior Authorization (PA)

3 Submit a Professional Claim

1. Click **Submit Professional Claim** in the "What would you like to do?" section of the Claims page. The Professional Claim form will be displayed.

Figure 6 Professional Claim Form

3.1 Professional Claim Panel

Users may enter a claim's header information on the Professional Claim panel.

Note: Fields marked with an asterisk (*) are required fields. Certain fields may not apply to the user's claim type or program. CLTS providers can contact the CLTS operations team at 844-942-5870 for any questions about their program requirements.

Figure 7 Professional Claim Panel

Information cannot be entered in the ICN field. ForwardHealth will automatically assign an internal control number (ICN) when the claim is submitted.

For all providers except hospitals and non-healthcare providers, the Provider ID field will be populated with the National Provider Identifier (NPI) under which the user is logged in. For non-healthcare providers, the Provider ID field will be populated with their Medicaid ID.

For users logged in with a hospital account, this field will have a drop-down menu containing the hospital's main NPI and any sub-part NPIs assigned to that hospital.

1. From the Provider ID drop-down menu, select the NPI to be indicated on the claim being submitted.

Figure 8 Provider ID Drop-Down Menu for Hospital Accounts

2. Enter the member's ID in the Member ID field.

   Note: After entering the member's ID, click anywhere on the gray area of the form. The Last Name, First Name, MI, and Date of Birth fields will populate with the member's information.

3. Enter the provider's internal number assigned to the patient's account in the Patient Account # field.

4. Enter the provider-assigned medical record number for the service(s) being processed in this claim in the Medical Record # field.

5. Enter the NPI or Medicaid ID of any provider who performed services in the Rendering Provider field.

6. Enter the NPI or Medicaid ID of the provider, or providers, who referred the member for services in the Referring Provider 1 and Referring Provider 2 fields if applicable. Users may enter an NPI or Medicaid ID in the field, or search for the NPI or Medicaid ID using the adjoining Search link.

   Note: If a field exists at both the header and detail level, enter the information in one or the other but not necessarily both. The header will apply automatically to all details. Enter information at the detail only if different than the header value for these details.

7. Select a Medicare disclaimer status from the Medicare Disclaimer drop-down menu for traditional Medicare Part A, traditional Medicare Part B, or Medicare Advantage payers. The only valid options include the following:

   - *No Disclaimer*—No disclaimer exists.

   - *7 Mcare disallowed/denied pymt*—Medicare has disallowed or denied the payment according to Medicare rules. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted.

   - *8 Noncovered Mcare srv*—The service provided to the member was not billed to Medicare because the service is not covered under certain circumstances.

Note: The Medicare Disclaimer field should be used to indicate a claim by a Medicare provider for a member with Medicare coverage that the provider wishes to have processed as if it were a primary claim by ForwardHealth (that is, not secondary to Medicare). If a Medicare disclaimer is used, no information should be entered in the Medicare Information (Header) or the Medicare Information (Detail) panels.

8. The Other Insurance Indicator drop-down menu is no longer used on claims submitted on or after June 14, 2014, but remains on this panel for viewing claims submitted before June 14, 2014. Providers are required to use the Other Insurance Header, Detail, and EOB Information panels to report other insurance (OI) information.

9. Enter the referral number in the Referral Number field. The referral number is a unique identifier that can be used to locate the records of a submitted claim.

10. Enter the total charge for the service(s) being provided to the member in the Total Charge field.

11. Enter the amount that was paid by a commercial insurance carrier in the Other Insurance Amount field.

    Information cannot be entered in the Total Amount Paid field. The total amount paid will be automatically calculated after the claim is submitted.

12. The Net Difference is the paid amount differences between the original ICN and adjustment ICN. This amount is displayed after an adjustment is processed to completion (paid/deny) for an ICN.

13. Enter the PA number in the PA Number field.

    Note: The PA Number field will only be displayed for CLTS providers.

3.1.1 Diagnosis Panel

1. Click **Diagnosis** at the bottom of the Professional Claim panel.

Figure 9 Diagnosis Link

The Diagnosis panel will be displayed.

Figure 10 Diagnosis Panel

2. Enter a diagnosis code from the International Classification of Diseases (ICD) coding structure in the Diagnosis 1 field or search for a code using the Search link to the right of the field.

   Note: Do not use a decimal point when entering a diagnosis code. For example, for ICD diagnosis code 041.00, enter 04100.

   For more information about covered services and reimbursement, refer to the ForwardHealth Online Handbook.

To search for a diagnosis code, complete the following steps:

a. Click **Search** to the right of the applicable Diagnosis field. The Diagnosis search panel will be displayed.
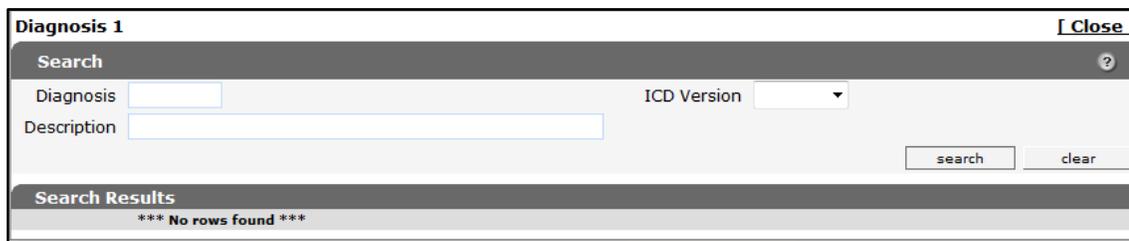
Figure 11 Diagnosis Search Panel

b. Enter a description of the code.

- If the entire description is unknown, enter a key word or partial description.

- When entering a partial description, use the percent symbol (%) as a wildcard search character on either side of a word to display all codes containing that word.

c. Click Search. Any diagnosis codes matching the query will be displayed in the "Search Results" section of the panel.

Figure 12 Search Results Panel

d. Click the applicable diagnosis code. The Diagnosis search panel will close, and the selected code will populate the Diagnosis field.

Figure 13 Diagnosis Code Added to Professional Claim Form

3. Add additional diagnosis codes to the claim, if necessary. To delete a diagnosis code, erase the entry.

Note: The same procedure can be used for other search links on the Professional Claim form.
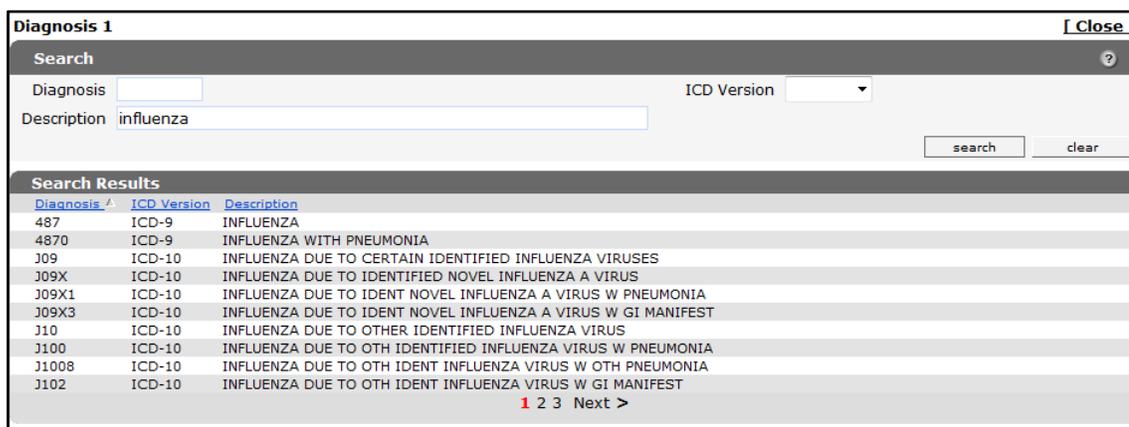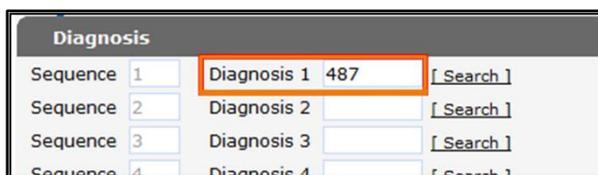
4. Enter additional diagnosis codes, if necessary. Providers may enter up to 12 diagnosis codes per claim.

3.1.2 Condition Panel

Through the Condition panel, users can enter a code(s) identifying a condition related to this claim, if applicable. For more information, refer to the UB-04 Billing Manual available through the National Uniform Billing Committee website at nubc.org/.

1. Click **Condition** at the bottom of the Professional Claim panel.

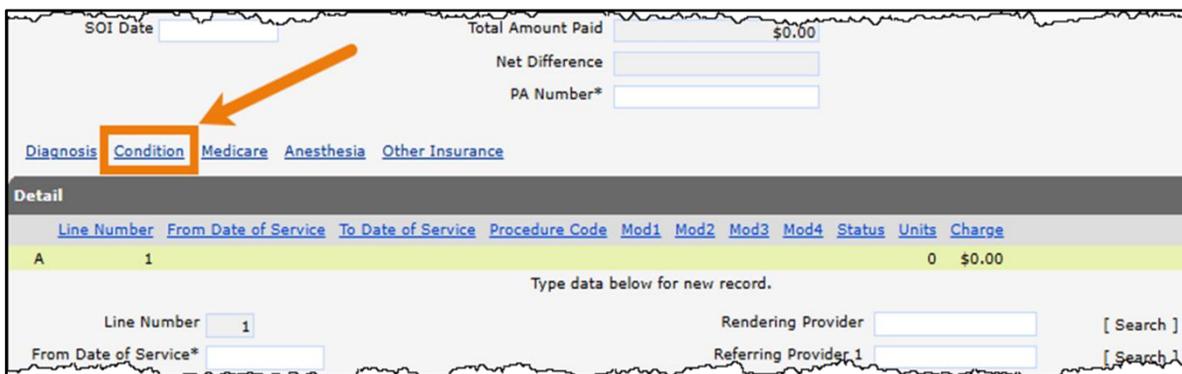**Figure 14** Condition Link

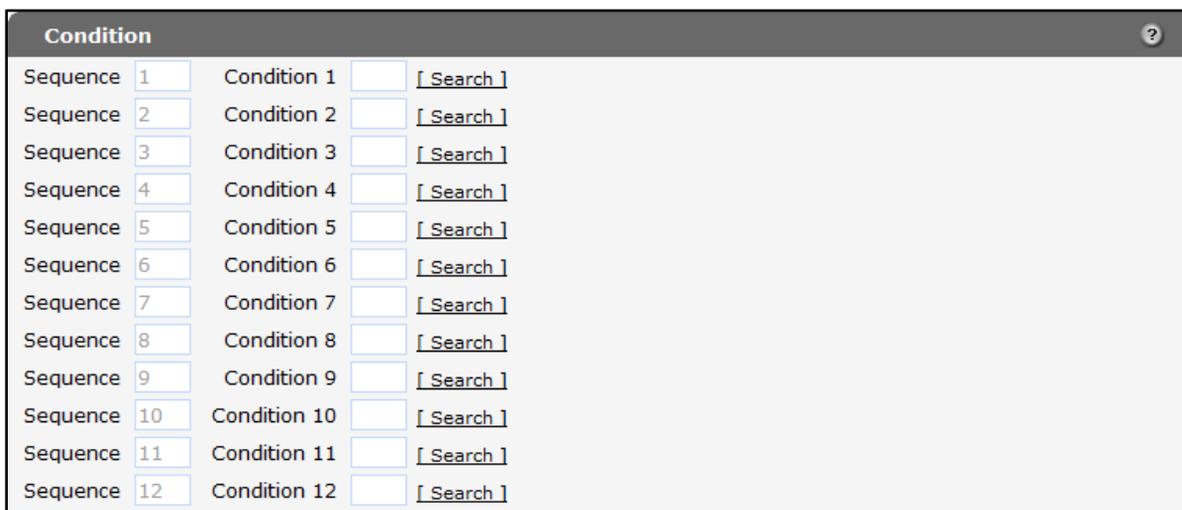The Condition panel will be displayed.

Figure 15 Condition Panel

2. Enter the code that identifies conditions relating to the claim that may affect processing in the Condition Code 1 field or search for a code using the Search link to the right of the field.

3. Enter additional condition codes, if necessary. Providers may enter up to 12 condition codes per claim.

3.1.3 Medicare Information (Header) Panel

Through the Medicare Information panels (Header and Detail), users can report Medicare (or Medicare Advantage Plan) payment and adjustment information, which allows ForwardHealth to process a Medicare secondary claim.

Note: If Medicare does not cover the entire claim, do not use the Medicare Information (Header) and/or Medicare Information (Detail) panels. Return to Step 7 of 3.1 Professional Claim Panel to select the appropriate Medicare disclaimer code.

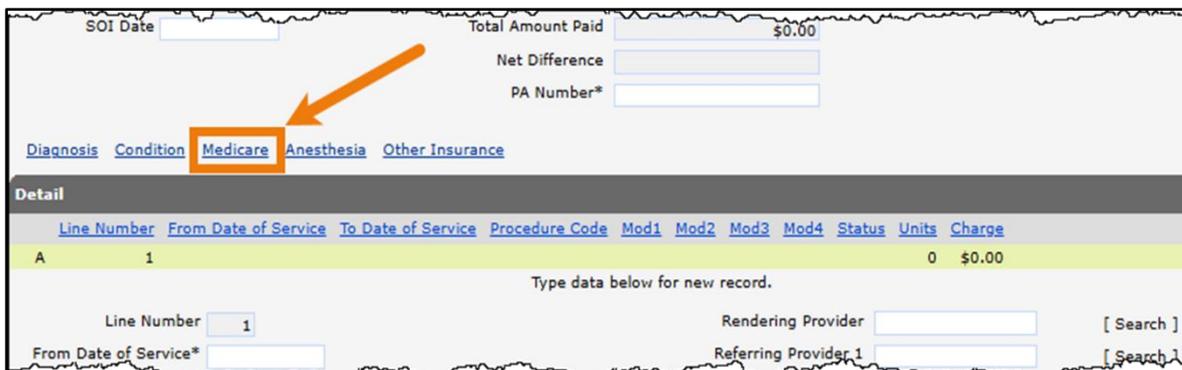1. Click **Medicare** at the bottom of the Professional Claim panel.

Figure 16 Medicare Link

The Medicare Information (Header) panel will be displayed.

Figure 17 Medicare Information (Header) Panel

2. Enter the date that Medicare paid the claim in the Medicare Date Paid field.

3. Enter the amount Medicare paid for the claim in the Medicare Paid Amount field.

   Note: The Medicare paid amount on the Medicare Information (Header) panel should be a sum of the paid amounts on the Medicare Information (Detail) panel. The paid amounts must be entered on both panels or the claim will not pay correctly.

4. Enter the amount of the claim not allowed by Medicare in the Medicare Non Covered Charge field. (The noncovered amount on the Medicare Information [Header] panel is the difference between the claim's total charge amount on the Professional Claim panel and the Medicare paid amount on the Medicare Information [Header] panel.)

- The Medicare Deductible field will be inactive on the Medicare Information (Header) panel. The Medicare deductible amount must be entered on the Medicare Information (Detail) panel.

- The Medicare Coinsurance field will be inactive on the Medicare Information (Header) panel. The Medicare coinsurance amount must be entered on the Medicare Information (Detail) panel.

- The Psychiatric Reduction field will be inactive on the Medicare Information (Header) panel. The Medicare psychiatric reduction amount must be entered on the Medicare Information (Detail) panel.

- The Medicare Copayment field will be inactive on the Medicare Information (Header) panel. The Medicare copayment amount must be entered on the Medicare Information (Detail) panel.

3.1.4 Anesthesia Panel

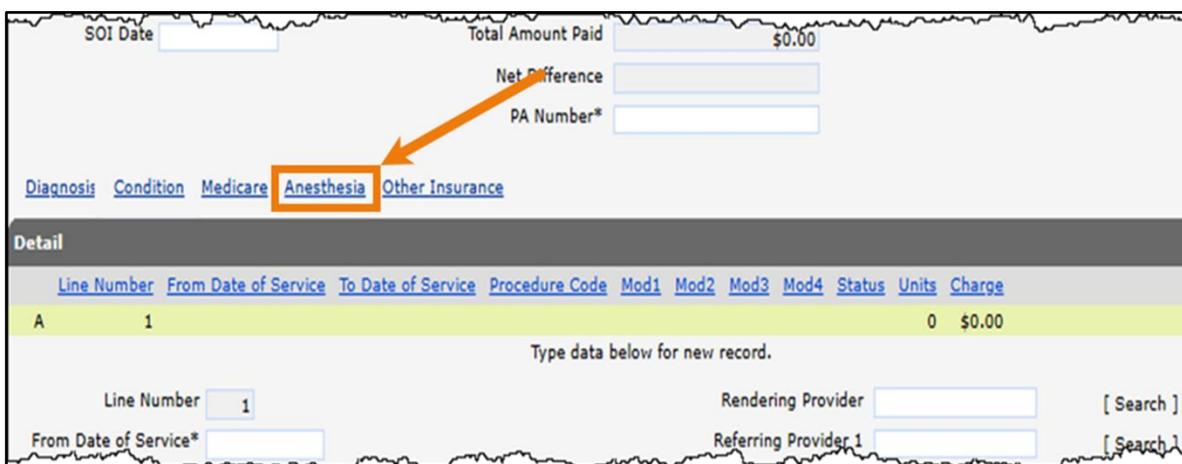1. Click **Anesthesia** at the bottom of the Professional Claim panel.

Figure 18 Anesthesia Link

The Anesthesia panel will be displayed.

Figure 19 Anesthesia Panel

2. Enter a primary anesthesia ICD procedure code in the Primary Procedure Code field or search for a code using the Search link to the right of the field, if applicable.

3. Enter a secondary anesthesia ICD procedure code in the Secondary Procedure Code field or search for a code using the Search link to the right of the field, if applicable.

3.1.5 Other Insurance Header Information Panel

The Other Insurance Header Information panel is used to enter header level information for each OI carrier.

1. Click **Other Insurance** at the bottom of the Professional Claim panel.
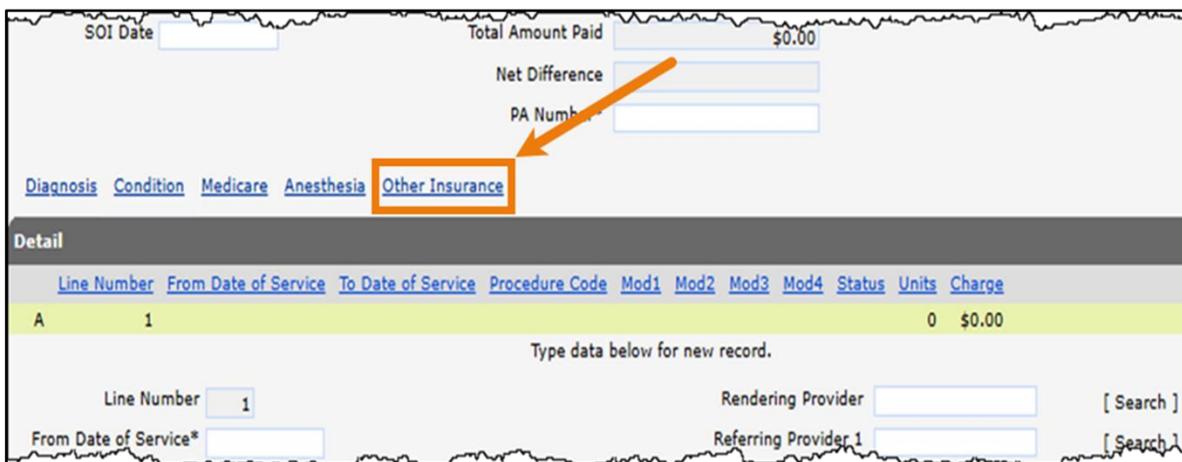

Figure 20 Other Insurance Link

The Other Insurance Header Information panel will be displayed. The Other Insurance Detail Information and Other Insurance EOB Information panels will also be displayed further down the form.
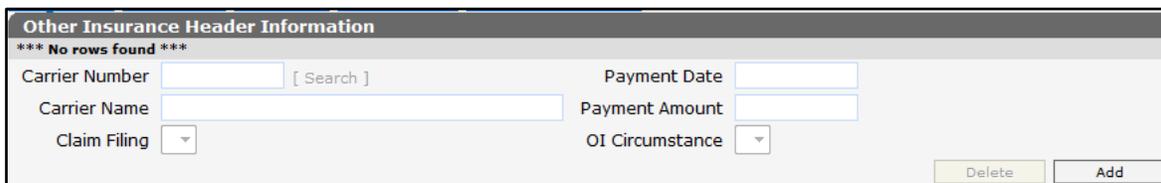

Figure 21 Other Insurance Header Information Panel

2. Click **Add**. The page will refresh, a yellow row will be added to the top of the panel, and the fields will become active to allow for information to be entered.
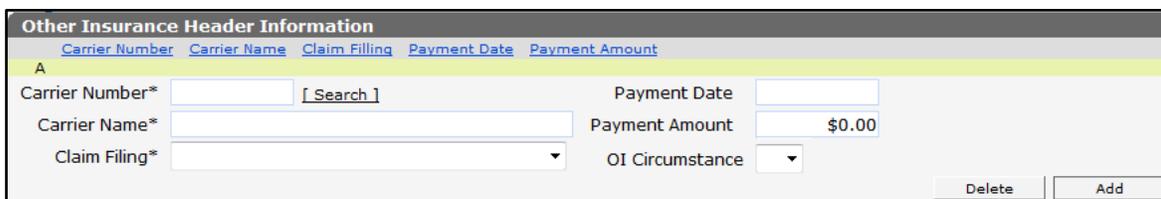

Figure 22 Add Other Insurance

3. Enter a carrier number and name or search for a carrier using the Search link next to the Carrier Number field.

To search for a Carrier, complete the following steps:

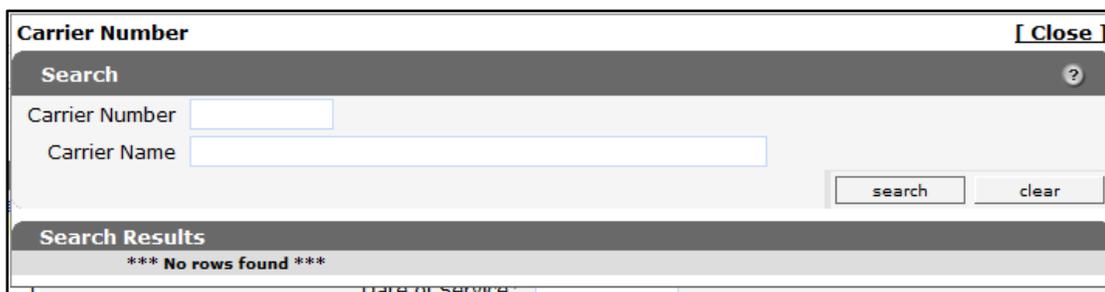a. Click **Search** to the right of the Carrier Number field. The Carrier Number search panel will be displayed.

Figure 23 Carrier Number Search Panel

b. Enter a full or partial name for the carrier, if the user knows the carrier's number, they may also search using that number.

c. Click **Search**. Any carrier matching the query will be displayed in the "Search Results" section of the panel.
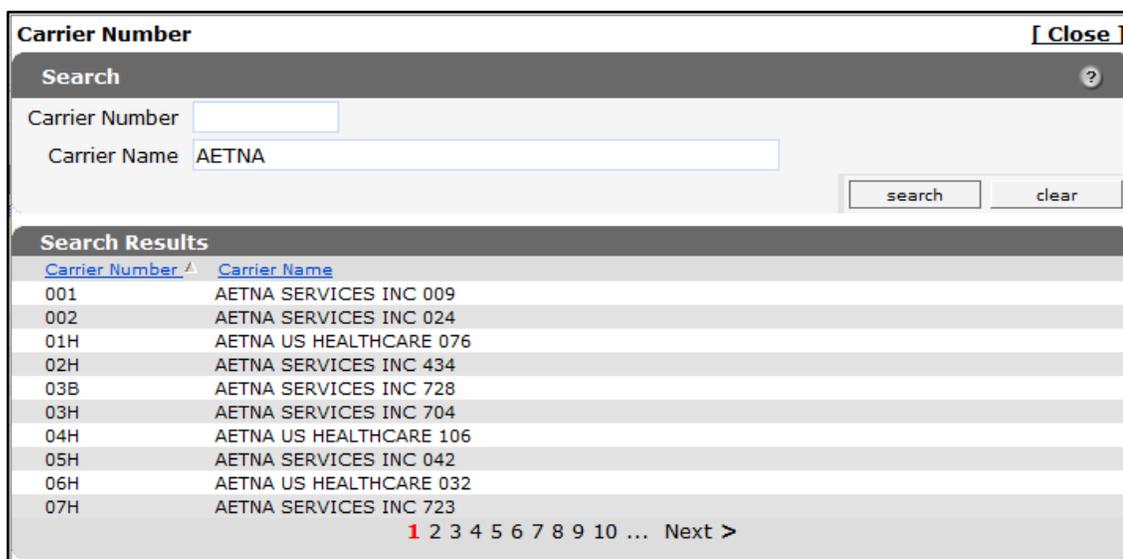

Figure 24 Search Results Panel

d. Click the applicable carrier. The Carrier Number search panel will close, and the selected carrier's number and name will populate the carrier fields.
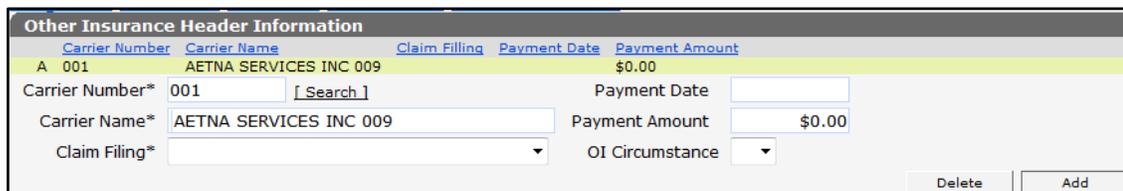

Figure 25 Carrier Number and Name Added to Professional Claim Form

Note: The above procedure can be used for other search links on the Professional Claim Form.

4. Add additional carriers to the claim if necessary.

   To delete a carrier, select the applicable row and click **Delete**.

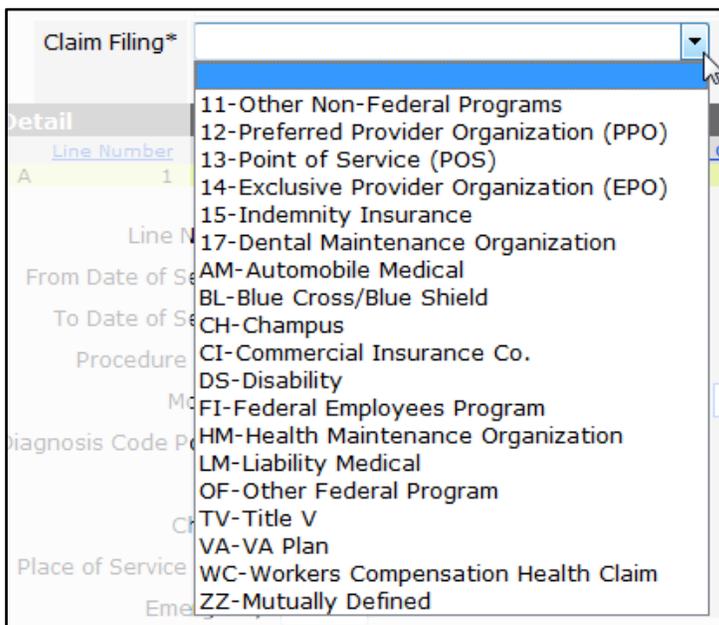5. Select the Claim Filing from the drop-down menu.

Figure 26 Claim Filing Drop-Down Menu

The claim filing indicates the type of OI billed prior to Medicaid claims submission.

6. Enter the Payment Date.

7. Enter the Payment Amount.

   Note: The Payment Date and Payment Amount will not be active if *"Y"* is selected in the OI Circumstance drop-down menu. If the user inadvertently enters information in these fields and then selects *"Y,"* the information will be deleted, and the fields will be blank.

8. Use the OI Circumstance drop-down menu to select *"Y"* for any of the reasons listed below.
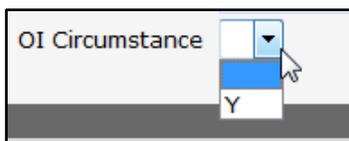

Figure 27 OI Circumstance Drop-Down Menu

"Y" indicates the member has commercial health insurance or commercial HMO coverage, but the commercial plan was not billed for reasons including, but not limited to, the following:

- The member denied coverage or will not cooperate.

- The provider knows the service in question is not covered by the carrier.

- The member's commercial health insurance failed to respond to initial and follow-up claims.

- Benefits are not assignable or cannot get assignment.

- Benefits are exhausted.

For any carrier where OI Circumstance is set to Y, the user is not allowed to enter a paid amount, paid date, or detail or explanation of benefits (EOB) information.

9. Click **Add** to add any other carriers.

Figure 28 Noncovered Carrier Added to Claim

When finished adding carriers, the information for the last carrier entered will be added to the top row when proceeding on to another panel or clicking the Submit button.

3.2 Detail Panel

Figure 29 Detail Panel

The Line Number field will be populated with the number of the detail currently being added. Line number 1 will be automatically added when the Professional Claim form is loaded.

1. Enter the date that the service began in the From Date of Service field.

2. Enter the date that the service was completed in the To Date of Service field.

3. Enter the procedure code that identifies the service performed or provided in the Procedure Code field or search for a code using the Search link to the right of the field.

4. Enter the modifier that may be added to the procedure code to provide additional information about the service performed or provided in the first Modifiers field or search for a modifier using the Search link to the right of the field. Enter all the modifiers that apply to the procedure code indicating the service performed or provided.

5. Enter the number (1, 2, 3, or 4) in the Diagnosis Code Pointers field that points to the applicable diagnosis code in the Diagnosis panel that indicates which diagnosis (or diagnoses) applies to this detail line.

   Note: The Diagnosis Code Pointers field is only required when it is necessary to point to a diagnosis related to the detail line. This field is always required for the CLTS Program.

6. Enter the number of units billed by the provider in the Units field.

7. Enter the total charge of the detail line in the Charge field.

8. Enter a place of service code identifying where the service was provided or performed in the Place of Service Code field or search for a code using the Search link to the right of the field.

9. Enter a brief description in the Notes field if additional information is needed to substantiate the medical treatment indicated if the information is not supported elsewhere on the claim form.

10. Enter the NPI or Medicaid ID of the provider performing the services in the Rendering Physician field if the rendering provider ID is different from the ID the user is logged in with and the ID was not entered at the header level. Generally, only enter a number if there are two or more rendering providers on the claim and it is necessary to distinguish between the providers at the detail level.

11. Enter the NPI or Medicaid ID of the provider, or providers, who referred the member for services in the Referring Provider 1 and Referring Provider 2 fields if applicable and if the ID was not entered at the header level.

12. Select **Yes** or **No** from the Emergency drop-down menu to indicate if the service was provided as a result of an emergency situation. The field will default to No if an option is not selected.

13. Select **Y** from the Family Planning drop-down menu if the service provided is related to family planning services. Leave the field blank if the service provided is not related to family planning services.

Information cannot be entered in the Status, Allowed Amount, and CoPay Amount fields. Information will populate these fields when the claim is submitted.

14. Enter a description of the service provided or performed in the Professional Service Description field if the provider is indicating an unlisted or not otherwise classified procedure code. In addition, enter information in this field for manual pricing purposes.

15. Click **Add** to add more details to the claim. Enter the necessary information for each detail added. Providers may enter up to up to 50 detail lines per claim.

16. Select the desired row and click **Delete** to remove a detail line. A dialog box will be displayed. Click **OK** to delete the specified row.

3.2.1 NDC Panel

ForwardHealth requires NDCs to be indicated on claims for all provider-administered drugs to identify the drugs and invoice a manufacturer for rebates, track utilization, and receive federal funds. A provider-administered drug is either an oral, injectable, intravenous, or inhaled drug administered by a physician or a designee of the physician (for example, nurse, nurse practitioner, physician assistant) or incidental to a physician service.

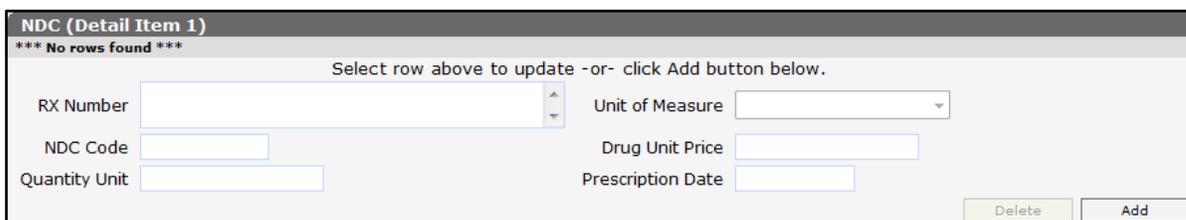1. Click **NDCs for JCode** at the bottom of the Detail panel. The NDC panel will be displayed.

Figure 30 NDC Panel

Note: A corresponding detail line must be selected before any information can be entered on the NDC panel.

2. Click **Add**. A row will be added to the NDC panel, and the fields will activate.
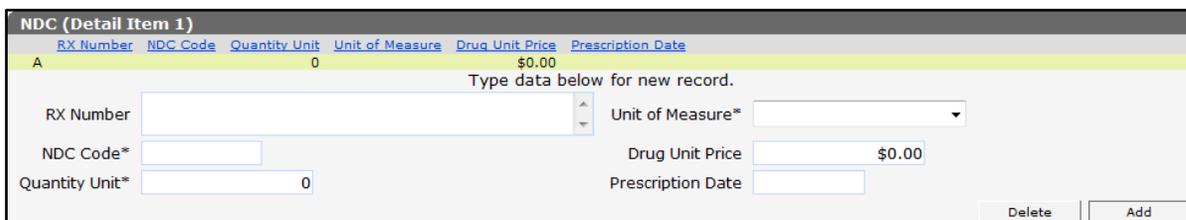

Figure 31 NDC Panel With Added Row

3. Click the applicable line item from the Detail panel if the user added multiple line items to the Detail panel. The NDC panel title will reflect the detail line item selected.

4. Enter the prescription number of the NDC in the RX Number field. If more than three numbers are entered, the up and down arrows will become active, allowing the user to scroll through the information entered.

5. Enter the NDC that supplements the procedure code entered on the detail line item in the NDC Code field.

6. Enter the number of units that are being requested for this claim in the Quantity Unit field.

7. Select the applicable Unit of Measure from the drop-down menu. Available options include the following:

    •   F2—International Unit

    •   GR-Gram

    •   ME—Milligram

    •   ML—Milliliter

    •   UN—Unit

8. Enter the price per unit in the Drug Unit Price field.

9. Enter the date of the prescription in the Prescription Date field.

3.3 Other Insurance Detail Information Panel

The Other Insurance Detail Information panel is used to enter OI related information for the claim details.

If any information is entered in the Other Insurance Detail Information panel, all information must be supplied, even if it seems similar to information entered in the Other Insurance Header Information panel.
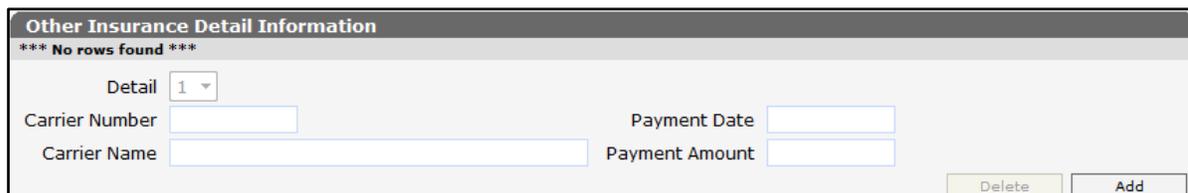
Figure 32 Other Insurance Detail Information Panel

Note: Other Insurance information should be added to only the header, or both the header and detail depending on how the individual carrier adjudicated the claim.

•   If the other payer's EOB to the provider contains detail specific information, the information should be added to both the header and detail.

•   If the other payer adjudicated the claim only at the header (no detail specific information), the provider can only enter header information.

•   If there is more than one other payer involved, it is possible for one payer to be entered only in the header and the other in both the header and detail depending on how the individual carriers adjudicated the claim.

To enter an Other Insurance detail:

1. If there is more than one carrier in the Other Insurance Header Information panel, scroll up to that panel and click the carrier for which to add the detail. The page will refresh and the carrier will be highlighted.
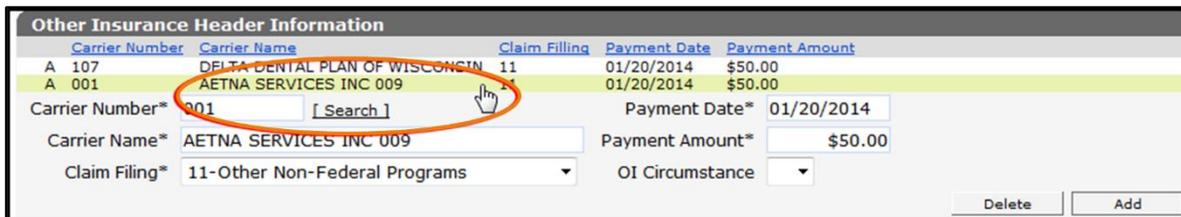

Figure 33 Select Carrier in Header

If there is only one carrier listed in the Other Insurance Header panel, step 1 may be skipped.

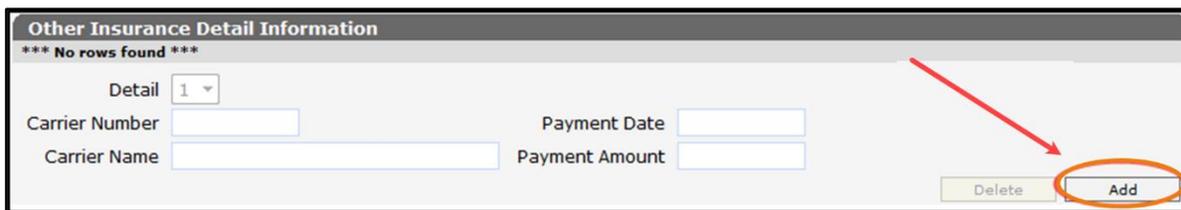2. Return to the Other Insurance Detail Information panel and click **Add**.

Figure 34 Other Insurance Detail Panel

Note: If *Y* is selected for a carrier in the OI Circumstance field in the header, the user will be unable to add information for that carrier in the Other Insurance Detail Information panel.

The page will refresh, and a yellow row will be added to the top of the panel with the carrier's name and number. The fields will also become active to allow for further information to be entered. The Detail number will display as "1" but can be changed when adding additional information.
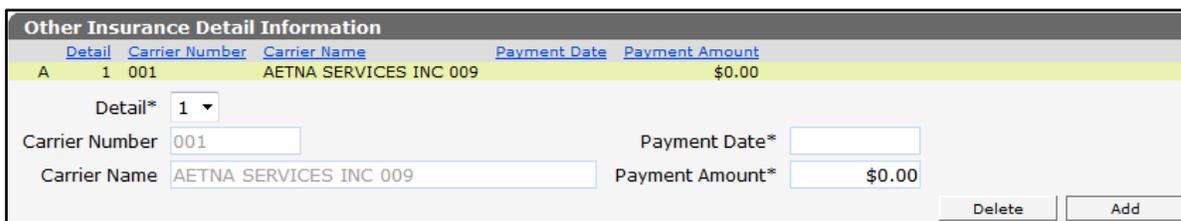
Figure 35 Carrier Added to Other Insurance Detail Information Panel

3. Select the detail number for which the OI information applies from the drop-down menu, if applicable. The default setting is the number of the detail selected on the Other Insurance Detail Information panel. A header value of 0 (zero) is not allowed on this panel.

4. Enter the date the other insurance paid the claim in the Payment Date field.

5. Enter the total amount of dollars the OI carrier paid on the detail in the Payment Amount field.

6. To add another carrier, scroll up to the Other Insurance Header Information panel and click the carrier for which to add the detail information.
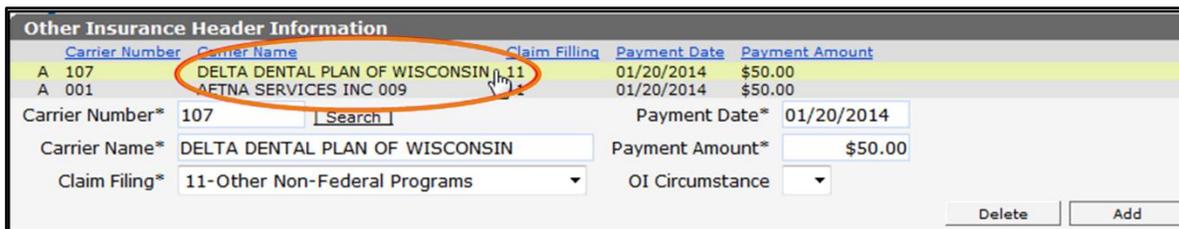
Figure 36 Select Additional Carrier in Header

When returning to the Other Insurance Detail Information panel, the previous carrier's information will be removed, and the fields will be grayed out.
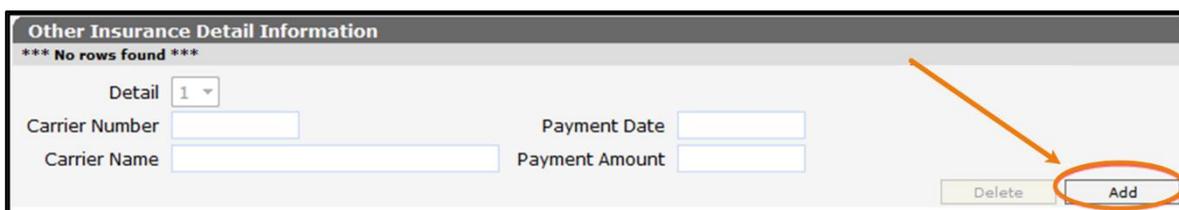

Figure 37 Blank Other Insurance Detail Information Panel

7. Click **Add**. The page will refresh, a yellow row will be added to the top of the panel with the carrier's name and number. The fields will also become active to allow for further information to be entered.

Figure 38 Additional Carrier Added

8. When finished adding carriers, the information for the last carrier entered will be added to the top row when going to another panel or clicking the Submit button.

3.4 Other Insurance EOB Information Panel

The Other Insurance EOB Information panel is used to enter the adjustment codes that explain why a carrier did not pay the billed amount.
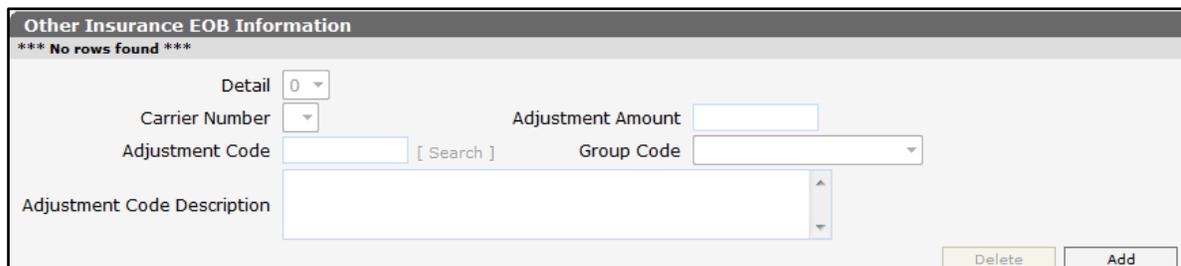
Figure 39 Other Insurance EOB Information Panel

Note: If *Y* is selected for a carrier in the OI Circumstance field in the header, information cannot be added for that carrier in the Other Insurance EOB Information panel.

To enter an OI EOB code:

1. Click **Add**. A yellow row will be added to the top of the panel and the fields will become active to allow further information to be entered.

2. Select the Detail Number from the drop-down menu, if applicable. Leave at "0" (zero) if the OI paid at the header. Detail "0" indicates that the other insurance paid the claim at the header.

3. Use the drop-down menu in the Carrier Number field to select the Carrier Number from the carriers already entered on the claim.
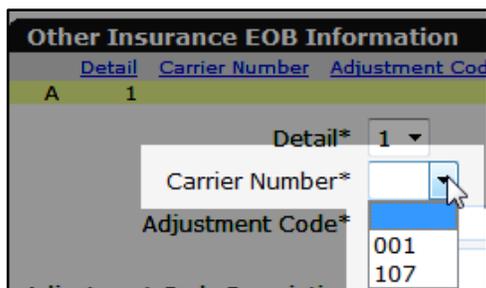
Figure 40 Select Carrier Number

4. In the Adjustment Code field, enter the EOB adjustment code from the carrier's EOB. The EOB description will be entered automatically.

If an adjustment code is not available, search for one.

a. To search for an adjustment code, click **Search** to the right of the Adjustment Code field.

Figure 41 Adjustment Code Search Link

The Adjustment Code search panel will be displayed.
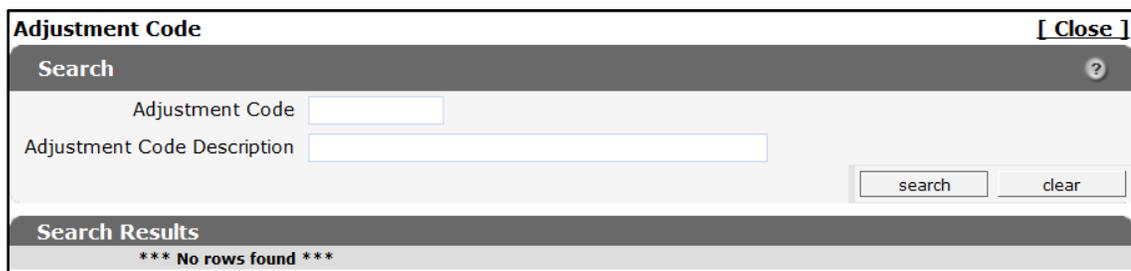
Figure 42 Adjustment Code Search Panel

b. Enter the adjustment code description.

Figure 43 Exact Description

If the exact description is unknown, use the "%" sign as a wildcard to search for any word or group of words in the description.
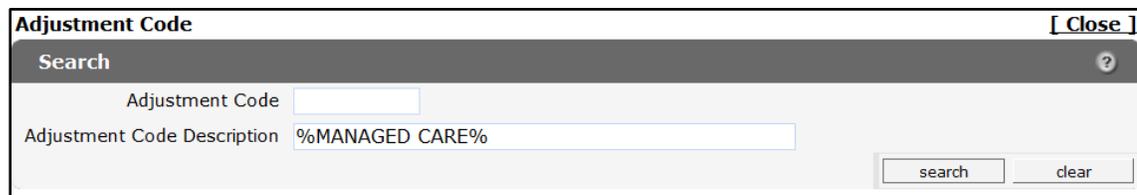
Figure 44 Wild Card Search

c. Click **Search**. The codes matching the query will be displayed in the "Search Results" section of the panel.

Figure 45 Search Results for Exact Description

Figure 46 Wildcard Search Results

d. Click the applicable code. The Adjustment Code search panel will close, and the selected adjustment code and description will populate the fields on the Other Insurance EOB Information Panel.
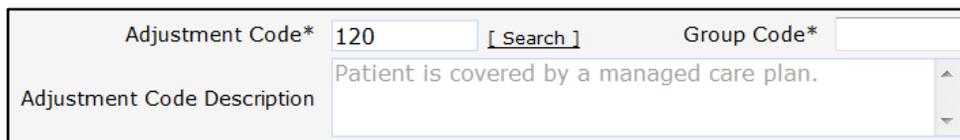
Figure 47 Adjustment Code and Description Added to the Panel

The following list includes some common American National Standards Institute (ANSI) codes that are used by ForwardHealth to process claims. The most current and complete listing of all valid ANSI codes are available online.

Code	Description
1	Deductible Amount.
2	Coinsurance Amount.
3	Co-payment Amount.
23	The impact of prior payer(s) adjudication including payments and/or adjustments.
24	Charges are covered under a capitation agreement/managed care plan.
35	Lifetime benefit maximum has been reached.

Code	Description
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
66	Blood Deductible.
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or National Council for Prescription Drug Programs Reject Reason Code.)
119	Benefit maximum for this time period or occurrence has been reached.
122	Psychiatric reduction.
149	Lifetime benefit maximum has been reached for this service/benefit category.

5. Enter the Adjustment Amount.

6. Select the Group Code from the drop-down menu.
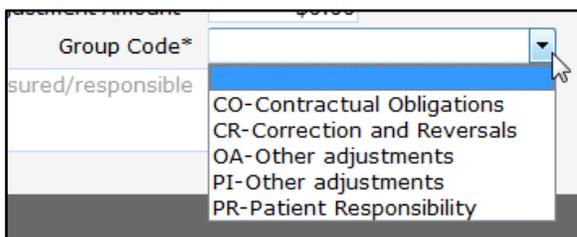
Figure 48   Select Group Code

7. Click **Add** to add additional adjustment codes.
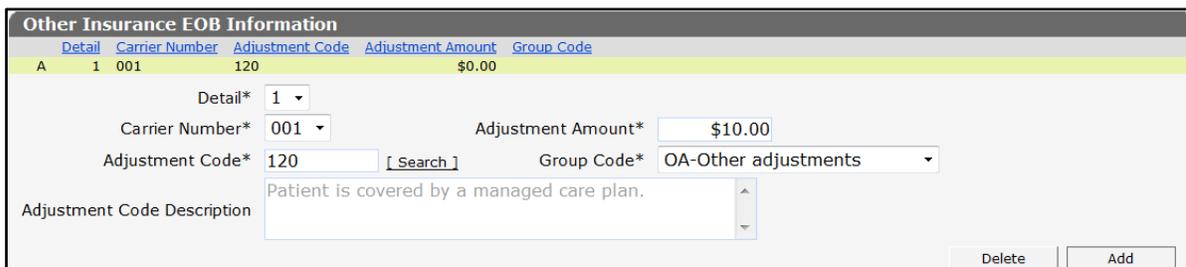
Figure 49   EOB Added

When finished adding EOBs, the last EOB entered will be added to the top row when going on to another panel or clicking the Submit button.

3.5 Medicare Information (Detail) Panel

Enter information on the Medicare Information (Detail) panel if the claim is secondary to a Medicare-allowed service.

Figure 50 Medicare Information (Detail) Panel

The Line Number field will be populated with the corresponding detail line number selected in the Detail panel.

Note: If Medicare denied a service, leave the fields on the Medicare Information (Detail) panel blank (or zero).

1. Enter the date that Medicare paid the detail line in the Medicare Date Paid field.

2. Enter the total amount that Medicare paid for the detail line in the Medicare Paid Amount field.

3. Enter the amount of the detail line not allowed by Medicare in the Medicare Non Covered Charge field.

    Note: If Medicare does not cover the entire claim, do not use the Medicare Information (Header) and/or Medicare Information (Detail) panels. Return to Step 7 of 3.1 Professional Claim Panel to select the appropriate Medicare disclaimer code.

4. Enter the deductible amount that Medicare applied to the detail line in the Medicare Deductible field.

5. Enter the coinsurance amount indicated by Medicare for the detail line in the Medicare Coinsurance field.

6. Enter the amount of psychiatric service reduction for the detail line in the Psychiatric Reduction field.

7. Enter the Medicare copay amount that the member paid for the detail line in the Medicare Copayment field.

8. Enter the remaining patient liability amount in the Remaining Patient Liability field. The remaining patient liability must equal the sum of the deductible amount, coinsurance amount, psychiatric reduction amount, and copay amount.

3.6 Attachments Panel
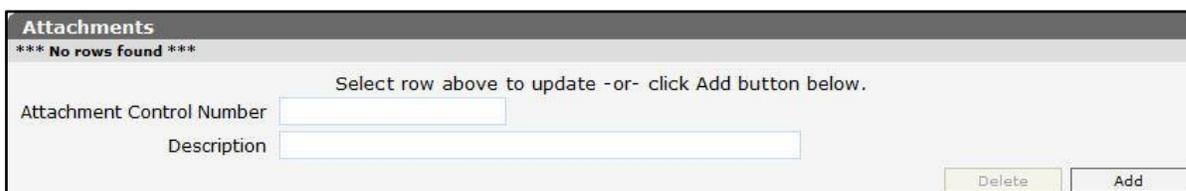
Figure 51 Attachments Panel

1. Click **Add** if any attachments need to be included with the claim. A row will be added to the Attachments panel, and the Description field will activate.

   The Attachment Control Number field is read-only. ForwardHealth will assign a number after the claim is submitted.

2. Enter a description of the attachment being submitted.

Figure 52 Attachments Panel With Added Row

Note: If it is indicated that an attachment will be included with the claim, the claim will suspend for seven days pending the receipt of the indicated attachment. Users may upload attachments electronically through the Portal or submit the attachment by mail or fax using the Claim Form Attachment Cover Page, F-13470, available on the Forms page of the Portal.

3.7 Submit the Claim

The Claim Status Information panel at the bottom of the Professional Claim form will indicate that the claim has not yet been submitted.
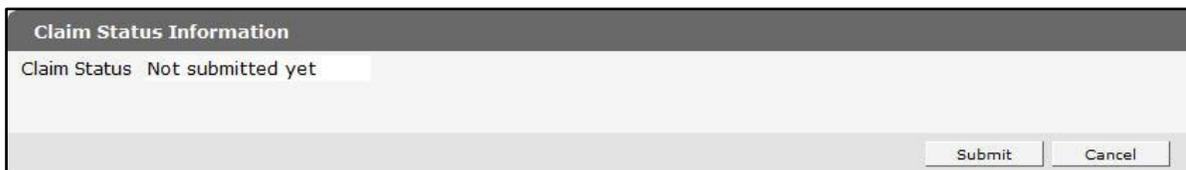
Figure 53 Claim Status Information Panel

1. Ensure that information has been entered in all the required fields on the Professional Claim form.

   Note: Since there is no Save feature for the Professional Claim form, if the claim is not submitted successfully and assigned an ICN, all information will be lost.

2. Click **Submit**.

If there is a problem and the claim does not process, an ICN will not be assigned, and an error message that indicates what needs to be corrected will be displayed at the top of the page.
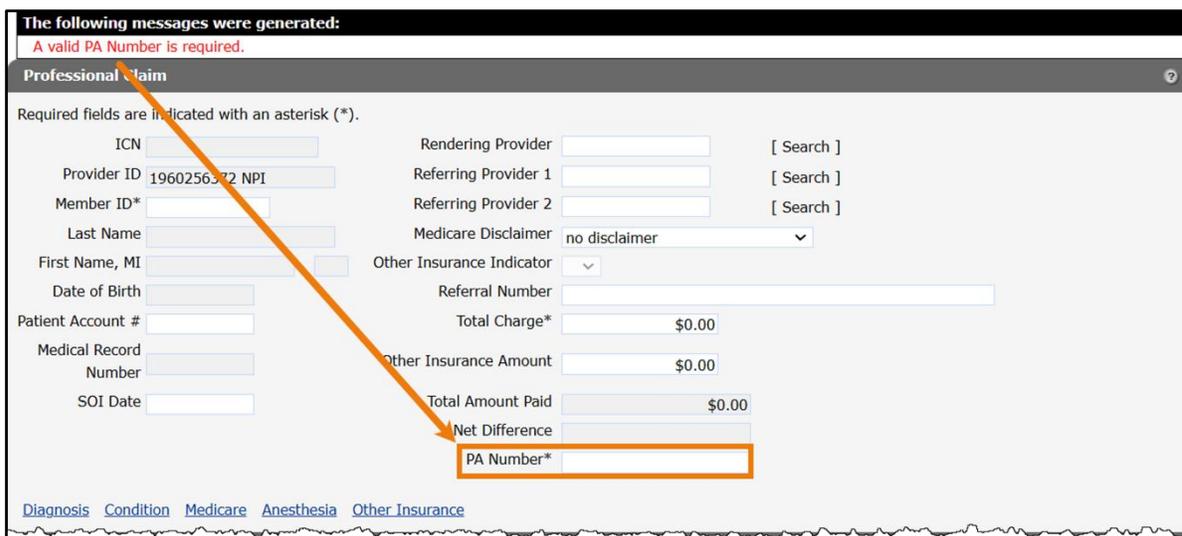
Figure 54 Error Message

If an attachment was indicated to be submitted with the claim, the claim will suspend, an attachment control number will be added to the Attachments panel, and the Upload Claim Attachments button will be displayed at the bottom of the page.
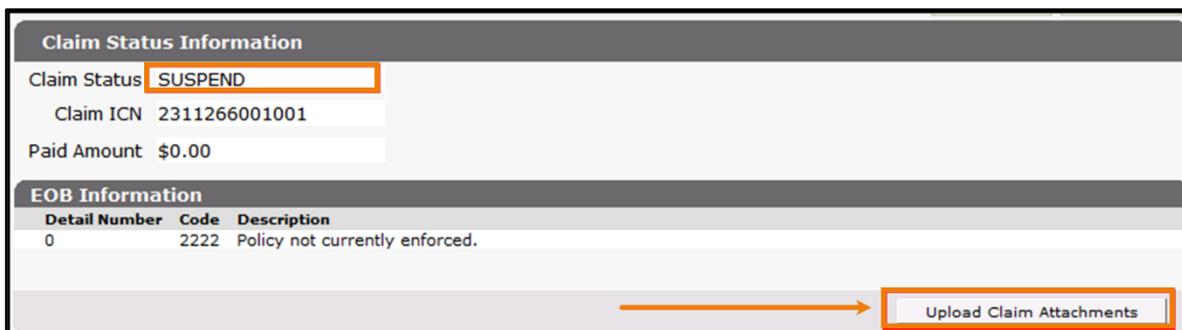
Figure 55 Submitted Claim With Attachments

If not ready to upload a file, exit from this page or go to another area of the Portal.

If ready to upload an attachment, click **Upload Claim Attachments**.

The Upload Claim Attachment File panel will be displayed. For information about uploading attachments, refer to the ForwardHealth Portal Uploading Claim Attachments Instruction Sheet, which is located on the Portal User Guides page of the ForwardHealth Portal.

If the claim is successfully submitted without an attachment, the Claim Status Information panel will display the ForwardHealth-assigned ICN and the claim's status. In addition, the EOB

Information panel will be displayed indicating how the claim was processed by ForwardHealth.

Figure 56 Claim Status Information and EOB Information Panels

If the claim is denied or adjusted, an EOB code or codes will be displayed indicating the reason for the adjustment.

4 Create a Claim From Prior Authorization

CLTS providers can search for a PA and create a claim from an existing PA via the Create a Claim From PA link on the Claims page for services provided to CLTS Program participants.

1. Click **Claims** on the main menu at the top of the page. The Claims page will be displayed.

Figure 57 Claims Page

2. Click **Create a Claim From PA** on the claims page. The Find PA Record panel will be displayed.

Figure 58 Find PA Record Panel

3. The provider can find a PA by either entering a PA number or entering information in one or more of the data fields.

4.1 Search by Prior Authorization Number

4. Enter the PA number in the PA number field.

5. Click **View PA Record**. If no results match the search, an error message will be displayed at the top of the page.

Figure 59 Example Error Message

If the PA number entered is valid, the PA Record panel will be displayed with information that was previously submitted. Note: Confirm the PA has an approved status at the top of the page. Users may only create a claim for approved PAs.

Figure 60 PA Record Panel

6. Proceed to [Step 11](#).

4.2 Search by Other Criteria

7. If the PA number is unknown, the provider can search for the PA using any of the remaining fields on the page. To refine a search, enter information in more than one field.

8. Enter or select information for any of the following fields:

- Process Type
- Member ID
- Requested Start Date
- PA Status
- Amendment Status

To view all previously submitted PAs, leave all the fields blank.

Figure 61 Search by Other Criteria

9. Click **Search**.

If no results match the criteria entered, an error message will be displayed at the top of the page. Revise the search criteria. Click **Search** again.

Figure 62 Example Error Message

If the entered information is valid, the Choose PA Record panel will be displayed.
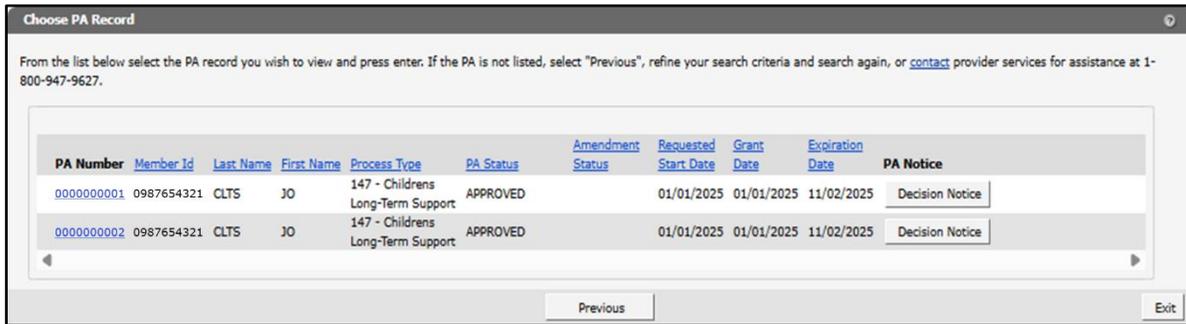
Figure 63 Choose PA Record Panel

Note: To sort the results by category, click a column heading once to sort the results in ascending order. Click the heading twice to sort the results in descending order.

10. Click the hyperlink of the desired PA number under the PA Number column.
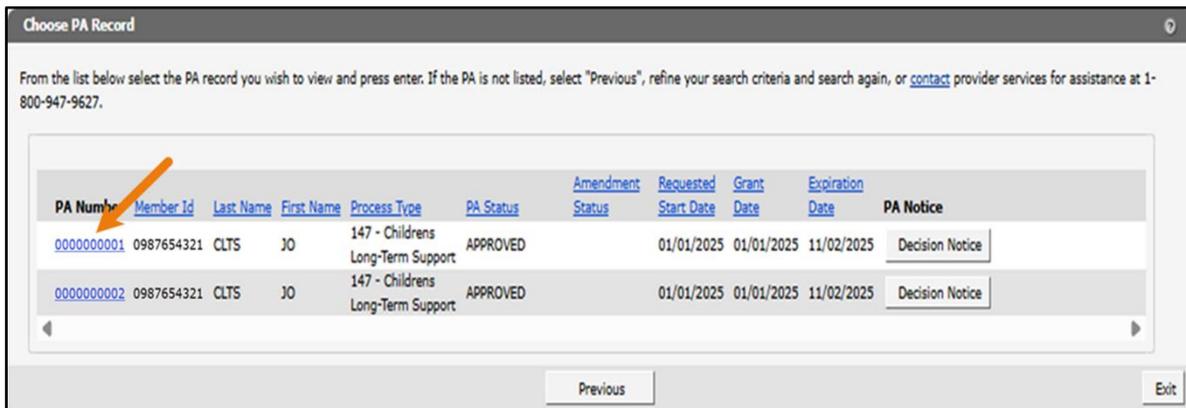
Figure 64 Choose PA Record Panel—Hyperlink

The PA Record panel will be displayed with information that was previously submitted. Note: Confirm the PA has an approved status at the top of the page. Users may only create a claim for approved PAs.

Figure 65 PA Record Panel

11. Review the PA details making sure the information aligns with the claim being submitted. Confirm that this information is correct and matches the services that should be billed:

- Units

- Procedure code

- Dollars

- Dates of service are after the requested start date

12. If the information is correct and matches the services that should be billed, proceed to Step 13.

    If the information does not match the services that should be billed, an adjustment will need to be made to the PA. Revisit the list of PAs for the client or reach out to the county waiver agency (CWA) for an updated PA for the services.

4.3 Create a Claim From Prior Authorization

13. Click **Create a Claim From PA** on the PA Record panel.
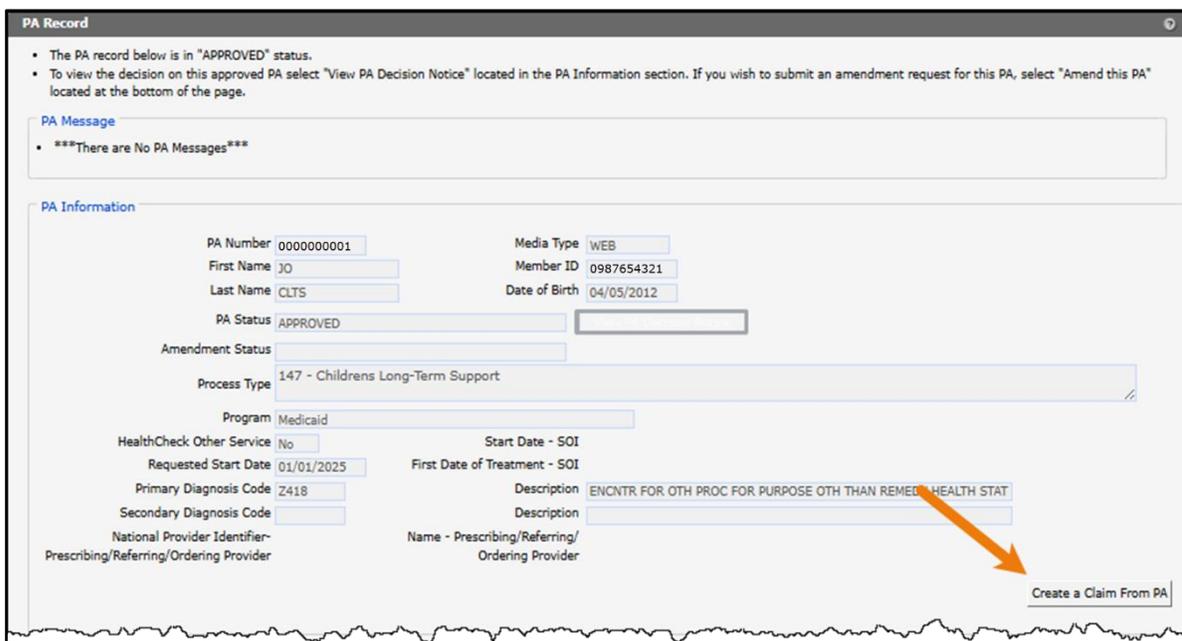
Figure 66 PA Record Panel—Create a Claim From PA Link

The Professional Claim panel will be displayed.

Figure 67 Professional Claim Panel

14. Click the line below the "Detail" section to open the template.
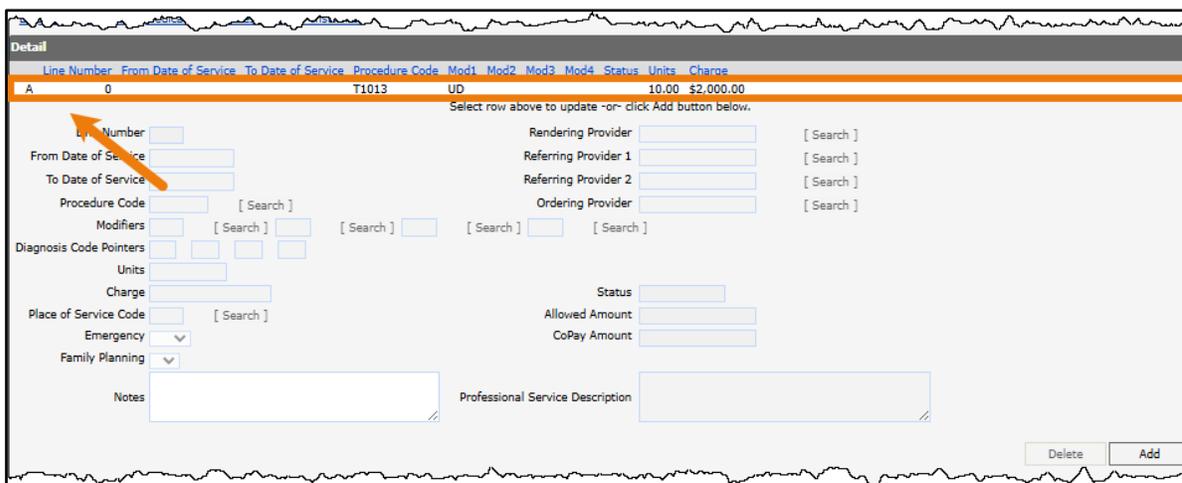
Figure 68 Professional Claim Panel—Detail Section

Information from the PA will be displayed such as the procedure code, units, and charge.
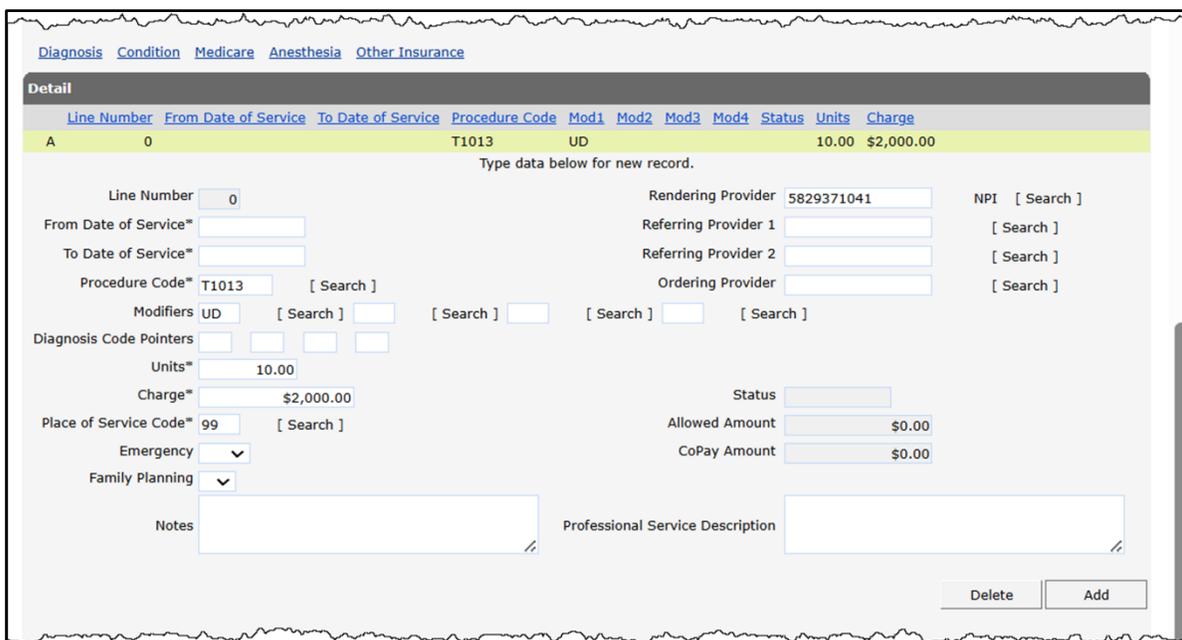
Figure 69 Professional Claim Panel—Detail Section

15. Verify and enter information in the From Date of Service and To Date of Service fields.

16. Verify the procedure code is correct in the Procedure Code field.

17. Add and/or verify that modifiers are correct in the Modifiers field.

18. Enter the diagnosis code pointer, usually the number 1, in the Diagnosis Code Pointers field. This connects the claim information to the diagnosis code on the PA submitted by the CWA.

19. Verify the units in the Units field. The number in this field may need to be changed to match the number of units completed on the date of service billed.

20. Verify and/or update the charge in the Charge field. Note: There are two places to verify charges on the claim:

    • Under the "Professional Claim" section where the client's name and information are listed—the total charge may need to be updated to match the charge under the Detail part of the claim

    • Under the "Detail" section

21. Enter the place of service (POS) code in the Place of Service Code field. Refer to the Children's Long-Term Support (CLTS) Program Benefit Code Crosswalk, P-02283, to confirm the correct POS, if necessary.

22. Leave the "Medicare Information (Detail)" section blank.

23. Only click Add in the "Attachments" section if billing procedure codes that require attachments. Refer to the Children's Long-Term Support Program Claim Attachments and Instructions for a list of procedure codes that require an attachment and instructions to add it.

24. Click **Submit** once the necessary claim information has been entered and verified.
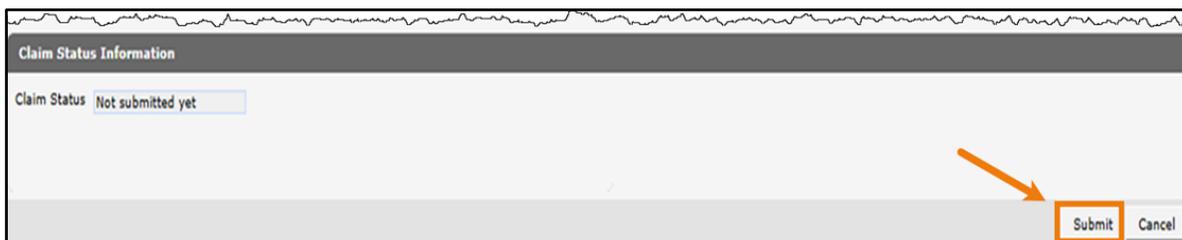

Figure 70 Professional Claim Panel—Submit
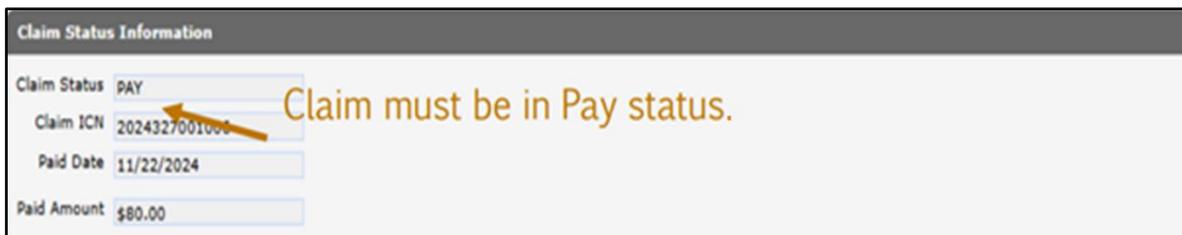
25. The status of the claim will be displayed.

Figure 71 Claim Status Information Panel

5 Prior Authorization Search-Bulk

CLTS providers can search for and view PA information in bulk via the PA Search-Bulk link on their secure provider page.

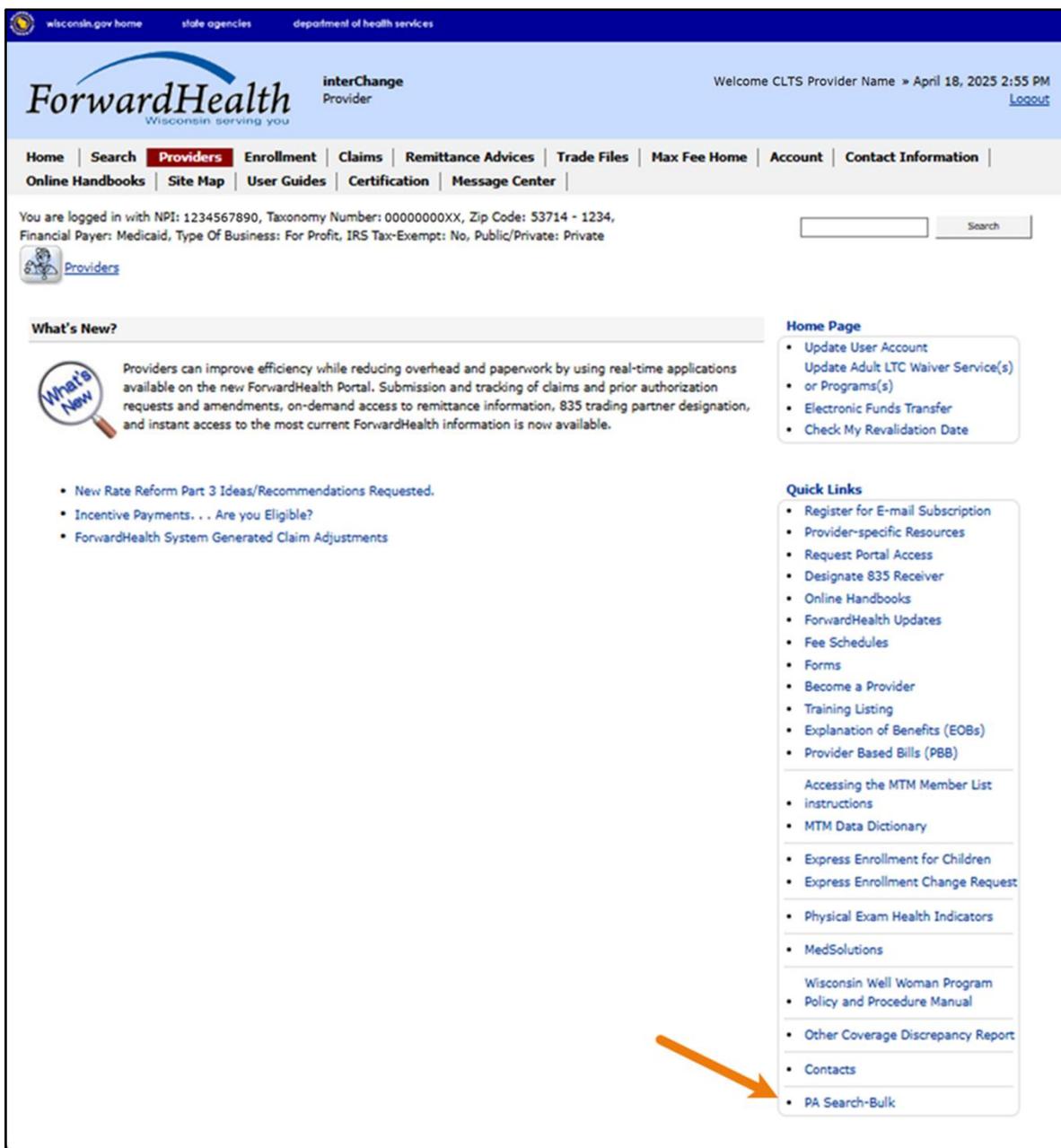1. On the secure Provider page, click **PA Search-Bulk.**

Figure 72 Secure Provider Page—PA Search-Bulk

The PA Search-Bulk panel will be displayed.

Figure 73 PA Search-Bulk Panel

2. Enter the information into the following fields. In order to search, users are required to enter the desired date span in the From DOS[*] and To DOS[*] fields in MM/CC/CCYY format.

- CWA ID—This is the number identifying the waiver agency.

- Provider ID—This is the number identifying the provider.

- PA Number—This is the number assigned to a PA request.

- CWA PA Number—This is the PA number assigned by the CWA.

- Member ID—This is the recipient's ID as specified on the PA request.

- Service Code—This is the service code as specified on the PA request.

- From DOS[*]—This is the authorized PA start date.

- To DOS[*]—This is the authorized PA stop date.

3. Click **Search**. The search results will be displayed at the bottom of the panel.
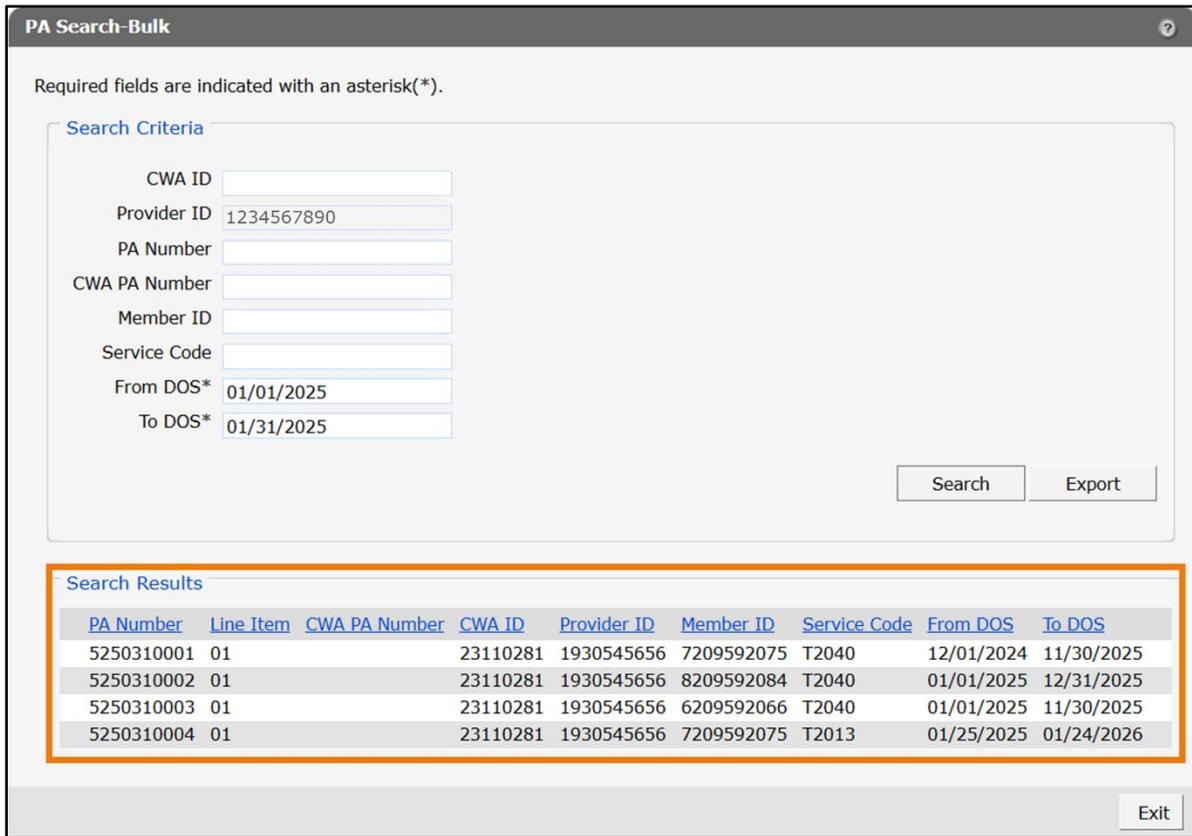

Figure 74 PA Search-Bulk-Search Results

4. Click **Export**. A PA bulk report Excel file will be downloaded.

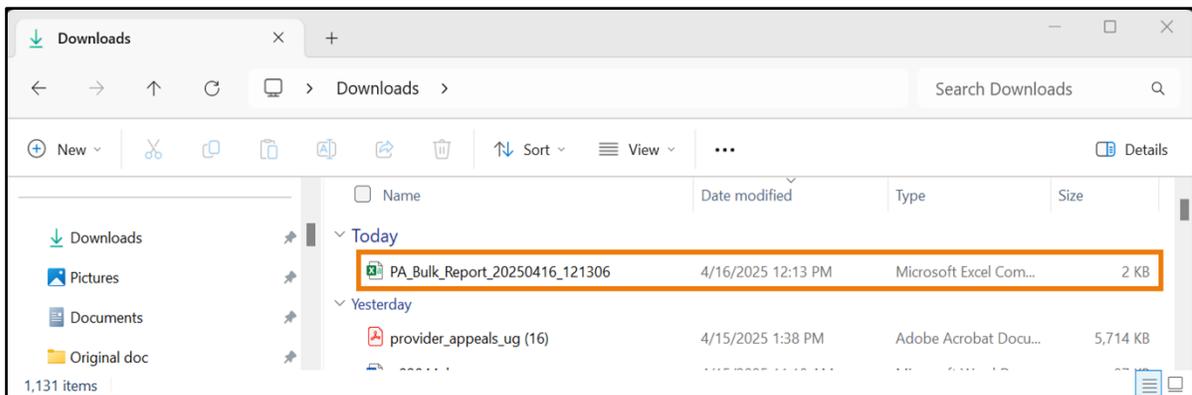5. Navigate to the location where the file was downloaded on the computer.

Figure 75 Downloads

6. Double-click to open the file. The comma-separated values file will be displayed in Excel.

Figure 76 Microsoft Excel Window-PA Bulk Report

Information for the following fields will be displayed:

- PA Number—This is the number assigned to a PA request.

- Line Item Number—This represents the PA line item number for the PA record. Each PA record may have up to 10 line items.

- CWA PA Number—This is the PA number assigned by the CWA.

- CWA ID—This is the number identifying the waiver agency.

- Billing Provider ID—This is the billing provider's ID as specified on the PA request.

- Member ID—This is the recipient's ID as specified on the PA request.

- First Name—This is the recipient's first name.

- Last Name—This is the recipient's last name.

- Start Date—This is the authorized PA start date.

- End Date—This is the authorized PA stop date.

- Amendment Status—Indicates "Y" or "N" if the PA has been amended.

- Primary Diagnosis Code—This is the primary diagnosis code as specified on the PA request.

- Secondary Diagnosis Code—This is the secondary diagnosis code as specified on the PA request.

- Rendering Provider ID—This is the performing provider ID as specified on the PA request.

- Service Code—This is the service code as specified on the PA request.

- Service Code Description—This is the service code description. This allows the entry of descriptions for unlisted procedure codes.

- Modifiers 1–4—These are procedure code modifiers of the PA.

- Units Authorized—This is the number of units authorized for the PA line item service.

- Units Used—This is the number of services that have been used to date for a service/PA line item for a particular claim detail.

- Units Remaining—This indicates the remaining units quantity, which is calculated by subtracting the used units quantity from the authorized units quantity.

- Dollars Authorized—This is the dollar amount authorized for the PA line item service.

- Dollars Used—This is the dollar amount that has been used to date for a service/PA line item for a particular detail.

- Dollars Remaining—This indicates the remaining units quantity, which is calculated by subtracting the used amount from the authorized amount.

- External Text—This displays the WPS-assigned PA number for the converted PAs.

7. Certain column field names may be cut off or may show scientific notation in place of long numbers such as PA numbers.
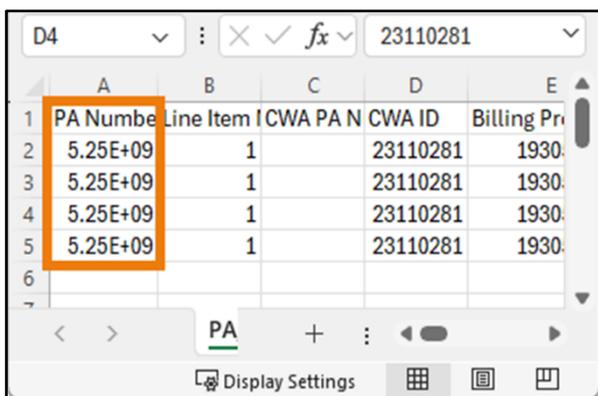

Figure 77 Microsoft Excel Window

8. To correct this, click and drag the vertical line at the top of the field column to expand the column.
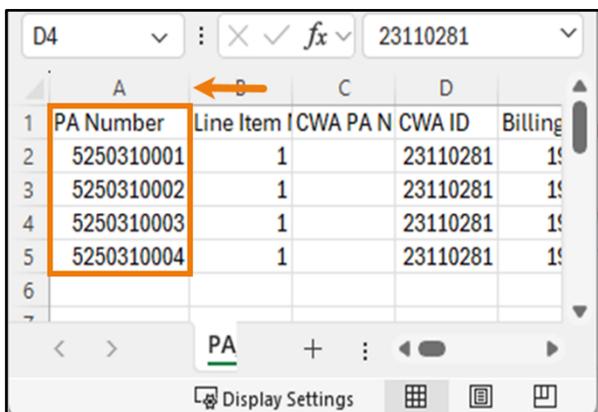

Figure 78 Microsoft Excel Window

9. Click **Save As** and name the file.

10. Choose a location on the computer or network and save the file.