QUICK START GUIDE

PROVIDER PORTAL

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INTRODUCTION

The Provider Portal is a robust tool which allows providers to submit and view data, as well as communicate directly with the organization. Within the portal, providers can perform key tasks including entering authorization requests, printing EOBs and performing eligibility verification. The portal also allows providers to create their own customer service requests, submit documentation, generate membership utilization reports, and communicate directly with their organization using a secure channel. Each of these functions serve to make your provider staff happier and more efficient, while reducing their need to make phone calls to the organization.

ELIGIBILITY

From the **Eligibility** module, users are able to verify member eligibility that is present in the IPA/medical group system. This may be useful if you are unable to find your member and wish to see if they exist in the system. From this module, you may at this point also notify the IPA/medical group of any eligibility discrepancies if you believe the member is in fact eligible.

Authorization/Referral
Claims
Communication
Customer Service
Eligibility
Eligibility Discrepancy - New
Member Verification
Information
PDR
Payment Processing
Security

MEMBER VERIFICATION SCREEN

From this screen, users are able to verify member eligibility.

Step 1: QuickCap Portal -> Left Panel -> **Eligibility** -> **Member Verification**

Step 2: The **Eligibility - Member Verification** screen will display as shown below.

Eligibility - Member Verification
* Member ID:
(OR)
* Last Name: Doe
First Name:
SSN:
* Gender: Female
Health Plan:
* Date of Birth: 01-01-1982
Service Date:
Verify Eligibility | Report Eligibility Discrepancy | Clear All

Step 3: Users can search for members in two different ways:

- Search by entering the **Member ID** for the specific person.
- Search by entering the **Last Name, Date of Birth**, and **Gender** of the member; all three fields must be completed.
- Users can search by the **Heath Plan** or **Service Date** if they want to be more specific. Regardless, it is mandatory to enter the member's last name, date of birth, and gender.

Step 4: Click the **Verify Eligibility** button. If the member exists in the system, their details will be displayed as shown below. You will be able to see demographics, plus benefit, eligibility, PCP and family information.

Details	Member ID	Name	Gender	Date of Birth	Member SSN	Health Plan	Provider ID	Name	Other Coverage?	Resp. Code	Policy #	Subscriber SSN	HP Status	PCP Status
	555444	DOE JANE	F	01-01-1982		BC	999999	Smith Micheal	No				Active	Active

Member Details Member ID: 555444, Name: DOE JANE, DOB: 01-01-1982, Age: 33.8, Other Member ID: and Status: VERIFIED

Address	Address 2	City	State	Zip	Phone	Work Phone	Extension	Fax	Email	Language
321 FIRST STREET		CHICAGO	IL	60004		847-555-1234				

Eligibility Details

PCP	Provider Name	From Date	To Date	Organization
999999	Smith Micheal	01-01-2014		Medical Organization, Inc.

Health Plan Details

HP Code	Health Plan Name	LOB	Coverage From	Coverage To	Other Coverage	Resp Code	Policy
BC	TEST HEALTH PLAN	GMC - MEDI-CAL	01-01-2014		No		

Benefit Code Details

Benefit Code	Benefit Description	Copay	From Date	To Date	Benefit Notes
01	ANTHEM BLUE CROSS MEDI PLAN 01	$0.00			

- To view additional details about the member, click the **Details** icon. More member information will be visible as shown in the figure above.

ELIGIBILITY DISCREPANCY

From this screen, users are able to add eligibility discrepancies for members and search for existing member eligibility discrepancies. The **Eligibility Discrepancy** screen is where providers can communicate regarding any member eligibility matters. Providers can easily add member information for those who do not exist in the system along with Proof of Eligibility or update current eligibility. Once it is reviewed by the IPA/medical group, they will send a determination back to you notifying you if they've added the member to the system, or have determined the member is still ineligible.

Step 1: QuickCap Portal -> Left Panel -> **Eligibility** -> **Eligibility Discrepancy**

Step 2: The **Eligibility Discrepancy** screen will display as shown below.

Report Eligibility Discrepancy Close

*Type: Member Not Exists
*Member ID:
*Gender: Male
*Last Name:
First Name:
*DOB:
*PCP Last Name:
*Health Plan:
*Effective Date:
Benefit Code:
Proof of Eligibility: Browse... No file selected.
[Max file size 128M]
Notes:

Save Reset

Step 3: The first section in this screen is **Add/Edit Eligibility Discrepancy**. Users add eligibility discrepancies for members in this area.

- Select the type of discrepancy being reported (Member not Exists, Update Eligibility) in the **Type** field.
- Enter all of the details of the member. Any field with a red asterisk is required to save the discrepancy.
- Any supporting documentation that needs to be submitted as proof of eligibility can be uploaded in the **Proof of Eligibility** field. Click the **Browse** icon to search for the file on your computer. ***Note:*** The document size should not be more than 120 MB.
- Click the **Save** button to add the Eligibility Discrepancy.

Step 4: On the right of the screen is **Search Eligibility Discrepancy**. From this section, users are able to search for any existing eligibility discrepancies for their members.

- Complete any of the available search fields based on the needed criteria and click the **Search** button. The search results will be displayed as shown below.

Edit	Type	Member ID	First Name	Health Plan	PCP	Eff. Dt	Note	Status	View	Created By	Created Date
	Member Not Exists	555444		Commercial	jane	01-01-2015		Pending		Deanna McQuillan	09-13-2015

Step 5: Users can export the search results in Excel by clicking the **Export** icon.

Step 6: To edit an existing Eligibility Discrepancy, click the **Edit** icon and update the information. Click the **Update** button to save the updated Eligibility Discrepancy.

Eligibility Discrepancy

Add/Edit Eligibility Discrepancy

*Type: Member Not Exists | *Member ID: 555444 | *Last Name: doe
*DOB: 01-01-1982 | *Gender: Female | First Name:
*Effective Date: 01-01-2015 | *PCP Last Name: jane | *Health Plan: Commercial
Benefit Code: | Status: Pending
Notes: | Update
Proof of Eligibility: Browse... No file selected. [Max file size 120M] | Cancel

AUTHORIZATION/REFERRAL

From the **Authorization/Referral** module, users are able to submit referral requests, as well as view and search for requested authorizations.

Authorization/Referral
New Auth Entry
View/Search Authorization
Claims
Customer Service - New
Eligibility
Information
Payment Processing
Reports
Security
Training Videos
Communication

AUTHORIZATION REQUEST SUBMISSIONS

This module will allow you to submit your own referral requests electronically and directly to your IPA/medical group. Please follow the steps below to accomplish this task.

Step 1: QuickCap portal -> **Authorization/Referral** -> **New Auth Entry.** The **New Auth Entry** screen will open as below.

Authorization

Member ID: DOB: Age: Sex:
Name: Address:
HP: Benefit: Efft dt:
PCP Name: Efft dt:

Authorization Date/Details

*Priority: ROUTINE * Requested Dt: 07-21-2015
*POS: 11 - OFFICE VISIT Service Req Dt: 07-21-2015

Basic Details Additional Details Medication Other

Requesting Provider Information

Speciality: Contract:
* Prov ID: Req Prov: undefined
Office: undefined
Phone: Fax:

Referring to Provider Information

Same as Requesting Provider?
* Referring To: Contract:
Specialty: undefined Provider: undefined
Fac Prov: None Selected Fac-Prov ID:

Diagnosis

* Diag 1: Diag description Diag 2: Diag description Diag 3: Diag description Diag 4: Diag description

Service Code Service Package Service Category:

(Press enter to add service details)

Service Code	Service Desc	Diag Ref	Modifier	Qty	Unit Type	Notes
			None Selected		None Selected	
			None Selected		None Selected	
			None Selected		None Selected	
			None Selected		None Selected	

+ Add

Clinical Indication For Request

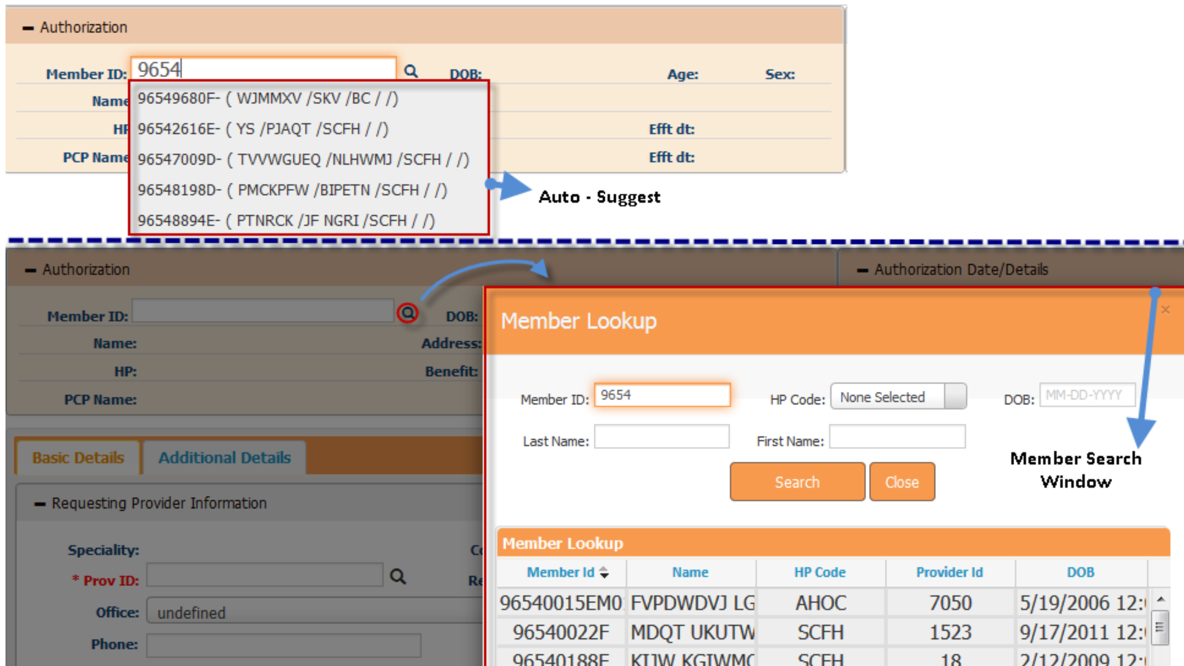
(include pertinent past medical hx. treatment, physical findings, and attach all relevant medical records and test results etc.)

Save Save & Add for same Member

Step 2: The first section is on the top-left and contains member information**.** Users can enter the member's information in one of two ways:

1. Enter the **Member ID** for the specific member. The system will being suggesting members once the user has entered part of an ID. Users can then select the correct ID to add the member's information to the screen.
2. Users can click on the **Magnifying Glass** icon to search for the member. The **Member Lookup** screen will open. From this screen, users can search using either exact parameters or a combination of **Member ID, Health Plan**, **First Name, Last Name,** and **DOB** to find the record. This section will also show you all members in the system that fit the criteria specified. Double click the correct record to add it to the authorization request.

Note: Some health plans or IPA/medical groups use a prefix and/or suffix for Member IDs – mostly with commercial plans. If you are unable to pull up the member using their ID, please try again without the prefix or suffix. For example, if XOH00001 fails, try entering 00001 instead.



Step 3: The details for the selected member will be populated on the screen as pictured below. NOTE: the system will default the **Requesting Provider** information field to match your organization's.

Step 4: The section to the right of the **Member Details** is the **Authorization Date/ Details**. The **Requested Date** field is non-editable and will always default to the date of submission.

- The **Service Requested Date -** displayed in the **Service Req. Dt** field below - should be entered as the date that the service will be performed, scheduled for, or for the authorization to become effective. This date will be approved by internal staff and is subject to their discretion and potential change.

Step 5: The user is then can select the **Priority** and the **Place of Service** for the request.

Authorization Date/Details

*Priority: ROUTINE

*POS:

ROUTINE
APPEAL
URGENT
RETRO

* Requested Dt: 07-21-2015

Service Req Dt: 07-21-2015

Medication Other

- Within the **Priority** dropdown menu, two options which will trigger a popup screen to appear.
  - **Urgent**: If selected, the **Required Information for Urgent Requests** screen will open. Enter the necessary information and click the **Add** button to complete this step.

Required information for urgent requests

Close

ABUSE OF URGENT PA STATUS WILL BE MONITORED.Urgent Request MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient in the provider's best professional judgement. Please explain reason for urgency in Clinical Indications for Request section below.

* Person Requesting:

* Phone Number:

* Fax Number:

Email Address:

Address:

Reason for Request/Comments:

Add

- **Retro**: If the services have already been provided, users should select **Retro.** A new field, **Retro Date**, will appear and require date entry.

Authorization Date/Details

*Priority: RETRO

* Requested Dt: 07-22-2015

*POS: 11 - OFFICE VISIT

Service Req Dt: MM-DD-YYYY

* Retro Dt: MM-DD-YYYY

Step 6: The **Basic Details** tab displays the **Requesting Provider Information**. This will default for the provider that is logged into the system. This screen includes **the Specialty, Contract Type, Provider ID**, **Requesting Provider Name**, and the contact information.

1. If the requesting provider needs to be changed, users can search for a new provider by clicking the **Magnifying Glass** icon on the right of the **Provider ID** field. The **Provider Search** screen will open as shown below. Search the provider by entering any of the available information.

- Click the **Provider ID** indicated in orange to populate the details of the requesting provider on the authorization request.

2. If the provider has multiple offices, users can select the correct office from the dropdown menu.

Step 7: The next section, **Referring to Provider Information,** allows users to enter the information for the provider that member is being referred to.

There are multiple options for selecting a Referring to Provider. Please read and understand each selection below for optimal use and understanding of the system:

1. For self-referrals, select the "**Same as Requesting Provider"** checkbox. This will auto-populate the information from the **Requesting Provider** screen.
2. If you are referring to a specialty only, meaning you do not have a provider name, please select the specialty from the **Specialty** field. Then, the system will populate all providers in the IPA/medical group's system into the **Provider** pull-down menu to the right of it. You may then either select a provider from that list, or may always select **Unassigned Provider**, which defaults at the top of each specialty.
3. To search for a **Referring To** Provider using information such as city, first name, last name, organization name or other, click the **Magnifying Glass** icon beside the **Referring To** field. The **Provider Search** screen will populate as shown in the above section. Users can search for the specific provider. Click the correct **Provider ID** to enter the details of the referring provider on the authorization request.

Once your provider is selected, the information will appear in the section such as below:

- Then, select the **Referring Office** from the dropdown menu.

Step 8: Optional. Users can enter **Facility Provider Information** for the request, if needed. You may either search by selecting from the pull-down menu **Fac Prov**, or may search using the magnifying glass to the right of the **Fac-Prov ID** field.

Step 9: The next section, **Diagnosis**, is where users will enter all diagnosis details for a request.

Diagnosis

* Diag 1: Diag description Diag 2: Diag description

- Enter all ICD codes related to the request in the **Diagnosis Code** field.
  - If the user knows the ICD code, they can enter it into the field and press **tab** on their keyboard to move to the next diagnosis code. The system will populate the description to the right in the **Diag. Description** field. The system will also auto suggest codes if codes are only partially entered.
  - To search for the diagnosis code by part of the code or a descriptive word, click the **Magnifying Glass** icon by the **Diagnosis Code** field. The **Diagnosis Search** screen will populate, as shown below.

Diagnosis Search Close

Diagnosis Code: 10 Diagnosis Code 2: 10 Description: Contains

Version: ICD-9 Show Mapping Search Clear All

Diagnosis Code	Diagnosis Code 2	Description	Medium Description	Long Description	Version	Description Details
10	10	CONJUNTIVA OPERATIONS	PRIMARY TB COMPLEX UNS EXAM	PRIMARY TUBERCULOUS COMPLEX UNSPECIFIED EXAMINATION	ICD-9	
10.	10	H	H	H	ICD-9	
10.0	100	INCISE/REMOV CONJUNCT FB	INCISE/REMOVAL CONJUNCT FB	REMOVAL OF EMBEDDED FOREIGN BODY FROM CONJUNCTIVA BY INCISION	ICD-9	

Diagnosis Code	Diagnosis Code 2	Description	Medium Description	Long Description	Short Disclosure	Version
08CTXZZ	08CTXZZ	EXTIRPAT MATTER LT CONJUNCTIVA	EXTIRPATION MATTER LT CONJUNCTIVA EXTERNAL	Extirpation of Matter from Left Conjunctiva, External Approach		ICD-10
08CSXZZ	08CSXZZ	EXTIRPAT MATTER RT CONJUNCTIVA	EXTIRPATION MATTER RT CONJUNCTIVA EXTERNAL	Extirpation of Matter from Right Conjunctiva, External Approach	Best code alternative based on clinical review of Index/Tabular files and Official Coding Guidelines	ICD-10

- From the **Diagnosis Search** screen:
  - Enter either the diagnosis code or description to search for the code.
  - Select the version of the code. ICD 9 codes will default. However, users can search for ICD 9, ICD 10, or for both codes.
  - Users can view the mapping between versions by selecting the **Show Mapping** checkbox.
  - Click the **Search** button.
  - Click the **+** icon to the left of each code to view the mapping**.**
  - Select the desired code by clicking on the correct **Diagnosis Code** shown in orange.

  Note: Users can add 12 distinct diagnosis codes.

Step 10: The next section is used to enter the CPT/HCPCS codes for the requested services.

CPT/HCPCS Code   Service Package

CPT/HCPCS Code	Service Desc	Diag Ref	Modifier	Qty	Unit Type	Notes
99201	OFFICE/OUTPATIEI	1	None Selected	1	None Selected	SAMPLE NOTES
		1	None Selected	1	None Selected	
		1	None Selected	1	None Selected	
		1	None Selected	1	None Selected	
		1	None Selected	1	None Selected	

(Press enter to add service details)

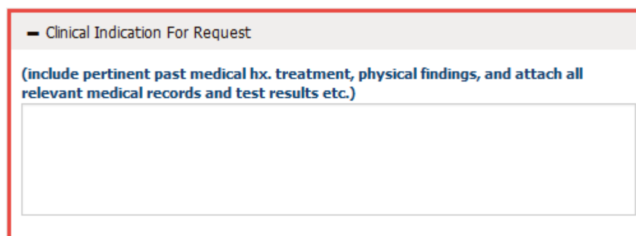
Service Code	Service Desc	Diag Ref	Modifier	Qty	Unit Type	Notes
99213	OFFICE/OUTPATIE	1	None Selected	1	None Selected	
			None Selected		None Selected	

(Press enter to add service details)

Service Code	Service Desc	Diag Ref	Modifier	Qty	Unit Type	Notes
99213	OFFICE/OUTPATIENT	1	None Selected	1	None Selected	
			None Selected		None Selected	

- The option for **CPT/HCPCS Code** defaults for entry; users can select **Service Package** if it is enabled. This will be described further below.
- To utilize the **CPT/HCPCS Code** option, users can enter the service code or search for the service code by clicking **F2** on the keyboard to search by part of a code or by word description.
- If **Service Package** is selected, users can select the package from the dropdown menu. **Service Packages** may consist of multiple codes that are affiliated or groups of codes that would all be acceptable for approval. This can be used to identify certain services such as Office Visits or Consultation visits.
- After the code is entered, the description will auto populate into the **Service Desc** field.
- Users can enter the **Diagnosis Reference**. The system will default automatically to 1, which indicates that the code is linked to the first ICD code from the **Diagnosis** section. Users can change the digit corresponding to which diagnosis code the service should reference.
- Users can enter a quantity for the service and select the unit type. If none is selected, it will default to **None** and for 1 for the **Quantity**.
- Users can add any modifiers if needed. Modifiers can be selected from the dropdown menu or manually enter the code.
- Press **tab** on the keyboard to go to the next CPT (service) line.

Step 11: The next section is **Clinical Indication for Request**. In this section, users can add the member's past medical history, physical findings, service notes being requested, or attach all relevant medical records and test results.



Step 12: The second information tab is **Additional Details.** Within this tab, three more sections will appear.

Step 13: The first section is **Documents**. Users can upload and attach documents to the referral request. Users are also able to fax documents to the organization. To upload documentation and submit it electronically with the referral request:

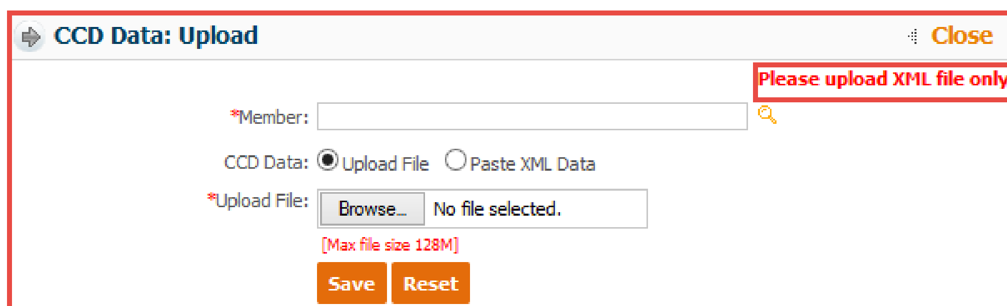
- Select the **Category** and **Priority** of the document.
- Click **Browse** to find the file from the computer directory
- Upload documents in the following formats: .doc,.docx,.xls,.xlsx,.pptx,.xps,.psd,.htm,.pdf,.tiff, .rtf, and text.
- Click the **Add Additional Documents** button to add multiple documents.
- Once users click **Save**, the document will send with the referral automatically.
- The **FAX (Fax Cover Page)** allows users to fax the documents.

Note: This may not be enabled for all organizations. Please contact the **Systems Administrator** at the group for more information.

- To properly link the documentation to the request, the cover page must be submitted with the authorization request. If not, it will cause delay or the documentation not to be processed.

2. FAX
Click here to print a FAX Cover Page for this auth to fax with the additional documentation.
(You MUST use the cover page linked above when faxing us documentation for this authorization. If you use any other cover page, or no cover page at all, the authorization will not be processed or the process will be delayed.)

Step 14: This section is optional. Users have the ability to upload the **Continuity of Care Document (CCD)**. Click the icon and the **CCD Data Upload** screen will open.



- On this screen, the member's name will auto populate. Users can also search the member by clicking the **Magnifying Glass** icon.
- Select the **CCD Data** type. Users can upload the XML file or paste in the XML Data.
- To upload the file, click **Browse**. To manually enter the XML data, paste the XML data in the text field.
- Click the **Save** button.

Note: Users can upload or enter XML data only.

Step 15: After verifying the data entered, users can save the request.

- To submit the referral request, click **Save**.
- To submit the referral request and add another request for the same member, click **Save and Add for Same Member**.

Note 1: When an authorization or referral request is submitted, users will receive a notification detailing the authorization request number with the status. Then on the **Authorization** screen, the recently submitted authorization number will be displayed automatically on the header portion.

Note 2: Users will also be unable to modify any authorization once it has been submitted to the IPA/medical group. If you wish to request a change, you must do one of three things:

1. Use the communication link that is provided on the authorization itself. This button is pictured below and is the envelope next to the word Authorization. This opens up an internal communication tool which looks similar to an email. This is secure and you may send information to and from the IPA/medical group using any sensitive information needed. To send to the UM department, simply begin typing "UM Department" and this entry will appear for you. You only need to click on it to be sent.
2. Use the customer service module described in another section, or
3. Call the IPA/medical group.

Authorization 20140722T8800001 Requested

Member ID:		DOB:	Age:	Sex:
Name:		Address:		
Health Plan:		Benefit:	Efft dt:	
PCP Name:			Efft dt:	

Step 16: Users have the option to **Print Auth** on the lower section of the screen once it is saved. This feature allows users to print authorization requests. The popup window gives options to print and export the request.

Authorization [Authorization # : 20150820T8800004 Status: REQUESTED] Authorization Date/Details

CPT/HCPCS Code Service Package

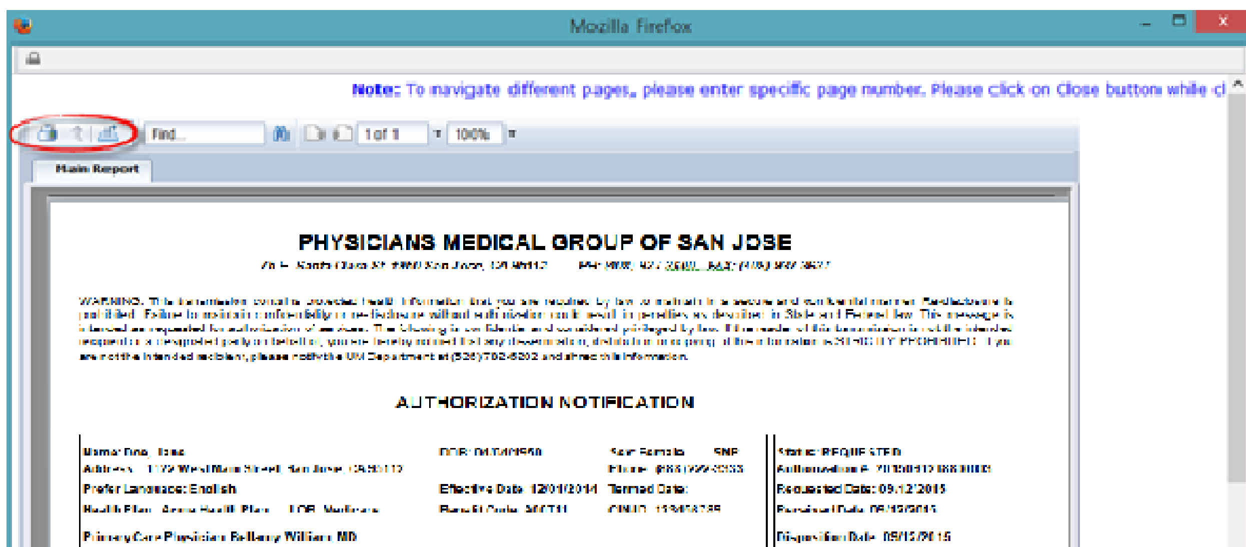
CPT/HCPCS Code	Service Desc	Diag Ref	Modifier	Qty	Unit Type	Notes
99214	OFFICE/OUTPATIENT	1	None Selected	1	None Selected	
		1	None Selected	1	None Selected	
		1	None Selected	1	None Selected	
		1	None Selected	1	None Selected	
		1	None Selected	1	None Selected	

Add

Clinical Indication For Request

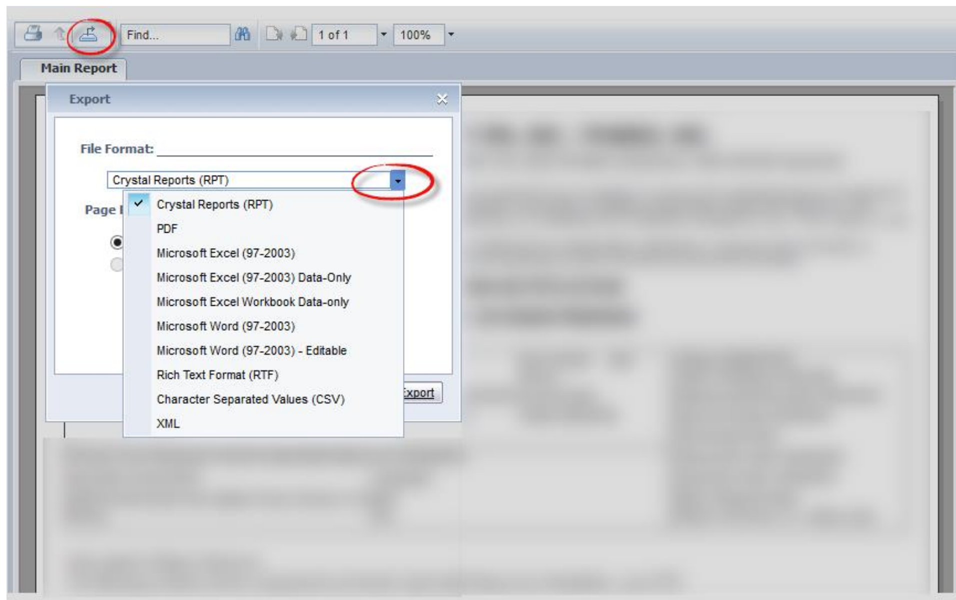
(include pertinent past medical hx. treatment, physical findings, and attach all relevant medical records and test results etc.)

Save | Save & Add for same Member | Print Auth | Go to Search Member Page



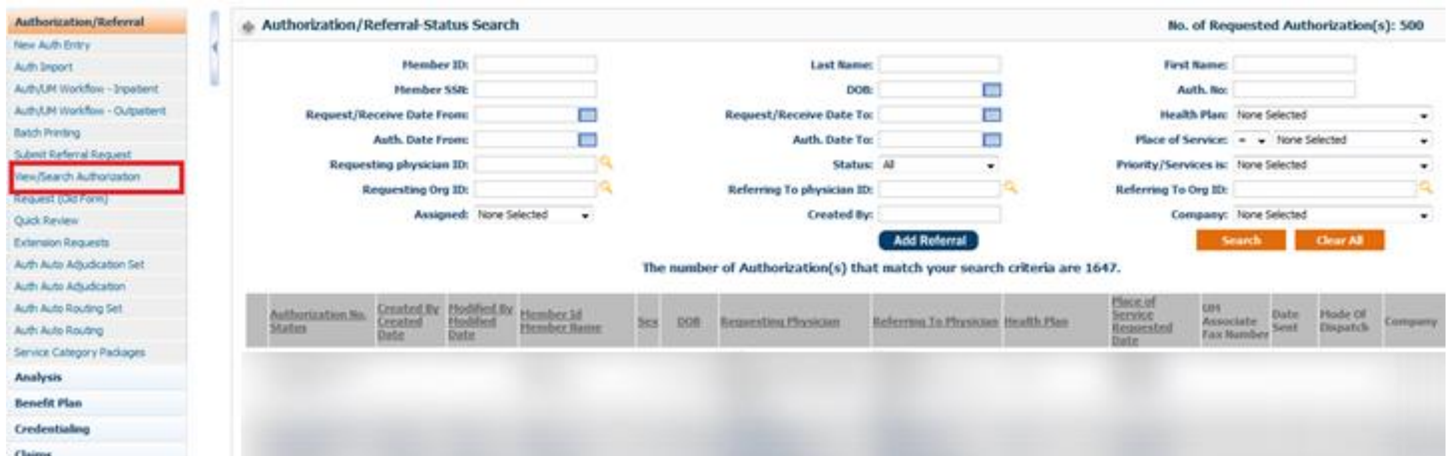
- **Export Options:** There are several options that the reports can be exported to:
  - Crystal Reports (RPT)
  - PDF
  - Excel 97 – 2003

- Excel 97 – 2003 Data Only
- Excel Workbook Data Only
- Word 97 – 2003
- Word 97 – 2003 Editable
- Rich Text Format (RTF)
- Character Separated Values (CSV)
- XML



REVIEWING A REFERRAL / AUTHORIZATION AFTER SUBMISSION

After submitting the authorization, users are able to view the request by clicking back on the left module panel and selecting the **View/Search Authorization** module.



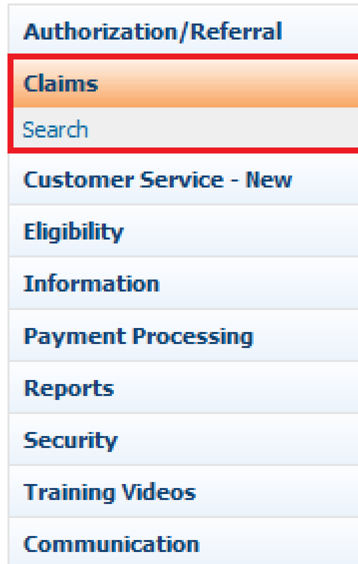
Step 1: Use any of the search criteria fields available to search for the specific referral or authorization request. Click on the **Search** button to populate the results.

Step 2: After the referral/authorization request populates, click on the link to view the request.

Step 3: The user will be redirected to the **Authorization Detail** screen. Users can review the request; internal users can update the statuses.

CLAIMS

From the Claims module, users are able to submit claims for payment. Users can also view and search for previously submitted claims.



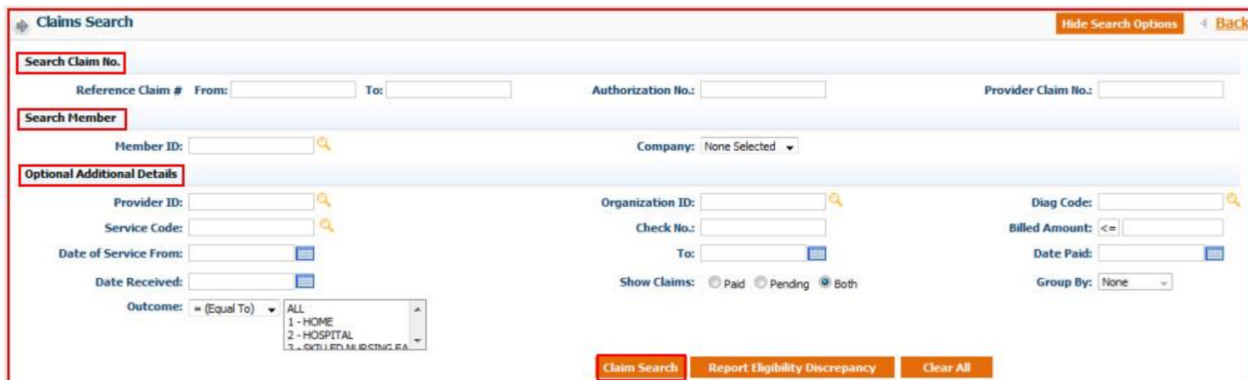
CLAIMS SEARCH / STATUS SCREEN

From this screen, users are able to view and search for submitted claims. You will as a default see all of your organization's claims listed at the bottom. You may further use any of the filters available to see only the claims you are searching for.

Note: For sections with ID, you may click on the magnifying glass to pull up other options to search for those specific entities.

Step 1: QuickCap Portal -> Left Panel -> **Claims** -> **Claims Search/Status**

Step 2: The **Claim Search** screen will display. On this screen, there are three subsections to search claims by.



Step 3: Based on the criteria users have input, the search results will display in Claim Details section.

Claim Details — Notes:** All blue text is clickable, N/A = Not Applicable.

	Claim No.	Service Date	Received Date	Auth. No.	Place Of Service	Member	Provider	Organization	Payee	Billed Amount	Net Amount	Company	Outcome
+	20150913T8800001	09-01-2015	09-13-2015		11 OFFICE VISIT	555444 DOE JANE	999999 Smith Micheal	778899 Medical Organization, Inc.	Organization	$95.00	24.00	QUICKCAP	TEMPORARY

Step 4: To view the service details of the claim, click the **(+)** icon. The details of the service will open.

Step 5: To view more details about the claim, click anywhere on the row. The **Claim Details** screen will display as shown below.

Claim Details — Notes:** All blue text is clickable, N/A = Not Applicable.

	Claim No.	Service Date	Received Date	Auth. No.	Place Of Service	Member	Provider	Organization	Payee	Billed Amount	Net Amount	Company	Outcome
−	20150913T8800001	09-01-2015	09-13-2015		11 OFFICE VISIT	555444 DOE JANE	999999 Smith Micheal	778899 Medical Organization, Inc.	Organization	$95.00	24.00	QUICKCAP	TEMPORARY

Service Date	ServiceCode	Modifier(s)	Diag. Code	Financial Resp.	Adjust Descr.	Paid Date	Check No.	Qty	Billed	CoPay	Coinsurance	Deductible	Adjust	Net	Admin. Fee/Withhold	Status
09-01-2015	99213 OFFICE/OUTPATIENT VISIT EST		339.83	IPA				1	95.00	0.00	0.00	0.00	0.00	24.00	0.00	MANUAL HOLD

Print CMS 1500

Step 6: If there is an associated authorization, the number will populate in the **Claim Details**. To view more information for the authorization, click on the **Authorization Number**. The **Authorizations** screen will display as shown below.

Authorization Details

Auth. No.	Request/Receive Date	Authorization Date	Expiration Date	Retro Date	Places Of Service	Member	Provider	Request Provider	Net Amount	Status	Records	CCS	Company
20150810T8800002 Show Claims Info	08-10-2015	08-10-2015	08-20-2015		11 OFFICE VISIT	555444 DOE,JANE	999999 Smith Micheal (CONTRACT CAPITATION) ANESTHESIOLOGY	112233 Smith John 778899 Medical Organization, Inc. (CONTRACT FEE FOR SERVICE) ANESTHESIOLOGY	$80.00	DENIED	No		QUICKCAP

Service Code	Description	Modifier	Diagnosis	Financial Resp.	Adjust Descr.	Qty	Net	Adjust
99214	OFFICE/OUTPATIENT VISIT EST		10.1-CONJUNCTIVA INCISION OTHER	IPA	Paid through settlement	1	$80.00	$0.00

Old Status	Status Changed	Changed By	Request/Review Date	Comments	Assigned To	Assigned By
SYSTEM HOLD	SYSTEM HOLD	IPA IPA	08-10-2015			
DENIED	DENIED	AUTO	08-10-2015			

112233

Provider Details

Provider ID :	999999	Name :	Smith Micheal
Address :	Medical Organization, Inc.	City :	Chicago
State :	IL	Zip :	123456
Phone :		Fax :	
Organization Name :	Medical Organization, Inc.	NPI :	
Provider Class :	BOTH (PCP+SPECIALIST)	Provider Contract :	CONTRACT CAPITATION
Effective From :	01-01-2015	Effective To :	

Step 7:

To view the provider details, click on the Provider ID. The **Provider Details** screen will display as shown below.

Step 8: To view and print the claim in CMS 1500 format, click the **Print CMS 1500** button.

DATE RECEIVED
SEPTEMBER 13, 2015 00:00:0

TEST HEALTH PLAN
BLUE CROSS OF CALIFORNIA 21555 OXNARD STREE
WOODLAND HILLS, CA 91367

CARRIER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#) X

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 555444

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE,JANE

3. PATIENT'S BIRTH DATE MM DD YY: 01 01 82 — SEX M ☐ F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): DOE,JANE

5. PATIENT'S ADDRESS (No., Street): 321 FIRST STREET

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): 321 FIRST STREET

CITY: CHICAGO — STATE: IL

8. RESERVED FOR NUCC USE

CITY: CHICAGO — STATE: IL

ZIP CODE: 60004 — TELEPHONE (Include Area Code): ( )

ZIP CODE: 60004 — TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 01

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES X NO

a. INSURED'S DATE OF BIRTH MM DD YY: 01 01 82 — SEX M ☐ F X

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES X NO — PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: TEST HEALTH PLAN

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes, complete items 9, 9a, and 9d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE — DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

PATIENT AND INSURED INFORMATION

PAYMENT PROCESSING

From the **Payment Processing** module, users are able to generate Explanation of Benefits (EOBs) for members that claims have been submitted and paid for.

CLAIM EOB

From this screen, users are able to generate EOBs for paid claims.

Step 1: QuickCap Portal -> Left Panel -> **Payment Processing** -> **Claims EOB**

Step 2: The **Claims - Explanation of Benefits** screen will display as shown below.

Claims - Explanation of Benefits

Member Name:

*Organization Name:

Check No: Retrieve Checks *Click Retrieve Checks if you do not know the check number.

*Paid Date From: To:

Display EOB

Step 3: Enter the specific member's name that you want to generate the EOB for.

Note: Users can skip this search criteria if they want to generate EOBs for multiple members from an organization.

Step 4: Enter the correct organization name or search the organization by clicking the magnifying glass icon. The **Organization Search** screen will be displayed as below. Only organizations that users are affiliated with will show in the search screen.

Organization Search Close

Organization ID: Name: Medical Organization, Inc Tax ID:
NPI: Category: Search Clear All

Organization ID	Name	Category	Tax ID	Address1	City	State	Zip	Email	Phone	Fax	NPI
778899	Medical Organization, Inc.	2 - Primary Care	7894561230	123 Main Road	Chicago	IL	60614				7894561230

- Search the organization by entering any of the available information.
- Select the organization by clicking the **Organization ID.**

Step 5: Enter the check number that the EOB was paid with. If the user does not know the check number, they can search for the check by clicking the **Retrieve Check** button. The **Check No Search** screen will display as shown below.

Check No Search Close

Check No.:
From Date: 03-13-2015 To Date: 09-13-2015 Search Clear All

Prefix	Check No	Paid Date	Amount
1	948230	09-13-2015	$24.00
2525	1	09-02-2015	$21.00

- Search the check by entering either the check number or by entering date ranges. To search for all checks ever paid, leave the fields blank and click the **Search** button.
- Select the check by clicking on the **Check No**.

Step 5: By entering the check number, the **Paid Date** field will be populated with the dates automatically. Click the **Display EOB** button and the EOBs will be generated as shown below.

Find... 1 of 3 100%

Main Report

QuickCap

555 WEST CHICAGO AVENUE, CHICAGO, IL

EXPLANATION OF BENEFITS

09/13/2015
Page 1 of 2

CHECK NO: 948230
PAID DATE: 09/13/2015

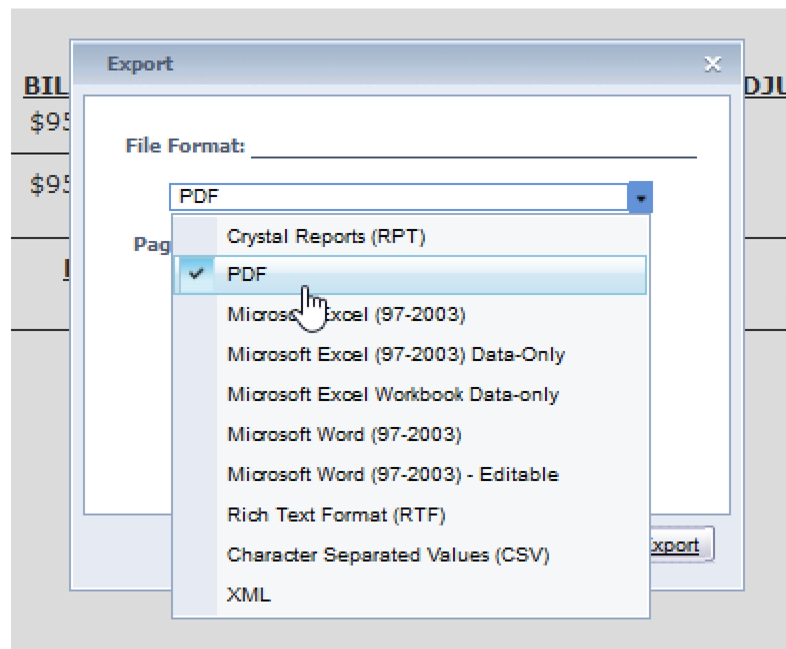
ORGANIZATION: 778899 Medical Organization, Inc.
PROVIDER: 999999 Smith, Micheal
MEMBER: 555444 DOE JANE
CLAIM #: 20150913T8800001

SERVICE CODE & DESCRIPTION	MOD	SVCDATE	BILLED	CNTRCT	COPAY	ADJUST	W/H	INT	NET	ADJUSTMENT CODE & DESCRIPTION
P-99213 - OFFICE/OUTPATIEN... AUTH #: PROV ACCT:		9/1/2015	$95.00	$24.00	$0.00	$0.00	$0.00	$0.00	$24.00	
CLAIM TOTAL:			$95.00	$24.00	$0.00	$0.00	$0.00	$0.00	$24.00	

HEALTH PLAN:BLUE CROSS

	BILLED	CNTRCT	COPAY	ADJUST	W/H	INT	NET	NET + INT
ORGANIZATION TOTAL:	$95.00	$24.00	$0.00	$0.00	$0.00	$0.00	$24.00	$24.00

- To print the report, click the **Print** icon.
- To export the report, click the **Export** icon. An **Export** dialogue box will be populated as shown below.



- Select which file format to save the report in.
- Click the **Export** button. The report will be exported in the selected file format.

CUSTOMER SERVICE

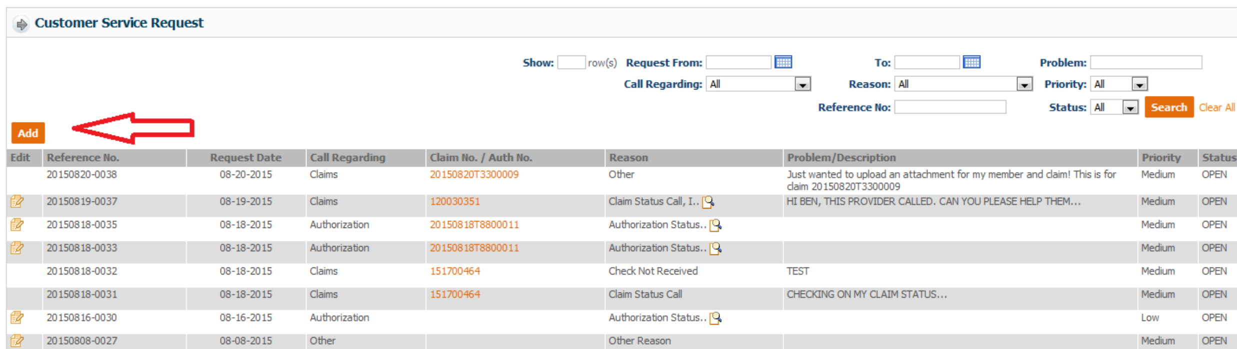
From the Customer Service module, users are able to add and view existing customer service requests for their organization. This module provides a request tracking system without the back and forth of telephone calls. You may log information requests or complaints regarding claims, authorizations, provider services, member services, and IT services, among other options. The customer Service Request link will be found under the Customer Service Module link, as pictured below.

ADDING CUSTOMER SERVICE REQUESTS

From this screen, users are able to add customer service request into the portal. Once an external user submits a request, internal users will then be able to review and process as needed.

Step 1: QuickCap Portal -> **Customer Service** -> **Customer Service Request.** The **Customer Service Request** screen will open.

Step 2: Click the **Add** button shown to the left in the below screenshot.



Edit	Reference No.	Request Date	Call Regarding	Claim No. / Auth No.	Reason	Problem/Description	Priority	Status
	20150820-0038	08-20-2015	Claims	20150820T3300009	Other	Just wanted to upload an attachment for my member and claim! This is for claim 20150820T3300009	Medium	OPEN
	20150819-0037	08-19-2015	Claims	120030351	Claim Status Call, I..	HI BEN, THIS PROVIDER CALLED. CAN YOU PLEASE HELP THEM...	Medium	OPEN
	20150818-0035	08-18-2015	Authorization	20150818T8800011	Authorization Status..		Medium	OPEN
	20150818-0033	08-18-2015	Authorization	20150818T8800011	Authorization Status..		Medium	OPEN
	20150818-0032	08-18-2015	Claims	151700464	Check Not Received	TEST	Medium	OPEN
	20150818-0031	08-18-2015	Claims	151700464	Claim Status Call	CHECKING ON MY CLAIM STATUS...	Medium	OPEN
	20150816-0030	08-16-2015	Authorization		Authorization Status..		Low	OPEN
	20150808-0027	08-08-2015	Other		Other Reason		Medium	OPEN

Step 3: The **Customer Service Request – Add** screen will populate. Users can fill in the information below to submit a request. The fields with asterisks are required.

- **Call Regarding:** This dropdown menu allows users to select the purpose of the call. For example, the call could in regards to claims or authorizations.
- **Priority:** This allows users to select the severity between **low, medium,** and **high**.
- **Pref. Comm:** This field represents the best way to contact back incase follow up is needed. The selection includes **Fax, Email,** and **Phone.**
- **Reason:** This field indicates what the user was calling in regards to. Depending on the field selected above from the **Call Regarding** field, the **Reasons** will change.
- **Problem/Description:** Users can add a description to explain further the purpose of this request. This information will assist the representative reviewing the request.
- **Attachment:** Users can attach any documents that would aid the representative in completing the request.

Customer Service Request - Add

*Call Regarding: | *Priority: Medium
*Pref. Comm: Phone | Email:
Fax: | *Phone: 555-555-5555 Ext.:
Reason:
Problem/Description:
(Select Reason or Enter Problem/Description)
Attachments: File attachment | Type | Note | Remove
Browse... No file selected. [Select Type]
[Total file size can not exceed: 128M] Attach more..
Save

Step 4: Press **Save** to submit the request. A customer service request reference number will be given upon saving the request. This can be used later to check for updates.

Customer service request saved successfully.
Reference Number: 20150831-6892

SEARCHING CUSTOMER SERVICE REQUESTS

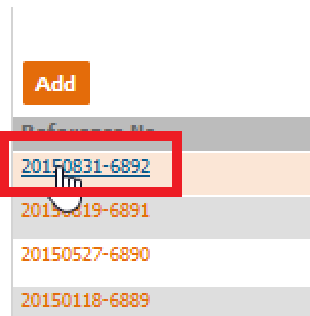
External users can check in the portal to view statuses of previously submitted requests.

Step 1: QuickCap Portal -> **Customer Service** -> **Customer Service Request.** The **Customer Service Request** screen will open.

Step 2: Enter information in any of the below fields to populate the search results specific to your organization.

Show: row(s) Request From: To: Problem:
Call Regarding: All Reason: All Priority: All
Reference No: Status: All Search Clear All

Step 3: Press **Search** to show the results. Click the **Reference Number** associated to the request to open the entire request. Users can update or add information to an existing request at this time.



INFORMATION

From the Information module, users are able to search and view the code references for ICD codes, CPT codes, and modifiers. This provides you with a quick and easy way to see if these codes exist within the IPA/medical group, and to help you potentially during your authorization submission or claim submission purposes.

CODE REFERENCE - CPT

From this screen, users are able to search and view CPT codes.

Step 1: QuickCap Portal -> **Information** -> **Code Reference-CPT**

Step 2: The **CPT Search** screen will display as shown below.

Step 3: Users can search for codes either by entering the CPT Code or by entering the Description.

Note: It is necessary to enter data in at least one field. It is better to search with less specific descriptions as the search function will find more possible matches.

Step 4: Click the **Find CPT** button. The search results will display as shown below.

CPT Code	Description	Medium Description	Long Description	GuideLines	NCCI Edits
10100	DRAINAGE OF INFECTED NAIL	DRAINAGE OF INFECTED NAIL	DRAINAGE OF INFECTED NAIL		View
10101	DRAINAGE OF INFECTED NAIL(S)	DRAINAGE OF INFECTED NAIL(S)	DRAINAGE OF INFECTED NAIL(S)		View
1010F	SEVERITY ANGINA BY ACTVTY	SEVERITY OF ANGINA ASSESSED BY LEVEL OF ACTIVITY	Severity of angina assessed by level of activity (CAD)		View
1011F	ANGINA PRESENT	ANGINA PRESENT	Angina present (CAD)		View

- To view more details regarding the CPT code, click the **CPT Description Details** icon. The **CPT Description** screen will populate as shown below.

CPT Description Close

CPT Description:

Code:	10100
Short Desc:	DRAINAGE OF INFECTED NAIL
Medium Desc:	DRAINAGE OF INFECTED NAIL
Long Desc:	DRAINAGE OF INFECTED NAIL
Hierarchy:	DRAINAGE OF INFECTED NAIL
Code Tip:	

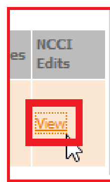
Guideline Documents:

Service Group	Service From	Service To	Specialty	Gender	Notes	Health Plan(s)	File Name
No Document(s) Found.							

CPT Guidelines:

CPT Code	Specialty	Document Name
No Guideline(s) Found.		

- To view the NCCI Edits, click the **View** link for the specific row. The NCCI Edits screen will be populated in a separate screen.



CODE REFERENCE - ICD

From this screen, users are able to search and view ICD codes.

Step 1: QuickCap Portal -> Left Panel -> **Information** -> **Code Reference-ICD**

Step 2: The **ICD Search** screen will display as shown below.

ICD Search

ICD Code: [ ] Description: Contains [ ]

Version: All (All / ICD-9 / ICD-10) ☐ Show Mapping | Find ICD | Clear All

Step 3: Users can search for codes either by entering the ICD Code (ICD-9 or ICD-10) or by entering the description.

Note: It is necessary to enter data in at least one field. It is better to search with less specific descriptions as the search function will find more possible matches.

Step 4: Users are able to select an ICD-version in the Version field. This allows the system to search by ICD-9, ICD-10, or include both in the search results.

Step 5: User should select the **Show Mapping** button if they would like to have the comparable ICD code map between ICD-9 and ICD-10.

Step 6: Click the **Find ICD** button. The search results will display as shown below.

	ICD Code	Description	Medium Description	Long Description	Version
⊞	10.	H	H	H	ICD-9
⊟	10.0	INCISE/REMOV CONJUNCT FB	INCISE/REMOVAL CONJUNCT FB	REMOVAL OF EMBEDDED FOREIGN BODY FROM CONJUNCTIVA BY INCISION	ICD-9

Diagnosis Code	Diagnosis Code 2	Description	Medium Description	Long Description	Short Disclosure	Version
08CTXZZ	08CTXZZ	EXTIRPAT MATTER LT CONJUNCTIVA	EXTIRPATION MATTER LT CONJUNCTIVA EXTERNAL	Extirpation of Matter from Left Conjunctiva, External Approach		ICD-10
08CSXZZ	08CSXZZ	EXTIRPAT MATTER RT CONJUNCTIVA	EXTIRPATION MATTER RT CONJUNCTIVA EXTERNAL	Extirpation of Matter from Right Conjunctiva, External Approach	Best code alternative based on clinical review of Index/Tabular files and Official Coding Guidelines	ICD-10

Step 7: Click the **(+)** icon to view the mapping details.

Step 8: To view more details about the ICD code, click the **ICD Description Details** icon. The **ICD Description** screen will populate as shown below.

ICD Description Close

Code:	10.0
Short Desc:	INCISE/REMOV CONJUNCT FB
Long Desc:	REMOVAL OF EMBEDDED FOREIGN BODY FROM CONJUNCTIVA BY INCISION
Hierarchy:	INCISE/REMOVAL CONJUNCT FB
Code Tip:	

CODE REFERENCE - MODIFIER

From this screen, users are able to search and view modifier codes.

Step 1: QuickCap Portal -> Left Panel -> **Information** -> **Code Reference-Modifier**

Step 2: The **Modifier Search** screen will display as shown below.

Modifier Search

Modifier Code: Description: Find Modifier Clear All

Modifier Code	Description
20	MICROSURGERY
22	UNUSUAL SERVICES
23	UNUSUAL ANESTHESIA
26	PROF. COMPONENT
30	ANESTHESIA

- Users can search either by entering the Modifier Code or by entering the description. Users can also search by directly clicking the **Find Modifier** button.

ABOUT MEDVISION

MedVision creates innovative, cost-effective, and intuitive software systems that enable organizations to operate efficiently in care coordination and population health management business processes. QuickCap™ v7.0, is a complete health benefits software solution that leverages advanced technology to automate workflow, enable superior analytics, integrate business processes and improve patient outcomes, while reducing operating costs.

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