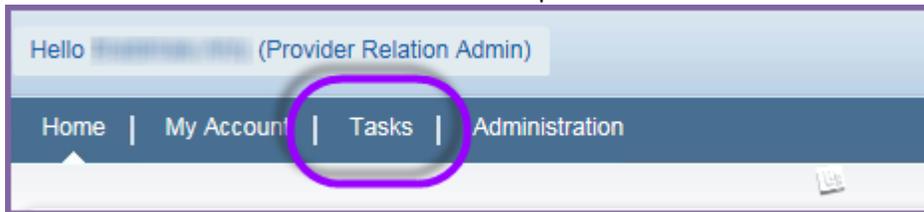


Please see below for instructions on how to submit a Participating Provider Dispute through the Secure Provider Portal:

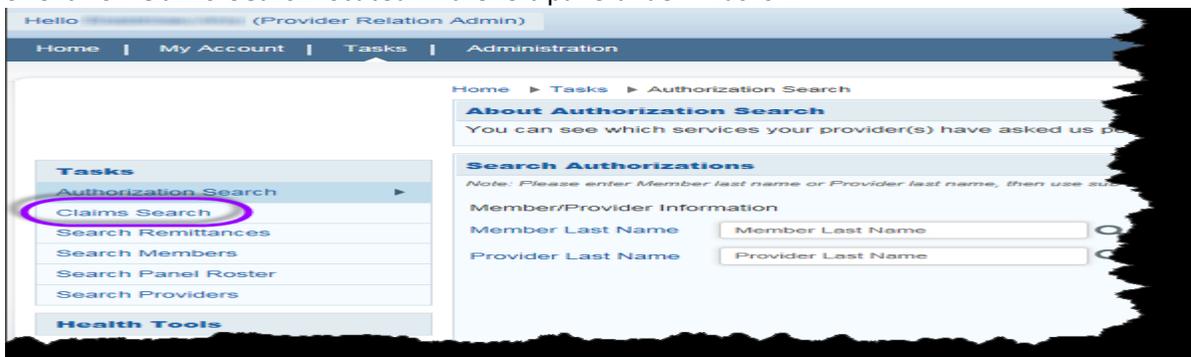
## Dispute Steps though Web Portal

*(Please note, this is not the process for a corrected claim. Corrected claims can be submitted through the same process as submitting a new claim using our WebConnect tool and designating the claim as a corrected claim.)*

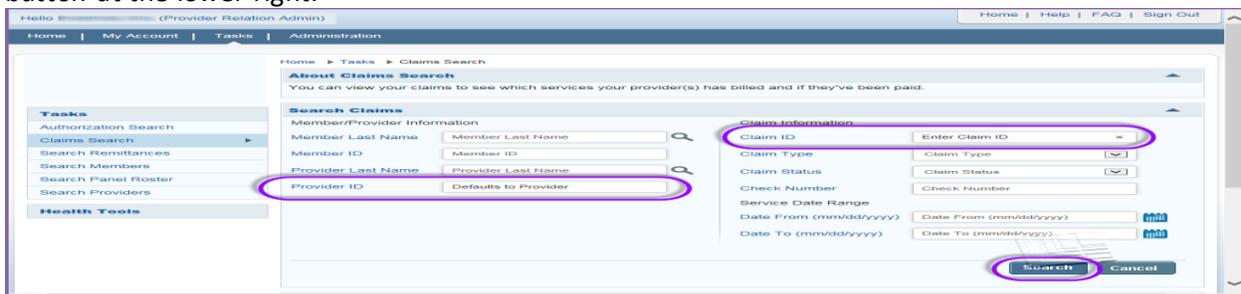
1. The Provider logs into the Secure Provider Portal **Medicaid Web Portal (MWP)**.
2. Click on **Tasks** from the banner on the top



3. Click on **Claims Search** located in the left pane under "Tasks".



4. The **Provider Name** should default to the logged in provider. Enter **Claim ID**, and click the **search** button at the lower right.



5. The Search results grid will load.
6. The Provider will see "**Claim Deliverable**" link under the **Claim Deliverable** column in the Search results grid. Click on the **Claim Deliverable** link to begin the Dispute process for the selected claim.

Home > Tasks > Claims Search > Claims Search Results

**About Claims Search**

This page lists claim records matching your input criteria. Select the Claim Number to display the details of the claim. You can Print or Download the claim list using the icon links on the page.

**Search Claims**

**Search Results (1)**

| Claim ID | Check No | Claim Type  | Member Name | Paid Date | Provider Name | Claim Status | Total Billed Amount | Total Paid | Claim Deliverable |
|----------|----------|-------------|-------------|-----------|---------------|--------------|---------------------|------------|-------------------|
|          |          | Professiona |             |           | OLIN, KEVIN S | OPENL        | \$235.00            | \$124.98   | Claim Deliverable |

Showing 1 - 1 of 1 results

7. This will take the Provider to the **Upload Claim Deliverables** screen.

8. Most of the information on the screen will be 'Auto populated' based on the claim number

9. Provider will select a **Type of Claim Resubmission (Dispute)** from the dropdown and enters the information in the relevant Mandatory fields;

a. **Submitter's First Name,**

b. **Submitter's Last Name, &**

c. **Submitter's Phone Number**

**Upload Claim Deliverables**

This form is only for resubmissions, which do not require a Corrected Claim. All Resubmissions require supporting documentation. This form shall not be used to submit Grievances and Appeals

|                          |               |                            |                         |                         |                    |
|--------------------------|---------------|----------------------------|-------------------------|-------------------------|--------------------|
| Claim Number             | 14210E32035   | Type of Claim Resubmission | ---Select---            | NPI                     | 1043293632         |
| Provider Name            | OLIN, KEVIN S | Submitter's First Name     |                         | Submitter's Last Name   |                    |
| Submitter's Phone Number |               | Provider Street Address    | 6225 S Rural Rd Ste 111 | Provider City           | Tempe              |
| Provider State           | AZ            | Provider ZIP               | 85283                   | Provider Contact Number | 4807207488         |
| Remittance Advise Date   |               | Date of Service (From)     | 04/02/2014              | Date of Service (To)    | 04/02/2014         |
| Amount Billed            | 235.0000      | Amount Paid                | 124.9800                | Member Name             | QSYSY133, PQOFJ532 |
| Member ID                | 932865088     | Comments                   |                         |                         |                    |

Browse... Submit

10. The **Comments** field is a mandatory input required, *when* the selected Type of claim Resubmission (Dispute) is "Other"

**Upload Claim Deliverables**

This form is only for resubmissions, which do not require a Corrected Claim. All Resubmissions require supporting documentation. This form shall not be used to submit Grievances and Appeals

|                          |               |                            |                         |                         |                    |
|--------------------------|---------------|----------------------------|-------------------------|-------------------------|--------------------|
| Claim Number             | 14210E32035   | Type of Claim Resubmission | ---Select---            | NPI                     | 1043293632         |
| Provider Name            | OLIN, KEVIN S | Submitter's First Name     |                         | Submitter's Last Name   |                    |
| Submitter's Phone Number |               | Provider Street Address    | 6225 S Rural Rd Ste 111 | Provider City           | Tempe              |
| Provider State           | AZ            | Provider ZIP               | 85283                   | Provider Contact Number | 4807207488         |
| Remittance Advise Date   |               | Date of Service (From)     | 04/02/2014              | Date of Service (To)    | 04/02/2014         |
| Amount Billed            | 235.0000      | Amount Paid                | 124.9800                | Member Name             | QSYSY133, PQOFJ532 |
| Member ID                | 932865088     | Comments                   |                         |                         |                    |

Browse... Submit

11. The Provider can upload supporting documentation (any type of file) from here by clicking the “Browse” button and thus activating the Browse functionality.

**Upload Claim Deliverables**

This form is only for resubmissions, which do not require a Corrected Claim. All Resubmissions require supporting documentation. This form shall not be used to submit Grievances and Appeals

|                          |               |                            |                         |                         |                    |
|--------------------------|---------------|----------------------------|-------------------------|-------------------------|--------------------|
| Claim Number             | 14210E32035   | Type of Claim Resubmission | ---Select---            | NPI                     | 1043293632         |
| Provider Name            | OLIN, KEVIN S | Submitter's First Name     |                         | Submitter's Last Name   |                    |
| Submitter's Phone Number |               | Provider Street Address    | 6225 S Rural Rd Ste 111 | Provider City           | Tempe              |
| Provider State           | AZ            | Provider ZIP               | 85283                   | Provider Contact Number | 4807207488         |
| Remittance Advise Date   |               | Date of Service (From)     | 04/02/2014              | Date of Service (To)    | 04/02/2014         |
| Amount Billed            | 235.0000      | Amount Paid                | 124.9800                | Member Name             | QSYSYT33, PQOFJ532 |
| Member ID                | 932865088     | Comments                   |                         |                         |                    |

**Browse** **Submit**

12. On successful attachment of the supporting documentation, the Provider clicks “Submit” at the bottom and receives a **Confirmation message** window. Upon clicking “Yes” the provider receives a success message, completing the workflow for submission.

**Confirmation**

Are you sure you want to Submit this Claim deliverable?

**Yes** **No**

**Upload Claim Deliverables**

This form is only for resubmissions, which do not require a Corrected Claim. All Resubmissions require supporting documentation. This form shall not be used to submit Grievances and Appeals

**Claim Deliverable has been submitted successfully !!!**

13. The Provider can view a previously submitted document (any type of file) from the below screen through clicking the link under the **Claim ID** column of the displayed grid, thus activating the **View Deliverable** functionality.

14. The submitted resubmission form is displayed, and the user can view the previously submitted information on the form and download the attachment by clicking the **Download File** button or through the **Button** below the **View Deliverable** column of the displayed Grid

**Resubmission Form**

|                             |                          |
|-----------------------------|--------------------------|
| Claim Number(s):            | 14210E32035              |
| Type of Claim Resubmission: | Medical Records Required |
| NPI:                        | 1043293632               |
| Provider Name:              | OLIN, KEVIN S            |
| Submitter's name:           | Tejas, Moola             |
| Submitter's Phone Number:   | 7654329876               |
| Provider Street Address:    | 6225 S Rural Rd Ste 111  |
| Provider City:              | Tempe                    |
| Provider State:             | AZ                       |
| Provider Zip:               | 85283                    |
| Provider Phone Number:      | 4807207488               |
| Date of Service (From):     | 4/2/2014 12:00:00 AM     |
| Date of Service (To):       | 4/2/2014 12:00:00 AM     |
| Remittance Advise Date:     |                          |
| Amount Billed:              | 235.0000                 |
| Amount Paid:                | 124.9800                 |
| Member Name:                | QSYSYT33, PQOFJ532       |