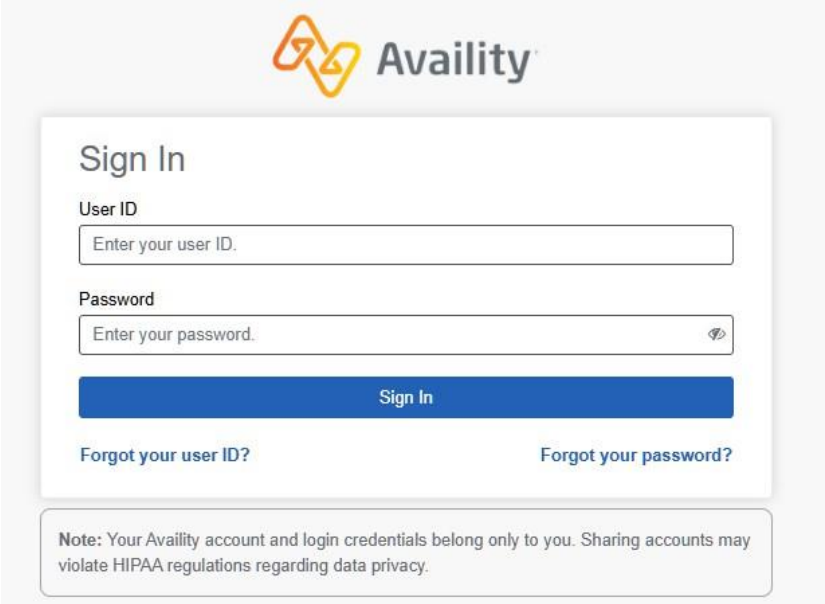
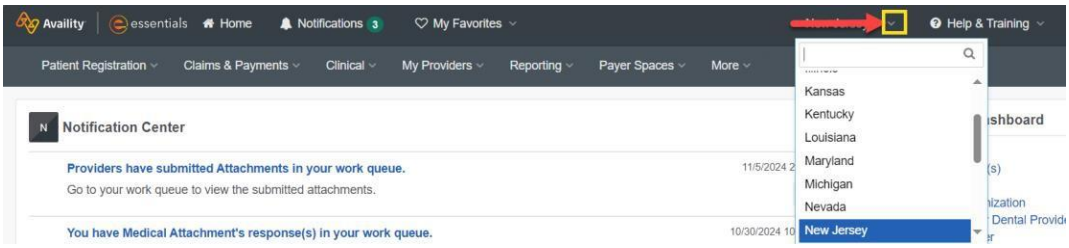
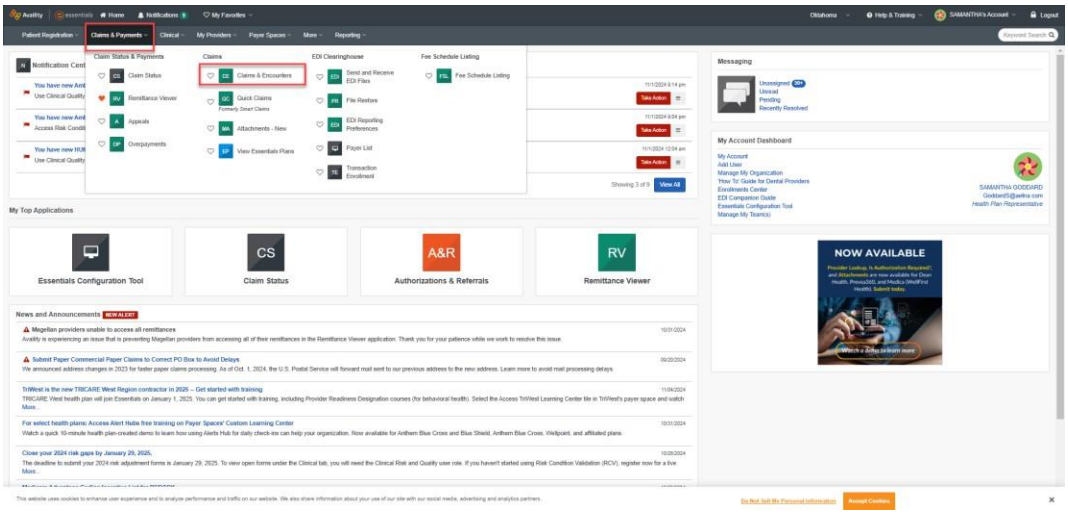
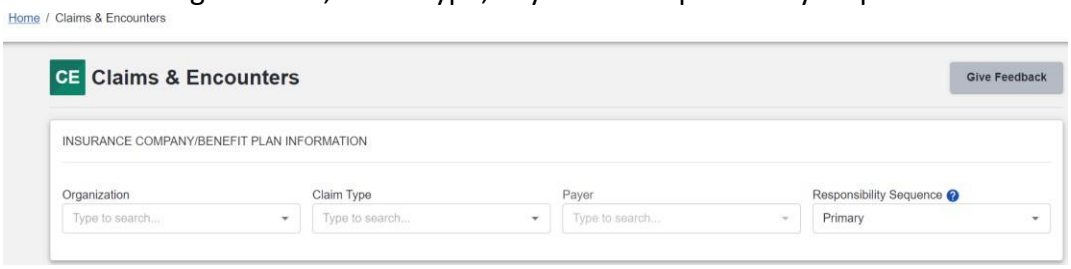
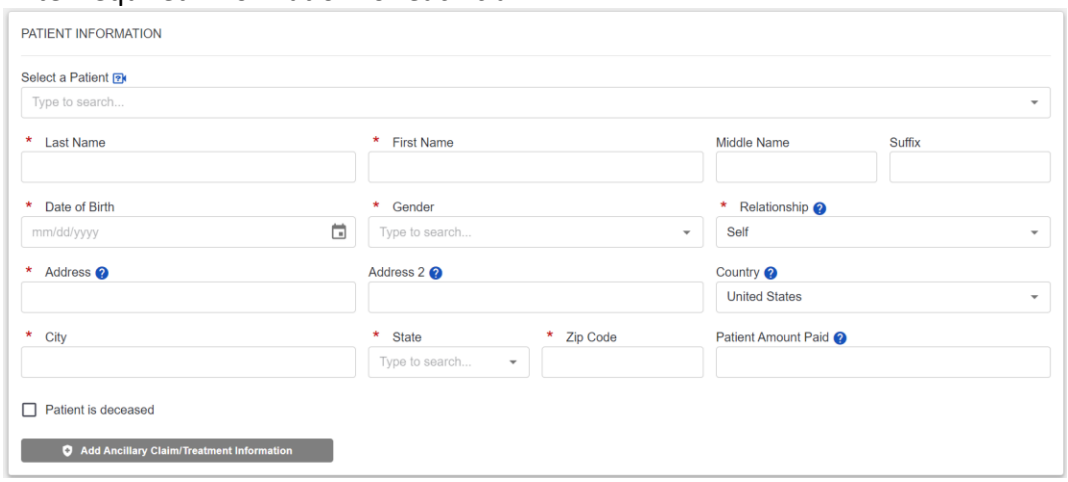
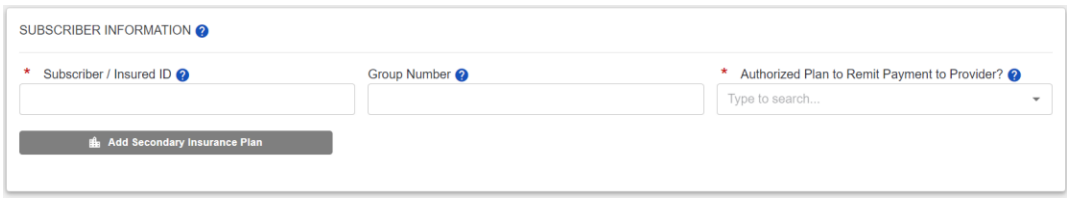
AMA- How to Submit a Claim in the Provider Portal

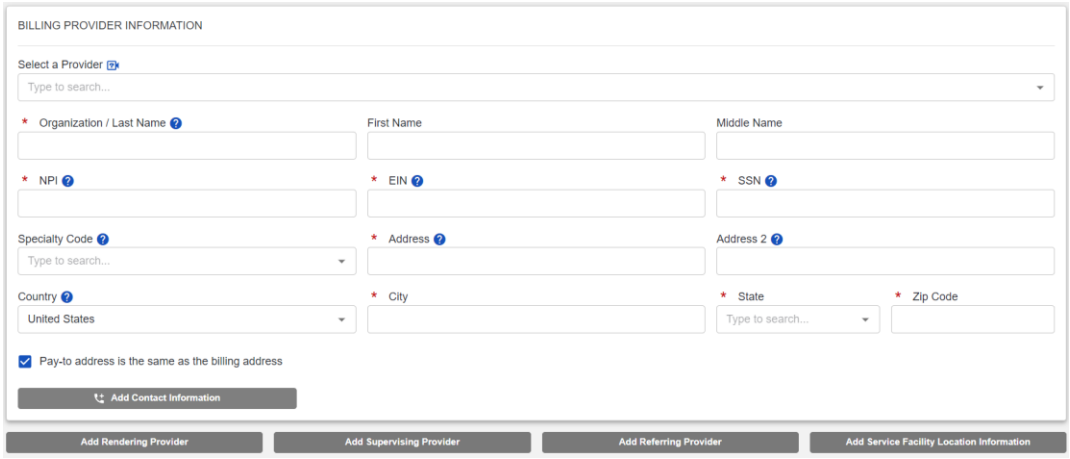
Introduction

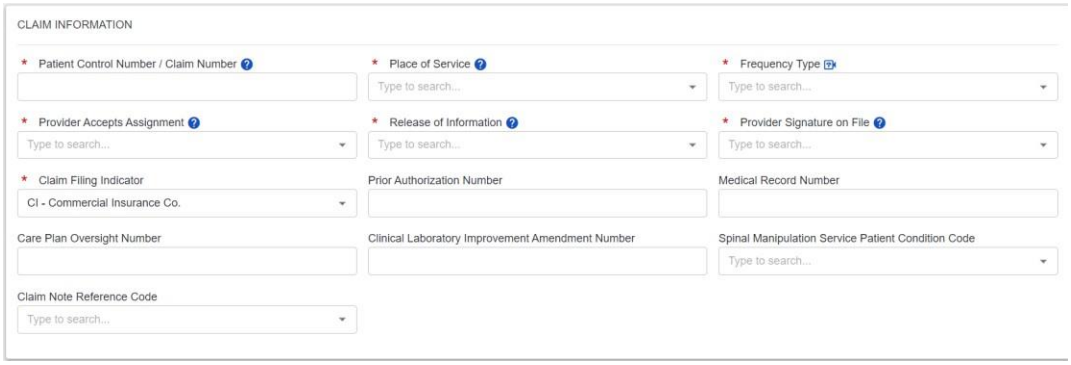
This Job Aid outlines what steps a provider will take to submit a claim through the Provider Portal, using Claims & Encounters.

Step	Action
1.	**Log on** to the portal using your credentials. 
2.	**Select** the appropriate health plan region (health plan state) 

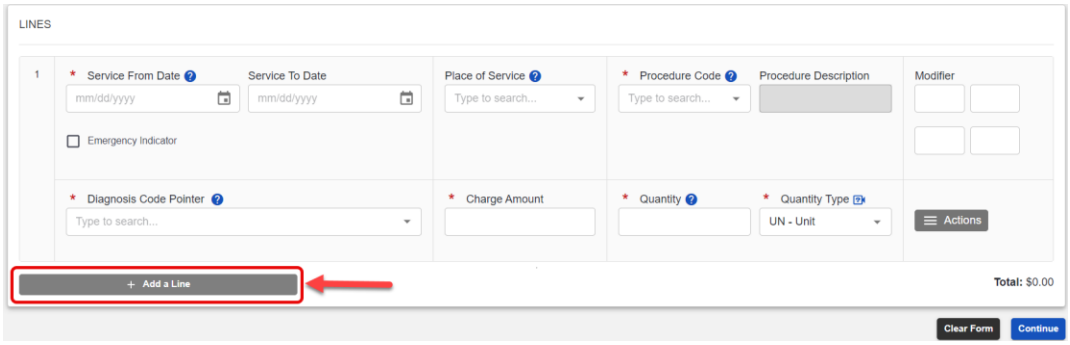
3.	**Open** the Claims & Encounters multi-payer tool within the “Claims & Payments” drop-down. 
4.	Choose the Organization, Claim Type, Payer and Responsibility Sequence 
5.	**If Professional claim proceed to step 6** **If Facility claim skip to step 8**
6.	**Professional Claims:** Enter required information for each claim: 

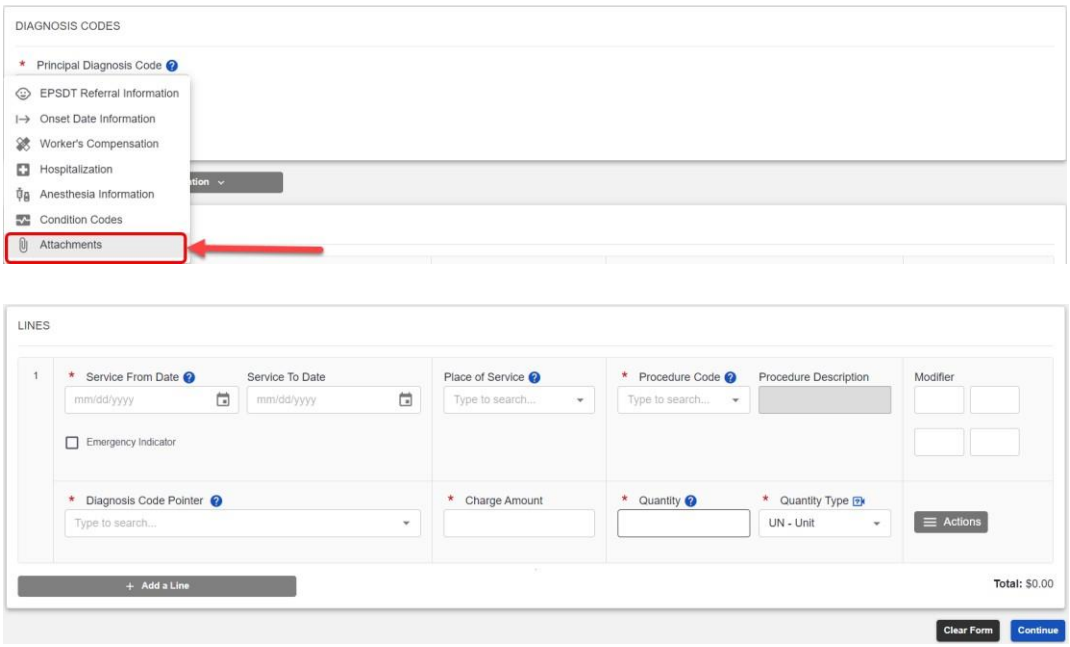






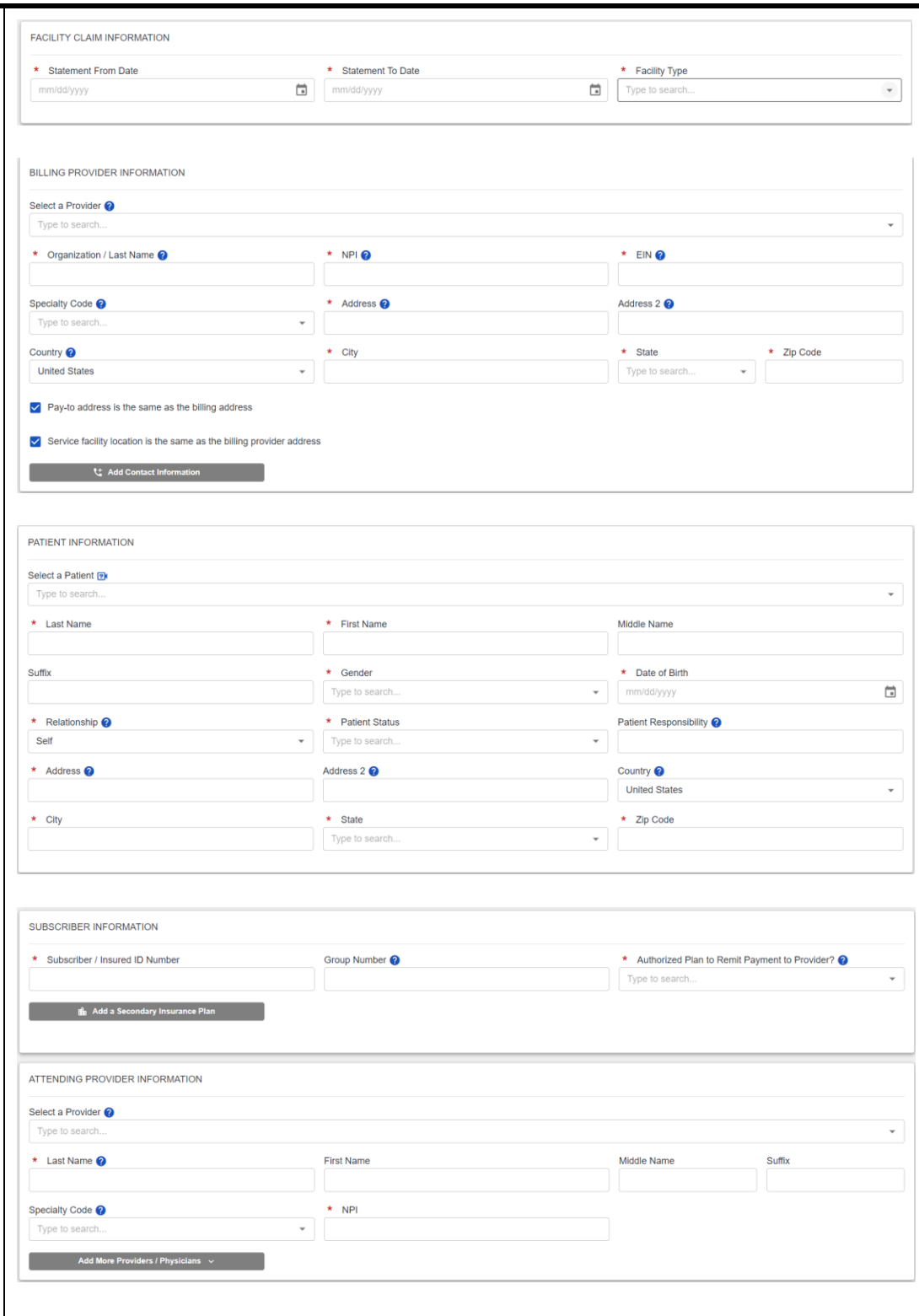
IMPORTANT: To add attachments, click on "Add Additional Claim Information"



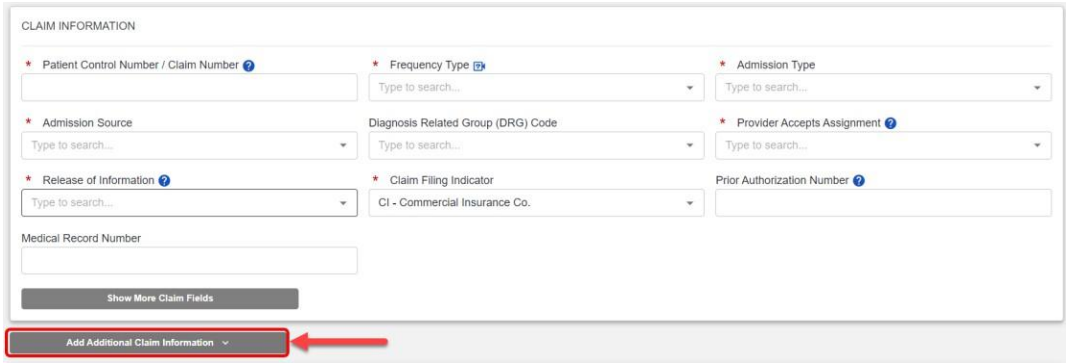


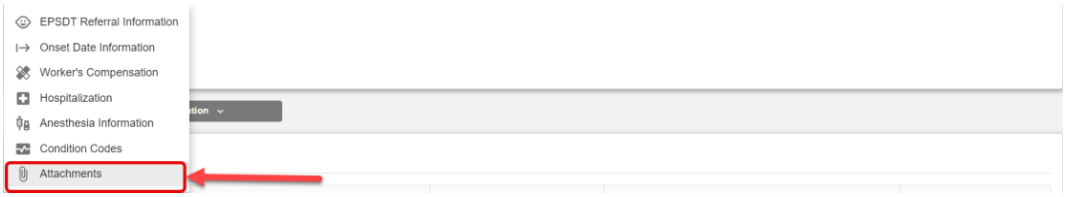
7. Click continue to be taken to the summary page. Click **Submit**.

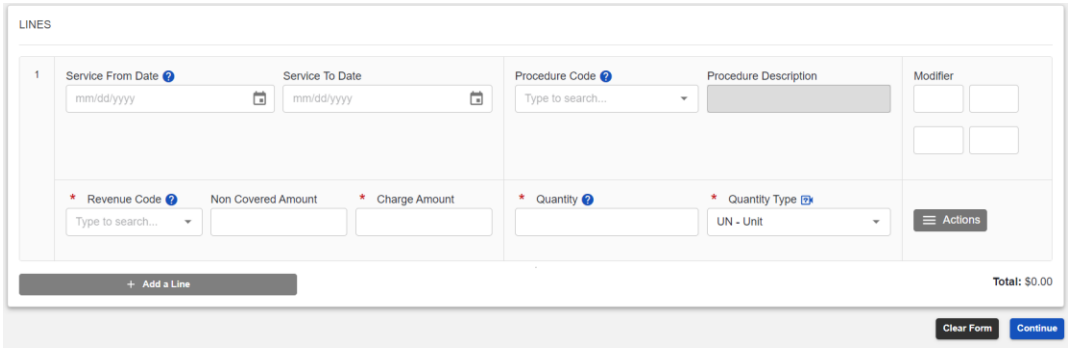
8. **Facility Claims:**
Enter the required information for each claim


FACILITY CLAIM INFORMATION
* Statement From Date
mm/dd/yyyy
* Statement To Date
mm/dd/yyyy
* Facility Type
Type to search...
BILLING PROVIDER INFORMATION
Select a Provider
Type to search...
* Organization / Last Name
* NPI
* EIN
Specialty Code
Type to search...
* Address
Address 2
Country
United States
* City
* State
Type to search...
* Zip Code
Pay-to address is the same as the billing address
Service facility location is the same as the billing provider address
Add Contact Information
PATIENT INFORMATION
Select a Patient
Type to search...
* Last Name
* First Name
Middle Name
Suffix
* Gender
Type to search...
* Date of Birth
mm/dd/yyyy
* Relationship
Self
* Patient Status
Type to search...
Patient Responsibility
* Address
Address 2
Country
United States
* City
* State
Type to search...
* Zip Code
SUBSCRIBER INFORMATION
* Subscriber / Insured ID Number
Group Number
* Authorized Plan to Remit Payment to Provider?
Type to search...
Add a Secondary Insurance Plan
ATTENDING PROVIDER INFORMATION
Select a Provider
Type to search...
* Last Name
First Name
Middle Name
Suffix
Specialty Code
Type to search...
* NPI
Add More Providers / Physicians

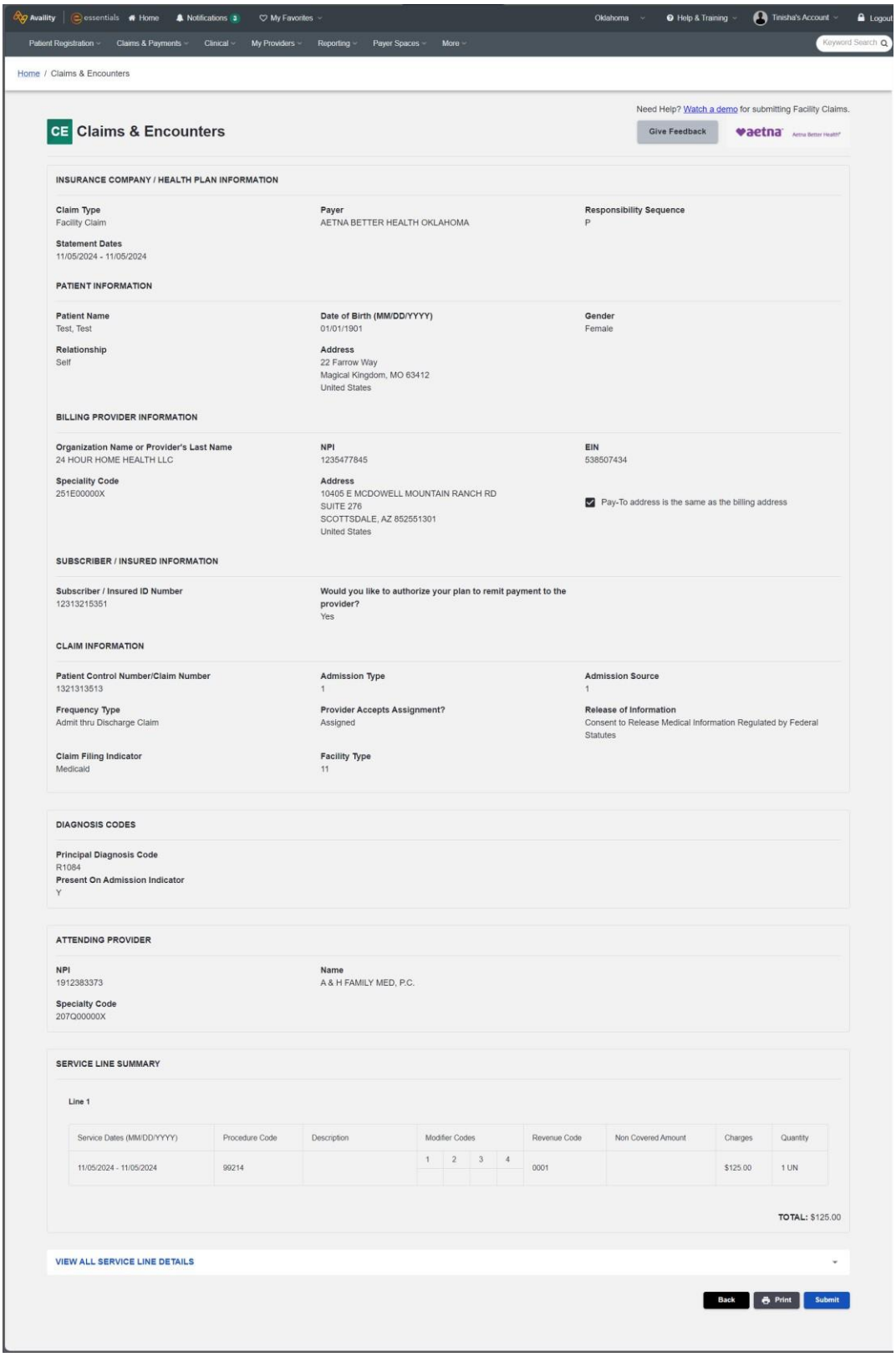
IMPORTANT: To add attachments, click on "Add Additional Claim Information"







9.	Click continue to be taken to the summary page. Click **Submit**.


Availity
essentials
Home
Notifications 3
My Favorites
Oklahoma
Help & Training
Tinisha's Account
Logout
Patient Registration
Claims & Payments
Clinical
My Providers
Reporting
Payer Spaces
More
Keyword Search
Home / Claims & Encounters
Need Help? Watch a demo for submitting Facility Claims.
CE Claims & Encounters
Give Feedback
aetna
INSURANCE COMPANY / HEALTH PLAN INFORMATION
Claim Type
Facility Claim
Payer
AETNA BETTER HEALTH OKLAHOMA
Responsibility Sequence
P
Statement Dates
11/05/2024 - 11/05/2024
PATIENT INFORMATION
Patient Name
Test, Test
Date of Birth (MM/DD/YYYY)
01/01/1901
Gender
Female
Relationship
Self
Address
22 Farrow Way
Magical Kingdom, MO 63412
United States
BILLING PROVIDER INFORMATION
Organization Name or Provider's Last Name
24 HOUR HOME HEALTH LLC
NPI
1235477845
EIN
538507434
Speciality Code
251E00000X
Address
10405 E MCDOWELL MOUNTAIN RANCH RD
SUITE 276
SCOTTSDALE, AZ 852551301
United States
Pay-To address is the same as the billing address
SUBSCRIBER / INSURED INFORMATION
Subscriber / Insured ID Number
12313215351
Would you like to authorize your plan to remit payment to the provider?
Yes
CLAIM INFORMATION
Patient Control Number/Claim Number
1321313513
Admission Type
1
Admission Source
1
Frequency Type
Admit thru Discharge Claim
Provider Accepts Assignment?
Assigned
Release of Information
Consent to Release Medical Information Regulated by Federal Statutes
Claim Filing Indicator
Medicaid
Facility Type
11
DIAGNOSIS CODES
Principal Diagnosis Code
R1084
Present On Admission Indicator
Y
ATTENDING PROVIDER
NPI
1912383373
Name
A & H FAMILY MED, P.C.
Specialty Code
207Q00000X
SERVICE LINE SUMMARY
Line 1
Service Dates (MM/DD/YYYY)
Procedure Code
Description
Modifier Codes
1
2
3
4
Revenue Code
Non Covered Amount
Charges
Quantity
11/05/2024 - 11/05/2024
99214
0001
$125.00
1 UN
TOTAL: $125.00
VIEW ALL SERVICE LINE DETAILS
Back
Print
Submit

10.	**End of Process**