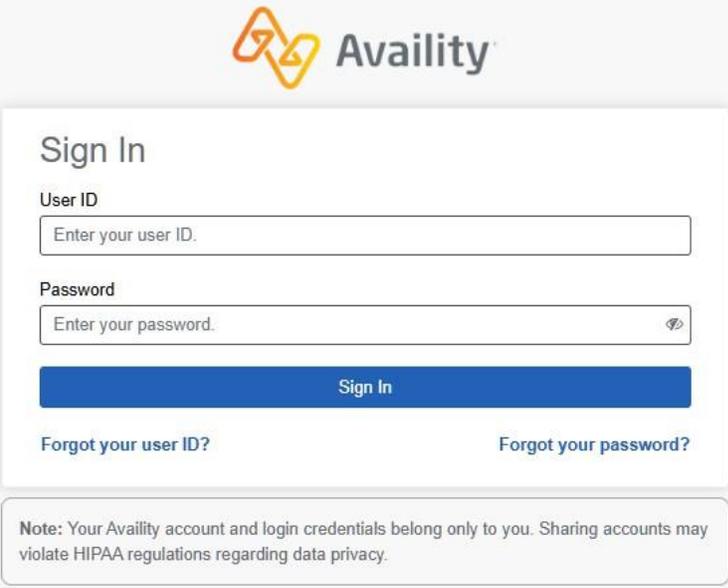
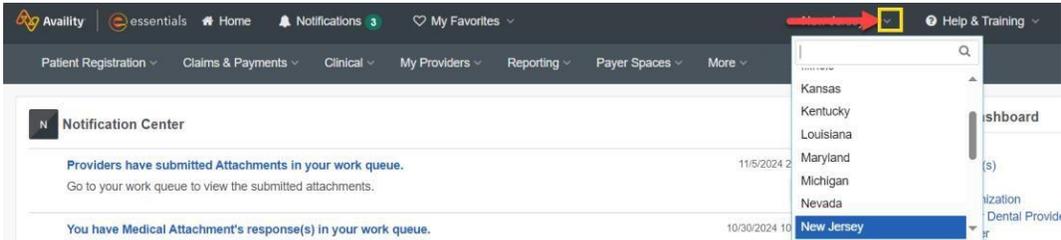




## AMA- How to Submit a Claim in the Provider Portal

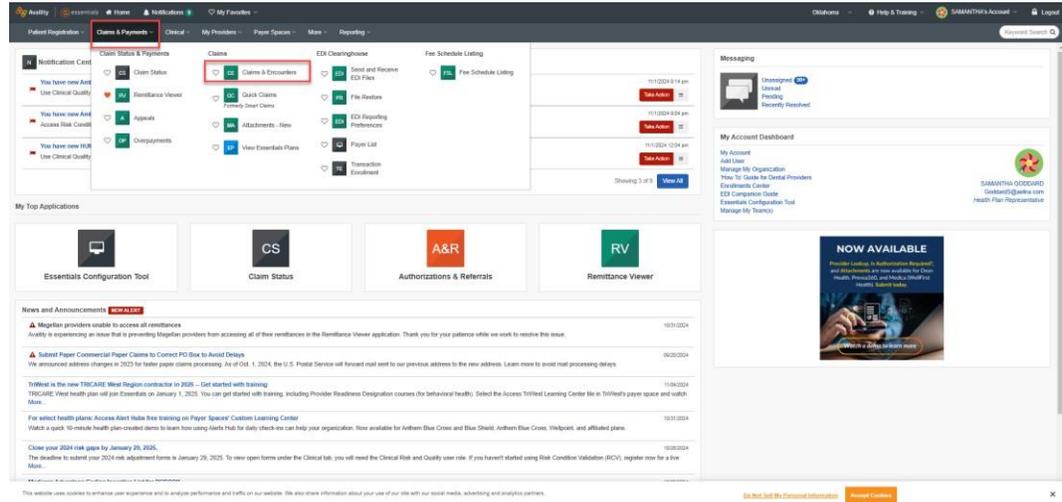
### Introduction

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

Step	Action
1.	<p><b>Log on</b> to the portal using your credentials.</p> 
2.	<p><b>Select</b> the appropriate health plan region (health plan state)</p> 

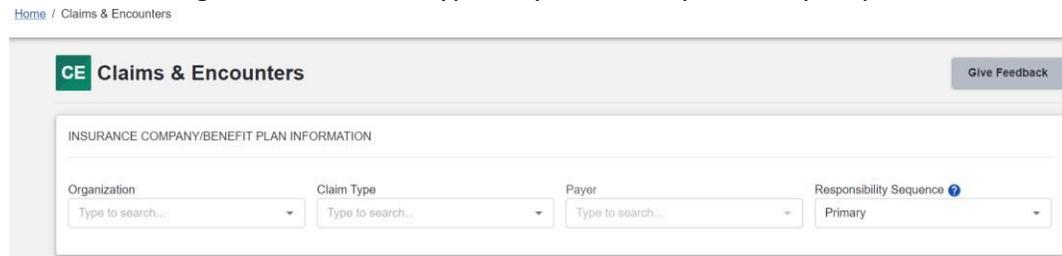
3.

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:

PATIENT INFORMATION

Select a Patient [+](#)

Type to search...

\* Last Name  \* First Name  Middle Name  Suffix

\* Date of Birth  \* Gender  \* Relationship [?](#)

\* Address [?](#)  Address 2 [?](#)  Country [?](#)

\* City  \* State  \* Zip Code  Patient Amount Paid [?](#)

Patient is deceased

[Add Ancillary Claim/Treatment Information](#)

SUBSCRIBER INFORMATION

\* Subscriber / Insured ID  Group Number  \* Authorized Plan to Remit Payment to Provider?

BILLING PROVIDER INFORMATION

Select a Provider

\* Organization / Last Name  First Name  Middle Name

\* NPI  \* EIN  \* SSN

Specialty Code  \* Address  Address 2

Country  \* City  \* State  \* Zip Code

Pay-to address is the same as the billing address

CLAIM INFORMATION

\* Patient Control Number / Claim Number  \* Place of Service  \* Frequency Type

\* Provider Accepts Assignment  \* Release of Information  \* Provider Signature on File

\* Claim Filing Indicator  Prior Authorization Number  Medical Record Number

Care Plan Oversight Number  Clinical Laboratory Improvement Amendment Number  Spinal Manipulation Service Patient Condition Code

Claim Note Reference Code

**IMPORTANT:** To add attachments, click on “Add Additional Claim Information”

LINES

1	* Service From Date <input type="text"/>	Service To Date <input type="text"/>	Place of Service <input type="text"/>	* Procedure Code <input type="text"/>	Procedure Description	Modifier
	<input type="checkbox"/> Emergency Indicator					
	* Diagnosis Code Pointer <input type="text"/>	* Charge Amount <input type="text"/>	* Quantity <input type="text"/>	* Quantity Type <input type="text"/>	<input type="button" value="Actions"/>	



Total: \$0.00

DIAGNOSIS CODES

- \* Principal Diagnosis Code
- EPSDT Referral Information
- Onset Date Information
- Worker's Compensation
- Hospitalization
- Anesthesia Information
- Condition Codes
- Attachments**

LINES

1	* Service From Date	Service To Date	Place of Service	* Procedure Code	Procedure Description	Modifier
	mm/dd/yyyy	mm/dd/yyyy	Type to search...	Type to search...		
	<input type="checkbox"/> Emergency Indicator					
	* Diagnosis Code Pointer	* Charge Amount	* Quantity	* Quantity Type	Actions	
	Type to search...			UN - Unit		

+ Add a Line

Total: \$0.00

Clear Form Continue

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

Claims & Encounters

INSURANCE COMPANY / HEALTH PLAN INFORMATION

Claim Type: Professional Claim  
Fayer: AETNA BETTER HEALTH OKLAHOMA  
Responsibility Sequence: P

PATIENT INFORMATION

Patient Name: Test, Test  
Date of Birth (MM/DD/YYYY): 01/01/1901  
Gender: Female  
Relationship: Self  
Address: 22 Farmer Way, Wagon Kingdom, MO 63412, United States

BILLING PROVIDER INFORMATION

Organization Name or Provider's Last Name: A.B. FAMILY MED, INC.  
NPI: 1612893373  
EIN: 606246479  
Address: 6763 N BELLEVUE AVE, NILES, IL 60714-4818, United States  
 Pay to address in the same as the billing address

SUBSCRIBER / INSURED INFORMATION

Subscriber / Insured ID Number: 123456789  
Would you like to authorize your plan to remit payment to the provider?: Yes

CLAIM INFORMATION

Patient Control Number/Claim Number: 123456789  
Place of Service: H  
Frequency Type: Allow this Encounter Claim  
Provider Acceptance Assignment?: Assigned  
Release of Information: Consented to Release Medical Information (Regulated by Federal HIPAA)  
Provider Signature on File: Yes  
Claim Filing Indicator: Manual

DIAGNOSIS CODES

Principal Diagnosis Code: H0202

SERVICE LINE SUMMARY

Line 1	Service Dates (MM/DD/YYYY)	Place of Service	Procedure Code	Description	Modifier Codes	Diagnosis Code Pointer	Charges	Quantity
	1/1/2024 - 1/1/2024	H	9075		1 2 3 4	H0202	\$100.00	1 UN

TOTAL: \$125.00

VIEW ALL SERVICE LINE DETAILS

Back Print Submit

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

FACILITY CLAIM INFORMATION

\* Statement From Date   \* Statement To Date   \* Facility Type

BILLING PROVIDER INFORMATION

Select a Provider

\* Organization / Last Name  \* NPI  \* EIN

Specialty Code  \* Address  Address 2

Country  \* City  \* State  \* Zip Code

Pay-to address is the same as the billing address

Service facility location is the same as the billing provider address

PATIENT INFORMATION

Select a Patient

\* Last Name  \* First Name  Middle Name

Suffix  \* Gender  \* Date of Birth

\* Relationship  \* Patient Status  Patient Responsibility

\* Address  Address 2  Country

\* City  \* State  \* Zip Code

SUBSCRIBER INFORMATION

\* Subscriber / Insured ID Number  Group Number  \* Authorized Plan to Remit Payment to Provider?

ATTENDING PROVIDER INFORMATION

Select a Provider

\* Last Name  First Name  Middle Name  Suffix

Specialty Code  \* NPI

DIAGNOSIS CODES

\* Principal Diagnosis Code ⓘ  
 Type to search...  
 Present on Admission Indicator  
 Type to search...  
 + Add

**IMPORTANT:** To add attachments, click on “Add Additional Claim Information”

CLAIM INFORMATION

\* Patient Control Number / Claim Number ⓘ      \* Frequency Type ⓘ      \* Admission Type  
 Type to search...      Type to search...      Type to search...  
 \* Admission Source      Diagnosis Related Group (DRG) Code      \* Provider Accepts Assignment ⓘ  
 Type to search...      Type to search...      Type to search...  
 \* Release of Information ⓘ      \* Claim Filing Indicator      Prior Authorization Number ⓘ  
 Type to search...      C1 - Commercial Insurance Co.        
 Medical Record Number  
 Show More Claim Fields

Add Additional Claim Information ▾

- ⊞ EPSDT Referral Information
- ↳ Onset Date Information
- ⊞ Worker's Compensation
- ⊞ Hospitalization
- ⊞ Anesthesia Information
- ⊞ Condition Codes
- 📎 Attachments

LINES

1	Service From Date ⓘ	Service To Date	Procedure Code ⓘ	Procedure Description	Modifier
	mm/dd/yyyy	mm/dd/yyyy	Type to search...		
	* Revenue Code ⓘ	Non Covered Amount	* Charge Amount	* Quantity ⓘ	* Quantity Type ⓘ
	Type to search...				UN - Unit

+ Add a Line      Total: \$0.00  
 Clear Form    Continue

9.

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

Avality essentials Home Notifications My Favorites Oklahoma Help & Training Tinesha'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](#)  Active Better Health!

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**INSURANCE COMPANY / HEALTH PLAN INFORMATION**

<b>Claim Type</b> Facility Claim	<b>Payer</b> AETNA BETTER HEALTH OKLAHOMA	<b>Responsibility Sequence</b> P
<b>Statement Dates</b> 11/05/2024 - 11/05/2024		

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**PATIENT INFORMATION**

<b>Patient Name</b> Test, Test	<b>Date of Birth (MM/DD/YYYY)</b> 01/01/1901	<b>Gender</b> Female
<b>Relationship</b> Self	<b>Address</b> 22 Farrow Way Magical Kingdom, MO 63412 United States	

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**BILLING PROVIDER INFORMATION**

<b>Organization Name or Provider's Last Name</b> 24 HOUR HOME HEALTH LLC	<b>NPI</b> 1235477845	<b>EIN</b> 538507434
<b>Specialty Code</b> 251E0000X	<b>Address</b> 10405 E MCDOWELL MOUNTAIN RANCH RD SUITE 276 SCOTTSDALE, AZ 852551301 United States	
<input checked="" type="checkbox"/> Pay-To address is the same as the billing address		

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**SUBSCRIBER / INSURED INFORMATION**

<b>Subscriber / Insured ID Number</b> 12313215351	<b>Would you like to authorize your plan to remit payment to the provider?</b> Yes
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**CLAIM INFORMATION**

<b>Patient Control Number/Claim Number</b> 1321313513	<b>Admission Type</b> 1	<b>Admission Source</b> 1
<b>Frequency Type</b> Admit thru Discharge Claim	<b>Provider Accepts Assignment?</b> Assigned	<b>Release of Information</b> Consent to Release Medical Information Regulated by Federal Statutes
<b>Claim Filing Indicator</b> Medicaid	<b>Facility Type</b> 11	

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**DIAGNOSIS CODES**

<b>Principal Diagnosis Code</b> R1084
<b>Present On Admission Indicator</b> Y

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**ATTENDING PROVIDER**

<b>NPI</b> 1912383373	<b>Name</b> A & H FAMILY MED, P.C.
<b>Specialty Code</b> 207Q0000X	

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**SERVICE LINE SUMMARY**

Line 1

Service Dates (MM/DD/YYYY)	Procedure Code	Description	Modifier Codes				Revenue Code	Non Covered Amount	Charges	Quantity
			1	2	3	4				
11/05/2024 - 11/05/2024	99214						0001		\$125.00	1 UN

**TOTAL: \$125.00**

[VIEW ALL SERVICE LINE DETAILS](#)

[Back](#) [Print](#) [Submit](#)

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10.	<b>End of Process</b>
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