# Connecticut Medical Assistance Program
# Web Claim Billing Guide
# Professional

The Professional Claim Submission, Re-submission, Adjustment and Inquiry processes are real-time transactions, which the provider can perform from this Secure Web site. Providers may submit Professional claims from this page by entering the claim data directly onto the Web page, or they may perform an inquiry to retrieve previously adjudicated claims to view or use to re-submit claims or adjustments. It is recommended that this billing guide be printed for easy reference when using the claim submission tool.

## Claim Submission

Professional claim submission is used by a provider to enter and submit claim data and receive claim adjudication results in real-time. By clicking on the Professional tab, a provider can enter all of the information required to submit a Professional claim, with either single or multiple detail lines. When all of the required claim data is entered, the submit button is clicked. Missing or invalid data submitted will result in an error message being returned that identifies the problem and allows the correction to be made to the claim. The claim remains in a Not Submitted yet status and the error message will appear at the top of the Web page. Once the correction(s) is made, the submit button is clicked again. If the claim has all of the appropriate claim information, the claim is processed by the interChange system.

The claim is adjudicated in "real-time" and the finalized claim data is returned by the interChange system and populates the Professional claim screens. The adjudicated claim will now return a Claim Status Information panel containing an Internal Control Number (ICN), Claim Status, and Paid Amount, if applicable. An EOB Information panel (Explanation of Benefits) will display the detail line of the claim, the code and the EOB description.

**NOTE:** Once a provider has started entering a claim, there is no way to save the information and come back to that claim later. Additionally, there are time limits for entering the claim (approximately 40 minutes), so it is recommended that the provider gather all information needed to submit a claim prior to begin entering the data for the claim.

Once a claim has been submitted and paid, the provider can copy that claim and modify it, rather than creating a new claim. This functionality saves providers keystrokes and time. A claim, for example, can be copied for a client from a prior visit and modified for the current visit, or a claim with a widely used procedure code can be modified and submitted for different clients. It is important to note that the new claim will inherit all of the data from the claim that was copied, including all diagnosis codes, detail lines or prior payments such as other insurance or Medicare. All data on the new claim must be reviewed for accuracy before it is submitted.

## Claim Re-submission

If a claim that was submitted was denied due to a billing error, a provider may also re-submit the claim by first performing an inquiry on the Claim Inquiry page to retrieve the claim, update the necessary fields on the denied claim, and click the re-submit button to re-submit the claim. The claim can also be re-submitted with no changes if desired. For example, if the claim denied because the client was not eligible, and the client was subsequently made retroactively eligible, the claim can simply be re-submitted with no changes.

## Claim Adjustments/Voids

If the provider wishes to correct or void a previously paid claim, the provider must first perform an inquiry on the Claim Inquiry page to retrieve the claim. If a claim is in a paid status but needs to be adjusted, that claim information can be changed as needed by first changing the appropriate claim data and then clicking on the adjust button. **Do not click the adjust button without first making the changes to the claim or the adjustment will process without changes.** A claim can also be adjusted without making a change, such as when all units on a claim are not paid, if the Prior Authorization (PA) has been exhausted. If additional units are added to the PA, the claim may be adjusted without making changes to pay the remaining units on the claim or units up to the PA change. If a paid claim needs to be completely recouped, the provider simply clicks the void button. Both of these functions result in the interChange system creating a new claim and assigning an adjustment Internal Control Number (ICN).

## Claims that cannot be adjusted via the Web portal:

**Claims that exceed the timely filing limit will be recouped in full if adjusted to pay more via the Web.** As a reminder, claims must be submitted to Gainwell Technologies within 365 days of the date of service. Please refer to the Timely Filing Guidelines section in Chapter 5 for additional information, available at www.ctdssmap.com by selecting Information, then Publications and scrolling down to Provider Manual Chapter 5. Providers may adjust claims that exceed the timely filing limit only if the claim adjustment is submitted to pay the same or less than the original claims. These claims will bypass timely filing edits for claims with a date of service or last paid date over the filing limit.

**Claims with an ICN that begins with either 12 or 13.** These claims were special handled by Gainwell Technologies. An adjustment to these claims may also need to be specially handled. The provider should contact Gainwell Technologies before attempting to adjust these claims.

**Paid Medicare crossover claims cannot be adjusted.** They must be voided, and then re-submitted. This is easily accomplished by completing the following steps:

1. Void the paid Crossover claim.
2. Copy the original Crossover claim.
3. Make the necessary changes to the claim data.

4. Click the submit button.

**NOTE:** There are no restrictions to claim voids. They can occur at any time.

## Professional Claim Submission Instructions

The Professional claim is completed by entering data in the appropriate fields. The Professional claim sections are included below. A list of fields, their description, field length, and field requirements are also included for each section. Field requirements indicate whether the field is:

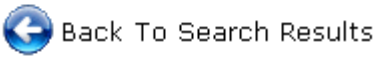
- R = Required – These fields must be completed in order for a claim to be submitted.
- S = Situational – This indicates that this field is required if another field or a certain value is provided on the claim.
- O = Optional – This field is not required and is optional for completion of the claim.
- Auto-populated – This indicates that this field is automatically populated with data.

If the required fields are not completed correctly, and the submit button is clicked, the Claim Status will indicate Not Submitted yet. Error messages will appear at the top of the page. The missing or invalid data must be corrected before the claim can be successfully submitted. Once the claim is successfully submitted, the claim will adjudicate and post the claim status at the bottom of the page.

More detailed billing instructions are located at www.ctdssmap.com, by selecting Information, then Publications, and selecting the appropriate provider type from the Chapter 8 drop down field. Additionally, the provider can left click on any field name to obtain field level help.

**Note: The back button in the top left corner of your Web page  should not be used because it will not return the previous Web page. This is for security purposes. Should the back button be clicked, the provider will be required to log back into their Secure Web account.**

In order to return to the search results of the previous claim search, click on the following Back To Search Results arrow located in the top left portion of the claim panel, beneath the instructions for submitting professional claims.



## Claim Sections

- **Professional Claim**

Contains header level claim information including provider, client, dates of service, total charges, third party liability amount, copay amount, and accident information.

- **Diagnosis**

Contains diagnosis code entry. The Code Set drop-down defaults to ICD 10, the other options being ICD 9 and OTHER. Complete the Principal and Other diagnosis code fields, if applicable. Click the add more button in the lower left-hand corner to allow the entry of more diagnosis codes. A total of 12 diagnosis codes may be entered. To remove a diagnosis code, simply delete the code from the field.

- **Condition**

Contains the condition code related to the abortion procedure that is entered at the detail level of the claim. To enter the condition code information, click the add button located on the lower left-hand corner to allow the entry of one or more condition codes or the delete button located on the lower left-hand corner to allow the removal of an individual condition code.

- **Detail**

Contains the service detail information such as procedure codes, modifiers, charges, service dates and Medicare data. To add the first detail, complete the fields on the panel as appropriate. Click the add button located on the lower left-hand corner to enter additional claim details. Up to fifty (50) details are allowed per claim. Highlight the Detail Item line and click the delete button located on the lower left-hand corner to allow the removal of an individual claim detail.

- **Additional NDCs**

Contains NDC information, if more than one NDC exists for a claim detail. To add additional NDC information, select the detail in the Detail panel to which the NDC information needs to be added. In the Additional NDCs panel, click the add button located on the lower left-hand corner to enter additional NDC details. Highlight the Additional NDC line and click the delete button located on the lower left-hand corner to allow the removal of an individual NDC.

## • TPL

Contains third party liability coverage entries or Medicare denials. To enter TPL information, click the add button located on the lower left-hand corner to allow the entry of one or more TPL resources or the delete button located on the lower left-hand corner to allow the removal of individual TPL resources. This section must only be completed to report a third party payment or denial or a Medicare denial. All active insurance policies as reported on the client's eligibility file that provide coverage for the service billed must be entered on the TPL panel.

For additional information on other insurance or Medicare billing, providers should refer to Chapter 11 of the Provider Manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 11. From the drop-down box, select the Professional Other Insurance/Medicare Billing Guide.

## • Claim Status Information

Contains claim status information. For a new claim that is being completed, the status will show Not Submitted yet. Once a claim has been successfully submitted, the status will indicate PAID, DENIED, SUSPENDED or ADJUSTED/VOIDED with the associated Claim Internal Control Number (ICN) assigned and Paid Amount if applicable. Depending on the status of the claim, different actions may be performed from this section of the page.

## • EOB Information

The EOB (Explanation of Benefits) will indicate the detail number, the EOB code, and the associated description. A detail number of "0" signifies that the error applies to the entire claim.

For additional information on resolving the most common claim errors, providers should refer to Chapter 12 of the Provider Manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 12 – Claim Resolution Guide. The Chapter is also available under "Quick Links" at the top of the Claims Web page.

| Professional Claim Section | | | |
|---|---|---|---|
| **Field** | **Description** | **Length** | **Required (R)/ Situational (S)/ Optional (O)** |
| ICN | Displays the unique 13-digit Internal Control Number (ICN) assigned by the system to the claim once a claim has been submitted for processing. This field will remain grayed out while the claim is still in a Not Submitted yet status. | 13 | Auto-populated |
| Provider ID | Automatically displays the National Provider Identifier (NPI) or non-medical provider ID based on how the provider logged into the Secure site.<br><br>If this is not the ID to be submitted on the claim, sign out of the Secure site and log on to the correct account. | 10 | Auto-populated |
| AVRS ID | Identification number assigned to each provider for use with the AVRS. | 9 | Auto-populated |
| Client ID | Unique 9-digit identification number of the client. Once entered during claim submission, the provider must then click anywhere outside of this field to initiate the auto-population of the client name and date of birth. | 9 | R |
| Last Name | Automatically displays the last name of the client based on the client ID entered. Be sure to view this field to validate that you have entered the client ID correctly. | 20 | Auto-populated |
| First Name, MI | Automatically displays the first name of the client (up to 15 characters) and middle initial of the client (1 character) based on the client ID entered. Be sure to view this field to validate that you have entered the client ID correctly. | 16 | Auto-populated |
| Date of Birth | Automatically displays the client's date of birth based on the client ID entered. | 10 | Auto-populated |
| Patient Account # | Identification number for a client assigned by the provider. | 38 | O |
| Medical Record Number | Medical record number (MRN). | 50 | O |
| Referring Physician | The National Provider Identifier (NPI) of the referring physician, if applicable. This field has a search option which allows the user to enter search parameters and select the desired code from the search results. | 10 | S, required if claim involved a referral |

| Professional Claim Section | | | |
|---|---|---|---|
| **Field** | **Description** | **Length** | **Required (R)/ Situational (S)/ Optional (O)** |
| SSN | Social Security Number (SSN) or Employer Identification Number (EIN) of the performing provider is required when all Waiver, Special or State Plan self-directed program services billed by the Program Fiduciary or Administrative Agency on the claim do not require individual or agency performers to be enrolled as Connecticut Medical Assistance Program providers. This would be applicable to the ABI, Autism, CHC, MHW, PCA, MFP Comprehensive and MFP IFS Waivers, Birth to Three Special Services Program and the CFC and MFP State plans. This field is inactive or grayed out when claims are submitted under any other billing provider number. | 9 | S |
| Accident Related | Indicates whether service was performed as a result of an accident. Valid values are blank, Yes, or No. | Drop Down Box | S, required if Accident Related = Y |
| Accident Date | The date of occurrence of the reported accident. Format is MM/DD/CCYY. | 10 | S, required if Accident Related = Y |
| Accident Related Causes | Up to four Accident Related Cause codes can be assigned to a reported accident. Valid values are Auto Accident, Another Party Responsible, Employment Related, or Other Accident. | Checkbox | S, required if Accident Related = Y |
| From Date | The earliest From Date on the claim detail(s). Format is MM/DD/CCYY. This field will be populated with the date of service from the detail panel and cannot be changed. | 10 | Auto-populated |
| To Date | The most recent To Date on the claim detail(s). Format is MM/DD/CCYY. This field will be populated with the date of service from the detail panel and cannot be changed. | 10 | Auto-populated |
| Admission Date | The date the client was admitted to the facility, if applicable. Format is MM/DD/CCYY. | 10 | S |
| EPSDT Referral | The code that indicates EPSDT referral. Valid values are Available – Not Used, Not Used, Under Treatment, or New Services Requested. | Drop Down Box | S |
| Total Charges | The total dollar amount charged for a claim and is the sum of the Charges entered on the Claim Detail panel. | 8 | Auto-populated |
| Total Paid | The total dollar amount paid for the claim. | 8 | Auto-populated |
| TPL Amount | The total TPL amount which is the sum of the TPL amounts entered on the TPL panel. | 8 | Auto-populated |

| Professional Claim Section | | | |
|---|---|---|---|
| **Field** | **Description** | **Length** | **Required (R)/ Situational (S)/ Optional (O)** |
| CoPay Amount | Sum of the copay amount on the claim details. | 8 | Auto-populated |
| Medicare Crossover | Indicates whether Medicare was billed and if Medicare made a payment. Valid values are Yes or No. Yes indicates Medicare made a payment and No indicates no Medicare coverage or Medicare denied the claim. | Drop Down Box | O |
| 837 Version | The claim's HIPAA version. | N/A | Auto-populated |
| Service Location | This field will only be present for Person Centered Medical Home (PCMH) providers. When creating a new claim, this field will default to the primary Service Location address for the provider. For a previously processed claim returned in the claim inquiry search results, this field will display the address with an Entity Type 77 at the header of an 837 electronic claim. If no header address exists on the 837 electronic claim, then the address will display the first instance of Entity Type 77 at the detail. If no Entity Type 77 addresses exist on the claim, then it will display the address with Entity Type 85.<br><br>The Change link above the address allows providers to view a list of all service location and alternate service location addresses associated to the provider ID. The provider can select the correct address for the service being billed. Whichever address is present in the "Service Location" field is the address that will be used as the Entity Type 77 at the header of an 837 electronic claim. | N/A | Auto-populated |
| Confirm Address | This field will only be present for PCMH providers. Once the provider searches for and selects an address in the field above, the "Confirm" check box will be automatically filled. If there is no check present in the checkbox, an error message will be displayed to confirm the address. | Checkbox | S |

| Diagnosis Section | | | |
|---|---|---|---|
| **Field** | **Description** | **Length** | **Required (R)/ Situational (S)/ Optional (O)** |
| Diag-Sequence | Indicates the diagnosis sequence associated to the diagnosis code. Valid values are Principal and Other 1 through Other 11. | N/A | Auto-populated |
| Diagnosis | Indicates the ICD-10-CM diagnosis code. | 3 - 7 | S |
| Description | Indicates the description of the diagnosis code. | N/A | Auto-populated |
| Code Set | The Code Set drop-down defaults to ICD 10. ICD 10 Code Set has been in use for claims with dates of service 10/1/2015 forward. | Drop Down Box | Auto-populated |
| Principal | The principal diagnosis code. There is an implied decimal after the first three characters (V2200 = V22.00). **Do not enter the decimal.** The Search button to the right of this field allows the user to search for the correct value and select the desired code from the search results. | 3 – 7 | R |
| Other (1 – 11) | Additional diagnosis codes. To enter more than 8 additional diagnosis codes, click the "add more" button. There is an implied decimal after the first three characters (V2200 = V22.00). **Do not enter the decimal.** The Search button to the right of this field allows the user to search for the correct value and select the desired code from the search results. | 3 – 7 | S |

| Condition Section | | | |
|---|---|---|---|
| **Field** | **Description** | **Length** | **Required (R)/ Situational (S)/ Optional (O)** |
| Cond-Sequence | The order of the Condition code in the list of Condition codes associated with the claim. | 2 | S, if entering condition code, must enter a sequence |
| Condition | Condition code related to the abortion procedure that is entered at the detail level of the claim. The Search button to the right of this field allows the user to search for the correct value and select the desired code from the search results. | 2 | S |

| Detail Section | | | |
|---|---|---|---|
| **Field** | **Description** | **Length** | **Required (R)/ Situational (S)/ Optional (O)** |
| Item | The detail line number. | 3 | Auto-populated |
| From DOS | Beginning date on which service was provided. Format is MM/DD/CCYY. For subsequent details added after the first detail, this field will be populated with the date of service from the previous detail line. Once it is populated, it may be updated. | 10 | R |
| To DOS | Ending date on which service was provided. Format is MM/DD/CCYY. For subsequent details added after the first detail, this field will be populated with the date of service from the previous detail line. Once it is populated, it may be updated. | 10 | R |
| Procedure | Code used to identify the professional procedure provided. The detail procedure field has a search option which allows the provider to enter search parameters and select the desired code from the search results. | 6 | R |
| Modifiers | Four fields are provided for reporting modifiers. This is a two-character code used to further define a procedure provided. This field has a search option which allows the user to enter search parameters and select the desired code from the search results. | 2 | O |
| Units | Number of units billed for the service. This is automatically populated as 1.00, but can be changed. | 6 | R |
| Facility Type Code | Facility Type Code (FTC) indicates the place of treatment. This field has a search option which allows the provider to enter search parameters and select the desired code from the search results. | 2 | R |
| Charges | The usual and customary charge for the service provided. | 8 | R |
| Rendering Physician | The 10-digit NPI of the rendering provider who actually performed the detail service. For Waiver, Special Services and State Plans, the billing provider is populated in the rendering provider field, when the performing provider is not enrolled in the CT Medical Assistance Program and the rendering identifier for the detail service is the SSN (indiv) or EIN (Agency) in the SSN/EIN field. This field has a search option which allows the user to enter search | 10 | S, required if not same as billing |

| Detail Section | | | |
|---|---|---|---|
| **Field** | **Description** | **Length** | **Required (R)/ Situational (S)/ Optional (O)** |
| | parameters and select the desired code from the search results. | | |
| SSN | Social Security Number (SSN) or Employer Identification Number (EIN) of the performing provider is required when the detail Waiver, Special or State Plan self-directed program services billed by the Program Fiduciary or Administrative Agency on the claim do not require individual or agency performers to be enrolled as Connecticut Medical Assistance Program providers. This would be applicable to the ABI, Autism, CHC, MHW, PCA, MFP Comprehensive and MFP IFS Waivers, Birth to Three Special Services Program and the CFC and MFP State plans. This field is inactive or grayed out when claims are submitted under any other billing provider number. | 9 | S |
| Referring Provider | The 10-digit NPI of the referring provider. This field has a search option which allows the user to enter search parameters and select the desired code from the search results. | 10 | S |
| Ordering Provider | The 10-digit NPI of the ordering provider. This field has a search option which allows the user to enter search parameters and select the desired code from the search results. | 10 | S |
| Diagnosis Code Pointer | A two-digit code which indicates which diagnosis (or diagnoses) applies to services provided. Up to 4 diagnosis pointers may be entered for each claim detail line. The associated diagnosis code must be entered in the Diagnosis Section. | 2 | S |
| National Drug Code | The National Drug Code (NDC), if applicable. If more than one NDC is applicable for a detail, additional NDCs can be entered on the Additional NDCs panel described below. | 11 | S, required if billing Q, S or J series procedure codes |
| NDC Quantity | NDC indicated quantity. | 15 | S |
| NDC Unit of Measurement | Unit of measure for the NDC. Valid values are International Unit, Gram, Milliliter (CC) or Unit. | Drop Down Box | S |

| Detail Section | | | |
|---|---|---|---|
| **Field** | **Description** | **Length** | **Required (R)/ Situational (S)/ Optional (O)** |
| Status | Claim status on the detail line. This will be grayed out while the claim is in a Not Submitted yet status. Once processed, this will contain the status PAID, DENIED, SUSPENDED or Adjusted/Voided. A suspended claim will be resolved by Gainwell Technologies or DSS. | 1 | Auto-populated |
| Emergency Indicator | Indicates whether service was provided as the result of an emergency situation. Valid values are No or Yes. | Drop Down Box | O |
| Pregnancy | A code which indicates if the client is pregnant. Valid values are blank, Not Pregnancy Related, or Pregnancy Related. | Drop Down Box | O |
| EPSDT Referral | EPSDT Referral. Valid values are None, abnormal, dental, hearing, other or vision. | Drop Down Box | O |
| Family Planning | Indicates if a service is related to Family Planning. Valid values are blank, Yes, or No. | Drop Down Box | O |
| Allowed Amount | Amount approved to pay for services provided to a client. This will be populated once a claim has been processed. | 9 | Auto-populated |
| CoPay Amount | Amount paid by client for services performed. This will be populated once a claim has been processed. | 6 | Auto-populated |
| Medicare Paid Date | The date Medicare paid for the services. Format is MM/DD/CCYY.<br><br>NOTE: For additional detailed information on other insurance and Medicare billing, providers should refer to Chapter 11 of the Provider Manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 11. From the drop-down box, select the Professional Other Insurance/Medicare Billing Guide. | 10 | S, required if client has Medicare and Medicare paid |
| Medicare Calc Allowed Amount | Amount allowed by Medicare. | 9 | S, required if client has Medicare and Medicare paid |
| Medicare Paid Amount | Amount paid by Medicare. | 9 | S, required if client has Medicare and Medicare paid |

| Detail Section | | | |
|---|---|---|---|
| **Field** | **Description** | **Length** | **Required (R)/ Situational (S)/ Optional (O)** |
| Medicare Deductible Amount | The client's deductible amount due. | 9 | S |
| Medicare Coinsurance Amount | The client's coinsurance amount due. | 9 | S |

| Additional NDCs Section | | | |
|---|---|---|---|
| **Field** | **Description** | **Length** | **Required (R)/ Situational (S)/ Optional (O)** |
| National Drug Code | The National Drug Code (NDC), if applicable. | 11 | S |
| Quantity | NDC indicated quantity. | 15 | S |
| Unit of Measurement | Unit of measure for the NDC. Valid values are International Unit, Gram, Milliliter (CC) or Unit. | Drop Down Box | S |

| TPL Section | | | |
|---|---|---|---|
| **Field** | **Description** | **Length** | **Required (R)/ Situational (S)/ Optional (O)** |
| For additional information on other insurance or Medicare billing, providers should refer to Chapter 11 of the provider manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 11. From the drop-down box, select Professional Other Insurance/Medicare Billing Guide. | | | |
| Client Carriers | This is a drop-down field that lists the three-digit carrier codes for all Other Insurance Carriers that are currently on the client's eligibility file or may have been on the client's file in the past. Select the appropriate carrier code from the drop down menu or, if you do not see the carrier code for the primary | Drop Down Box | S |

| TPL Section | | | |
|---|---|---|---|
| **Field** | **Description** | **Length** | **Required (R)/ Situational (S)/ Optional (O)** |
| | payer in this field, select “Other” and enter the three digit carrier code for the Other Insurance Payer in the next field titled “Carrier Code”. | | |
| Carrier Code | The three-digit code that identifies the other insurance carrier. Carrier codes can be obtained via AEVS or at www.ctdssmap.com, under Information, then Publications then Chapter 5 of the Provider Manual. MPA and MPB should be used to report Medicare Part A, Part B or Medicare HMO denials. This field has a search option which allows the user to enter search parameters and select the desired code from the search results. | 3 | S |
| Plan Name | The other insurance policy holder’s plan name. | 60 | O |
| Policy Number | The policy number of the other insurance policy holder. | 30 | O |
| Paid Amount | The amount that has been paid by third party insurances. If other insurance denied, this should be 0 (zero). | 9 | S |
| Paid Date | The date that the claim is paid or denied by the third-party insurance or Medicare. Format is MM/DD/CCYY. | 10 | S |
| Adjustment Reason Code | Three fields are provided for reporting Third Party insurance carrier Adjustment Reason Codes. Each field is associated with the corresponding Adjustment Amount. The Other Insurance Explanation of Benefits should contain this code. Refer to the www.wpc-edi.com Web site for a list of valid adjustment reason codes. Enter the code exactly as seen on that list. For example, if the code is 1, do not enter 001. This field has a search option which allows the user to enter search parameters and select the desired code from the search results. | 1 - 3 | S, required if payment amount from the carrier is less than the billed amount to the carrier. |

| TPL Section | | | |
|---|---|---|---|
| **Field** | **Description** | **Length** | **Required (R)/ Situational (S)/ Optional (O)** |
| Adjustment Amount | Three 8-digit fields are provided for reporting Third Party insurance carrier adjustment dollar amounts. Each field is associated with the corresponding Adjustment Reason Code. This is the amount that the Other Insurance **did not pay**. It represents the difference between what the other insurance was billed and what the provider was paid by that other insurance, up to and including the entire billed amount | 9 | S, required if payment amount from the carrier is less than the billed amount to the carrier. |
| Relationship | The client's relationship to the other insurance policy holder. | 51 | O |
| Last Name | The last name of the other insurance policy holder. | 35 | O |
| First Name, MI | The first name and middle initial of the other insurance policy holder. | 26 | O |
| Date of Birth | The date of birth of the other insurance policy holder. Format is MM/DD/CCYY. | 10 | O |

| Claim Status Information Section | | | |
|---|---|---|---|
| **Field** | **Description** | **Length** | **Required (R)/ Situational (S)/ Optional (O)** |
| Claim Status | If the claim has not yet been submitted, this field will appear with the description, Not Submitted yet. If the claim has been submitted, this will indicate the status of the claim, i.e. PAID, DENIED or SUSPENDED. A suspended claim will be resolved by Gainwell Technologies or DSS. | 100 | Auto-populated |
| Claim ICN | Once processed, this field will contain the Internal Control Number (ICN) of the claim. | 13 | Auto-populated |
| Denied Date | This field will not appear until the claim has been processed through a financial cycle. This field will then display the date the claim denied. | 10 | Auto-populated |
| Paid Date | This field will not appear until the claim has been processed through a financial cycle. This field will then display the date the claim paid. | 10 | Auto-populated |
| Paid Amount | The paid amount of the claim. | 9 | Auto-populated |
| Applied Income | Amount to be paid by client for services performed. This will be populated once a claim has been processed. | 10 | Auto-populated |
| Client Contribution | Amounts paid by Connecticut Home Care Program clients who are state funded under a Case Managed, Self-Directed or Assisted Living Intermediate or Limited Waiver benefit plan and are not fee-for-service eligible for the date of service. For all other claims that do not meet these criteria, this field will be blank. | 10 | Auto-populated |
| Charter Oak Coinsurance | N/A | 10 | Auto-populated |
| Charter Oak Deductible | N/A | 10 | Auto-populated |

| EOB (Explanation of Benefits) Information | | | |
|---|---|---|---|
| **Field** | **Description** | **Length** | **Required (R)/ Situational (S)/ Optional (O)** |
| For additional information on resolving the most common claim errors, providers should refer to Chapter 12 of the Provider Manual. This chapter is available at www.ctdssmap.com, by selecting Information, then Publications, and scrolling down to Provider Manuals Chapter 12 – Claim Resolution Guide. The Chapter is also available under "Quick Links" at the top of the Claims Web page. | | | |
| Detail Number | The number of the detail from the claim. Detail number "0" indicates that the EOB applies to the entire claim. | 2 | Auto-populated |
| Code | The EOB code assigned to the claim. | 4 | Auto-populated |
| Description | The description of the EOB. | 100 | Auto-populated |

| Buttons That Appear Based on Claim Status | | | |
|---|---|---|---|
| **Field** | **Description** | **Length** | **Required (R)/ Situational (S)/ Optional (O)** |
| Submit | Click on the submit button to submit the claim. If errors result from the submission, error messages will display at the top of the page.<br><br>Clicking this button will immediately submit the claim to the interChange system. | Button | N/A |
| Cancel | The cancel button will clear the data entered in a field on the claim submission or inquiry page. The cancel button will not void a claim. For example, if a provider enters data on the claim submission page and wants to remove that data before submitting the claim and start over, clicking the cancel button will clear all data entered on the Web page. It will not remove data from a claim once it has processed. | Button | N/A |
| Re-submit | The re-submit button allows a denied claim to be re-submitted **after changes have been made or when the claim errors have been resolved.**<br><br>Clicking this button will immediately re-submit the claim to the interChange system. | Button | N/A |

| Buttons That Appear Based on Claim Status | | | |
|---|---|---|---|
| **Field** | **Description** | **Length** | **Required (R)/ Situational (S)/ Optional (O)** |
| Adjust | The adjust button allows the current paid claim to be adjusted. **Changes to the claim must first be made, followed by clicking the adjust button.** This button will be absent when the claim cannot be adjusted.<br><br>Clicking this button will immediately submit an adjustment of the claim to the interChange system, whether or not changes have been made to the claim. | Button | N/A |
| Void | Button that allows the user to void the current paid claim. Voiding a claim will return a message at the top of the page stating that the claim is voided with the new ICN number.<br><br>Clicking this button will immediately void the claim in the interChange system. | Button | N/A |
| New Claim | The new claim button allows a user to begin a new claim without having to scroll up to the top of the page. | Button | N/A |
| Copy Claim | Button that creates a new claim with all of the data from the current claim, including all diagnosis codes, claim details and prior payments. The new claim should be changed and submitted. This button will only be available on paid claims. Denied claims must be re-submitted. | Button | N/A |