December 2023

Prevea360 Health Plan

Provider Portal User Guide

Prevea360 Health Plan Provider Portal

The secure Prevea360 Health Plan Provider Portal allows users 24/7 access to resources and self-service applications to simplify everyday tasks, promote efficiencies in business, and streamline electronic transactions.

This Prevea360 Health Plan Provider Portal User Guide details how to use the self-service applications available in the Portal once a Provider Portal account is created. If an account has not been established, refer to the Prevea360 Provider Portal Registration Guide for the registration process to create individual and organization Provider Portal accounts.

Google Chrome is recommended for optimum performance when using the Provider Portal.

Access the Prevea360 Health Plan Provider Portal directly:
https://provider.prevea360.medica.com

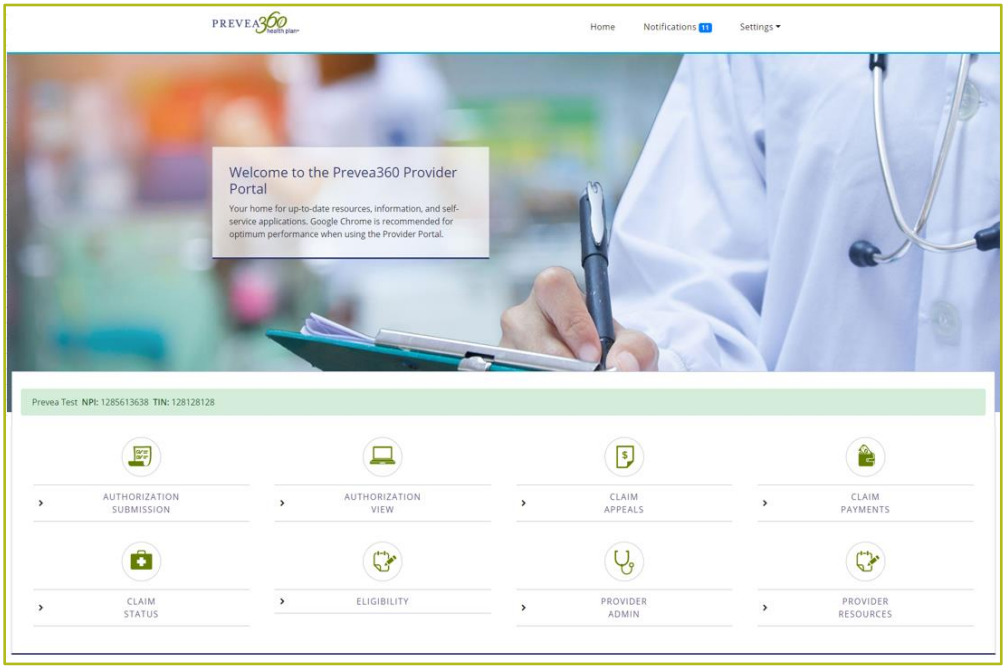
Table of Contents

I. Home Page

The Prevea360 Health Plan Provider Portal Home Page offers users access to:

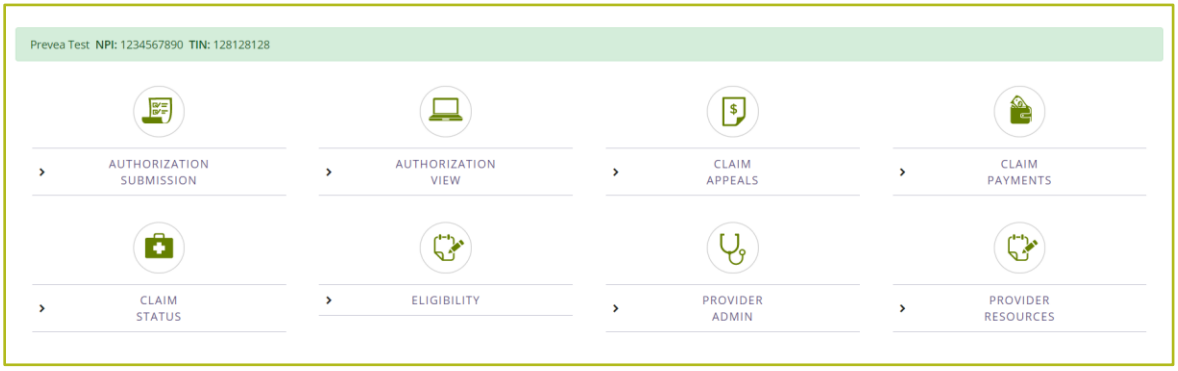
- Self-service claims and authorization applications
- Secure Notifications
- Account Settings

Whenever present, clicking the PREVEA360 health plan centered around you logo located at the top of the web page will return users to the Provider Portal Home Page.



Applications

Each user will only have access to the application(s) assigned to them by the Site Administrator for their organization. Available applications will be displayed on the Home Page and can be updated by the Site Administrator at any time. The Provider Admin application is reserved for Site Administrators only.

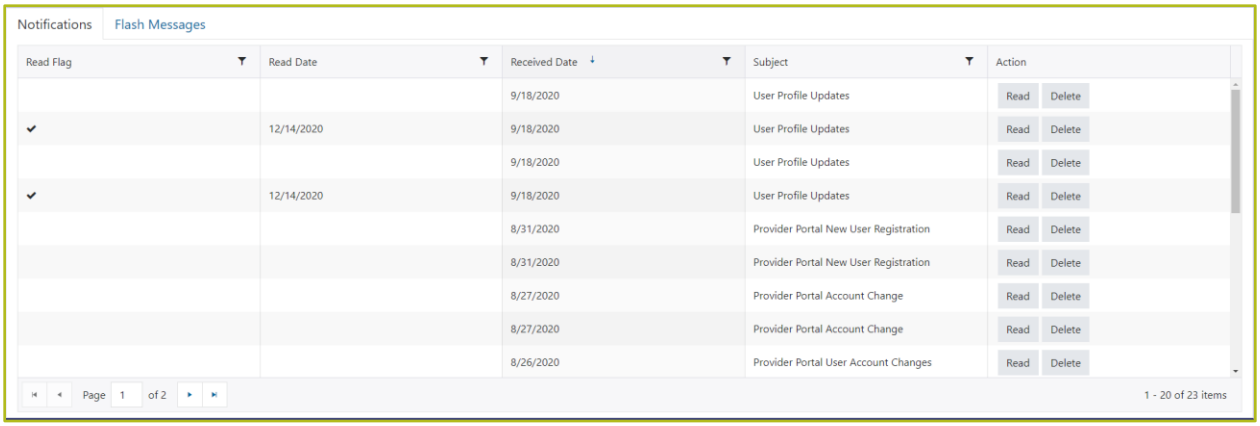


Notifications

The Notifications page stores all notifications that are delivered through the Provider Portal, including:

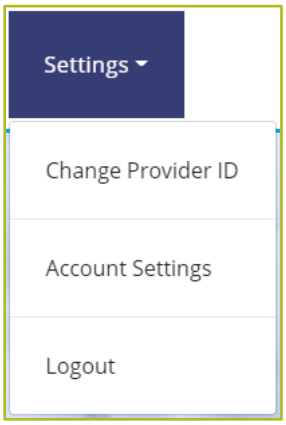
- Flash Messages
- Account Profile Updates
- New User Registration
- Claim Appeal Receipt Notice
- Claim Appeal Decision Notice

All Site Administrators are copied on Claim Appeal Decision Notices, Account Profile changes, and Individual User changes for all Portal users within their organization. Notifications can be either marked as read or deleted once reviewed by the Site Administrator.



Settings

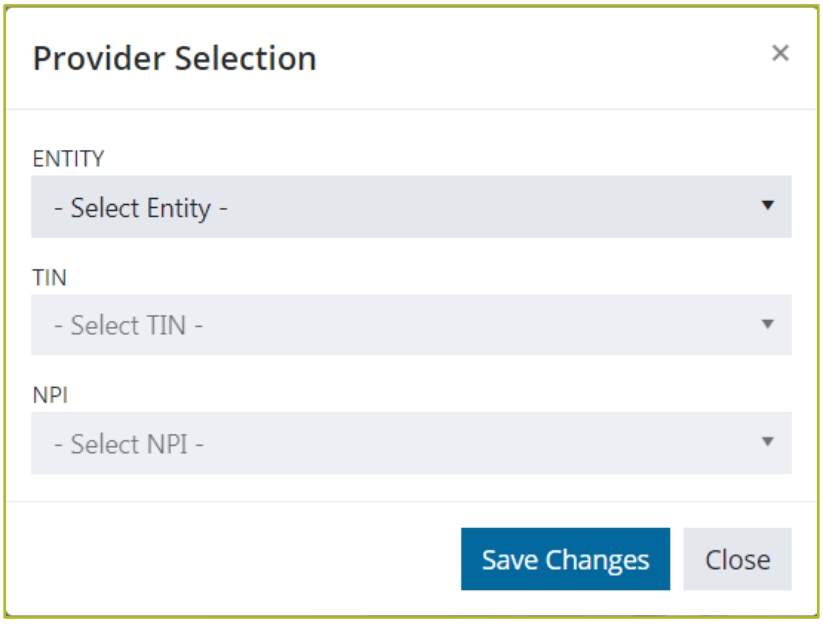
There are three options available under Settings: Change Provider ID, Accounts Settings, and Logout.



Change Provider ID

Users who have access to multiple Organization accounts can change their access without logging out. This can be done by selecting the Settings dropdown at the top, and click **Change Provider ID**.

The Organization Details box will appear. Select the Entity you would like to work under from the **Entity** dropdown. Then select the applicable Tax Identification Number (TIN) and National Provider Identifier (NPI) from the dropdowns and click **Save Changes**. Users will only be able to select a TIN and NPI that is registered under the Entity that is first selected and will only have access to information available on that account.



The selected Organization information will appear in the green panel above the application tiles.

Account Settings

From the **Settings** dropdown, select **Account Settings** options to make changes to your Account Profile.

This includes updates to an Individual: Email Address (Login ID), First and Last Name, Password and Code Verification Method.

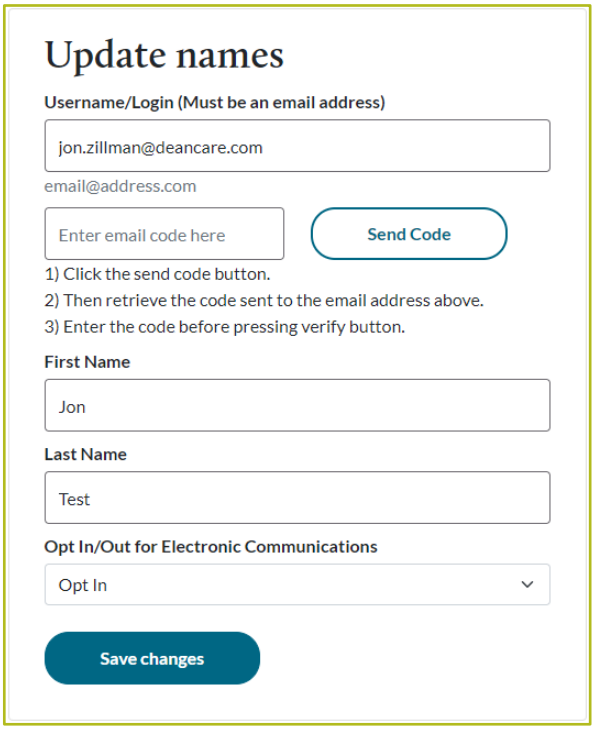
Update Names

To update the email address on file, enter the new email address that should be connected to the account. Click **Send Code** which will generate a code to the entered email address. Enter that code into the empty code field and click **Verify**. Finally, click **Save Changes** to create a new email address and Username.

The First and Last Name can also be updated by entering the new name and then clicking **Save Changes**.

If the Opt in/Out for Electronic Communications dropdown is defaulted to 'Opt Out', this preference can be changed to Opt In through the dropdown and then clicking **Save Changes**. By choosing Opt in, the Individual will receive direct and expedited provider email communications from the health plan. Opt In will not replace all paper communications.

Opting out after selecting Opt In is done through the "Unsubscribe" link at the bottom of email communications that you will receive from the health plan. Once you unsubscribe, your email address is automatically inactivated from the system and further electronic communications cannot be sent to that address.

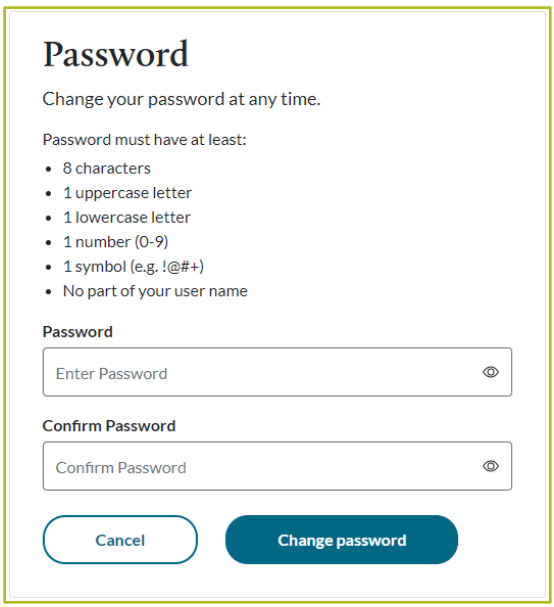


Tip

The email address is also the Username (Login ID). Changing the email address will also change the ID used for portal login.

Update Password

Password updates can be completed through the initial Sign-in screen, as well as through the **Account Settings** through the Update Password screen. Enter and Confirm the desired new password. Password requirements are shown under the fields. Select the "eye icon" to view and verify the Password and Password Confirmation are correct. Click **Save Changes** once completed.

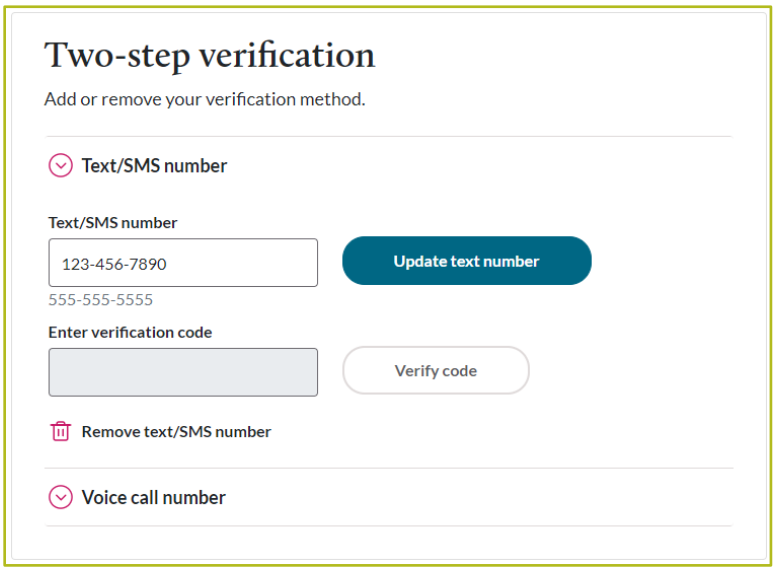


Update Two-step verification

During registration, each Individual must enroll in at least one method of Multi Factor Enrollment in order to complete registration. This determines how confirmation codes should be sent prior to logging in or updating a password.

To enroll in a new method, enter the phone number or email address in the Enroll in Text (SMS) Verification field, and click **Request Code**. Retrieve the code from the delivery method selected, enter it in the Verification Code Field, and click **Verify Code**. This will enroll the new Enrollment Factor.

A factor can also be deleted by clicking the **Delete Factor** option.



Tip

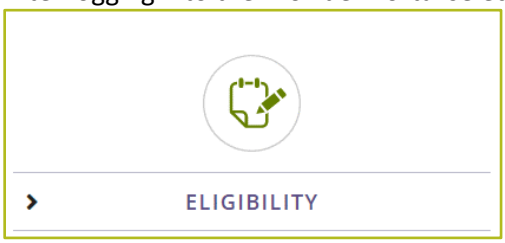
Email cannot be removed as an Enrollment factor as it is required for login.

II. Eligibility

This application provides human readable real-time EDI 270/271 transactions. The information includes detail regarding Prevea360 Health Plan member eligibility and benefit plan coverage, co-payments, and deductibles. It also provides the name of the member's primary health insurance carriers name, if applicable.

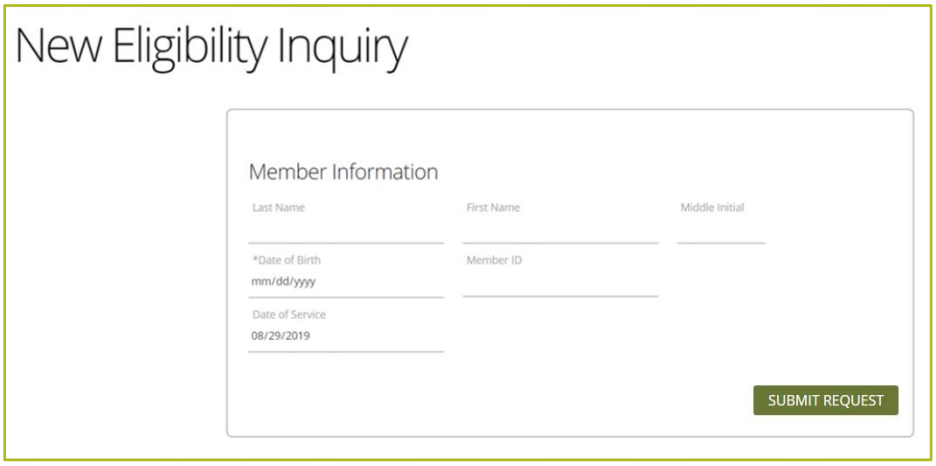
i. Access Eligibility

After logging into the Provider Portal select the **Eligibility** application located on Home Page.



ii. Submit Real-Time 270 Eligibility Transaction

Users are taken to the **New Eligibility Inquiry** page.



In order to successfully submit a 270 Eligibility Inquiry, the following fields must be filled:

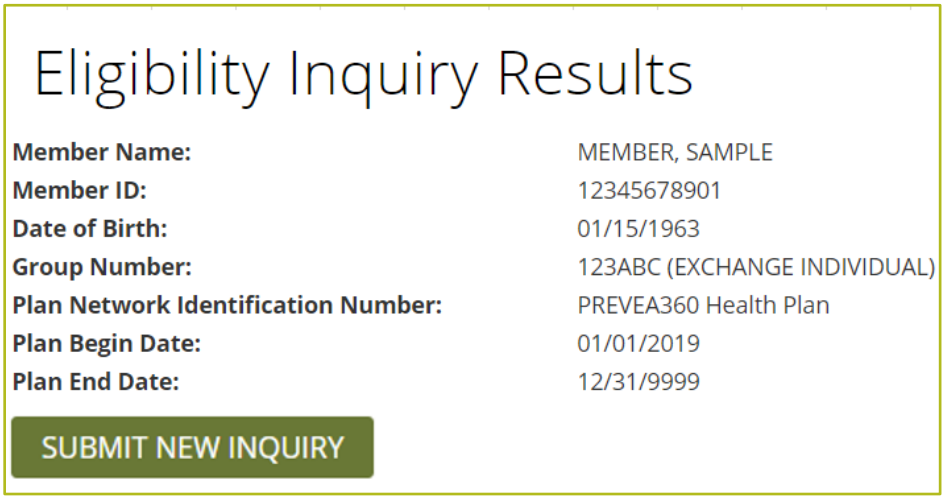
- Date of Service (this will be pre-populated with the current date)
- Member's Date of Birth
- Either the member's First and Last Name or the Member ID

The Date of service will default to the current date. Maximum eligibility lookup is 12 months.

Tip

Eligibility Inquiries can be submitted by searching by the member DOB and either their full name of their member ID.

iii. Eligibility Inquiry Response



The member's policy information will appear in the top, left portion of the screen. Verify that the correct member is showing on the screen.

Other Primary Policy

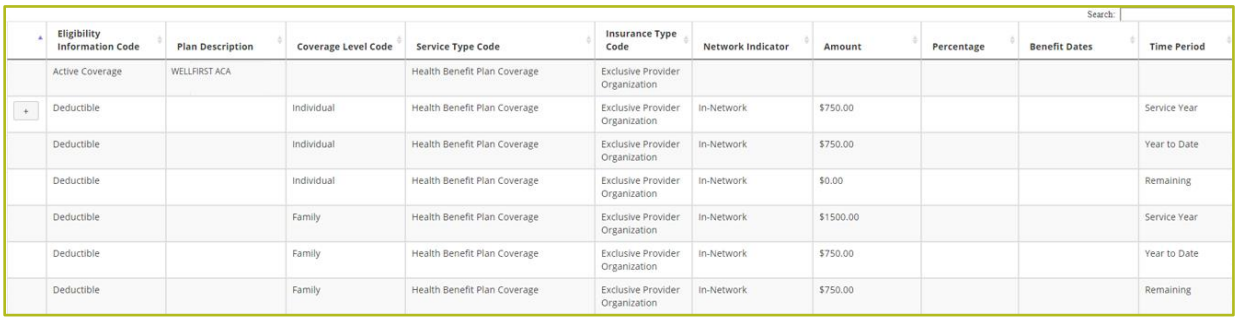
Other health insurance (Primary) information will be returned:

- If the health insurance is listed as the primary payer
- As the subscriber level (Loop 2120C)
- If the other health insurance is effective at the requested Plan Date in the 270 eligibility request (DTP*291), and will only return the Organization Name (NM103)

Coverage

The table will display member benefit information for the policy year that was searched.
Each column can be filtered alphabetically or numerically by selecting the arrows in the top row of each column.

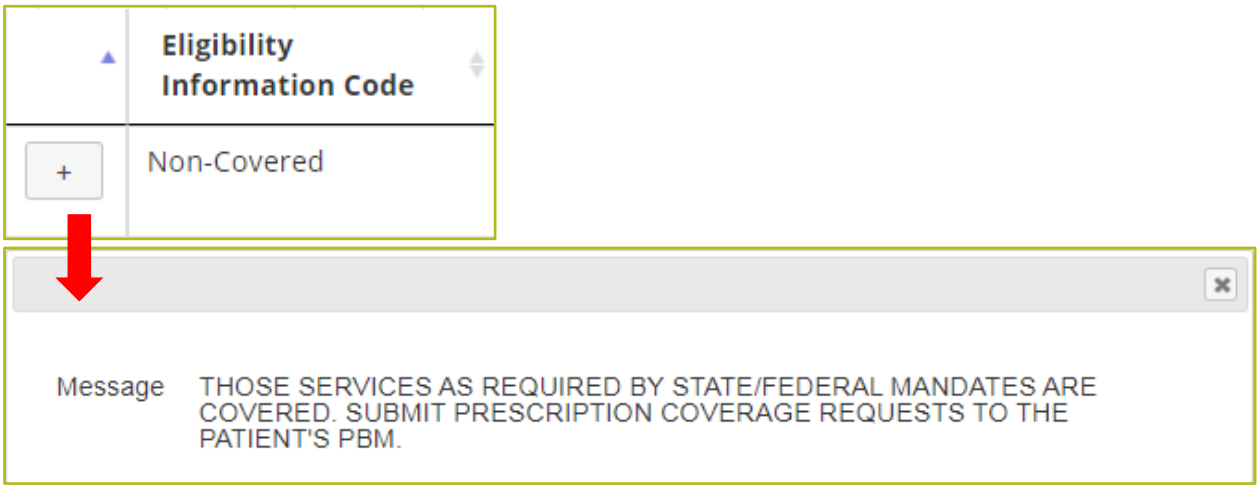
There is a **Search** field located in the upper right corner of the page next to the table. Enter a keyword or dollar value into this field to filter results to only show fields that contain those keywords or values.



Search:

	Eligibility Information Code	Plan Description	Coverage Level Code	Service Type Code	Insurance Type Code	Network Indicator	Amount	Percentage	Benefit Dates	Time Period
	Active Coverage	WELLFIRST ACA		Health Benefit Plan Coverage	Exclusive Provider Organization					
+	Deductible		Individual	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	$750.00			Service Year
	Deductible		Individual	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	$750.00			Year to Date
	Deductible		Individual	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	$0.00			Remaining
	Deductible		Family	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	$1500.00			Service Year
	Deductible		Family	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	$750.00			Year to Date
	Deductible		Family	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	$750.00			Remaining

Additional details may apply to specific benefits. These details are denoted by a box with a “+” in the left column of the table. Please select this box to review additional details that apply to this benefit.



Once benefits have been verified, users can submit a new inquiry by selecting the **Submit New Inquiry** under the member policy informationClick the Prevea360 Health Plan banner at the top of the screen to return to the Home Page, or close the tab to exit entirely.

III. Authorization Submission

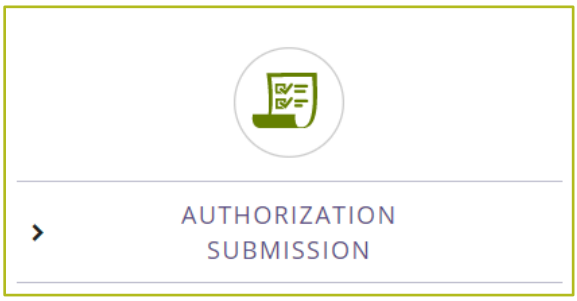
Prevea360 Health Plan authorization requests should be completed by the member's Primary Care Physician (PCP) or a Prevea360 Health Plan Specialty Provider. An authorization should not be submitted for the sole purpose of confirming the service is covered.

Once the steps under section iii, Select a Member and Classification are completed, the authorization request will be saved automatically and can be completed at a later time, if desired, through the **Authorization View** application. The authorization feature of the Provider Portal should not be used for the following types of services as these should be submitted to our applicable external vendor:

- Rehabilitative and Habilitative Outpatient Physical and Occupational Therapy
- High-End Radiology Services
- Musculoskeletal procedures
- Medical Injectables

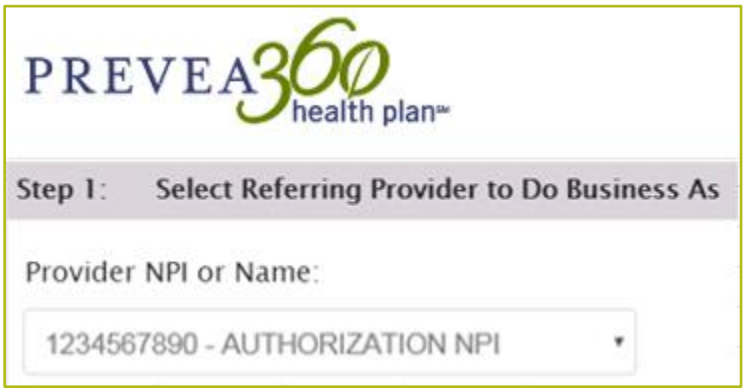
i. Access Authorization Submission

After logging into the Provider Portal select the **Authorization Submission** application located on Provider Portal Home Page.



ii. Select Referring Provider

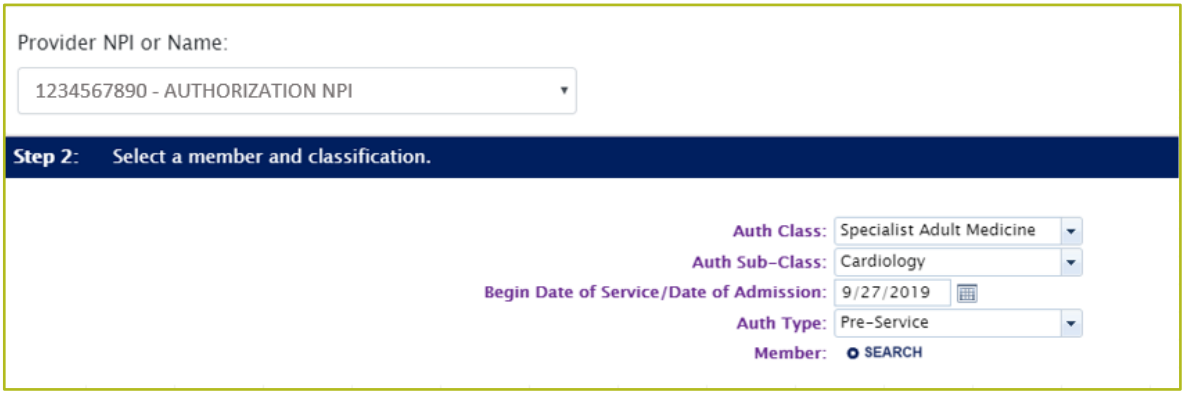
Select the NPI/Provider from the dropdown to submit the authorization request under. All NPIs that are tied to the Organization account will be selectable.



Tip

Selecting the incorrect NPI will result in an error message. Please contact the Site Admin for assistance with selecting the appropriate NPI.

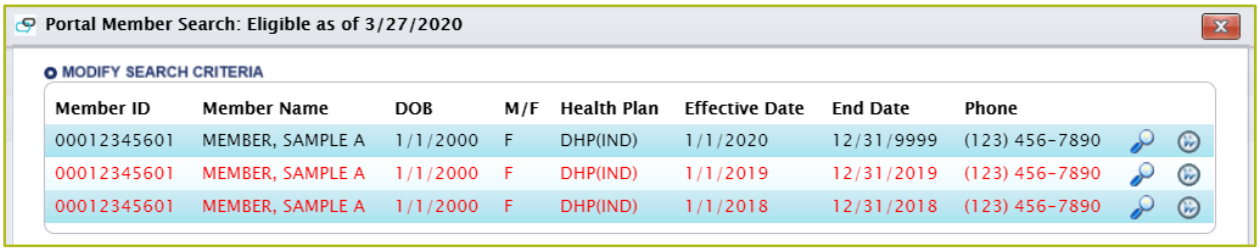
iii. Select a Member and Classification



All fields in this section are required:

- **Auth Class**
- **Auth Sub-Class**
- **Begin Date of Service/Date of Admission** – this field will populate once the **Auth Sub-Class** has been selected.
- **Auth Type**
- **Member** – Search options are Date of Birth and either member ID or First and Last name.

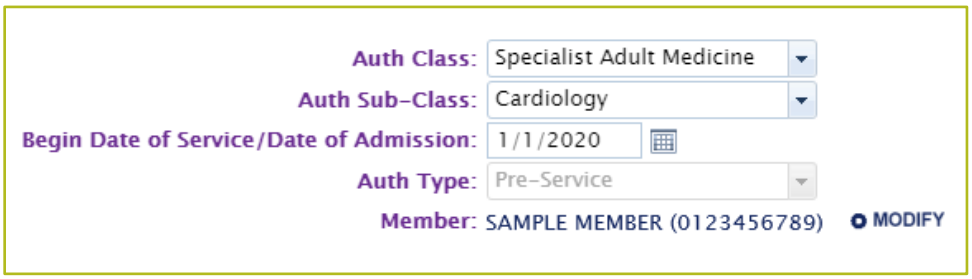
The member's information will populate into the Portal Member Search data window.



If a member has more than one record, such as active and inactive, both records will be displayed.

- A record in black reflects an active eligibility record
- A record in red reflects an inactive eligibility record

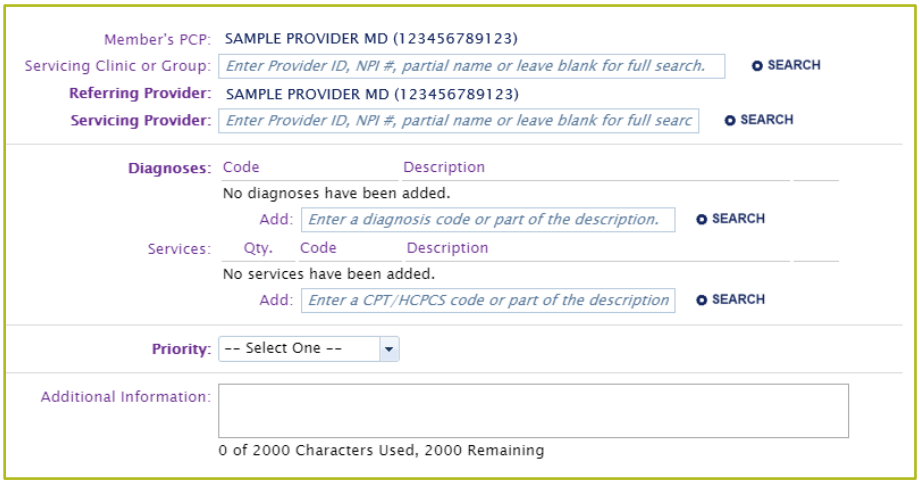
Select the applicable record by clicking the double arrow icon on the far-right side of the search. If the incorrect member is selected, the member information can be modified by clicking **Modify** . This will return to the Member Search screen.



Once all the field have been filled, click **Continue**. The authorization request will be saved after this step.

iv. Complete Detail Fields

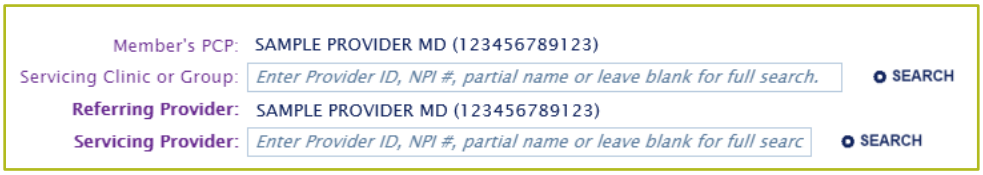
Fields in bold are required. The required data fields in this step will vary depending on the Auth Class entered in Step 1.



Provider Data Fields

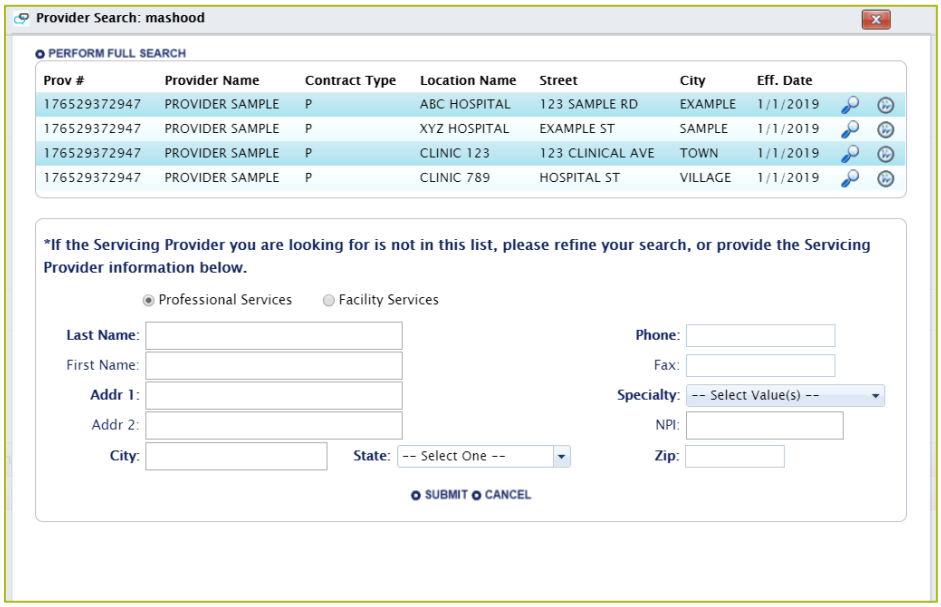
- **Member's PCP** – this will automatically populate, if known.
- **Referring/Submitting Provider** – this will auto-populate from Step 1. If not, enter provider name and click **Search**.
- **Servicing Provider** – this should not reflect a clinic name but rather the name of an individual practitioner or facility/hospital.

Note: If the servicing provider's name is unknown, the name of one of the practitioners with the same specialty, department and clinic location that the member is being referred to can be entered.



To select a Servicing Provider, enter the provider name or NPI and select **Search**.

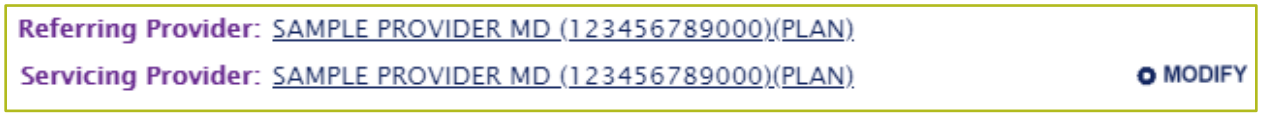
- If the Provider has only one location, this information will populate into the data field.
- If a provider has more than one location in the Prevea360 Health Plan system, all locations will populate into a window for review to determine which location is applicable.
- The Prov # column reflects Prevea360 Health Plan's internal ID number for that particular provider.
- The Contract Type column reflects P (Plan-Contracted) and NP (Non-Plan or Non-Contracted) with P contract type being displayed at the top.
- To select the provider location, select the double arrow located on the right side of the record. This provider will then populate into the applicable date field.
- To change the selected servicing provider, click **Modify** next to the record and choose a different provider.



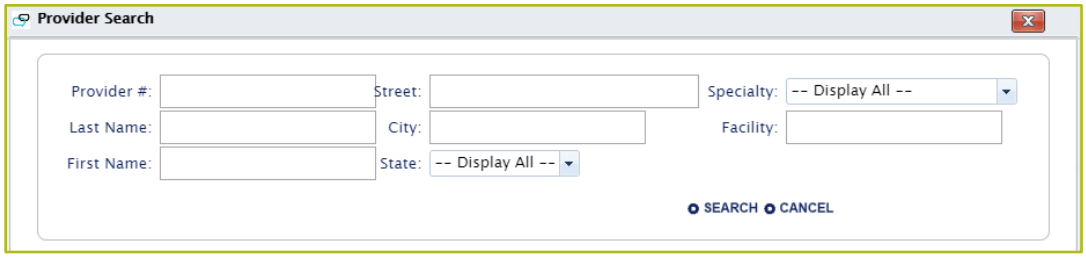
Tip

Only providers who are in the Prevea360 Health Plan system will populate.

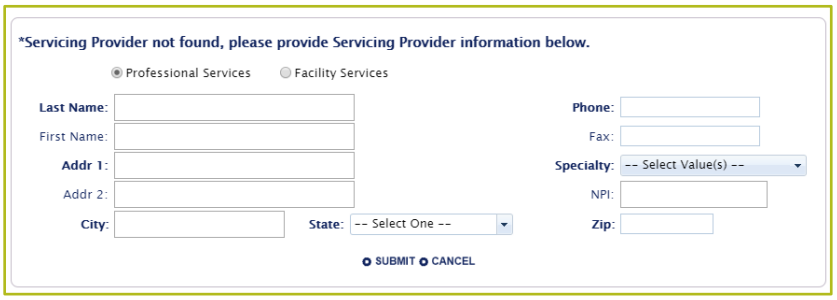
Once a provider has been selected, the information will populate into the applicable field.



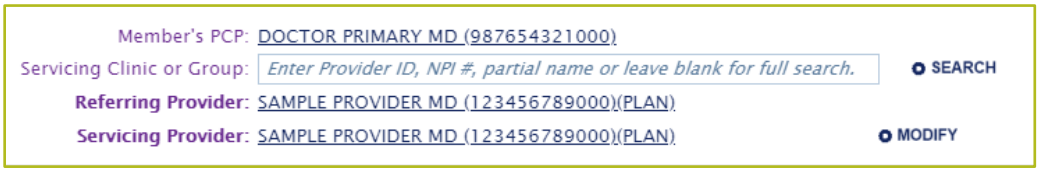
If the practitioner or facility does not show up in the results, use the **Provider Search** feature to enter additional information to narrow down the search.



If the practitioner or facility is still not found, their information can be added as an ad hoc provider. Select the appropriate radio button for Professional or Facility services.



The ad hoc provider will be displayed with (VENDORPROF) next to their name to show that this is an unlisted provider.



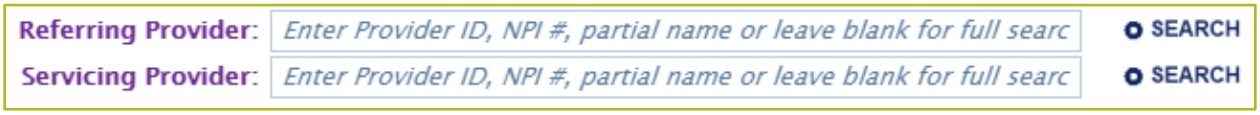
Settings

The provider requirements will vary depending on the setting and admission type. The provider fields will populate according to the Auth Class selected in Step 2 – Select a Member and Classification.

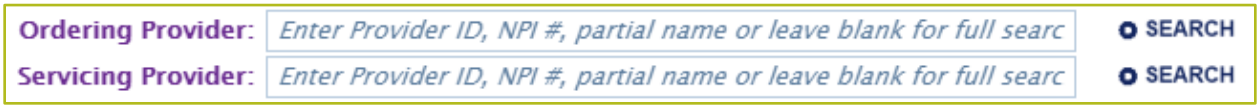
- **Clinic Setting** – The Servicing Provider on an authorization should not reflect a clinic name.
- **Office Setting** – If the services are being performed in an office setting, the Servicing Provider on an authorization should reflect an individual practitioner's name.
- **Outpatient Facility** – If the services are being performed in an outpatient facility, the Servicing Provider on an authorization should reflect the facility's name.
- **Facility/Hospital** – If the services are for inpatient hospitalization, the Servicing Facility on an authorization should reflect the facility's name.

Provider Data Entry Selection Examples:

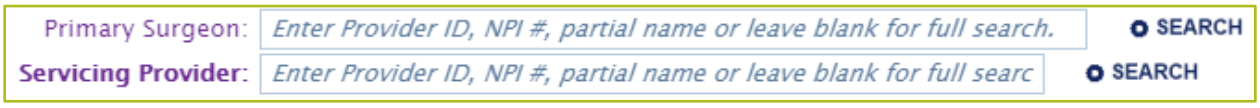
Office Setting



Outpatient Procedure

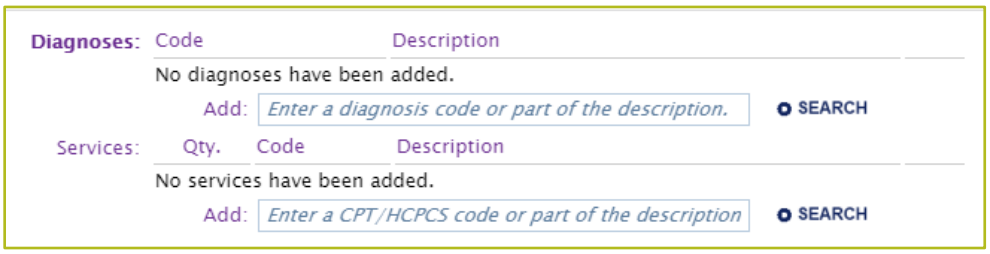


Outpatient Surgery or ASC Surgery



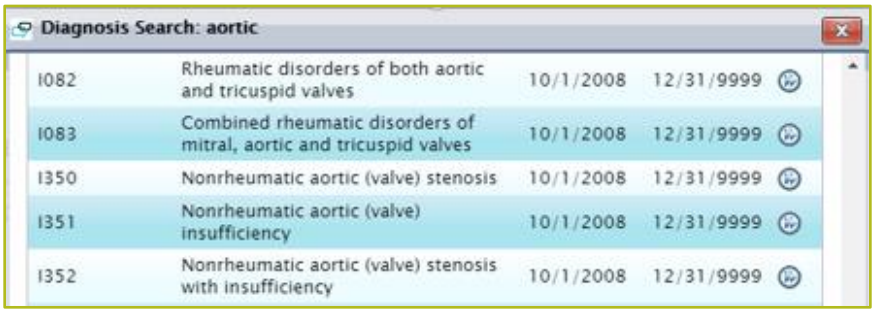
Inpatient Admission

Diagnoses

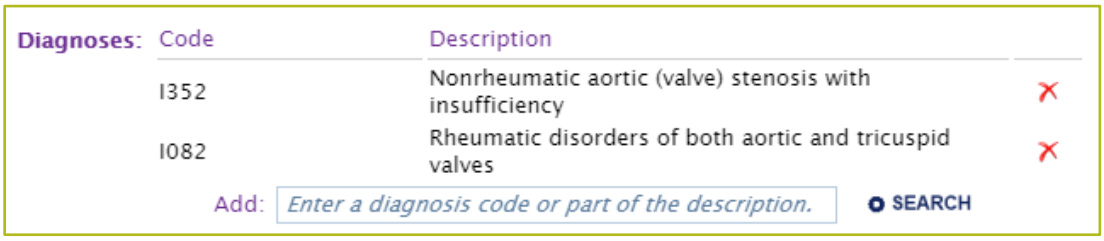


There are two ways to search for a diagnosis code:

1. Enter the diagnosis code (if known) and select search. The diagnosis will auto-populate in the blank field.
2. Enter a key word or phrase and select search. A list of related diagnosis will appear. Select the double arrow to the right of the desired diagnosis to apply it.

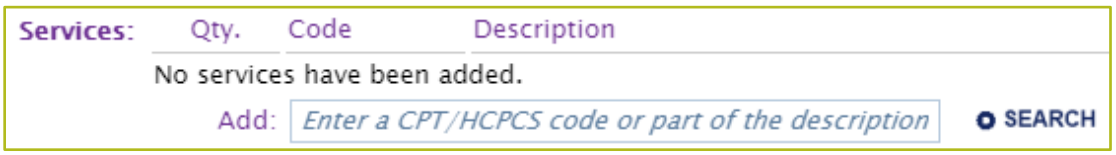


If the wrong diagnosis is selected, it can be removed by selecting the red "X." Multiple diagnoses may be added, and there is no limit to the number of diagnosis codes that can be added.



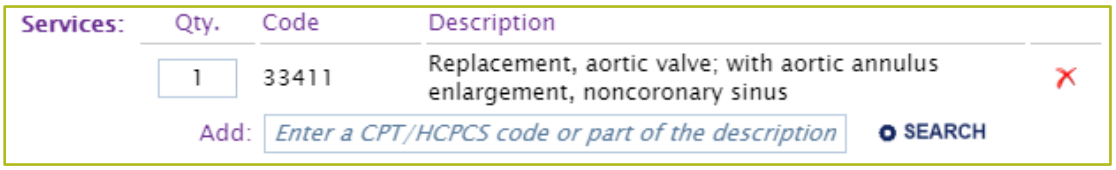
Services

The services field will only need to be completed when required by the selected Auth Class.



There are two ways to search for a CPT/HCPCS code:

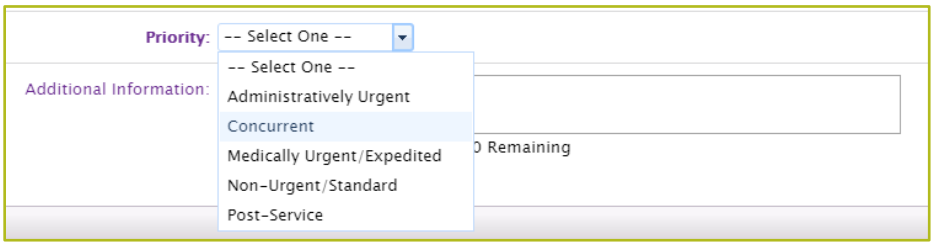
1. Enter the code (if known) and select search. The service will auto-populate in the blank field.
2. Enter a key word or phrase and select search. A list of related services will appear. Select the double arrow to the right of the desired code to apply it.



If the wrong service is selected, it can be removed by selecting the red "X." Multiple services may be added.

Priority

The Priority is used to communicate the urgency level of the services being requested. This will determine how quickly a determination is needed based on the member's medical condition.



Administratively Urgent – This priority status should be selected for services that are considered urgent because of the time sensitive diagnosis and appointment availability.

Concurrent – This priority status should be selected for notification of urgent/emergency admissions to a facility for inpatient/observation. It should not be used for an elective admission.

Medically Urgent/Expedited – This priority status should be selected ONLY if the member has an acute medical condition and is at the risk of life or limb. *This priority level requires a signature by the attending Physician.

Non-Urgent/Standard – This priority status should be selected for routine outpatient requests or elective inpatient admissions.

Post-Service – This priority status should be selected for requests that are received after the services have been rendered.

Additional Information

Entering information into the Additional Information field is optional, but strongly recommended. Information recommended to include:

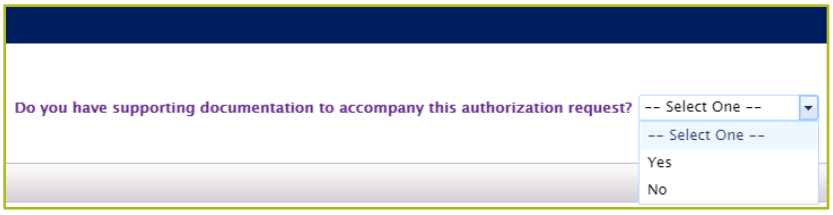
- Contract person with a direct phone number for any follow-up questions.
- If Prevea360 Health Plan has access to the records in Epic, identify the record number, date of service or any other guidance where to find related information.
- Please note what is specifically being requested. (For example: Left L4 SNRB, please see notes from office visit on 8/31/2019.)

After completing all required fields in Step 3 – click **Continue**.

Note: Prior to clicking Continuing, the information entered can be changed. Once **Continue** is clicked, a user cannot return to make updates to entered information.

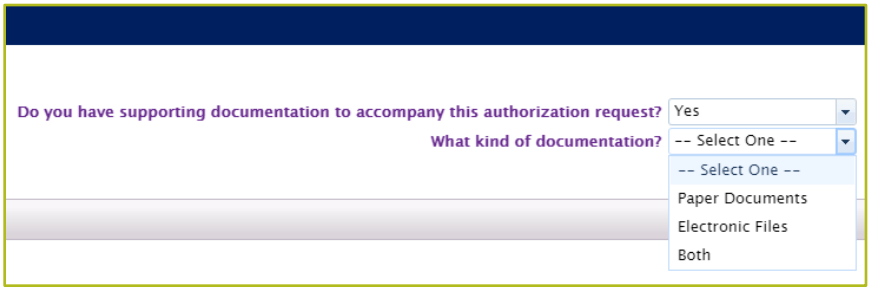
v. Attach Supporting Documentation

Click the dropdown to select if there is supporting documentation to attach.



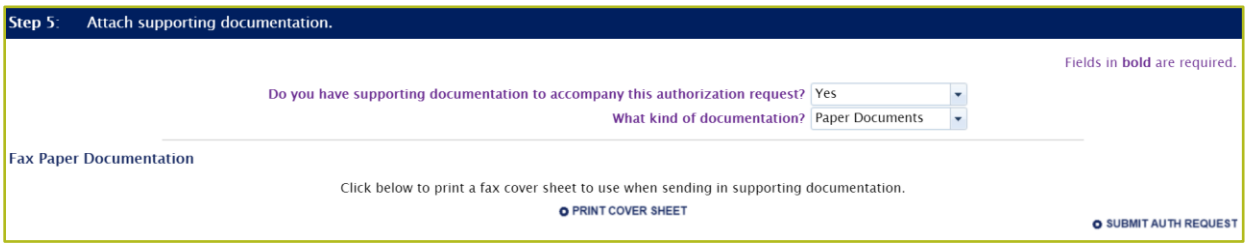
If there is no documentation to attached, select **No**. Once this is complete, click **Submit Auth Request** to send the authorization request to the health plan for review.

If there is documentation to attach, select **Yes**. This will create another dropdown to select the type of documentation (Paper documents, electronic files, or both).



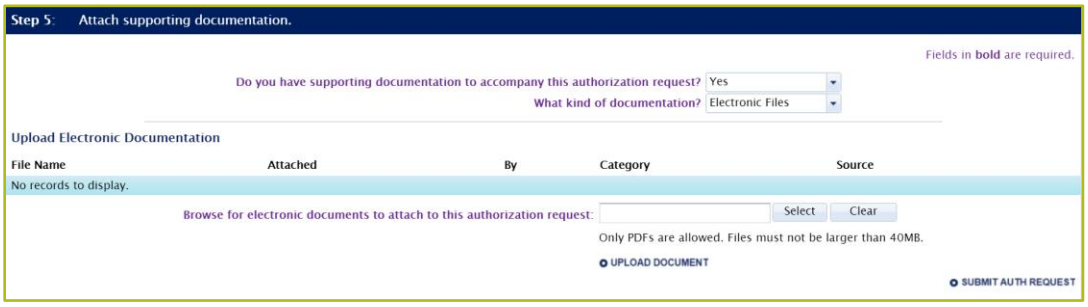
Paper Documents

Select the **Paper documents** option if the documentation will need to be mailed or faxed. If the documentation will be faxed, click **Print Cover Sheet** to be faxed with the documentation. Then click **Submit Auth Request** to send the authorization for review.

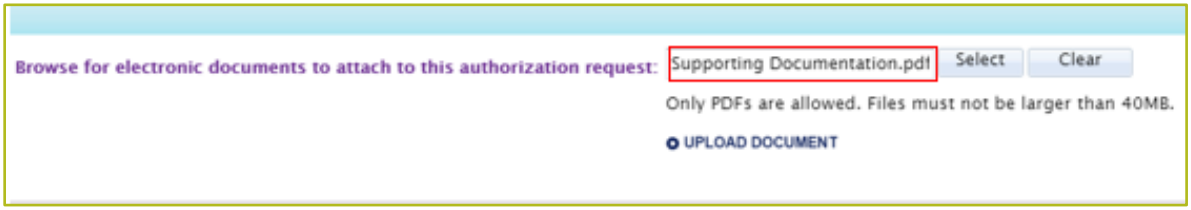


Electronic Files

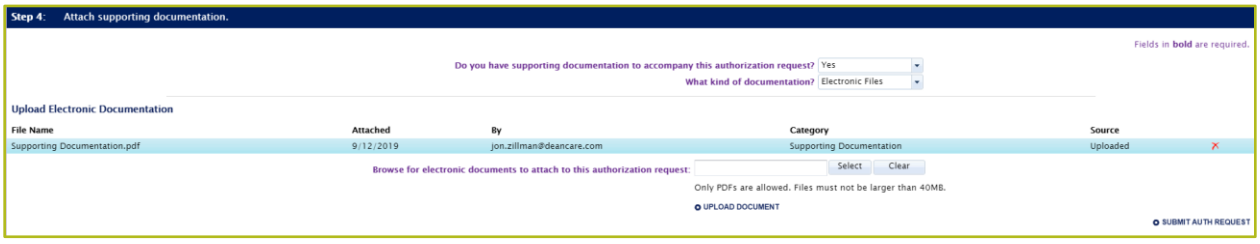
Select the **Electronic Files** option if documentation will be attached to this authorization request directly. Click **Select** to browse for the electronic document(s) to attach.



Once the appropriate document has been selected it will populate in the empty field.



Click **Upload Document** to attach it to the authorization request.



When a document is uploaded, a message will display indicating that the upload was successful and the file name of the document will display as an uploaded document. If the incorrect document is uploaded, it can be removed by selecting the red “X.”.

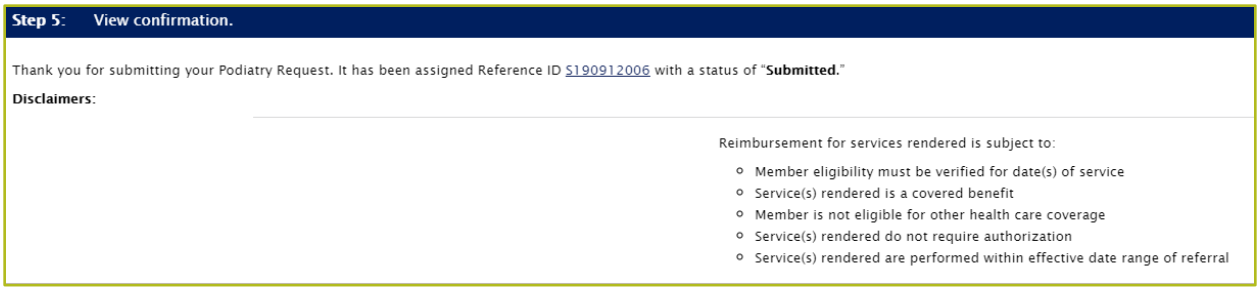
Both Paper Documents and Electronic Files

Select the **Both** option if Electronic Files and Paper Documents are to go with the authorization request. This will provide both the Print Cover Sheet and Upload Document options.

After uploading all applicable documents, click **Submit Auth Request** to complete the request.

vi. View Confirmation

After the authorization is submitted you will receive a message confirming receipt, and a Reference ID for the authorization request.



The Reference ID can be used to review the authorization to check the status of approval/denial.

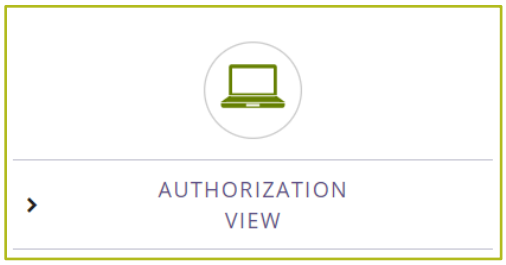
IV. Authorization View

The View Authorization application allows the ability to view authorizations that have been started and saved, and authorizations that have been completed and submitted.

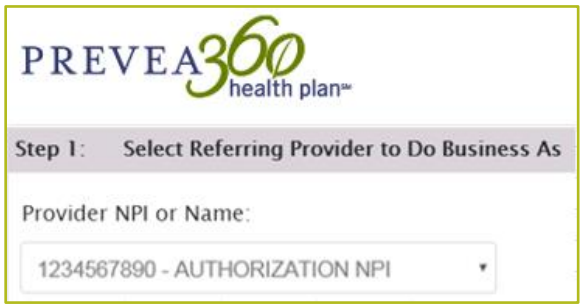
It is the responsibility of the referring/submitting Provider to check the authorization status on the Provider Portal. Prevea360 Health Plan will not send determination letters to the referring/submitting provider who entered the authorization via the Provider Portal.

i. Access Authorization View

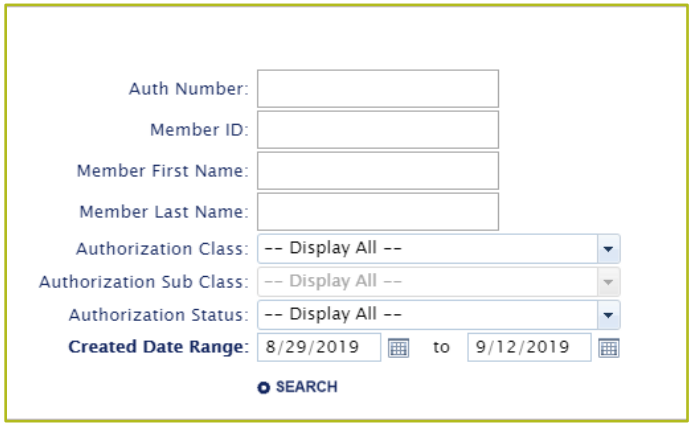
After logging into the Provider Portal, select **Authorization View** from the Portal Home Page



Select the Referring Provider for which the authorization request was submitted.

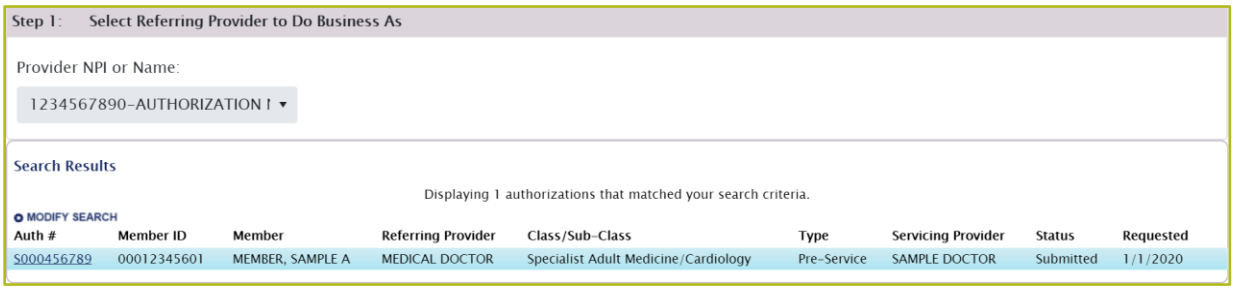


The Search Criteria will then be displayed. The **Created Date Range** is the only required field and will default to search for the previous two weeks. This will need to be changed if the authorization was submitted outside of this default date range.



The quickest way to search is by using the **Auth Number** field. Enter the Reference ID that displayed in the View Confirmation detail after the authorization was submitted. Once all relevant search criteria has been entered, click **Search**.

Note: The Reference ID may not be known if searching for saved authorizations that have not yet been submitted.



All authorizations that meet the search criteria will populate.

Submitted Authorizations

To view a submitted authorization, select the underlined **Auth #** at the beginning of the record. The authorization summary will be displayed.

Saved Authorizations

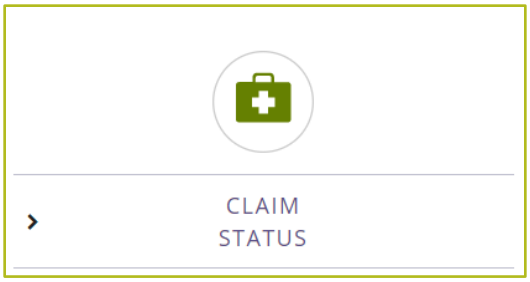
To view incomplete authorizations that have been started but not submitted, click the double arrow icon located at the end of the record. This will return the user to the authorization step that was last completed.

Auth #	Member ID	Member	Referring Provider	Class/Sub-Class	Type	Servicing Provider	Status	Requested
S200223005	00012345601	MEMBER, SAMPLE A	SAMPLE PROVIDER	Specialist Adult Medicine/Cardiology	Pre-Service	MEDICAL DOCTOR	Incomplete	>>

V. Claim Status

The Claim Status application provides human readable real time EDI (Electronic Data Interchange) 276/277 Claim Status Request and Response transactions that enables users to check the status of their submitted claims.

After logging into the Provider Portal click the **Claim Status** application located on Home Page.



Tip

Maximum claim status lookup is 12 months.

Users will be taken to the **New Claim Status Inquiry** page.

i. Submit Real-Time 276 Claim Status Transaction

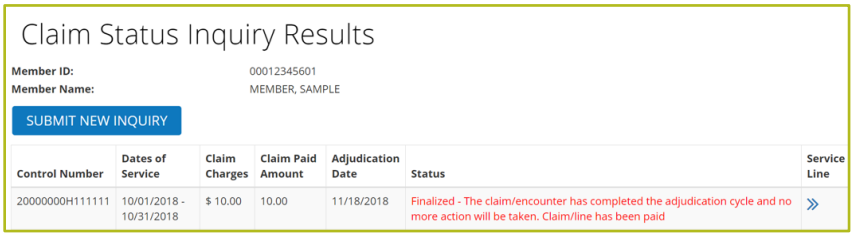
Select the Billing ID (NPI) from the Provider Billing ID dropdown. This should be the billing NPI that the claim(s) was submitted under. Enter information into all required fields denoted by (*):

- Member Last Name
- Member First Name
- Date of Birth
- Member ID
- Date of Service Start Date (If the start date is the not the exact date of service, the end date must also be entered.)

Once all required fields and desired optional fields have been filled, click **Submit Request**.

ii. 277 Claim Status Response

All claims that meet the search criteria will be returned in the results.



Claim Status Inquiry Results

Member ID: 00012345601
Member Name: MEMBER, SAMPLE

SUBMIT NEW INQUIRY

Control Number	Dates of Service	Claim Charges	Claim Paid Amount	Adjudication Date	Status	Service Line
20000000H111111	10/01/2018 - 10/31/2018	$ 10.00	10.00	11/18/2018	Finalized - The claim/encounter has completed the adjudication cycle and no more action will be taken. Claim/line has been paid	»

The claim header will show:

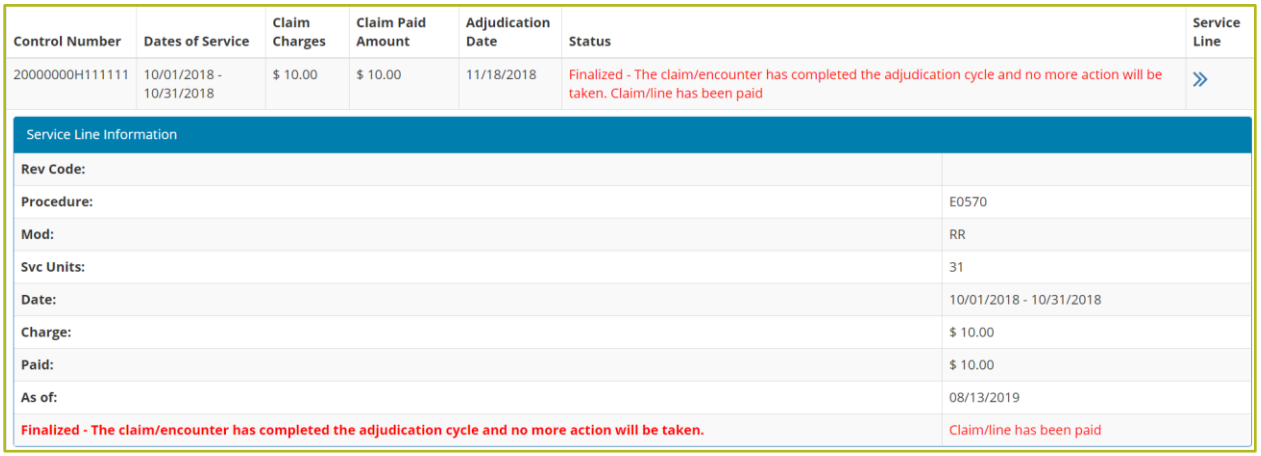
- Prevea360 Health Plan claim number
- Dates of Service
- Claim Charges
- Claim Paid Amount
- Adjudication Date
- Status (Pending or Finalized)

Tip

For additional details relating to each service line, click the double arrow to the right of the record under **Service Line**. This will display each service line individually.

Service Line
»

For additional details relating to each service line, select the double arrow on the right of the record under **Service Line**. This will display each service line individually.



Control Number	Dates of Service	Claim Charges	Claim Paid Amount	Adjudication Date	Status	Service Line
20000000H111111	10/01/2018 - 10/31/2018	$ 10.00	$ 10.00	11/18/2018	Finalized - The claim/encounter has completed the adjudication cycle and no more action will be taken. Claim/line has been paid	»

Service Line Information	
Rev Code:	
Procedure:	E0570
Mod:	RR
Svc Units:	31
Date:	10/01/2018 - 10/31/2018
Charge:	$ 10.00
Paid:	$ 10.00
As of:	08/13/2019
Finalized - The claim/encounter has completed the adjudication cycle and no more action will be taken.	Claim/line has been paid

The Service Line Information will display the following information:

- Revenue Code
- Service Units
- Modifier (if applicable)
- Date of Service
- Billed Charges
- Paid Amount
- Final Review Date
- Status

Click **Submit New Inquiry** to review additional claims or select the Prevea360 Health Plan banner to return to the Home Page.

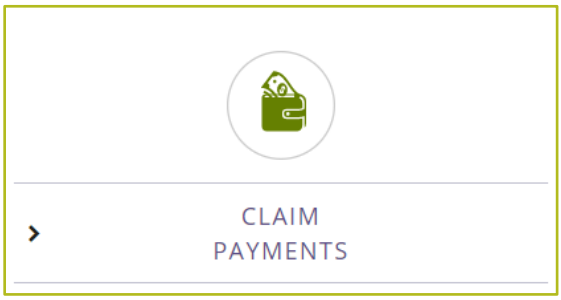
VI. Claim Payments

The Claim Payments application provides access to claim payment information online and allows Prevea360 Health Plan to deliver Electronic Remittance Advice (ERAs) or "remits" to providers online rather than mailing these documents. ERAs are statements from Prevea360 Health Plan documenting payments of claims.

> **Tip**
>
> It is recommended that date and patient information both be entered to return the most accurate search results.

i. Access Claim Payments

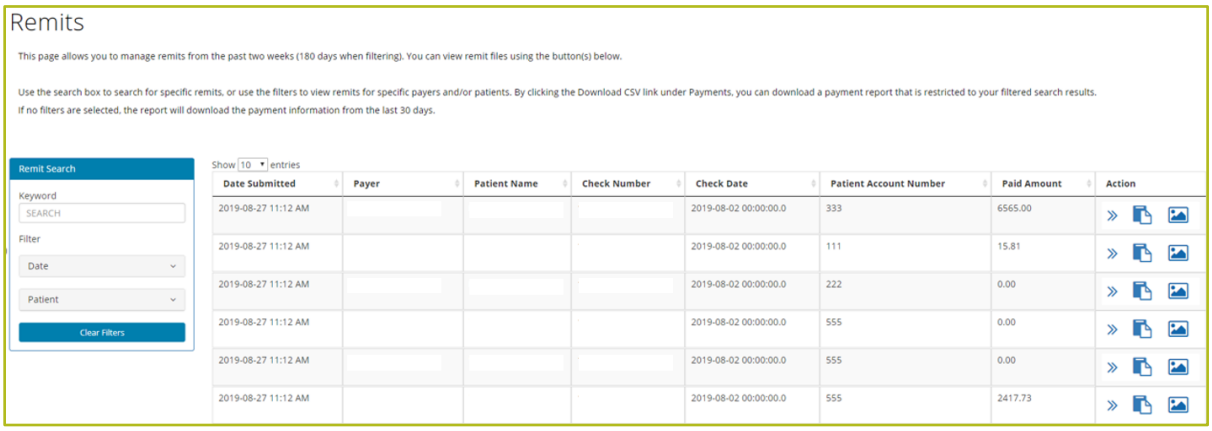
After logging into the Provider Portal select the **Claim Payments** application located on Home Page.



> **Tip**
>
> Remits from the past 180 days can be reviewed.

Remits

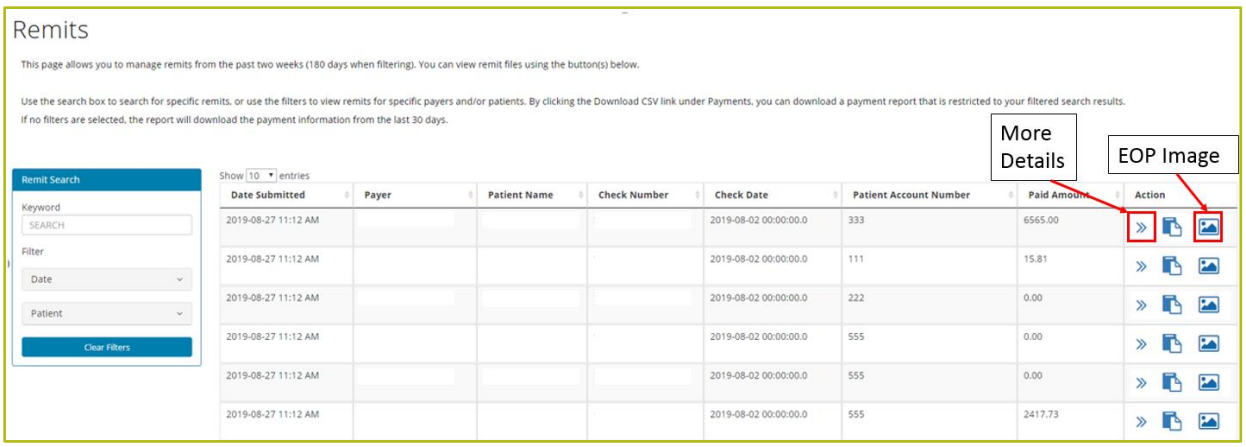
Use the **Remit Search** on the left side to filter for specific claim payments. If no search filters are selected, the report will default to payment information from the last 30 days.



Search Options:

- **Search bar** - Use the search bar to search by payment ID or Claim ID.
- **Timeframe dropdown** – expand the lookback timeframe to up to 6 months.
- **Advanced Search** – search by entering a check date, member name, member ID or Patient Acct Number.

Claim results will display as search criteria is entered. Continue entering search criteria until desired results are achieved.



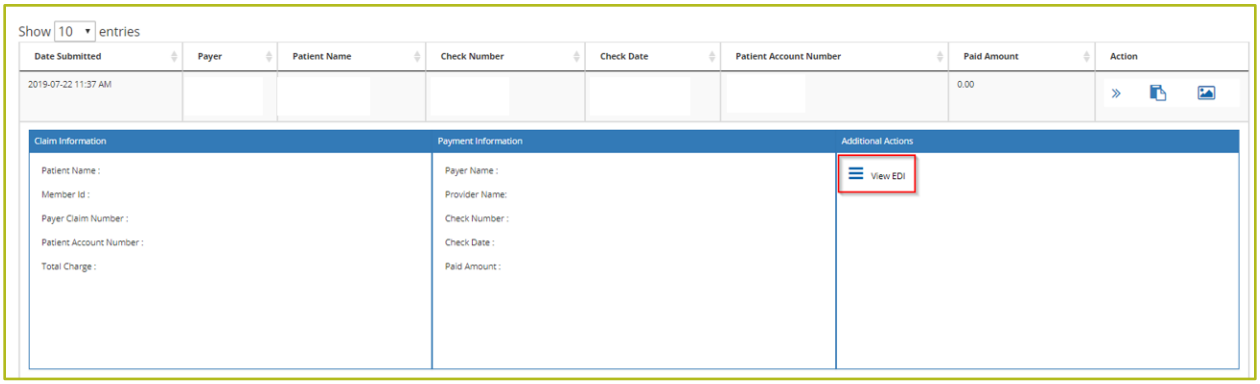
General claim information is available on this screen, but additional details are available through the **Action** items on the far-right column of each record. Available **Actions** include:

- Show details
- Add notes
- View Image

Show Details

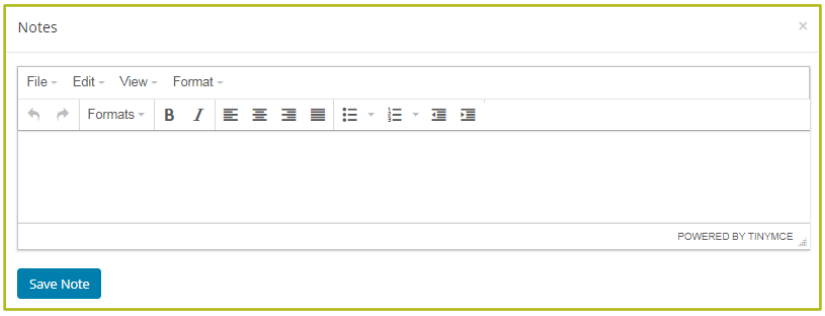
Select the double-arrow **Action** to expand the header line to view additional payment details including:

- Provider Information
- Payment Information
- EDI transactions



Add Notes

Select the clipboard and paper icon to enter payment specific notes that are viewable for all users with access to the same account.

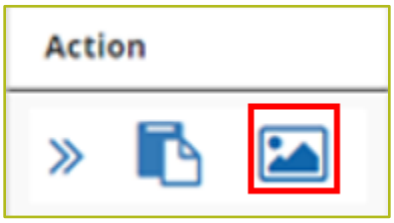


Tip

Once a note has been added to a payment, the note icon will turn green

EOP Image

Select the picture icon to view the EOP. This is a sample only and should not be used for business purposes.



VII. Claim Appeals

Claims that have finished processing and are in a finalized status (paid/denied) can be appealed directly through the Provider Portal.

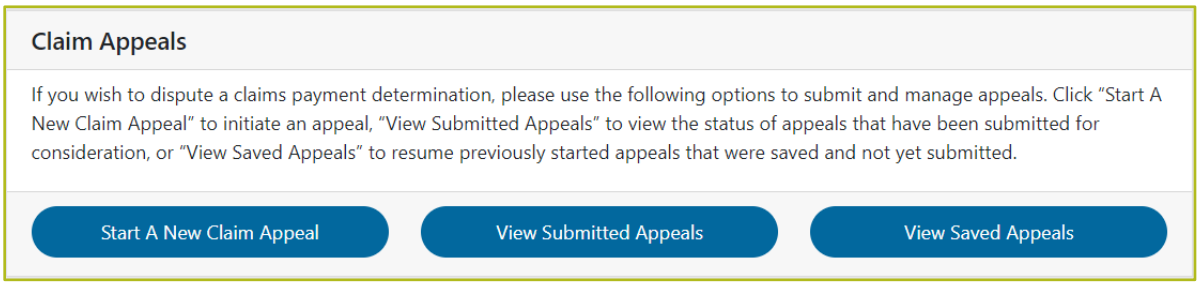
i. Access Claim Appeals

After logging into the Provider Portal select the **Claim Appeal** application

> **Tip**
>
> Corrected claims cannot be submitted via the Provider Portal.

The Claim Appeal feature has three options:

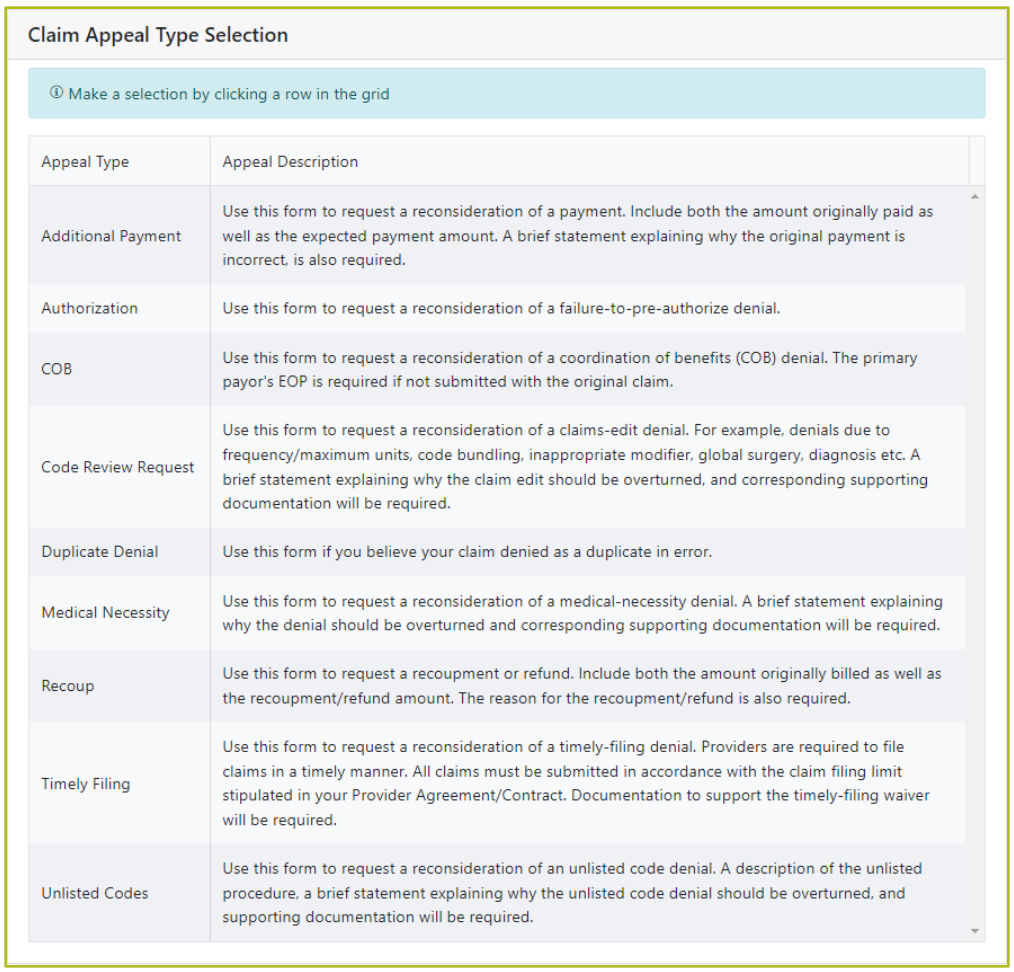
- **Start a New Claim Appeal** – allows the creation submission of a new Claim Appeal
- **View Submitted Appeals** – allows the search for claim appeals that were previously submitted
- **View Saved Claim Appeals** – allows the search for claim appeals that have been started and saved, but not submitted.



Note: Up to 500 submitted claim appeals within a six month period will be available to view.

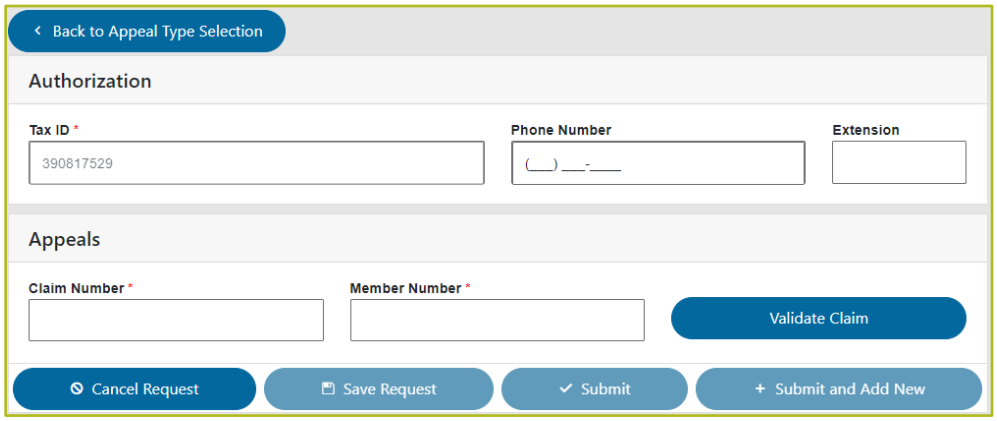
ii. Start a New Claim Appeal

To start a new claim, select the **Start a New Claim Appeal** action to prompt the **Select Claim Appeal Type** form to display. Select the radio button for the applicable claim appeal type and click **Select Form**.



Validate Claim

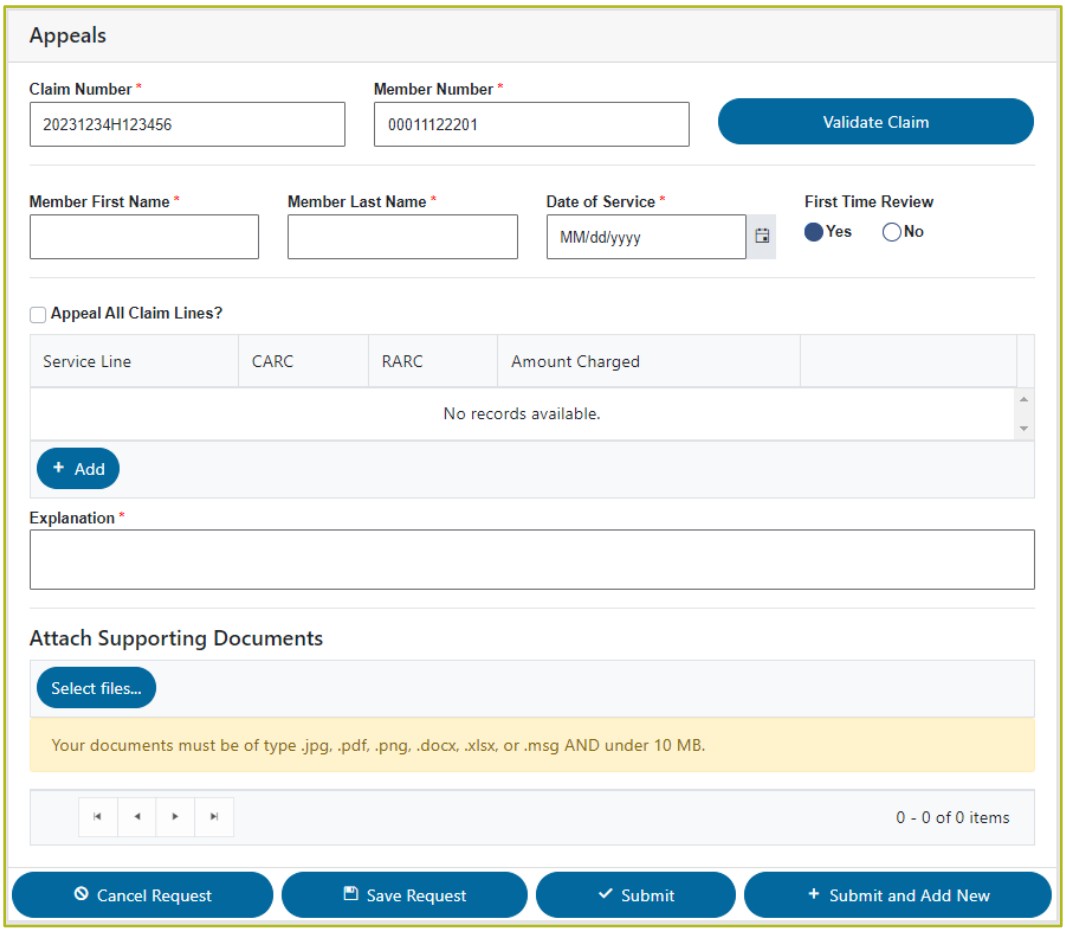
After selecting the applicable Claim Appeal Type, a validation form will be prompted. Validate the claim by entering the Claim Number and Member Number and click **Validate Claim**. Once validated, additional appeal fields will populate.



Although there is an option to Submit the appeal at the bottom of the page, claim appeals cannot be submitted until all required with a red asterisk "*" have been completed.

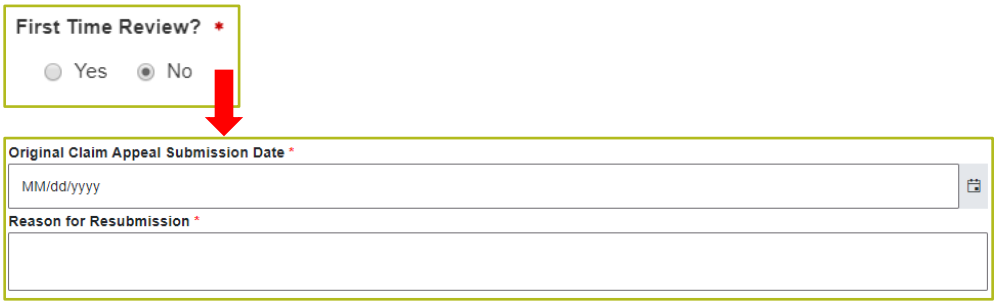
Required Fields include:

- Member Name
- Date of Services
- First Time Review
- Selecting Claim Lines
- Comments
- Attach Supporting Documents



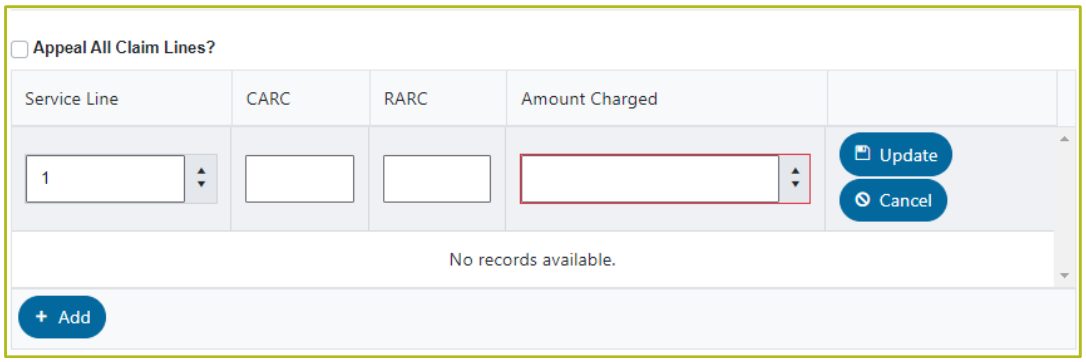
First Time Review

After entering the member name and date of services, select the appropriate radial button under First Time Review. If **No** is selected, you will be prompted to complete two additional fields – **Reason for Resubmission** and **Original Claim Appeal Submission Date**.

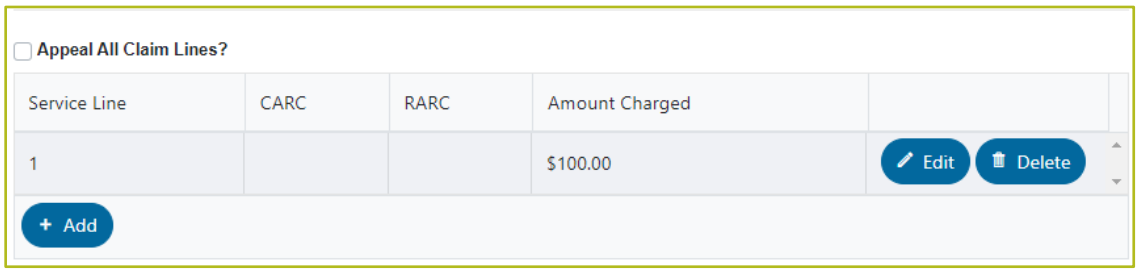


Adding Claim Lines

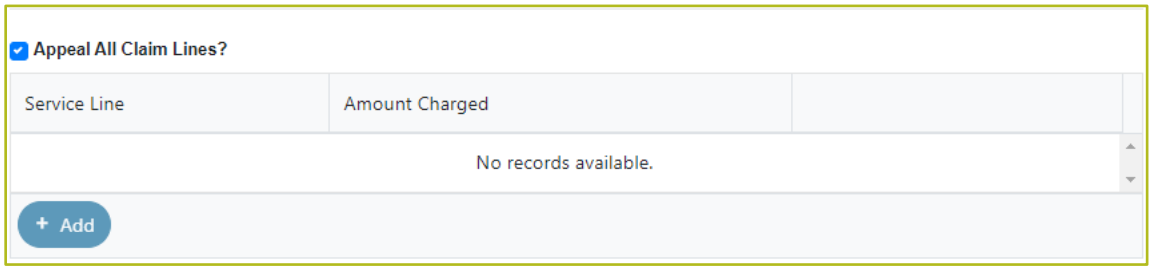
Service lines may be added by selecting (**+Add**) at the bottom of this section. All required fields in red will need to be completed before additional lines can be added. Once completed, click **Update** on the right to save the service line before being able to add another service line.



Once saved, the service line may be Edited or deleted, or select (**+Add**) to continue adding service lines.

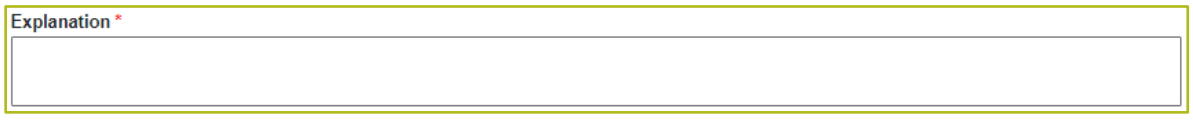


Certain appeal types will allow the selection to appeal all claim lines at once. If all service lines are being appealed, and the **Appeal all claim lines** checkbox is available, please select it. No additional service line information will need to be entered



Explanation

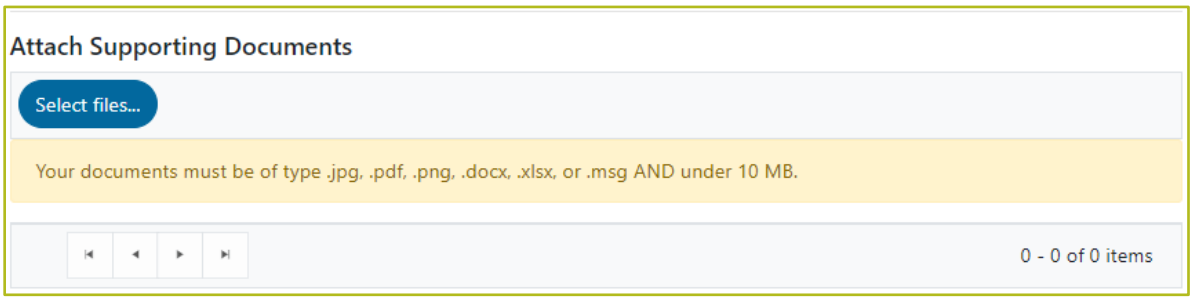
In the **Explanation Field**, include a brief but detailed explanation as to why the claim is being appealed. The explanation should include information related to the claim denial reason and should support why the original decision should be overturned. Be as detailed as necessary and include call reference numbers, if applicable.



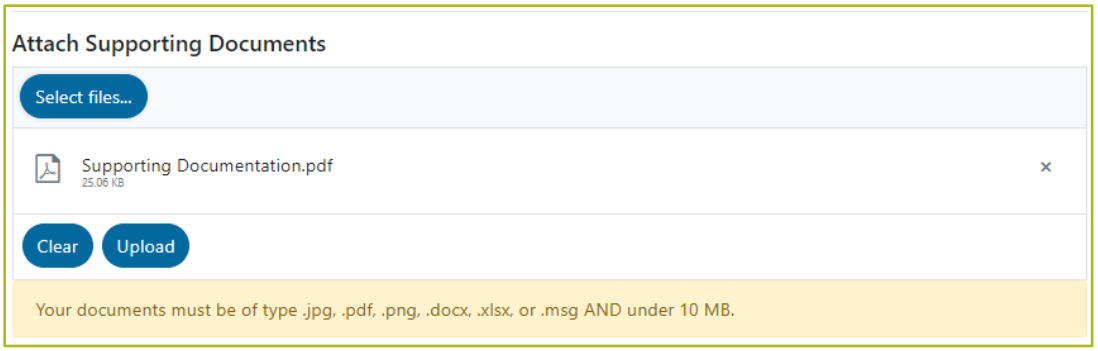
Attach Supporting Documents

- Attach only the documents that are applicable and will support the medical necessity. Required information must be legible and clearly marked. Do not use highlight markers as they do not always show up on scanned images.
- In adherence to the HIPAA Privacy Rule, only the minimum necessary documentation needed for review should be submitted. The member's entire record should not be submitted unless it can be specifically justified as needed for that purpose.
- Appropriate file types include .jpg, .pdf, .png, .docx, .xlsx, and .msg, AND must be under 10 MB in size.

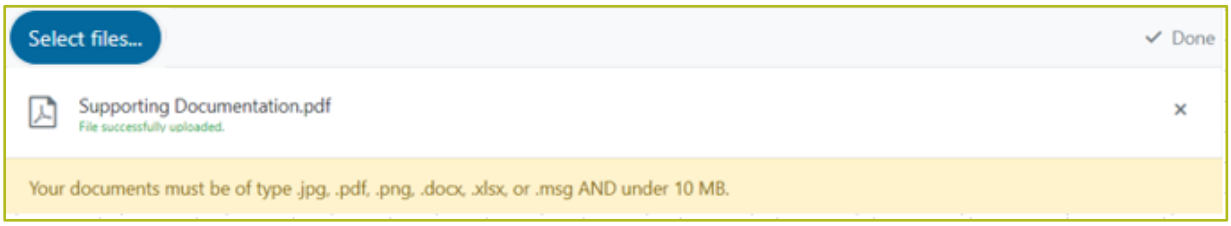
Click **Select files** to locate and select the applicable files to attach and submit with the appeal.



Select the appropriate file and double click to add it to the appeal. Once selected, the document will appeal within the application but still needs to be Uploaded.



Click the **Upload** option to attach the document. A confirmation message will display once the file has been successfully uploaded.



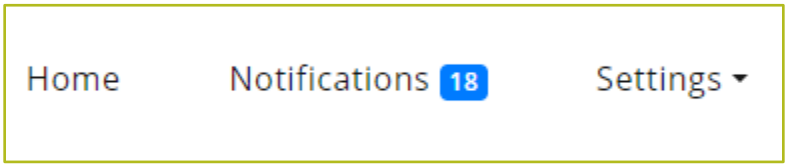
Once the documents are attached, they will appear in the Attach Supporting Documents section. Attachments can be deleted by clicking the "X".

After completion of the Claim Appeal form, there are four options located at the bottom of the form:

- **Cancel Request** – Choosing this option will prompt the message, "Are you sure?" If you cancel the request, entered data will be lost. This will also remove the request if it was previously saved.
- **Save Request** – Choosing this option will prompt the message, "Appeal request has been saved."
- **Submit** – Choosing this option will prompt the message, "Your claim appeal has been submitted successfully."
- **Submit and Add New –** Choosing this will submit the current claim appeal, and taking you back to the claim validation screen to begin a new claim appeal. This will automatically select the same **Claim Appeal Type** that was previously selected.

Submission

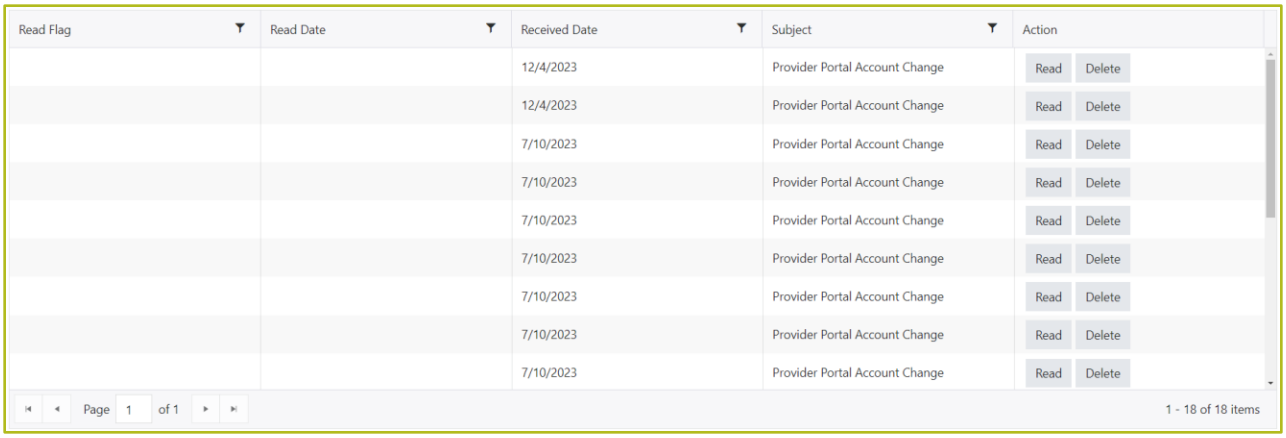
Once the appeal has been submitted, a Claim Appeal Acknowledgement will be sent through Notifications. Click **Notifications** on the Home Page to access this Acknowledgement.



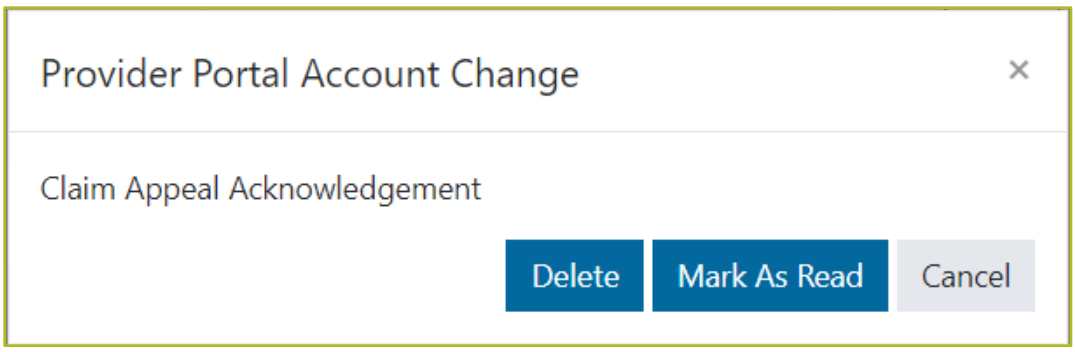
Tip

The number of unread Notifications is displayed in the Notifications field.

The most recent Notifications will be displayed at the top of the list and can be filtered by column. Look under the **Subject** column to find the **Claim Appeal Acknowledgement** with the applicable claim number identified and click **Read** to view the notification.



Click **Open Attachment** to download the Acknowledgement and click on the pdf that appears at the bottom of the screen to view the Acknowledgement Letter.



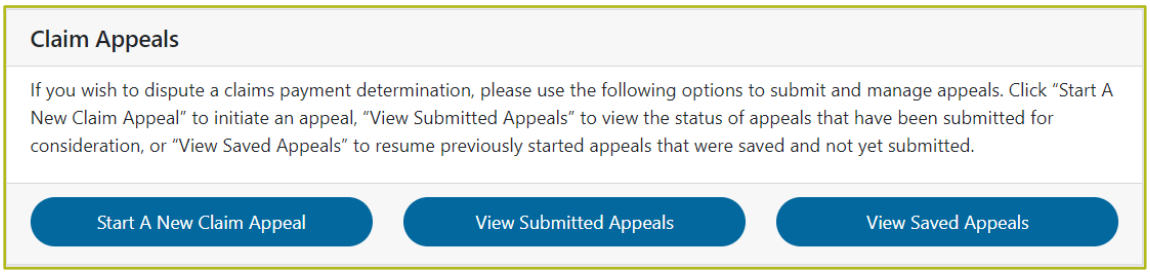
Once the health plan has reviewed the appeal, a **Determination Letter** will be sent through Notifications. This letter will indicate the review of the claim appeal was completed and the decision that was made.

Note: Claim appeal denial decisions can be re-appealed through online claim appeal submission. Denials should not be re-appealed if there is no new or supporting information to be reviewed.

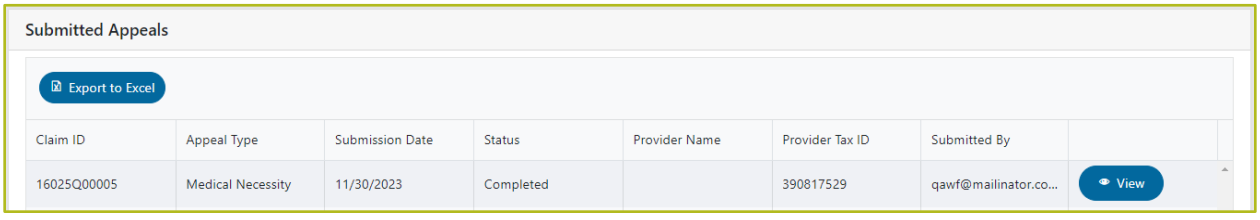
iii. View Submitted Claim Appeals

This feature enables the user to search for claim appeals that may have been started and saved, or active claim appeals that have been submitted.

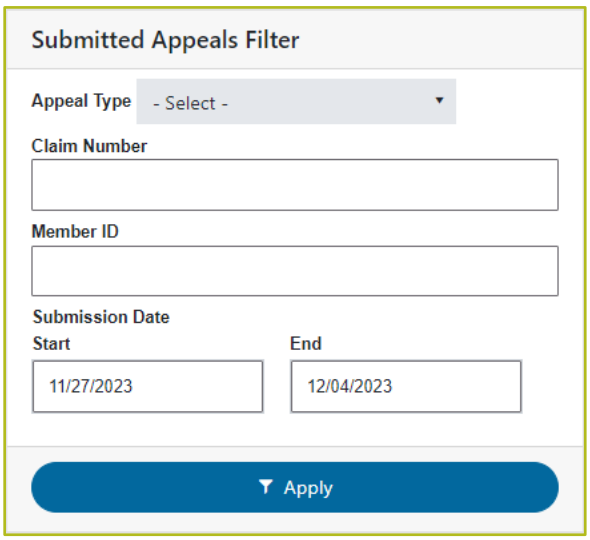
Select **View Submitted and Saved Claim Appeals** action.



After selecting the **View Submitted Appeals** action the following screen will be prompted, displaying all claim appeals submitted within the previous two weeks. Select the **View** option to review the information submitted.



There is also a search option to locate any appeals submitted more than two weeks ago. Enter all relevant search criteria, and select **Apply** to display all previously submitted appeals that match the searched criteria.



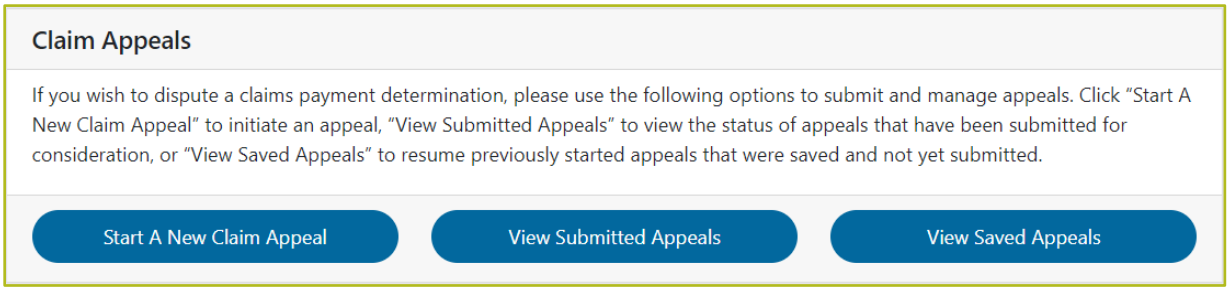
Tip

Up to 500 submitted claim appeals within a six month period will be available to view.

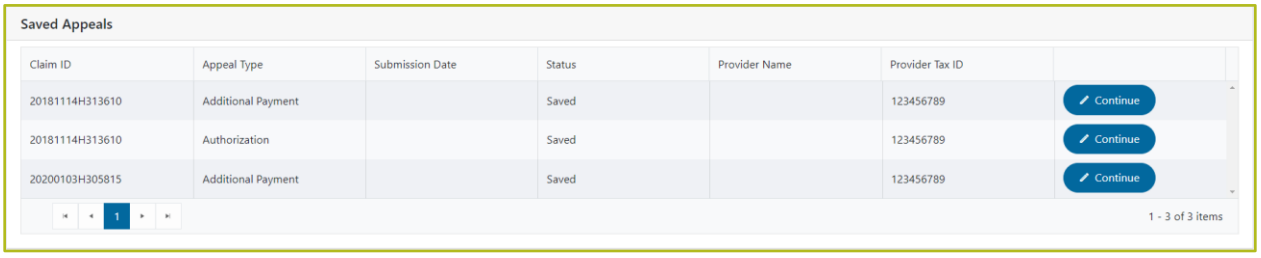
iv. View Saved Claim Appeals

This feature enables the search for claim appeals that have been started and saved, but not submitted.

Select the **View Saved Appeals** action.



If a claim appeal is started but not submitted, it can be resumed by clicking **Continue** at the end of the saved claim appeal record.



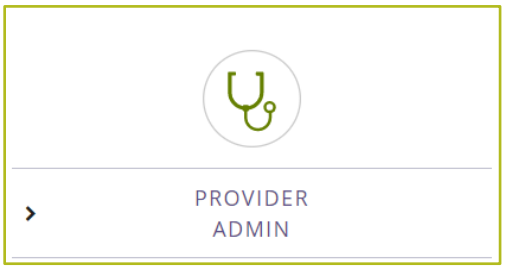
This will take you back into the appeal to pick up where it was left off. Once submitted, it will move from the **Saved Appeals** to the **Submitted Appeals**.

VIII. Provider Admin

This application allows Site Administrators to make updates to Individual user or Organization account information.

i. Access Provider Admin Application

After logging into the Provider Portal select the **Provider Admin** application on the Home Page.



Site Administrators have the following abilities within the Provider Admin application:

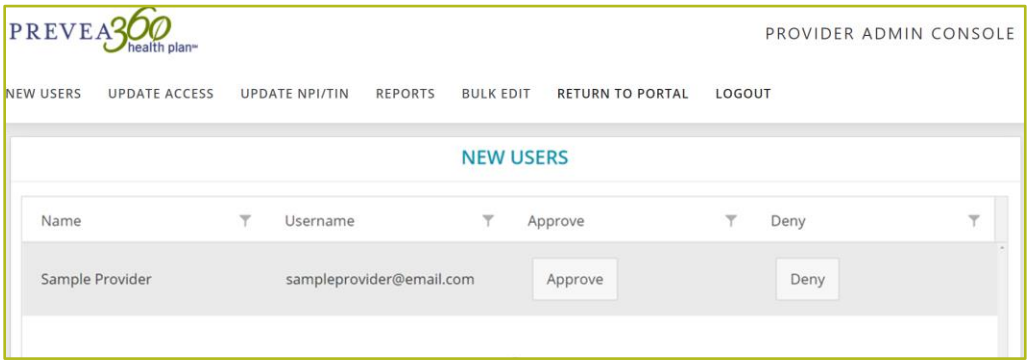
- Review and approve/deny new users who register under the Organization
- Update the access of an existing user who has access to the Organization account
- Submit a request to add an additional NPI or Tax ID to the account
- View number of users on the account

Tip

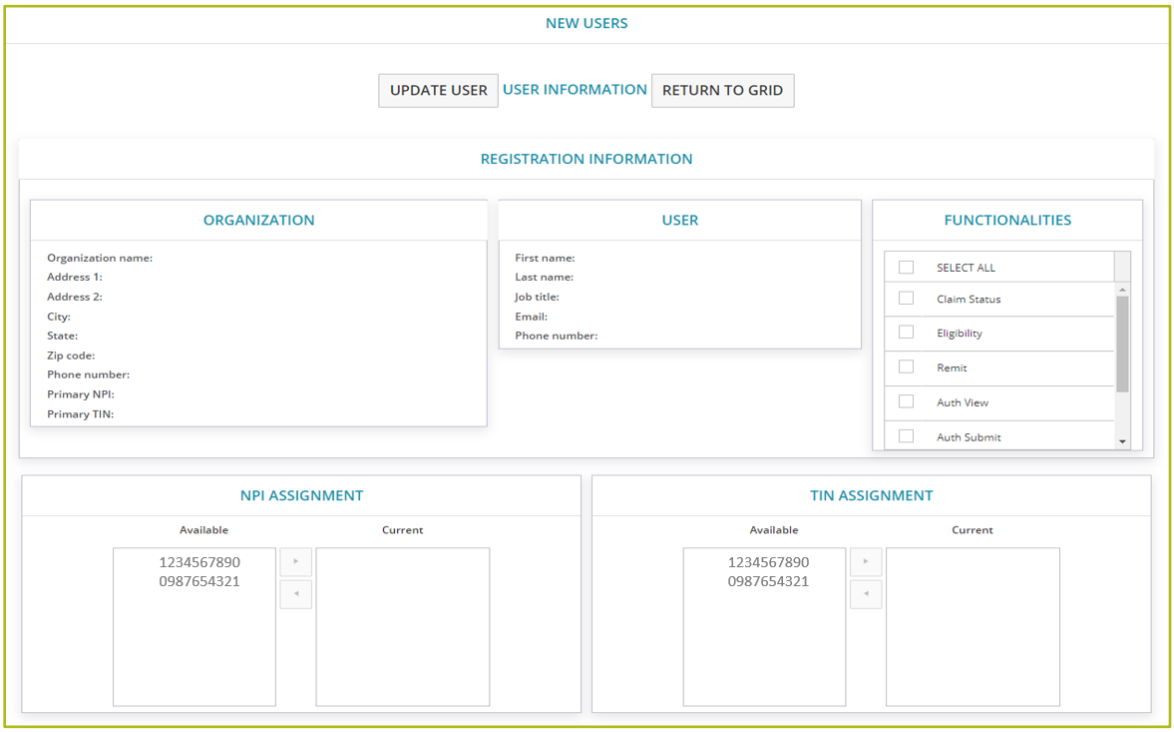
Only Site Administrators will have access to this application. It is strongly recommended that each Organization have at least two Site Administrators on the account.

ii. New Users

Click **New Users** to view a list of Individuals who have registered under the Organization. This page will auto-populate after clicking on the Provider Admin application. When a new Individual registers under the Organization account, each Site Administrator will be notified via secure notification on the Home Page to review the new user information in the Provider Admin application. Select to Approve or Deny the New User Registration.

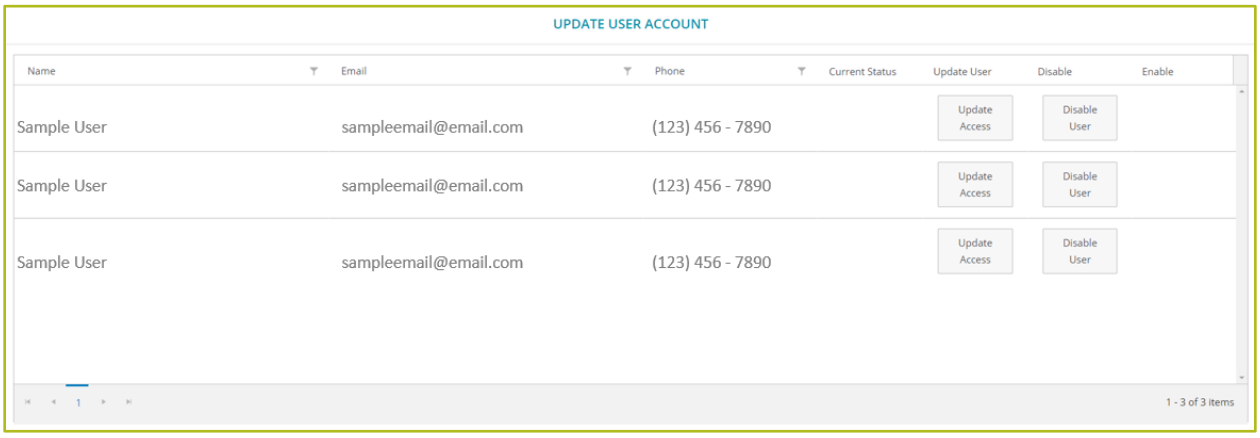


Selecting Approve will open the **Registration Information** screen. Select which applications, TINs and NPIs this Individual should have access to, and select **Approve User**.

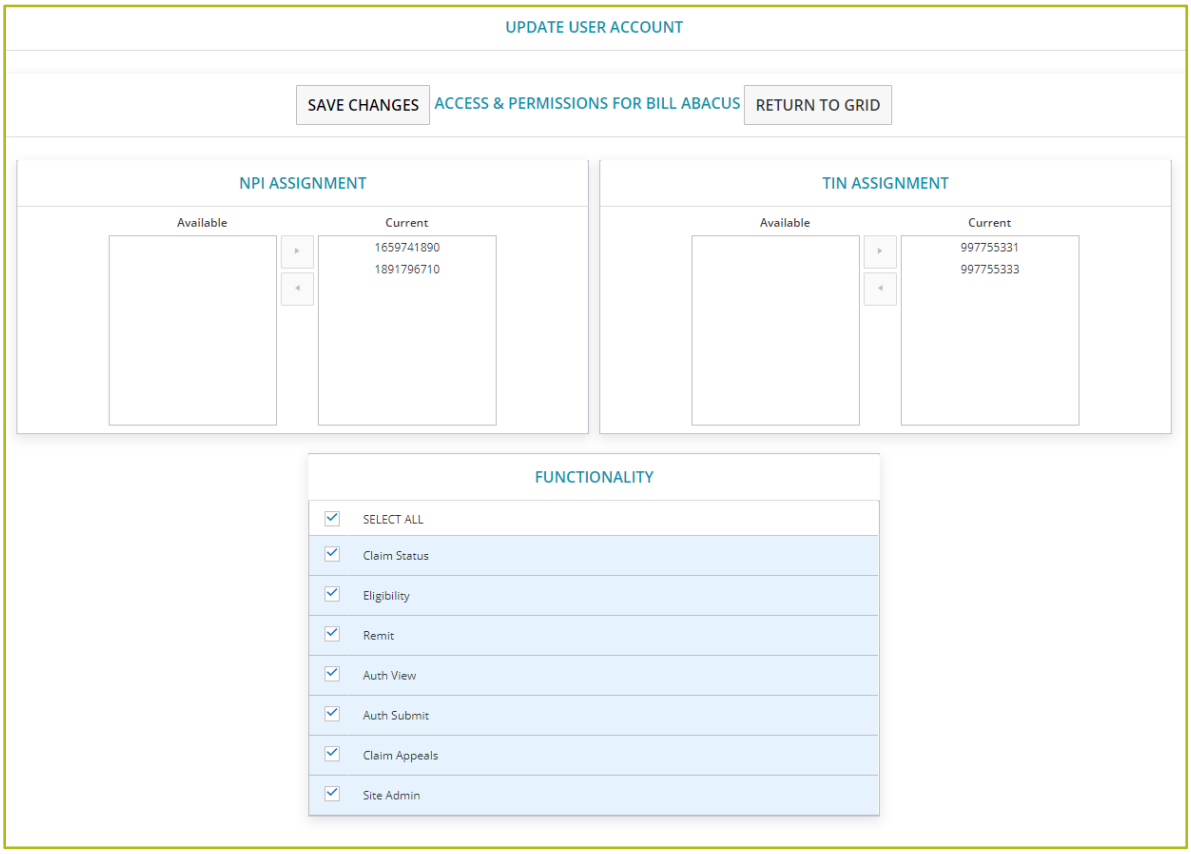


iii. Update Access

This option gives Site Administrators the ability to update the access of existing users or remove users who should no longer have access to the account.



NPIs, TINs, and Functionalities can all be reassigned based on the needs of the Individual user. Select Update Access on the user that requires updates.

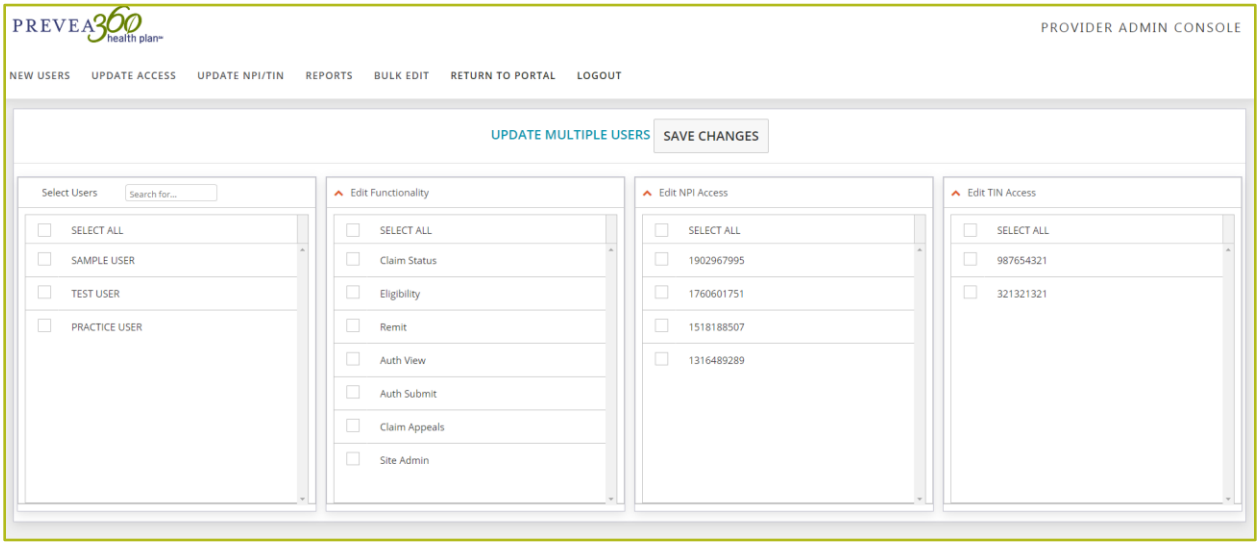


Once complete, click **Save Changes** or click **Return to Grid** to cancel these changes.

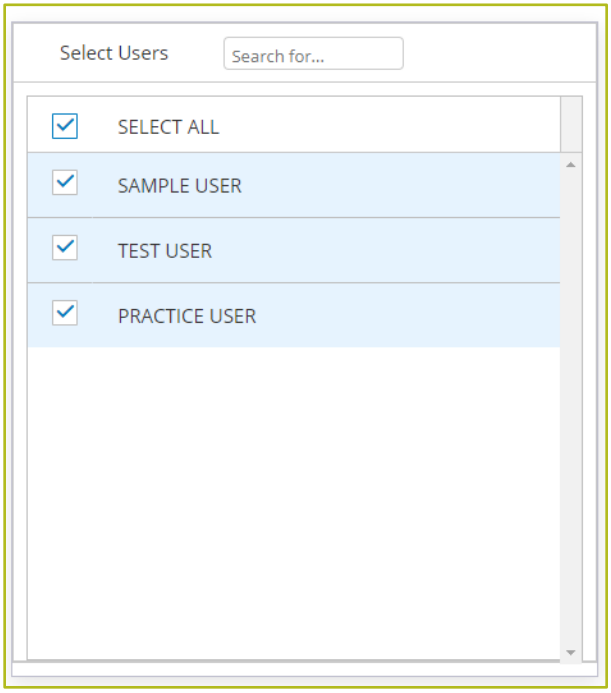
Bulk Edit

The **Bulk Edit** option gives Site Administrators the ability to make updates to multiple users at once.

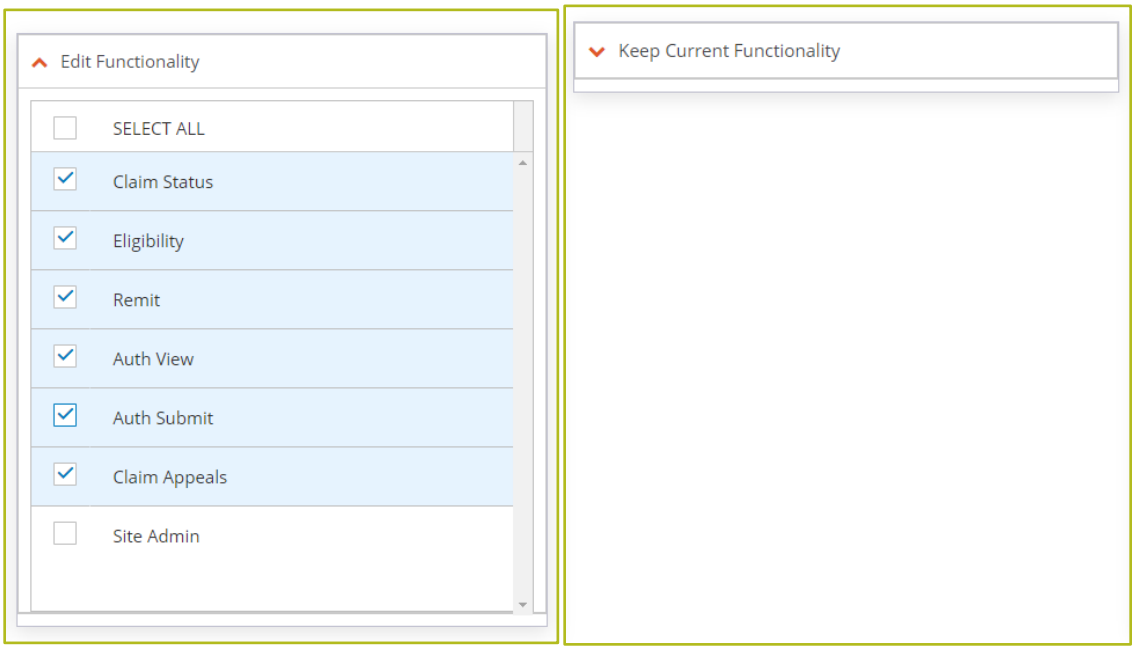
Note: Once submitted, changes made through the Bulk Edit feature will completely overwrite each user's existing access and will replace it with the Bulk Edit changes. If no changes are needed for a category, select the dropdown arrow at the top of the screen to close that category. This will prevent any Bulk Edit changes from being made to that category.



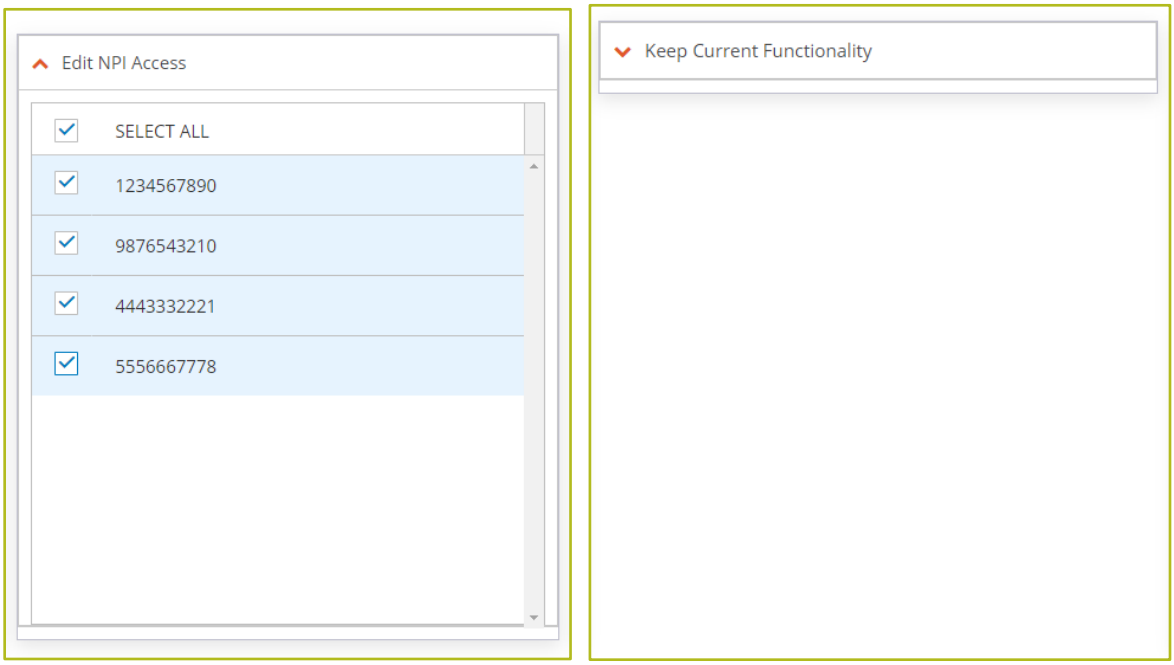
Under the Select Users category, select the users to be updated or **Select All** to select all users at once. There is also an option to search for a specific User. All selected users will receive the same updates.



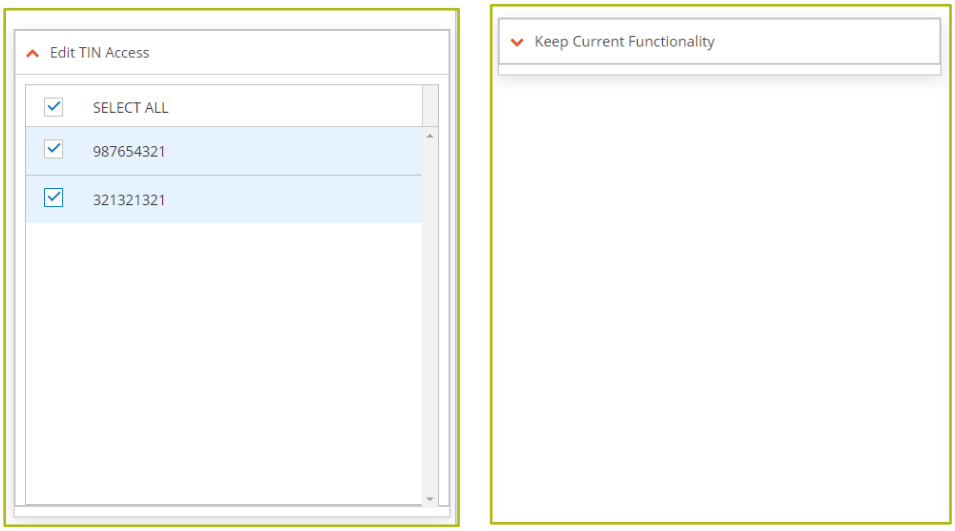
Select the Functionality that the selected users need. One, multiple, or all functionalities can be selected, as applicable. If no changes are needed to the users' Functionality access, select the dropdown at the top of the Edit Functionality screen to close that category and keep current functionality access for each selected user unchanged



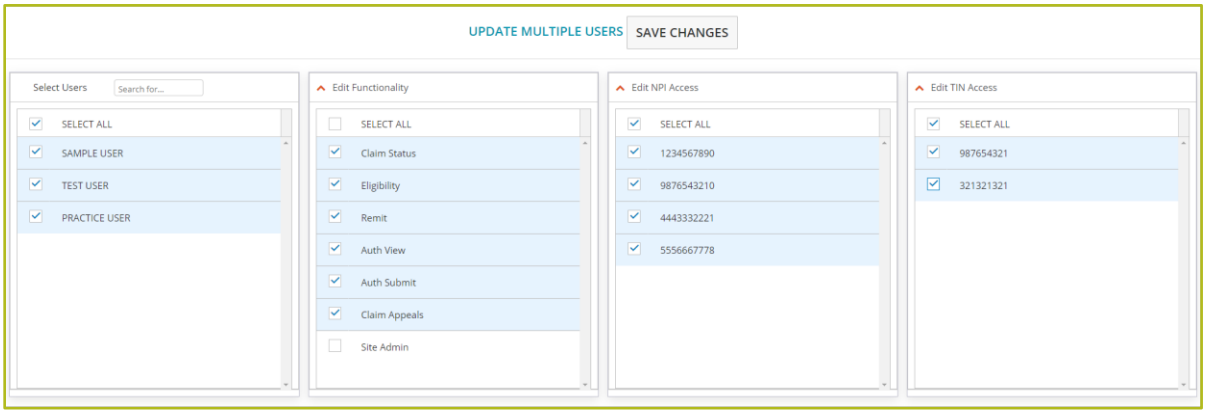
Select the NPIs that the list of selected users need access to or **Select All** to give each user access to all. If no changes are needed to the users' NPI access, select the dropdown at the top of the Edit NPI Access screen to keep current NPI access for each selected user unchanged.



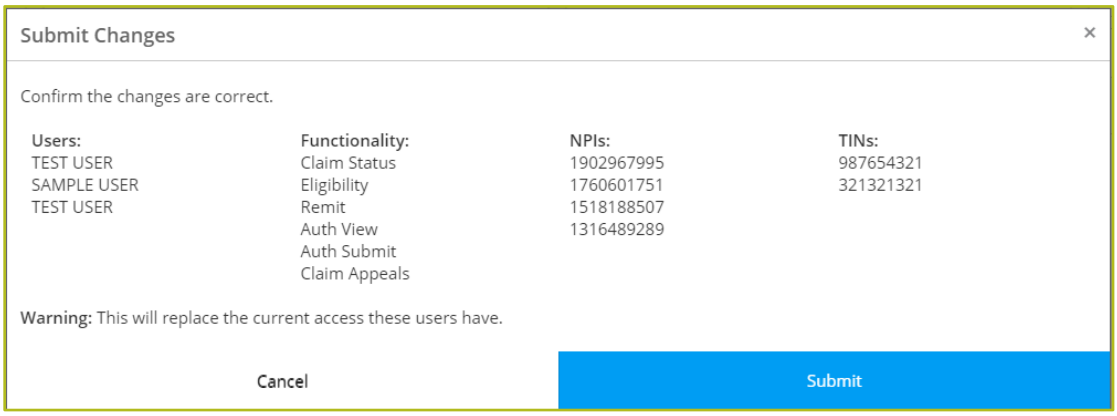
Select the Tax IDs that the list of selected users need access to or **Select All** to give each user access to all. If no changes are needed to the users' TIN access, select the dropdown at the top of the Edit TIN Access screen to keep current TIN access for each selected user unchanged.



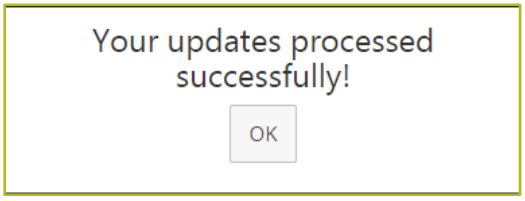
Once all the categories and details are completed, select **Save Changes**.



A recap of the requested changes will display. Please review to confirm your updates are correct before submitting as these changes will completely overwrite each selected user's current access.



Click **Submit** once you have confirmed your updates are correct. The following confirmation will display after the changes are successfully updated.

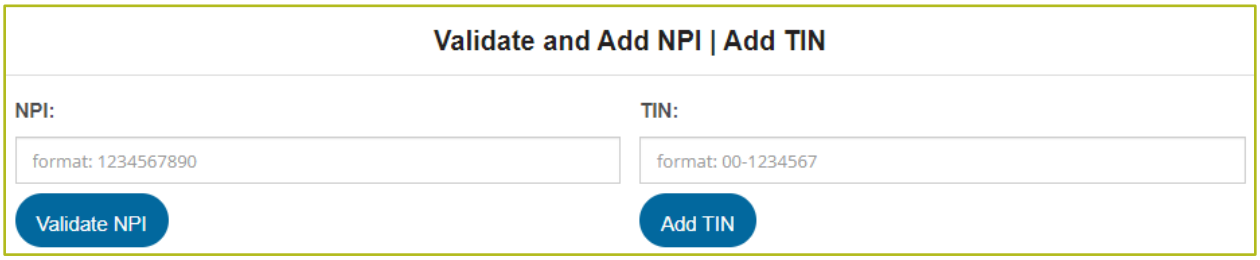


The Bulk Edit feature does not replace having to make separate, individual changes if not all users need the same access. Please limit user access to only those applications, NPIs, and TINs needed for business purposes

Update NPI/TIN

Additional NPIs and Tax IDs can be added to an Organization account upon request.

- To request to have a new NPI added, enter the NPI you wish to have added to the account and select **Validate NPI**. Please review the related information to confirm the correct NPI was entered. If so, select **Add NPI**. If not, select **Clear** and re-enter the NPI.
- To request to have a new TIN added, enter the TIN you wish to have added to the account and select **Add TIN**. The request will automatically be sent.



An Internal Administrator at the health plan will review all requests to verify that the information submitted is covered under the contract. If additional information is needed, the Internal Administrator will reach out to the Site Administrator who submitted the request. Once a decision has been made, all Site Administrators for the organization will receive secure notification of the decision.

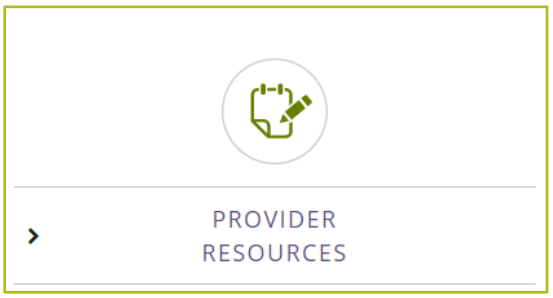
Reports

Reporting is available for Site Administrators to view the total number of users on the account.

- **Active Users** – users who have access to the portal account
- **New Registered Count** – users who have registered within the past two weeks.
- **Not Vetted Count** – new users who have registered under the portal account but have not yet been approved or denied.
- **Non Active Count** – users whose account access has been removed.

IX. Provider Resources

Select the Provider Resources application for access to all guides and resources related to the Provider Portal.



Available resources include:

- Links to vendor portals
  - RadMD
  - Confirmation Reports Portal
  - Navitus Prescriber Portal
- Medical Policies
- Provider Manuals
- Provider Newsletters
- Various Resources available through the Prevea360 website