SOUTH CAROLINA MEDICAID WEB-BASED CLAIMS SUBMISSION TOOL

USER GUIDE

February 1, 2004
Updated June 11, 2012
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CHAPTER 1: OVERVIEW OF THE WEB TOOL

The South Carolina Medicaid Web-based Claims Submission Tool (Web Tool) is an online application for submitting HIPAA-compliant claims to South Carolina Medicaid. With the Web Tool, South Carolina providers can quickly and easily send CMS-1500, UB-04, and their associated adjustments to South Carolina Medicaid via the Internet.

How does it work? The tool allows direct data entry to the Medicaid Management Information System (MMIS). Since the provider is, in effect, typing information directly into the MMIS, data format is not an issue. The Web Tool is a great means to achieve HIPAA compliance and offers the following features:

- **Easy to use and learn:** The tool is basically an online claim form (updated with HIPAA fields). Users are already familiar with the fields.
- **Fast, accurate:** Users develop their own lists of frequently used information (beneficiaries, procedure codes, diagnosis codes, etc.). The ability to select information rather than keying it saves valuable time and increases accuracy.
- **Simple, affordable technology:** No software is needed to use this application — just the login ID and password. Another benefit is savings on postage-related costs.
- **Data is automatically archived:** You may review the claims you have sent — or if your system crashes, you have a backup.
- **Automatic Data Purge:** The Data Purge process runs on the first day of every month to delete all submitted claims, submitted batches, and pending claims that are more than three months old.

Technical Requirements

The minimum necessary requirements for using the South Carolina Medicaid Web-based Claims Submission Tool are:

- Microsoft Internet Explorer (version 7.0, 8.0); Firefox 4; Safari; or Google Chrome
- An Internet Service Provider (ISP)
- A Pentium series or better processor is recommended
- A minimum of 1 gigabyte of memory
- A minimum of 20 gigabytes of hard drive storage

*Note:* Providers wishing to use the Web Tool must first execute a Trading Partner Agreement (TPA) with South Carolina Medicaid. Upon completion of the TPA, providers who wish to submit other electronic transactions to SCDHHS should download a Trading Partner Enrollment form from the SCDHHS Web site: [www.scdhhs.gov](http://www.scdhhs.gov). The provider must then select the South Carolina Medicaid Web-based Claims Submission Tool as an option to send claims. These steps are described in Chapter 2: Getting Started.
CHAPTER 2: GETTING STARTED

Getting a Login ID and Password

HIPAA legislation recommends that covered entities sign agreements with trading partners with whom they exchange HIPAA ANSI transactions. The South Carolina Department of Health and Human Services (SCDHHS) follows this recommendation. In order to submit claims and check beneficiary eligibility using the Web Tool, you must first complete and sign a Trading Partner Agreement and Trading Partner Enrollment Form.

When SCDHHS receives these signed documents, you will be mailed a login ID and password, as well as the Web address of the Web Tool. All users must have individual logins and passwords. Individuals cannot share login and password information. Users in the same organization will be able to share information created using the List Management function without having to share the same login ID.
Changing Your Password

The South Carolina Web-based Claims Submission Tool offers the ability to change the default password which is provided once you complete a Trading Partner Agreement or update your current password, whenever the need arises.

Change Password
1. From the Home screen, click Login.
2. Enter your User Name and Password.
3. Click Login.
4. Select a provider from the drop-down menu at the top (reads: “Please select a provider to work with:”) and choose the Select button.

Note: You can only see provider numbers which have been submitted on the Trading Partner Agreement for your particular office.

5. From the Menu, choose Change PWD to retrieve the Change Password screen.

6. Enter the new password in the Enter New Password field (according to the Password rules).

a) The new password must:
   • Be at least eight characters in length.
   • Contain one non-numeric character.
   • Contain one numeric character.
   • Contain at least two of the following three options:
     o upper case
     o lower case
     o special character ("@","#","$").

7. Re-enter your new password in the Verify New Password field.

8. Click Submit.

Note: Click Clear to refresh both fields.
CHAPTER 2: GETTING STARTED

Changing Your Password

SC Medicaid Portal Home

You've successfully updated your password.

Welcome to the South Carolina Medicaid Web Portal.

- To update your password, please click the Change PWD link.
- To download or view payment e-Remit statements, please click the e-Remit link.

FAQ

Q: How long are the remits (or remittance advices) available on the Portal?
A: Remits are only available through the portal for the last 25 weeks. If you need a remit over 25 weeks old, please call your program representative.
The Web Tool Screen

At your Internet Web browser’s address bar, type in the Web Tool address that was mailed to you with your login ID and password. The Home screen for the Web Tool appears. (Helpful Hint: Adding this address to your Favorites list will allow easy access to the Web site.)
As shown below, each Web Tool screen is divided into two sections: the Browser Menu and the Entry Screen. This is a Web application, so you need only click once on any link or button to proceed to that location.

**Browser Menu**
If you are already an Internet user, the Browser Menu will look familiar. You do not need this menu for Web filing, but you do have the option to visit other Web pages, such as Favorites or your e-mail, while this application is open. After all, the Web Tool is just another Web page!

**Entry Screen**
The Entry Screen is where you actually enter the data pertaining to claims submission, beneficiary eligibility requests, and claims status searches. Each menu option of the Web Tool is accessible from the Entry Screen.
CHAPTER 3: LISTS

The South Carolina Medicaid Web-based Claims Submission Tool will be most useful if you take advantage of the List feature. Building lists allows you to create and modify records of information that can be used repeatedly when entering data on a Claims Entry screen. Use of the Lists function is NOT required for claims entry. However, using lists to auto-populate fields makes claims entry and submission much faster!

EXAMPLE: You enter patient John Doe’s information into your Beneficiary List. The next time you enter a claim for John, you can have the system automatically populate his information on the claim. Also, if you have developed lists for frequently used procedure and diagnosis codes, you can simply select from the list of codes rather than reentering the information. The same applies for the other options noted under Lists.

All the lists allow the user to view, add, edit, or delete the entries within the lists.

The list screens also allow you to view list entries as “active” or a combination of “active” and “inactive.” The Show All button displays both active and inactive entries. To view only the active entries on the list, use the Show Active button.

Since these functions work the same way for all the lists, detailed instructions on executing them are covered in this manual using the Beneficiary List as the example. Other List explanations will simply contain screen shots of the fields and refer the reader back to the Beneficiary List example if more detailed instructions are required.

Note: Lists are sharable between multiple logins within the same organization.
Creating Lists

1. Click on Lists to retrieve a drop-down menu of all available list types.
2. Select a provider from the drop-down menu at the top (reads: “Please select a provider to work with:”) and click the Select button.

Note: You can only see provider numbers which have been submitted on the Trading Partner Agreement for your particular office.
3. From the drop-down menu, choose the list you want to build, depending on your needs.

**Note:** While both CMS-1500 and UB-04 billers may use the List function, not all lists will apply to both bill types.
**Beneficiary List**

The *Beneficiary List* is a record of patient names, medical record numbers, Medicaid IDs, and patient account numbers. When keying a claim, you can select a patient from the list and that individual’s information will automatically populate in the claim fields.

**View Beneficiary List**

1. Select **Beneficiary** from the **Lists** menu to retrieve the *Beneficiary List Management* screen.
The *Beneficiary List Management* screen displays only the *active* beneficiaries in your list. It also allows you to add new individuals to the *Beneficiary List*.

*Type new beneficiary information here.*

*View your current Beneficiary List.*
CHAPTER 3: LISTS

Beneficiary List

Add a Beneficiary

1. Type the new beneficiary’s information into the fields.
   
   **Note:** Denoted by asterisks, the Medicaid ID, Date of Birth, and First and Last name are required fields.

You will also notice two additional fields: Account Number and Record Number. These fields are for your internal use. If a beneficiary has an account or record number unique to your facility, you may enter it in one or both of the fields to further distinguish the beneficiary from another in your office. This feature is helpful if you have more than one beneficiary with the same first and last name.

All other data is optional, including the ability to make the beneficiary active or inactive.

2. Once you have entered all of the required data, simply click Add to add this beneficiary to your list.

   **Note:** Click Clear to erase the data you have keyed in these fields.
Sorting a List

After you have added more than one beneficiary to your list, you have the ability to “organize” them so locating their record will be very simple. Each header can be sorted in ascending or descending order.

1. Click on the header to sort and your list will be arranged according to your selection.

![Sort by any column header](image)
Editing and Active/Inactive

Web Tool offers the ability to edit your beneficiaries’ status. They can either be “active” or “inactive”. Making a beneficiary inactive on your list is a way to narrow your list without deleting the beneficiary record. While you can delete them, making them inactive “hides” them from the list of beneficiaries who are currently receiving services at your facility.

To make a beneficiary active or inactive,
1. Click **Edit**.
2. Edit the beneficiary’s information.
3. Make the entry active by simply placing a check in the **Active** status box.  
   *Note:* Removing the check mark from the **Active** status box will make the beneficiary inactive.

4. Click **Update** to save the changes.  
   *Note:* Click **Close** to exit the menu without making any changes.
The record has now been updated and shows the record as “active”. You may also view only active records, only inactive records, or all existing records. To view all records, click **Show All**. To view only active beneficiaries, click **Show Active**. To view only inactive beneficiaries, click **Show Inactive**.

The record now shows as “active.”
Deleting a Record
A record may also be removed from your list completely. If you no longer have a need for the beneficiary to be in your list,

1. Click **Delete** to erase all information pertaining to this beneficiary.
   
   **Note:** This will not erase any claim information for this beneficiary, just the record in your *Beneficiary List* you have saved with his or her name, Medicaid ID, DOB, etc.

2. Click **OK** when prompted to confirm your selection. By clicking **OK**, the recipient’s information will be removed from your list.
   
   **Note:** Click **Cancel** if you do not wish to delete the record.
Provider List

Just like building a list of beneficiaries, you may also build a list of providers within your organization. Like using the beneficiary list to populate claim information regarding your beneficiary, you may utilize a Provider List, even if just one provider, to populate his or her required data into a claim form instead of manually keying their information. Identical to your beneficiary list, you may also Edit or Delete the records at any time.

Add a Provider

1. Click on Provider from the Lists menu to retrieve the Provider List Management screen.
2. Enter data into the fields to identify the provider.
   **Note:** The required fields, which are denoted by asterisk, are the *Provider Last Name or Organization Name* and *Provider Identification*.
3. After entering the required data, click **Add**.
   **Note:** Click **Clear** to erase the data you have keyed in these fields.

Your provider will now be added to your *Provider List*. Even if just for one provider, building a list allows you to populate your claim forms with his or her required information saving time and keystrokes when entering claim information.
CHAPTER 3: LISTS

Insured List

Another list you may utilize is an Insured List. If a beneficiary has other insurance on file you may choose to build records of his or her insurance information to save and use when building claims for that beneficiary. Just like any other buildable list, you can Edit and/or Delete these records at anytime. You may also change the Active/Inactive status as the need arises.

Note: Web Tool cannot be used to file claims to other insurances; all proper billing procedures apply.

Add Insured Information

1. Click Insured from the Lists menu to retrieve the Insured List Management screen.
2. Add records of beneficiaries’ additional insurance policy/policies he or she may have. Records must have a **Last Name, First Name**, and from the drop-down menu, you must select the **Relation To Insured** (Example: Self, Child, Employee, etc.). You must include the insurance **Policy Number**, **Other Insurance Claim Filing Indicator**, and **Carrier Code**. 

**Note:** A complete Carrier Code listing can be found in Appendix 2 of your Provider Manual.

Though not a required field, you may also include the insurer’s name in the **Insurer Name** field.

3. After entering all required fields, click **Add**. 

**Note:** Click **Clear** to erase the data you have keyed in these fields.
Diagnosis Code List

Another helpful list that can be utilized is a Diagnosis Code List. You may choose to build a list of codes specific to your organization that may be used over and over again.

This function allows you to build a list of frequently used codes for later reference when entering claim information. Like any other buildable list, you can Edit and/or Delete these records at anytime. You may also change the Active/Inactive status as the need arises.

Add a Diagnosis Code

1. Click Diagnosis Codes from the Lists menu to retrieve the Diagnosis Codes List Management screen.

Select Diagnosis Codes to begin building your Diagnosis Codes List.
2. Type the diagnosis code and a description of the code into the fields. 
   *Note:* The **Diagnosis Code** field allows space for five characters. If decimal point(s) within a code will not allow the entire numeric/non-numeric code to fit in the Diagnosis Code field, you may omit the decimal point. Descriptions can be specific or general to help you identify the Diagnosis Code. A full listing of Diagnosis Codes can be found in Section 4 of your provider manual.

3. Click **Add**. 
   *Note:* Click **Clear** to erase the data you have keyed in these fields
Now that you have built your customized lists, you can enter claims information. In this chapter, you will learn how to add, edit, delete, and copy claims, as well as how to view the history of claims previously submitted. The claim forms (CMS-1500 and UB-04) are the same ones you use today, and you will complete them as you always have. Although the CMS-1500 and UB-04 claims entry screens do not look like the hardcopy forms, you will enter the same required information.

In addition to entering original claims, you can also use the Web Tool to enter adjustment claims. Adjustments to paid CMS-1500 claims can be filed using the Web Tool regardless of the submission method of the original claim. However, paid UB-04 adjustment claims must be filed using the same method with which the original claim was submitted (i.e., paper, electronic, Web Tool).

The types of adjustments for a submitted claim are:

- **Void Only**: The original paid claim is “voided” in the South Carolina Medicaid claims processing system. The entire paid amount for the original claim will be deducted from the next Remittance Advice.

- **Void/Replacement**: The original paid claim is “voided” and is replaced with a new, corrected claim. If the claim has not been purged from the Web Tool, you should use the copy and edit functions to adjust and resubmit your claim. The entire paid amount of the voided claim will be deducted from the next Remittance Advice. A Void/Replacement claim cannot be used, under any circumstances, to correct the Provider ID or beneficiary Medicaid ID.

If the replacement claim is processed during the same claim payment cycle as the voided claim, the replacement claim will pay and appear with the voided original claim on the Remittance Advice. If the voided claim and the replacement claim do not process in the same payment cycle, the voided claim is reported on one Remittance Advice, and the replacement claim is reported on a separate Remittance Advice when it completes processing. The voided claim is always reported first.

**Note**: If Third Party Liability is the reason for your adjustment (beneficiary has other health insurance), file the adjustment as a Void/Replacement. The claim will update the beneficiary’s other health insurance information, which will flag future claims.

The Web Tool also offers an easy way to file your claims when South Carolina Medicaid is the secondary payer. CMS-1500 and UB-04 billers can file Medicaid secondary claims online without submitting a hard copy Explanation of Benefits (EOB) from the other insurance carrier. All of the required fields are on the Web Tool.
Web Tool Screen Features

Let’s get acquainted with some features you will encounter in the Web Tool screens:
- *Get from List* link
- Drop-down Boxes
- Navigation Buttons

**Get from List Link**
Whenever you encounter a *Get from List* link, one of your lists is available for reference and for populating the field. In the illustration below, there is a Beneficiary List available for use in populating the Beneficiary Info tab.

![Get from List Link: Click on the link to choose from your lists.](image-url)
Drop-down Boxes
These are available wherever you see a black arrow next to the field. Just click the arrow for a list of items you can use to populate the field. In this example, you have a Drop-down Box for Place of Service field.
**Navigation Buttons**

When you click one of these buttons, you will be transferred to another screen where you can key additional information necessary to complete the claim; *e.g.*, *Go to Provider Info* screen is illustrated below.

![Navigation Buttons: Click to bring up another screen in which to enter more detailed information.](image)
Add a Claim

1. From the Menu, hover over Claims Entry, then select CMS-1500 (Professional) Claims to retrieve the CMS-1500 Pending Claims screen.  
   Note: This screen displays links to both draft and completed claims and several features.

2. Select a provider from the drop-down menu at the top (reads: “Please select a provider to work with:”) and click the Select button.
   Note: You can only see provider numbers which have been submitted on the Trading Partner Agreement for your particular office.
Edit a Claim

1. From the CMS-1500 Pending Claims screen, click the link under the Name column for either draft or completed claims. The CMS-1500 Claim Entry screen displays and allows you to update that claim.

Copy a Claim

1. From the CMS-1500 Pending Claims screen, select one or more draft claims by clicking the checkbox.
2. Click the Copy Sel. button to make a copy of those claims in the draft claims.

Delete a Claim

1. From the CMS-1500 Pending Claims screen, select one or more draft or completed claims by clicking the checkbox.
2. Click the Delete Sel. button to delete those claims from the draft claims.

View a Claim

1. From the CMS-1500 Pending Claims screen, select one or more draft or completed claims by clicking the checkbox.
2. Click the View Sel. button to display the Claim View screen, showing all the claim details for the selected claims. From this screen, you can print one or all of the claim detail summaries.
3. Once you are in the Claim View screen, click the Go Back button to return to the CMS-1500 Pending Claims screen.

Search Name

1. From the CMS-1500 Pending Claims screen, enter the first or last name of the beneficiary in the field next to the Search Name button.
2. Click the Search Name button to filter the draft and completed claims to show only the rows where the first or last name is as you specified.
Enter New Claim

1. From the CMS-1500 Pending Claims screen, click the **Enter New Claim** button to display the CMS-1500 Claim Entry screen.

2. Follow the tabs from left to right to fill in all the data necessary to process the claim.

   **Note:** You can select the navigation button on the lower right-hand side to take you to the next tab, e.g., **Go to Provider** button
Get from List

1. To populate many of the fields using information from Lists, click the Get from List link. The corresponding selection data will display in a box, if you have created a list.
2. Click the link of the row you want to use to populate the fields.
**CHAPTER 4: CLAIMS ENTRY**

**CMS-1500**

**Finish Claim**

1. Click the **Finish Claim** button in the **Other Cov** tab to check for any final validation errors. If there are errors, you may update the information and click **Finish Claim** again. The **CMS-1500 Pending Claims** screen will appear and your claim will be catalogued under the **Completed Claims** table.
Add a CMS-1500 Adjustment Claim
1. From the Menu, choose **Claims Entry**, then **CMS-1500 (Professional) Claims** to retrieve the **CMS-1500 Pending Claims** screen.
2. From the **CMS-1500 Pending Claims** screen, click the **Enter New Claim** button.
3. Complete the information required under the **Beneficiary** and **Provider** tabs.
4. Select the **Misc Info** tab.
5. Under the **Create Adjustment** section, place a check in the **Initiate Adjustment Request** field.
6. Type the Claim Control Number (CCN) of the claim you want to void or void/replace in the **Orig. CCN** field.
7. Choose **Void/Replace** or **Void** from the **Reason Code** field.
Void Only
For a Void Only claim, do not add any claim detail lines.
1. Click the Finish Claim button in the Other Cov tab to save your Void Only claim.
2. Submit your adjustment using the Claim Submission function.

Void/Replacement
A claim is easily adjusted if the claim has not been purged from the Web Tool. You cannot adjust a paid original claim that was filed by any method other than the Web Tool.
1. Copy your claim as described earlier in this section.
2. Open the copied claim.
3. Type in the claim control number you want to adjust in the Original CCN field.
4. Make the necessary corrections to your claim.
   Note: If your original claim has been purged deleted from the Web Tool, you must enter your corrected line detail information in the CMS-1500 Detail Lines section.
5. Click the Finish Claim button in the Other Cov tab to save your replacement claim.
6. Submit your replacement claim using the Claim Submission function.
Add a Medicaid Secondary Claim

1. From the Menu, hover over Claims Entry, then select CMS-1500 (Professional) Claims to retrieve the CMS-1500 Pending Claims screen.
2. From the CMS-1500 Pending Claims screen, click the Enter New Claim button.
3. Complete the information required for each tab as you do for a regular claim.
4. Select the Other Cov tab.
5. Type in the other insurance carrier information or click the Get from List link to populate the fields from the Lists feature.
6. Click the Save Coverage Record button to add the record.
   - You may enter additional payers and save them.
   - You may edit, copy or delete these records using the:
     - Edit link
     - Copy Sel. Records button
     - Delete Sel. Records button
7. Click the Finish Claim button under the Other Cov tab to save your claim.
8. Submit your claim using the Claim Submission function.

![Image of CMS-1500 Claim Entry]

Click to Save, Copy or Delete

Click the Navigation button to finish the claim.
UB-04

Add a Claim

1. From the Menu, hover over Claims Entry, then select UB-04 (Hospital) Claims to retrieve the UB-04 Pending Claims screen.
   Note: This screen displays links to both draft and completed claims and several features.
2. Select a provider from the drop-down menu at the top (reads: “Please select a provider to work with:”) and click the Select button.
   Note: You can only see provider numbers which have been submitted on the Trading Partner Agreement for your particular office.

Click UB-04 (Hospital) Claims to enter a new claim.
CHAPTER 4: CLAIMS ENTRY

UB-04

Edit a Claim
1. From the *UB-04 Pending Claims* screen, click the link under the **Name** column for either draft or completed claims. The UB-04 Claim Entry screen displays and allows you to update that claim.

Copy a Claim
1. From the *UB-04 Pending Claims* screen, select one or more draft claims by clicking the checkbox.
2. Click the **Copy Sel.** button to make a copy of those claims in the draft claims.

Delete a Claim
1. From the *UB-04 Pending Claims* screen, select one or more draft or completed claims by clicking the checkbox.
2. Click the **Delete Sel.** button to delete those claims from the draft claims.

View a Claim
1. From the *UB-04 Pending Claims* screen, select one or more draft or completed claims by clicking the checkbox.
2. Click the **View Sel.** button to display the Claim View screen, showing all the claim details for the selected claims. From this screen, you can print one or all of the claim detail summaries.
3. Once you are in the *Claim View* screen, click the **Go Back** button to return to the UB-04 Pending Claims screen.

Search Name
1. From the UB-04 Pending Claims screen, type in the first or last name of the beneficiary in the field next to the **Search Name** button.
2. Click the **Search Name** button to filter the draft and completed claims to show only the rows where the first or last name is as you specified.

Use the checkbox to Copy, Delete, and View claims
Enter New Claim

1. From the UB-04 Pending Claims screen, click the Enter New Claim button to display the UB-04 Claim Entry screen.
2. Follow the tabs from left to right to fill in all the data necessary to process the claim.

   Note: You can select the navigation button on the lower right-hand side to take you to the next tab, e.g., Go to Provider button.
Get from List

1. To populate many of the fields using information from Lists, click the Get from List link. The corresponding selection data will display in a box, if you have created a list.
2. Click the link of the row you want to use to populate the fields.

Click the link to populate the fields.
Finish Claim

1. Click the **Finish Claim** button in the **Other Cov** tab to check for any final validation errors. If there are errors, you may update the information and click **Finish Claim** again. Otherwise, the **UB-04 Pending Claims** screen will appear and your claim will be catalogued in the **Completed Claims** table.
Add a UB-04 Adjustment Claim

A UB-04 adjustment claim can be submitted to void a claim that was originally submitted via the Web Tool.

1. From the Menu, choose **Claims Entry**, then **UB-04 (Hospital) Claims** to retrieve the **UB-04 Pending Claims** screen.
2. From the **UB-04 Pending Claims** screen, click the **Enter New Claim** button.
3. Complete the information required under the **Beneficiary** and **Provider** tabs.
4. Select the **Addl Info** tab.
5. In the **Type of Bill** field, select your adjustment bill type. For Void Only claims, the third digit of the type of bill is the number 8. The third digit for Void/Replacement claims is the number 7.
6. Type the CCN of the claim you want to void or void /replace in the Orig. CCN field.

**Void Only**

For a Void Only claim, do not add any claim detail lines.

1. Click the **Finish Claim** button under the **Other Cov** tab to save your Void Only claim.
2. Submit your adjustment using the Claim Submission function.

**Void/Replacement**

A claim is easily adjusted if the claim has not been purged from the Web Tool. You cannot adjust a paid original claim that was filed by any method other than the Web Tool.

1. Copy your claim as described earlier in this section.
2. Open the copied claim.
3. Type in the claim control number you want to adjust in the Payer Original CCN field.
4. Make the necessary corrections to your claim.
   *Note:* If your original claim has been purged deleted from the Web Tool, you must enter your corrected line detail information in the UB-04 Detail section.
5. Click the **Finish Claim** button under the **Other Cov** tab to save your replacement claim.
6. Submit your replacement claim using the Claim Submission function.
**Add a Medicaid Secondary Claim**

1. From the Menu, hover over Claims Entry, then select UB-04 (Hospital) Claims to retrieve the UB-04 Pending Claims screen.
2. From the UB-04 Pending Claims screen, click the Enter New Claim button.
3. Complete the information required for each tab as you do for a regular claim.
4. Select the Other Cov tab.
5. Type in the other insurance carrier information or click the Get from List link to populate the fields from the Lists feature.
6. Click the Save Coverage Record button to add the record.
   a. You may enter additional payers and save them.
   b. You may edit, copy or delete these records using the:
      i. Edit link
      ii. Copy Sel. Records button
      iii. Delete Sel. Records button
7. Click the Finish Claim button under the Other Cov tab to save your claim.
8. Submit your claim using the Claim Submission function.
CHAPTER 5: CLAIM SUBMISSION

Once you have entered your claims, you can then submit them for payment. If you wish to review the list of claims prior to submission, you can view all the claims by claim type from the Claims Submission Information section on the Claims Submission screen.

Claims submission works the same way for CMS-1500 and UB-04 claims. We will use the CMS-1500 claim type as an example.

1. From the Menu, choose Claim Submission. This will take you to the Claim Submission screen.
2. Type in your contact information or select from List Management by clicking the Get from List link.
3. In the Claim Submission Information section, click the Radio button by CMS-1500.
4. If you want to submit all claims within that batch:
   a. Click Submit. A pop-up screen will ask if you are sure you want to send the claims.
   b. Click the YES button to submit your claims.
5. If you want to submit only specific claims within a claim type:
   a. Click the **Edit** button to bring up the full list of claims.

Submit claims by claim type.

Submit claims by claim type.
b. Select the claims you wish to submit by clicking the **Radio** buttons next to the claim entries.

c. Click **Submit Select Claims**. A pop-up screen will ask if you are sure you want to send the claims.

d. Click the **YES** button to submit your claims.
The following screen appears and indicates successful claim(s) submission.

Thank you for submitting your claims via the web. We have received your transmission and will process your claims in a timely manner. Below is the summary of the batch.

- Claim #1 Claim ID: 333505
- Batch Number: 407593
- Batch ID number
- Batch Filename: 837PC39753.dat
CHAPTER 6: HISTORY

The History feature allows you to view specific claims that you have submitted via the South Carolina Medicaid Web-based Claims Submission Tool. You may choose to copy a claim into your Pending Claims list to rebuild a new claim. The Web Tool also allows you to print a particular claim, if needed.

Note: The South Carolina Department of Health and Human Services (SCDHHS) runs a monthly data purge on the first day of each month. This process deletes all submitted claims, submitted batches, and pending claims that are more than three months old from the Web Tool.

Viewing Claims History

1. Select a provider from the drop-down menu at the top (reads: “Please select a provider to work with:”) and click the Select button.
2. From the Menu, hover over History and select one of these options from the submenu:
   - Search Submitted Claims
   - Dental Submitted Batches
   - CMS-1500 Submitted Batches
   - UB-04 Submitted Batches

Search Submitted Claims

1. From the Menu, hover over History, and select Search Submitted Claims to retrieve the Claim History Search screen.
2. Select a Claim Type: CMS-1500 or UB-04
3. Optionally, select the **Show/Hide Search Filters** checkbox to display further search criteria. You may search by:
   - **Batch Information**
     - Batch ID
     - Submitted By
     - Submitted Date From (mm/dd/yyyy)
     - Submitted Date Before (mm/dd/yyyy)
   - **Recipient Information**
     - Medicaid ID
     - Recipient Account Number
     - Recipient First Name
     - Recipient Last Name

4. Click **Search** to retrieve information.
   **Note:** Click the **Clear** button to refresh the form.

---

Select CMS-1500 or UB-04.
CHAPTER 6: HISTORY

Search Submitted Claims

Claim History Search: Search Results
The search results display all submitted claims that meet the selected criteria. You may sort the claim data by the different column headings.

Copy a Claim
To copy a claim to the Pending Claims list in Claims Entry:

1. Click the Copy button next to the desired claim. You will receive this message: “You are leaving History and will be redirected to the Claims Listing page. The newly copied Claims will be listed under the Draft section on the Claims Listing Page.”
Claim View

To view detail on all of the displayed claims on the Claim History Search screen:

1. Click the View All button.
   - To view detail of one particular claim, click the Claim ID link for that claim under the View Claim Detail column.
The Claim View screen displays all of the claims or the one claim you chose to view.

2. From the Claim View screen, you may click on the following navigation and print options:
   - **Go Back**: Click to return to the Claim History Search screen.
   - **Print All**: Click to print a copy of all claims displayed.
   - **Print This Claim**: Click to print a copy of one selected claim.
**CMS-1500 Submitted Batches**

From the Menu, hover over History, and select CMS-1500 Submitted Claims to retrieve the CMS Submitted Batches screen. You may sort the claim data by the different column headings.

**Copy a Batch**

To copy a batch, so you can edit and re-submit it as a new batch:

1.) Click the **Copy** button.

2.) Click **OK** to the dialog box which reads: "You are leaving History and will be redirected to the Claims Listing page. The newly copied Claims will be listed under the Draft section on the Claims Listing Page."

![Copy a batch to edit and re-use.](image-url)
**View Batch Detail**

To view a list of all claims in a batch:

1. Click the selected Claim ID link under the **View Batch Detail** column.
The table displays the summary for each batch. You can sort by any column header:

- View Claim Detail (Claim ID)
- Recipient Last Name
- Recipient First Name
- Recipient Account Number
- Recipient Medicaid ID
- Total Charge
- Balance Due

<table>
<thead>
<tr>
<th>Copy</th>
<th>View Claim Detail</th>
<th>Recipient Last Name</th>
<th>Recipient First Name</th>
<th>Recipient Account Number</th>
<th>Recipient Medicaid ID</th>
<th>Total Charge</th>
<th>Balance Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>125289</td>
<td>CAIN</td>
<td>10540164</td>
<td>$60.02</td>
<td>$60.02</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>125281</td>
<td>HAYES</td>
<td>10497074</td>
<td>$269.00</td>
<td>$269.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>125283</td>
<td>JONES</td>
<td>10534409</td>
<td>$151.83</td>
<td>$151.83</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>125283</td>
<td>WHITENBERG</td>
<td>10520557</td>
<td>$52.00</td>
<td>$52.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>125284</td>
<td>BENTON</td>
<td>10497582</td>
<td>$444.00</td>
<td>$330.24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>125285</td>
<td>MOON</td>
<td>10580101</td>
<td>$30.93</td>
<td>$30.93</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>125286</td>
<td>MOON</td>
<td>10491184</td>
<td>$58.21</td>
<td>$58.21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>125287</td>
<td>McCULLOUGH</td>
<td>10535528</td>
<td>$20.00</td>
<td>$20.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>125289</td>
<td>HUBBARD</td>
<td>10574850</td>
<td>$28.00</td>
<td>$28.20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>125292</td>
<td>HUBBARD</td>
<td>10564360</td>
<td>$272.00</td>
<td>$175.16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>125293</td>
<td>HUBBARD</td>
<td>10496079</td>
<td>$470.00</td>
<td>$330.10</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Claim View

To view the detail of an individual claim:

1. Click the Claim ID link for that claim under the **View Claim Detail** column to view the detail of one particular claim.
   - Click the **View All** button to view detail on all of the displayed claims.
   - Click **Go Back** to return to the **CMS-1500 Submitted Batches** screen.
CHAPTER 6: HISTORY

UB-04 Submitted Batches

From the Menu, hover over History, and select UB-04 Submitted Claims to retrieve the UB Submitted Batches screen. You may sort the claim data by the different column headings.

Copy a Batch

To copy a batch, so you can edit and re-submit it as a new batch:
1. Click the Copy button.
2. Click OK to the dialog box which reads: “You are leaving History and will be redirected to the Claims Listing page. The newly copied Claims will be listed under the Draft section on the Claims Listing Page.”
CHAPTER 6: HISTORY
UB-04 Submitted Batches

View Batch Detail
To view a list of all claims in a batch:
1. Click the selected Claim ID link under the View Batch Detail column.

Click the selected Claim ID link.
The table displays the summary for each batch. You can sort by any column header:

- View Claim Detail (Claim ID)
- Recipient Last Name
- Recipient First Name
- Recipient Account Number
- Recipient Medicaid ID
- Total Charge
- Balance Due
Claim View

To view the detail of an individual claim:

1. Click the Claim ID link for that claim under the View Claim Detail column to view the detail of one particular claim.

   Note: Click the View All button to view detail on all of the displayed claims. Click Go Back to return to the UB-04 Submitted Batches screen.
CHAPTER 7: STATUS

Whether or not you use the South Carolina Medicaid Web-based Claims Submission Tool to enter and submit your claims, you can check claims status for CMS-1500 (A), UB-04 (Z), and Premium Payment (J) claims, as well as their associated adjustments (U). The Provider ID is required to complete your search. You also have the ability to narrow your search results. Claims are available for search using the Status feature for up to six months from the check date for paid or rejected claims, and up to six months from the process date for approved, denied or suspended claims.

Check Status

3. Select a provider from the drop-down menu at the top (reads: “Please select a provider to work with:")) and choose the Select button.

Note: You can only see provider numbers which have been submitted on the Trading Partner Agreement for your particular office.

4. From the Menu, choose Status to retrieve the Claim Status screen.
CHAPTER 7: STATUS

Filter Results

1. Check the option *Show/Hide Additional Search Options*. A menu of search fields will appear.
2. Type in criteria to contain the results:
   a. Medicaid ID
   b. Claim Control Number (CCN)
   c. To/From Dates of Service (mm/dd/yyyy)
   d. Min/Max Amount Billed (Only use numbers, and a period if needed. Special characters and signs like +, -, $ are not allowed.)
3. Click *Search* to display the results of your query. (Alternatively, click *Clear* to reset the form fields to blank.)

Narrow the search by entering your criteria.
No Search Results
If the search criteria you entered yields no results, a message will display: *There is no data to display.* A search may not yield results if:
- The claim(s) have not been adjudicated.
- The claim(s) have been purged from the system (older than six months from the check date for paid or rejected claims, or older than six months from the process date for approved, denied or suspended claims).
- Your search criteria were inaccurate (incorrect Provider ID or Medicaid ID).
- Your search criteria were too narrow.

If you enter data that is not valid for the field, you will be prompted to correct the error.
To try again, refine the data in the search fields and click *Search.*
CHAPTER 7: STATUS

Sort Results
Click any underlined header (example: Date of Service) to sort the claims table by that column. Note:

- Your first click will sort the data ascending. Click it again, to sort the list descending.
- You can only sort by one column at a time.
- The arrows below the header values will indicate how the data is sorted:
  - Double arrow: not sorted
  - Arrow up: ascending
  - Arrow down: descending

![Image of claims table with sorting arrows highlighted]

This column is sorted descending (arrow down).

This column is not sorted (double arrow).
Claims Status Results
The Claims Status screen displays all claims that are associated with the Provider ID that have not been purged (deleted) from the Web Tool.

The columns appear in the following order:

<table>
<thead>
<tr>
<th><strong>CCN</strong></th>
<th>Claim control number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beneficiary Name</strong></td>
<td>The last name of the beneficiary followed by first and middle initials</td>
</tr>
<tr>
<td><strong>Medicaid ID</strong></td>
<td>The beneficiary’s 10-digit Medicaid ID number</td>
</tr>
<tr>
<td><strong>Amount Billed</strong></td>
<td>Total amount South Carolina Medicaid was billed for the claim</td>
</tr>
<tr>
<td><strong>Date of Service</strong></td>
<td>Date of service range for the claim</td>
</tr>
<tr>
<td><strong>Check Date</strong></td>
<td>Date the payment cycle was finalized. For claims with a “Paid” status, the check date is the date on the actual check or the date the electronic funds transferred to your account. For claims with a “Rejected” status, the check date is the Remittance Advice (RA) date</td>
</tr>
<tr>
<td><strong>Check Num</strong></td>
<td>(Check Number): Number of your payment check or, if you use electronic funds transfer, the transaction number provided by your financial institution</td>
</tr>
<tr>
<td><strong>Payment Type</strong></td>
<td>Indicates whether the payment was made by check (CHK) or by electronic funds transfer (ACH)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>Amount paid based on adjudication through the South Carolina Medicaid claims processing system</td>
</tr>
<tr>
<td><strong>Claim Status</strong></td>
<td>Status of the claim currently in South Carolina Medicaid’s system</td>
</tr>
<tr>
<td><strong>Claim Status Date</strong></td>
<td>Date the claim last processed through the adjudication system for claims with a status of “Approved”, “Denied” or “Suspended”</td>
</tr>
<tr>
<td><strong>Original CCN</strong></td>
<td>Original CCN for adjustment (U) claims that were submitted</td>
</tr>
</tbody>
</table>
Claim Status Codes

The table below shows the five possible claim status options. The sortable column headings on the Claims Status — Search Results screen display across the first row. The check marks indicate that information will appear for that particular status. BLANK simply states that information will not be returned for that status.

<table>
<thead>
<tr>
<th>CLAIMS STATUS</th>
<th>CCN</th>
<th>Beneficiary Name</th>
<th>Medicaid ID</th>
<th>Amount Billed</th>
<th>Dates of Service</th>
<th>Check Date</th>
<th>Check Number</th>
<th>Payment Type</th>
<th>Total Payment</th>
<th>Claim Status Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAID</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>BLANK</td>
</tr>
<tr>
<td>~Claim Payment Made</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APPROVED</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>BLANK</td>
<td>BLANK</td>
<td>BLANK</td>
<td>✓</td>
</tr>
<tr>
<td>~Claim Processed and Payment Scheduled</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>REJECTED</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>BLANK</td>
<td>BLANK</td>
<td>BLANK</td>
<td>BLANK</td>
</tr>
<tr>
<td>~Claim Processed through Payment Cycle; ECF Issued</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DENIED</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>BLANK</td>
<td>BLANK</td>
<td>BLANK</td>
<td>BLANK</td>
</tr>
<tr>
<td>~Claim Adjudicated, Assigned Edit Code(s), and Approval Denied</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUSPENDED</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>BLANK</td>
<td>BLANK</td>
<td>BLANK</td>
<td>✓</td>
</tr>
<tr>
<td>~Claim in Process</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Claims Processing Cycle

Wednesday through Monday – Claims process each night.
*Tuesday – Payment runs.
Friday – Payment is applied for Electronic Funds Transfer.

*Once the Payment Cycle runs, the Approved status will change to Paid and the Denied status will change to Rejected.
Verify One Recipient

1. Select a provider from the drop-down menu at the top (reads: “Please select a provider to work with:”) and click the Select button.
   Note: You can only see provider numbers which have been submitted on the Trading Partner Agreement for your particular office.
2. From the Menu, hover over Eligibility and choose Single Query to retrieve the Eligibility Verification Inquiry screen.
3. Enter your selection criteria in one of the following three possibilities:
   - Date of Service, Medicaid ID
   - Date of Service, Date of Birth, Social Security Number (SSN)
   - Date of Service, Date of Birth, Full Name
4. Click the Check Eligibility button.
The next screen you will see is the *Eligibility Verification Inquiry: Selection Summary* screen. Place a check in the *Sel* column beside the beneficiary’s information, and click the *Display* button to view the beneficiary’s eligibility results.
Eligibility Verification Results

Once you make a selection from the Selection Summary screen, you will see the detailed results for that recipient(s) on the Eligibility Verification Results screen. If you choose multiple recipients’ results to view, they will be listed one after the other. From this screen you can:

- Research data concerning: the beneficiary, benefit information, the beneficiary’s special programs, and third party liability (TPL).
- Print a single beneficiary’s record (Print Response button)
- Print all the beneficiaries’ records listed on the page (Print All button)
- Add a single beneficiary to your beneficiary list (Add Beneficiary link)
- Add all the beneficiaries listed to your beneficiary list (Add All Beneficiaries button)
- Click Back (link) to return to the Selection Summary screen

Adding Beneficiaries to Lists

You can select Add Beneficiary or Add All Beneficiaries from the Eligibility Verification Results screen to add that person(s) to your Lists.

- If successful, you will receive a confirmation message: Beneficiary List - Insert Summary: A total of X Beneficiaries have been selected to be added to your list. Any errors found are listed below.
• Otherwise, you may receive a message like this: **ERRORS FOUND: You have selected to add a Beneficiary, MedicaidID: [xxxxxxxxxx], from Eligibility that is already on file. Please correct and re-enter.**
• To remove these confirmation and error messages, click the Close Summary button to return to the original Eligibility Verification Results view.

**Verify Multiple Recipients**

1. From the Menu, hover over Eligibility and choose Multiple Queries to retrieve the Eligibility Verification Inquiry screen.
2. Select a provider from the drop-down menu at the top (reads: “Please select a provider to work with:”) and choose the Select button.
3. Type the Date of Service you are seeking in the Date of Service field (format: mm/dd/yyyy)
   a. Select the Change Dates button to update all the search fields, if needed.
4. In the Key Type column, select whether you are searching by:
   a. Medicaid ID
   b. *SSN
   c. *Name (Must be an exact match, including middle initial)
   *Requires: Date of Birth; format: mm/dd/yyyy or mm-dd-yyyy
5. Click the Submit button to display results.
   **Note:** Click Clear to refresh both fields.
Add from Beneficiary List
You can manually type in beneficiary information to search eligibility. Alternatively, you may select beneficiaries that you have already stored in your Beneficiary List.

1. From the Eligibility Verification Inquiry screen, click the Beneficiary List button. This will open the Beneficiary Selection List screen.

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Key Type</th>
<th>Key Value</th>
<th>Birth Date</th>
<th>Date of Service</th>
<th>Key Type</th>
<th>Key Value</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
</tr>
<tr>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
<td>08/30/2011</td>
<td>Medicaid</td>
<td>DOB</td>
<td></td>
</tr>
</tbody>
</table>
2. Click on the Medicaid ID link to select a single beneficiary. (You will automatically return to the *Eligibility Verification Inquiry* screen with that beneficiary’s Medicaid ID populated in the **Key Value** field.)

- Alternatively, select the checkbox next to each beneficiary you want to transfer from your **Beneficiary List**. Or, click the **Select All** button to check all the boxes.
- Select the **Clear All** button to refresh the checkboxes to blank.
- Finally, click the **Populate Query** button to transfer all selected beneficiaries to the *Eligibility Verification Inquiry* screen.
- The **Cancel** button returns you to the *Eligibility Verification Inquiry* screen with no changes made.
Eligibility Results
Once you submit a request from the Eligibility Verification Inquiry screen, the Eligibility Verification Inquiry: Selection Summary screen opens, displaying the:

- Medicaid ID
- Name
- Date of Birth
- Status (eligible or ineligible)
- Gender
- Date of Service

You might instead receive a message that: “The Subscriber entered was not found in our database.” If that happens, you may need to refine your search request.

There are several ways to view individual or multiple query details.

- Individual details may be displayed by clicking on the hyperlink within the Medicaid ID box, or by clicking on one of the checkboxes and then clicking the Display button.
- Multiple details may be selected by clicking multiple checkboxes and then clicking the Display button; or to see all details, click the Display All button.
The purpose of an Electronic Remittance Package (e-Remit) is to show all payments, denials, and any accompanying claims data submitted to South Carolina Medicaid. The electronic process allows providers to access remittance advices and associated edit correction forms (ECFs) through the South Carolina Medicaid Web-Based Claims Submission Tool (Web Tool). Providers can view, save, and print their remittance advice(s), but do not have access to other providers’ remittance information. Remittance advices and ECFs for the most recent twenty-five (25) weeks are available after which the oldest week will purge, allowing the latest week to be available for view. To obtain any remits older than 25 weeks, you must contact your program area representative.

Distributing remittance advices and associated ECFs through the Web Tool is a more cost-effective and secure manner for providers to receive this information. Also, providers are able to access this information earlier. Electronic remittance packages are available no later than the Friday morning the remittance is dated.

**Viewing e-Remits**

1. From the Menu, choose **e-Remit** to retrieve the Remittance Selection Screen.
2. Once, you have clicked **e-Remit**, you must then select a provider from the drop-down menu at the top (reads: “Please select a provider to work with:")) and click the **Select** button.
3. You may now choose to open, save and/or print your desired e-Remit from the list of available Remits.

*Note:* Remits are in PDF format which requires you to use ADOBE READER 9.0 to open and print the file.
Click *Open* to display your desired e-Remit.

**Saving e-Remits**

1. After clicking your desired e-Remit, click *Save* to save your e-Remit.
2. Choose your desired drive or save destination.
Printing e-Remits

1. Select **File** from the browser bar.
2. Select **Print** from the File menu.

**Note:** Remember to set page scaling to “Shrink to Printable Area” to ensure all content is visible.
To close the document, click on the “X” in the upper right-hand corner of the screen.

Select “Shrink to Printable Area.”
CHAPTER 10: REFERENCE MATERIALS

The Contact link in the upper-right of the Home screen includes contact information for the South Carolina Medicaid Electronic Data Interchange (EDI) Support Center.

Web Tool Publications include:

- **The Web Tool User Guide**
- **The CMS-1500 and UB-04 Addenda**: Each Addendum describes the relationship between the Web Tool screen fields and the CMS-1500 and UB-04 paper claim fields.
- **The Web Tool Times**: South Carolina Department of Health and Human Services (SCDHHS) publishes a quarterly newsletter that provides users with the latest information about the Web Tool. The newsletter focuses on specific topics that need clarification, and also includes information about revisions and enhancements to the Web Tool as they are developed.
- **The Web Tool Quick Reference Guide**: The Quick Reference Guide summarizes the most frequently used claims submission commands. The guide is designed to give users quick access to instructions on how to enter, submit, and/or check the status of their claims and adjustments.
## DOCUMENT CHANGE HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description of Change</th>
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<tbody>
<tr>
<td>06/11/2012</td>
<td>Page 70: Chapter 8, Updated Eligibility screenshot to reflect newly added MCO/MHN eligibility verification fields.</td>
</tr>
<tr>
<td>03/06/2012</td>
<td>Page 41: Chapter 4, Added verbiage about the Noncontracted amount field.</td>
</tr>
<tr>
<td>02/28/2012</td>
<td>Updated TOC fields to reflect new page numbers.</td>
</tr>
<tr>
<td>02/28/2012</td>
<td>Page 41: Chapter 4, Updated UB-04 screenshot with the non-contracted provider field.</td>
</tr>
<tr>
<td>02/28/2012</td>
<td>Page 36: Chapter 4, Updated CMS-1500 screenshot with the non-contracted provider field.</td>
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<tr>
<td>02/28/2012</td>
<td>Page 35: Chapter 4, Updated CMS-1500 screenshot with the non-contracted provider field.</td>
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<tr>
<td>02/28/2012</td>
<td>Page 33: Chapter 4, Updated CMS-1500 screenshot with the non-contracted provider field.</td>
</tr>
<tr>
<td>01/06/2012</td>
<td>Entire document updated to reflect Web Tool Redesign header change.</td>
</tr>
<tr>
<td>01/06/2012</td>
<td>Page 2: Chapter 2, Inserted important login and password requirement information.</td>
</tr>
<tr>
<td>08/24/2011</td>
<td>Entire document updated to reflect Web Tool Redesign.</td>
</tr>
<tr>
<td>08/10/10</td>
<td>Updated Title page to reflect new revision date.</td>
</tr>
<tr>
<td>08/10/10</td>
<td>Updated TOC fields to reflect new page numbers.</td>
</tr>
<tr>
<td>08/10/10</td>
<td>Page 39: Chapter 4, Inserted new 1st paragraph, Important Notice for Dental Providers (in red).</td>
</tr>
<tr>
<td>08/10/10</td>
<td>Page 43: Chapter 4, Inserted Important Notice for Dental Providers info.</td>
</tr>
<tr>
<td>08/10/10</td>
<td>Page 47: Chapter 4, Incorrect screen shot on this page. Inserted correct screen shot.</td>
</tr>
<tr>
<td>08/10/10</td>
<td>Page 72: Chapter 6, Deleted info re: copying a claim. Same info covered on next page in Copy a Claim section.</td>
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<tr>
<td>08/10/10</td>
<td>Page 73: Chapter 6, Deleted info re: viewing claims not yet submitted. Same info covered on previous page.</td>
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<tr>
<td>08/10/10</td>
<td>Page 86: Chapter 9, Deleted Medicaid ID # from 2nd screen shot.</td>
</tr>
<tr>
<td>08/10/10</td>
<td>Page 89, Chapter 10, Deleted “Providers are urged to use this new feature now so that any potential issues can be resolved prior to February 1, 2010.” Out dated information. Changed future tense language on the page to present tense.</td>
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<tr>
<td>08/10/10</td>
<td>Page 100: Chapter 10, Deleted part of 1st sentence that refers to searching for the e-remit using provider number. By this time user reaches this step, he/she has already searched for and found the e-remit.</td>
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<tr>
<td>05/10/2010</td>
<td>Added new Chapter 10, Electronic Remittance Packages to the Table of Contents.</td>
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<tr>
<td>05/10/2010</td>
<td>Added new Chapter 10, Electronic Remittance Packages, pages 87 – 103.</td>
</tr>
<tr>
<td>05/10/2010</td>
<td>Updated screen shots throughout User Guide to reflect e-Remit Package.</td>
</tr>
<tr>
<td>04/27/2010</td>
<td>Page 6, in the last paragraph capitalized List Management.</td>
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<tr>
<td>04/27/2010</td>
<td>Deleted references to Dental throughout the User Guide to include the Table of Contents and a whole section.</td>
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<tr>
<td>04/27/2010</td>
<td>Changed the word recipient to beneficiary throughout the User Guide.</td>
</tr>
<tr>
<td>09/09/2009</td>
<td>Updated all screen shots to show the HIDE/MENU feature described on page 4.</td>
</tr>
<tr>
<td>07/27/2009</td>
<td>Page 17: Added new screen shot showing the second half of the Insured screen and the Edit and Delete buttons related to that screen shot.</td>
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<tr>
<td>07/24/2009</td>
<td>Page 85: Added call outs for Provider ID and NPI Information in addition to callout for Name and DAB or SSN and DOB.</td>
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<td>12/01/07</td>
<td>Pages 37, 40, 43: Updated screenshots due to the addition of the Prior Authorization Qualifier field in the Recipient Information section of the CMS-1500 main screen.</td>
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<tr>
<td></td>
<td>12/01/07 Page 39: Corrected explanatory box to reflect a valid purge date for the example given.</td>
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<td>12/01/07 Page 54: Corrected the second bullet under Step 3 to say, “Click the UB Insurance Add/Edit Details button.”</td>
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<td></td>
<td>12/01/07 Pages 54, 58, 60, 61, 62: Replaced all UB Insurance Add/Edit Details screenshots to reflect the addition of new fields for Claim Adjustment Reason Codes and Amounts that correspond with the code(s).</td>
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<tr>
<td></td>
<td>12/01/07 Page 87: Replaced screenshot to display the deletion of the SSN column from the Eligibility Verification Multi Inquiry Results screen.</td>
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<tr>
<td></td>
<td>12/01/07 Page 88: Changed the first paragraph to delete reference to the Self-paced Training Guide; this option is no longer available on the Web Tool.</td>
</tr>
<tr>
<td>06/07/07</td>
<td>Corrected the original publication date on the cover page to reflect the correct date of February 1, 2004.</td>
</tr>
<tr>
<td>05/25/07</td>
<td>Revised instructions in the Eligibility section to include the Date of Birth as required when searching by the recipient’s Social Security number.</td>
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<td></td>
<td>05/25/07 Updated instructions and screenshots in the Claims Status section to include the new option to provide the NPI when performing a claims status search.</td>
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<tr>
<td></td>
<td>05/25/07 Replaced screenshot on page 84 to reflect the deletion of the Social Security and family number fields on the Eligibility Verification Results screen.</td>
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<tr>
<td></td>
<td>05/25/07 Changed all Claims Entry screenshots to illustrate the addition of the Billing Provider Zip Code field.</td>
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<tr>
<td></td>
<td>05/25/07 Updated all screenshots to reflect the implementation of the UB-04 Claim Form.</td>
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<tr>
<td></td>
<td>05/25/07 Changed all instructions that reflected UB-92 to UB-04.</td>
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<tr>
<td>01/01/07</td>
<td>Page 9: New screenshot illustrates the deletion of the address, city, state, zip, phone, extension, and status columns in the View Contact Information table at the bottom of the screen.</td>
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<tr>
<td></td>
<td>01/01/07 Page 46: Updated screenshot to reflect the Service Facility Location Zip.</td>
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<tr>
<td>11/01/06</td>
<td>Updated all screenshots to show the National Provider Identifier (NPI) fields (where applicable) and the Internet browser and task bar.</td>
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<tr>
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<td>11/01/06 Page 58: Removed the claim control number entry instruction from step 9 and incorporated the instruction in step 10</td>
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<tr>
<td></td>
<td>11/01/06 Pages 57, 59: Replaced screenshots to reflect the deletion of Treatment Authorization Codes B and C</td>
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<tr>
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<td>11/01/06 Page 60: Removed the Drop-down Box selection instruction for the Patient Relationship, Insured Responsibility Sequence, and Claims Filing Indicator fields and incorporated the instruction in step 7</td>
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<td>11/01/06 Page 79: Updated text and replaced screenshot to reflect the fix to the Recipient Last Name field to sort by the recipient’s last name and first name</td>
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<tr>
<td></td>
<td>11/01/06 Page 83, 84: Removed the Recipient Eligibility Information screenshot with corresponding CoPay field verbiage from page 83 and inserted information in new page 84</td>
</tr>
<tr>
<td>09/01/05</td>
<td>Complete revision to incorporate all previous changes and new material on Claims Status and Web-Submitted Claims</td>
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