



(A quick guide for Standalone users)

Version 2.0.2

CLAIM-it

. Generate . Submit . Analyze

The provider-end claims generation application

Contents

1.0	GENERAL INFORMATION	5
1.1	System Overview	5
1.2	Organization of Manual.....	5
2.0	GETTING STARTED	7
2.1	System Requirements.....	8
2.2	Installation.....	8
2.3	Starting Claim-IT	10
2.4	Loading Credentialing File	12
2.5	Changing Username and Password	14
3.0	ADDING USERS	15
3.1	General Overview.....	16
3.2	User Roles	16
3.3	Creating Users.....	17
3.4	Editing Users	20
3.5	De-activating/Blocking Users	21
1.3	Deleting Users.....	22
4.0	USING THE SYSTEM	23
4.1	General Overview.....	24
4.2	General Outlook	24
4.2.1	Home Screen and Navigation of views	24
4.3	Generating Claims	28
4.3.1	Entering member details	34
4.3.2	Entering Dates.....	34
4.3.3	Entering Service details	35
4.3.4	Entering GDRGs.....	36
4.3.5	Entering Diagnosis/ICD-10s	37
4.3.6	Entering Medicines	39
4.3.7	Adding Entries.....	40
4.3.8	Editing and Deleting Entries	40
4.3.9	Attachment of Documents.....	41
4.3.10	Adding Comments to Claims	42
4.3.11	Adding Patient Vitals to a Claim	43
4.4	Saving Claims.....	46
4.5	Editing Claims	48
4.6	Deleting Claims.....	48

4.7	Searching for claims.....	48
4.8	Preparing Claims for Submission (Exporting Claims).....	49
4.9	Exporting and Importing claims.....	53
5.0	UPDATING THE SYSTEM	55
5.1	General Information	56
5.2	System Update.....	56
5.3	Installing Updates	56
5.3.1	Direct Update	56
5.3.2	Offline Update.....	57
6.0	REPORTING	59
6.1	General Information	60
6.2	Types of Report.....	60
6.3	Accessing reports.....	61
6.4	Submission Advice Report.....	63
7.0	DATA BACKUP.....	65
7.1	General Information	66
7.2	Backup Feature	66
8.0	TROUBLESHOOTING.....	68
8.1	General Information	69
8.2	Troubleshooter Utilization	69
9.0	SOFTWARE UNINSTALLATION.....	71
9.1	General Information	72
9.2	Uninstalling CLAIM-it	72

TABLE OF TABLES AND FIGURES

Figure 2-1: CLAIM-it shortcut icon	11
Figure 2-2 : CLAIM-it Login screen	11
Figure 2-3 : CLAIM-it Home screen	11
Figure 2-4 : CLAIM-it change password screen.....	14
Figure 3-1: Options menu	17
Figure 3-2: User management option	18
Figure 3-3: User addition form.....	18
Figure 3-4: User role selection.....	19
Figure 3-5: Activating a user	19
Figure 3-6: List of users.....	20
Figure 3-7: User edit form.....	20
Figure 3-8: List of users with arrow showing the active/de-activate toggle button.	21
Figure 3-9: List of users with arrow showing a de-activated user.....	21
Figure 3-10: User management with arrow showing the delete button.....	22
Figure 3-11: Deletion confirmation.....	22

Figure 4-1: Navigation flow through the various vies of the application	24
Figure 4-2: Home screen of the application with no claims data	25
Figure 4-3 : Drop down menu for changing year in view	25
Figure 4-4: Home screen of the application with claims data	26
Figure 4-5: List of claims for a month.....	26
Figure 4-6: Claim Preview	27
Figure 4-7: Claims entry form	28
Figure 4-8: Patient detail section	29
Figure 4-9: Illustration of dependent confirmation	30
Figure 4-10 : Service details section	31
Figure 4-11 : Procedure section.....	31
Figure 4-12 : Diagnoses section.....	32
Figure 4-13 : Investigation section.....	32
Figure 4-14 : Pre-authorization section	33
Figure 4-15: Data entry utility.....	33
Figure 4-16: Entry utility descriptions.....	34
Figure 4-17: Date picker for date selection	35
Figure 4-18: The service section of the claim form.....	35
Figure 4-19 : GDRG Entries	36
Figure 4-20 : GDRG Selection.....	37
Figure 4-21: Adding diseases using direct search	38
Figure 4-22: Adding diseases using extended search/ Adding exception diagnosis	38
Figure 4-23: Making medicine and prescription entries.....	39
Figure 4-24: Alternative prescription entry	40
Figure 4-25: Adding entries (excerpts from diagnosis entry).....	40
Figure 4-26: Editing entries	41
Figure 4-27 Attachment section of entry form.....	41
Figure 4-28: Attachment Details.....	42
Figure 4-29: View for an attached file	42
Figure 4-30: Addition of comments	43
Figure 4-31: Patient Vitals Form	44
Figure 4-32: Addition of vitals	44
Figure 4-33: Capturing and saving vitals	45
Figure 4-34: List of captured vitals	46
Figure 4-35: Saving claims showing validation pane	46
Figure 4-36: Successfully saved claim	47
Figure 4-37: Claims preview page.....	47
Figure 4-38: Claims list page showing the Export button.....	50
Figure 4-39: Claims Submission / Export page.....	50
Figure 4-40: Confirmation for online submission	51
Figure 4-41: Submission progress monitor	51
Figure 4-42: Submission status indicator	52
Figure 4-43: Submission feedback	52
Figure 4-44: Merge claims dialog box	54
Figure 4-45: Uploaded export file for merging	54
Figure 5-1: Home screen showing the Provider info section	57
Figure 5-2: Provider info view showing updated details.....	58
Figure 6-1: Dashboard	61
Figure 8-1: Automatic trouble-shooter prompt	69

1.0 GENERAL INFORMATION

This section explains in general, the system and its intended purpose.

1.1 System Overview

CLAIM-it is a software that serves as a platform which allows health providers credentialed by the National Health Insurance to generate and submit claims. It implements and enforces all the necessary claims generation rules and protocols of the NHIS. Hence all claims submitted for reimbursement have to be validated by the software therefore ensuring due diligence prior to claims submission. The application runs fully offline allowing users to interact with the internet only where necessary for the purposes of system updates and claims submission.

CLAIM-it can be installed and operated on a single user computer or implemented as a network application with as many user nodes as needed. It can also be integrated into any existing Hospital Health Management System (HMS).

Claims are submitted electronically by downloading and saving claims on a flash drive for later submission or submitted directly to NHIS over the internet. The application also has a printing feature for the printing of claims where necessary.

1.2 Organization of Manual

The user's manual consists of **nine (9)** major sections: General Information, Getting Started, Adding Users, Using the System, Updating the system, Reporting, Data Backup, Troubleshooting and Software Uninstallation.

The General Information section explain, in general, the purpose of the system as well as providing an overview of the system and its usefulness.

The Getting Started section explains the basic requirements for the software for successful installation and operation as well as where to find help when needed.

The Adding Users section touches on how to add users to the applications as well as the various user roles and privileges or access levels within the application.

The Using the System section provides a detail description of all features of the application.

The Updating system section also provides a detailed walk through the update feature of the application.

The Reporting section of this manual presents to the user the various reports available for the data captured by the application.

The Data backup section touches on the data backup features of the application and how to prepare for unplanned system failures.

The Troubleshooting section of this manual will bring into perspective the troubleshooting feature of the application, showing how to get the application back online should you encounter any technical difficulties.

The Software Uninstallation section takes users through the process of removing the application from the user's computer.

2.0 GETTING STARTED

This section explains the basic requirements of the software for successful installation and operation.

2.1 System Requirements

The following are the minimum requirements for optimum performance of the application:

Table 2-1: Minimum system requirements

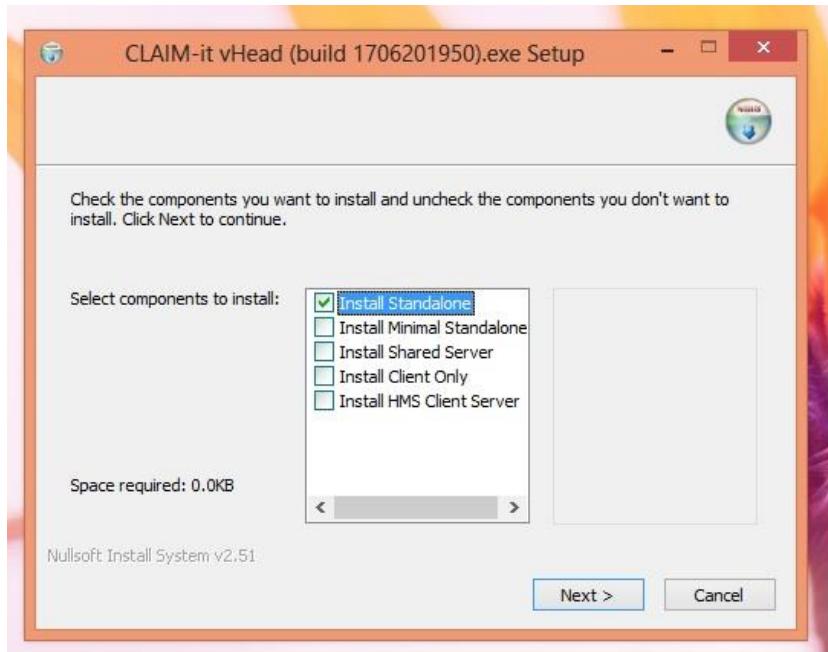
Operating System	Windows 7 or later
Processor	Dual core, 2.0GHz
Memory	2GB
Storage Space	120 GB

Note: System requirements are subject to the volume of claims being processed by the facility. Hence, higher memory allocation, for instance, is recommended for computers processing greater claims volumes.

2.2 Installation

This user manual assumes you already have a copy of the setup file for the software. However, you can always visit the **NHIS CLAIM-it website (claimit.nhia.gov.gh)** to download a new copy of the setup file.

To install the software, double-click on the setup file and follow through the various prompts to complete your installation. In addition to the software (CLAIM-it), the setup file contains all the pre-requisite applications necessary for the smooth operations of the application. Hence, all pre-requisites will be installed before the software is configured on your computer. The following illustrates the installation process.

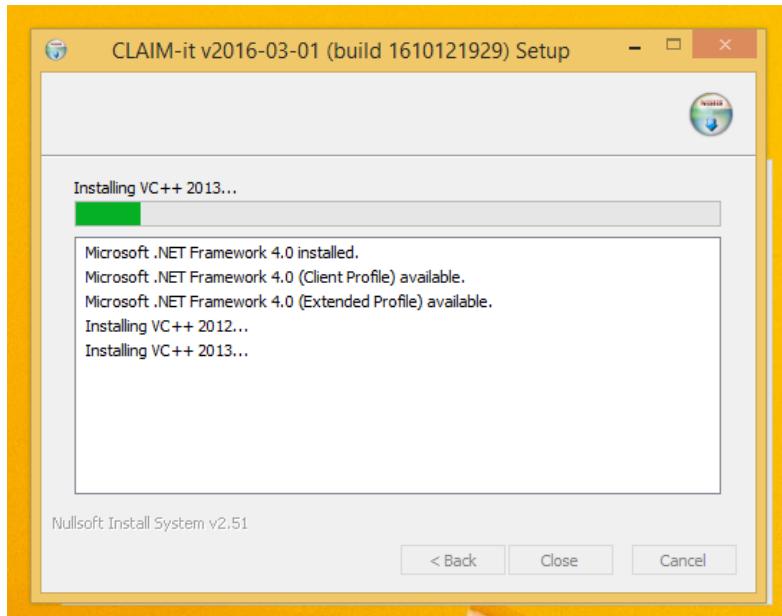


If the installation is for a single independent computer, use the default setting, else select the option that applies to your setting. Below are brief explanations to the various installation types.

- a. **Install Standalone:** This installs and configures the CLAIM-it installation as an independent environment where the database resides locally on the computer.
- b. **Install Minimal Standalone:** This is much similar to the standalone installation. However, this is more suited if the computer has a lower memory size of about 1GB or a few MB short of the minimal requirements.
- c. **Install Shared Server:** This option configures the computer to serve other CLAIM-it users (Client user) that are connected to it. Hence, it hosts both the server and the database. This configuration is suitable for environments with a Local Area Network (LAN).
- d. **Install Client Only:** This option installs only the client version of the application. This option assumes that the client will be connecting to a CLAIM-it server via a network address. A local database is therefore not installed on this computer. Note that for the client to work, the server has to be up and running.
- e. **Install HMS Client Server:** This configures the computer just like a standalone installation. The only difference here is that the software is configured to receive and process claims XML files generated from a Health Management System (HMS) that is compliant with the CLAIM-it standards. Hence, direct claims

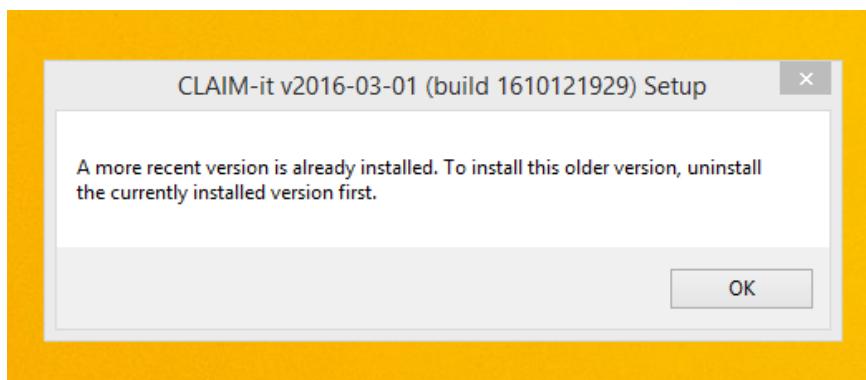
addition/generation cannot be performed via the application. All corrections will have to be done from the primary source of the data. i.e. HMS.

Click on install to start the installation process



Installation in progress

If there is an already existing installation, the application determines if the installed version is higher than that being installed. If it is older, you will be prompted to uninstall the current version as shown in the figure below.



2.3 Starting Claim-IT

After installation double-click on the CLAIM-it shortcut icon located on the desktop of your computer (Figure 2-1). This will initialize the application and popup a login screen. The default username and password are **admin** and **admin** respectively. Illustrated in Figure 2-2.

Figure 2-1: CLAIM-it shortcut icon



Figure 2-2 : CLAIM-it Login screen

The login screen consists of two panels. The left panel is white with a dark teal header containing the NHIS CLAIM-it logo and three buttons: "generate", "submit", and "analyze". Below the logo is a descriptive text block: "CLAIM-it allows health providers credentialed by the National Health Insurance to generate, validate and submit claims. It implements and enforces all the necessary claims generation rules and protocols of the NHIS". At the bottom of this panel is a red warning message: "Use of this product is limited to NHIS credentialed health providers only." The right panel is dark teal with a white "LOGIN" section. It contains fields for "Username" and "Password" with corresponding icons (a user icon for Username and a lock icon for Password). A large blue "LOGIN" button is centered below the fields.

A successful login will open the home screen for the application as shown in Figure 2-3.

Figure 2-3 : CLAIM-it Home screen

The home screen has a dark teal header with the NHIS CLAIM-it logo and three buttons: "Smart Claims", "Smart Forms", and "Smart Reports". The main content area has a light gray background. On the left, there is a large screenshot of the "Smart Forms" interface showing a form for "CLIENT INFORMATION" with fields like "Facility ID", "Facility Name", "Client Name", "Date of Birth", and "Gender". To the right of the screenshot, there is a message: "Activation file is not installed. Install your facility's credentialing file to activate the application for use." Below this message is a "Pick Credential File" button. Further down, there is a "Check for Updates" button. On the far right, there is a "Installed Components" table:

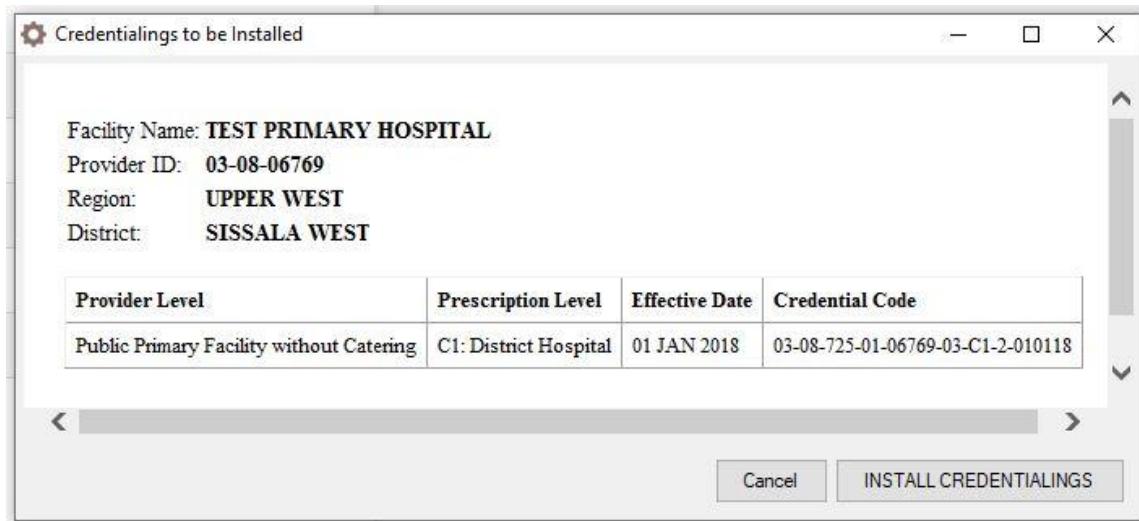
2.4 Loading Credentialing File

The “**Credentialing file is not installed. Install your facility’s credentialing file to activate the application**” message on the left top corner of the home screen simply means, no credentialing details were detected by the application. The accreditation file contains the credentialing details of a health facility. The credentialing file can be obtained from NHIA.

The application will not function without a valid credential file

To load the credentialing file, follow the following steps;

1. Double-click on the credentialing file to display the credentialing that will be installed.



2. Confirm that the credentialing details displayed are accurate. If you believe any information is inaccurate, click on “Cancel” and contact NHIA for clarifications and/or corrections. In the case of a correction, a new Credentialing File will be sent to you.
3. However, if all the details are correct, click on “Install Credentialing’s” to install.
4. Finally, provide your CLAIM-it Login details when prompted, and click on “Login” to authorize the installation.

Alternatively,

1. Login to the application

Activation Required

In order to use the ClaimIt system to generate claims, you must activate the application using your facility's credentialing file. The credentialing file contains your facility's credentialing information that is needed to properly setup the application for use by your facility. If you do not have your credentialing file, kindly contact your nearest NHIS district/regional/CPC office to obtain one. If you have your credentialing file, [click on 'Pick Credential File' from below then select the file and upload](#) to activate the application.

Click button below to pick Credential file

 [Pick Credential File](#)

2. Click on “Pick credentialing file” and browse to where the file is located.
3. Click on “Upload” to start system configuration.

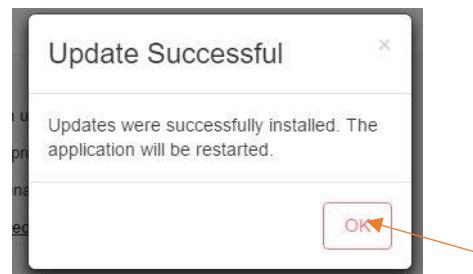
In order to use the ClaimIt system to generate claims, you must activate the application using your facility's credentialing file. The credentialing file contains your facility's credentialing information that is needed to properly setup the application for use by your facility. If you do not have your credentialing file, kindly contact your nearest NHIS district/regional/CPC office to obtain one. If you have your credentialing file, [click on 'Pick Credential File' from below then select the file and upload](#) to activate the application.

TEST PRIMARY HOSPITAL [03-08-06769] [PUB-PRI-CE-RX-C1] (1).ccf



 [UPLOAD](#)

4. Click on “OK” to restart the application.



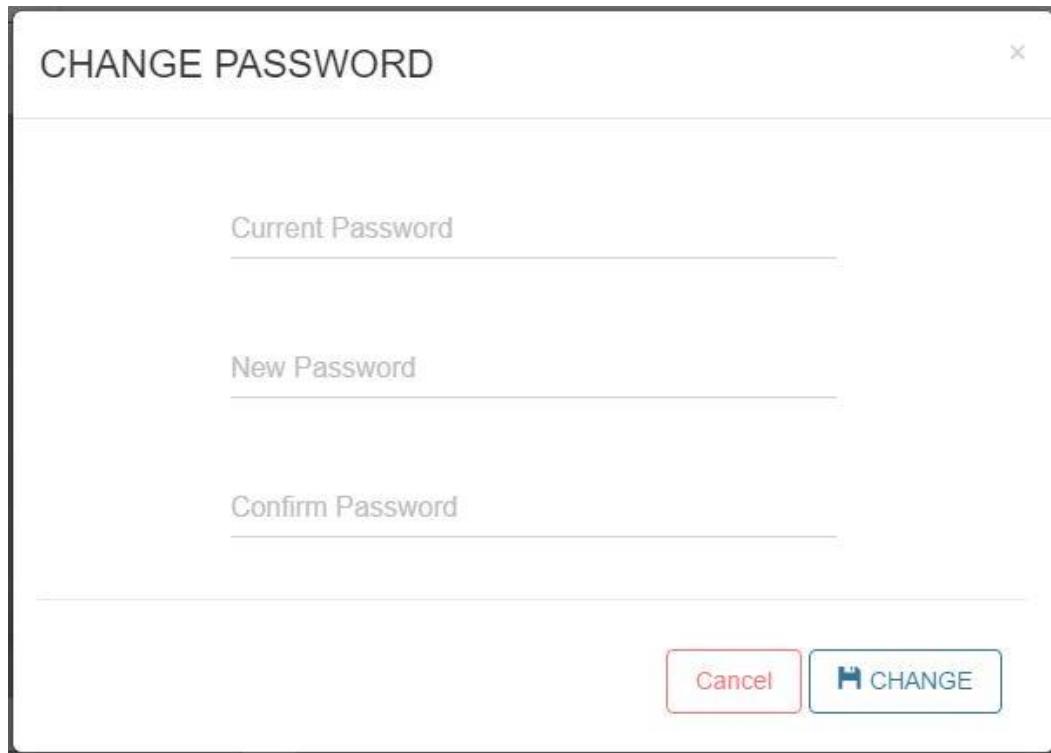
Updates can only be run by authorized users. See section 3.6 of manual

2.5 Changing Username and Password

The default password is only intended to be used for first time login. For security reasons, the application will require the first time user to change the default password to a more personal and secured one. Best practices for password setting are recommended during password setting.

To change the password, enter the current password followed by the new password.

Figure 2-4 : CLAIM-it change password screen



3.0 ADDING USERS

3.1 General Overview

This section provides information on the processes involved in the creation of users as well as the various user roles and privileges available within the application.

3.2 User Roles

There are four (4) major user types that allows users to perform one or more actions within the application. Depending on the role of the user, certain features will not be available for use. The user types with their corresponding roles are showed in Table 3-1.

Table 3-1: Illustration of user types and their roles

By way of further explanation to the roles,

1. **The Supervisor role** is allowed to view claims, submit claims, view reports, run system updates and manage users. This role is not allowed to add or edit claims.
2. **The Admin role** is allowed to perform all activities within the application excluding claims submission. The Entry Admin role also has the same privileges.
3. **The Entry Clerk role** is allowed to view claims, add and edit claims as well as export and import claims. The entry clerk cannot delete claims, neither can it view reports, run updates or manage users.
4. **The Insurance Officer role** is the highest role in the application. Hence every feature of the application can be assessed by the Insurance Officer role.

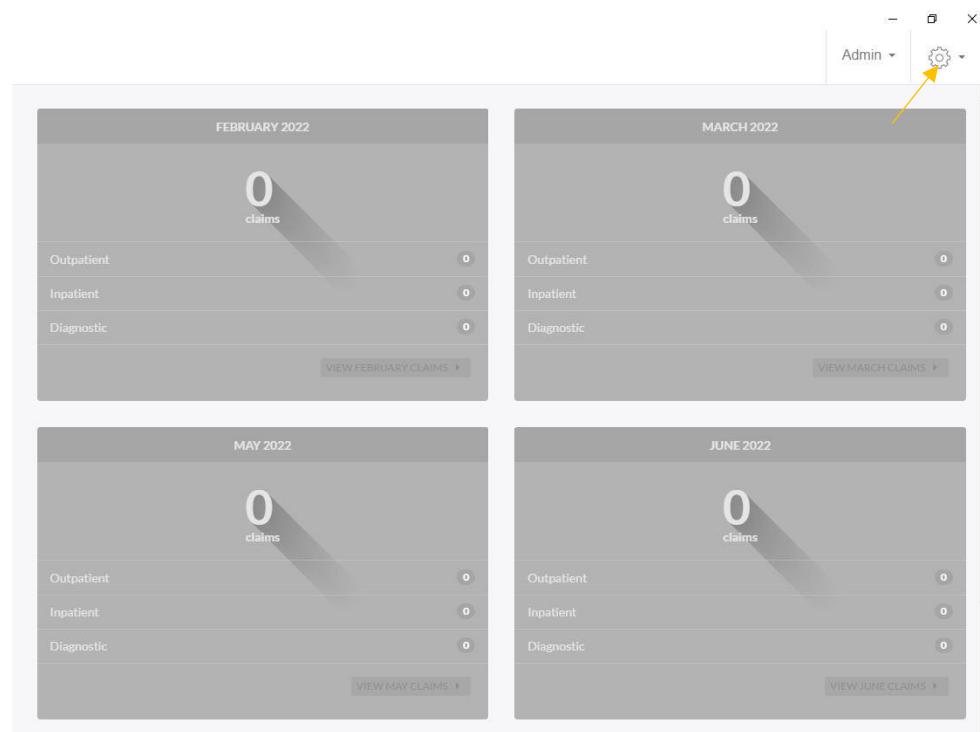
3.3 Creating Users

To create a user, follow the steps below;

1. Log into the application with an admin account. i.e. the default admin account or an account that has the privileges of adding users. (refer to Table 3-1).

2. Click on the settings menu  located at the top right corner of the homepage.(Figure 3-1)

Figure 3-1: Options menu



3. Click on “**Manage Users**”. This will open a window that shows the list of existing users and a button to add a new user. Refer to Figure 3-2.

Figure 3-2: User management option

USER MANAGEMENT		
NAME	USERNAME	ACTIVE
Admin	admin	✓
 NEW USER		

4. Click on “**New User**”. This action opens a form similar to Figure 3-3

Figure 3-3: User addition form

NEW USER	
Username	
Name	
User Role	▼
Password	
Confirm Password	
	Cancel SAVE

5. Fill the user addition form with the right details.
 - a. The Username should be one word and can contain only numbers and alphabets.
 - b. The Name field may contain the full name of the user or a suitable description for the user.
 - c. The Role option provides for selection, all the user roles mentioned in section 3.1. (Figure 3-4)

Figure 3-4: User role selection

The screenshot shows a 'NEW USER' form with the following fields:

- Username:** A text input field.
- Name:** A text input field.
- User Role:** A dropdown menu currently set to 'Supervisor'. Other options listed are 'Insurance Officer', 'Entry Admin', and 'Entry Clerk'. The 'Supervisor' option is highlighted with a blue background.
- Confirm Password:** A text input field.
- Buttons:** 'Cancel' and 'SAVE'.

- d. Enter a password and repeat the same password.
6. Click on “Save” to save new user or “Cancel” to terminate the user addition process.
7. The final step is user activation. To do this click on the button indicated by the arrow in Figure 3-5. This will mark the user as active.

Figure 3-5: Activating a user

The screenshot shows a 'USER MANAGEMENT' table with the following data:

NAME	USERNAME	ACTIVE	
Admin	admin	✓	
MyFirstname MySurname	andrew57	(indicated by a blue arrow pointing to it)	

At the bottom left is a green button labeled 'NEW USER'.

3.4 Editing Users

The steps for editing users are much similar to that for user creation. To do this activity;



1. Click on the settings menu and click on “Manage Users”.
2. Look through the list of users in the pop-up window to locate the user to be edited.
3. Click on the edit icon as shown by the arrow in Figure 3-6

Figure 3-6: List of users

USER MANAGEMENT		
NAME	USERNAME	ACTIVE
Admin	admin	✓
MyFirstname MySurname	andrew57	✓

4. Click on “Edit” in the new window as shown in Figure 3-7. This exposes the various fields for editing.

Figure 3-7: User edit form

User andrew57

Username	andrew57
Name	MyFirstname MySurname
User Role	Insurance Officer
Password	
Confirm Password	

5. Click on “**Save**” once the necessary changes have been effected.

3.5 De-activating/Blocking Users

To block a user, do the following;

1. Click on settings, then on “**Manage Users**” to show the list of users in the application.
2. Click on the activate icon indicated by the arrow in Figure 3-8 to de-activate the user. A change in the symbol from correct sign to the hyphen symbol signifies a de-activated user.(Figure 3-9)

Figure 3-8: List of users with arrow showing the active/de-activate toggle button.

NAME	USERNAME	ACTIVE
Admin	admin	✓
MyFirstname MySurname	andrew57	✓

A blue arrow points to the "ACTIVE" column for the user "MyFirstname MySurname".

NEW USER

Figure 3-9: List of users with arrow showing a de-activated user.

NAME	USERNAME	ACTIVE
Admin	admin	✓
MyFirstname MySurname	andrew57	-

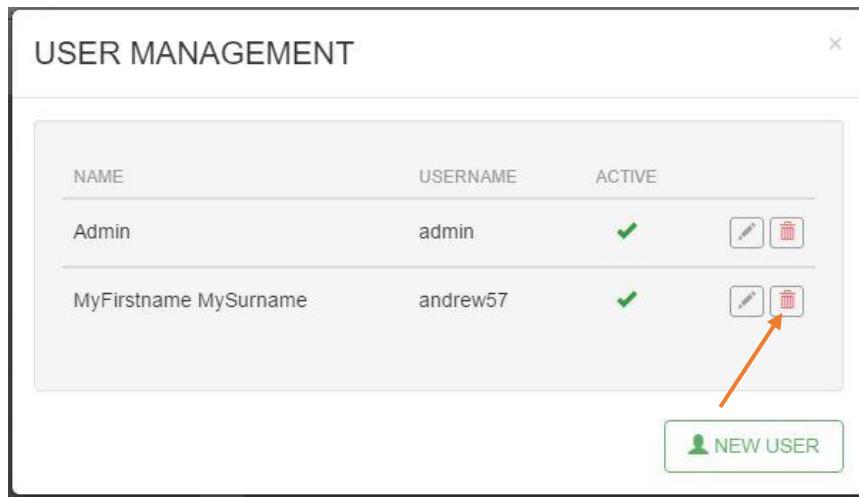
A yellow arrow points to the "ACTIVE" column for the user "MyFirstname MySurname".

NEW USER

1.3 Deleting Users

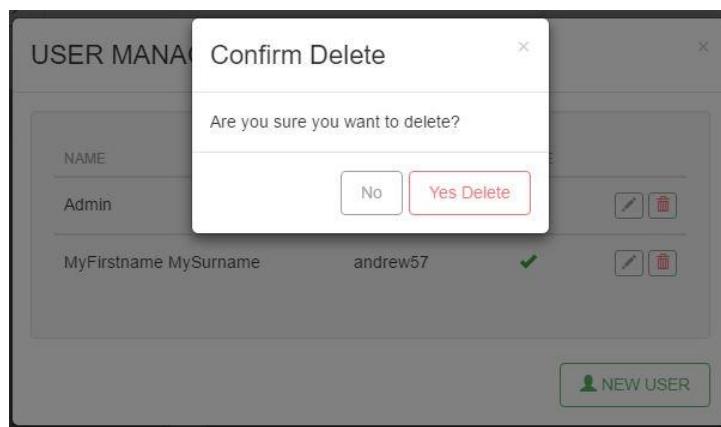
To delete users click on the delete icon next to the edit button/icon (Figure 3-10).

Figure 3-10: User management with arrow showing the delete button



This action will request for a confirmation of delete as shown in Figure 3-11.

Figure 3-11: Deletion confirmation



4.0 USING THE SYSTEM

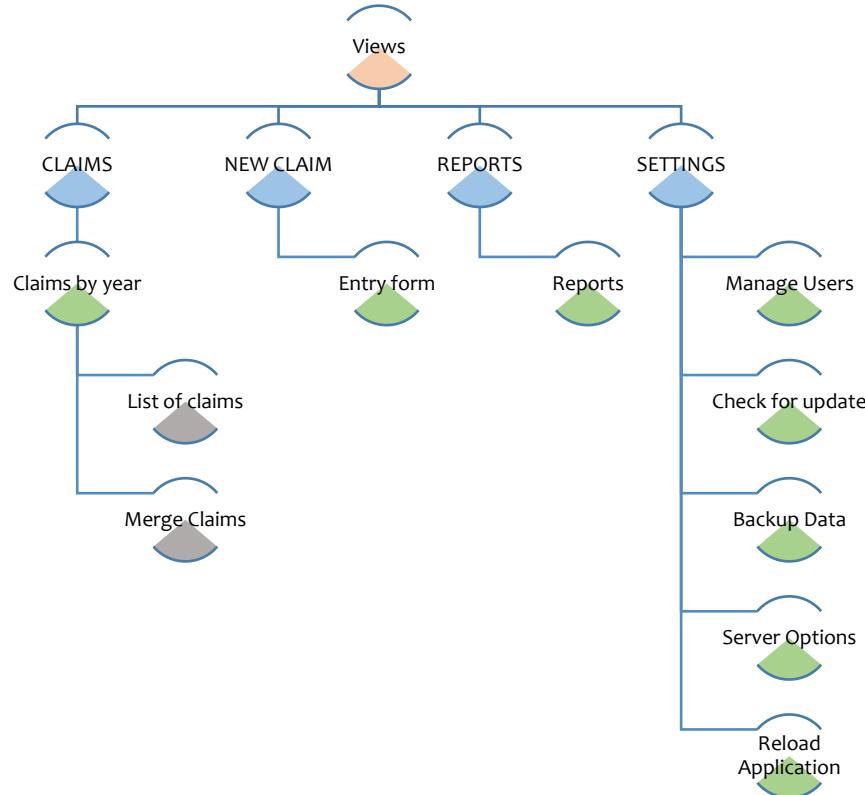
4.1 General Overview

This section provides a detailed description of all the features of the application.

4.2 General Outlook

The application has four (4) major views or menus namely **Claims**, **New Claim**, **Reports** and **Settings**. Figure 4-1 shows a navigation flow through the various views of the application.

Figure 4-1: Navigation flow through the various vies of the application

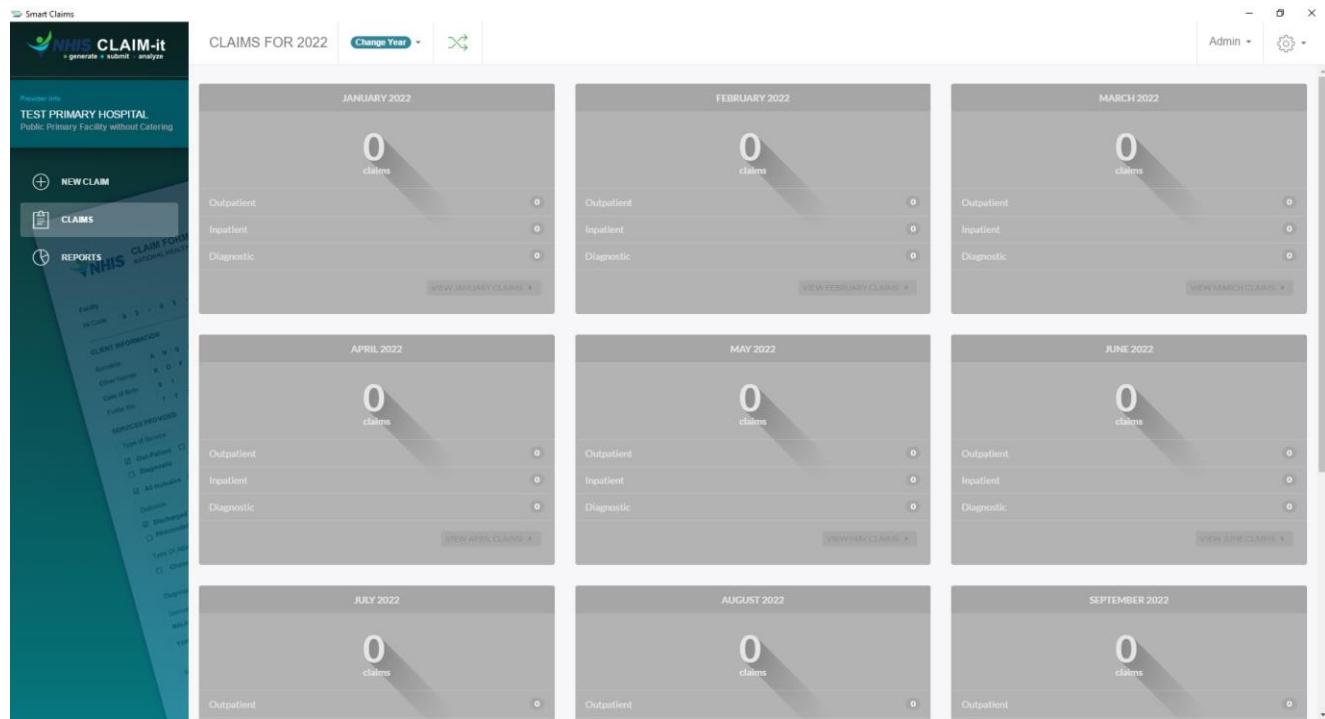


Additionally, the left panel of the home screen also provides information on the facility name, facility type, prescribing level of the facility, the login status of the user, entry and performance statistics.

4.2.1 Home Screen and Navigation of views

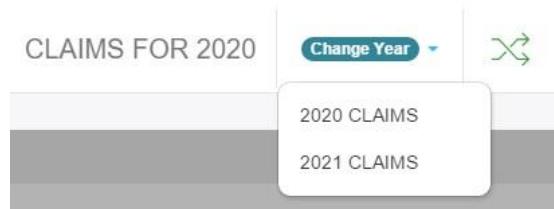
Figure 4-2 illustrates the home screen also representing the “Claims” menu of the application.

Figure 4-2: Home screen of the application with no claims data



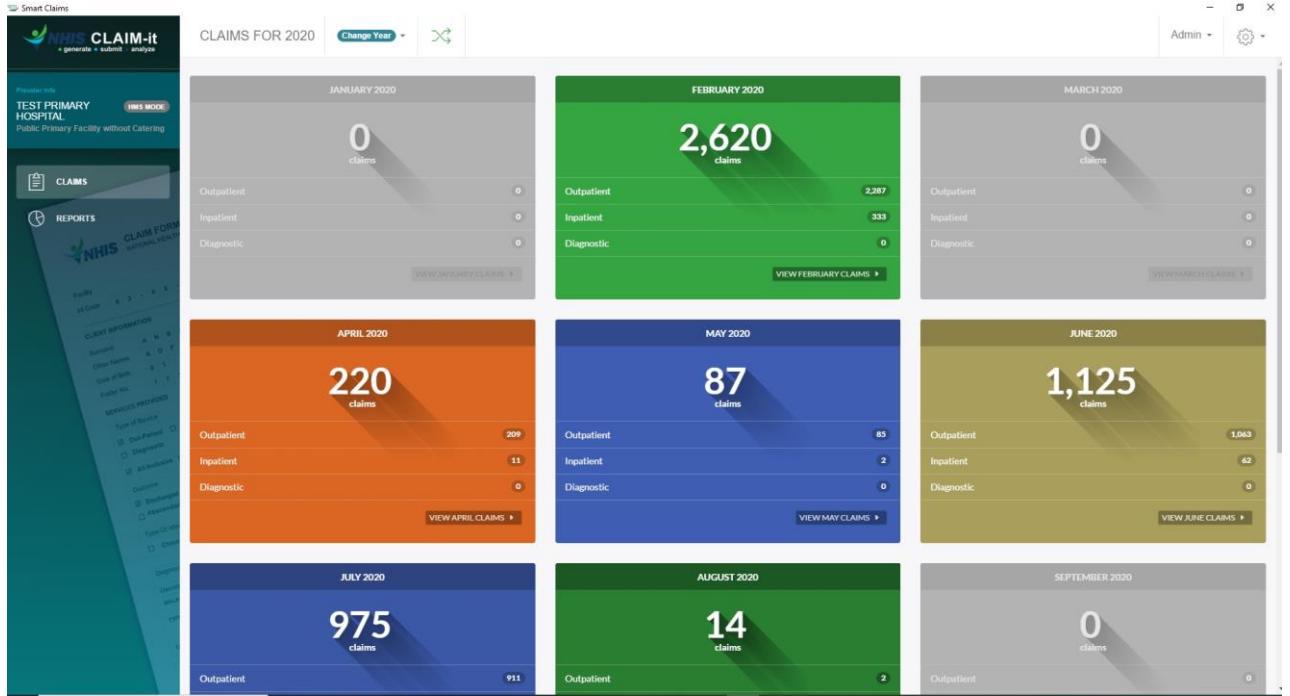
As observed in the figure above, claims are visualized by year and month. By default the application loads claims data for the current year. The year under view can be seen at the top corner, leftward of the home screen. To change the year of view, click on “**Change Year**” and select the year of interest (Figure 4-3). However, it must be noted that the drop down list only contains the list of years for which claims have been entered.

Figure 4-3 : Drop down menu for changing year in view



Months with no claims data are greyed out as seen in Figure 3-2. However, months with claims data have a coloured background with a summary of the volumes per type of service of data captured for that month (Figure 4-4).

Figure 4-4: Home screen of the application with claims data



To view the list of claims for any month, click on the month of interest. Claims are grouped according to the various types of services. Figure 4-5 shows the list of claims for the month of June 2020.

Figure 4-5: List of claims for a month

The figure shows the list of claims for June 2020. The top navigation bar includes 'CLAIMS FOR JUN 2020', 'Change Month', and 'Admin'. The main table has tabs for 'ALL' (1,125), 'IPD' (2), and 'OPD' (1,123). Under the 'ALL' tab, there are further sub-tabs: 'ALL' (1,125), 'MEDI' (20), 'OBGY' (13), 'PAED' (13), 'ANC' (20), 'ENTH' (3), 'OPDC' (22), 'DPHT' (3), 'ZOOM12' (3), and 'ZOOM95' (3). The table lists individual claims with columns for CLAIM DATE, MEMBER NO., NAME, ADDED, TYPE, COST (eG), and three small icons (lock, edit, delete) for each row. An orange arrow points to the delete icon in the last row.

CLAIMS FOR JUN 2020									
Change Month									
Admin									
ALL (1,125)	IPD (2)	OPD (1,123)							
ALL	MEDI (20)	OBGY (13)	PAED (13)	ANC (20)	ENTH (3)				
01 MON	41000121	DAIDON HACTORIA		22 FEB 2022	OPD	11.63			
01 MON	04477040	FRANCIS ALICE		22 FEB 2022	OPD	11.78			
01 MON	97340003	ANDAM AARUD		22 FEB 2022	OPD	19.99			
01 MON	00000102	PAULINE APRIL		22 FEB 2022	OPD	18.84			
01 MON	00000103	PAULINE APRIL		22 FEB 2022	OPD	26.04			
01 MON	00000000	OLIVIA ANNA		22 FEB 2022	OPD	24.24			
01 MON	01000001	LUKASIA TIA		22 FEB 2022	OPD	17.04			
01 MON	02000002	MEDALIA APOLINA		22 FEB 2022	OPD	23.07			

As can be observed in Figure 4-5, each service type has a tab which in turn provides information on the total volume of claims for that service type. The “ALL” tab contains all claims that have been entered for that month.

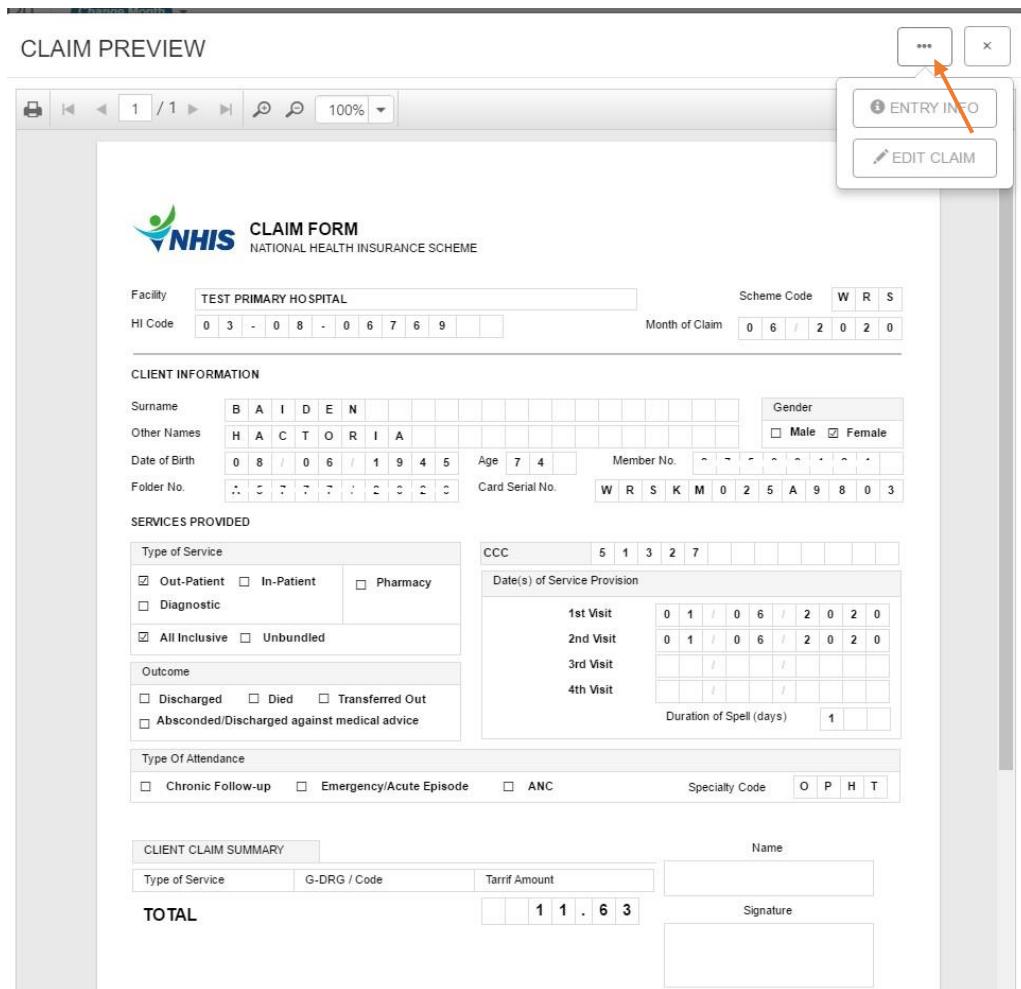
Under each major tab is a further grouping of data based on the specialty attended.

Each data row represents an entered claim specifying the date of the claim, member number, name of member, date claim was generated, type of service and the cost of the

claim. The **two (2)** icons (indicated with the arrow in figure 4-5) are used to either preview or delete a claim. The icon on the left, the delete button, performs the action of deleting a claim while the icon on the right, the preview button, performs the action of opening a claim in the preview mode. A detailed description of the edit and delete features can be found in the section 4.3.

To preview a claim, click on the preview button  next to the claim of interest. This will show the claim in its traditional view (Figure 4-6). Printing of claims can be done in this view, if necessary.

Figure 4-6: Claim Preview



The screenshot shows the 'CLAIM PREVIEW' window of the NHIS CLAIM FORM software. The window has a toolbar at the top with various icons for printing, navigating, and searching. The main area contains several data entry fields and tables. In the top right corner, there is a context menu with three dots (...), which is highlighted by a red arrow. Below the menu are two buttons: 'ENTRY INFO' with a person icon and 'EDIT CLAIM' with a pencil icon.

Facility: TEST PRIMARY HOSPITAL

HI Code: 0 3 - 0 8 - 0 6 7 6 9

Scheme Code: W R S

Month of Claim: 0 6 / 2 0 2 0

CLIENT INFORMATION:

- Surname: B A I D E N
- Other Names: H A C T O R I A
- Date of Birth: 0 8 / 0 6 / 1 9 4 5
- Age: 7 4
- Member No.: 0 0 0 0 0 0 0 0 0 0
- Gender: Male Female
- Folder No.: A 0 7 7 7 : 2 0 2 0
- Card Serial No.: W R S K M 0 2 5 A 9 8 0 3

SERVICES PROVIDED:

- Type of Service:
 - Out-Patient
 - In-Patient
 - Pharmacy
 - Diagnostic
 - All Inclusive
 - Unbundled
- Outcome:
 - Discharged
 - Died
 - Transferred Out
 - Absconded/Discharged against medical advice
- Type Of Attendance:
 - Chronic Follow-up
 - Emergency/Acute Episode
 - ANC

CCC: 5 1 3 2 7

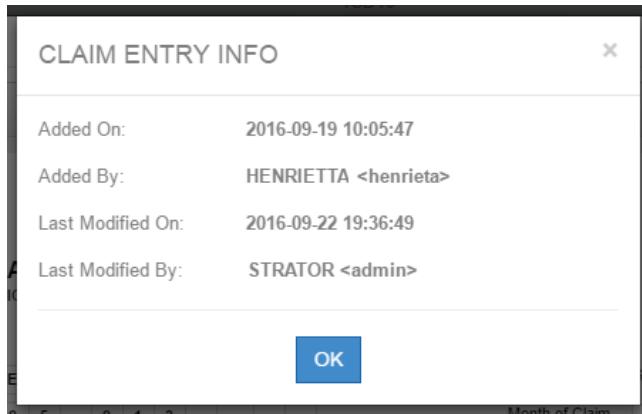
Date(s) of Service Provision:

Visit	0 1 / 0 6 / 2 0 2 0
1st Visit	0 1 / 0 6 / 2 0 2 0
2nd Visit	
3rd Visit	
4th Visit	

CLIENT CLAIM SUMMARY:

Type of Service	G-DRG / Code	Tariff Amount	Name
TOTAL		1 1 . 6 3	Signature

Clicking on the three dots at the top right corner as shown in the arrow in Figure 4-6 shows two functionalities, the “**Entry Info**” and “**Edit Claim**” button. By clicking on Entry Info, details of all users who have interacted with the claim in view are shown as depicted in the figure below.



The Edit Claim button (Figure 4-5) also allows users to bring up the claim in the edit mode.

4.3 Generating Claims

One of the most important features of the application is to help with claims generation. This require users to generate claims that resulted from a valid attendance, using an electronic claims entry form. Figure 4-7 shows a general outlook of the claims entry form.

Figure 4-7: Claims entry form

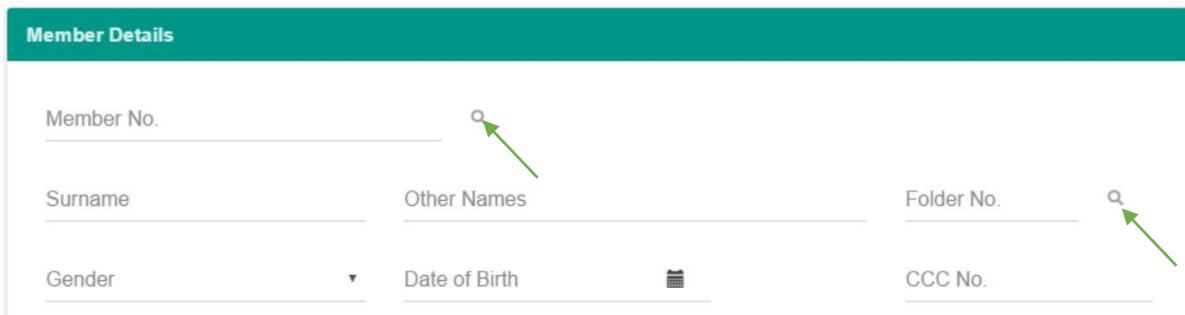
Member Details		Type of Service(s)		Service Outcome		Dates Of Service		Specialties Attended	
Member No.		<input type="checkbox"/> Outpatient	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Discharged	<input type="checkbox"/> Died	1st Visit	<input type="checkbox"/> ASUR	<input type="checkbox"/> DENT
Surname	Other Names	<input type="checkbox"/> Diagnostic	<input type="checkbox"/> UnBundled	<input type="checkbox"/> All-Inclusive	<input type="checkbox"/> Transferred Out	<input type="checkbox"/> Absconded	2nd Visit	<input type="checkbox"/> MEDI	<input type="checkbox"/> OBGY
Gender	Date of Birth	<input type="checkbox"/> Post-natal					3rd Visit	<input type="checkbox"/> OPHT	<input type="checkbox"/> ORTH
							4th Visit	<input type="checkbox"/> PAED	<input type="checkbox"/> RSUR
Type of Attendance									
<input type="checkbox"/> Chronic Follow-up		<input type="checkbox"/> Emergency/Acute Episode		<input type="checkbox"/> Ante-natal					
<input type="checkbox"/> Post-natal									
Referral Info									
Referring Facility Name									
Referral Code / CCC									
Authorization Codes									
Physician Name/ID									
								Pre-authorization Code(s)	

To enter claims, click on  button found on the side bar menu of the home screen. This should pop up a blank claims entry form similar in view to what is displayed above.

Entering claims requires the user to apply the NHIS claims generation guidelines with respect to providing required data as well as satisfying all other claims entry protocols. Reference should be made to the NHIS tariff operational manual for further information on claims generation guidelines and policy. The entry form has seven major sections;

1. **Patient Details section:** This section captures all patient centred details. The entry fields in this section are;
 - a. Patient name (Surname and other names)
 - b. Member number
 - c. Date of birth
 - d. Folder number
 - e. Claims Check Code (CCC)
 - f. Card serial number

Figure 4-8: Patient detail section



Member Details					
Member No.	Surname		Other Names	Folder No.	CCC No.
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Gender	Date of Birth	<input type="button" value=""/>			

Users are also able to pre-populate patient member details by using the search button next to the Member no field (shown by the green arrow) upon entering the member number. Member detail pre-population is also possible using the folder number of the patient. Please note, however, that this feature is only functional if claims have ever been captured for that member. This is illustrated in the diagram below.

MEMBER NO.	FOLDER NO.	SURNAME	OTHER NAMES	GENDER	DOB
11111111	12/12	test	test others	M	12/12/2002
11111111	12/13	test	test two	M	12/12/2001

The diagram above is an illustration of member no. 11111111 having past claim entries with two different folder numbers. In this case the claim officer will have to choose the preferred record to use.

Note: Once the application detects that the age of the patient is within a three (3) month period, it prompts the user to confirm if the NHIS member number being used is that of the child or not. The age is always computed against the first date of service provision. This is illustrated in Figure 4-9.

Figure 4-9: Illustration of dependent confirmation

Member Details

Member No.	34444444		
Surname	Other Names		
TEST	PATIENT		
Gender	Date of Birth		
MALE	21/2/2022 <input type="button" value="Calendar"/>		
Age: 1days			
Is the NHIA Card for this Baby? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Folder No. CCC No. 12345			

2. Service Information Section: This section captures service and attendance details.

The entry fields in this section are;

- a. Type of service
- b. Date of service (Date of attendance and date of discharge)
- c. Outcome of service
- d. Referral details (referring facility name/ facility ID/ CCC)
- e. Specialties attended

Figure 4-10 : Service details section

Type of Service(s)	Service Outcome	Dates Of Service
<input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Diagnostic <input type="checkbox"/> Pharmacy <input type="checkbox"/> UnBundled <input type="checkbox"/> All-Inclusive	<input type="checkbox"/> Discharged <input type="checkbox"/> Died <input type="checkbox"/> Tranferred Out <input type="checkbox"/> Absconded	1st Visit 22/2/2022 2nd Visit 3rd Visit 4th Visit
Type of Attendance		
<input type="checkbox"/> Chronic Follow-up <input type="checkbox"/> Emergency/Acute Episode <input type="checkbox"/> Ante-natal <input type="checkbox"/> Post-natal		
Referral Info	Specialties Attended	
Referring Facility Name Referral Code / CCC	<input type="checkbox"/> ASUR <input type="checkbox"/> DENT <input type="checkbox"/> ENTH <input type="checkbox"/> MEDI <input type="checkbox"/> OBGY <input type="checkbox"/> OPDC <input type="checkbox"/> OPHT <input type="checkbox"/> ORTH <input type="checkbox"/> PAED <input type="checkbox"/> PSUR <input type="checkbox"/> RSUR	

- 3. Procedure Section:** This section captures details on all valid procedures which were conducted. Data entry fields in this section are;
- Procedural GDRG
 - Diagnosis (ICD-10)
 - Date of service

Figure 4-11 : Procedure section

1 PROCEDURE					
#	GDRG	DESCRIPTION	DIAGNOSIS	ICD10	DATE
1.	ZOOM07A	DRESSING AND MINOR SUTURING >=12 YRS	LACERATION OF SCALP	S01.0	22 Feb 2022

- 4. Diagnosis Section:** This section captures details on consultations services (non-procedural) rendered to a patent. Data entry fields for this section include;
- Diagnosis GDRG
 - Diagnosis (ICD-10)

Figure 4-12 : Diagnoses section

1 DIAGNOSIS				
#	GDRG	DESCRIPTION	DIAGNOSIS	ICD10
1.	OPDC06A	GENERAL OPD - ADULT	MALARIA	B54

5. **Investigation Section:** This area captures details on all investigation or diagnostic services provided to the patient. The entry fields in this section are;
- Diagnostic GDRG
 - Date of service

Figure 4-13 : Investigation section

1 INVESTIGATION				
#	GDRG	DESCRIPTION	DATE	
1.	INVE34E	URINE C/S	22 Feb 2022	 

6. **Medicines Section:** This area captures all prescriptions and medicines dispensed to a patient. The data entry fields for this section are;
- Medicine name or code
 - Prescription (dose, duration and frequency)
 - Quantity dispensed
 - Date of service

1 MEDICINE					
#	CODE	DESCRIPTION	QTY	DATE	
1	PARACETA1	PARACETAMOL TABLET, 500 MG Rx: 1000 mg x tid x 5 Days	30	22 Feb 2022	 

7. **Pre-authorization Section:** This area captures all pre-authorization details for all services used for which pre-authorization was required. Details specified here are;
- Prescriber ID
 - Pre-authorization codes (separated by comma's)

Figure 4-14 : Pre-authorization section

The screenshot shows a form titled "Authorization Codes". It contains two input fields: "Physician Name/ID" and "Pre-authorization Code(s)".

Referral details are required for all referral services. E.g. diagnostic and pharmacy only

Some data entry utilities have been made available to aid in movement from one section of the entry form to another. This is to help limit the need to scroll through the various sections of the form. This utility is located at the top right section outside the claims entry form as illustrated in Figure 4-14.

Figure 4-15: Data entry utility

The screenshot shows the "UPDATE CLAIM" form with several sections: "Member Details", "Type of Service(s)", "Service Outcome", "Dates Of Service", "Type of Attendance", and "Specialties Attended". To the right of the main form is a sidebar titled "Entries" containing icons for "Add Procedure", "Add Diagnosis", "Add Investigation", and "Add Medicine". An orange arrow points from the "Add Investigation" icon to the "Service Outcome" section of the main form.

Hovering over the icon displays a description of its functionality. Figure 4-15 shows the icons and their corresponding functionality descriptions.

Figure 4-16: Entry utility descriptions



4.3.1 Entering member details

Entries of member/patient details naturally marks the beginning of all claim entries. Data entry in this section is as simple as typing out the required details into the input boxes provided.

The age of a member is calculated as the difference between the first date of service and member's date of birth.

4.3.2 Entering Dates

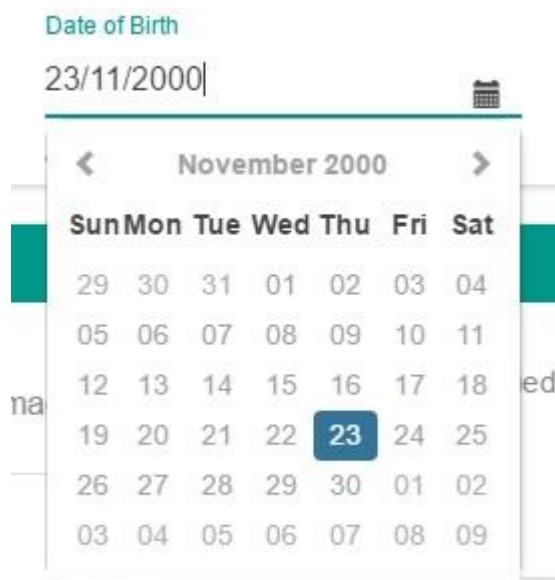
Date entries are required at the member details, procedure, investigations and medicines section. Dates can either be entered directly into the date input box or selected using the date picker. For direct entries, dates can be entered in one of three (3) different ways as illustrated below;

1. **12 Jun 2016**
2. **01/06/2016**
3. **1/6/2016**

To use the date picker, click on the “**calendar icon**” to the right of the date input box.

This will open a date picker window for the user to navigate and select the preferred date. This is illustrated in figure 4-16.

Figure 4-17: Date picker for date selection



4.3.3 Entering Service details

The service section of the form requires the user to provide details on the type of service, date of service, type of attendance, outcome of the service, specialties attended and referral details if required.

In cases where the patient accessed care from more than one specialty, the user is free to check as many specialties as applicable.

Figure 4.10 illustrates the service section of the claim form.

Figure 4-18: The service section of the claim form

Type of Service(s)	Service Outcome	Dates Of Service
<input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Diagnostic <input type="checkbox"/> UnBundled <input checked="" type="checkbox"/> All-Inclusive	<input checked="" type="checkbox"/> Discharged <input type="checkbox"/> Died <input type="checkbox"/> Tranferred Out <input type="checkbox"/> Absconded	1st Visit 12/12/2020 2nd Visit 3rd Visit 4th Visit
Type of Attendance		
<input type="checkbox"/> Chronic Follow-up <input checked="" type="checkbox"/> Emergency/Acute Episode <input type="checkbox"/> Ante-natal <input type="checkbox"/> Post-natal		
Referral Info		Specialties Attended
Referring Facility Name		<input type="checkbox"/> ASUR <input type="checkbox"/> DENT <input type="checkbox"/> ENTH <input type="checkbox"/> MEDI <input type="checkbox"/> OBGY <input checked="" type="checkbox"/> OPDC <input type="checkbox"/> OPHT <input type="checkbox"/> ORTH <input type="checkbox"/> PAED <input type="checkbox"/> PSUR <input type="checkbox"/> RSUR
Referral Code / CCC		

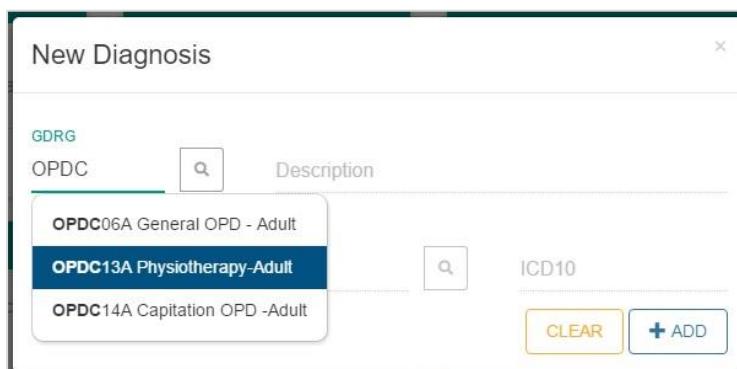
The information provided at the member and service section of the claim form determines the type of GDRGs that will be available for selection. Eg. If the age of the patient is < 12yrs, type of service is OPD and specialty attended is OPDC, then only OPDC GDRGs with a split of C will be available for selection at the diagnosis section of the claim form.

4.3.4 Entering GDRGs

Entry of GDRGs are required at the procedure, diagnosis and investigation sections of the form and the processes for entry are the same. A GDRG can be selected in two (2) ways;

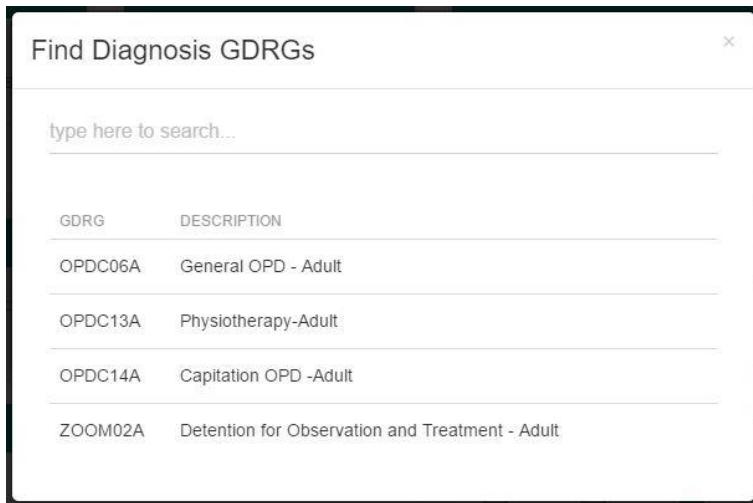
1. Type either the GDRG code or its description in the GDRG input box. A dropdown picker (list) automatically appears, once the user starts entering any text. The dropdown makes available and does an automatic search for GDRGs based the available pre-filtered GDRGs based on data entered at the member and service details section of the form. The more you type, the more detailed the search.

Figure 4-19 : GDRG Entries



2. Alternatively, click on the magnifying glass icon next to the GDRG input box. This should popup a list of pre-filtered GDRGs with a search area at the top of the list. Typing the required GDRG code or its description in the search area automatically sorts the list based on the information provided in the search area. The GDRG is then selected by clicking on the preferred GDRG.

Figure 4-20 : GDRG Selection



Upon selecting the required GDRGs, the GDRG code is displayed in the GDRG input box while the description of the GDRG is either displayed below the diagnosis input box as observed at the diagnosis section or within a text box, in the case of procedures.

4.3.5 Entering Diagnosis/ICD-10s

Entry of diagnosis is required for every entry of GDRGs done at the procedure and diagnosis section of the form. The investigation section does not require the input of diagnosis (ICD-10s) and hence has no diagnosis input box.

Similar to the selection of GDRGs, to input diagnosis the user may do either of the following;

1. Type either the ICD-10 code or its description of the diagnosis in the diagnosis input box. A dropdown picker (list) automatically appears once the user starts entering any text. The dropdown does an automatic search for diagnosis based on what has been typed so far. The more you type, the more detailed the search. Claim officers can also search for applicable GDRGs for any diagnosis of interest. For instance, if “hypertension” is entered as the diagnosis, the application will automatically list all applicable GDRGs linked to that diagnosis. This feature serves as a quick reference and utility for Claim Officers when it comes to selecting diagnosis and their related GDRGs and vice versa.

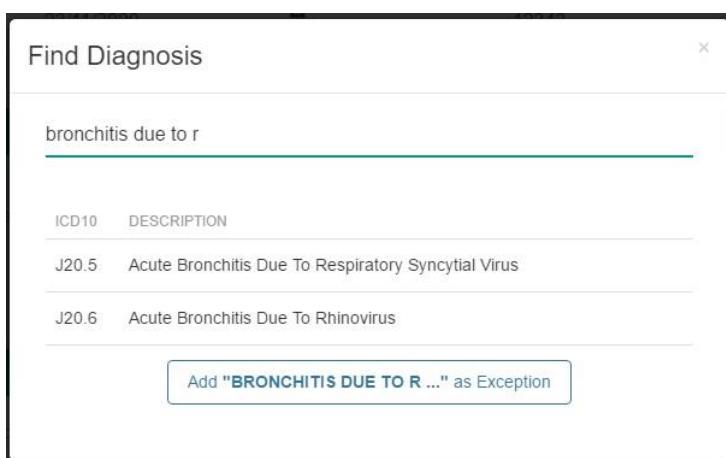
Figure 4-21: Adding diseases using direct search



2. An extended search can be done by clicking on the magnifying glass icon next to the input box. This should popup a list of diseases (ICD-10s) with a search area at the top of the list. Typing the required diagnosis or ICD-10 code in the search box, automatically sorts the list based on the information provided. The diagnosis is then selected by clicking on the preferred diagnosis.

When a diagnosis is not found in the search box, the user has the option of including the diagnosis as an “**exception diagnosis**”. This simply means that, diagnosis was not found in the list provided but was exactly what was diagnosed. The exception diagnosis will be available for selection the next time another claim is being captured.

Figure 4-22: Adding diseases using extended search/ Adding exception diagnosis



The selection of procedural GDRGs in the procedure section results in the pre-sorting of diagnosis/ICD-10 code as specified in the ANNEX C of the NHIS tariff operational manual. However, this doesn't prevent users from selecting other diagnosis using the processes specified in step 2 above.

4.3.6 Entering Medicines

Capturing of medicine is quite similar to selecting GDRGs. Hence steps 1 and 2 for entering GDRGs also applies to the selection of medicines.

In capturing the prescription, the dose, frequency and duration needs to be captured. The dose is prepopulated based on the type of medicine selected. Similarly, the frequency and duration inputs are also prepopulated with the necessary data as per prescription standards. An example of a typical prescription is 250mg x tds x 5 days.

Figure 4-23: Making medicine and prescription entries

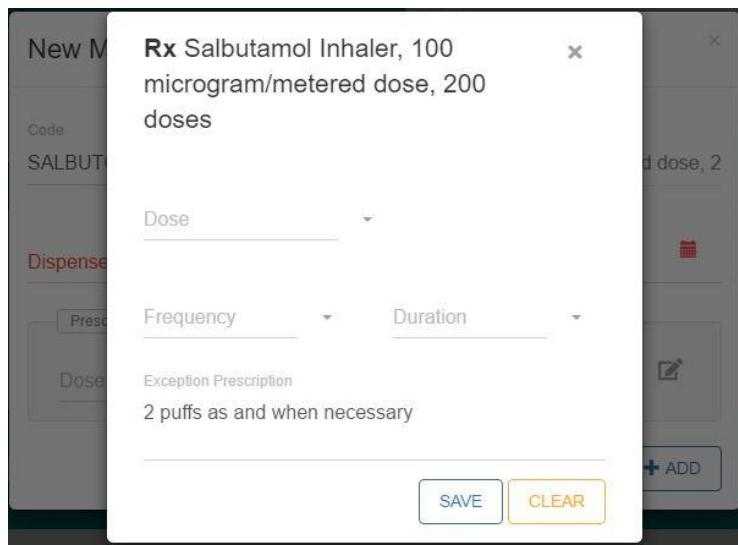
Prescription		
Dose	Frequency	Duration
1000 mg	tds	5 Days

Considering that not all medicines have a definite prescription, partial prescriptions are allowed for some medicine entries.

The prescribing level of the health facility determines the list of medicines available for selection during data entry.

Instances where the prescription doesn't fit the traditional dose, frequency, duration structure, users are allowed to make free text prescription entries. The feature is activated by clicking on the pencil icon, indicated by the arrow in figure 4-22. This will open a window, illustrated in Figure 4-24, that will allow for the entry of prescriptions in the desired way. The exception section of the form, allows for free text entry of prescriptions. E.g. "2 puffs when necessary".

Figure 4-24: Alternative prescription entry



4.3.7 Adding Entries

The procedure, diagnosis, investigation and medicine sections of the form allows users to make multiple entries where necessary. The button at the top right corner of each section allows users to add entries. The display for each entry form is subject to the data requirements for that section.

To add an entry to the list of entries, provide all required data for that section and click on the button to add the GDRG/Medicine and its corresponding details to the list. To clear all data that have been provided for an entry, click on the button to clear the entries. Figure 4-24 is an illustration of this functionality.

Figure 4-25: Adding entries (excerpts from diagnosis entry)

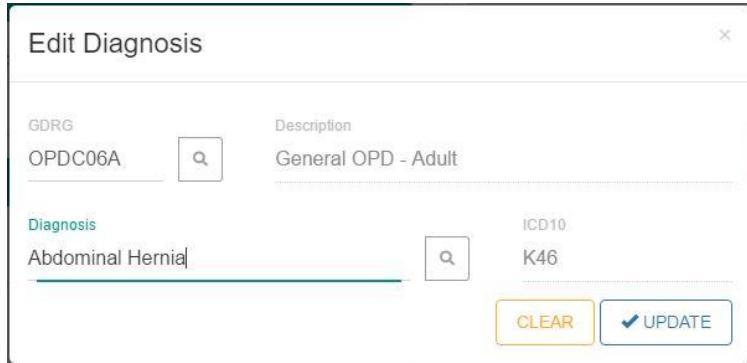
2 DIAGNOSES				
#	GDRG	DESCRIPTION	DIAGNOSIS	ICD10
1.	OPDC06A	GENERAL OPD - ADULT	ABDOMINAL HERNIA	K46
2.	OPDC06A	GENERAL OPD - ADULT	ACUTE BRONCHITIS	J20.9

4.3.8 Editing and Deleting Entries

Entries made can be edited or deleted from the list of entries. The edit or delete buttons are found at the right side of each entry. To edit an entry, click on the edit button (pencil icon shown by the green arrow in Figure 4-25 above). This loads the data for that entry

and allows for changes to be made. Click on the  button to complete the update. This is illustrated in Figure 4-25.

Figure 4-26: Editing entries



The screenshot shows a software interface titled "Edit Diagnosis". It contains four main sections: "GDRG" with value "OPDC06A" and a search icon; "Description" with value "General OPD - Adult" and a search icon; "Diagnosis" with value "Abdominal Hernia" and a search icon; and "ICD10" with value "K46". At the bottom are two buttons: "CLEAR" and "UPDATE" (highlighted with a yellow border).

To delete an entry simply click on the “trash can icon”,  . It must however be noted that deletion of an entry is an **irreversible action**, hence the need for **caution**.

The editing and deletion features are available at the procedure, diagnosis, investigation and medicine sections as well.

4.3.9 Attachment of Documents

There are instances where it becomes necessary to attach supporting documents to a claim. Supporting documents includes but not limited to prescriptions, lab results and lab requests. For instance, the use of some medicines on the NHIS medicines list requires the attachment of lab results to support the claim.

To attach a supporting document follow the following steps;

1. Go to the attachments section of the entry form and click on  icon as illustrated in Figure 4-26

Figure 4-27 Attachment section of entry form



2. This will open an explorer window, that allows users to select the appropriate file to attach.

3. After selecting the file to attach, the user will be required to select the type or category (prescription, lab request, scan etc) of attachment.

Figure 4-28: Attachment Details

The screenshot shows a modal dialog titled "Attachment Details". It contains two input fields: "Type of Attachment" and "Comments", both with dropdown menus. At the bottom are two buttons: "CANCEL" and "ATTACH".

4. Click on “**Attach**” button to save attached file. This will look similar to Figure 4-28, showing the name of the attached file and a button to delete the attachment. However, a delete confirmation will be required before deletion. The user can click on the attached file to view the document as well. Optionally, the user can also add a comment to the attachment if necessary. Illustrated in Figure 4-28.

Figure 4-29: View for an attached file



5. To attach another document, repeat the process.

4.3.10 Adding Comments to Claims

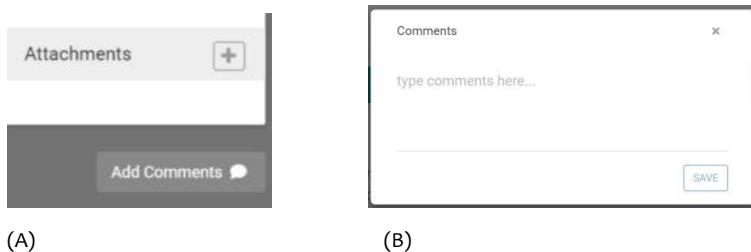
With the introduction of the new version of the CLAIMit application, users are now able to add comments to a claim. This allows for the inclusion of information relevant to a claim to be passed on to vetting officers during claims processing. However, users are advised to be circumspect during the addition of comments. If any information is relevant to giving better insight to the details on a claim under generation, then add that information as a comment.

While generating a new claim or editing an existing claim, include a comment by:

[In Edit Mode]

1. Click on the “**Add Comments**” button found below the attachment section of the claim (*Diagram A*). This will pop up a form that allows for the addition of comments as free text (*Diagram B*).

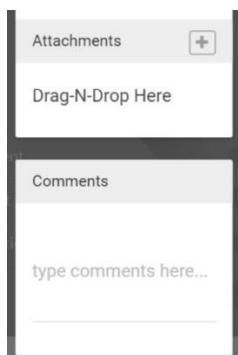
Figure 4-30: Addition of comments



2. Add comments and click on save when done. This process can be repeated several times to add as many comments as required.

[New Claim Mode]

1. Click in the comments area below the attachment section of the claim form and add your comments as free text to the claim. The comments would be saved as part of the claim. You can edit the claim to add as many notes as needed.



4.3.11 Adding Patient Vitals to a Claim

This feature is ONLY applicable to health providers on the Value Based Care program of the NHIA. Hence, you may skip this section if it doesn't apply to your context.

The Value Based Care program of the NHIA has as part of its requirements, the collection of patient vitals like weight, height, blood pressure and glucose readings. These readings

will only be required for a sample of patients within the facility in question. NHIA will agree and communicate to the provider, the list of patients who the extra details are required.

Note: The form for capturing patient vitals automatically pops-up for applicable patients. An instance of the form is illustrated in Figure 4-31 below.

Figure 4-31: Patient Vitals Form

The screenshot shows a modal window titled "Patient Vitals". A green header bar contains the text "Kindly provide the vital readings for this patient as part of the Value Based Care program.". Below the header is a table with columns: #, DATE, BP, BLOOD SUGAR, WEIGHT, HEIGHT, and BMI. A message "No vital readings added." is displayed above a button labeled "Click to Add Vitals Reading". At the bottom right are "Cancel" and "✓ Continue" buttons.

To add patient vitals, do the following;

1. Click on **Add another Vitals Reading** and fill in the required information per the details required as vitals for the patient. Figure 4-32 gives an impression of the details required.

Figure 4-32: Addition of vitals

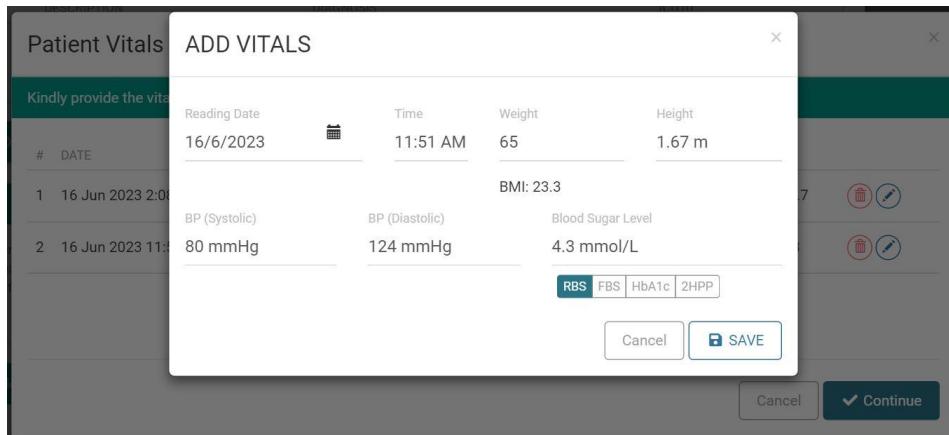
The screenshot shows a modal window titled "ADD VITALS". It contains fields for "Reading Date" (with a calendar icon), "Time", "Weight", "Height", and "BMI:". Below these are fields for "BP (Systolic)" and "BP (Diastolic)". A "Blood Sugar Level" section includes checkboxes for "RBS", "FBS", "HbA1c", and "2HPP". At the bottom are "Cancel" and "SAVE" buttons.

As shown in the Figure above, the details required are;

- a. **Reading Date:** The date the readings was taken. **Required**
- b. **Time:** The time the readings were taken.
- c. **Weight:** The weight of the patient in Kilograms. **Required**
- d. **Height:** The height of the patient in Meters.
- e. **BP (Systolic):** The Systolic reading of the Patient's Blood Pressure. **Required**
- f. **BP (Diastolic):** The Diastolic reading of the Patient's Blood Pressure. **Required**
- g. **Blood Sugar Level:** The Blood Sugar Reading of the Patient. In stating this, the type of sugar test reading has to be specified. The options for this reading are;
 - a. Random Blood Sugar (**RBS**)
 - b. Fasting Blood Sugar (**FBS**)
 - c. Hemoglobin A1c Test (**HbA1c**)
 - d. 2-hour Postprandial (**2HPP**)

2. Click on  to add the readings to the claim. Shown in Figure 4-33

Figure 4-33: Capturing and saving vitals



The screenshot shows a mobile application interface for capturing patient vitals. The main title is 'ADD VITALS'. On the left, there is a sidebar titled 'Patient Vitals' with a note 'Kindly provide the vital'. The main area contains the following data:

Reading Date	Time	Weight	Height
16/6/2023	11:51 AM	65	1.67 m
BMI: 23.3			
BP (Systolic)	BP (Diastolic)	Blood Sugar Level	
80 mmHg	124 mmHg	4.3 mmol/L	

Below the table, there is a row of buttons for selecting the blood sugar level: RBS, FBS, HbA1c, and 2HPP. At the bottom right of the form are 'Cancel', 'SAVE' (highlighted in blue), and 'Continue' buttons.

3. To Edit the details on previously recorded vitals, open the claim in Edit Mode and re-save the claim. This will re-open the form, showing previously captured details with and edit button  next to each recording, as shown in Figure 4-34.

Figure 4-34: List of captured vitals

The screenshot shows a modal window titled "Patient Vitals". A message at the top reads: "Kindly provide the vital readings for this patient as part of the Value Based Care program." Below this is a table with two rows of vital data:

#	DATE	BP	BLOOD SUGAR	WEIGHT	HEIGHT	BMI
1	16 Jun 2023 2:08 PM	90 /125 mmHg	4.5 mmol/L	52.7 kg	0.58 m	156.7
2	16 Jun 2023 11:51 AM	80 /124 mmHg	4.3 mmol/L	65	1.67 m	23.3

Each row has a red trash icon and a blue edit icon. At the bottom left is a "Add another Vitals Reading" button. At the bottom right are "Cancel" and "✓ Continue" buttons.

4. Click on to save the new edits.

4.4 Saving Claims

Once all entries have been made, the next action is to save the claim. Click on the

or

button to save a claim. The latter will save the claim and make available another blank claim form for a new entry.

Upon clicking on the save button, the application validates the entries that have been done against the set NHIS claims generation guidelines and protocols as well as data quality and validity rules. Should the application encounter any error(s) within the entries, such will be communicated to the user on the validation results pane found at the right side of the claims entry form (indicated by arrow in Figure 4-36). By clicking on the error message, the application highlights the field contributing to the error.

Figure 4-35: Saving claims showing validation pane

The screenshot shows the "UPDATE CLAIM" form with several validation errors displayed in a red box on the right side:

- "Service outcome must be provided" (with an arrow pointing to the "Service Outcome" section)
- "One or more specialties attended must be provided" (with an arrow pointing to the "Specialties Attended" section)

The main form fields include:

- Member Details:** Member No. 44543232, Surname PATIENT, Gender FEMALE, Date of Birth 23/11/2000, Age: 20yrs.
- Type of Service(s):** Outpatient (checked), Inpatient (unchecked), Diagnostic (unchecked), Unbundled (unchecked), All-Inclusive (checked).
- Service Outcome:** Discharged (unchecked), Died (unchecked), Transferred Out (unchecked), Absconded (unchecked).
- Dates Of Service:** 1st Visit: 12/12/2020, 2nd Visit, 3rd Visit, 4th Visit.
- Type of Attendance:** Chronic Follow-up (unchecked), Emergency/Acute Episode (checked), Ante-natal (unchecked), Post-natal (unchecked).
- Specialties Attended:** This section is currently empty.

The application computes the cost of the claim and saves it once it passes validation.

The Principal GDRG is required for all IPD cases especially those involving multiple GDRGs. The selected GDRG cannot be outside the list of GDRGs used on the claim form.

Figure 4-36: Successfully saved claim

PATIENT TEST

Member No.	Date of Birth	Age	Gender
44543232	23 Nov 2000	20yrs	F
CCC No.	Folder No	Claim Month	
12343	212/12	DEC 2020	

CLAIM SUMMARY

TYPE OF SERVICE	GDRG/CODE	AMOUNT
Outpatient	OPDC06A	12.24

Total **GHC 12.24**

PREVIEW **EDIT** **CLOSE SUMMARY**

As shown in Figure 4-37, a saved claim can be edited directly using the **EDIT** button or previewed using the **PREVIEW** button. A previewed claim looks similar to Figure 4-28

Figure 4-37: Claims preview page

CLAIM PREVIEW

CLAIM FORM
NATIONAL HEALTH INSURANCE SCHEME

Facility	TEST PRIMARY HOSPITAL	Scheme Code	W R S		
Hl Code	0 3 - 0 8 - 0 6 7 6 9	Month of Claim	0 6 2 0 2 0		
CLIENT INFORMATION					
Surname	B A I D E N	Gender	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female		
Other Names	H A C T O R I A				
Date of Birth	0 8 / 0 6 / 1 9 4 5	Age	7 4		
Folder No.	A 2 7 7 2 2 2 2	Member No.	- - - - -		
		Card Serial No.	W R S K M 0 2 5 A 9 8 0 3		
SERVICES PROVIDED					
Type of Service	<input checked="" type="checkbox"/> Out-Patient <input type="checkbox"/> In-Patient <input type="checkbox"/> Pharmacy <input type="checkbox"/> Diagnostic <input checked="" type="checkbox"/> All Inclusive <input type="checkbox"/> Unbundled	CCC	6 1 3 2 7		
Outcome	<input type="checkbox"/> Discharged <input type="checkbox"/> Died <input type="checkbox"/> Transferred Out <input type="checkbox"/> Absconded/Discharged against medical advice	Date(s) of Service Provision	1st Visit 0 1 / 0 6 / 2 0 2 0 2nd Visit 0 1 / 0 6 / 2 0 2 0 3rd Visit / / / 4th Visit / / /		
Type Of Attendance	<input type="checkbox"/> Chronic Follow-up <input type="checkbox"/> Emergency/Acute Episode <input type="checkbox"/> ANC	Duration of Spell (days)	1		
		Specialty Code	O P H T		
CLIENT CLAIM SUMMARY			Name		
Type of Service	G-DRG / Code	Tariff Amount			
TOTAL		1 1 . 6 3	Signature		

4.5 Editing Claims

It is also possible to edit claims that have been saved previously, should there be the need to do so. To edit a claim;

1. Click on the  menu and select your preferred year and month.
2. At the claim list view, use the type of service tabs (OPD, IPD, DIAG, etc.) to narrow your search.
3. You may manually search for the claim or use the search feature to do so (See section 4.7).
4. Click on the claim of interest to open, the claims in edit mode (to effect the needed changes).
5. Click on  to save all changes that have been made.

4.6 Deleting Claims

To delete a claim, follow the following steps;

1. Click on the  menu and select your preferred year and month.
2. At the claim list view, use the type of service tabs (OPD, IPD, DIAG, etc.) to narrow your search.
3. You may manually search for the claim or use the search feature to do so.
4. Once you find the claim you want to delete, click on the  to delete the claim. **Please note that once a claim is deleted, it cannot be retrieved.**

An alternative approach is opening the claim in the edit mode and clicking on the “Delete” button at the bottom of the form.

4.7 Searching for claims

Claims can be searched for by either visually perusing a list of claims or using the advanced search option. The steps for doing the latter are specified below;

1. Click on the  menu and select your preferred year and month.
2. Click on the  icon, found at the right top section of the page. This will open a search form.
3. The user is allowed to search for a claim or claims using one or a combination of the parameters available on the search form. The parameters are;
 - a. Member no.
 - b. Member name
 - c. Claims Check Code (CCC)
 - d. Date range (Start date and end date)
4. Once the needed parameters are entered, click on the  button to start the search.
5. Search results are aggregated under a “**Search tab**” with an indication of the total number of claims found.

4.8 Preparing Claims for Submission (Exporting Claims)

Once all claims have been entered for a month, the next major step is to prepare the claims for submission to NHIS. Claims can only be exported for submission by a user with such privileges (**refer to section 3.2**). The application offers two (2) options for claims submission. The user has the option to;

1. Uploading claims directly to the NHIS server via the internet, or
2. Downloading an encrypted claims file and physically sending it to NHIS using a flash drive,

To prepare claims for submission, the following are the steps;

1. Open the month of interest (refer to section 4.1) and click on the submit clams button =>  button found at the centre left section of the view (indicated by arrow in Figure 4-33). This should open a page that provides more detailed information on the action(s) to be performed (illustrated in Figure 4-40).

Figure 4-38: Claims list page showing the Export button

Smart Claims

NHIS CLAIM-it
generate submit analyze

Provider Info
TEST PRIMARY HOSPITAL
Public Primary Facility without Catering

NEW CLAIM

CLAIMS

CLAIMS FOR FEB 2020

Change Month

ALL 2,620 IPD 333 OPD 2,287

Search 5

CLAIM DATE	MEMBER NO	NAME
05 WED	10691994	NANA MEMUNA
10 MON	21587765	MOHAMMED NANA WAWA

Figure 4-39: Claims Submission / Export page

SUBMIT BATCH FOR FEB 2020

Total Volume **2,620** claims

Total Cost **119,715.14** GHC

	VOLUME	COST
Outpatient	2,287	54,701.59
Inpatient	333	65,013.55

Service Cost	72.78%
GHC 87,124.41	

Medicine Cost	27.22%
GHC 32,590.73	

Disclaimer
You are about to export claims for **Feb 2020**.

* Claims generated from this system are still subject to adjudication by NHIA.
Continue with Submission only if you agree.

* Claims for Feb 2020 will be LOCKED. You can unlock later after the submission.

* It is recommended that you run the [Submission Advice Report](#) for Feb 2020 to review pending issues.

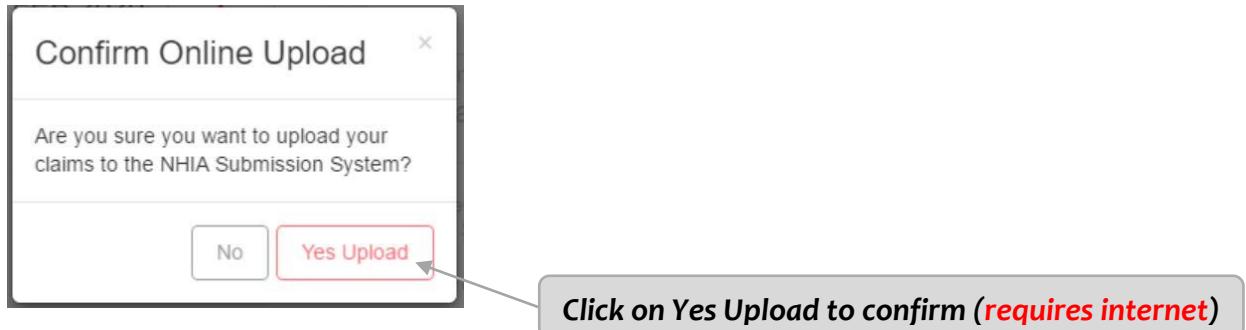
Submit Offline **Submit Online**

The submission/export page displays among others the total volume and cost of claims segregated by type of service and the percentage distribution for service and medicine cost. This is illustrated in Figure 4-40 above.

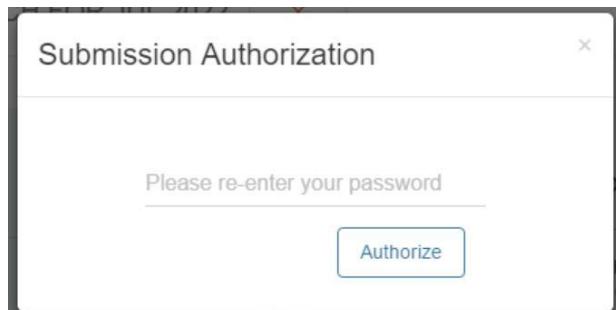
Additionally, the user also gets to see information on all recent claims submissions and uploads. It is also recommended that a **submission advice report** be generated before claims are submitted. To do this, refer to the **Reports section** of this document.

2. Click on Submit Online button  to start the online process of claims submission which will go through the following processes;
- 2.0.1 The system will request for a confirmation from the user to start the online claims submission process, as illustrated in Figure 4-41 below.

Figure 4-40: Confirmation for online submission



- 2.0.2 The process will initiate once the user authorizes the submission by re-entering the password. Please note that only the **Insurance Officer** role has the user privilege of submitting claims online.



The status or progress of the ongoing submission will be displayed to the user as shown in Figure 4-41 and 4-42 below. The upload process may happen within a minute or more depending on the current queue.

Figure 4-41: Submission progress monitor

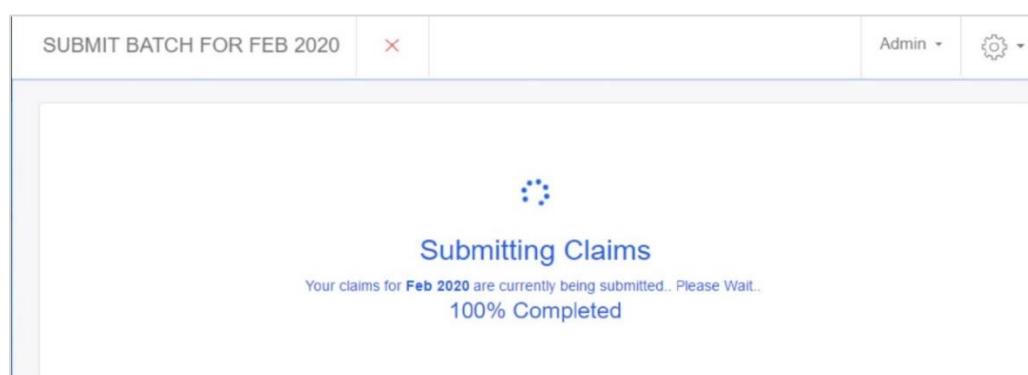
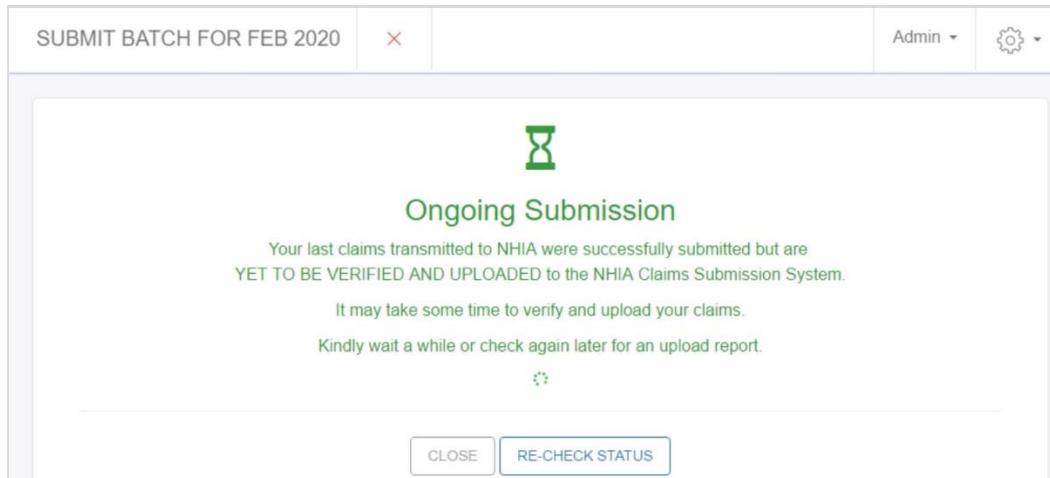
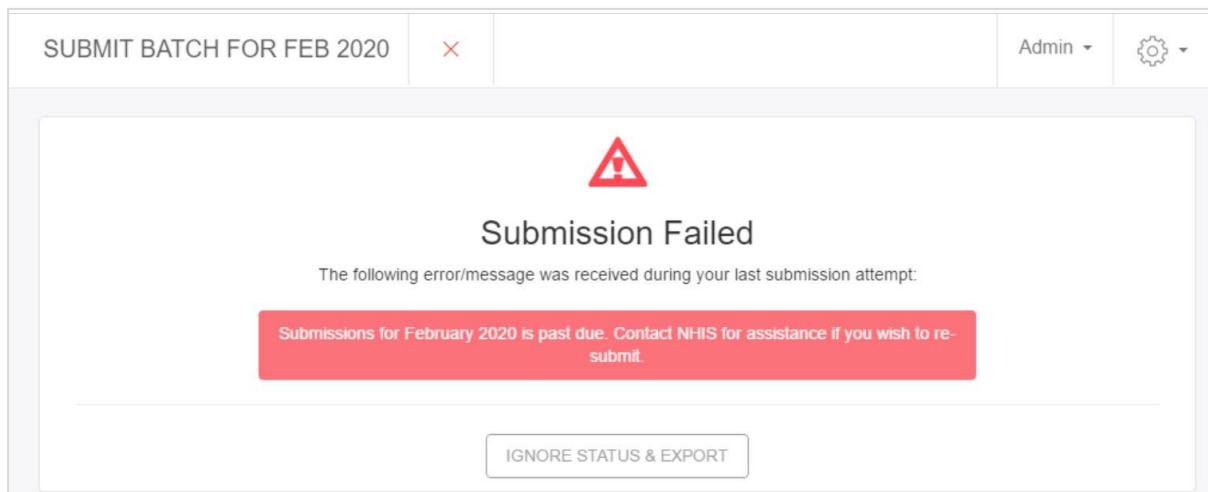


Figure 4-42: Submission status indicator



2.0.3 The final step of the online submission process is for the user to wait for a feedback, to indicate if the submission was successful or otherwise. (as illustrated in Figure 4-43). A submission confirmation email is sent to the email address of the user or health facility once claims are successfully submitted. Should there be a failure in anyway, the user will be informed via the application as illustrated below.

Figure 4-43: Submission feedback



To submit claims offline go through the following steps;

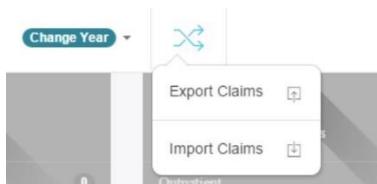
1. Click on the Submit Offline button  as shown in Figure 4-34.
2. This will generate an encrypted claims file which can be saved on a flash drive (popularly called, Pen drive).
3. Submit this file on the flash drive to the closest NHIA district office or Claims Processing Centre.
4. A confirmation receipt will be printed and given to the submitter while an email is equally sent the email address assigned to the providers account.

4.9 Exporting and Importing claims

This feature helps with easy movement of claims data from other computers to a “central computer” in order to aggregate claim entries within a facility prior to submission. This feature is recommended for scenarios where a health facility has no Local Area Network but with multiple computers and persons involved in data entry. Under such conditions the application is installed on all user computers but data aggregation at the end of entries are manually done on a single computer through the **claims export and import feature**. Hence all other users export their entries which are then imported into the application on the computer being used as the collation point. Claims management is therefore done at the point of aggregation.

To export claims, please do the following;

1. Click on the Export/Merge button  located at the top section of the general claims view area of the application. This will pop-up two options (export claims/import claims) as shown in the diagram below.



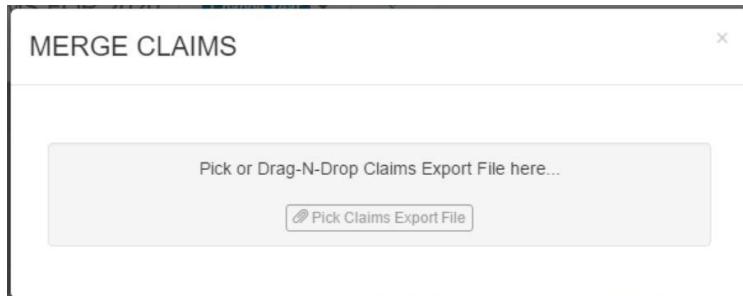
2. Select “Export Claims” and indicate the month of interest as illustrated below.



To import exported claims;

1. Click on the Merge Claims button  and select “Import Claims”.
2. A dialogue box will open, requesting the user to select a location of the exported file. Alternatively, the user can drag and drop the exported file into the area shown in Figure 4-44 below.

Figure 4-44: Merge claims dialog box



3. Click on the  button to finally start the import process.

Figure 4-45: Uploaded export file for merging



Users are notified once claims importation is successfully completed.

5.0 UPDATING THE SYSTEM

5.1 General Information

This section describes the update feature of the application that enables users to keep the application up to date.

The claim-it application, from time to time will require a system update. The update feature of the application enable users to keep the application up to date.

5.2 System Update

There are two (2) major types of system updates.

1. **Policy and tariff updates:** This has to do with update on claims generation protocols, GDRGs and tariffs.
2. **Application updates:** This refers to update to the structure and (other component) feel of the application.

However, all these types of updates are installed in the same manner. Once system updates are available, emails and/or text messages will be sent to all users of the application to notify them.

5.3 Installing Updates

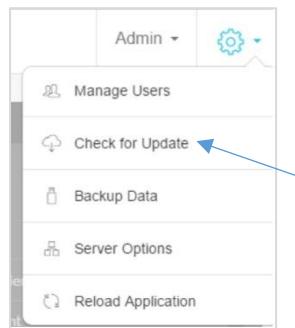
Updates can either be installed directly via the internet or downloaded and installed offline.

5.3.1 Direct Update

To update the application directly via the internet, do the following;

1. Click on the Settings  button and click on “Check for Update”.

Figure 5-01: Settings menu indicating check update button



2. The application then checks for any recent updates and informs the user through a prompt.

3. Click on “**Install Update**” to start the installation i.e. if any updates are found.

The application periodically **checks for updates automatically** once it detects an internet connection. However, the user is always informed of any available updates prior to installation. Anytime new updates are available, user will be prompted by a red button indicating “**Update Available**” on the left side of the home screen of the application. By clicking on this button, the download process is initialized.

5.3.2 Offline Update

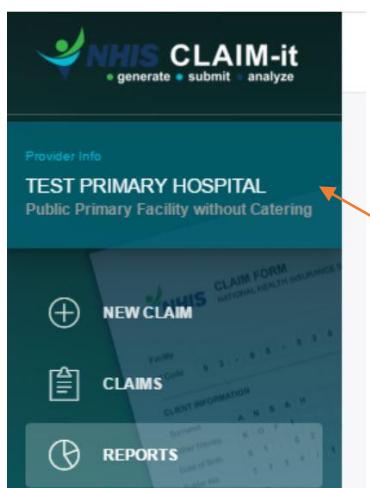
This option requires the user to download and manually install the update file. To do this;

1. Open a web browser and enter **claimit.nhia.gov.gh**. Go to the **Updates** section of the webpage to download the required update. Your update file will then be saved to the default download directory of your browser.
2. Double-click on the update file to install. You will be notified once the installation is complete.

Update files can also be accessed at any NHIS district office or CPC.

Details of updates that have been run on the system with regards to Base Data, Service tariffs, Medicine prices, Validation rules and Credentialing information can be found at the Setup Detail section of the application. To open this section, click on the Provider Info area at the left section of the application after login, as shown in Figure 5-1 below;

Figure 5-1: Home screen showing the Provider info section



The section as shown in Figure 5-2 shows information on credentialing and system updates. For instance a description of “version 2016-03-01” under Service tariffs simply means the most current tariff version in the application are tariffs with an effective date of March 2016 so on and so forth. Figure 5-2 is a further illustration of this section.

Figure 5-2: Provider info view showing updated details

The screenshot displays two panels of a software interface for managing provider information and system components.

Provider Information Panel:

- Setup Details:** A header bar with an 'i' icon, 'Setup Details', and a close button ('X').
- Provider Information:** A blue header bar.
- Details:**
 - Provider Name: TEST PRIMARY HOSPITAL
 - Provider ID: 03-08-06769
 - Facility Type: Public Primary Facility without Catering
 - Prescribing Level: C1
- Installed Credentials:** A blue header bar.
- Credentials Table:** A table with columns: Unique Code, Facility Type, and Effective Date.

Unique Code	Facility Type	Effective Date
03-08-725-01-06769-03-C1-2-010118	Public Primary Facility without Catering	01 Jan 2018
- Update Credentialing:** A blue button with a gear icon and text.

Installed Components Panel:

- Installed Components:** A blue header bar.
- Components Table:** A table with columns: Component and Version.

Component	Version
Base Data	Mar 2016
Service Tariffs	Mar 2016 , Apr 2019
Medicine Prices	Mar 2016 , Jul 2018 , Jul 2019 , Apr 2020 , Mar 2021
Validation Rules	Mar 2016
Client Application	Head
- Check for Updates:** An orange button with a checkmark icon and text.

6.0 REPORTING

6.1 General Information

This section describes the various reports and visualizations in the application.

6.2 Types of Report

The application comes with **seven (7)** report types. The reports are categorized under seven (7) themes, i.e. Dashboard, Overview, Attendance, Medicines, Services, Submission Advice and Excel Summary.

1. Dashboard:
 - a. Summary attendance.
 - b. Claims submission volume and cost.
 - c. Top 10 Diagnosis.
 - d. Top 10 Prescribed Medicines.
2. Overview:
 - a. Claims volume and cost by type of service for the current month.
 - b. Claims volume and cost, month on month for the current year.
3. Attendance:
 - a. Attendance by gender and age grouped by specialty. For both OPD and IPD cases.
4. Medicines:
 - a. Top ten (10) most prescribed medicines.
 - b. Top ten (10) most utilized medicines by cost.
 - c. Most utilized therapeutic classes by volume
5. Services:
 - a. Top ten (10) most utilized GDRGs by volume.
 - b. Top ten (10) most utilized GDRGs by cost.
 - c. Top five (5) Major Diagnosis Categories (MDCs) by volume.
6. Submission Advice:
 - a. List of claims that require further attention, categorized into;
 - i. Potential duplicates
 - ii. Multiple ANC claims
 - iii. Attachment required claims
7. Excel Summary:

- a. Excel Workbook containing sheets on various volume and cost summaries on claims

6.3 Accessing reports

To access the desired report(s), the user simply clicks on the  menu and selects the desired report by clicking on the select  button. All reports are defaulted to report on the current year. However, the period of reporting can be changed by clicking on the filter  button to specify the range of choice. Figures 6.1 to 6.4 illustrates some of the reports generated by the application.

Figure 6-1: Dashboard

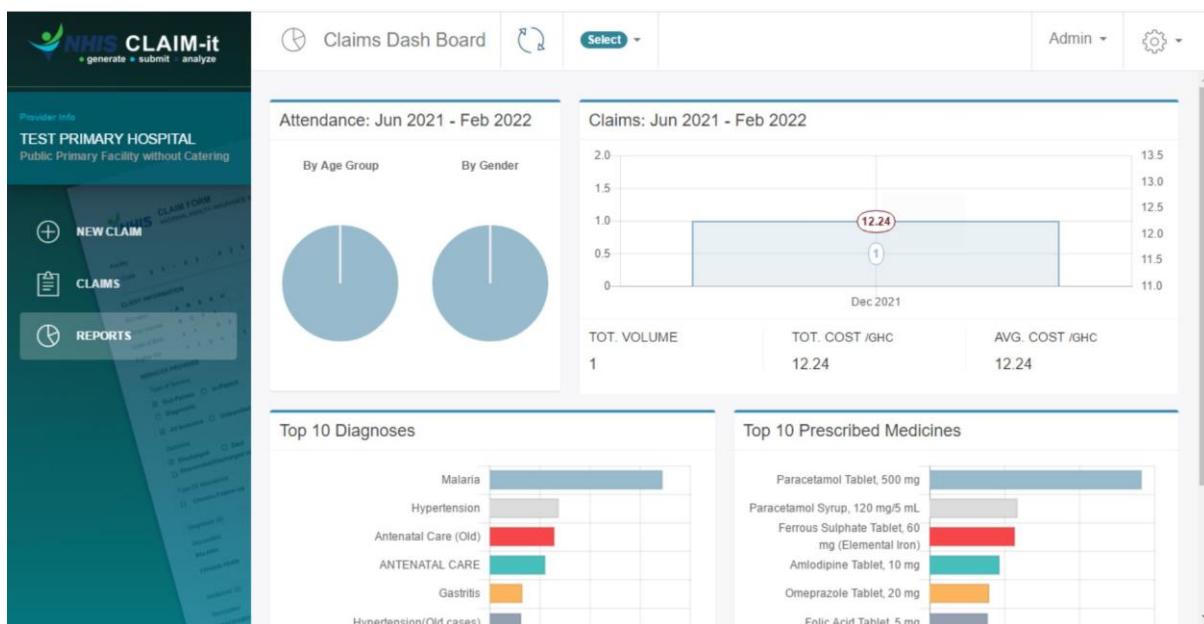


Figure 6-2: Overview of claims report

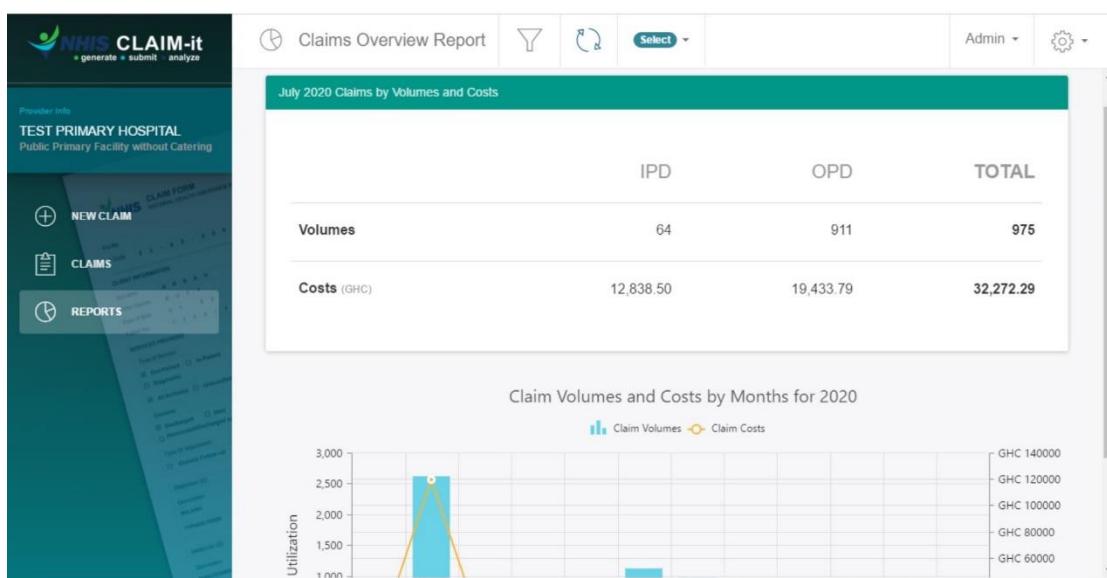


Figure 6-3: Attendance report

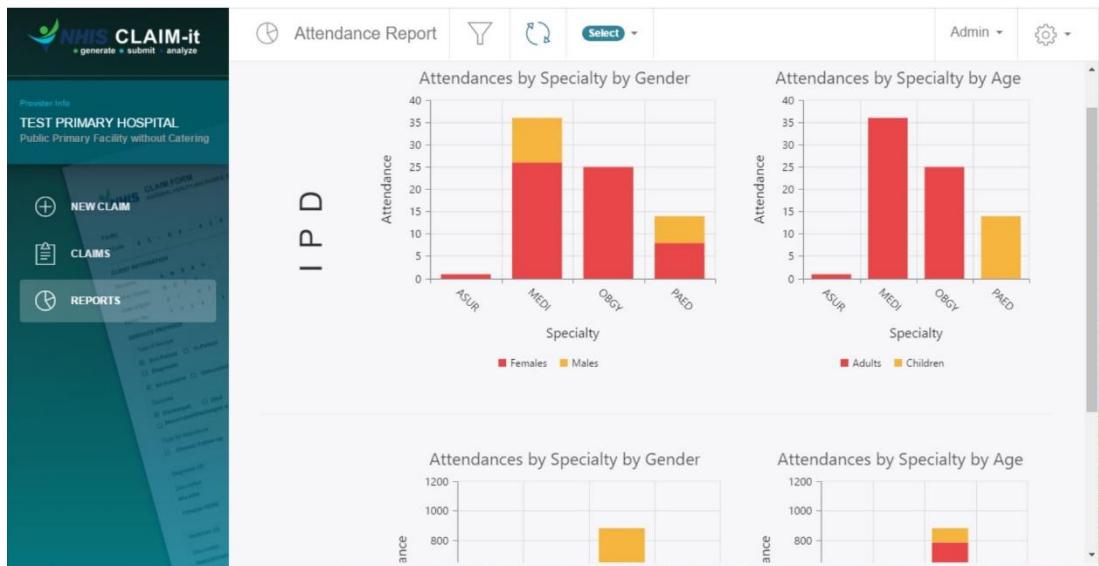


Figure 6-4: Report on service utilization



Figure 6-5: Report on medicine utilization



6.4 Submission Advice Report

This report forms part of the reports available at the reports section of the application. The submission advice report gives the health facility's insurance officer a report on claims that may require some extra attention prior to submission. For instance, based on the types of medicines dispensed, the lab results that prompted the prescription of such medicines are required by NHIA during vetting to serve as proof. Hence, such a document will have to be scanned and attached to the affected claims in all such instances. Therefore, it is advised that a submission advice report be generated prior to claims submission.

To generate a submission advice report do the following;

- a. Click on the Reports menu
- b. Click on and select the Submission Advice.
- c. Click on and select the month of interest
- d. Click on to show the reports. Depending on the issues detected the number of reports can span from one to several. This is illustrated in Figure 6-5.

Figure 6-5: Report on medicine utilization

Submission Advice Report

 Filter 

Filters: Claim Month: Apr 2017

Diagnostic Claim Attachment Required

1 Diagnostic Claim(s) require attachment of their Diagnostic Request Forms.
[Download](#)

Supporting Documents Required

17 Claim(s) require attachment of their supporting documentation.
[Download](#)

- e. Click on the “**download**” button below each report and save it at a desired location.

7.0 DATA BACKUP

7.1 General Information

The data backup features of the application elaborates further on how it could be utilized to prepare users to recover from unknown system failures.

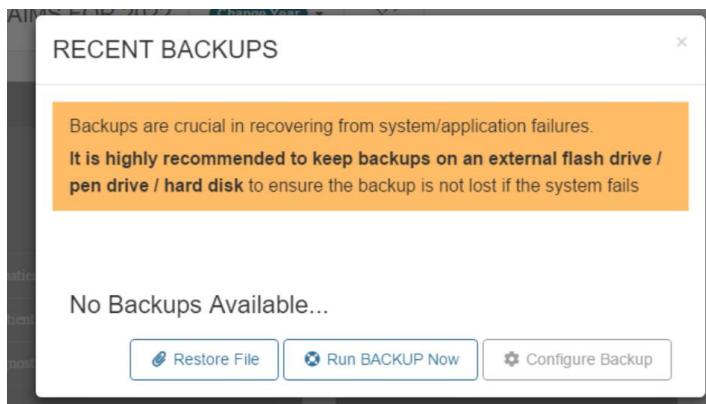
7.2 Backup Feature

The application is equipped with an automatic backup feature, allowing a copy of generated claims data to be created based on the preferred period of the user. Automatic backups can be configured to create daily, weekly or monthly backup. However, by default automatic backups are scheduled to run every day. Backups are created for each month, **over a three (3) months period**. Users are therefore **advised to download and save such data** on an external storage device.

Once a backup is created, a notification icon will appear on the settings icon to indicate the availability of a backup for download.

However, to generate or restore a backup, please go through the following steps;

1. Click on the settings icon and select Backup/Restore Data



2. Click on “Configure Backup” if there is a need to change the default Backup settings. Else,
3. Click on “Run BACKUP Now” to create a recent backup of your claims as illustrated by the diagram below.

RECENT BACKUPS

Backups are crucial in recovering from system/application failures.
It is highly recommended to keep backups on an external flash drive / pen drive / hard disk to ensure the backup is not lost if the system fails

Kindly click on the backups below and choose to save them on an external flash drive / pen drive / hard disk

CLAIM MONTH	BACKUP TIME		
JUL 2022	03 JUL 2022 09:36:10	 RESTORE	 DOWNLOAD
JUN 2022	03 JUL 2022 09:36:10	 RESTORE	 DOWNLOAD
MAY 2022	03 JUL 2022 09:36:10	 RESTORE	 DOWNLOAD

[Restore File](#) [Run BACKUP Now](#) [Configure Backup](#)

By clicking on this button, the user is presented with a list of available backups and the options to either download and/or Restore any of the applicable backups.

8.0 TROUBLESHOOTING

8.1 General Information

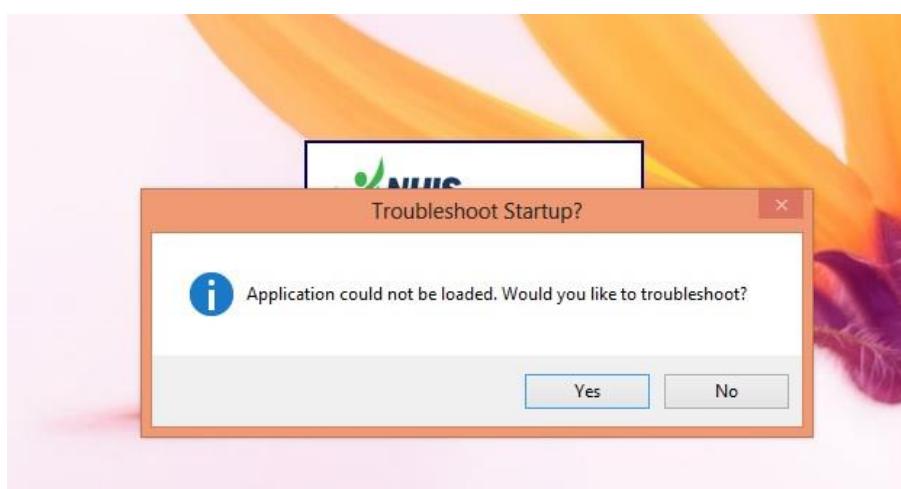
This section explains the processes that users should go through in order to solve some basic technical glitches which may cause the application not to start.

8.2 Troubleshooter Utilization

Anytime the application is started, it checks to see if everything is fine for its efficient operation. If it encounters any error, application loading is truncated and the user prompted with the option to run the trouble-shooter utility.

This is illustrated in Figure 8-1.

Figure 8-1: Automatic trouble-shooter prompt



By clicking on “Yes”, this utility will diagnose the problem and automatically try to fix all identified issues. Illustrated in Figure 8-2.

Figure 8-2: Troubleshooter Utility



The results of the troubleshooting will be displayed to the user. If there is any reason to re-run trouble-shooting, click on “**RUN**”.

In very extreme circumstances where the troubleshooter is not successful at fixing the identified issues, NHIA may require the user to click on “**Download Troubleshoot File**” to download and email that file to NHIA for further inspection to determine what might be wrong.

The user, by clicking on “**Backup Data**”, can also backup all data in the database and save to a flash drive. This helps to keep essential data safe, preventing data loss in worse case scenarios.

9.0 SOFTWARE UNINSTALLATION

9.1 General Information

This section shows the user how to safely remove the application and all its components from the user's computer.

9.2 Uninstalling CLAIM-it

The uninstallation of CLAIM-it is no different from the processes entailed in uninstalling any software from a Windows Operating System. To uninstall follow the following steps;

- a. Open “**Control Panel**” and click on “**Programs and Features**”
- b. Identify and click on “**CLAIM-it vHead**”
- c. Click on uninstall to start the uninstallation process
- d. The user will be prompted to either uninstall or keep the database. The latter will complete the installation but keep the database intact. The option is mostly ideal when the intention is to use the same database for a future installation.

Note: *The folder containing backups are automatically placed on the Desktop of the user during the uninstallation process. This is to ensure that inadvertent uninstallations don't result in the permanent loss of data.*