Provider Portal User Guide

Disclaimer:

All efforts have been made to provide the most comprehensive and accurate information in this document. The information and materials have been made available keeping users' interest in mind. The information is however, subject to change without prior notice. MeridianHealth does not warrant the accuracy or completeness of this information and expressly disclaims liability for any errors or omissions or delays in updating this information and materials. MeridianHealth hereby disclaims all liability from any damages resulting from the use of this document or the MeridianHealth Provider Portal.

Table of Contents

Introduction

Welcome to the MeridianHealth Provider Portal user guide. Meridian is dedicated to making a difference in the lives of our members and providers in the healthcare industry. The Provider Portal allows providers to verify member eligibility and submit authorization requests; view member information such as name, address, phone number, authorizations, HEDIS data, immunizations and additional insurance; view a provider's enrollment, HEDIS bonus data and claim status; and submit new claims and edit rejected claims.

Getting Started

In the upper right corner of the MeridianHealth website (http://www.mhplan.com), there is a link to the Provider Portal Login. Select the login drop-down menu and click **Provider**. You will be redirected to an overview of the Provider Portal. Select your corresponding state from the drop-down and then register as a new user or log in with your user ID and password.

Access the Provider Portal

To gain access to the web portal, providers must be contracted with the health plan. You will then need to register to obtain a unique user ID and password. Click the **New Provider? Register Here** link to begin the process.

Registration

When registering for the MeridianHealth Provider Portal, all three sections of the Provider User Registration page must be completed. This includes the provider group information, office contact information, and the NPI numbers of the providers in the provider group. After the information is verified, the unique user id and password entered will be sent to the email address provided in the Office Contact section.

- Provider Group Information: Name of provider group and location of facility
- Enter the Office Contact Information: Contact information for users requiring access to the portal.
- Add Providers to the Group: National Provider Identification (NPI) of each provider included in your group

Log In

1. Go the website of the health plan and select the Providers link.
2. Select the Provider Login link to open the web portal.
3. Type your unique user ID name in the ID field.
4. Enter in the password that was emailed to you.
5. Select login and the MeridianHealth Provider Portal will display.

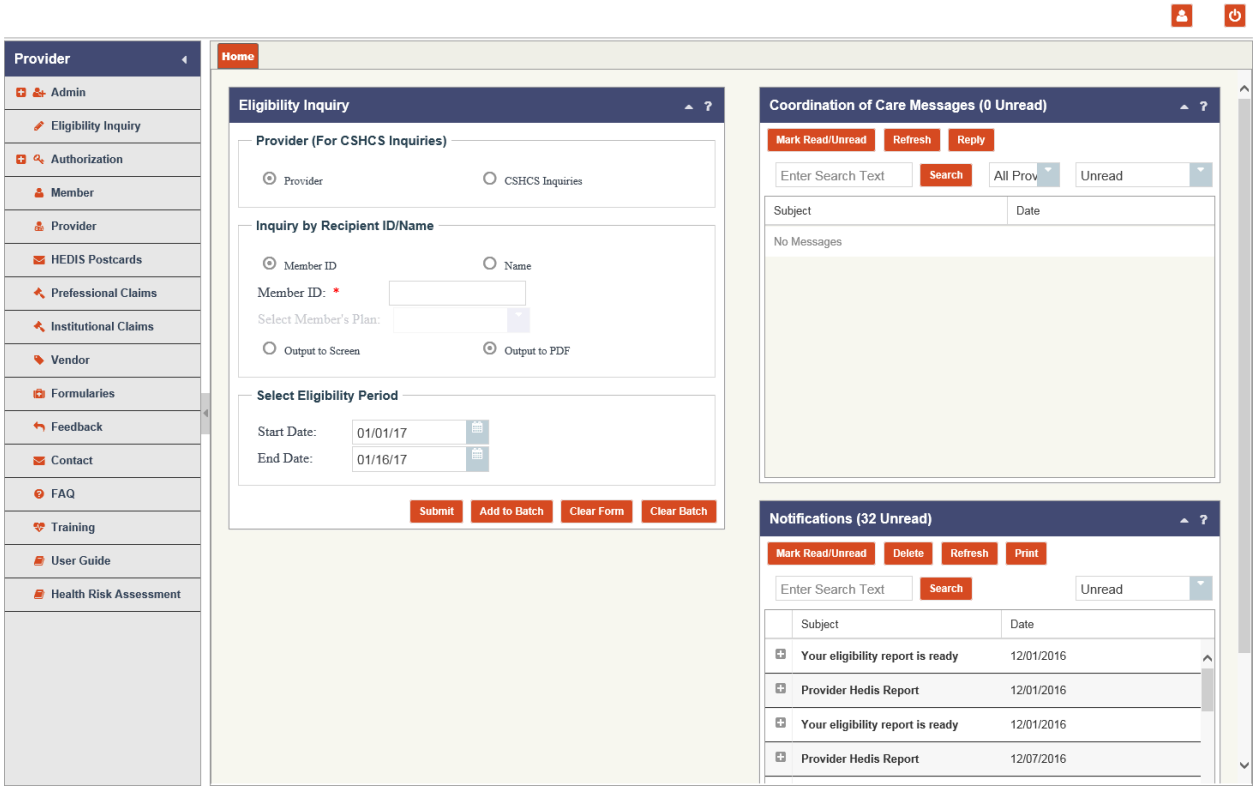
A unique username is required for you to log in. If this is the first time you are logging in, a page will display explaining the security feature of setting up secret questions and answers. After reading this page, select the Thank you button. After clicking **Thank you**, the Secret Question/Answer window will prompt you to select two security questions and answers. Once the questions have been selected, you can click the **Proceed** button to login.

User Interface

The user-friendly interface, accessed via internet, is a valuable tool for anyone wanting to successfully manage a member's healthcare needs. The user interface (UI) allows providers to easily access and utilize information regarding members under their care. Providers can give commands by selecting and clicking on icons or choose commands from lists displayed on the page.

When you log in to the Provider Portal, the Home page is selected by default. On the Home page, notice the Navigation Menu and the Command bar. The Navigation Menu provides quick access to the information indicated. The User Settings and Reset buttons display on the Command bar. Click the User Settings button to change your password. Click the Reset button to clear your information and start over.

Functions and information available on each page are explained in subsequent parts of this documentation.



Home

The Home page will display after you successfully log in to the Provider Portal. From here, you have access to Eligibility Inquiry, Message(s), and Notifications(s). You also

have the option to navigate to other pages in the portal. The arrow button will minimize the navigation menu allowing you to expand your workspace. When the navigation menu is hidden, you still have access to opened pages within the display.

Eligibility Inquiries

When you first log in to the MeridianHealth Provider Portal, the Eligibility Inquiry page will display. This can be used to see which health plan the member has had for the past twelve months. Eligibility can be verified by using the member's recipient identification number, name, date of birth or Social Security number. You can also select different time frames to check the eligibility, but all verifications must be performed in 90 day increments. If the provider office does not have the member's id number, the office can search using the member's name plus birth date or social security number. This report is based on a rolling twelve month time frame and will export as a PDF version of the member's eligibility.

Verify Eligibility by Recipient ID

1. Select the Provider check box.
2. Select the member ID check box for inquiries by member ID.
3. Type the member's recipient ID number in the Member ID field.
4. Enter the Start Date and End Date for the eligibility inquiry. If you do not enter a date in the End Date field, the system assumes the current date.
5. Click **Add to Batch** if searching multiple members.
6. Click **Submit** to generate a PDF version of the eligibility report.

Verify Eligibility by Name, Date of Birth, or Social Security Number

1. Select the Provider check box.
2. Select the Name check box for inquiries by name.
3. Type the member's name, date of birth and social security number into the text fields.
4. Enter the Start Date and End Date for the eligibility inquiry. If you do not enter a date in the End Date field, the system assumes the current date.

5. Click **Add to Batch** if searching multiple members.

6. Click **Submit** to generate a PDF version of the eligibility report.

Verify Eligibility for CSHCS Members

You can review eligibility of members if they are enrolled with Children's Special Health Care Services (CSHCS) through the Eligibility Inquiry function. On the top portion of the page, select “CSHCS Inquires” and enter the NPI or Medicaid ID number.

1. Select the CSHCS check box.

2. Type the NPI or Medicaid ID in the text field.

3. Follow Steps 2-6 in the above section to search by member ID or name.

Use the Message Pane

The message pane consists of two separate windows that Meridian uses to communicate with providers. You can use the Coordination of Care Message inbox to communicate with a member's care coordinator. The Notifications inbox allows MeridianHealth to send bulletins, messages, reports and notifications of receipt for authorizations submitted online. If you do a batch eligibility request, those eligibility reports also display up here. All of your unread messages will display in bold. You can minimize the Care Coordination Message(s) inbox or Notification(s) inbox on the Home page by clicking the on the top right of each of the pages. To view the page, click the button.

View your Batch Eligibility Report

The plus sign next to the report will display a description stating your eligibility report is ready. Click the **Print** Icon to display a PDF version of the report.

Deleting an Eligibility Report

When you open an eligibility report, the message is automatically marked as 'read' meaning that it has been opened. If you want to mark it as unread again, select the Mark Read/Unread button. If a message has been marked as 'unread', the next time you click it, it disappears. To view message again, click the **Refresh** button. A message is not gone until you click the **Delete** button.

Admin

Admin within the navigation menu can be expanded to display the administrative functions of the portal. Full access to this section is only available to the group administrator. This user is identified by a 001 at the end of the User ID. Within the Admin section you are able to modify settings for the entire group. As the administrator, you have the ability to manage all user and provider preferences, accessibilities and information.

User Preferences

The User Preferences page stores your name, address, email address and phone number. You can change the information on the User Information side of the page. Click the **Save Preferences** button to save information you have updated. You can click the **Clear** button to delete all the current user information and display red exclamation points next to the text fields that require information. An explanation of the fields is below.

Field	Description
Username	Portal user name
Provider ID number	Provider ID
Provider Name Group	Name of the office/institution that is utilizing the Provider Portal
Default Report Output	PDF or a page will display with information pertaining to the provider group

Change User Password

You can change your password to the MeridianHealth Provider Portal at any time. Note: Passwords are case sensitive and must be at least eight characters.

1. Click **Change Password** option to display the Change Password dialog box.
2. Select the Old Password field and enter the password you are currently using to log in to the web portal.
3. Type the password that you want to use in the text field labeled New Password.
4. Type identical password in the text field labeled Confirm New Password.

5. Click the **Change Password** button to save your new password.

Change Security Questions

When you sign into the Provider Portal, they will be asked questions before they have access to the Home Page. You need to pick two security questions that you can easily remember the answers to. These questions can help you log in if you forget your password. The Change Security Questions page will allow you to change your questions.

1. In the Secret Question / Answer Setup dialog box, select the Question #1 drop-down list and pick a question.

2. Type your answer in Answer Field #1.

3. Select Question #2 drop-down list and pick a question.

4. Type your answer in Answer Field #2.

5. Select the Remember Me check box. This will store your answers on your computer and you will not have to answer your secret questions each time you login to the MeridianHealth Provider Portal. If the Remember Me check box is not checked, you need to answer your questions upon each login. If you log in from a different computer, you need to supply the answers to your questions regardless of whether the Remember Me check box was selected.

6. Click the **Save Secret Answers** button.

Manage Accounts

The Manage Accounts option under the Administration menu is available only to the user designated as the administrator of the group. The administrator of the group has 001 after the first three letters of their login id. On the Manage Accounts page, as the administrator, you can perform the following actions:

- Create new user ids for the provider group
- Terminate a user
- Display a list of active and terminated users
- Reset passwords
- Export user information

Create New User Id's

All users in your office need to have their own user id. If users are trying to use the same id they may have trouble logging in to the web portal. In the New User Request section the administrator can create additional ids when necessary. Enter the number of new users you want to add in the text field and click the **Create Additional Users** button.

Terminate a User

When an employee leaves your office, the administrator needs to terminate that user's web portal log in id. This ensures that the user cannot log in and access member and provider data from another computer. In the User Information section, enter the user ID you want to terminate in the text field. Select the Terminate check box and click the **Update User** button. A confirmation box will ask if you want to terminate this user. If you select Yes a red window will display stating the user has been terminated.

Display a List of Active and Terminated Users

The administrator user can check which user ids are being used, those that have never been used and those that have been terminated on the Manage Accounts page of the Admin menu. To display a list of active user select the Manage Accounts option under Admin. Then click the **Active Users** button and the list will display under the Never used/Active/Terminated User(s) Section. You can also click the **Terminated Users** and ID's **Never Used** button to display lists according to each property.

Reset Passwords

You can reset a user's password, or reset a range of users' passwords at one time. Enter the user id into the text field in the User Information section and click the **Change Password** button. A red notification will display the new password. If you need to reset multiple passwords click the **Bulk Password Reset** button. Enter the username of the ids you want to reset in the text field and click the **Reset Password** button. A red notification will display the password. Make a note of this password because the users need it to log in to the web portal.

Export User Information

Click the **Export User Information** button to generate an Excel file of the data.

Manage Providers

The Manage Providers option under the Administration menu is only available to the user designated as the administrator of the group. As the primary administrator, you have the ability to remove an existing provider or add a new provider. The provider location information will automatically populate when you select the provider. The Export Providers button generates an Excel spreadsheet that includes address information for each provider under the group. Any of the requests made can be submitted to Meridian for final change.

Remove Providers

1. Select provider from the Remove Existing Providers drop-down.
2. Click the **Add** to list button
3. Click **Del** from list button
4. Click the **Submit Request** button

Add Providers

1. Enter provider's NPI number in the Add NPI# text field.
2. Click the **Add** to list button.
3. Click the Submit Request button Authorizations.

Authorizations

From the authorization page you can submit an authorization or inquire about an authorization electronically rather than by fax or phone. You can click the **Authorizations** drop down within the navigation menu of the Provider Portal and select either Create New Request or Inquiry. If necessary, you have access to the contact information of authorized participants and providers on the member's Integrated Care Team (ICT). Also included here is information about the member's Individual Integrated Care Plan along with any data received from Integrated Care Bridge Record (ICBR) transactions.

Care Team

Care Team page will display the contact information of authorized care givers on the member's account. The member's primary care physician (PCP) will often be included in the ICT. The care givers are presented in list form, you can click on each individual to view more details. The following information about the care giver will be displayed:

- Provider ID
- Care Giver ID
- First Name
- Last Name
- Specialty
- Participant Type

Integrated Care Data

Integrated Care Data will include any information about the member received through ICBR transactions or reported by their care coordinator. The source and receive date of each ICBR transaction displays next to the associated data. Information found in the individual ICT is continuously updated by the care coordinator after any type of contact with member. Assessments and screenings will be included when the reports are received from the state. Each section is explained further below.

Section	Information Displayed
Patient Information	Demographics, Personal, and Contact
Nursing Facility	Location, Status, Start date, Completion and Comments
Medications	Medication, Assessments, Form, Instructions, Frequency, Diagnosis Type, Route, Prescribed, Over the Counter, Herbal Supplement, Prescriber NPI, Diagnosis code, NDC, Quantity, Fill Date and Days Supplied
Social History	Education, Employment, Living Arrangement, Health and Safety Problems, Correction Status, Veteran Status, Smoking Status, Family History
Initial Screening	Results of the report received from state ICBR transactions
Level I Assessment	Results of the report received from state ICBR transactions
Level II Assessment	Results of the report received from state ICBR transactions

Individual Integrated Care Plan	Plan of Care (POC) Due and Start Date, Problem, Barriers, Strengths, Member Centered POC Priority, POC Goal, POC Term of The Goal, Interventions, POC Goal Start Date, Goal End Date, Goal Decline Date, Time Frame for Completion.
Care Team	Information on authorized care givers for the member
Integrated Conditions	Medical (Top Ten) and Behavioral (Top Ten) Integrated Conditions
Continuity of Care	Waiver Code and Allergies

Create New Request

From the New Request page can be used to submit a prior authorizations request. The Authorization Procedure Overview link will display a description of Prior Authorization procedures. Anything that has an asterisk is a required field that needs to be filled out in order for the correct authorization to be processed. The following steps will guide you through the process of creating a new authorization request. A field description table is also provided to help clarify any questions on the required information.

1. Click **New Request** to automatically generate a new window.

2. Type the desired member ID in the text field. All information will auto-populate.

3. Select the level of service (Inpatient or Outpatient).

4. Depending on your level of service, options for procedure category will change. Note: Both Inpatient and Outpatient options for procedure categories are not the same.

5. Select the desired Requesting Provider with a drop-down menu option.

6. Choose the Place of Service from the drop-down menu.

7. If the servicing provider is OON (Out of Network), click to put in the servicing provider information. There will be an option to either search by Provider Name or search by NPI number.

8. Fill in the Start Date, End Date, Admit Date, and Discharge Date. If an authorization is inpatient, the Admit and Discharge dates will be active. If the authorization is an outpatient, then the Admit and Discharge dates will not be

active.

9. If the authorization is accident related or if there is another Primary Payer responsible for the authorization, those options will be available and the proper information will need to be entered. Once all of the required fields have been entered into the referral, the Next button towards the bottom will be active and the Service page will be active to input information.

10. When a referral is entered through the portal, click **Next** and a SERVICE page will be available.

11. Type the desired Procedure Codes in the text fields. There is no limit to the number of Procedure Codes that can be used.

12. Diagnosis Codes can also be entered through the Service page. There is no limit to the number of Diagnosis Codes that can be used.

13. Once the Procedure Codes and the Diagnosis Codes have been entered, click the **Contact Notes** button.

14. Fill out the Contact, Name, Phone Number and Notes sections. The Subject will always be Submission.

15. Once all of the information has been filled in, click **Submit**.

16. The Request ID will display in the new window once submitted. There will also be the option to attach clinical documentation once the authorization has been submitted. This ID can be used to inquire about that specific claim. Even though it is a confirmation, the authorization doesn't necessarily mean that it is automatically approved. The authorization will be placed on a Hold Status once it has been submitted.

Field	Description
Request ID	Authorization number
Start Date	Start date of the time span the authorizations cover
End Date	End date of the time span the authorizations cover
Member ID	Member's ID number
Level of Service	Outpatient: A patient who receives medical treatment without being admitted to a hospital. Inpatient: A patient who stays in a hospital while under treatment.

Status	Current state of the authorization you are inquiring about. N = new, V = void, H = on-hold, O = approved, D = denied
Member Name	Member's full name
Referring Provider	Name of the provider that referred the member for the procedure
Servicing Provider	Name of the provider that is performing the procedure
Servicing Facility	Name of the facility where the procedure will take place
PCP	Name of the member's primary care physician
ICD 10 Codes	International Classification of Diseases
CPT Codes	Current Procedural Terminology

Authorization Inquiry

The Authorization Inquiry page located under Authorizations within the navigation menu can be used to search for a member's authorizations. You can search by the Type of Authorization, Start Date, End Date, Provider referred to or Facility referred to. Enter all relevant information into the text fields and click the **Search** button to populate the results. You can select View to review the desired authorization. If necessary, adding notes to the authorization is available; all notes will be saved to the authorization and submitted to Meridian. You can select Print on the Authorization ID page or (on the main Inquiry page) to bring up a PDF displaying details of the authorization.

Member

In order to search a member in the Provider Portal, the provider must be currently treating the member. Meridian is able to track this from previously submitted claims. Providers can utilize this function by entering the Member ID number, or by searching the member's name or Social Security number. Selecting the Magnifying Glass icon next to the Member ID will allow providers to search by name. There are six pages in the member section. Functions of each page are described below.

Demographics

The Demographics page in the Member section shows the member's address and phone number. If the member is a minor, the guardian information section is also

entered. The Notify Health Plan button is used to send notifications to the health plan's Member Services department to alert them of a member's change in address or phone number. This button is also used to advise the Case Management department of the health plan if the member meets the criteria for case management. The Print Member Report button at the bottom of the Demographics and HEDIS pages of the Member section lets you generate several different reports for members.

Notify Health Plan

This is where you are able to notify the health plan of a member's change of address or a change of phone number.

Create Member Report

You can choose from the following information:

- Family Members
- Eligibility History
- HEDIS
- Member Profile
- HRA Summary
- Six-Month Pharmacy Detail

Member Authorizations

The Authorizations page of the Member section displays all authorizations the member has with the health plan. You can use this page to find the status of an authorization, sort authorizations, locate an authorization id number, print an authorization and begin the process of submitting a new authorization. The buttons at the bottom of the page allow you to do this.

Button	Function
Print Report	The Print Report button creates a report in Adobe of all authorizations listed on the page.
Print Authorization	The Print Authorization button creates a report in Adobe of the authorization that is selected on the page.
New	The New button opens the Authorization Request page with the member's name, id number and PCP entered.

Find the Status of an Authorization

If you want to sort authorizations by status, you can select a specific status from the Status drop-down list. For example, if you only want to see approved authorizations, you would select Open from the Status list. There are other authorizations statuses to select including hold, new and incomplete, among others.

1. Click the **Authorizations** page from the Member program.
2. Enter the member's id number in the ID field and press enter to display the member's information.
3. Select the type of authorization you want to see from the Status drop-down list.
4. Click the **Refresh** button and all authorizations with the status you selected will display in the list box.

HEDIS

The HEDIS page in the Member section allows you to view the HEDIS measures a member has had and is due to have based on the HEDIS guidelines. These measures encompass services for children, women's health and specific measures related to such diseases as diabetes. By default, you only see measures that a member is due to receive. If you want to see all measures, click the All option. Each HEDIS measure that is assigned to the member displays in this list box which is divided into five columns.

Column	Explanation
Measure	The Measure field displays the procedure that needs to be performed. For example, you may see comprehensive diabetes care.
Sub Description	The Subject Description lists the individual procedures necessary for the measure listed in the Measure column. For example, you may see HbA1c Test.
Due By	The Due By column displays the date by which the measure must be completed. • For childhood immunizations, the measure is due by the child's 2nd birth date. • For adolescent immunizations, the measure is due by the child's 13th birth date. • For well child visits in the first 15 months, the measure is due by the child's 15 month birth date.

	• All other measures are due by the end of the reporting year.
HEDIS Hit Date	This HEDIS Hit Date column displays the date of service on the claim for the selected measure. This is the date that the HEDIS measure was performed. This column is only populated after a claim has been paid for the measure.
Report HEDIS	If a member has an incomplete HEDIS measure, the Edit icon (report_icon.png) displays in this column. If the provider office knows that this measure has been completed, the office can click this icon and enter the requested information for the measure.

As you click the measure, a description displays beneath the list box.

Immunizations

This page lists all immunization records for a member previously recorded by the State. The Blood Lead Tests box contains all the blood lead tests for the member that the State has recorded and sent to the health plan. This is updated each month with a file exchange between Meridian and the State. If there are no records, a message will display in red at the bottom of the page. Always enter the Member ID number or search for the member by name by clicking the Magnifying Glass icon at the top of the Member page.

COB

COB (Coordination of Benefits) indicates to providers if a member has other insurance coverage. A red **C** located under Alerts on the right side of the Demographics page indicates the member has other coverage. If there is no COB, a message in red will display at the bottom of the page. The COB page also lists following information.

- Insurance company name
- Group #
- Policy #
- Effective date
- Term date

Claims Status

The Claim Status page in the Member section displays all claims filed for the member. When you click the Claim Status page, the Claim Status page of the Provider section

opens displaying the member's claims. In the claim list is an E icon. If you click this, the member's eligibility displays in an Adobe file.

Provider

As a contracted Meridian provider, this menu is important to you. The Provider drop-down within the navigation menu allows you to perform the following actions:

- Create provider enrollment and HEDIS reports
- View provider enrollment and HEDIS
- View claims status
- Self-Report

Enrollment

The Enrollment page of the Provider program shows all members who are assigned to the provider selected in the Provider list. If the provider is a PCP, you can view their members for the month on this page. The Member Count underneath the list box indicates the number of members assigned to the provider for the current month. The Locations drop-down list lets you switch between the different office locations of the provider. The provider may have different members assigned to them at the different office locations. The HEDIS notification next to a member's name indicates that the member has a HEDIS measure due. If you select a line that has a HEDIS notification, the HEDIS page of the Member section opens showing which HEDIS measure is due. The Member Count underneath the list box shows how many members are assigned to the entered provider for the month.

Create Provider Enrollment & HEDIS Reports

The Enrollment page of the Provider section allows providers create several different reports to help in managing their enrollment and their members' HEDIS needs. These reports include the members name, address, phone number, date of birth, gender and their needed measures, if any. In addition, some reports include the potential bonus the provider can receive when the member completes each measure. The following table lists the different reports created with each of the four buttons at the bottom of the Enrollment page.

Button	Summary of Report
Print (PDF)	The Print button opens a report in Adobe displaying all of the entered provider's members with their address, phone, age, date of birth, gender and the needed HEDIS measure, if any.

Print All Providers (PDF)	The Print All Providers button lets you choose to print a separate report for each provider in the practice, or a combined enrollment list encompassing the entire practice. The report shows all members and the HEDIS measures needed for each.
Export All Providers (Excel)	The Export All Providers button creates an Excel file of all members assigned to a provider's group. A member's outstanding HEDIS measures also display on this report.
Export HEDIS (Excel)	The Export HEDIS button opens a report in Excel. When the report is ready, you are prompted to choose to open the report or to save it to a location on your computer. The report lists each member assigned to the group and the HEDIS measure the member needs. A member can be displayed on this report more than once if they have more than one HEDIS measure due.
Print HEDIS (PDF)	The Print HEDIS button lets you choose to create a report for a specific practitioner within the group or the entire practice. The report opens in Adobe. The first page of it is a breakdown of HEDIS measures.

Provider HEDIS

The Provider HEDIS page displays all the HEDIS measures that a provider's members have due and the possible bonus available if the measure is performed.

If you expand a measure, you see the following information.

- any sub-measures within the main measure
- the number of members needing it
- the hits for the prior year
- the hits for the current year
- the percentage of members who completed this measure
- the bonus that has been paid out this year
- the possible bonus available

The percentage is calculated by adding the numbers in the Prior Year Hits and YTD (Year to Date) Hits columns and dividing the sum by the number in the Members column (YTD Hits + Prior Year Hits / Members = Percentage). If you click the **Print** icon next to each measure, a report opens in Adobe displaying which members need the measure.

Provider Claims Status

The Claims Status page of the Provider section displays all claims filed for a provider or an institution. Doctors use the Professional view while hospitals use the Institutional view. By default, when the Claim Status page opens, the claims are collapsed and are separated by claim number. In the claim list is an E icon. If you click this, the member's eligibility opens in an Adobe file.

You can expand each claim to see further details. This includes the following information.

- the amount paid and denied for each line of the claim
- the revenue and procedure code indicated on the claim
- the number of units on the claim
- the check number
- check date of the claim

View a Provider's Claims

Select the Provider bar on the left. Choose the provider whose claims you want to display from the drop-down list. Select the Claims status page and the Provider's claims display on the page.

HEDIS Self Reporting

You can update a member's HEDIS information on the HEDIS page of the Member section. For example, if the MeridianHealth Provider Portal displays that a member is due for a childhood immunization and then your office knows that it was done, you can enter that information in the MeridianHealth Provider Portal. Please wait at least one business day to see the update in the HEDIS list.

1. Enter member ID number in Id text field.
2. Click the **Icon** to display the HEDIS Update dialogue box.
3. Enter the requested information in the field that needs to be updated.
4. Click the **Update HEDIS** button.

HEDIS Postcards

As a contracted Meridian provider, you can receive bonuses for completing services that meet HEDIS guidelines. Meridian helps you achieve these bonuses by allowing you to send postcards from your office. These postcards are designed and paid for by Meridian. They remind members about needed services and list the provider's name and phone number to call for an appointment. Add the offices you wish to mail the postcards from and then select the appropriate HEDIS measures check box. After you have the correct offices and measures selected, click the **Submit** button to initiate the mailing of the postcards.

Submit Professional Claims

You can submit claims directly through the MeridianHealth Provider Portal. Click **Professional Claims**, located within the navigation menu, to begin the process. All required fields have an asterisk next to them. If the claim has all the required information entered, it is submitted to the health plan. If it does not, a notification will display and allow you to enter the information that was missed. The following steps will guide you through the process of submitting a professional claim. A field description table is also provided to help clarify any questions on the required information.

1. Select the Provider drop-down list and click the name of the provider for whom you want to submit the claim. The provider's NPI should automatically display in the Billing NPI field

2. Type the Medicaid or Medicare identification number of the member for whom you are entering the claim into the Member ID text field.

3. Type the provider's tax identification number used for billing purposes into the Billing TIN text field

4. Type the patient's account number into the Patient Account # text field.

5. Type the authorization number for the claim into the Prior Auth# text field.

6. Click **Place of Service** drop-down and select the code for where the service was performed.

7. Type the first diagnosis code for the claim into the Diag Code text field. You can enter additional diagnosis codes in the boxes provided in the Diag Code line.

8. If the member has additional insurance:
   a) Select the Carrier field and type the name of the carrier.
   b) Select the Insured field and type the name of the insured.
   c) Select the Paid Amount field and type the amount the other insurance paid.
   d) Select the Deny Reason field and type the reason the other insurance denied the claim, if any.

9. To add service lines:
   a) Click the red plus sign next to Service Line. The boxes that are orange are required fields. These include service from date, procedure code, NDC, Units, Billed and Diagnosis Code.
   b) Type the required information in the appropriate fields.
   c) When you finish entering information for a line, click OK.
   d) Repeat the above steps for each claim of the line that you want to add.
   e) When you finish adding lines to a claim, click Submit Claim.

10. When you finish entering claim information, click the **Submit Claim** button.

11. A Claim Submission Response box will display. You can then click **Ok** to complete the process.

Field	Description
Provider	Name of the provider submitting the claim.
Primary Specialty	Specialty of the provider submitting the claim
Member ID	Member's ID, Medicaid/Medicare number
Select Member's Plan	Member's health Plan
Prior Auth#	Associated prior authorization number
Patient Account#	Applicable patient account number
Billing NPI	National Provider Identification number for the billing provider
Servicing Prov NPI	National Provider Identification number for the servicing provider
Billing TIN	Tax Identification Number for the billing provider
Serv Prov Taxonomy	A hierarchical code set that consists of codes, descriptions, and definitions associated with the provider
Claim Freq Code	Original or Replacement

Orig Claim Ref	Original claim reference number
Facility NPI	Associated facility National Provider Identification number
Admit Date	Date of member's admission to the facility
Discharge Date	Date of member's discharge from the facility
Diag. code	Associated diagnosis codes for the claim
Carrier	Name of member's other insurance carrier
Insured	Who is insured under the plan
Paid Amount	Amount paid by other insurance carrier
Deny Reason	Denial reason for other insurance carrier
LMP Date	Date of the member's Last Menstrual Period
Notes	Any relevant notes for the claim being submitted
OB Visits	Dates of relevant Obstetrics and Gynecology visits for the member
Serv. From	Start date of service for the claim
To	End date of service for the claim
Proc. Code	Relevant procedure codes for the claim
Description	Description of reasoning for the procedures codes
NDC	National Drug Code pertaining to the procedure codes
Units	How many units are be billed for
Billed	Total amount billed for
Diag Cd	Relevant diagnosis code for service line
Other Ins Paid	Amount other insurance paid for the service line

Edit Rejected Claims

When a claim is rejected, you can edit the claim and re-submit it directly from the MeridianHealth Provider Portal. On the Claim Status page, if this icon is present, it indicates that the claim was rejected. Click the icon to edit the rejected claim. To fix a line of the claim, click the icon in the Edit column. Once you are finished click Submit Claim. If the claim is acceptable, it is re-submitted to the health plan. If it is not, the fields that are rejected display in red on the page. You can select field the in red to see why it is rejected. As you select the field, an explanation of the rejection will display.

OB/GYN Visits

For OB/GYN providers, OB visit dates must be entered before Meridian will pay the claim. Above the Submit/Resubmit Claim button is an OB Visits button. Click the **OB Visits** button and enter in the date of each visit. Not entering the dates slows down the payment process. Entering these dates online ensures timely claims processing. Click **Update OB Visits** after adding the date(s).

Submit Institutional Claim

You can submit claims directly through the MeridianHealth Provider Portal. Click **Institutional Claims**, located within the navigation menu, to begin the process. If the claim has all the required information entered, it is submitted to the health plan. If it does not, a notification will display and allow you to enter the information that was missed. The following steps will guide you through the process of submitting an institutional claim. A field description table is also provided to help clarify any questions on the required information.

1. Select the Provider drop-down list and click the name of the provider for whom you want to submit the claim. The provider's NPI should automatically display in the Billing NPI field

2. Type the Medicaid or Medicare identification number of the member for whom you are entering the claim into the Member ID text field.

3. Type the provider's tax identification number used for billing purposes into the Billing TIN text field

4. Select the type of bill from the Type Of Bill drop-down menu.

5. Select the Statement From and Statement Thru dates from the calendar option.

6. Select the discharge hour and discharge status from the drop-down menus.

7. Type the first diagnosis code for the claim into the Diag Code text field. You can enter additional diagnosis codes in the boxes provided in the Diag Code line.

8. Type the admitting diagnosis codes in the Admit Diag text field.

9. If the member has additional insurance:
   a) Select the Carrier field and type the name of the carrier.
   b) Select the Insured field and type the name of the insured.
   c) Select the Paid Amount field and type the amount the other insurance paid.

d) Select the Deny Reason field and type the reason the other insurance denied the claim, if any.

10. To add service lines:
    a) Click the red plus sign next to Service Line. The boxes that are orange are required fields. These include service from date, procedure code, NDC, Units, Billed and Diagnosis Code.
    b) Type the required information in the appropriate fields.
    c) When you finish entering information for a line, click OK.
    d) Repeat the above steps for each claim of the line that you want to add.
    e) When you finish adding lines to a claim, click Submit Claim.

11. When you finish entering claim information, click the **Submit Claim** button.

12. A Claim Submission Response box will display. You can then click **Ok** to complete the process.

Field	Description
Provider	Name of the provider submitting the claim
Primary Specialty	Specialty of the provider submitting the claim
Member ID	Member's ID, Medicaid/Medicare number
Select Member's Plan	Member's health Plan
Prior Auth#	Associated prior authorization number
Patient Account#	Applicable patient account number
Billing NPI	National Provider Identification number for the billing provider
Servicing Prov NPI	National Provider Identification number for the servicing provider
Billing TIN	Tax Identification Number for the billing provider
Serv Prov Taxonomy	A hierarchical code set that consists of codes, descriptions, and definitions associated with the provider
Claim Freq Code	Original or Replacement
Orig Claim Ref	Original claim reference number
Facility NPI	Associated facility National Provider Identification number
Admit Date	Date of member's admission to the facility

Discharge Date	Date of member's discharge from the facility
Diag. code	Associated diagnosis codes for the claim
Carrier	Name of member's other insurance carrier
Insured	Who is insured under the plan
Paid Amount	Amount paid by other insurance carrier
Deny Reason	Denial reason for other insurance carrier
LMP Date	Date of the member's Last Menstrual Period
Notes	Any relevant notes for the claim being submitted
OB Visits	Dates of relevant Obstetrics and Gynecology visits for the member
Serv. From	Start date of service for the claim
To	End date of service for the claim
Proc. Code	Relevant procedure codes for the claim
Description	Description of reasoning for the procedures codes
NDC	National Drug Code pertaining to the procedure codes
Units	How many units are be billed for
Billed	Total amount billed for
Diag Cd	Relevant diagnosis code for service line
Other Ins Paid	Amount other insurance paid for the service line

Edit Rejected Claims

When a claim is rejected, you can edit the claim and re-submit it directly from the MeridianHealth Provider Portal. On the Claim Status page, if this icon  is present, it indicates that the claim was rejected. Click the  **icon** to edit the rejected claim. To fix a line of the claim, click the  **icon** in the Edit column. Once you are finished click **Submit Claim**. If the claim is acceptable, it is re-submitted to the health plan. If it is not, the fields that are rejected display in red on the page. You can select field the in red to see why it is rejected. As you select the field, an explanation of the rejection will display.

OB/GYN Visits

If an OB visit occurred at the hospital, be sure to add the visit date to the OB Visits page. Above the Submit/Resubmit Claim button is the OB Visits button. Click the **OB Visits button** and enter in the date of each visit. Not entering the dates slows down the payment process. Entering these dates online ensures timely claims processing. Click **Update OB Visits** after adding the date(s).

Formularies

Formularies will display a list of covered drugs according to the member's plan. Drug coverage can vary between plans. All of the available plan formularies are available to view. You can click the desired plan to display a PDF of the formulary.

Vendor

To view Explanation of Benefits (EOBs) from paid claims and look at check details (similar to a Remittance Advice), select this option from the menu at the left. Providers can filter the search by dates. The EOBs are listed for the entire group, not by individual provider. Select the name of the facility from the Vendor drop-down menu. If you are in practice alone, your name will display in the drop-down menu. If you do not see your organization name in the drop-down on the vendor page, contact your Administrator, who will contact the Provider Network Development Representative to assist. A list of checks displays in the page below. You can refine your search to a specific date range by entering the desired dates in the Check Date From and To fields. Select the check you want to view. Then click **Print** at the bottom. A PDF with a detailed check displays in a new window. Automatically create an 835 file by selecting the claim and selecting the Create 835 button on the bottom. A new window with the PDF of the form displays.

Feedback

Meridian is always interested in hearing from our users to better improve our services. Use this form in the Provider Portal to submit feedback directly to Meridian. If you want a response to an inquiry, please enter your Name and Email in the Optional Information text fields. Select the Subject from the drop-down menu. Enter the Message in the text box. When you are done, click **Submit**.

Contact

If you are unable to perform a needed function within the Provider Portal, Meridian has a list of frequently used phone numbers under this menu option. Contact information is available for general MeridianHealth; for Members, Physicians, and Behavioral Health Providers and for Pharmacy Prior Authorization Requests.

FAQ

If you have questions while in the Provider Portal, select the FAQ menu option on the left. The default page will be for questions regarding Administration. To see the answer to the question, click on the red question. To find a question in a different category, select it from the FAQ Category drop-down menu. If you still have questions, please call Provider Services at 888-773-2647.

Health Risk Assessment

In order to meet member's needs, Meridian Health would like the members to complete a personal Health Risk Assessment (HRA). An HRA is a State Mandated series of health related questions that help Meridian Health better coordinate the members care. These questions and answers can determine if a member needs additional care ex: care coordinator, disease management, behavioral health, and smoking cessation.

Schedule Training

A Provider Network Development Representative will come to your office to further assist you on using the Provider Portal. Meridian also offers online trainings for the Provider Portal that are held on Wednesdays from 2 p.m. until 2:30 p.m. EST. To request online Provider Portal training, click on the Training located within the navigation menu

1. Select the date that works for you from the Available Dates drop-down menu.
2. Fill in your Name and Email address and click Submit.
3. You will receive a notification confirming your request for training. Select OK.
4. To the right, there are mandatory modules that must be completed as well. Select the Cultural Competency or Medicare Training links to access the trainings.

Logout

When you are finished working in the MeridianHealth Provider Portal, you need to log out by clicking the Logout link. It is important that you do not click the X button on your browser. If you do not click the Logout link, another user may have trouble logging in next.

Conclusion

Thank you for using the Meridian online Provider Portal. We hope this User Guide has been helpful. For information on how to set up your computer for optimal use and for a description of administrative functions, please see the Provider Portal Overview User Guide. Keep your User ID, Password and Secret Questions and Answers in a confidential place, as the Provider Portal allows access to PHI. We hope that the Meridian Provider Portal is a useful resource and tool to you. Thank you for your continued support.