



Direct Claim Submission (DCS) User Guide For Professional Claims in ProviderConnect

Direct Claim Submission (DCS) allows the provider/submitter to enter a claim directly into our ProviderConnect portal without using any special software. This expedites both the processing of the claim and the payment being sent to you. DCS is recommended for providers submitting a low volume of outpatient claims. If you are a high volume claim submitter, please contact the EDI Helpdesk to discuss batch submission options.

For all web browsers, please make sure you have your browser settings equipped to allow Javascript, cookies, and pop-up windows from www.valueoptions.com and www.beaconhealthoptions.com.

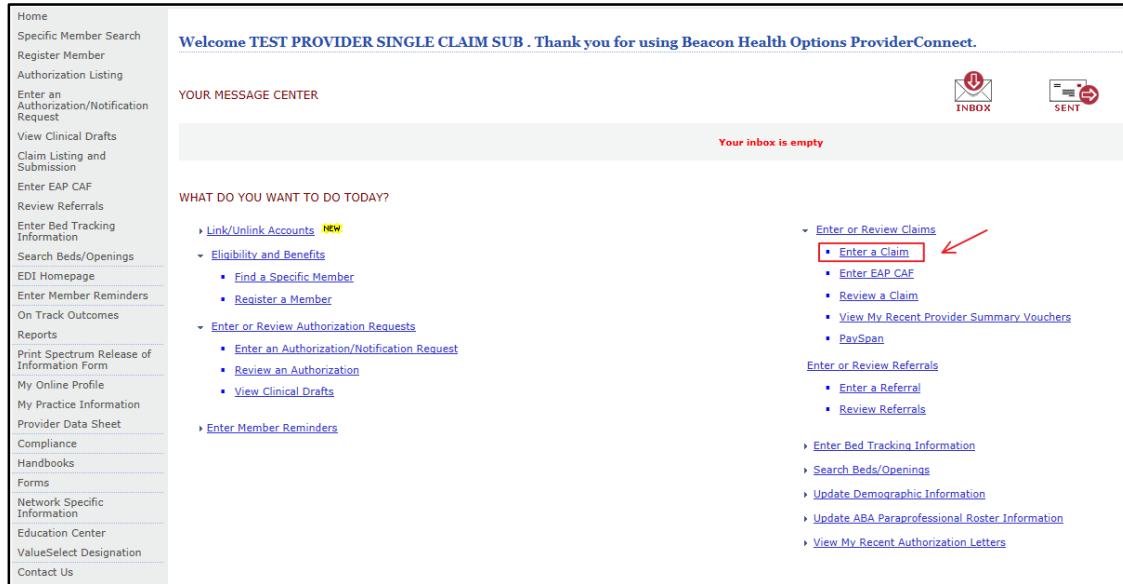
You must register for ProviderConnect in order to access DCS. To register online or locate the Online Services Account Request Form, visit www.beaconhealthoptions.com/providers/beacon/providerconnect/.

If you have questions or need technical assistance, contact the EDI Helpdesk at 888-247-9311, Monday-Friday, 8 a.m.-6 p.m. ET or email e-supportservices@beaconhealthoptions.com.

Note: When sending email to Beacon, do not include any Protected Health Information (member #s, DOBs, etc.), unless you are sending via secure email. For more about how to send and receive secure email from Beacon, see the "General Information" section here: www.beaconhealthoptions.com/providers/beacon/contact-information/.

Direct Claim Submission

At the ProviderConnect homepage, click on the “Enter a Claim” link.



Select your service location by choosing the radio button applicable to your submission. If the listed address options are incorrect or out of date and you are a contracted provider or facility please use the “Update Demographic Information” function in ProviderConnect. If you are not a contracted provider, please contact our National Provider Service Line at 800-397-1630 to update your provider file.

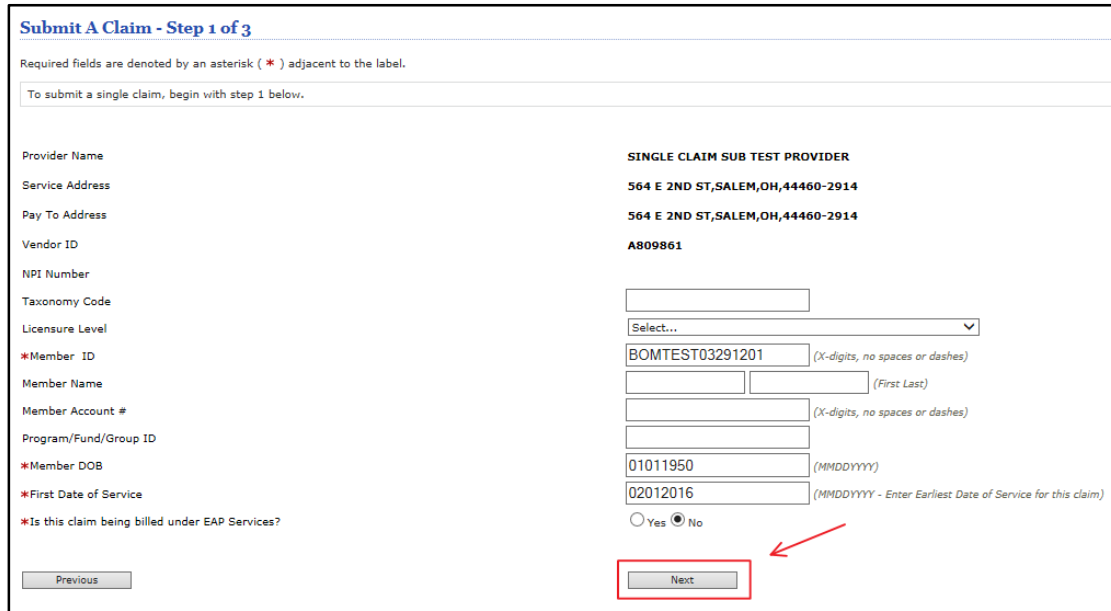


If you have multiple provider numbers associated with your online account, you can select from the Provider drop down menu in the upper left corner of this screen to access additional providers.

Once you have the correct provider and service location information selected, click “Next.”

Step 1 of 3: Submit a Claim- Enter member information:

When entering a claim via Direct Claim Submission, only the items with an asterisk (*) next to the field are required for entry.



Submit A Claim - Step 1 of 3

Required fields are denoted by an asterisk (*) adjacent to the label.

To submit a single claim, begin with step 1 below.

Provider Name: SINGLE CLAIM SUB TEST PROVIDER
 Service Address: 564 E 2ND ST,SALEM,OH,44460-2914
 Pay To Address: 564 E 2ND ST,SALEM,OH,44460-2914
 Vendor ID: A809861
 NPI Number:
 Taxonomy Code:
 Licensure Level:
 *Member ID: BOMTEST03291201 (X-digits, no spaces or dashes)
 Member Name: (First Last)
 Member Account #: (X-digits, no spaces or dashes)
 Program/Fund/Group ID:
 *Member DOB: 01011950 (MMDDYYYY)
 *First Date of Service: 02012016 (MMDDYYYY - Enter Earliest Date of Service for this claim)
 *Is this claim being billed under EAP Services? Yes No

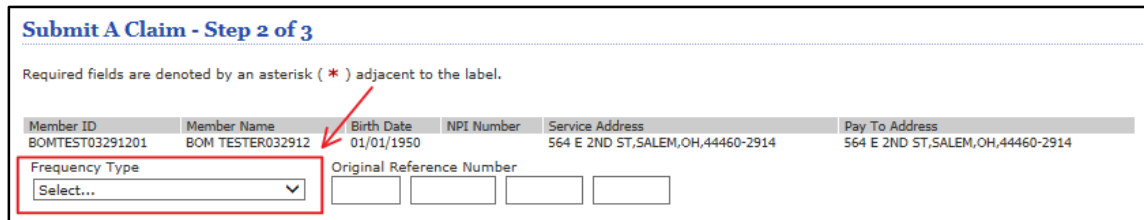
Once you have entered all of the required information, click “Next.” If the information is accurate, you will be taken to Step 2.

If any member information is inaccurate, you will receive an error message in red at the top of the screen. Please validate the member’s ID and date of birth, and then enter the correct information.

*Special note regarding Taxonomy code field: Enter this only if the code is required. This field may be required in certain circumstances where the provider is contracted for multiple specialties.

Step 2 of 3: Submit a Claim- Frequency Type

Frequency Type: If this is a new claim, select “Original.” If you are submitting a “Replacement” or “Corrected Claim,” refer to page 7 of this guide. If there is no Coordination of Benefits (COB) on this claim, click “Next” and continue to page 5 of this guide for Step 3. See below if COB applies to your submission.



Submit A Claim - Step 2 of 3

Required fields are denoted by an asterisk (*) adjacent to the label.

Member ID	Member Name	Birth Date	NPI Number	Service Address	Pay To Address
BOMTEST03291201	BOM TESTER032912	01/01/1950		564 E 2ND ST,SALEM,OH,44460-2914	564 E 2ND ST,SALEM,OH,44460-2914

Frequency Type:
 Original Reference Number:

Coordination of Benefits (COB) / Other Payer Information: This is your opportunity to include information for up to three COB entries that will apply to the entire claim. If the claim you are submitting requires COB, click on the button for “Yes” as seen below. Next, check the box to indicate if there is Primary, Secondary, or Tertiary entries. Once the option for COB is selected, additional fields will become available in order to enter other payer information.

Only populate **Other Payer Information** fields(s) if Coordination of Benefit (COB) information is applicable to dates of service on this claim. I.e., If any payment from other payer entities were previously applied to this claim.

Does a COB exist for this claim?
 Yes No
 Primary
 Secondary
 Tertiary

Other Payer Information - Primary

Payer Responsibility **PRIMARY**

Subscriber is Patient

Subscriber ID

Name Last, First

Date Of Birth Sex

COB Patient Paid COB Allowed Amount Other Carrier Claim Information

COB Claim Adjudication Date

Patient Relationship

Group Name

Group Number

Payer Name

Payer ID

Release of Information

Assignment of Benefits

Patient Signature Source

Claim Filing Indicator

Insurance Type Code

Adjustment Group

Adjustment Reason

Once these fields are complete, click on “Next” to continue to Step 3.

Step 3 of 3: Submit a Claim: Service Line Entry

On this screen, patient information and your service address location should be reviewed for accuracy. If any data is incorrect, click “Previous” at the bottom of the page to correct.

The fields with an asterisk (*) must be completed.

- Enter the details for the first (or only) line of service for the claim
- Click on “Add Service Line” to enter the information into the claim
- Repeat (a) & (b) as needed, for a maximum of 10 service lines

Submit A Claim - Step 3 of 3

Required fields are denoted by an asterisk (*) adjacent to the label.
Note: Disable pop-up blocker functionality to view all appropriate links.

Member ID: 90764321 Member Name: PETER, TUNMAG Birth Date: 12/02/1979 NPI Number: 407654321 Service Address: 24 BEAVER TRAIL, STE C, NARNIA, VA 12345-1234 Pay To Address: 14 BEAVER TRAIL, STE C, NARNIA, VA 12345-1234

To enter detail service lines for the claim, please follow these steps:
 1. Enter your first (or only) service line entry.
 2. Click the “Add Service Line” button to add that information into the claim.
 3. Repeat steps 1-2 as needed, up to a maximum of 10 service lines.
 4. The Service Through date will default to the Service From date if not keyed.

Service Line Entry

*Service From: 12122008 (MMDDYYYY)
 *Service Through: (MMDDYYYY)
 *Service Code: (ex: 86.75.3)
 Modifier Code 1: (no spaces or dashes)
 Modifier Code 2: (no spaces or dashes)
 Modifier Code 3: (no spaces or dashes)
 Modifier Code 4: (no spaces or dashes)
 NDC Number: (no spaces or dashes)
 Charge Amount (\$): (ex: 123.45)
 *Place of Service: (00 - 99)
 *Units: (3-digits)
 NDC Units: (ex: 765.4 OR 765.0)
 *Diagnosis Code 1: (ex: 765.4)
 Diagnosis Code 2: (ex: 765.4)
 Diagnosis Code 3: (ex: 765.4)
 Diagnosis Code 4: (ex: 765.4)
 Diagnosis Code 5: (ex: 765.4)
 Diagnosis Code 6: (ex: 765.4)
 Diagnosis Code 7: (ex: 765.4)
 Diagnosis Code 8: (ex: 765.4)
 Association Qualifier: (ex: XZ)
 Association Number: (ex: 123456ABC)

Primary Payer: COB Payer Paid 1: (ex: 99999.99) COB Units Paid 1: (ex: 999)
 Secondary Payer: COB Payer Paid 2: (ex: 99999.99) COB Units Paid 2: (ex: 999)
 Tertiary Payer: COB Payer Paid 3: (ex: 99999.99) COB Units Paid 3: (ex: 999)

Add Service Line This will add this service line information to the claim

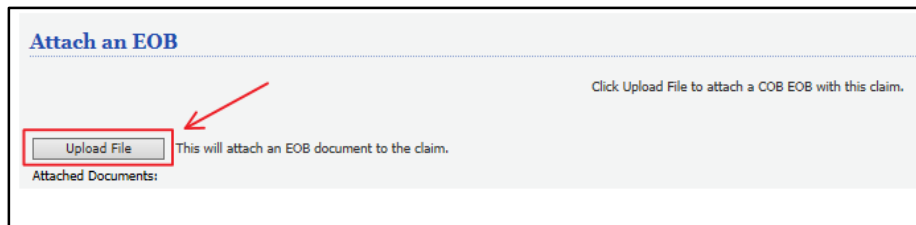
Please note the following helpful hints when completing these fields:

- Do not include the dollar sign (\$) in the charge amount field. (for example, type 120.00, not \$120.00)
- You must enter the decimal in the diagnosis code if applicable (for example, F92.2 would require a decimal)
- The letter at the beginning of the diagnosis code should always be capitalized (for example, the “f” in F32.9 must be capitalized)

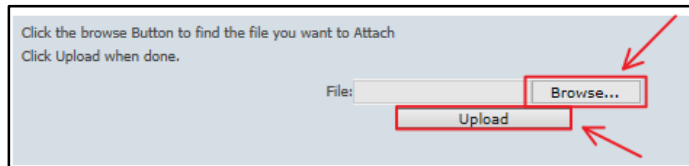
If you have included COB information in Step 2, the accompanying Explanation of Benefit (EOB) will need to be attached to the claim. If the claim does not include COB, see “Ready to Submit” on page 6.

To do so:

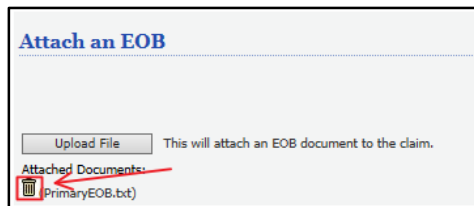
- a) Click on the “Upload File” button.



- b) Click on the “Browse” button to locate the EOB
c) Click on “Upload” to attach the file (Note: The only valid file types are: PDF, DOC, DOCX, TXT, TIF, XLS, XLSX)



Repeat steps a-c as needed. Click on the trash can icon to remove the file if needed



Once “Add Service Line” is selected, you are “Ready to Submit.” If you decide you need to remove one of the service lines you have entered, select the “Click to Remove” radio button for that individual line – then press the “Remove” button. Repeat this process if there is more than one service line you need to remove prior to submission.

Step 3 of 3 continued: Review Claim Detail

Then you can re-enter the correct service line(s) by following the directions on the page 4.

Claim Detail: Ready to Submit

Click to Remove	Service Date		Service Code	Modifier Code 1	Modifier Code 2	Charge Amount (\$)	Diagnosis Code 1	COB Payer Paid			NDC Number
	Start Date	End Date						Primary	Secondary	Tertiary	
<input type="radio"/>	02012016	02012016	90853			100.00	F40.11				
<input checked="" type="radio"/>	02082016	02082016	90853			100.00	F40.11				
Total								0.00	0.00	0.00	

To remove a service line, select the "Click to Remove" button for the line needed to be removed, then click the "Remove" button below

Attach an EOB

Click Upload File to attach a COB EOB with this claim.

Upload File This will attach an EOB document to the claim.

Attached Documents:

This will remove the service line selected above This will submit the entire claim (including all service lines added) This will return to the preceding data entry page

Ready to Submit

Once "Add Service Line" is selected and you have determined there is no data that requires removal, you are "Ready to Submit."

Click "Submit."

Claim Detail: Ready to Submit

Click to Remove	Service Date		Service Code	Modifier Code 1	Modifier Code 2	Charge Amount (\$)	Diagnosis Code 1	COB Payer Paid			NDC Number
	Start Date	End Date						Primary	Secondary	Tertiary	
<input type="radio"/>	02012016	02012016	90853			100.00	F40.11				
Total								0.00	0.00	0.00	

To remove a service line, select the "Click to Remove" button for the line needed to be removed, then click the "Remove" button below

Attach an EOB

Click Upload File to attach a COB EOB with this claim.

Upload File This will attach an EOB document to the claim.

Attached Documents:

This will remove the service line selected above This will submit the entire claim (including all service lines added) This will return to the preceding data entry page

Summary Page


This is the submission results page. A claim number will be automatically generated based on your submission.

Submit A Claim

Submission Results : ***** CLAIM ENTERED *****

Your claim has been submitted successfully. You may contact Claims Customer Service with any questions related to this claim.

Provider Name/ ID: SINGLE CLAIM SUB-478263
 Vendor ID: A809861
 Patient ID: BOMTEST03291201
 Patient Name: TESTER032912, BOM
 Program/Fund/Group ID:
 Patient Date of Birth: 01/01/1950
 NPI Number:
 Taxonomy Code:
 Licensure Level:

Claim # 051816-04055-00001 

Line #	Service Date		Service Code	Modifier Code 1	Modifier Code 2	Charge Amount (\$)	Diagnosis Code 1	COB Payer Paid			To-Pay	Status	Dollar Amount (\$)					Fund	NDC Number
	Start Date	End Date						Primary	Secondary	Tertiary			Allowed	Deductible	Pre-Paid	COIN	CoPay		
1	02/01/2016	02/01/2016	90853			100.00	F40.11	0.00	0.00	0.00	0.00	0	100.00	100.00	0.00	0.00	0.00		
Total								0.00	0.00	0.00									

No EOB COB Documents Attachments

Attached EOBs :

Note: If at this point, an error is discovered you may adjust the claim by submitting a corrected claim. Consult the next section for instructions.

If you wish to enter another claim, press the “Enter New Claim” button at the bottom of this screen. This will take you back to Step 1.

For additional detail on this claim, you can click on the Claim Number (blue hyperlink). This will bring you to the “Claim Search Results” page where more information is provided.

Submitting a Corrected, Replacement or Voided Claim Via Direct Claim Submission

This feature is available if the claim submitted is “In Process” status. If your claim is in “Processed” status, refer to the Guide to Changing or Reprocessing Professional Claims Online here: <https://www.beaconhealthoptions.com/providers/beacon/providerconnect/>.

Submitting a replacement or corrected claim in the DCS module will supersede all information from the previous claim. This process does not allow for selective replacement of individual claim lines. For instance, if the original claim had 3 lines, and the corrected claim only has 1 line, the original 3 lines will be reversed and only the 1 line on the corrected claim will be processed.

Frequency Type Definitions:

- Corrected/Replacement: You can change information on a claim, including detailed information such as dates of service, service codes, modifiers, diagnosis codes, etc.
- Void: When a claim was submitted in error, you can void the entire claim. Changes cannot be made to any information on the claim to being voided.

Steps:

1. Obtain the claim number from your original claim. Claim number: 01-051816-04055-00001.
2. Follow the instructions for submitting a new claim, with the following changes:
3. On the screen labeled “Step 2 of 3,” select the “Frequency Type” as either “Replacement” “Corrected” or “Void.”
4. Enter original claim number as shown below in the “Original Reference Number” fields.

Frequency Type ORIGINAL	Original Reference Number 01 051816 04055 00001
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5. Submit all service lines on the next page and add COB information (if needed), as if this was a brand new claim.

After the claim is submitted, a summary page will display, including your new claim number.