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Disclaimer

- SoonerCare policy is subject to change.
- The information included in this presentation is current as of April 2019.
- Current information can be found on the OHCA public website: www.okhca.org.

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What is Third Party Liability (TPL)?

- TPL means another party is responsible for paying health care costs before SoonerCare pays.
- All other available third-party resources must meet their legal obligation to pay claims first. SoonerCare is the payer of last resort.
- Exceptions to this policy include:
 - Indian Health Services (IHS)
 - Crime victims compensation

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Eligibility

NOTICE: Member's medical benefits will end soon. Please advise them to reapply.

Effective/End dates are shown only for the period of time requested.

Verification Number 1x23sas12: Status A

[Expand All](#) | [Collapse All](#)

Eligibility			
Coverage		Effective Date	End Date
SoonerCare Choice		03/06/2018	03/06/2018
Non Emergency Transportation		03/06/2018	03/06/2018
Mental Health and Substance Abuse		03/06/2018	03/06/2018
Title 19		03/06/2018	03/06/2018

Managed Care Information			
Provider Name	Provider Phone	Health Plan Name	Health Plan Phone
PCMH CLINIC	1-405-555-2000		

EPSDT	

TPL	

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TPL

Carrier Name (Carrier ID)	Policy Number	Group ID (Employer ID)	Policy Holder (Relationship)	Policy Type	Coverage Type	Effective	End
BLUE ADVANTAGE ADMINISTRATORS OF AR	YABADABA2	- (-)	Fee Lingbetter		MAJOR MEDICAL	11/25/2017	12/31/2018

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Claim Submission

Electronic Data Interchange (EDI) Submission

If the primary payer paid:

- Under Other Subscriber Information, in loop 2320, send the SBR segment, AMT segment and IO segment with the amount paid.
 - All CAS segments at the line level.
 - No attachment is required.

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EDI Submission (cont.)

If the primary denied the claim or applied it to deductible:

- The same procedure is followed, with 0.00 entered in the AMT segment.
 - You will then add an attachment to the claim.
 - Add PWK segment with Attachment Control Number (ACN).

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EDI Submission (cont.)

- Provider indicates attachment required for claim and creates the attachment control number.
- Clearinghouse creates a PWK segment, which includes the attachment control number created by the provider.
- Once an electronic (EDI) claim is submitted, provider prints and completes the HCA-13 (attachment cover sheet).
- Provider faxes/mails attachments.

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Attachment Cover Sheet (HCA-13)

Oklahoma HealthCare Authority
Oklahoma Health Care Authority
Electronic Claim Paper Attachment Form
Cover Sheet

The three fields below are required and must match claim.

- 1. Provider Number
- 2. Client ID Number
- 3. Attachment Control Number

Purpose:
This form is to be used when a claim requiring a paper attachment is being submitted electronically. Submission of this completed form along with the required attachment and electronically submitted claim will allow the appropriate review process to be conducted by the OHC/A.

- Instructions:**
1. In box 1, fill in the pay to Provider Number used for filing the electronic claim.
 2. In box 2, fill in the 9-digit client identification number submitted on the electronic claim.
 3. In box 3, fill in the Attachment Control Number (ACN) used for filing the electronic claim. The ACN on this form must be the same number entered in the control number field of the direct data entry (DDE) screen (Medicaid on the Web) or the FWK segment of the 837 transaction. Make sure the ACN is clear and legible on the HCA-13. Illegible information could delay or stop the attachment process. Numbers are the only characters that should be used in the ACN section. Do not use dashes or spaces in the ACN section.
 4. Place this completed form on top of the attachment(s) for each electronic claim. (DO NOT INCLUDE ADDITIONAL COVER SHEETS)
 5. Mail to: DXC Technology
P.O. Box 18500, OHC, OK 73154
Fax: 865-947-3394

NOTE: Do not place another fax cover sheet on top of this form.

***This form is for use with electronically filed claims requiring attachment.**

Sender's Name: Phone Number:

This fax contains confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this e-fax by mistake and destroy the fax you received. Fax transmissions cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete. The sender therefore does not accept liability for any errors or omissions in the content of this message, which arise as a result of fax transmission.

OKLAHOMA
REVISION 02/17

HCA-13

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Portal Submission Professional

Primary Paid

Submit Professional Claim: Step 1

* Indicates a required field.

Claim Type: Professional

Provider Information

This panel contains provider information.

Billing Provider ID	11221122334	ID Type	NPI	Name	FIXEM LP MEDICINE
Zip Code	74105	Contract Code	G	Taxonomy	11221122334
Referring Provider ID		ID Type		SC Provider Number	10013405A
Ordering Provider ID		ID Type		Ordering Zip Code	

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID		First Name	Middle
Last Name			
Birth Date			

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type		Date of Current	
Accident Related		Expected Delivery Date	
Patient Account Number		From Date	To Date
CLIA Number		*Other Insurance	Include
		HMO Copy	No
		Total Charged Amount	\$0.00

Continue Cancel

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TPL Amount

Submit Professional Claim: Step 2

* Indicates a required field.

Claim Type: Professional

Provider Information

Billing Provider ID	11221122334	ID Type	NPI	Name	FIXEM LP MEDICINE
Zip Code	74105	Contract Code	G	Taxonomy	11221122334
				SC Provider Number	10013405A

Patient and Claim Information

Member ID	812345678	Gender	Male
Member	Foe Lingbetter	Total Charged Amount	\$0.00
Birth Date	07/11/2010		
CLIA Number			

Expand All Collapse All

Diagnosis Codes

Select the row number to edit the row. Click the Remove link to remove the entire row.

#	ICD Version	Diagnosis Code	Action
1			

*ICD Version: ICD-10-CM *Diagnosis Code

Add Reset

Other Insurance Details

TPL Amount

Back to Step 1 Continue Cancel

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Primary Denied

Submit Professional Claim: Step 1

* Indicates a required field.

Claim Type: Professional

Provider Information

This panel contains provider information.

Billing Provider ID: 11221122334 ID Type: NPI Name: FIXEM UP MEDICINE
 Zip Code: 74105 Contract Code: G Taxonomy: 11221122334 SC Provider Number: 100123456A
 Referring Provider ID: ID Type: Ordering Provider ID: ID Type: Ordering Zip Code:

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID: B12345678
 Last Name: Lingbetter First Name: Fee Middle:
 Birth Date: 07/11/2010

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type: Date of Current: Expected Delivery Date: To Date: HMO Copay: No
 Patient Account Number: From Date: To Date: Total Charged Amount: \$0.00
 *Other Insurance: Denied

Buttons: Continue, Cancel

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Adding Attachments

Submit Professional Claim: Step 3

* Indicates a required field.

Claim Type: Professional

Provider Information

Billing Provider ID: 11221122334 ID Type: NPI Name: FIXEM UP MEDICINE
 Zip Code: 74105 Contract Code: G Taxonomy: 11221122334 SC Provider Number: 100123456A

Patient and Claim Information

Member ID: B12345678 Gender: Male
 Member: Fee Lingbetter Total Charged Amount: _
 Birth Date: 07/11/2010
 CLIA Number: _

[Expand All](#) | [Collapse All](#)

Diagnosis Codes

Service Details

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
1	Click	attachment.			

Buttons: Back to Step 1, Back to Step 2, Submit, Cancel

NOTE: Attachments work the same for all claim types

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Insurance Denied

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #
<input type="checkbox"/>	Click to collapse.		

*Transmission Method: FT-File Transfer

*Upload File: **Browse...**

*Attachment Type: 77-Support Data for Verification

Description: Primary Insur denial attached

Add **Cancel**

Back to Step 1 **Back to Step 2** **Submit** **Cancel**

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Oklahoma HealthCare Authority | DXC.technology

Fax Attachment

[Contact Us](#) | [Logout](#)

[Claims](#) > Claim Receipt

Your Claim was successfully submitted. The claim status is Suspended.

The Claim ID is 2300123987456

Click **Attachment Coversheet(s)** to view the claim attachments coversheet(s).

Click **Print Preview** to view the claim details as they have been saved on the payer's system.

Click **Copy** to copy member or claim data.

Click **View** to view the details of the submitted claim.

Attachment Coversheet(s) **Print Preview** **Copy** **New** **View**

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Oklahoma HealthCare Authority | DXC.technology

Attachment Cover Sheet

**Oklahoma Health Care Authority
Electronic Claim Paper Attachment Form
Cover Sheet**

Four fields below are required and must match claim.

1. **Provider Number:** 100000000D
2. **Client ID Number:** 001122334
3. **Attachment Control Number:** 2001070899555
4. **Claim Number:** 2310001111111
5. **Date/Time:** 7/15/2015 9:41 AM

Purpose:
This form is to be used when a claim requiring a paper attachment is being submitted electronically. Submission of this completed form along with the required attachment and electronically submitted claim will allow the appropriate review process to be conducted by the OHCA.

Instructions:

1. In box 1, fill in the pay to Provider Number that will be used for filing the electronic claim.
2. In box 2, fill in the nine-digit client identification number that was submitted on the electronic claim.
3. In box 3, fill in the fill in the Attachment Control Number (ACN) that was used for filing the electronic claim. The ACN on this form must be the same number as the assigned control number field of the SoonerCare Portal screen (Medicaid on the Web) or the PWK segment of the 837 transaction. Make sure the ACN is clear and legible on the HCA-13. Illegible information could delay or stop the attachment process. Alphabetic and numeric are the only characters that should be used in the ACN selection. Do not use dashes and spaces in the ACNs.
4. In box 4, fill in the identification number that was assigned to the electronically submitted claim.
5. Place the completed form on top of the attachment(s) for each electronic claim.
6. Mail to EDS, P.O. Box 18500 OKC, OK 73154, fax 405-947-3394




**Note: Do not place another Fax Cover Sheet on top.
*This form is for use with electronically filed claims requiring attachments.**

Sender's Name: _____ **Phone Number:** _____

This fax contains confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately by phone if you have received this fax by mistake and destroy the fax you received. Fax transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete. The sender therefore does not accept liability for any errors or omissions in the contents of this message which arise as a result of fax transmission.

OKLA HCA HCA-13
Revised 06/24/09

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HMO Copay

Submit Professional Claim: Step 1

* Indicates a required field.

Claim Type:

Provider Information

This panel contains provider information.

Billing Provider ID: 11221122334	ID Type: 11221122334	Name: FIXEM UP MEDICINE
Zip Code: 74105	Contract Code: G	Taxonomy: 261QP2000X
Referring Provider ID: <input type="text"/>	ID Type: <input type="text"/>	SC Provider Number: 100123456A
Ordering Provider ID: <input type="text"/>	ID Type: <input type="text"/>	Ordering Zip Code: <input type="text"/>

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID:

Last Name: First Name: Middle:




Birth Date:

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type: <input type="text"/>	Date of Current: <input type="text"/>
Accident Related: <input type="text"/>	Expected Delivery Date: <input type="text"/>
Patient Account Number: <input type="text"/>	From Date: <input type="text"/> To Date: <input type="text"/>
CLIA Number: <input type="text"/>	*Other Insurance: <input type="text" value="None"/>
<input type="button" value="HMO Copay"/> <input type="text" value="Yes"/>	
Total Charged Amount: \$0.00	

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Commercial Insurance (Institutional)

Step 1—Primary Paid

Submit Institutional Claim: Step 1

* Indicates a required field.

Claim Type

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID	1000000000	Contract Code		ID Type	207V00000X	Name	Bob SoonerCare, MD
Institutional Provider ID	<input type="text" value="0123456789"/>			ID Type	<input type="text" value="NPI"/>	SC Provider Number	1000000000
Attending Provider ID	<input type="text"/>			ID Type	<input type="text"/>		
Operating Provider ID	<input type="text"/>			ID Type	<input type="text"/>		
Referring Provider ID	<input type="text"/>			ID Type	<input type="text"/>		

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name First Name Middle

Birth Date

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

*Covered Dates <input type="text"/> - <input type="text"/>	Covered Days <input type="text"/>
*Admission Date/Hour <input type="text"/> (hh:mm)	Discharge Hour <input type="text"/> (hh:mm)
*Admission Type <input type="text"/>	*Admission Source <input type="text"/>
*Admitting ICD Version <input type="text" value="ICD-9-CM"/>	*Admitting Diagnosis <input type="text"/>
*Patient Status <input type="text"/>	*Type of Bill <input type="text"/>
Patient Account Number <input type="text"/>	Other Insurance <input type="text" value="Include"/>
HMO Copy <input type="text" value="No"/>	Total Charged Amount \$0.00

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Commercial Insurance (Institutional) (cont.)

Step 2—Primary Paid

Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	ICD Version	Diagnosis Code	POA	Action
1				

1 *ICD Version *Diagnosis Code

Present on Admission

Emergency Diagnosis Code

Only one emergency diagnosis code is allowed per claim.

ICD Version Diagnosis Code

Other Insurance Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	Payer Code	Prior Amount	Estimated Amount Due	Action
1				

1 *Payer Code *Prior Amount Estimated Amount Due

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Commercial Insurance (Institutional) (cont.)

Submit Institutional Claim: Step 1 ?

* Indicates a required field.

Claim Type **Step 1—Primary Denied**

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID 100000000	ID Type NPI	Name Bob SoonerCare, MD
Zip Code	Taxonomy	SC Provider Number 100000000
Institutional Provider ID	ID Type <input type="text" value="NPI"/>	
Attending Provider ID 0123456789	ID Type <input type="text"/>	
Operating Provider ID	ID Type <input type="text"/>	
Referring Provider ID	ID Type <input type="text"/>	

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name First Name Middle

Birth Date

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

*Covered Dates <input type="text"/> - <input type="text"/>	Covered Days <input type="text"/>
*Admission Date/Hour <input type="text"/> (hh:mm)	Discharge Hour <input type="text"/> (hh:mm)
*Admission Type <input type="text"/>	*Admission Source <input type="text"/>
*Admitting ICD Version <input type="text" value="ICD-9-CM"/>	*Admitting Diagnosis <input type="text"/>
*Patient Status <input type="text"/>	*Type of Bill <input type="text"/>
Patient Account Number <input type="text"/>	Other Insurance <input type="text" value="Denied"/>
HMO Copay <input type="text" value="No"/>	Total Charged Amount \$0.00

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Institutional Claim – HMO Copay

Submit Institutional Claim: Step 1 ?

* Indicates a required field.

Claim Type **Step 1—HMO Copay**

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID 100000000	ID Type NPI	Name Bob SoonerCare, MD
Zip Code	Taxonomy	SC Provider Number 100000000
Institutional Provider ID 0123456789	ID Type <input type="text" value="NPI"/>	
Attending Provider ID	ID Type <input type="text"/>	
Operating Provider ID	ID Type <input type="text"/>	
Referring Provider ID	ID Type <input type="text"/>	

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name First Name Middle

Birth Date

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

*Covered Dates <input type="text"/> - <input type="text"/>	Covered Days <input type="text"/>
*Admission Date/Hour <input type="text"/> (hh:mm)	Discharge Hour <input type="text"/> (hh:mm)
*Admission Type <input type="text"/>	*Admission Source <input type="text"/>
*Admitting ICD Version <input type="text" value="ICD-9-CM"/>	*Admitting Diagnosis <input type="text"/>
*Patient Status <input type="text"/>	*Type of Bill <input type="text"/>
Patient Account Number <input type="text"/>	Other Insurance <input type="text" value="None"/>
HMO Copay <input type="text" value="Yes"/>	Total Charged Amount \$0.00

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Resources

Resources

- OHCA Public Site: www.okhca.org
- OHCA Provider Forms: www.okhca.org/forms
 - TPL-1 form
- Billing Manual (Chapter 14)
 - www.okhca.org/provider/billings/manual/manual.pdf
- OHCA Provider Helpline
 - 800-522-0114 (toll free) or 405-522-6205 (OKC area)
 - Option 3,2 for Third Party Liability

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Resources *(cont.)*

- Onsite Visits: soonercaeducation@okhca.org
- Spring 2019 Provider Workshop
 - Registration available on the OHCA Public Site <http://okhca.org/xtraining.aspx>
 - Lawton – April 30
 - Durant – May 9
 - Guymon – May 15
 - Oklahoma City – May 22-23
 - Tulsa – May 29-30

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Questions



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