# *How to submit an eClaim Part A in eMedicaid*

eMedicaid URL - https://encrypt.emdhealthchoice.org/emedicaid/

Must be a Participating Maryland Medicaid Provider with an established eMedicaid Account.
If your do not have an eMedicaid Account please refer to How to register for eMedicaid to get started.

Administrators will need to authorize eclaim Part A services to all users that will be submitting claims.
For instructions of how to manager users please refer to How to manage eMedicaid Accounts .

1. Log into Maryland Department of Health's eMedicaid Site with your provider ID and Password.

**Maryland**

MEDICAL PROGRAMS

*Web Services*

*... brought to you by the Maryland Department of Health*

**Welcome to our site!**

If you are not a Maryland Medicaid provider or their representative, please visit our home page.

**Healthcare Professionals:**
This site provides secure online services for Maryland Medicaid Providers where you can verify recipient eligibility, obtain payment information and Remittance Advice (RA).

**Step 1:** Apply to participate in Maryland's Medicaid Program as a Medical Care Provider through ePREP. please select 'go!' next to Step 1. go!

**Step 2:** If you already have a Medicaid Provider Number, Register to use this go! site. Check eMedicaid User's guide for help.

**Step 3:** Sign in!

Creating and Managing eMedicaid Accounts.
eMedicaid User's guide
EVS Help
eClaim Overview
eClaim Tutorial
eClaim PartB Tutorial new
New Password Info
MFA Tutorial

*For best results when using this site, do not use your browser's "Back" button for navigation.*

| Sign In | |
|---|---|
| User ID: | |
| Password: | |
| | Sign In |
| Forgot Your Password? | |

2. Signing in will take you to the home page.
   This page provides the different services available under your account. Please click on eClaim (UB04 Part A) to begin entering a claim.

This page you can submit a new claim or search all the claims previously submitted.

## eClaim (Part A / CMS UB04)

1. In order to submit a new claim, choose from which location you will submit the claim(if applicable).
2. To view the past claims click on the claim history link.
3. Delete this test new branch

**Browser: Chrome; Version: 134**
**Chrome is supported**

Provider Name:

Provider Base Number:

Provider Location:

New Medicare Crossover Claim:  [ New Claim ]

**User type is 'Provider User': You can search all claims which you have submitted**

| Claim No.: | | Claim Version: | | Recipient MAID: | | |
| Prov Base Num: | | Date Start >= | | Recip First Name: | | [ Find Claim ] |
| Prov Loc: | | Date End <= | | Recip Last Name: | | |
| Status: | --Claim Status-- | ICN: | | | | |

**Number of results: 3**

| Emedicaid Claim Number | Claim Version | Recipient MAID | Recipient First Name | Recipient Last Name | Provider No. | Submitter | Submit Time |
|---|---|---|---|---|---|---|---|

3. To start an eClaim Part A lookup the recipient by entering the Recipient MA ID. This will pre-populate all the recipient details that was Previously entered under your provided id.

   NOTE: Usage notes are available to assist in completing the form.
   You can always hide this display by clicking on the box next to Usage Notes

a. Enter the required eClaim Part A fields.

Required Fields:

3a. PAT. CTRL#

4. TYPE OF BILL

6. STATEMENT COVER PERIOD: FROM AND THOUGH

8. PATIENTS NAME

10. BIRTH DATE

14. ADMISSION: TYPE

14. ADMISSION: SRC

17. STAT

39. VALUE CODES: CODE, AMOUNT

(There are 2 boxes for amount: 1st box enter dollars and 2nd box enter cents)

b. Enter the Pat. CNTL #

Hover over the box to see details on the field and required format.

| 3a. PAT. CNTL # | 12345678912 | 4 | TYPE OF |
|---|---|---|---|
| b. MED REC # | | 13 | ⌄ |
| 5 FED TAX NO. | | | |

Patient control number. Required. Enter the patient's unique alphanumeric control number assigned to the patient by the hospital. A maximum of 20 positions will be returned on the remittance advice to the provider.

01/01/2025   01/10/2025

S    a

c. Enter the EOB details:

Required Fields:

38. EOB Summary Information: Medicaid Paid Date and Medicare Paid Amount

       a) Total Deductible

       b) Total Coinsurance

       c) Total Copay

42. REV CD.

45. SERV. DATE

46. SERV. UNITS

47. TOTAL CHARGES

**EOB Summary Information**

| | |
|---|---|
| Medicare Paid Date: | 03/01/2025 |
| Medicare Paid Amount: | 257 |

| | |
|---|---|
| A. Total Deductible: | 0 |
| B. Total Coinsurance: | 65 |
| C. Total Copay: | 0 |

| | 42 REV CD. | EOB | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 0915 | | | | 01/01/2025 | 1 | Unit | 378 69 | | 1 |
| 2 | 0915 | | | | 01/02/2025 | 1 | Unit | 378 69 | | 2 |
| 3 | 0915 | | | | 01/03/2025 | 1 | Unit | 378 69 | | 3 |
| 4 | 0915 | | | | 01/04/2025 | 1 | Unit | 378 69 | | 4 |
| 5 | | | | | | | | | | 5 |
| 6 | | | | | | | | | | 6 |
| 7 | | | | | | | | | | 7 |
| 8 | | | | | | | | | | 8 |

d. Enter the Payer details.
   Required Fields:
   50. PAYER NAME
   58. INSURED NAME (Enter name in "c")
   60. INSURED UNIQUE ID (Enter MAID in "c")
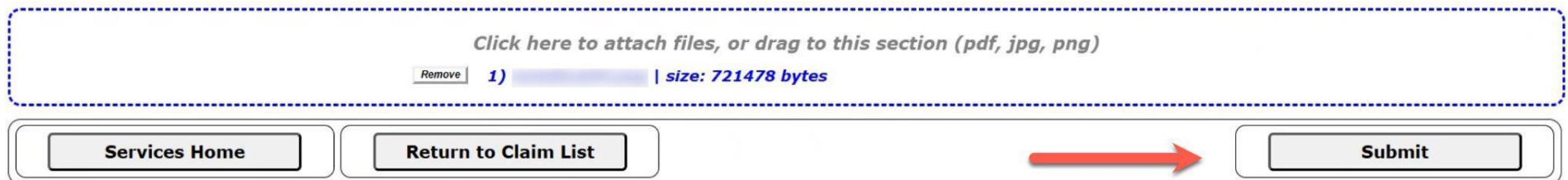   66. Principal Diagnosis code

| 50 PAYER NAME [+] | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | 1184712085 | |
|---|---|---|---|---|---|---|---|---|
| A Medicare | | ⌄ | ⌄ | | | 57 | 45100 | A |
| B Secondary payer | | ⌄ | ⌄ | | | OTHER | | B |
| C MARYLAND MEDICAID | | Y ⌄ | Yes ⌄ | | | PRV ID | | C |

| 58 INSURED'S NAME | | | 59 P.REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO. | |
|---|---|---|---|---|---|---|---|
| A First Name | Middle | Last Name | ⌄ | | | | A |
| B First Name | Middle | Last Name | ⌄ | | | | B |
| C Tinker | Middle | Bell | 18 Self ⌄ | 34245672441 | | | C |

| 63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME | |
|---|---|---|---|
| A | | | A |
| B | | | B |
| C Prior Auth #: Enter DHMH 3808 Document Number (if applicable) | | | C |

| 66 DX | t82110a 67 | A | B | C | D | E | F | G | H | 68 |
|---|---|---|---|---|---|---|---|---|---|---|
| | I | J | K | L | M | N | O | P | Q | |

e. To attach a file to the claim. Click the box and select a file or drag and drop a file to this box. Attachment is required. Attachments formats only; PNG, PDF, JPG.

*Click here to attach files, or drag to this section*

| Services Home | Return to Claim List | | Submit |
|---|---|---|---|

Activate Windows

f. Once all the required details are entered with the attachment, submit the eClaim by clicking on submit button as shown below.

*Click here to attach files, or drag to this section (pdf, jpg, png)*

Remove   **1)** ▮▮▮▮▮▮▮ **| size: 721478 bytes**

| Services Home | Return to Claim List | | Submit |
|---|---|---|---|

g. Successful submission you will be provided a date and time stamp and a Claim Number for reference.

> *Click here to attach files, or drag to this section (pdf, jpg, png)*

CLAIM SUCCESSFULLY SUBMITTED AT: 2025-03-14 11:50:11.435. CLAIM NUMBER: 250733000002, VERSION: 1

| Services Home | Return to Claim List | | Submit |
|---|---|---|---|

h. Any errors in the submission you will receive the below error message displaying the respective claim field number (see number is box for reference) with the error and a brief description. Resolve all errors and re-submit the claim.

**Claim Submittal Results**

Run number: 185

Errors:
1) Missing field 3: patient control number
2) Field 4: Missing type of bill
3) Field 67: Missing principal diagnosis code
4) Error 982415: Claim data did not pass rules check

Warnings: None

Info Messages: None

| Services Home | Return to Claim List | | Submit |
|---|---|---|---|