Using eClaim Service:

- When the authorized user logs in to the eMedicaid site, a new link "eClaim" will appear on the page.

- Click on the eClaim link to navigate to "Claim Home" page.
- User can submit new claim, view recently submitted claims or search the claim history.
- If the user is authorized to submit claim from only one location, that location is pre-selected.
- In order to submit a new claim the user must:

  - click on "New Claim" button, however,
  - if the user is authorized to submit claims from **more than one location**, all authorized locations are displayed in a drop down list and the user must select the location from which he is submitting the claim and then click "New Claim" button.

- If the user has submitted claims from any of the authorized locations in the past, the recently submitted claims will appear on the screen. Only the most current 100 claims are displayed in the "Recently Submitted Claims" box. The list can be sorted by clicking on the column name. Optionally, the list can be exported to Excel file.

You are currently signed in as
[redacted] test1 labtest
sign out

eClaim

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.

New Claim

Provider Name: **Provider Name**
Provider Base Number: **1234567**
Provider Location: **00** [redacted]

New Claim

Click on Claim History button to search all past claims from the locations that you are authorized to submit claims..

Claim History Services Home

Recent claims submitted by **test1 labtest**

7 recent claims found, displaying all recent claims.

1

Claim Num	MAID	Patient Last Name	Patient First Name	Prov Num	Submitter	Submitted Date
090420000005	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]P0002	02/11/2009 09:22:11 AM
090420000004	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]P0002	02/11/2009 09:17:15 AM
090420000003	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]P0002	02/11/2009 09:10:55 AM
090420000002	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]P0002	02/11/2009 09:06:44 AM
090420000001	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]P0002	02/11/2009 09:03:50 AM
090230000001	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]P0002	01/23/2009 12:18:36 PM
090140000002	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]P0002	01/14/2009 02:01:09 PM

Export: Excel

Submitting a new claim

- If you are authorized to submit claims from more than one locations, you must select the location from where you are submitting the claim

- If you are authorized to submit claim from only one location, that location is pre-selected.

- Click on “New Claim” button. It will navigate to “Recipient Information” page.

- Complete the recipient information on this page. Patients Last Name, First Name and Medical Assistance (MA#) number are required fields. MA# must be reported in block 9a.

Auto Fill Recipient Information

- If you have submitted a claim for this patient from one of the authorized locations before, you can auto fill recipient information.

    - Type in the recipient’s MA# number in “Recipient Lookup” box and click “Lookup” button. If patient’s information is found, the system will populate and auto-fill the information. You should verify the auto filled information before continuing. Some fields on this form are not auto filled and you must type in the information manually (if applicable).

    - If the patient’s information is not found, it will display a message. You can continue typing the recipient information manually.

    - The auto-fill only searches data that was previously entered by your sites. **No validation of Recipient is done.**

- Once the recipient information is entered, click “Continue” button.

You are currently signed in as
[redacted]0002 test1 labtest
sign out

eClaim

Step 1 of 3 ***Recipient Information***
- If the patient has visited this office before, use the lookup function to autofill recipient information.

Recipient Lookup
11 digit Medical Assistance Number (MAID): Lookup

HEALTH INSURANCE CLAIM FORM (1)

1. MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
Medicare# Medicaid# Sponsor's SSN Member ID# SSN or ID SSN ID

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME(Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE (MM/DD/YYYY) / /
SEX M F

4. INSURED'S NAME(Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY
STATE -- Select State --

8. PATIENT STATUS
Single Married Other
Employed Full-Time Student Part-Time Student

CITY
STATE -- Select State --

ZIP CODE
TELEPHONE (Include Area Code) - -

ZIP CODE
TELEPHONE (Include Area Code) - -

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER
Select Rejection Reason

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous)
YES NO

a. INSURED'S DATE OF BIRTH
sex M F

b. OTHER INSURED'S DATE OF BIRTH
SEX M F

b. AUTO ACCIDENT?
YES NO
PLACE(State) -- Select State --

b. EMPLOYER'S NAME OR SCHOOLE NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT?
YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefit to the undersigned physician or supplier for services described below.
SIGNED

Continue Cancel

- If everything is valid, it will navigate to “Service Information” page.

You are currently signed in as
[redacted]P0002 test1 labtest
sign out

eClaim

Step 2 of 3 ***Service Information***

- Click on NDC button to enter NDC codes (if applicable).
- In order to clear the contents of service line, click on the clear button on the right side of the line.
- If you need to add more services click on Add Service Line button.

HEALTH INSURANCE CLAIM FORM (2)

14. DATE OF CURRENT: (MM/DD/YY) ILLNESS (First symptom)OR INJURY (Accident)OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE: (MM/DD/YY)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: (MM/DD/YY) FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (Last Name, First Name)

17 a. ID

17 b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVISES: (MM/DD/YY) FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ○ YES ○ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to item 24E by line)

1. 2. 3. 4.

22. MEDICAID RESUBMISSTION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24.A. DATE(S) OF SRVICE From (MM/DD/YYYY) To (MM/DD/YYYY)	B. PLACE OF SERVICE	c. EMG	D.PROCEDURES,SEVICES,OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID.#	
1	/ /	Lookup								ID / NPI		Clear
	ndc											
2	/ /	Lookup								ID / NPI		Clear
	ndc											
3	/ /	Lookup								ID / NPI		Clear
	ndc											
4	/ /	Lookup								ID / NPI		Clear
	ndc											
5	/ /	Lookup								ID / NPI		Clear
	ndc											

Select the number of service lines to add 1 Add More Service Lines

- Some fields on this page are required for certain provider types only. Depending upon your provider type, you will be asked to provide the information. To see what fields should be entered, you can simply click “Continue” button on “Service Information” page. All required fields will be highlighted with red border and appropriate validation message will appear at the top of the screen.

- Five service lines are displayed on this page. If you need more service lines, select the number of lines that you need to add from the drop down list and click on the “Add More Service Lines” button.

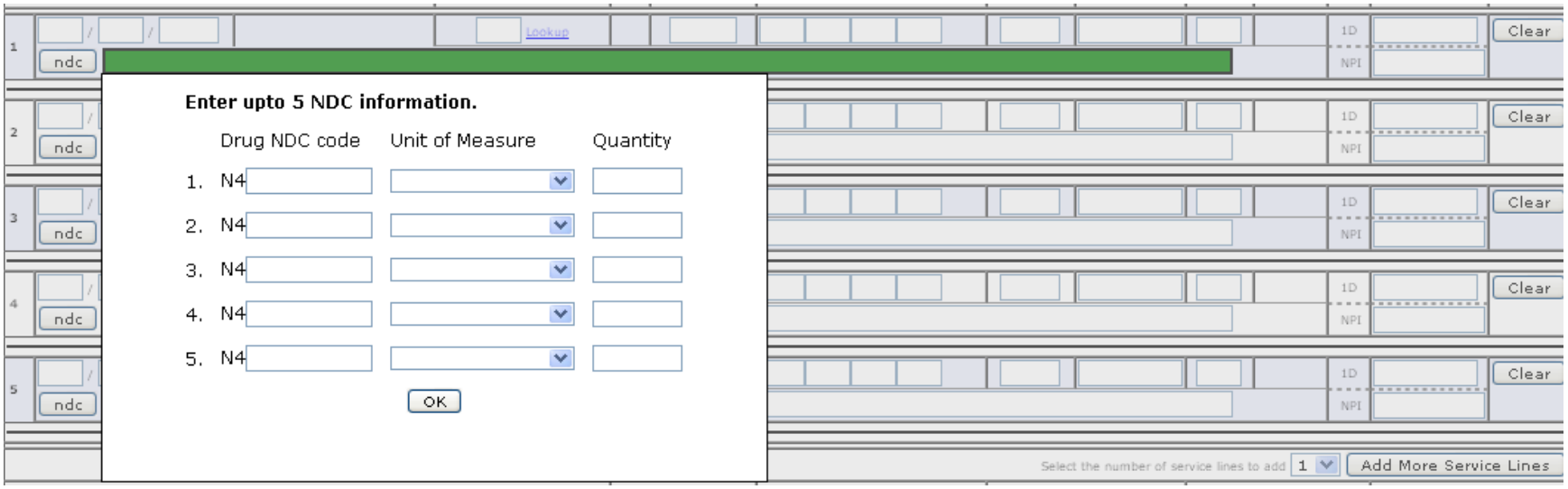
- You cannot delete service lines; however, you can clear the data of any service line by clicking on “Clear” button on the right side of the service line.

- All blank service lines are disregarded.

- If you do not know the appropriate “Place of Service Code”, you can click on the “Look-up” link next to the box. Click on the desired place of service and it will populate that code in the field. If you already know the Place of Service Code, you may type it in the box.

- If you need to enter “NDC” information in a service line, click on “NDC” button or click on the long text box next to “NDC” button. It will open another window where you can provide up to 5 NDC information. **Remember**, the qualifier **N4** is already filled for you. Do not include N4 in Drug NDC Code. When you are done, click “Ok”. The NDC information will be filled in the long text box.

- If you have already filled the NDC and need to update the information, repeat the procedure above.



- When you are done entering all service information, click “Continue” button.
- A summary page will be displayed which will allow you to review the information that you have entered. If you need to make any changes, click on “Make Changes” button.
- If no changes are required, agree to Electronic Signature and click “Submit” button and wait for the “Transaction Confirmation” page.

Transaction Confirmation

Please print this page for your records.

CLAIM NUMBER: 100353000001

Submission Date: 02/04/2010

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER
Medicare# / Medicaid# / Sponsor's SSN / Member ID# / SSN or ID / SSN / ID

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME(Last Name, First Name, Middle Initial)
TEST TEST

3. PATIENT'S BIRTH DATE(MM/DD/YYYY)

SEX M F

4. INSURED'S NAME(Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS
Single Married Other
Employed Full-Time Student Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER
12345678912

a. EMPLOYMENT? (Current or Previous)
YES NO

a. INSURED'S DATE OF BIRTH | sex M F

b. OTHER INSURED'S DATE OF BIRTH | SEX M F

b. AUTO ACCIDENT? PLACE(State)
YES NO

b. EMPLOYER'S NAME OR SCHOOLE NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT?
YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefit to the undersigned physician or supplier for services described below.
SIGNED

14. DATE OF CURRENT: (MM/DD/YY) ILLNESS (First symptom)OR INJURY (Accident)OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE: (MM/DD/YY)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: (MM/DD/YY)
FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (Last Name, First Name)
DR REFERRER

17 a. ID **123456789**
17 b. NPI **1234567893**

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVISES: (MM/DD/YY)
FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES
YES NO

21. DIAGNOSIS OT NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to item 24E by line)
1. **D12345** 2.
3. 4.

22. MEDICAID RESUBMISSTION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.A. DATE(S) OF SRVICE From (MM/DD/YYYY)	To (MM/DD/YYYY)	B. PLACE OF SERVICE	C. EMG	D.PROCEDURES,SEVICES,OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID.#
1 **01/01/2010**	**01/01/2010**	**81**		**C1234**		**1**	**$100.00**	**1**		ID NPI	

25.FEDERAL TAX I.D. NUMBER
SSN EIN

26.PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims. see back)
YES NO

28. TOTAL CHARGE **$ 100.00**

29. AMOUNT PAID **$ 0.00**

30. BALANCE DUE **$ 100.00**

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
(I certify that the sstatements on the reverse apply to this bill and are made a part threof.)
SIGNED **DATE 02/04/2010**

32. SERVICE FACILITY LOCATION INFORMATION
a. NPI b. ID

33. BILLING PROVIDER INFO
[redacted]
a. NPI [redacted] b. ID [redacted]

Submitted By: test1 labtest
[redacted]

Electronic Signature

☑ I agree to the terms set forth below:

- I have read and understand all warnings, restrictions, information, policies, and general rules that are relevant to this electronic transaction. I am responsible for any misinformation or mistakes that are made.
- I understand that my electronic signature is as legally binding as my handwritten signature.
- I agree that the Departmental electronic signature, if any, is an original signature as legally binding as a handwritten signature.
- I affirm that the information I have provided in this electronic transaction is true and complete to the best of my knowledge and belief.

- Each claim is assigned a unique 12 digit claim number.
- While you are on the confirmation page, if you want to submit another claim from the same location, click on “New Claim From This Location” button.
- If you want to submit claim from another location or want to view the recently submitted claim, click on “Claim Home” button.

View the submitted claim

You can view the recently submitted claim on "Claim Home" page. Click on the claim number link to view the detail.

You are currently signed in as
[redacted]0002 test1 labtest
sign out

eClaim

View Claim

CLAIM NUMBER: 090410000004

Claim Summary View

Claim Number: **090410000004**
Patient's MAID: [redacted]
Billing Prov Name: [redacted]

Claim Submission Date: **02/10/2009**
Patient's Last Name: [redacted]
Billing Prov Num: [redacted]

Claim Submitted By: [redacted]P0001
Patient's First Name: [redacted]
Billing Prov NPI: [redacted]

	DATE(S) OF SRVICE From (MM/DD/YYYY)	To (MM/DD/YYYY)	PLACE OF SERVICE	PROCEDURES,SEVICES,OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				DIAGNOSIS POINTER	$CHARGES	DAYS OR UNITS	ID. QUAL	RENDERING PROVIDER ID.#	TCN
1	12/17/2008	12/17/2008	81	85732	U3				1	$55.32	1	ID NPI	[redacted]	6345916
2	12/17/2008	12/17/2008	81	86147	U3				1	$302.72	2	ID NPI	[redacted]	6345917
3	12/17/2008	12/17/2008	81	83894	U3				1	$110.57	3	ID NPI	[redacted]	6345918

Total Charge:**$468.61** Amount Paid:**$0.00** Balance Due:**$468.61**

Click Here to view Detail

Claim History | Claim Home | Services Home

- By default, it displays the compact version of the claim. You can click on "Click Here to View Detail" link to view the detailed information.
- You can search the past claims by clicking on "Claim History" button. **Remember**: the search result will display only the claims from the locations that you are currently authorized to submit claims. If you are authorized to submit claims from location 0 and location 1 then the search result will display all the claims that matched your search criteria in location 0 and location 1.

IMPORTANT INFORMATION

- **Once you submit a claim, it cannot be modified.** As soon as you submit the claim, it will be transferred to the claim processing system for adjudication. Claims go through final adjudication on the Saturday after they are submitted.

- Claims received by 1:00 PM on Thursday will be processed in the weekly payment cycle. Any necessary changes due to State holidays, will be posted on the main eMedicaid page.

- The disposition of all claims including those entered on this site can be viewed in the Remittance Advice which is available Monday morning.

If you have questions, please send them to: mdh.eMedicaidMD@maryland.gov You can expect a response within three business days.