

December 2023

Prevea360 Health Plan

Provider Portal User Guide



Prevea360 Health Plan Provider Portal

The secure Prevea360 Health Plan Provider Portal allows users 24/7 access to resources and self-service applications to simplify everyday tasks, promote efficiencies in business, and streamline electronic transactions.

This Prevea360 Health Plan Provider Portal User Guide details how to use the self-service applications available in the Portal once a Provider Portal account is created. If an account has not been established, refer to the Prevea360 Provider Portal Registration Guide for the registration process to create individual and organization Provider Portal accounts.

Google Chrome is recommended for optimum performance when using the Provider Portal.

Access the Prevea360 Health Plan Provider Portal directly:

<https://provider.prevea360.medica.com>

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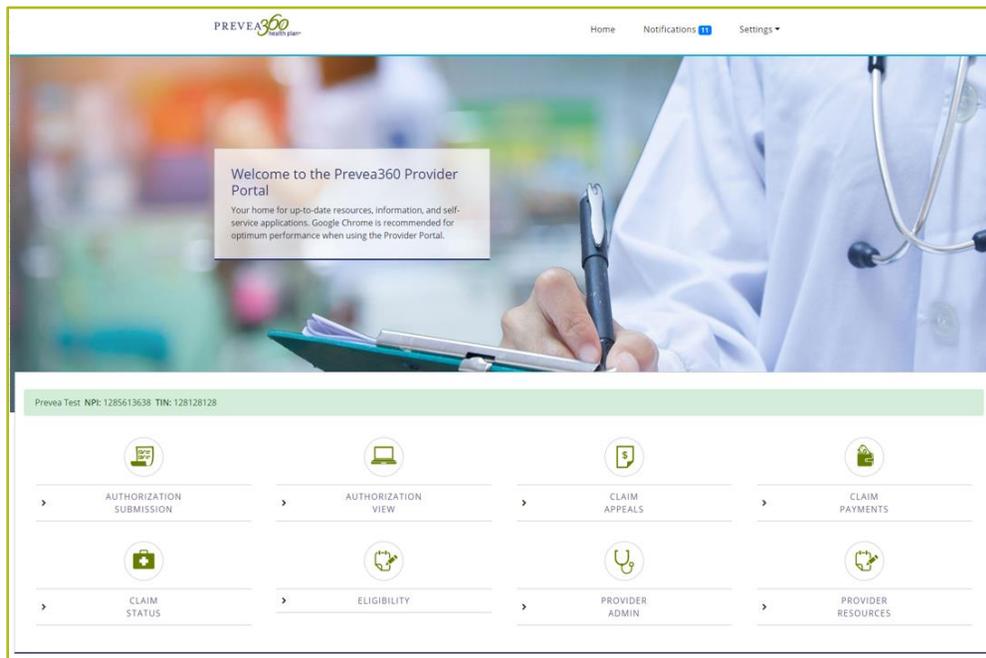
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I. Home Page

The Prevea360 Health Plan Provider Portal Home Page offers users access to:

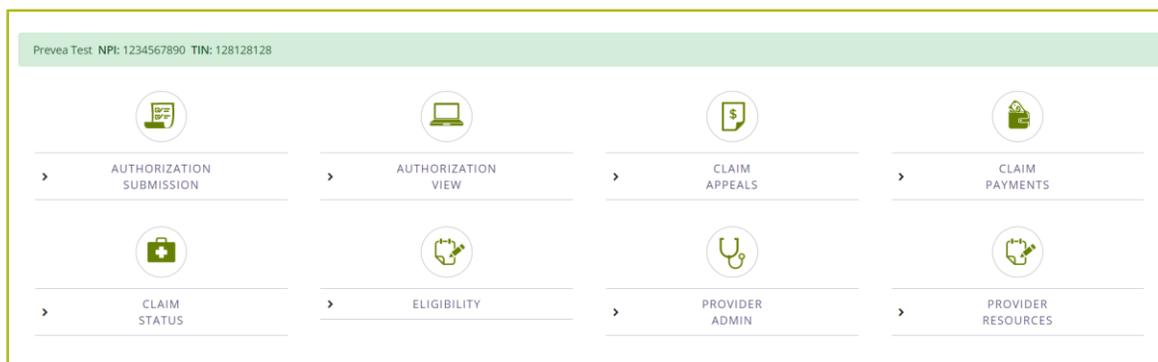
- Self-service claims and authorization applications
- Secure Notifications
- Account Settings

Whenever present, clicking the  logo located at the top of the web page will return users to the Provider Portal Home Page.



Applications

Each user will only have access to the application(s) assigned to them by the Site Administrator for their organization. Available applications will be displayed on the Home Page and can be updated by the Site Administrator at any time. The Provider Admin application is reserved for Site Administrators only.



Notifications

The Notifications page stores all notifications that are delivered through the Provider Portal, including:

- Flash Messages
- Account Profile Updates
- New User Registration
- Claim Appeal Receipt Notice
- Claim Appeal Decision Notice



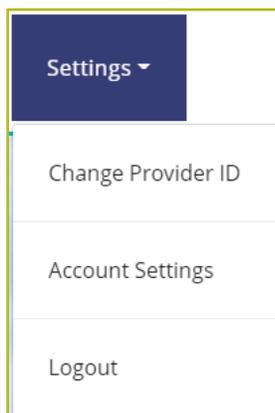
All Site Administrators are copied on Claim Appeal Decision Notices, Account Profile changes, and Individual User changes for all Portal users within their organization. Notifications can be either marked as read or deleted once reviewed by the Site Administrator.

Read Flag	Read Date	Received Date	Subject	Action
		9/18/2020	User Profile Updates	Read Delete
✓	12/14/2020	9/18/2020	User Profile Updates	Read Delete
		9/18/2020	User Profile Updates	Read Delete
✓	12/14/2020	9/18/2020	User Profile Updates	Read Delete
		8/31/2020	Provider Portal New User Registration	Read Delete
		8/31/2020	Provider Portal New User Registration	Read Delete
		8/27/2020	Provider Portal Account Change	Read Delete
		8/27/2020	Provider Portal Account Change	Read Delete
		8/26/2020	Provider Portal User Account Changes	Read Delete

Page 1 of 2 1 - 20 of 23 Items

Settings

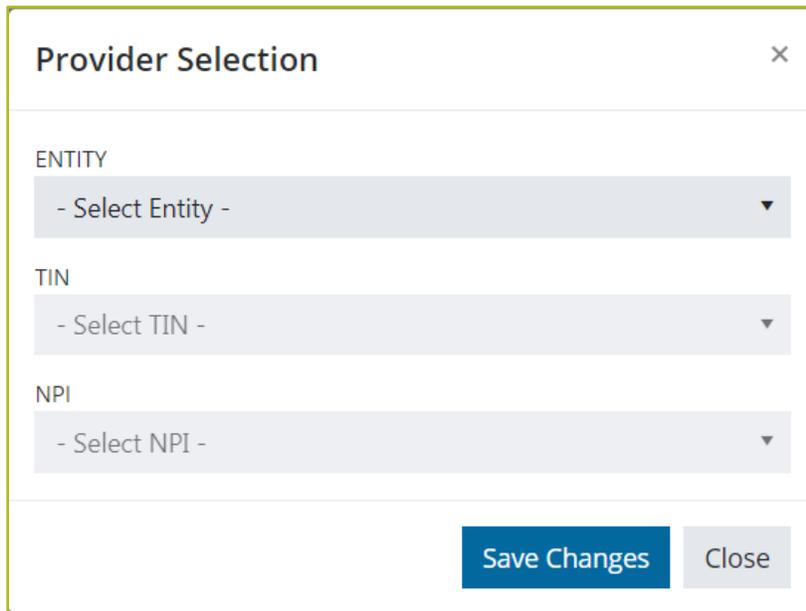
There are three Messages options available under Settings: Change Provider ID, Accounts Settings, and Logout.



Change Provider ID

Users who have access to multiple Organization accounts can change their access without logging out. This can be done by selecting the Settings dropdown at the top, and click **Change Provider ID**.

The Organization Details box will appear. Select the Entity you would like to work under from the **Entity** dropdown. Then select the applicable Tax Identification Number (TIN) and National Provider Identifier (NPI) from the dropdowns and click **Save Changes**. Users will only be able to select a TIN and NPI that is registered under the Entity that is first selected and will only have access to information available on that account.



The screenshot shows a modal window titled "Provider Selection" with a close button (X) in the top right corner. Inside the modal, there are three dropdown menus. The first is labeled "ENTITY" and has a selection of "- Select Entity -". The second is labeled "TIN" and has a selection of "- Select TIN -". The third is labeled "NPI" and has a selection of "- Select NPI -". At the bottom right of the modal, there are two buttons: a blue "Save Changes" button and a grey "Close" button.

The selected Organization information will appear in the green panel above the application tiles.



Account Settings

From the **Settings** dropdown, select **Account Settings** options to make changes to your Account Profile.

This includes updates to an Individual: Email Address (Login ID), First and Last Name, Password and Code Verification Method.

Update Names

To update the email address on file, enter the new email address that should be connected to the account. Click **Send Code** which will generate a code to the entered email address. Enter that code into the empty code field and click **Verify**. Finally, click **Save Changes** to create a new email address and Username.

The First and Last Name can also be updated by entering the new name and then clicking **Save Changes**.

If the Opt in/Out for Electronic Communications dropdown is defaulted to 'Opt Out', this preference can be changed to Opt In through the dropdown and then clicking **Save Changes**. By choosing Opt in, the Individual will receive direct and expedited provider email communications from the health plan. Opt In will not replace all paper communications.

Opting out after selecting Opt In is done through the "Unsubscribe" link at the bottom of email communications that you will receive from the health plan. Once you unsubscribe, your email address is automatically inactivated from the system and further electronic communications cannot be sent to that address.

Update names

Username/Login (Must be an email address)

jon.zillman@deancare.com

email@address.com

Enter email code here **Send Code**

1) Click the send code button.
2) Then retrieve the code sent to the email address above.
3) Enter the code before pressing verify button.

First Name

Jon

Last Name

Test

Opt In/Out for Electronic Communications

Opt In

Save changes

Tip

The email address is also the Username (Login ID). Changing the email address will also change the ID used for portal login.

Update Password

Password updates can be completed through the initial Sign-in screen, as well as through the **Account Settings** through the Update Password screen. Enter and Confirm the desired new password. Password requirements are shown under the fields. Select the "eye icon" to view and verify the Password and Password Confirmation are correct. Click **Save Changes** once completed.

Password

Change your password at any time.

Password must have at least:

- 8 characters
- 1 uppercase letter
- 1 lowercase letter
- 1 number (0-9)
- 1 symbol (e.g. !@#+)
- No part of your user name

Password

Confirm Password

Update Two-step verification

During registration, each Individual must enroll in at least one method of Multi Factor Enrollment in order to complete registration. This determines how confirmation codes should be sent prior to logging in or updating a password.

To enroll in a new method, enter the phone number or email address in the Enroll in Text (SMS) Verification field, and click **Request Code**. Retrieve the code from the delivery method selected, enter it in the Verification Code Field, and click **Verify Code**. This will enroll the new Enrollment Factor.

A factor can also be deleted by clicking the **Delete Factor** option.

Two-step verification

Add or remove your verification method.

Text/SMS number

Text/SMS number

555-555-5555

Enter verification code

Remove text/SMS number

Voice call number

Tip

Email cannot be removed as an Enrollment factor as it is required for login.

II. Eligibility

This application provides human readable real-time EDI 270/271 transactions. The information includes detail regarding Prevea360 Health Plan member eligibility and benefit plan coverage, co-payments, and deductibles. It also provides the name of the member's primary health insurance carriers name, if applicable.

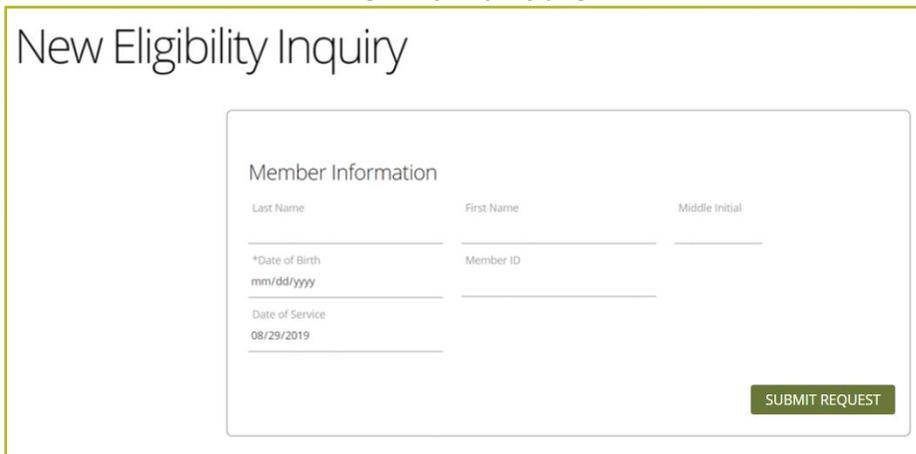
i. Access Eligibility

After logging into the Provider Portal select the **Eligibility** application located on Home Page.



ii. Submit Real-Time 270 Eligibility Transaction

Users are taken to the **New Eligibility Inquiry** page.



In order to successfully submit a 270 Eligibility Inquiry, the following fields must be filled:

- Date of Service (this will be pre-populated with the current date)
- Member's Date of Birth
- Either the member's First and Last Name or the Member ID

The Date of service will default to the current date. Maximum eligibility lookup is 12 months.

Tip

Eligibility Inquiries can be submitted by searching by the member DOB and either their full name of their member ID.

iii. Eligibility Inquiry Response

Eligibility Inquiry Results

Member Name:	MEMBER, SAMPLE
Member ID:	12345678901
Date of Birth:	01/15/1963
Group Number:	123ABC (EXCHANGE INDIVIDUAL)
Plan Network Identification Number:	PREVEA360 Health Plan
Plan Begin Date:	01/01/2019
Plan End Date:	12/31/9999

SUBMIT NEW INQUIRY

The member’s policy information will appear in the top, left portion of the screen. Verify that the correct member is showing on the screen.

Other Primary Policy

Other health insurance (Primary) information will be returned:

- If the health insurance is listed as the primary payer
- As the subscriber level (Loop 2120C)
- If the other health insurance is effective at the requested Plan Date in the 270 eligibility request (DTP*291), and will only return the Organization Name (NM103)

Coverage

The table will display member benefit information for the policy year that was searched.

Each column can be filtered alphabetically or numerically by selecting the arrows in the top row of each column.

There is a **Search** field located in the upper right corner of the page next to the table. Enter a keyword or dollar value into this field to filter results to only show fields that contain those keywords or values.

	Eligibility Information Code	Plan Description	Coverage Level Code	Service Type Code	Insurance Type Code	Network Indicator	Amount	Percentage	Benefit Dates	Time Period
	Active Coverage	WELLFIRST ACA		Health Benefit Plan Coverage	Exclusive Provider Organization					
+	Deductible		Individual	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	\$750.00			Service Year
	Deductible		Individual	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	\$750.00			Year to Date
	Deductible		Individual	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	\$0.00			Remaining
	Deductible		Family	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	\$1500.00			Service Year
	Deductible		Family	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	\$750.00			Year to Date
	Deductible		Family	Health Benefit Plan Coverage	Exclusive Provider Organization	In-Network	\$750.00			Remaining

Additional details may apply to specific benefits. These details are denoted by a box with a “+” in the left column of the table. Please select this box to review additional details that apply to this benefit.

▲	Eligibility Information Code	▼
+ 	Non-Covered	

Message THOSE SERVICES AS REQUIRED BY STATE/FEDERAL MANDATES ARE COVERED. SUBMIT PRESCRIPTION COVERAGE REQUESTS TO THE PATIENT'S PBM. ✕

Once benefits have been verified, users can submit a new inquiry by selecting the **Submit New Inquiry** under the member policy information. Click the Prevea360 Health Plan banner at the top of the screen to return to the Home Page, or close the tab to exit entirely.

III. Authorization Submission

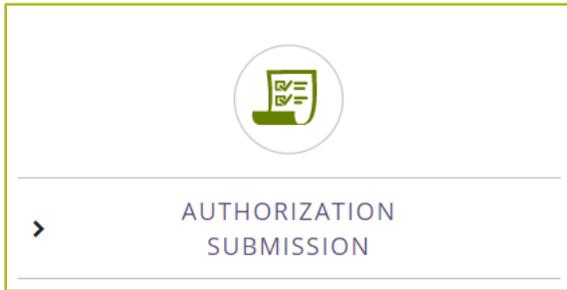
Prevea360 Health Plan authorization requests should be completed by the member’s Primary Care Physician (PCP) or a Prevea360 Health Plan Specialty Provider. An authorization should not be submitted for the sole purpose of confirming the service is covered.

Once the steps under section iii, Select a Member and Classification are completed, the authorization request will be saved automatically and can be completed at a later time, if desired, through the **Authorization View** application. The authorization feature of the Provider Portal should not be used for the following types of services as these should be submitted to our applicable external vendor:

- Rehabilitative and Habilitative Outpatient Physical and Occupational Therapy
- High-End Radiology Services
- Musculoskeletal procedures
- Medical Injectables

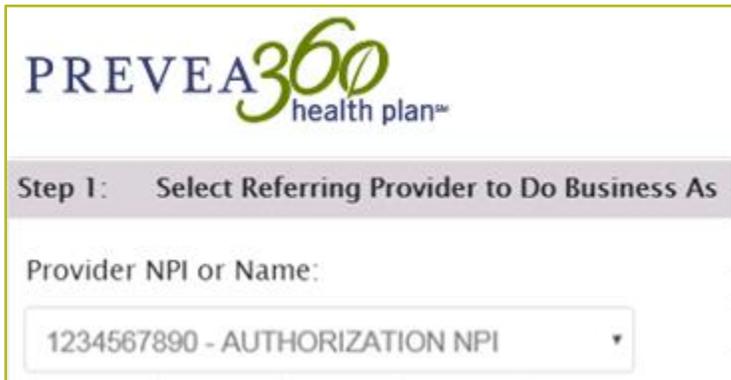
i. Access Authorization Submission

After logging into the Provider Portal select the **Authorization Submission** application located on Provider Portal Home Page.



ii. Select Referring Provider

Select the NPI/Provider from the dropdown to submit the authorization request under. All NPIs that are tied to the Organization account will be selectable.



Tip

Selecting the incorrect NPI will result in an error message. Please contact the Site Admin for assistance with selecting the appropriate NPI.

iii. Select a Member and Classification

Provider NPI or Name:

Step 2: Select a member and classification.

Auth Class:

Auth Sub-Class:

Begin Date of Service/Date of Admission:

Auth Type:

Member: SEARCH

All fields in this section are required:

- **Auth Class**
- **Auth Sub-Class**
- **Begin Date of Service/Date of Admission** – this field will populate once the **Auth Sub-Class** has been selected.
- **Auth Type**
- **Member** – Search options are Date of Birth and either member ID or First and Last name.

D.O.B.:

One of the following is required:

Member ID:

OR

First Name:

Last Name:

SEARCH CANCEL

The member’s information will populate into the Portal Member Search data window.

Portal Member Search: Eligible as of 3/27/2020

MODIFY SEARCH CRITERIA

Member ID	Member Name	DOB	M/F	Health Plan	Effective Date	End Date	Phone
00012345601	MEMBER, SAMPLE A	1/1/2000	F	DHP(IND)	1/1/2020	12/31/9999	(123) 456-7890
00012345601	MEMBER, SAMPLE A	1/1/2000	F	DHP(IND)	1/1/2019	12/31/2019	(123) 456-7890
00012345601	MEMBER, SAMPLE A	1/1/2000	F	DHP(IND)	1/1/2018	12/31/2018	(123) 456-7890

If a member has more than one record, such as active and inactive, both records will be displayed.

- A record in black reflects an active eligibility record
- A record in red reflects an inactive eligibility record

Select the applicable record by clicking the double arrow icon on the far-right side of the search. If the incorrect member is selected, the member information can be modified by clicking **Modify** . This will return to the Member Search screen.

Auth Class: Specialist Adult Medicine

Auth Sub-Class: Cardiology

Begin Date of Service/Date of Admission: 1/1/2020

Auth Type: Pre-Service

Member: SAMPLE MEMBER (0123456789)

Once all the field have been filled, click **Continue**. The authorization request will be saved after this step.

iv. Complete Detail Fields

Fields in bold are required. The required data fields in this step will vary depending on the Auth Class entered in Step 1.

Member's PCP: SAMPLE PROVIDER MD (123456789123)

Servicing Clinic or Group:

Referring Provider: SAMPLE PROVIDER MD (123456789123)

Servicing Provider:

Diagnoses: Code Description

No diagnoses have been added.

Add:

Services: Qty. Code Description

No services have been added.

Add:

Priority: -- Select One --

Additional Information:

0 of 2000 Characters Used, 2000 Remaining

Provider Data Fields

- **Member's PCP** – this will automatically populate, if known.
- **Referring/Submitting Provider** – this will auto-populate from Step 1. If not, enter provider name and click **Search**.
- **Servicing Provider** – this should not reflect a clinic name but rather the name of an individual practitioner or facility/hospital.

Note: If the servicing provider's name is unknown, the name of one of the practitioners with the same specialty, department and clinic location that the member is being referred to can be entered.

Member's PCP: SAMPLE PROVIDER MD (123456789123)

Servicing Clinic or Group:

Referring Provider: SAMPLE PROVIDER MD (123456789123)

Servicing Provider:

To select a Servicing Provider, enter the provider name or NPI and select **Search**.

- If the Provider has only one location, this information will populate into the data field.
- If a provider has more than one location in the Prevea360 Health Plan system, all locations will populate into a window for review to determine which location is applicable.
- The Prov # column reflects Prevea360 Health Plan’s internal ID number for that particular provider.
- The Contract Type column reflects P (Plan-Contracted) and NP (Non-Plan or Non-Contracted) with P contract type being displayed at the top.
- To select the provider location, select the double arrow located on the right side of the record. This provider will then populate into the applicable date field.
- To change the selected servicing provider, click **Modify** next to the record and choose a different provider.

Prov #	Provider Name	Contract Type	Location Name	Street	City	Eff. Date
176529372947	PROVIDER SAMPLE	P	ABC HOSPITAL	123 SAMPLE RD	EXAMPLE	1/1/2019
176529372947	PROVIDER SAMPLE	P	XYZ HOSPITAL	EXAMPLE ST	SAMPLE	1/1/2019
176529372947	PROVIDER SAMPLE	P	CLINIC 123	123 CLINICAL AVE	TOWN	1/1/2019
176529372947	PROVIDER SAMPLE	P	CLINIC 789	HOSPITAL ST	VILLAGE	1/1/2019

*If the Servicing Provider you are looking for is not in this list, please refine your search, or provide the Servicing Provider information below.

Professional Services Facility Services

Last Name: Phone:
 First Name: Fax:
 Addr 1: Specialty: -- Select Value(s) --
 Addr 2: NPI:
 City: State: -- Select One -- Zip:

Tip
Only providers who are in the Prevea360 Health Plan system will populate.

Once a provider has been selected, the information will populate into the applicable field.

Referring Provider: [SAMPLE PROVIDER MD \(123456789000\)\(PLAN\)](#)

Servicing Provider: [SAMPLE PROVIDER MD \(123456789000\)\(PLAN\)](#)

If the practitioner or facility does not show up in the results, use the **Provider Search** feature to enter additional information to narrow down the search.

Provider #: Street: Specialty: -- Display All --
 Last Name: City: Facility:
 First Name: State: -- Display All --

Inpatient Admission

Attending Provider:	<i>Enter Provider ID, NPI #, partial name or leave blank for full search</i>	<input type="button" value="SEARCH"/>
Servicing Facility:	<i>Enter Provider ID, NPI #, partial name or leave blank for full search</i>	<input type="button" value="SEARCH"/>

Diagnoses

Diagnoses:	Code	Description	
No diagnoses have been added.			
	Add:	<i>Enter a diagnosis code or part of the description.</i>	<input type="button" value="SEARCH"/>
Services:	Qty.	Code	Description
No services have been added.			
	Add:	<i>Enter a CPT/HCPCS code or part of the description</i>	<input type="button" value="SEARCH"/>

There are two ways to search for a diagnosis code:

1. Enter the diagnosis code (if known) and select search. The diagnosis will auto-populate in the blank field.
2. Enter a key word or phrase and select search. A list of related diagnosis will appear. Select the double arrow to the right of the desired diagnosis to apply it.

Diagnosis Search: aortic					
I082	Rheumatic disorders of both aortic and tricuspid valves	10/1/2008	12/31/9999	<input type="button" value="↔"/>	
I083	Combined rheumatic disorders of mitral, aortic and tricuspid valves	10/1/2008	12/31/9999	<input type="button" value="↔"/>	
I350	Nonrheumatic aortic (valve) stenosis	10/1/2008	12/31/9999	<input type="button" value="↔"/>	
I351	Nonrheumatic aortic (valve) insufficiency	10/1/2008	12/31/9999	<input type="button" value="↔"/>	
I352	Nonrheumatic aortic (valve) stenosis with insufficiency	10/1/2008	12/31/9999	<input type="button" value="↔"/>	

If the wrong diagnosis is selected, it can be removed by selecting the red "X." Multiple diagnoses may be added, and there is no limit to the number of diagnosis codes that can be added.

Diagnoses:	Code	Description	
	I352	Nonrheumatic aortic (valve) stenosis with insufficiency	<input type="button" value="X"/>
	I082	Rheumatic disorders of both aortic and tricuspid valves	<input type="button" value="X"/>
	Add:	<i>Enter a diagnosis code or part of the description.</i>	<input type="button" value="SEARCH"/>

Services

The services field will only need to be completed when required by the selected Auth Class.

Services:	Qty.	Code	Description
No services have been added.			
Add:	<input type="text" value="Enter a CPT/HCPCS code or part of the description"/>		<input type="button" value="SEARCH"/>

There are two ways to search for a CPT/HCPCS code:

1. Enter the code (if known) and select search. The service will auto-populate in the blank field.
2. Enter a key word or phrase and select search. A list of related services will appear. Select the double arrow to the right of the desired code to apply it.

Services:	Qty.	Code	Description
	<input type="text" value="1"/>	33411	Replacement, aortic valve; with aortic annulus enlargement, noncoronary sinus
Add:	<input type="text" value="Enter a CPT/HCPCS code or part of the description"/>		<input type="button" value="SEARCH"/>

If the wrong service is selected, it can be removed by selecting the red "X." Multiple services may be added.

Priority

The Priority is used to communicate the urgency level of the services being requested. This will determine how quickly a determination is needed based on the member's medical condition.

Priority:	<input type="text" value="-- Select One --"/>
Additional Information:	<input type="text" value="Administratively Urgent"/>
	<input type="text" value="Concurrent"/>
	<input type="text" value="Medically Urgent/Expedited"/>
	<input type="text" value="Non-Urgent/Standard"/>
	<input type="text" value="Post-Service"/>

Administratively Urgent – This priority status should be selected for services that are considered urgent because of the time sensitive diagnosis and appointment availability.

Concurrent – This priority status should be selected for notification of urgent/emergency admissions to a facility for inpatient/observation. It should not be used for an elective admission.

Medically Urgent/Expedited – This priority status should be selected ONLY if the member has an acute medical condition and is at the risk of life or limb. ***This priority level requires a signature by the attending Physician.**

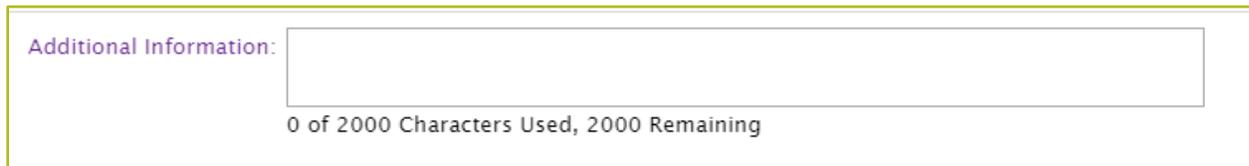
Non-Urgent/Standard – This priority status should be selected for routine outpatient requests or elective inpatient admissions.

Post-Service – This priority status should be selected for requests that are received after the services have been rendered.

Additional Information

Entering information into the Additional Information field is optional, but strongly recommended. Information recommended to include:

- Contract person with a direct phone number for any follow-up questions.
- If Prevea360 Health Plan has access to the records in Epic, identify the record number, date of service or any other guidance where to find related information.
- Please note what is specifically being requested. (For example: Left L4 SNRB, please see notes from office visit on 8/31/2019.)



Additional Information:

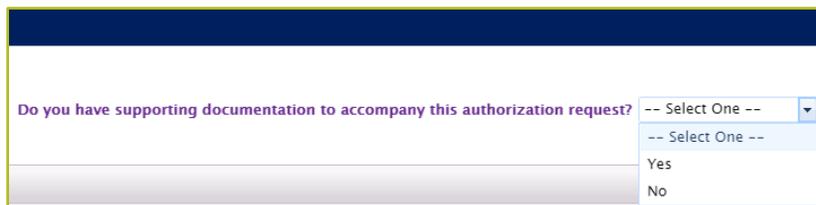
0 of 2000 Characters Used, 2000 Remaining

After completing all required fields in Step 3 – click **Continue**.

Note: Prior to clicking Continuing, the information entered can be changed. Once **Continue** is clicked, a user cannot return to make updates to entered information.

v. Attach Supporting Documentation

Click the dropdown to select if there is supporting documentation to attach.

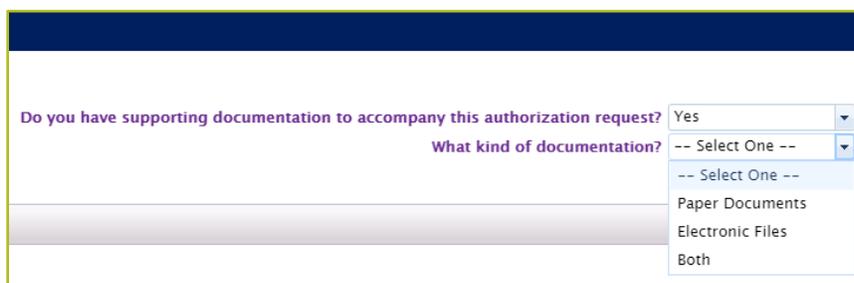


Do you have supporting documentation to accompany this authorization request? -- Select One --

- Select One --
- Yes
- No

If there is no documentation to attached, select **No**. Once this is complete, click **Submit Auth Request** to send the authorization request to the health plan for review.

If there is documentation to attach, select **Yes**. This will create another dropdown to select the type of documentation (Paper documents, electronic files, or both).



Do you have supporting documentation to accompany this authorization request? Yes

What kind of documentation? -- Select One --

- Select One --
- Paper Documents
- Electronic Files
- Both

Paper Documents

Select the **Paper documents** option if the documentation will need to be mailed or faxed. If the documentation will be faxed, click **Print Cover Sheet** to be faxed with the documentation. Then click **Submit Auth Request** to send the authorization for review.

Step 5: Attach supporting documentation. Fields in bold are required.

Do you have supporting documentation to accompany this authorization request? Yes

What kind of documentation? Paper Documents

Fax Paper Documentation

Click below to print a fax cover sheet to use when sending in supporting documentation.

[PRINT COVER SHEET](#) [SUBMIT AUTH REQUEST](#)

Electronic Files

Select the **Electronic Files** option if documentation will be attached to this authorization request directly. Click **Select** to browse for the electronic document(s) to attach.

Step 5: Attach supporting documentation. Fields in bold are required.

Do you have supporting documentation to accompany this authorization request? Yes

What kind of documentation? Electronic Files

Upload Electronic Documentation

File Name	Attached	By	Category	Source
No records to display.				

Browse for electronic documents to attach to this authorization request: [Select](#) [Clear](#)

Only PDFs are allowed. Files must not be larger than 40MB.

[UPLOAD DOCUMENT](#) [SUBMIT AUTH REQUEST](#)

Once the appropriate document has been selected it will populate in the empty field.

Browse for electronic documents to attach to this authorization request: **Supporting Documentation.pdf** [Select](#) [Clear](#)

Only PDFs are allowed. Files must not be larger than 40MB.

[UPLOAD DOCUMENT](#)

Click **Upload Document** to attach it to the authorization request.

Step 4: Attach supporting documentation. Fields in bold are required.

Do you have supporting documentation to accompany this authorization request? Yes

What kind of documentation? Electronic Files

Upload Electronic Documentation

File Name	Attached	By	Category	Source
Supporting Documentation.pdf	9/12/2019	jon.zillman@deancare.com	Supporting Documentation	Uploaded X

Browse for electronic documents to attach to this authorization request: [Select](#) [Clear](#)

Only PDFs are allowed. Files must not be larger than 40MB.

[UPLOAD DOCUMENT](#) [SUBMIT AUTH REQUEST](#)

When a document is uploaded, a message will display indicating that the upload was successful and the file name of the document will display as an uploaded document. If the incorrect document is uploaded, it can be removed by selecting the red "X."

Both Paper Documents and Electronic Files

Select the **Both** option if Electronic Files and Paper Documents are to go with the authorization request. This will provide both the Print Cover Sheet and Upload Document options.

After uploading all applicable documents, click **Submit Auth Request** to complete the request.

vi. View Confirmation

After the authorization is submitted you will receive a message confirming receipt, and a Reference ID for the authorization request.

Step 5: View confirmation.

Thank you for submitting your Podiatry Request. It has been assigned Reference ID [S190912006](#) with a status of "Submitted."

Disclaimers:

Reimbursement for services rendered is subject to:

- Member eligibility must be verified for date(s) of service
- Service(s) rendered is a covered benefit
- Member is not eligible for other health care coverage
- Service(s) rendered do not require authorization
- Service(s) rendered are performed within effective date range of referral

The Reference ID can be used to review the authorization to check the status of approval/denial.

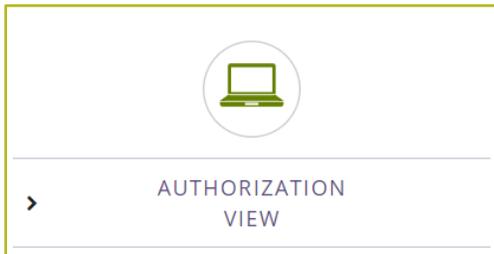
IV. Authorization View

The View Authorization application allows the ability to view authorizations that have been started and saved, and authorizations that have been completed and submitted.

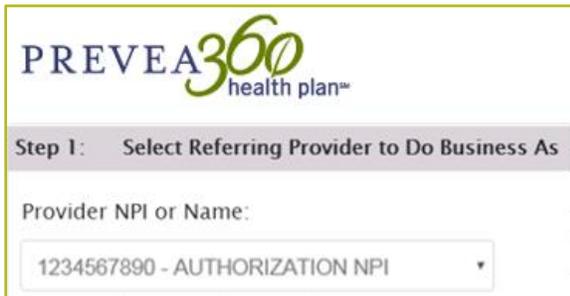
It is the responsibility of the referring/submitting Provider to check the authorization status on the Provider Portal. Prevea360 Health Plan will not send determination letters to the referring/submitting provider who entered the authorization via the Provider Portal.

i. Access Authorization View

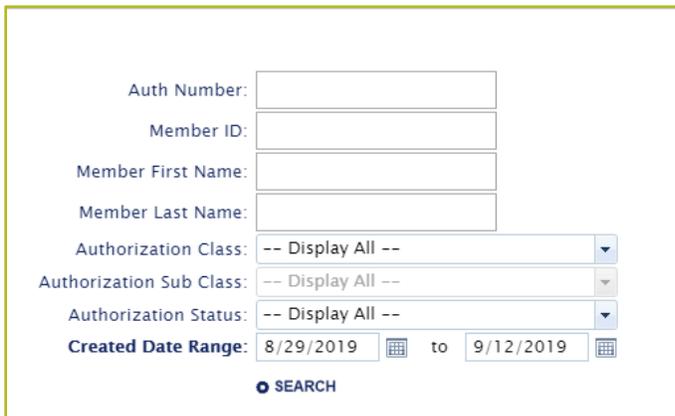
After logging into the Provider Portal, select **Authorization View** from the Portal Home Page



Select the Referring Provider for which the authorization request was submitted.



The Search Criteria will then be displayed. The **Created Date Range** is the only required field and will default to search for the previous two weeks. This will need to be changed if the authorization was submitted outside of this default date range.

A screenshot of a search criteria form. It contains several input fields and dropdown menus: "Auth Number:", "Member ID:", "Member First Name:", "Member Last Name:", "Authorization Class:" (dropdown menu with "-- Display All --"), "Authorization Sub Class:" (dropdown menu with "-- Display All --"), "Authorization Status:" (dropdown menu with "-- Display All --"), and "Created Date Range:" (two date pickers with "to" in between, showing "8/29/2019" and "9/12/2019"). At the bottom is a "SEARCH" button with a magnifying glass icon.

The quickest way to search is by using the **Auth Number** field. Enter the Reference ID that displayed in the View Confirmation detail after the authorization was submitted. Once all relevant search criteria has been entered, click **Search**.

Note: The Reference ID may not be known if searching for saved authorizations that have not yet been submitted.

Step 1: Select Referring Provider to Do Business As

Provider NPI or Name:

Search Results

Displaying 1 authorizations that matched your search criteria.

[MODIFY SEARCH](#)

Auth #	Member ID	Member	Referring Provider	Class/Sub-Class	Type	Servicing Provider	Status	Requested
<u>S000456789</u>	00012345601	MEMBER, SAMPLE A	MEDICAL DOCTOR	Specialist Adult Medicine/Cardiology	Pre-Service	SAMPLE DOCTOR	Submitted	1/1/2020

All authorizations that meet the search criteria will populate.

Submitted Authorizations

To view a submitted authorization, select the underlined **Auth #** at the beginning of the record. The authorization summary will be displayed.

Authorization Summary

[EXPORT TO PDF](#)

Authorization Info

Essette Auth #: S000123456
 : -
 Auth Class: Specialist Adult Medicine
 Status: Submitted
 End Date: -
 Source of Admission: -
 Priority: Concurrent
 LOB: DHP ACA
 Approved Visit:
 Member Name: SAMPLE MEMBER
 Address: 123 EXAMPLE DR
 -
 CITY, WI 12345-6789
 Servicing Clinic or Group: -
 Referring Provider: [MEDICAL DOCTOR \(112233445566\)](#)
 Servicing Provider: [SAMPLE PROVIDER \(987654321000\)](#)

Auth Type: Pre-Service
 Request Date: 02/21/2020 9:27 AM
 Start Date: -
 Admission/Service Date: 1/1/2020
 Member ID: 00012345601
 Date of Birth: 9/16/1939 (Age: 80)
 Phone: (123) 456-7890

Code	Description
I130	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease

Qty Req'd	Code	Description	Determination / Reason	Qty Approved	Determination Dates of Service
No services have been added.					

Notes

Created	Created By	Category (Sub Category)	Note
No records to display.			

Saved Authorizations

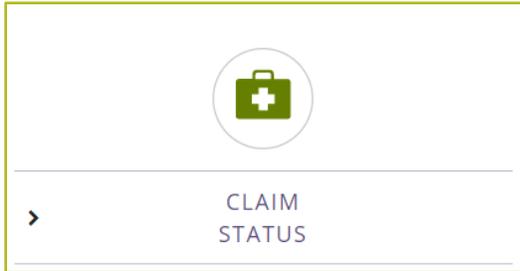
To view incomplete authorizations that have been started but not submitted, click the double arrow icon located at the end of the record. This will return the user to the authorization step that was last completed.

Auth #	Member ID	Member	Referring Provider	Class/Sub-Class	Type	Servicing Provider	Status	Requested
S200223005	00012345601	MEMBER, SAMPLE A	SAMPLE PROVIDER	Specialist Adult Medicine / Cardiology	Pre-Service	MEDICAL DOCTOR	Incomplete	>>

V. Claim Status

The Claim Status application provides human readable real time EDI (Electronic Data Interchange) 276/277 Claim Status Request and Response transactions that enables users to check the status of their submitted claims.

After logging into the Provider Portal click the **Claim Status** application located on Home Page.



Tip

Maximum claim status lookup is 12 months.

Users will be taken to the **New Claim Status Inquiry** page.

i. Submit Real-Time 276 Claim Status Transaction

Select the Billing ID (NPI) from the Provider Billing ID dropdown. This should be the billing NPI that the claim(s) was submitted under. Enter information into all required fields denoted by (*):

- Member Last Name
- Member First Name
- Date of Birth
- Member ID
- Date of Service Start Date (If the start date is the not the exact date of service, the end date must also be entered.)

Once all required fields and desired optional fields have been filled, click **Submit Request**.

ii. 277 Claim Status Response

All claims that meet the search criteria will be returned in the results.

Claim Status Inquiry Results						
Member ID:		00012345601				
Member Name:		MEMBER, SAMPLE				
SUBMIT NEW INQUIRY						
Control Number	Dates of Service	Claim Charges	Claim Paid Amount	Adjudication Date	Status	Service Line
20000000H111111	10/01/2018 - 10/31/2018	\$ 10.00	10.00	11/18/2018	Finalized - The claim/encounter has completed the adjudication cycle and no more action will be taken. Claim/line has been paid	>>

Tip

For additional details relating to each service line, click the double arrow to the right of the record under **Service Line**. This will display each service line individually.



The claim header will show:

- Prevea360 Health Plan claim number
- Dates of Service
- Claim Charges
- Claim Paid Amount
- Adjudication Date
- Status (Pending or Finalized)

For additional details relating to each service line, select the double arrow on the right of the record under **Service Line**. This will display each service line individually.

Control Number	Dates of Service	Claim Charges	Claim Paid Amount	Adjudication Date	Status	Service Line
20000000H111111	10/01/2018 - 10/31/2018	\$ 10.00	\$ 10.00	11/18/2018	Finalized - The claim/encounter has completed the adjudication cycle and no more action will be taken. Claim/line has been paid	>>
Service Line Information						
Rev Code:						
Procedure:	E0570					
Mod:	RR					
Svc Units:	31					
Date:	10/01/2018 - 10/31/2018					
Charge:	\$ 10.00					
Paid:	\$ 10.00					
As of:	08/13/2019					
Finalized - The claim/encounter has completed the adjudication cycle and no more action will be taken.					Claim/line has been paid	

The Service Line Information will display the following information:

- Revenue Code
- Service Units
- Modifier (if applicable)
- Date of Service
- Billed Charges
- Paid Amount
- Final Review Date
- Status

Click **Submit New Inquiry** to review additional claims or select the Prevea360 Health Plan banner to return to the Home Page.

VI. Claim Payments

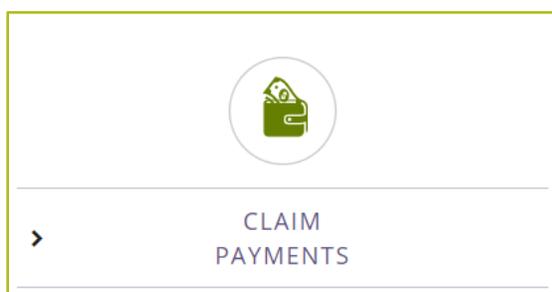
The Claim Payments application provides access to claim payment information online and allows Prevea360 Health Plan to deliver Electronic Remittance Advice (ERAs) or “remits” to providers online rather than mailing these documents. ERAs are statements from Prevea360 Health Plan documenting payments of claims.

Tip

It is recommended that date and patient information both be entered to return the most accurate search results.

i. Access Claim Payments

After logging into the Provider Portal select the **Claim Payments** application located on Home Page.



Tip

Remits from the past 180 days can be reviewed.

Remits

Use the **Remit Search** on the left side to filter for specific claim payments. If no search filters are selected, the report will default to payment information from the last 30 days.

Remits

This page allows you to manage remits from the past two weeks (180 days when filtering). You can view remit files using the button(s) below.

Use the search box to search for specific remits, or use the filters to view remits for specific payers and/or patients. By clicking the Download CSV link under Payments, you can download a payment report that is restricted to your filtered search results. If no filters are selected, the report will download the payment information from the last 30 days.

Remit Search		Show 10 entries							
Keyword	Filter	Date Submitted	Payer	Patient Name	Check Number	Check Date	Patient Account Number	Paid Amount	Action
SEARCH		2019-08-27 11:12 AM				2019-08-02 00:00:00.0	333	6565.00	>> [Download] [View]
	Date	2019-08-27 11:12 AM				2019-08-02 00:00:00.0	111	15.81	>> [Download] [View]
	Patient	2019-08-27 11:12 AM				2019-08-02 00:00:00.0	222	0.00	>> [Download] [View]
	Clear Filters	2019-08-27 11:12 AM				2019-08-02 00:00:00.0	555	0.00	>> [Download] [View]
		2019-08-27 11:12 AM				2019-08-02 00:00:00.0	555	0.00	>> [Download] [View]
		2019-08-27 11:12 AM				2019-08-02 00:00:00.0	555	2417.73	>> [Download] [View]

Search Options:

- **Search bar** - Use the search bar to search by payment ID or Claim ID.
- **Timeframe dropdown** – expand the lookback timeframe to up to 6 months.
- **Advanced Search** – search by entering a check date, member name, member ID or Patient Account Number.

Claim results will display as search criteria is entered. Continue entering search criteria until desired results are achieved.

Remits

This page allows you to manage remits from the past two weeks (180 days when filtering). You can view remit files using the button(s) below.

Use the search box to search for specific remits, or use the filters to view remits for specific payers and/or patients. By clicking the Download CSV link under Payments, you can download a payment report that is restricted to your filtered search results. If no filters are selected, the report will download the payment information from the last 30 days.

Remit Search

Keyword
SEARCH

Filter

Date ▾

Patient ▾

Clear Filters

Show 10 entries

Date Submitted	Payer	Patient Name	Check Number	Check Date	Patient Account Number	Paid Amount	Action
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	333	6565.00	» » 📄 🖼️
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	111	15.81	» » 📄 🖼️
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	222	0.00	» » 📄 🖼️
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	555	0.00	» » 📄 🖼️
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	555	0.00	» » 📄 🖼️
2019-08-27 11:12 AM				2019-08-02 00:00:00.0	555	2417.73	» » 📄 🖼️

General claim information is available on this screen, but additional details are available through the **Action** items on the far-right column of each record. Available **Actions** include:

- Show details
- Add notes
- View Image

Show Details

Select the double-arrow **Action** to expand the header line to view additional payment details including:

- Provider Information
- Payment Information
- EDI transactions

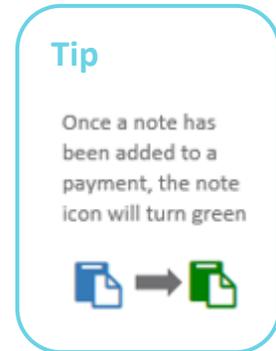
Show 10 entries

Date Submitted	Payer	Patient Name	Check Number	Check Date	Patient Account Number	Paid Amount	Action
2019-07-22 11:37 AM						0.00	» » 📄 🖼️

Claim Information	Payment Information	Additional Actions
Patient Name : Member Id : Payer Claim Number : Patient Account Number : Total Charge :	Payer Name : Provider Name : Check Number : Check Date : Paid Amount :	<div style="border: 1px solid #0070C0; padding: 2px; display: inline-block;"> View EDI </div>

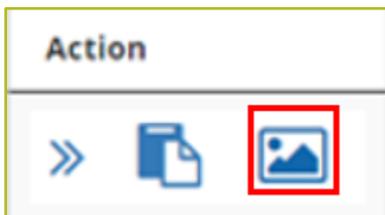
Add Notes

Select the clipboard and paper icon to enter payment specific notes that are viewable for all users with access to the same account.



EOP Image

Select the picture icon to view the EOP. This is a sample only and should not be used for business purposes.



VII. Claim Appeals

Claims that have finished processing and are in a finalized status (paid/denied) can be appealed directly through the Provider Portal.

i. Access Claim Appeals

After logging into the Provider Portal select the **Claim Appeal** application

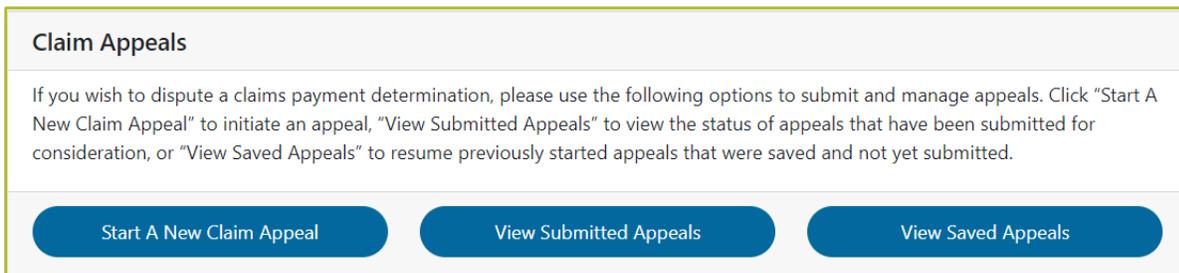


Tip

Corrected claims cannot be submitted via the Provider Portal.

The Claim Appeal feature has three options:

- **Start a New Claim Appeal** – allows the creation submission of a new Claim Appeal
- **View Submitted Appeals** – allows the search for claim appeals that were previously submitted
- **View Saved Claim Appeals** – allows the search for claim appeals that have been started and saved, but not submitted.



Note: Up to 500 submitted claim appeals within a six month period will be available to view.

ii. Start a New Claim Appeal

To start a new claim, select the **Start a New Claim Appeal** action to prompt the **Select Claim Appeal Type** form to display. Select the radio button for the applicable claim appeal type and click **Select Form**.

Claim Appeal Type Selection	
① Make a selection by clicking a row in the grid	
Appeal Type	Appeal Description
Additional Payment	Use this form to request a reconsideration of a payment. Include both the amount originally paid as well as the expected payment amount. A brief statement explaining why the original payment is incorrect, is also required.
Authorization	Use this form to request a reconsideration of a failure-to-pre-authorize denial.
COB	Use this form to request a reconsideration of a coordination of benefits (COB) denial. The primary payor's EOP is required if not submitted with the original claim.
Code Review Request	Use this form to request a reconsideration of a claims-edit denial. For example, denials due to frequency/maximum units, code bundling, inappropriate modifier, global surgery, diagnosis etc. A brief statement explaining why the claim edit should be overturned, and corresponding supporting documentation will be required.
Duplicate Denial	Use this form if you believe your claim denied as a duplicate in error.
Medical Necessity	Use this form to request a reconsideration of a medical-necessity denial. A brief statement explaining why the denial should be overturned and corresponding supporting documentation will be required.
Recoup	Use this form to request a recoupment or refund. Include both the amount originally billed as well as the recoupment/refund amount. The reason for the recoupment/refund is also required.
Timely Filing	Use this form to request a reconsideration of a timely-filing denial. Providers are required to file claims in a timely manner. All claims must be submitted in accordance with the claim filing limit stipulated in your Provider Agreement/Contract. Documentation to support the timely-filing waiver will be required.
Unlisted Codes	Use this form to request a reconsideration of an unlisted code denial. A description of the unlisted procedure, a brief statement explaining why the unlisted code denial should be overturned, and supporting documentation will be required.

Validate Claim

After selecting the applicable Claim Appeal Type, a validation form will be prompted. Validate the claim by entering the Claim Number and Member Number and click **Validate Claim**. Once validated, additional appeal fields will populate.

[< Back to Appeal Type Selection](#)

Authorization

Tax ID *	Phone Number	Extension
<input type="text" value="390817529"/>	<input type="text" value="() ___-__"/>	<input type="text"/>

Appeals

Claim Number *	Member Number *	Validate Claim
<input type="text"/>	<input type="text"/>	

Cancel Request
Save Request
Submit
Submit and Add New

Although there is an option to Submit the appeal at the bottom of the page, claim appeals cannot be submitted until all required with a red asterisk “*” have been completed.

Required Fields include:

- Member Name
- Date of Services
- First Time Review
- Selecting Claim Lines
- Comments
- Attach Supporting Documents

Appeals

Claim Number * Member Number *

Member First Name * Member Last Name * Date of Service * First Time Review Yes No

Appeal All Claim Lines?

Service Line	CARC	RARC	Amount Charged
No records available.			

Explanation *

Attach Supporting Documents

Your documents must be of type .jpg, .pdf, .png, .docx, .xlsx, or .msg AND under 10 MB.

0 - 0 of 0 items

First Time Review

After entering the member name and date of services, select the appropriate radial button under First Time Review. If **No** is selected, you will be prompted to complete two additional fields – **Reason for Resubmission** and **Original Claim Appeal Submission Date**.

First Time Review? *

Yes No

Original Claim Appeal Submission Date *

Reason for Resubmission *

Adding Claim Lines

Service lines may be added by selecting **(+Add)** at the bottom of this section. All required fields in red will need to be completed before additional lines can be added. Once completed, click **Update** on the right to save the service line before being able to add another service line.

Appeal All Claim Lines?

Service Line	CARC	RARC	Amount Charged	
1				<input type="button" value="Update"/> <input type="button" value="Cancel"/>
No records available.				

Once saved, the service line may be Edited or deleted, or select **(+Add)** to continue adding service lines.

Appeal All Claim Lines?

Service Line	CARC	RARC	Amount Charged	
1			\$100.00	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

Certain appeal types will allow the selection to appeal all claim lines at once. If all service lines are being appealed, and the **Appeal all claim lines** checkbox is available, please select it. No additional service line information will need to be entered

Appeal All Claim Lines?

Service Line	Amount Charged	
No records available.		

Explanation

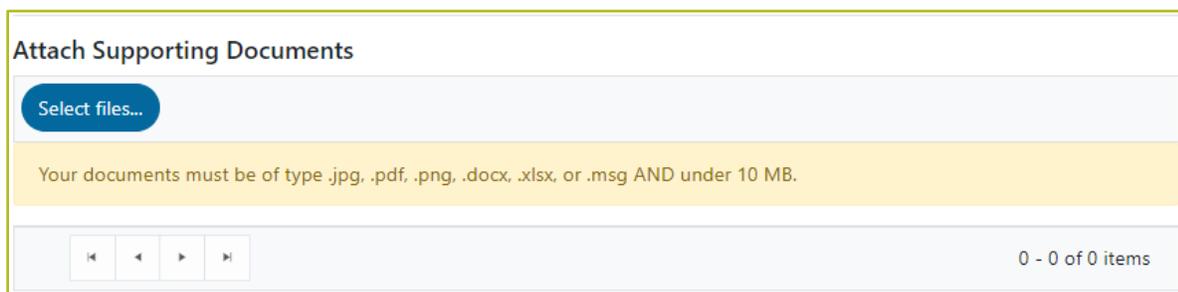
In the **Explanation Field**, include a brief but detailed explanation as to why the claim is being appealed. The explanation should include information related to the claim denial reason and should support why the original decision should be overturned. Be as detailed as necessary and include call reference numbers, if applicable.

Explanation *

Attach Supporting Documents

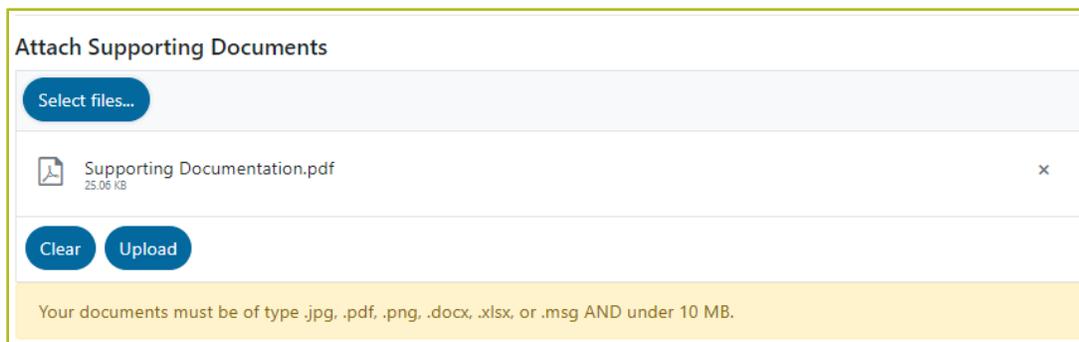
- Attach only the documents that are applicable and will support the medical necessity. Required information must be legible and clearly marked. Do not use highlight markers as they do not always show up on scanned images.
- In adherence to the HIPAA Privacy Rule, only the minimum necessary documentation needed for review should be submitted. The member’s entire record should not be submitted unless it can be specifically justified as needed for that purpose.
- Appropriate file types include .jpg, .pdf, .png, .docx, .xlsx, and .msg, AND must be under 10 MB in size.

Click **Select files** to locate and select the applicable files to attach and submit with the appeal.



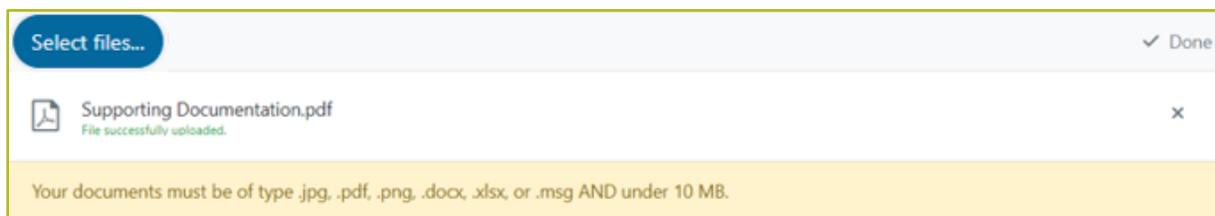
The screenshot shows the 'Attach Supporting Documents' section. At the top, there is a blue button labeled 'Select files...'. Below this, a yellow banner contains the text: 'Your documents must be of type .jpg, .pdf, .png, .docx, .xlsx, or .msg AND under 10 MB.' At the bottom of the interface, there are navigation arrows and a status indicator that reads '0 - 0 of 0 items'.

Select the appropriate file and double click to add it to the appeal. Once selected, the document will appear within the application but still needs to be Uploaded.



The screenshot shows the 'Attach Supporting Documents' section. The 'Select files...' button is still present. Below it, a file named 'Supporting Documentation.pdf' (25.06 KB) has been added to the list, with a small 'x' icon to its right. Below the file list, there are two buttons: 'Clear' and 'Upload'. A yellow banner at the bottom contains the text: 'Your documents must be of type .jpg, .pdf, .png, .docx, .xlsx, or .msg AND under 10 MB.'

Click the **Upload** option to attach the document. A confirmation message will display once the file has been successfully uploaded.



The screenshot shows the 'Attach Supporting Documents' section. The 'Supporting Documentation.pdf' file is now shown with a green checkmark and the text 'File successfully uploaded.' below it. The 'Select files...' button is now greyed out, and a 'Done' status with a checkmark is visible in the top right corner. The yellow banner at the bottom remains the same: 'Your documents must be of type .jpg, .pdf, .png, .docx, .xlsx, or .msg AND under 10 MB.'

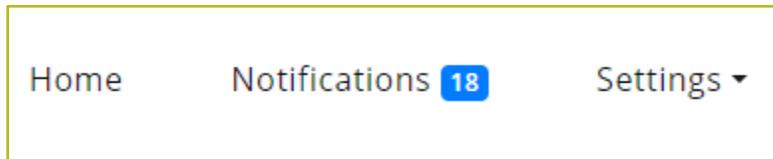
Once the documents are attached, they will appear in the Attach Supporting Documents section. Attachments can be deleted by clicking the “X”.

After completion of the Claim Appeal form, there are four options located at the bottom of the form:

- **Cancel Request** – Choosing this option will prompt the message, “Are you sure?” If you cancel the request, entered data will be lost. This will also remove the request if it was previously saved.
- **Save Request** – Choosing this option will prompt the message, “Appeal request has been saved.”
- **Submit** – Choosing this option will prompt the message, “Your claim appeal has been submitted successfully.”
- **Submit and Add New** – Choosing this will submit the current claim appeal, and taking you back to the claim validation screen to begin a new claim appeal. This will automatically select the same **Claim Appeal Type** that was previously selected.

Submission

Once the appeal has been submitted, a Claim Appeal Acknowledgement will be sent through Notifications. Click **Notifications** on the Home Page to access this Acknowledgement.



Tip

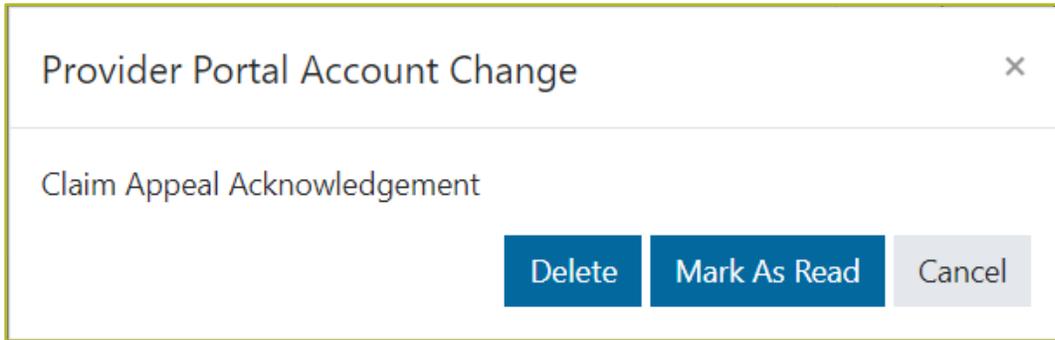
The number of unread Notifications is displayed in the Notifications field.

The most recent Notifications will be displayed at the top of the list and can be filtered by column. Look under the **Subject** column to find the **Claim Appeal Acknowledgement** with the applicable claim number identified and click **Read** to view the notification.

Read Flag	Read Date	Received Date	Subject	Action
		12/4/2023	Provider Portal Account Change	Read Delete
		12/4/2023	Provider Portal Account Change	Read Delete
		7/10/2023	Provider Portal Account Change	Read Delete
		7/10/2023	Provider Portal Account Change	Read Delete
		7/10/2023	Provider Portal Account Change	Read Delete
		7/10/2023	Provider Portal Account Change	Read Delete
		7/10/2023	Provider Portal Account Change	Read Delete
		7/10/2023	Provider Portal Account Change	Read Delete
		7/10/2023	Provider Portal Account Change	Read Delete

Page 1 of 1 1 - 18 of 18 items

Click **Open Attachment** to download the Acknowledgement and click on the pdf that appears at the bottom of the screen to view the Acknowledgement Letter.



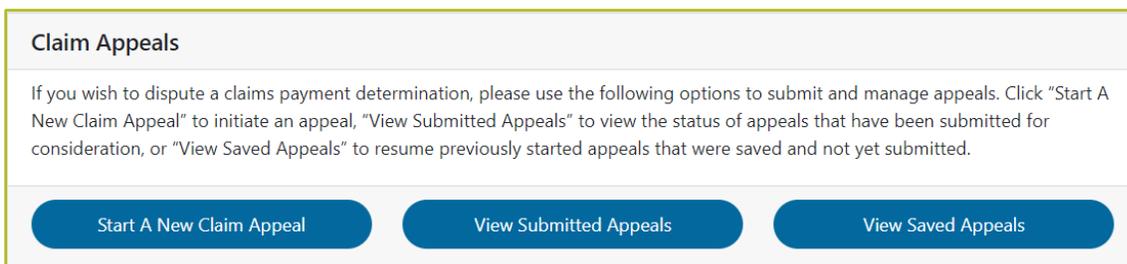
Once the health plan has reviewed the appeal, a **Determination Letter** will be sent through Notifications. This letter will indicate the review of the claim appeal was completed and the decision that was made.

Note: Claim appeal denial decisions can be re-appealed through online claim appeal submission. Denials should not be re-appealed if there is no new or supporting information to be reviewed.

iii. View Submitted Claim Appeals

This feature enables the user to search for claim appeals that may have been started and saved, or active claim appeals that have been submitted.

Select **View Submitted and Saved Claim Appeals** action.



After selecting the **View Submitted Appeals** action the following screen will be prompted, displaying all claim appeals submitted within the previous two weeks. Select the **View** option to review the information submitted.

Submitted Appeals							
Export to Excel							
Claim ID	Appeal Type	Submission Date	Status	Provider Name	Provider Tax ID	Submitted By	
16025Q00005	Medical Necessity	11/30/2023	Completed		390817529	qawf@mailinator.co...	View

There is also a search option to locate any appeals submitted more than two weeks ago. Enter all relevant search criteria, and select **Apply** to display all previously submitted appeals that match the searched criteria.

Submitted Appeals Filter

Appeal Type - Select -

Claim Number

Member ID

Submission Date

Start End

Apply

Tip

Up to 500 submitted claim appeals within a six month period will be available to view.

iv. View Saved Claim Appeals

This feature enables the search for claim appeals that have been started and saved, but not submitted.

Select the **View Saved Appeals** action.

Claim Appeals

If you wish to dispute a claims payment determination, please use the following options to submit and manage appeals. Click "Start A New Claim Appeal" to initiate an appeal, "View Submitted Appeals" to view the status of appeals that have been submitted for consideration, or "View Saved Appeals" to resume previously started appeals that were saved and not yet submitted.

Start A New Claim Appeal
View Submitted Appeals
View Saved Appeals

If a claim appeal is started but not submitted, it can be resumed by clicking **Continue** at the end of the saved claim appeal record.

Saved Appeals

Claim ID	Appeal Type	Submission Date	Status	Provider Name	Provider Tax ID	
20181114H313610	Additional Payment		Saved		123456789	Continue
20181114H313610	Authorization		Saved		123456789	Continue
20200103H305815	Additional Payment		Saved		123456789	Continue

1 - 3 of 3 items

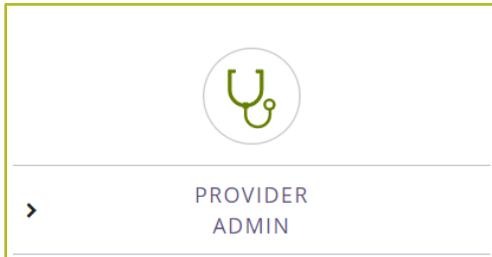
This will take you back into the appeal to pick up where it was left off. Once submitted, it will move from the **Saved Appeals** to the **Submitted Appeals**.

VIII. Provider Admin

This application allows Site Administrators to make updates to Individual user or Organization account information.

i. Access Provider Admin Application

After logging into the Provider Portal select the **Provider Admin** application on the Home Page.



Site Administrators have the following abilities within the Provider Admin application:

- Review and approve/deny new users who register under the Organization
- Update the access of an existing user who has access to the Organization account
- Submit a request to add an additional NPI or Tax ID to the account
- View number of users on the account

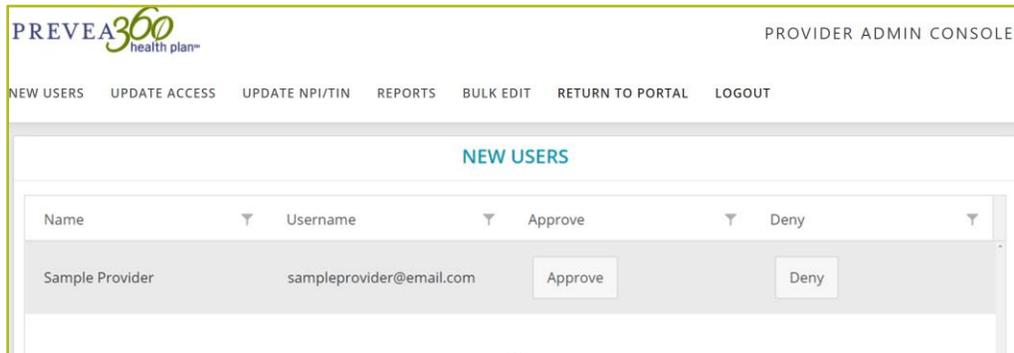


Tip

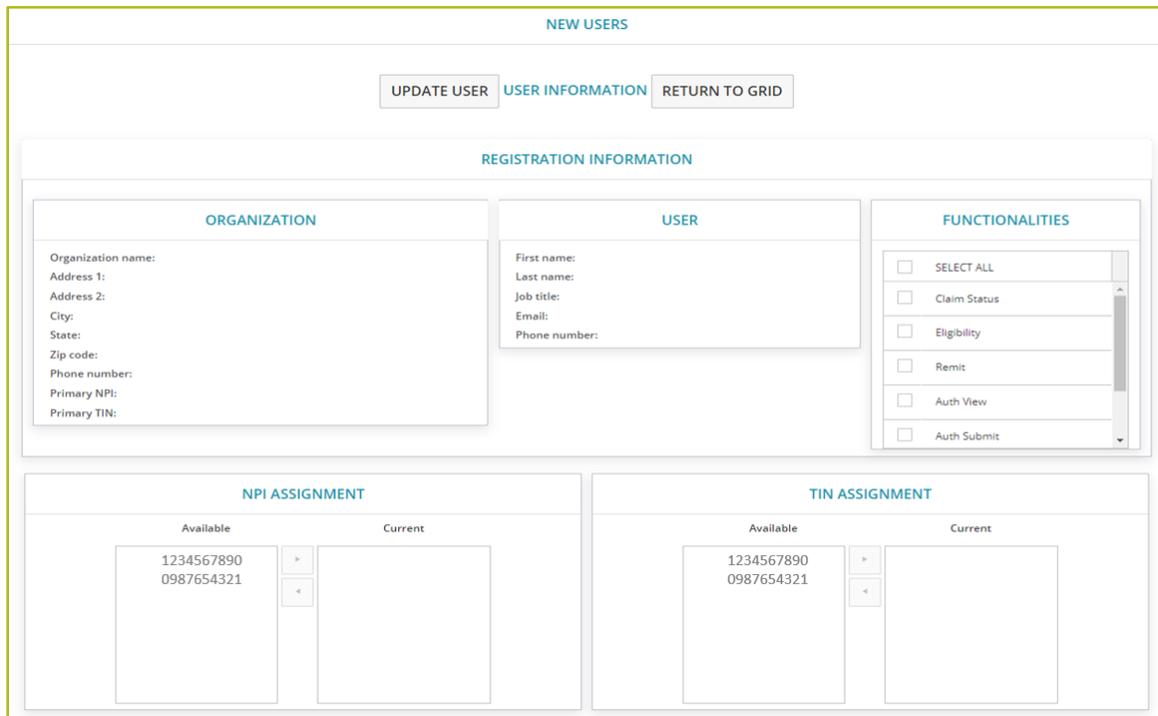
Only Site Administrators will have access to this application. It is strongly recommended that each Organization have at least two Site Administrators on the account.

ii. New Users

Click **New Users** to view a list of Individuals who have registered under the Organization. This page will auto-populate after clicking on the Provider Admin application. When a new Individual registers under the Organization account, each Site Administrator will be notified via secure notification on the Home Page to review the new user information in the Provider Admin application. Select to Approve or Deny the New User Registration.



Selecting Approve will open the **Registration Information** screen. Select which applications, TINs and NPIs this Individual should have access to, and select **Approve User**.



iii. Update Access

This option gives Site Administrators the ability to update the access of existing users or remove users who should no longer have access to the account.

Name	Email	Phone	Current Status	Update User	Disable	Enable
Sample User	sampleemail@email.com	(123) 456 - 7890		Update Access	Disable User	
Sample User	sampleemail@email.com	(123) 456 - 7890		Update Access	Disable User	
Sample User	sampleemail@email.com	(123) 456 - 7890		Update Access	Disable User	

NPIs, TINs, and Functionalities can all be reassigned based on the needs of the Individual user. Select Update Access on the user that requires updates.

UPDATE USER ACCOUNT

SAVE CHANGES ACCESS & PERMISSIONS FOR BILL ABACUS RETURN TO GRID

NPI ASSIGNMENT

Available	Current
	1659741890 1891796710

TIN ASSIGNMENT

Available	Current
	997755331 997755333

FUNCTIONALITY

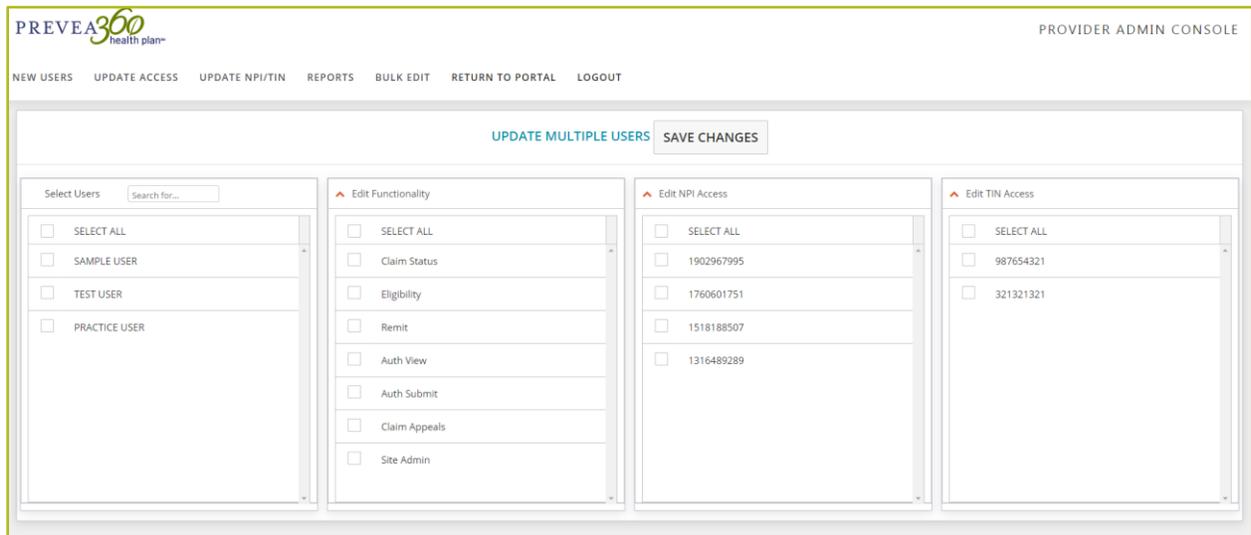
<input checked="" type="checkbox"/>	SELECT ALL
<input checked="" type="checkbox"/>	Claim Status
<input checked="" type="checkbox"/>	Eligibility
<input checked="" type="checkbox"/>	Remit
<input checked="" type="checkbox"/>	Auth View
<input checked="" type="checkbox"/>	Auth Submit
<input checked="" type="checkbox"/>	Claim Appeals
<input checked="" type="checkbox"/>	Site Admin

Once complete, click **Save Changes** or click **Return to Grid** to cancel these changes.

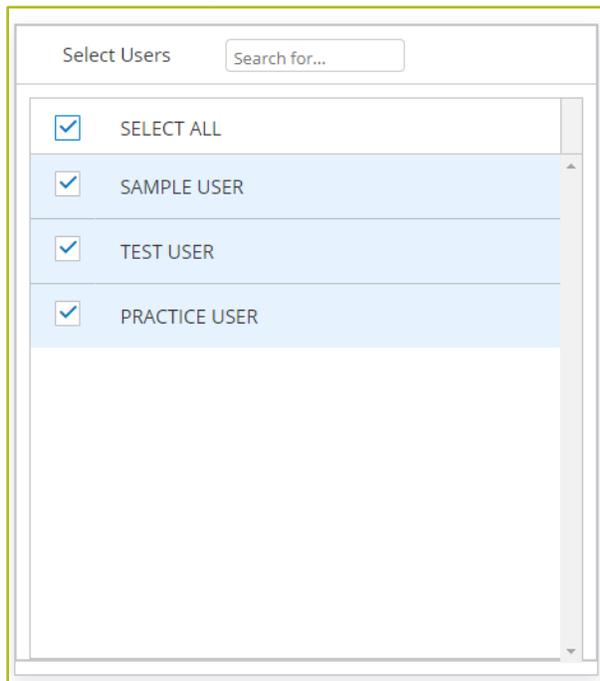
Bulk Edit

The **Bulk Edit** option gives Site Administrators the ability to make updates to multiple users at once.

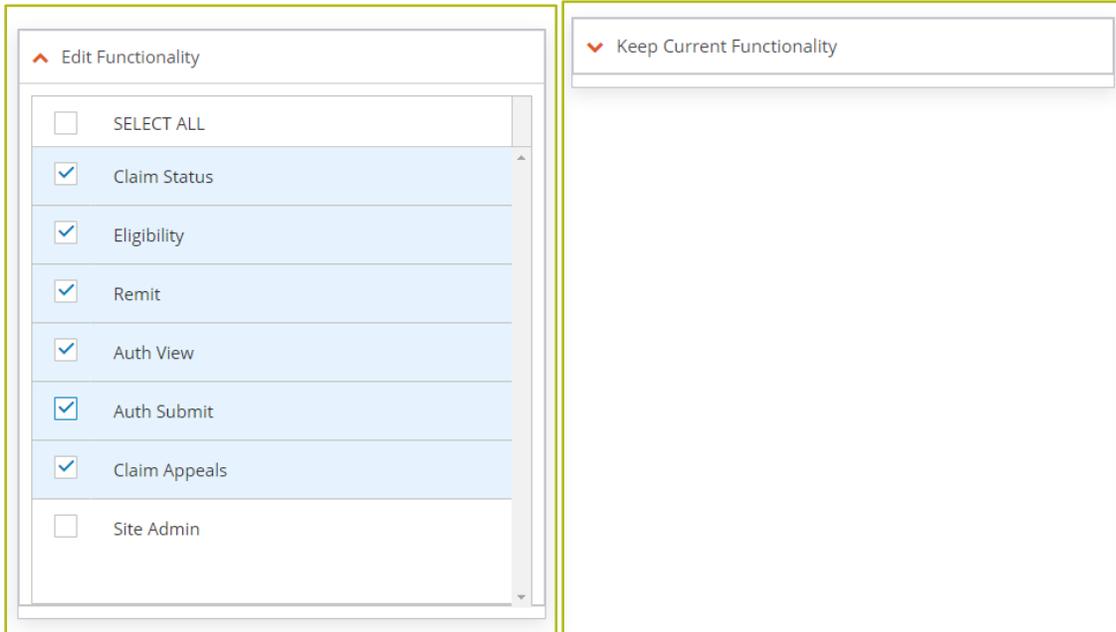
Note: Once submitted, changes made through the Bulk Edit feature will completely overwrite each user's existing access and will replace it with the Bulk Edit changes. If no changes are needed for a category, select the dropdown arrow at the top of the screen to close that category. This will prevent any Bulk Edit changes from being made to that category.



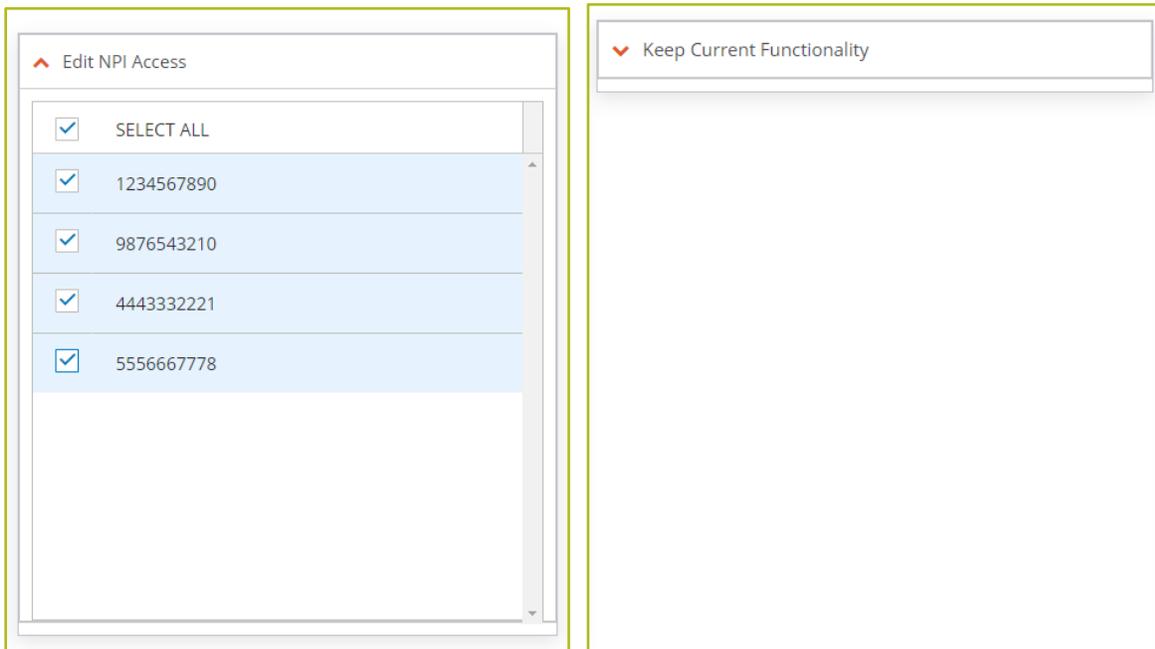
Under the Select Users category, select the users to be updated or **Select All** to select all users at once. There is also an option to search for a specific User. All selected users will receive the same updates.



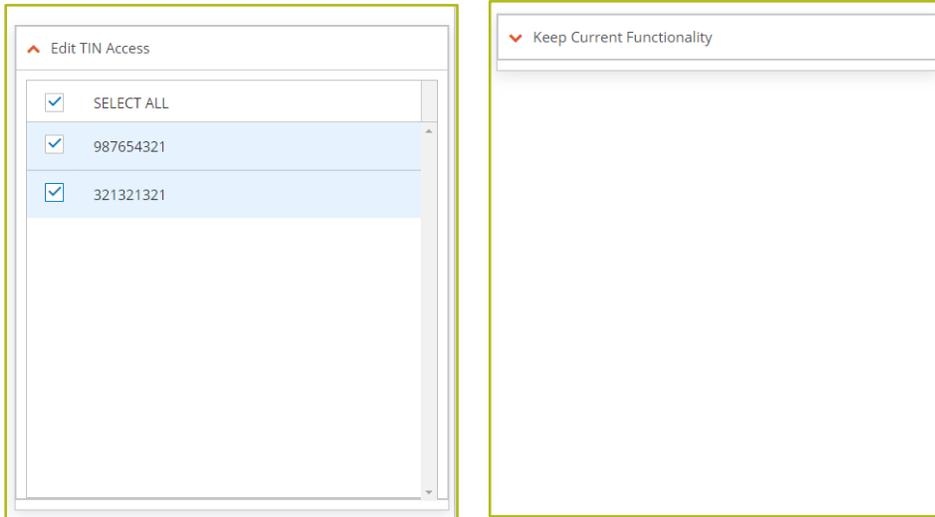
Select the Functionality that the selected users need. One, multiple, or all functionalities can be selected, as applicable. If no changes are needed to the users' Functionality access, select the dropdown at the top of the Edit Functionality screen to close that category and keep current functionality access for each selected user unchanged



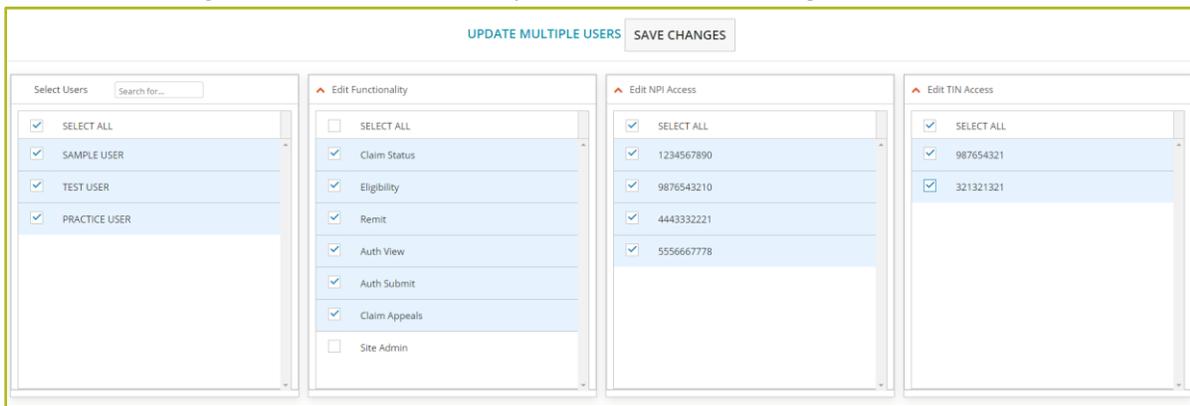
Select the NPIs that the list of selected users need access to or **Select All** to give each user access to all. If no changes are needed to the users' NPI access, select the dropdown at the top of the Edit NPI Access screen to keep current NPI access for each selected user unchanged.



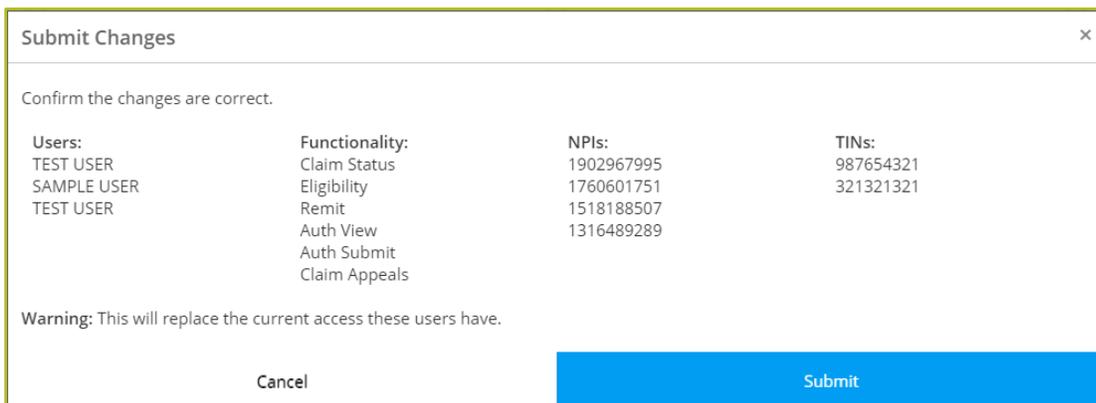
Select the Tax IDs that the list of selected users need access to or **Select All** to give each user access to all. If no changes are needed to the users' TIN access, select the dropdown at the top of the Edit TIN Access screen to keep current TIN access for each selected user unchanged.



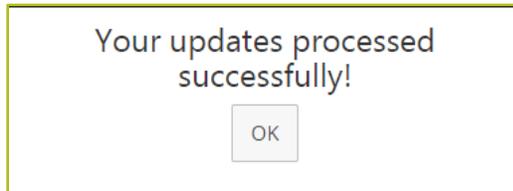
Once all the categories and details are completed, select **Save Changes**.



A recap of the requested changes will display. Please review to confirm your updates are correct before submitting as these changes will completely overwrite each selected user's current access.



Click **Submit** once you have confirmed your updates are correct. The following confirmation will display after the changes are successfully updated.

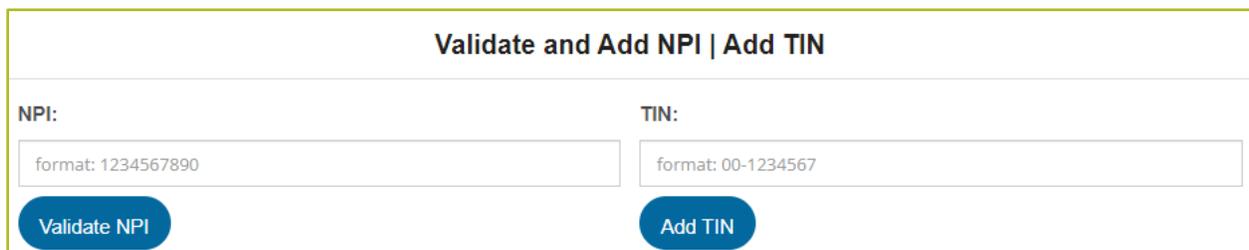


The Bulk Edit feature does not replace having to make separate, individual changes if not all users need the same access. Please limit user access to only those applications, NPIs, and TINs needed for business purposes

Update NPI/TIN

Additional NPIs and Tax IDs can be added to an Organization account upon request.

- To request to have a new NPI added, enter the NPI you wish to have added to the account and select **Validate NPI**. Please review the related information to confirm the correct NPI was entered. If so, select **Add NPI**. If not, select **Clear** and re-enter the NPI.
- To request to have a new TIN added, enter the TIN you wish to have added to the account and select **Add TIN**. The request will automatically be sent.

A white rectangular form with a thin green border. At the top center, the title "Validate and Add NPI | Add TIN" is displayed in a bold, dark grey font. Below the title, there are two columns. The left column is labeled "NPI:" and contains a text input field with the placeholder text "format: 1234567890" and a blue button labeled "Validate NPI". The right column is labeled "TIN:" and contains a text input field with the placeholder text "format: 00-1234567" and a blue button labeled "Add TIN".

An Internal Administrator at the health plan will review all requests to verify that the information submitted is covered under the contract. If additional information is needed, the Internal Administrator will reach out to the Site Administrator who submitted the request. Once a decision has been made, all Site Administrators for the organization will receive secure notification of the decision.

Reports

Reporting is available for Site Administrators to view the total number of users on the account.

- **Active Users** – users who have access to the portal account
- **New Registered Count** – users who have registered within the past two weeks.
- **Not Vetted Count** – new users who have registered under the portal account but have not yet been approved or denied.
- **Non Active Count** – users whose account access has been removed.

IX. Provider Resources

Select the Provider Resources application for access to all guides and resources related to the Provider Portal.



Available resources include:

- Links to vendor portals
 - RadMD
 - Confirmation Reports Portal
 - Navitus Prescriber Portal
- Medical Policies
- Provider Manuals
- Provider Newsletters
- Various Resources available through the Prevea360 website

> MAGELLAN PORTAL	> NAVITUS PRESCRIBER PORTAL	> MEDICAL POLICIES	> MEDICAL INJECTABLES LIST
> PORTAL USER GUIDE	> PNC TEAM CONTACT LIST	> DOCUMENT LIBRARY	> PORTAL USER GUIDES/FAQS
> MEDICAL MANAGEMENT HOME	> MASTER SERVICE LIST	> PROVIDER PAGE	> PROVIDER MANUALS
	> CONFIRMATION REPORTS PORTAL	> PROVIDER NEWSLETTER	