

*Illinois Mental Health
Collaborative*
**Provider
Guide to Using
Direct Claim Submission**

www.illinoismentalhealthcollaborative.com

Direct Claim Submission allows the provider/submitter to enter claims directly into the Collaborative claims processing system through our website, without using any special software. Direct Claim Submission expedites both processing and payment of the claim.

If you have any questions, or need technical guidance, contact the e-Support Helpdesk at 888-247-9311, Monday through Friday, 8am – 6pm EST. You may also email the Helpdesk directly at e-supportservices@valueoptions.com

Please note, any questions regarding how a claim was processed (payment or denial questions) must be directed to the Claims Customer Service Department at 866-359-7953.

Instructions for Direct Claim Submission

You must have an electronic account established with the Collaborative to submit claims. If you do not currently have an electronic account, register online at www.illinoismentalhealthcollaborative.com, or contact the e-Support Helpdesk at (888) 247-9311 for assistance. Please note, a completed Account Request Form is required to establish an account. This form can be downloaded from the website (click on For Providers, then ProviderConnect Helpful Resources, then Forms on the left side of the page) or can be obtained by contacting the e-Support Helpdesk.

Once an account is set up, go to <http://www.illinoismentalhealthcollaborative.com> and click on the For Providers link. This will display the Provider Online Services Home Page.

Click on Log In, which displays the ProviderConnect Log In page. Enter your User ID (Submitter ID) and password.

After logging in, select “Yes” at the User Agreement screen before proceeding.

The Welcome page now displays. The menu options are displayed on the left side of the screen.

To enter a Direct Claim, click on the “Enter A Claim” link.

Select the provider:

Choose which provider you are submitting this claim for

Provider

Provider: PROVIDER - TEST1 Provider Last Name: PROVIDER Provider First Name: TEST

Verify the service location:

Click the radio button to indicate the correct combination of Service Location and Pay To address. **(If the listed address options are incorrect or out of date, please contact our National Provider Line at 800-397-1630 to update your provider file)**

Provider

Provider: PROVIDER - TEST1 Provider Last Name: Vendor Provider First Name: ILL Admin

Select Service Address

Capture	Vendor ID	Service Address	Pay To Address
<input type="radio"/>	IL1000000	IL ADMIN VENDOR 240 CORPORATE BLVD NORFOLK, VA 23502-4948	IL ADMIN VENDOR 240 CORPORATE BLVD NORFOLK, VA 23502-4948

If necessary, a different provider may be selected at this point

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

Verify NPI # and enter consumer information:

[Submit A Claim - Step 1 of 3](#)

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

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

Provider Name	PROVIDER TEST
Service Address	240 CORP, NORFOLK, VA 23502
Pay To Address	240 CORP, NORFOLK, VA 23502
Vendor ID	ATEST1
NPI Number	9876543210
Taxonomy Code	
Licensure Level	Select...
*Member ID	123456789 <small>(X-digits, no spaces or dashes)</small>
Member Name	<input type="text"/> <input type="text"/> <small>(First Last)</small>
Member Account #	<input type="text"/> <small>(X-digits, no spaces or dashes)</small>
Program/Fund/Group ID	ABC
*Member DOB	01011990 <small>(MMDDYYYY)</small>
*First Date of Service	12012008 <small>(MMDDYYYY - Enter Earliest Date of Service for this claim)</small>

When entering a claim via Direct Claim Submission, the following fields are required for entry.

1. **NPI Number:** Select the correct NPI number for the provider on this claim. If this number is wrong or missing, contact our National Provider Line at 800-397-1630 to update your provider file.

2. **Consumer ID: REQUIRED.** This is the consumer's **RIN**. Do not enter any spaces or special characters in this field. Only numbers and alpha characters are allowed.

3. **Program/Fund/Group ID: REQUIRED.** This is the Program Code for which you are submitting services.

4. **Consumer DOB: REQUIRED.** This is the consumer's date of birth. It must be entered in MMDDYYYY format. Do not enter any dashes or slashes in this field.

5. **First Date Of Service: REQUIRED.** Enter the first date of service for this claim. It must be entered in MMDDYYYY format. Do not enter any dashes or slashes in this field.

Once all of the required information is entered, click "Next". If the information is accurate, the Service Line Entry Screen will display.

If any information is inaccurate, an error message will appear in red at the top of the screen, and you can enter the correct information.

Staff Level & Coordination of Benefit Entry

Submit A Claim - Step 2 of 3

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

member ID	member Name	Birth Date	NPI Number	Service Address	Pay To Address
123456789	DOE JOHN	01/01/1990	9876543210	240 CORP, NORFOLK, VA 23502	240 CORP, NORFOLK, VA 23502

Frequency Type Original Reference Number

Service Recipient Code Patient Relationship Details 1 Patient Relationship Details 2

Patient Account Number Document Control Number

Staff Qualification Level 1 Staff Qualification Level 4

Staff Qualification Level 2 Staff Qualification Level 5

Staff Qualification Level 3 Staff Qualification Level 6

Purchased Service Provider Information

Provider ID Provider First Name Provider Last Name

Other Payer Information (1)

Payer Responsibility **PRIMARY**

Subscriber is Patient

Subscriber ID

Name Last, First

Date Of Birth Sex

Other Carrier Claim Information

COB Consumer Paid COB Allowed Amount

COB Claim Adjudication Date

Patient Relationship

Group Name

Group Number

Payer Name

Payer ID

Release of Information

Assignment of Benefits

Patient Signature Source

Claim Filing Indicator

Insurance Type Code

Adjustment Group Adjustment Reason

- Frequency Type –this is a drop down to select the type of claim being submitted- Original, Corrected, Replacement, or Void
 - o If the Frequency Type is other than “Original,” an original reference (claim) number is required. – this is the Collaborative’s claim number from the original claim.
- Service Recipient Code defaults to “Consumer.” However if the recipient of services is other than the consumer, select either “Family” or “Collateral.” If Family or Collateral is selected, the patient relationship details should be completed.
- Patient Account Number is defined by the provider and is not required
- Document Control Number is defined by the provider and is not required
- Staff Qualification Level – this is a drop down to select the staff level rendering the services.
- Purchased Service Provider – if services were subcontracted to another agency, enter the FEIN of that agency here. Also enter the agency name in the Last Name field.
- **Other Payer Information (up to 3 instances):** This is your opportunity to include up to 3 entries of Coordination Of Benefits information that will apply to the entire claim. Click on the text “Other Payer Information” to open the 2nd and 3rd entries.
 - Payer Responsibility – select from the drop down whether the other coverage is primary, secondary or tertiary.
 - If the “Subscriber is Patient” field (this is the subscriber on the other coverage) is checked, all the consumer demographic information will fill.

- If the subscriber on the other coverage is not the patient, do not check this field. Complete the demographic information for the other coverage subscriber.
- COB Payer Paid – show the amount the other coverage paid for all the services on the claim.
- Group Name – this is the name of the other insurance carrier i.e. Medicare B
- Release of Information- this is a drop down, select the correct Release of information identifier
- Assignment of Benefits- this is a drop down, select yes or no
- Patient Signature Source- this is a drop down, the signature source
- Claim Filing Indicator- this is a drop down, select the indicator that pertains to this insurance carrier
- Insurance Type code- this is a drop down, select the indicator that pertains to this insurance type

Click “Next” at the far bottom of the screen to continue to the next page.

Service Line Entry

Submit A Claim - Step 3 of 3

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

Consumer ID 123456789	Consumer Name DOE JOHN	Birth Date 01/01/1990	NPI Number 9876543210	Service Address 240 CORP, NORFOLK, VA 23502	Pay To Address 240 CORP, NORFOLK, VA 23502
---------------------------------	----------------------------------	---------------------------------	---------------------------------	---	--

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

Service Line Entry

*Service From: 12012008 (MMDDYYYY)
 *Service Through: (MMDDYYYY)
 *Service Code: (ex: 06753)
 Modifier Code 1: (no spaces or dashes)
 Modifier Code 2: (no spaces or dashes)
 Modifier Code 3: (no spaces or dashes)
 Modifier Code 4: (no spaces or dashes)

*Charge Amount (\$): (ex: 123.45)
 *Place of Service: (00-99)
 *Units: (3-digit)

*Diagnosis Code 1: (ex: 765.4)
 *Diagnosis Code 2: (ex: 765.4)
 *Diagnosis Code 3: (ex: 765.4)
 *Diagnosis Code 4: (ex: 765.4)
 *Diagnosis Code 5: (ex: 765.4)
 *Diagnosis Code 6: (ex: 765.4)
 *Diagnosis Code 7: (ex: 765.4)
 *Diagnosis Code 8: (ex: 765.4)

Line Control number: (ex: 123.45)
 Patient Paid Amt: (ex: 123.45)
 *Delivery Method: Select...
 *Service Begin Time: HHMM (9999 is valid)
 *Service Duration Time: HMM

Group ID: (ex: 9999.99)
 Number of Clients in Group: (ex: 999)
 Number of Staff in Group: (ex: 99999.99)
 Staff ID: (ex: 999)

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

This will add this service line information to the claim

This is the claim detail page. The consumer information, service address, and pay to location will carry from information entered in Step 1. If the information is incorrect, click "Previous" at the bottom of the page to enter correct information.

The fields with an asterisk (*) are required.

1. Enter the details for the first (or only) line of service for the claim.
2. Click on "Add Service Line" to enter the information into the claim.
3. Repeat 1 & 2 as needed, for a maximum of 10 service lines.

Please refer to the **Illinois Mental Health Collaborative Service Matrix** for the correct Service Code, sequence of Modifier Codes. Enter the charge amounts, units, and diagnosis code for the service.

Please note the following when completing these fields:

- All "date fields" must be entered in MMDDYYYY format, no slashes or dashes.
- Charge Amount: Do not include the dollar sign (\$) in this field. (i.e.: 120.00, not \$120.00)
- Enter the decimal in the "diagnosis code."

Line Control number- is defined by the provider and is not required

Patient Paid Amount- enter this if the Consumer has paid any amount on this service

Deliver Method- chose from drop down- face to face, telephone or video

Service Begin time- in Military time, if bundling multiple same day services this will be 9999

Service Duration time- this is the amount of time used for this service, if bundling multiple same day services this will be the total time for all services

Group ID- the ID number defined by the provider for this service, if bundling multiple same day service this will be the first Group ID of the day

Number of Clients in group- the total number of clients in the group session, if bundling multiple same day services this will be the total number of clients in for all group services

Number of Providers in group- the total number of providers in the group session, if bundling multiple same day services this will be the total number of providers in for all group services

- COB fields: If you entered Coordination of Benefits information on the previous page, you will be able to enter a distribution of how much of the payment and how many units applies to each individual claim line.

Review Service Line Entries

Claim Detail: [Ready to Submit](#)

Click to Remove	Service Date		Service Code	Modifier Code 1	Modifier Code 2	Charge Amount (\$)	Diagnosis Code 1	COB Payer Paid		
	Start Date	End Date	Place of Service	Modifier Code 3	Modifier Code 4			Primary	Secondary	Tertiary
<input type="radio"/>	07/19/2008	07/19/2008	H2011 11	HE		239.76	295.70			
<input type="radio"/>	07/19/2008	07/19/2008	H2011 11	HE		239.76	295.70			
Total								0	0	0

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

Attach an EOB

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

This will attach an EOB document to the claim.

Attached Documents:

All of the service lines you have entered in the “Service Line Entry” section will appear in the “Claim Detail: Ready to Submit” section on the lower portion of the screen. This gives you an opportunity to review what you have entered for the specific member and verify that you are submitting valid data.

If you decide you need to remove one of the service lines you have entered, click the “Check to Remove” button for that individual line – then press the “Remove” button. If there is more than one service line you need to remove prior to submission, repeat this process as appropriate. You can then re-enter correct service lines by following the directions on the previous page.

If you have also included Coordination of Benefit information, you will also need to include Explanation of Benefit documentation. To do so:

1. Click on the “Upload File” button.
2. Click on the “Browse” button, and locate the file that you need to attach.
3. Click on “Upload” to attach the file

Click the browse Button to find the file you want to Attach
Click Upload when done.

File:

Repeat 1-3 as needed. Click on the icon of the trash can to remove the file if needed.

Attach an EOB

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

This will attach an EOB document to the claim.

Attached Documents:

 (EOB Upload File.docx)

If everything has been entered, and you are satisfied that the information is accurate, click on the “Submit” button at the bottom of the screen.

Please note, once the “Submit” button is clicked, no further changes can be made to the claim. A corrected claim must be submitted. See Appendix 1 for instructions to submit a corrected claim.

Final Step: Summary Page

Submit A Claim

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

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

Provider Name/ ID **PROVIDER TEST**
 Vendor ID **ATES11**
 Patient ID **123456789**
 Patient Name **DOE JOHN**
 Program/Fund/Group ID
 Patient Date of Birth **01/01/1990**
 NPI Number **9876543210**
 Taxonomy Code
 Licensure Level
 Claim # **050407-09999-00001**

Line #	Service Date		Service Code	Modifier Code 1	Modifier Code 2	Charge Amount (\$)	Diagnosis Code 1	Place of Service	To-Pay	Status	Dollar Amount (\$)					Fund
	Start Date	End Date		Modifier Code 3	Modifier Code 4						Allowed	Deductible	Pre-Paid	COIN	CoPay	
1	07/01/2009	07/01/2009	90801			100.00	300.00	11	100.00	0	100.00	0.00	0.00	0.00	0.00	
2	07/02/2009	07/02/2009	90801			100.00	300.00	11	100.00	0	100.00	0.00	0.00	0.00	0.00	

Attached EOBs :

EOB Upload File.docx

This is the submission results page. The “Claim #” shown is the information needed when inquiring on the status of this claim. Please contact the Claims Customer Service department with claim questions at 866-359-7953.

To enter a claim for another consumer press the “Enter New Claim” button at the bottom of this screen.

For additional detail on a submitted claim, click on the Claim Number, which displays the “Claim Search Results” page where more information is provided:

Menu Options Home Provider Home Contact Us Log Out

Claim Summary **Service Line Detail**

Claim Detail [Return to search results](#)

Claim # **07300-11111-9999**
 Claim Status **In Process**
 Patient Account #
 Member ID **123456789**
 Member Name **DOE, JOHN**
 Provider Name **PROVIDER TEST**
 Group Name **STATE OF ILLINOIS**
 Statement Date:
 Charge Amount (\$): **199.00**

Service Lines

Line #	Service Date	Type of Service	Procedure Code	Charge Amount (\$)
1	07/01/2008 - 07/01/2008		H002	99.00
2	07/02/2008 - 07/02/2008		H004	100.00

If the Claim Status reads “In Process,” the claim is still open, and is not yet finalized.

If the Claim Status reads “Processed”, click on the tab for “Service Line Detail” to display payment or denial information on the claim.

Claim Summary **Service Line Detail**

Claim Detail [Return to search results](#)

Claim # **07300-11111-9999**
 Claim Status **In Process**
 Member ID **123456789**
 Member Name **DOE, JOHN**
 Amount Paid (\$): **9.00**
 Paid To **PROVIDER**

Service Line Detail

Line #	Service Date		Service/Modifier Code	Units	Charge Amount (\$)	DX	Amount Paid (\$)	Status	Dollar Amount (\$)				Paid Date	Check #	Fund	COP
	Start Date	End Date							Allowed	Deductible	CoPay	CoIns				
1	07/01/2008	07/01/2008	H015642	1	99.00	205.70	0.00	In Process	99.00	0.00	0.00	0.00				100
2	07/02/2008	07/02/2008	H004/H0	1	100.00	205.70	0.00	In Process	100.00	0.00	0.00	0.00				100

Explanation of Payment

COP Code	Code Description

If you have any technical questions please contact the EDI Helpdesk at 888-247-9311 (M-F, 8am-6pm EST) for assistance.

Appendix 1: Submitting a corrected/replacement claim.

Submitting a corrected/replacement claim is essentially the same process as submitting an original claim, with only one small change.

- Obtain the claim number from your original claim, either from your summary page, or from a claim search. For this example, we will use the claim number: 01-070308-11111-99999

- Follow the instructions as indicated above.
- **On Staff Level & Coordination of Benefit Entry screen, make the following entries:**
- For **“Frequency Type”** select Corrected or Replacement
- In the **“Original Reference Number”** enter 01 in the first box, and enter the segments of the claim number in the remaining three boxes.
- Complete any other fields on this page as needed for the claim.
- Click Next, and continue as instructed as above.

Submit A Claim - Step 2 of 3

member ID	member Name	Birth Date	NPI Number	Service Address	Pay To Address
111111111	Joe Patient	07/09/1964	987654321	240 CORP, NORFOLK, VA, 23502	240 CORP, NORFOLK, VA, 23502

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

Frequency Type:

Original Reference Number:

Service Recipient Code:

Patient Relationship Details 1: Patient Relationship Details 2:

Patient Account Number:

Document Control Number:

Staff Qualification Level 1: Staff Qualification Level 4:

Staff Qualification Level 2: Staff Qualification Level 5:

Staff Qualification Level 3: Staff Qualification Level 6:

Purchased Service Provider Information

Provider ID: Provider First Name: Provider Last Name:

Other Payer Information

Payer Responsibility:

Subscriber is Patient:

Subscriber ID:

Name Last, First:

Date Of Birth: Sex:

Patient Relationship:

Group Name:

Group Number:

Payer Name:

Payer ID:

Other Carrier Claim Information

COB Payer Paid: COB Allowed Amount:

COB Consumer Paid:

COB Claim Adjudication Date:

Release of Information:

Assignment of Benefits:

Patient Signature Source:

Claim Filing Indicator:

Insurance Type Code:

Adjustment Group: Adjustment Reason:

If you have any technical questions please contact the EDI Helpdesk at 888-247-9311 (M-F, 8am-6pm EST) for assistance.