

Indiana
Department
of
Health

Children's Special Health Care Services

WebDDE User Guide

January 2021

Revision History

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Version 1.0	October 2020		Initial Draft document	IDOH OTC
Version 1.1	January 2021	All	Production Release document	IDOH OTC

Contact Information

Department	Toll-Free Phone Number	Local Phone Number
CSHCS EDI/Web Portal Support	1-800-475-1355 option 5, 1	317-233-9803 direct
CSHCS Claims Inquiries/Problems	1-800-475-1355 option 5, 2	317-233-7833 option 5, 2
CSHCS Provider Relations	1-800-475-1355 option 5, 3	317-233-7833 option 5, 3
CSHCS Eligibility	1-800-475-1355 option 2	317-233-1351 option 2
CSHCS Prior Authorization	1-800-475-1355 option 3	317-234-1821 direct

CSHCS Web Portal Enrollment/Change Form	Fax Number	Email Address
	317-233-8199	edimail@isdh.in.gov

Website Links

Website	Website Uniform Resource Locator (URL)
CSHCS Web Portal	https://eportal.isdh.in.gov/cshcs/index.html
CSHCS WebDDE	Click on 'WEB-Enabled Direct Data Entry' link under CSHCS Web Portal 'Quick Links' section or use direct link https://cshcsclaims.isdh.in.gov/
CSHCS Home Page	https://www.in.gov/isdh/19613.htm

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Section 1: WEB-Enabled Direct Data Entry (WebDDE)

Introduction

The Indiana Department of Health, Children's Special Health Care Services (CSHCS) WEB-Enabled Direct Data Entry (WebDDE) system is now available. The WebDDE system allows registered provider or billing company users to submit individual non-pharmacy claims directly to CSHCS through a secure, Web-based application instead of submitting paper claims.

*** Note:** The WebDDE system will not replace current professional, institutional, and dental claims submitted electronically in the 837 American National Standards Institute (ANSI) formats. The WebDDE system will also not replace pharmacy claims submitted at the point of sale (POS) via National Council for Prescription Drug Programs (NCPDP) Version D.0 format.

Children's Special Health Care Services will continue to accept the following electronic transactions:

- 837P (Professional)
- 837I (Institutional)
- 837D (Dental)
- NCPDP Version D.0 (Pharmacy)

Children's Special Health Care Services will continue to send electronic remittance advice files to providers that have elected to receive the files.

- 835 (Health Care Claim Payment/Advice)

The WebDDE system accepts the following types of professional, institutional, and dental claims.

- Professional Medical, Therapy, Supply, and Transportation
- Institutional Inpatient, Outpatient
- Dental

The WebDDE system allows one claim to be entered in a batch. When entering a claim, the claim must be completed in its entirety before submitting. There is no feature to partially save a claim and complete it later.

The WebDDE application will display a warning after fifteen minutes of inactivity. If the user does not respond for more time, the application will time-out and all entered claim information will be lost.

The WebDDE system will also allow the user to enter Coordination of Benefits (COB) information directly from the Explanation of Benefit (EOB) forms.

The WebDDE system will allow the user to upload all necessary pages of supporting documentation into a single Portable Document Format (PDF) file (maximum 50 megabytes).

A claim submitted through the WebDDE system is assigned a claim ID which can be used for tracking purposes. The WebDDE system will be used in conjunction with the existing CSHCS Web Portal system that is used to verify a participant's eligibility information, verify claim status, and check claim payment information. Providers who have elected to receive the 835 Health Care Claim Payment/Advice file will also continue to receive these files.

Browser Requirements

Any modern browser can access the WebDDE application, such as Google Chrome, Firefox, Microsoft Edge, Safari, and Internet Explorer.

However, when the user needs to log in to the existing CSHCS Web Portal to look up claim status and payment information, the user must still use Internet Explorer as the browser and have compatibility view settings set. The user may contact EDI/Web Portal Support at the phone number listed in Contact Information section for help in setting compatibility if needed.

Access to WebDDE

A registered user with the current CSHCS Web Portal system will also be able to access the WebDDE system. If not registered, a request will be made using the same procedure as the current CSHCS Web Portal system. The user may call the CSHCS EDI/Web Portal Support phone number listed in the Contact Information section to obtain the CSHCS Web Portal Enrollment form. Alternately, the user may obtain the CSHCS Web Portal Enrollment form from the current CSHCS Web Portal system using the link listed in the Contact Information section and then clicking on the 'Enroll in CSHCS Web Portal' link or the 'WEB Portal Enrollment and Change Form' link under the Forms section. Billing company users must complete one form for the billing company, and the associated providers with the billing company must each complete a form granting the billing company access to the claim information. The completed forms may be faxed or emailed to CSHCS EDI/Web Portal Support at the fax number or email address listed in the Contact Information section.

The screenshot shows the homepage of the Children's Special Health Care Services Web Portal. At the top left is the Indiana State Department of Health logo. The main title is "Children's Special Health Care Services Web Portal". Below the title are two buttons: "Login to CSHCS Web Portal" and "Enroll In CSHCS Web Portal". A blue banner contains the Helpdesk number: "Helpdesk # (Indiana Only) : 1-800-476-1355 , Opt 5, then Opt 1. Local # 317-233-9803". Below this is a "Quick Links" section with links for "WEB-Enabled Direct Data Entry", "CSHCS Web Site", "CSHCS FAQs", and "Indiana Medicaid". The page is divided into two main columns. The left column is titled "New & Updates" and contains an update notice: "Update: Please review WEB Portal Compatibility View Settings in Forms section". The right column is titled "Program Details" and contains a paragraph describing the program: "Indiana Children's Special Health Care Services (CSHCS) provides supplemental medical coverage to help families of children who have serious, chronic medical conditions, age birth to 21 years of age, who meet the Program's financial and medical criteria, pay for treatment related to their child's condition." Below the "Program Details" section is a "Forms" section with a link for "WEB Portal Enrollment and Change Form".

Indiana State
Department of Health

Children's Special Health Care Services Web Portal

Login to CSHCS Web Portal ● Enroll In CSHCS Web Portal

Helpdesk # (Indiana Only) : 1-800-476-1355 , Opt 5, then Opt 1.
Local # 317-233-9803

Quick Links

- [WEB-Enabled Direct Data Entry](#)
- [CSHCS Web Site](#)
- [CSHCS FAQs](#)
- [Indiana Medicaid](#)

New & Updates

[Update: Please review WEB Portal Compatibility View Settings in Forms section](#)

Program Details

Indiana Children's Special Health Care Services (CSHCS) provides supplemental medical coverage to help families of children who have serious, chronic medical conditions, age birth to 21 years of age, who meet the Program's financial and medical criteria, pay for treatment related to their child's condition.

Forms

- [WEB Portal Enrollment and Change Form](#)

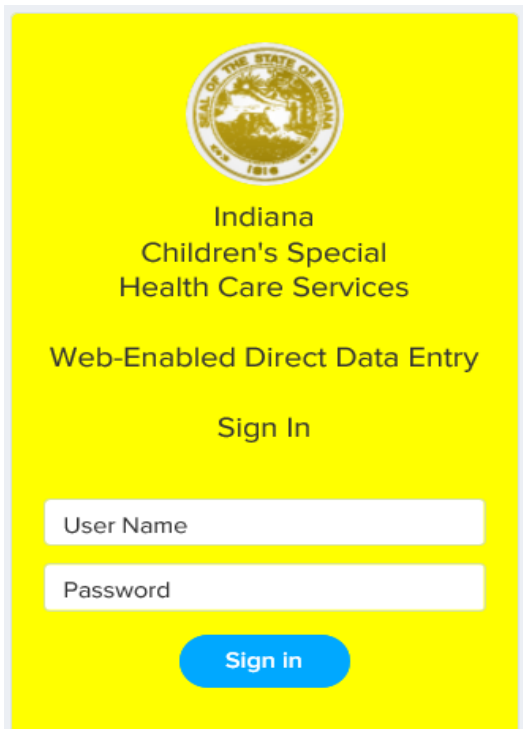
Logging In

A registered user with the current CSHCS Web Portal system will use the same login ID and password to access the WebDDE system. The user may access the current CSHCS Web Portal system using the link listed in the Contact Information section and then click on 'WEB-Enabled Direct Data Entry' link to access the WebDDE application. Alternately, the user may directly access the WebDDE application using the link listed in the Contact Information section.



The screenshot shows the top portion of the CSHCS Web Portal. On the left is the Indiana State Department of Health logo. The main heading is "Children's Special Health Care Services Web Portal". Below the heading are two buttons: "Login to CSHCS Web Portal" and "Enroll In CSHCS Web Portal". A blue banner contains the Helpdesk information: "Helpdesk # (Indiana Only) : 1-800-475-1355 , Opt 5, then Opt 1. Local # 317-233-9803". To the left of the banner is a photo of two young children looking at a book. To the right of the banner is a "Quick Links" section with a dark blue background and white text, listing: "WEB-Enabled Direct Data Entry", "CSHCS Web Site", "CSHCS FAQs", and "Indiana Medicaid".

The login for WebDDE is displayed. Enter User Name and Password and click 'Sign In'.



The screenshot shows a yellow sign-in page for the Web-Enabled Direct Data Entry system. At the top center is the Seal of the State of Indiana. Below the seal, the text reads: "Indiana Children's Special Health Care Services". Underneath that is "Web-Enabled Direct Data Entry" and "Sign In". There are two white input fields: "User Name" and "Password". At the bottom center is a blue "Sign In" button.

Dashboard

After logging in, the 'My Dashboard' screen will appear. The dashboard count of 'Total Claims Completed' will only display how many claims entered by the user for the current date that have completing loading to the CSHCS claims system.

For example, on 10/30/2020, the logged in user entered six claims. Only one claim, CSD2010300087, has completed loading to the CSHCS claims system. Once the other five claims complete loading to the CSHCS claims system on this date, the count will increase.

It will show a history of up to one-hundred claims submitted by claim type categories.

The screenshot shows the Web DDE dashboard for the Indiana State Department of Health Children's Special Health Care Services. The dashboard features a navigation menu with 'My Dashboard' and 'Submit a Claim'. A large blue box displays 'Total Claims Completed' with the number '1'. Below this are three tables of claim data:

Medical Claims:	
Claim Number	Date Submitted
CSM2010290493	10/29/2020
CSM2010230478	10/23/2020
CSM2010200477	10/20/2020
CSM2010200476	10/20/2020

InPatient / OutPatient Claims:	
Claim Number	Date Submitted
CSO2010300077	10/30/2020
CSI2010300098	10/30/2020
CSO2010300076	10/30/2020
CSO2010300075	10/30/2020
CSI2010300097	10/30/2020
CSI2010090094	10/9/2020

Dental Claims:	
Claim Number	Date Submitted
CSO2010300087	10/30/2020
CSO2010290086	10/29/2020
CSO2010290085	10/29/2020
CSO2010290084	10/29/2020
CSO2010190083	10/6/2020
CSO1910180058	10/18/2019

Submit a Claim

Click on 'Submit a Claim' when ready to enter a claim. Claim type categories will be displayed. Select the claim type desired.

The screenshot shows the 'Submit a Claim' screen in the Web DDE application. It features four large blue buttons arranged in a 2x2 grid, each with an icon and text:

- MEDICAL**: Submit Medical Claim (Icon: Rod of Asclepius)
- INPATIENT**: Submit In-Patient Claim (Icon: Hospital bed)
- OUTPATIENT**: Submit Out-Patient Claim (Icon: Person walking)
- DENTAL**: Submit Dental Claim (Icon: Person at a dental chair)

This example shows Medical Claim type was selected and a partial display of the claim form. Further sections of this manual contain explanation and guidance in completion of all claim types.

The screenshot shows the WebDDE interface for a Medical Claim. At the top left, the 'Web DDE' logo is followed by a hamburger menu icon. The header includes the Indiana State Department of Health logo and the text 'Indiana State Department of Health Children's Special Health Care Services'. A user profile icon is in the top right. On the left sidebar, there are two menu items: 'My Dashboard' and 'Submit a Claim'. The main content area is titled 'Medical Claim' and contains a warning: 'Please make sure all the values are entered correctly, to process your claim successfully. Incomplete / Incorrect Claims will be rejected.' Below this is the 'Provider Information' section with the following fields: 'Provider NPI' (text input), 'Service Location' (dropdown menu), 'Provider ID' (text input), 'Provider Name' (text input), 'Billing Date (mm/dd/yyyy)' (text input with a date mask), and 'Provider Tax ID' (text input). The form is currently collapsed, with the input fields appearing as thin lines.

The user may click on the three lines after WebDDE to expand the claim form for easier data entry. Clicking on the three lines again returns it back to the menu with the collapsed claim form.

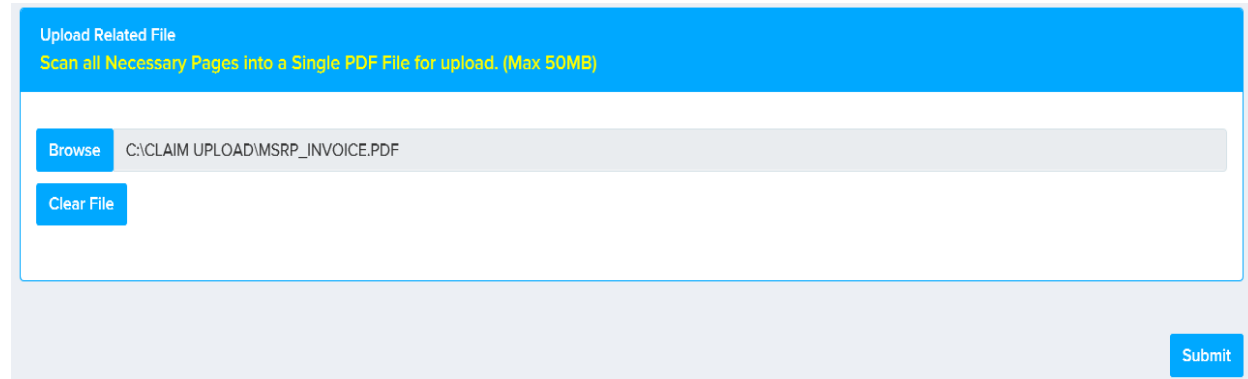
This screenshot is identical to the one above, but the 'Provider Information' form is expanded. The input fields for 'Provider NPI', 'Provider ID', 'Provider Name', 'Billing Date', and 'Provider Tax ID' are now fully visible and ready for data entry. The 'Service Location' dropdown menu is also expanded, showing a downward arrow. The warning message and the 'Medical Claim' title remain the same.

Uploading Supporting Documentation File

The end of each claim form type will allow the user to upload all necessary pages of supporting documentation into a single Portable Document Format (PDF) file (maximum 50 megabytes).

One example is the Manufacturer's Suggested Retail Price (MSRP) Invoice for professional supply claims that is required and must be uploaded. The user should browse for the location where the user has saved the PDF document on his/her computer. Only a single PDF document may be uploaded.

After the claim has been completed and any supporting documentation needed has been uploaded, the user will click 'Submit' to send the claim.



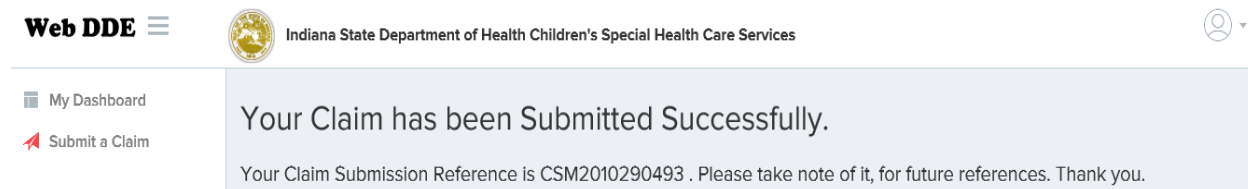
Upload Related File
Scan all Necessary Pages into a Single PDF File for upload. (Max 50MB)




Browse C:\CLAIM UPLOAD\MSRP_INVOICE.PDF


Clear File


Submit

A message will be returned with the Claim ID that was assigned. This claim ID can be used for tracking purposes.



Web DDE   Indiana State Department of Health Children's Special Health Care Services 

 My Dashboard

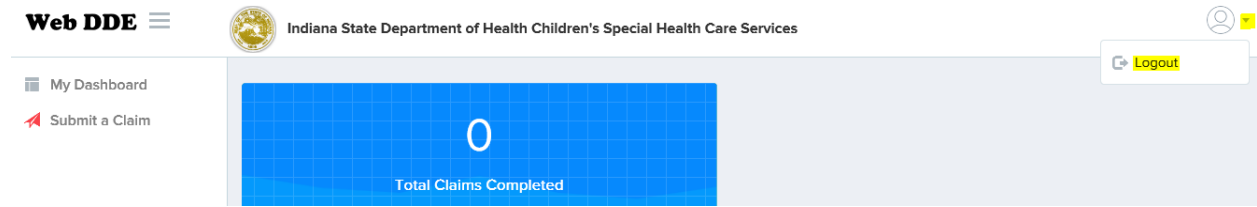
 Submit a Claim

Your Claim has been Submitted Successfully.

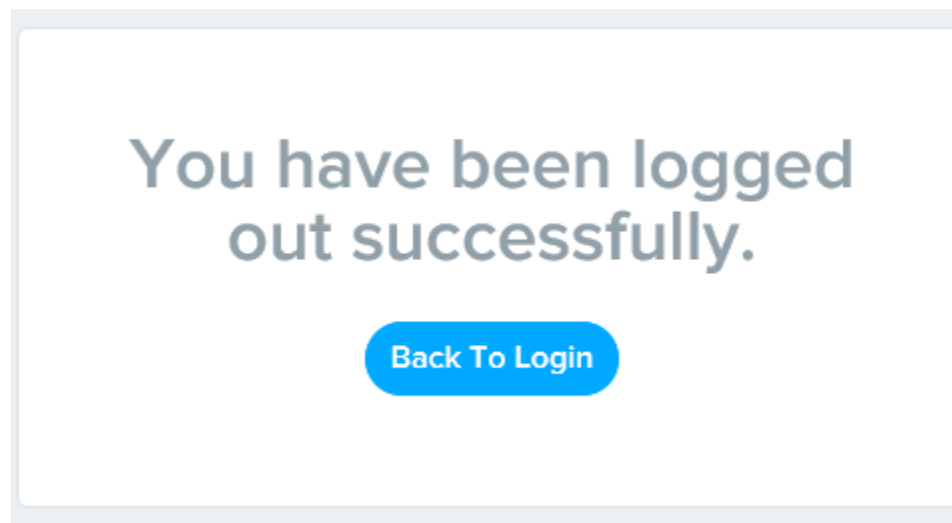
Your Claim Submission Reference is CSM2010290493 . Please take note of it, for future references. Thank you.

Logging Out

The user will click on the drop-down arrow after the figure image, and a logout option is displayed.



After clicking on the logout option, the following message is displayed. The user may choose to login again or close the browser.



Section 2: Data Element Description

Data element table sections contain a tabular representation of any required or situational field for the Indiana Department of Health, Children’s Special Health Care Services WebDDE claim form. Each data element table contains rows and columns describing different WebDDE claim form fields.

Paper Claim Field: The cross-reference to the standard paper claim form if applicable. It is marked with ‘N/A’ if not applicable.

Usage: Identifies the WebDDE claim form field as R-required, S-situational, or DO-display only.

WebDDE Field Name: Identifies the WebDDE claim form field name.

Field Length/Type: The field length and type of the WebDDE field.

Examples:

9(10)	The ‘9’ means the field is numeric, and the ‘(10)’ means the field is ten digits long.
X(8)	The ‘X’ means the field is alphanumeric, and the ‘(8)’ means the field is up to eight characters long. Do not enter leading spaces.
9(8)V99	The ‘9’ means the field is numeric, the ‘(8)’ means the first part of the field is up to eight digits long, the ‘V’ means there is an implied decimal point, and the last part of the field is up to two digits long after the decimal point. Do not enter leading zeroes or trailing zeroes after the decimal point first digit.

Comments/Valid Values: Comments regarding the WebDDE field and/or valid values.

Section 3: Professional Claims Instructions

Introduction Medical

The Indiana Department of Health, Children’s Special Health Care Services WEB-Enabled Direct Data Entry (WebDDE) professional claim mimics the CMS-1500 (02/12) paper claim form.

CSHCS is a payer of last resort, so Coordination of Benefits (COB) is needed to pay a claim if there are prior payers. The Medical COB section provides further explanation.

Medical WebDDE Claim Form

Medical Claim

Please make sure all the values are entered correctly, to process your claim successfully.
Incomplete / incorrect Claims will be rejected.

Provider Information

Provider NPI

Provider Name

Provider Tax ID

Service Location

Billing Date (mm/dd/yyyy)

Provider ID

Retrieval Patient Info

CMS 1500 Claim Form

Patient ID

Date Of Birth (mm/dd/yyyy)

First 3 letters of Last Name

Patient Name

Sex

Insured Name

Patient Address

18: Other Health Plan

21: ICD Indicator

19: Note

21: Diagnosis Codes:

A <input type="text"/>	B <input type="text"/>	C <input type="text"/>	D <input type="text"/>	E <input type="text"/>	F <input type="text"/>
G <input type="text"/>	H <input type="text"/>	I <input type="text"/>	J <input type="text"/>	K <input type="text"/>	L <input type="text"/>

23: Prior Auth ID

26: Patient Account Number

28: Total Charges

29a: Insurance Paid

29b: CoPay

Detail Lines

24: Line#	Dates Of Service From	Dates Of Service To	Place Of Service	EMG Ind	OPT/NCPCS	Modifier	Diagnosis Pointer	Charges	Days or Units	Insurance Paid	CoPay
1											

Upload Related File

Scan all Necessary Pages into a Single PDF File for upload. (Max 50MB)

Browse

Clear File

Provider Information and Billing Date

*** Note:** If the Provider NPI or Service Location does not exist in the CSHCS claims system, the claim cannot be continued. The provider needs to call the CSHCS Provider Relations phone number listed in the Contact Information section to establish this information. If the provider notices that the Service Location, Provider Name, or Provider Tax ID that is in the CSHCS claims system does not match the current provider information, the provider should also call CSHCS Provider Relations to have the information updated.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
32a. and/or 33a.	R	Provider NPI	9(10)	Valid Provider NPI in CSHCS. This is the Service Facility NPI or Billing Provider NPI. If the Service Facility NPI is different from the Billing Provider NPI, the Service Facility NPI is used.
32. or 33.	R	Service Location	X(158)	Drop-down select and display.
N/A	R	Provider ID	9(5) or 9(6)	Valid Provider ID in CSHCS; displays after Service Location is selected.
32. or 33.	DO	Provider Name	X(100)	The CSHCS Provider Name is displayed.
25.	DO	Provider Tax ID	9(9)	The CSHCS Provider Tax ID is displayed.
31. (Date)	R	Billing Date	X(10)	MM/DD/YYYY; the billing date must be greater than or equal to the claim Date of Service End (To) Date and less than or equal to the current date.

Subscriber Detail

*** Note:** In the CSHCS claims system, the participant (patient) is the subscriber. If the participant does not exist in the CSHCS claims system, the claim cannot be continued. The provider needs to call the CSHCS Eligibility phone number listed in the Contact Information section to establish this information. If the provider notices that the Patient Name, Date of Birth, Sex, Patient Address, or Insured Name that is in the CSHCS claims system does not match the current provider information, the provider should also call CSHCS Eligibility to have the information updated.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
1a.	R	Patient ID	9(6)	Valid Participant ID in CSHCS.
3. or 11a.	R	Date of Birth	X(10)	MM/DD/YYYY; participant's date of birth.
N/A	R	First 3 letters of Last Name	X(3)	First 3 letters of participant's last name.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
2. or 4.	DO	Patient Name	X(95)	The CSHCS Participant Name is displayed.
3. or 11a.	DO	Sex	X(1)	The CSHCS Participant's Sex is displayed.
9.	DO	Insured Name	X(95)	The CSHCS Insured Name for the participant is displayed.
5. or 7.	DO	Patient Address	X(157)	The CSHCS Participant Address is displayed.

Claim Information

*** Note:** WebDDE validates diagnosis codes against the codes in our system database. Therefore, when entering claims, the diagnosis codes must be entered with the decimal point for diagnosis codes greater than three characters. The maximum pattern is 'XXX.XXXX'. If a claim is entered with a new diagnosis code that is not yet in our system database, WebDDE will still allow the claim to be submitted.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
11d.	S	11d: Other Health Plan	X(1)	Y, N, or not selected. This field is used for Coordination of Benefits (COB) with CSHCS as needed. See the Medical COB section for explanation.
21.	R	ICD Indicator	X(1)	0 or 9; defaults to 0. All claims are now ICD-10, so 0 is the default.
19.	S	Note	X(80)	Optional; refer to the National Uniform Claim Committee (NUCC) 1500 Health Insurance Claim Form Version 02/12 Reference Instruction Manual for information regarding this field.
21.		Diagnosis Codes:		
21A	R	A	X(8)	ICD-10 Principal Diagnosis is required.
21B - 21L	S	B through L	X(8)	ICD-10 additional diagnosis codes reported.
23.	S	Prior Auth ID	9(7)	The CSHCS prior authorization obtained for the service(s) as needed.
26.	R	Patient Account Number	X(15)	Patient Account Number assigned by the provider of service's or supplier's accounting system.
28.	R	Total Charges	9(8)V99	Total billed amount of all service line charges.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
29.	S	29a: Insurance Paid	9(8)V99	This field is used for Coordination of Benefits (COB) with CSHCS as needed at the claim header level. See the Medical COB section for explanation.
N/A	S	29b: CoPay	9(8)V99	This field is used for Coordination of Benefits (COB) with CSHCS as needed at the claim header level. See the Medical COB section for explanation.

Claim Detail Lines

* **Note:** Up to fifty service lines may be entered for a professional claim.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
N/A	DO	Line#	9(1) or 9(2)	Automatically increments as service lines are entered.
24. A. From	R	Dates of Service From	X(10)	MM/DD/YYYY; the Date of Service 'From' date must be greater than or equal to the participant's date of birth. It must also be less than or equal to the participant's date of death if applicable. It must also be less than or equal to the Date of Service 'To' date and less than or equal to the billed date.
24. A. To	R	Dates of Service To	X(10)	MM/DD/YYYY; the Date of Service 'To' date must be greater than or equal to the Date of Service 'From' date and less than or equal to the billed date.
24. B.	R	Place of Service	9(2)	1) Code value for professional claim.
24. C.	S	EMG Indicator	X(1)	N, Y, or not selected.
24. D.	R	CPT/HCPCS	X(10)	CPT or HCPCS code value.
24. D.	S	Modifier	X(2)	2) Modifier if applicable; up to four modifiers may be entered for the line.
24. E.	R	Diagnosis Pointer	X(1)	The line letter from Item Number 21 that relates to the reason the service(s) was performed. Up to four diagnosis pointers may be entered for the line.
24. F.	R	Charges	9(8)V99	Total billed amount for the service line. The sum of the service line charges must equal the 28: Total

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
				Charges.
24. G.	R	Days or Units	9(5)V999	Number of days or units. If reporting a fraction of a unit, use the decimal point.
N/A	S	Insurance Paid	9(8)V99	This field is used for Coordination of Benefits (COB) with CSHCS as needed at the service line level. See the Medical COB section for explanation.
N/A	S	CoPay	9(8)V99	This field is used for Coordination of Benefits (COB) with CSHCS as needed at the service line level. See the Medical COB section for explanation.

- 1) https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html
- 2) <https://www.in.gov/medicaid/providers/693.htm>
Launch Provider Code Tables and Accept Agreement; select Procedure Code Modifiers for Professional Claims

Medical Coordination of Benefits (COB)

CSHCS is a payer of last resort, so Coordination of Benefits (COB) is needed to pay a claim if there are prior payers. The WebDDE system allows up to three prior payers. The COB information and/or adjustments will be entered at either the claim header level or the claim service line level but not both. The COB information must also match the claim information placement. If Insurance Paid and/or CoPay was entered at header level on the claim, then the COB information must also be entered at the claim header level. If Insurance Paid and/or Copay was entered at service line level on the claim, then the COB information must also be entered at the claim service line level.

Coordination of Benefits (COB) is controlled by answering the '11d: Other Health Plan' question. If there are no previous payers prior to CSHCS, the question may be answered with 'N' or left blank.

If there are previous payers prior to CSHCS, then the question should be answered with 'Y'. When the 'Y' is selected, a message will be displayed asking if the COB will be at the claim header level or the service line level. Select one of the options. Another message will be displayed confirming the selection, click 'OK'.

COB Details.

Enter all COB Fields in the COB Section below for
Successful Claim Submission. Please choose if the COB
Information you provide, is at Header Level or Line Level.



The image shows two blue buttons with white text. The first button is labeled 'Header Level' and the second button is labeled 'Line Level'. Both buttons have a slight shadow and rounded corners.

The appropriate COB section will appear at the bottom of the WebDDE claim form.

Medical Claim Header Level COB

COB / Deductible Details
Clear All COB Data

Payer 1

Sequence Number Code

Payer ID Payer Name Policy Number Ind Rel

Amount Description Amount

Header Level Details (To Add Multiple Rows, Press 'Tab' key after completing a Row.)

GRP	ARC	ARC Description	Amount
v	v		

Add Another Payer

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
Claim Placement Header Level Fields				
29.	S	29a: Insurance Paid	9(8)V99	The total Insurance Paid from all previous payers.
N/A	S	29b: CoPay	9(8)V99	The total CoPay paid from all previous payers.
COB / Deductible Header Details				
N/A	R	Sequence Number Code	X(1)	3) Defaults to 'P'. May add two additional prior payers, 'S' and 'T'.
N/A	S	Payer ID	X(80)	Optional Payer ID if known.
N/A	S	Payer Name	X(60)	Optional Payer Name if known.
N/A	S	Policy Number	X(50)	Optional Policy Number if known.
N/A	S	Ind Rel	9(2)	4) Optional Individual Relationship if known. Select from the drop-down.
N/A	R	(OI AMT PAID) Amount	9(8)V99	The total Insurance Paid by the payer denoted by the Sequence Number Code. It is acceptable to enter 0.00 if applicable.
N/A	S	GRP	X(2)	5) GRP (Claim Adjustment Group Code) if adjustment is made by the payer denoted by the Sequence Number Code.
N/A	S	ARC	X(8)	6) ARC (Adjustment Reason Code) if adjustment is made by the payer denoted by the Sequence Number

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
				Code.
N/A	DO	ARC Description	X(2000)	The ARC description is displayed after ARC code is chosen.
N/A	S	Amount	9(8)V99	The adjustment amount if adjustment is made by the payer denoted by the Sequence Number Code.

Medical Claim Service Line Level COB

COB / Deductible Details
Clear All COB Data

Payer 1

Sequence Number Code

Payer ID Payer Name Policy Number Ind Rel

Amount Description Amount

Line Level Details (To Add Multiple Rows, Press 'Tab' key after completing a Row.)

Line Number	GRP	ARC	ARC Description	Amount
	v	v		

Add Another Payer

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
Claim Placement Service Line Level Fields				
N/A	S	Insurance Paid	9(8)V99	The total line Insurance paid from all previous payers.
N/A	S	CoPay	9(8)V99	The total line CoPay paid from all previous payers.
COB / Deductible Service Line Details				
N/A	R	Sequence Number Code	X(1)	3 Defaults to 'P'. May add two additional prior payers, 'S' and 'T'.
N/A	S	Payer ID	X(80)	Optional Payer ID if known.
N/A	S	Payer Name	X(60)	Optional Payer Name if known.
N/A	S	Policy Number	X(50)	Optional Policy Number if known.
N/A	S	Ind Rel	9(2)	4 Optional Individual Relationship if known. Select from the drop-down.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
N/A	R	(OI AMT PAID) Amount	9(8)V99	The total Insurance Paid by the payer denoted by the Sequence Number Code. It is acceptable to enter 0.00 if applicable.
N/A	S	Line Number	9(2)	The claim line number being adjusted by the payer denoted by the Sequence Number Code.
N/A	S	GRP	X(2)	5) GRP (Claim Adjustment Group Code) if adjustment is made by the payer denoted by the Sequence Number Code.
N/A	S	ARC	X(8)	6) ARC (Adjustment Reason Code) if adjustment is made by the payer denoted by the Sequence Number Code.
N/A	DO	ARC Description	X(2000)	The ARC description is displayed after ARC code is chosen.
N/A	S	Amount	9(8)V99	The adjustment amount if adjustment is made by the payer denoted by the Sequence Number Code.

- 3)** Sequence Number Code (Payer) - see Appendix A: Code Values.
- 4)** Individual Relationship code - see Appendix A: Code Values.
- 5)** GRP (Claim Adjustment Group Code) - see Appendix A: Code Values.
- 6)** ARC (Adjustment Reason Code) - see Appendix A: Code Values.

Medical WebDDE Claim no COB

This is an example of a professional WebDDE claim with no Coordination of Benefits. The participant only has CSHCS for insurance. Nothing is entered in claim header level fields 29a: Insurance Paid and 29b: CoPay. Nothing is entered in service line level Insurance Paid and CoPay fields in Detail Lines section. This claim also had a MSRP Invoice that needed to be uploaded.

Medical Claim

Please make sure all the values are entered correctly, to process your claim successfully.
Incomplete / Incorrect Claims will be rejected.

Provider Information

Provider NPI 1497797963	Service Location 431 FERNHILL AVE,FORT WAYNE,IN,46805-1039	Provider ID 53409
Provider Name CORAM ALT SITE SERVICES INC	Billing Date (mm/dd/yyyy) 10/29/2020	
Provider Tax ID 760215922		

CMS 1500 Claim Form

Patient ID 902119	Date Of Birth (mm/dd/yyyy) 01/01/2001	First 3 letters of Last Name TES	Retrieve Patient Info
Patient Name NOCOB2 TEST	Sex M	Insured Name	Patient Address 444 N FOURTH STREET,MILFORD
1fd: Other Health Plan <input type="checkbox"/>	21: ICD Indicator <input type="checkbox"/>	19: Note	
21: Diagnosis Codes:			
A E70.0	B	C	D
E	F	G	H
I	J	K	L
23: Prior Auth ID 9106868	26: Patient Account Number 555902119	28: Total Charges 2032.00	29a: Insurance Paid 29b: CoPay

Detail Lines

24: Line#	Dates Of Service From	Dates Of Service To	Place of Service	EMG Ind	CPT/HCPCS	Modifier	Diagnosis Pointer	Charges	Days or Units	Insurance Paid	CoPay
1	10/25/2020	10/25/2020	12	<input type="checkbox"/>	B4157		A	2032.00	142		

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C:\CLAIM UPLOAD\MSRP_INVOICE.PDF

Medical WebDDE COB Claim Header Level

This is an example of a professional WebDDE claim with Coordination of Benefits at claim header level. There are two previous payers. The primary payer paid \$0, and the secondary payer paid \$50.

Medical Claim

Please make sure all the values are entered correctly, to process your claim successfully.
Incomplete / Incorrect Claims will be rejected.

Provider Information

Provider NPI 1255396883	Service Location 285 W 12TH ST,SUITE 102,PERU,IN,46970-1638	Provider ID 200937
Provider Name DUKES PHYSICIAN SERVICES		Billing Date (mm/dd/yyyy) 10/20/2020
Provider Tax ID 522379890		

CMS 1500 Claim Form

Patient ID 902120	Date Of Birth (mm/dd/yyyy) 01/01/2000	First 3 letters of Last Name TES	Retrieve Patient Info
Patient Name COB2 TEST	Sex F	Insured Name MOM2 TEST	Patient Address 555 N FIFTH STREET,INDIANAPOLIS
11d: Other Health Plan Y	21: ICD Indicator 0	19: Note	
21: Diagnosis Codes:			
A H65.193	B B34.9	C	D
E	F	G	H
I	J	K	L
23: Prior Auth ID	26: Patient Account Number 555902120	28: Total Charges 128.00	29a: Insurance Paid 50.00
			29b: CoPay 20.00

Detail Lines

24: Line#	Dates Of Service From	Dates Of Service To	Place of Service	EMG Ind	CPT/HCPCS	Modifier	Diagnosis Pointer	Charges	Days or Units	Insurance Paid	CoPay
1	09/16/2020	09/16/2020	11	▼	99213		A B	128.00	1		

COB / Deductible Details
Clear All COB Data

Payer 1

Sequence Number Code
P

Payer ID: Payer Name: ONE HEALTH PLAN Policy Number: Ind Rel: Child ▼

Amount Description: OI AMT PAID Amount: 0.00

Header Level Details (To Add Multiple Rows, Press 'Tab' key after completing a Row.)

GRP	ARC	ARC Description	Amount
▼	▼		

Payer 2

Sequence Number Code
S

Payer ID: Payer Name: HOOSIER INSURANCE CO Policy Number: Ind Rel: ▼

Amount Description: OI AMT PAID Amount: 50.00

Header Level Details (To Add Multiple Rows, Press 'Tab' key after completing a Row.)

GRP	ARC	ARC Description	Amount
Contractual Obligations ▼	45 ▼	45> CHARGE EXCEEDS FEE !	58.00
Patient Responsibility ▼	3 ▼	3> CO-PAYMENT AMOUNT	20.00

Add Another Payer

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Medical WebDDE COB Claim Service Line Level

This is an example of a professional WebDDE claim with Coordination of Benefits at service line level. There is one previous payer.

Medical Claim

Please make sure all the values are entered correctly, to process your claim successfully.
Incomplete / Incorrect Claims will be rejected.

Provider Information

Provider NPI 1932349594	Service Location 902 PROVIDENT DR STE A,WARSAW,IN,46580-3252	Provider ID 204998
Provider Name PEDIATRIC HEALTHCARE	Billing Date (mm/dd/yyyy) 10/20/2020	
Provider Tax ID 264214938		

CMS 1500 Claim Form

Patient ID 902117	Date Of Birth (mm/dd/yyyy) 01/01/2004	First 3 letters of Last Name TES	Retrieve Patient Info
Patient Name COB TEST	Sex M	Insured Name MOTHER TEST	Patient Address 222 N SECOND STREET,INDIANAPOLIS
1fd: Other Health Plan Y	2t: ICD Indicator 0	19: Note	
21: Diagnosis Codes:			
A J02.9	B Z00.129	C	D
E	F	G	H
I	J	K	L
23: Prior Auth ID	26: Patient Account Number 555902117	28: Total Charges 374.85	29a: Insurance Paid
			29b: CoPay

Detail Lines

24: Line#	Dates Of Service From	Dates Of Service To	Place of Service	EMG Ind	CPT/HCPCS	Modifier	Diagnosis Pointer	Charges	Days or Units	Insurance Paid	CoPay
1	09/25/2020	09/25/2020	11	▼	99214	Z5	A	188.00	1	75.54	30.00
2	09/25/2020	09/25/2020	11	▼	87880	QW	A	66.00	1	9.92	
3	09/25/2020	09/25/2020	11	▼	90686		B	61.85	1	20.00	
4	09/25/2020	09/25/2020	11	▼	90471		B	59.00	1	25.42	

COB / Deductible Details
Clear All COB Data

Payer 1

Sequence Number Code
P

Payer ID: ONEHLTH Payer Name: ONE HEALTH PLAN Policy Number: Ind Rel: Child

Amount Description: OI AMT PAID Amount: 130.88

Line Level Details (To Add Multiple Rows, Press 'Tab' key after completing a Row.)

Line Number	GRP	ARC	ARC Description	Amount
1	Contractual Obligations	45	45> CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLC	82.46
1	Patient Responsibility	3	3> CO-PAYMENT AMOUNT	30.00
2	Contractual Obligations	45	45> CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLC	56.08
3	Contractual Obligations	45	45> CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLC	41.85
4	Contractual Obligations	45	45> CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLC	33.58

Add Another Payer

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Section 4: Institutional Claims Instructions

Introduction Inpatient

The Indiana Department of Health, Children's Special Health Care Services WEB-Enabled Direct Data Entry (WebDDE) institutional claim mimics the NUBC UB-04 (CMS-1450) paper claim form.

CSHCS is a payer of last resort, so Coordination of Benefits (COB) is needed to pay a claim if there are prior payers. The Inpatient COB section provides further explanation.

Inpatient WebDDE Claim Form

InPatient Claim

Please make sure all the values are entered correctly, to process your claim successfully.
Incomplete / incorrect Claims will be rejected.

Provider Information

Provider NPI	Service Location	Provider ID
<input type="text"/>	<input type="text"/>	<input type="text"/>
Provider Name		Billing Date (mm/dd/yyyy)
<input type="text"/>		<input type="text"/>
Provider Tax ID		
<input type="text"/>		

In Patient Claim Form UB04

Patient ID	Date Of Birth (mm/dd/yyyy)	First 3 letters of Last Name	Retrieve Patient Info
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Patient Name	Sex	Insured Name	Patient Address
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other Health Plan	03a: Patient Control Number	04: Type Of Bill	14: Admission Type
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
06a: From Date	06b: To Date	07: Discharge Status	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Occurrence Code

31. Code	Date	32. Code	Date	33. Code	Date	34. Code	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

47 Ln 23: Total Billed Amount	54: Prior Payments
<input type="text"/>	<input type="text"/>
00: CoPay	63: PA Number
<input type="text"/>	<input type="text"/>

Diagnosis Code

66: ICD Ind	67: Princ Dg	A	B	C	D	E	F	G	H	I
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
J	K	L	M	N	O	P	Q	69: Admin Dg		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		

74 Procedure Code

Principal Code	Principal Date	74a: Proc Cd 1	74a: Proc Date 1	74b: Proc Cd 2	74b: Proc Date 2
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
74c: Proc Cd 3	74c: Proc Date 3	74d: Proc Cd 4	74d: Proc Date 4	74e: Proc Cd 5	74e: Proc Date 5
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Detail Lines

Line Number	42: Revenue Code	44: HCPCS Code	46: Service Units	47: Total Charges
1	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>

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Provider Information and Billing Date

*** Note:** If the Provider NPI or Service Location does not exist in the CSHCS claims system, the claim cannot be continued. The provider needs to call the CSHCS Provider Relations phone number listed in the Contact Information section to establish this information. If the provider notices that the Service Location, Provider Name, or Provider Tax ID that is in the CSHCS claims system does not match the current provider information, the provider should also call CSHCS Provider Relations to have the information updated.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/Type	Comments/Valid Values
56	R	Provider NPI	9(10)	Valid Provider NPI in CSHCS. This is the Service Facility NPI or Billing Provider NPI. If the Service Facility NPI is different from the Billing Provider NPI, the Service Facility NPI is used.
1	R	Service Location	X(158)	Drop-down select and display.
N/A	R	Provider ID	9(5) or 9(6)	Valid Provider ID in CSHCS; displays after Service Location is selected.
1	DO	Provider Name	X(100)	The CSHCS Provider Name is displayed.
5	DO	Provider Tax ID	9(9)	The CSHCS Provider Tax ID is displayed.
23 (Creation Date)	R	Billing Date	X(10)	MM/DD/YYYY; the billing date must be greater than or equal to the claim Date of Service End (To) Date and less than or equal to the current date.

Subscriber Detail

*** Note:** In the CSHCS claims system, the participant (patient) is the subscriber. If the participant does not exist in the CSHCS claims system, the claim cannot be continued. The provider needs to call the CSHCS Eligibility phone number listed in the Contact Information section to establish this information. If the provider notices that the Patient Name, Date of Birth, Sex, Patient Address, or Insured Name that is in the CSHCS claims system does not match the current provider information, the provider should also call CSHCS Eligibility to have the information updated.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
60	R	Patient ID	9(6)	Valid Participant ID in CSHCS.
10	R	Date of Birth	X(10)	MM/DD/YYYY; participant's date of birth.
N/A	R	First 3 letters of Last Name	X(3)	First 3 letters of participant's last name.
8b	DO	Patient Name	X(95)	The CSHCS Participant Name is displayed.
11	DO	Sex	X(1)	The CSHCS Participant's Sex is displayed.
58	DO	Insured Name	X(95)	The CSHCS Insured Name for the participant is displayed.
9 a,b,c,d	DO	Patient Address	X(157)	The CSHCS Participant Address is displayed.

Claim Information

*** Note:** WebDDE validates diagnosis codes against the codes in our system database. Therefore, when entering claims, the diagnosis codes must be entered with the decimal point for diagnosis codes greater than three characters. The maximum pattern is 'XXX.XXXX'. If a claim is entered with a new diagnosis code that is not yet in our system database, WebDDE will still allow the claim to be submitted.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
N/A	S	Other Health Plan	X(1)	Y, N, or not selected. This field is used for Coordination of Benefits (COB) with CSHCS as needed. See the Inpatient COB section for explanation.
3a	R	Patient Control Number	X(30)	Patient Control Number assigned by the provider of service's or supplier's accounting system.
4	R	Type of Bill	9(3)	Type of Bill.
14	R	Admission Type	9(3)	Admission Type drop-down.
6	R	From Date	X(10)	MM/DD/YYYY; the Date of Service

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
				'From' date must be greater than or equal to the participant's date of birth. It must also be less than or equal to the participant's date of death if applicable. It must also be less than or equal to the Date of Service 'To' date and less than or equal to the billed date.
6	R	To Date	X(10)	MM/DD/YYYY; the Date of Service 'To' date must be greater than or equal to the Date of Service 'From' date and less than or equal to the billed date.
17	R	Discharge Status	X(3)	Discharge Status.
		Occurrence Code		
31a	R	Code	X(5)	First occurrence code is required.
31a	R	Date	X(10)	MM/DD/YYYY; First occurrence code date is required.
31b	S	Code	X(5)	Additional occurrence code reported.
31b	S	Date	X(10)	MM/DD/YYYY; Additional occurrence code date reported.
32a	S	Code	X(5)	Additional occurrence code reported.
32a	S	Date	X(10)	MM/DD/YYYY; Additional occurrence code date reported.
32b	S	Code	X(5)	Additional occurrence code reported.
32b	S	Date	X(10)	MM/DD/YYYY; Additional occurrence code date reported.
33a	S	Code	X(5)	Additional occurrence code reported.
33a	S	Date	X(10)	MM/DD/YYYY; Additional occurrence code date reported.
33b	S	Code	X(5)	Additional occurrence code reported.
33b	S	Date	X(10)	MM/DD/YYYY; Additional occurrence code date reported.
34a	S	Code	X(5)	Additional occurrence code reported.
34a	S	Date	X(10)	MM/DD/YYYY; Additional occurrence code date reported.
34b	S	Code	X(5)	Additional occurrence code reported.
34b	S	Date	X(10)	MM/DD/YYYY; Additional occurrence code date reported.
		Occurrence Code		
47	R	Ln 23: Total Billed Amount:	9(8)V99	Total billed amount of all service line charges.
54	S	54: Prior Payments:	9(8)V99	This field is used for Coordination of Benefits (COB) with CSHCS as needed at the claim header level. See the

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
				Inpatient COB section for explanation.
N/A	S	00: CoPay	9(8)V99	This field is used for Coordination of Benefits (COB) with CSHCS as needed at the claim header level. See the Inpatient COB section for explanation.
63	S	PA Number:	9(7)	The CSHCS prior authorization obtained for the service(s) as needed.
Diagnosis Code				
66	R	ICD Ind	X(1)	0 or 9; defaults to 0. All claims are now ICD-10, so 0 is the default.
67	R	Princ Dg	X(8)	ICD-10 Principal Diagnosis is required.
67 A - Q	S	A through Q	X(8)	ICD-10 additional diagnosis codes reported.
69	R	Admin Dg	X(8)	ICD-10 Admitting Diagnosis is required.
Procedure Code				
74	S	Principal Code	X(8)	Principal Procedure Code.
74	S	Principal Date	X(10)	MM/DD/YYYY; Principal Procedure Date.
74 a - e	S	Proc Cd (1 through 5)	X(8)	Additional Procedure Codes.
74 a - e	S	Proc Date (1 through 5)	X(10)	MM/DD/YYYY; Additional Procedure Dates.

Claim Detail Lines

* **Note:** Up to ninety-nine service lines may be entered for an inpatient claim.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
N/A	DO	Line Number	9(1) or 9(2)	Automatically increments as service lines are entered.
42	R	Revenue Code	9(6)	Revenue Code.
44	S	HCPCS Code	X(8)	HCPCS code value if applicable.
46	R	Service Units	9(10)	Number of Service Units.
47	R	Total Charges	9(8)V99	Total billed amount for the service line. The sum of the service line charges must equal the Ln 23: Total Billed Amount.

Inpatient Coordination of Benefits (COB)

CSHCS is a payer of last resort, so Coordination of Benefits (COB) is needed to pay a claim if there are prior payers. The WebDDE system allows up to three prior payers. For Inpatient, the COB information and/or adjustments will be entered at the claim header level only. The COB information must also match the claim information placement.

Coordination of Benefits (COB) is controlled by answering the 'Other Health Plan' question. If there are no previous payers prior to CSHCS, the question may be answered with 'N' or left blank.

If there are previous payers prior to CSHCS, then the question should be answered with 'Y'. When the 'Y' is selected, a message will be displayed asking if the COB will be at the claim header level or the service line level. For Inpatient, only select 'Header Level'. Another message will be displayed confirming the selection, click 'OK'.

COB Details.

Enter all COB Fields in the COB Section below for Successful Claim Submission. Please choose if the COB Information you provide, is at Header Level or Line Level.



Header Level Line Level

The appropriate COB section will appear at the bottom of the WebDDE claim form.

Inpatient Claim Header Level COB

COB / Deductible Details
Clear All COB Data

Payer 1

Sequence Number Code

Payer ID Payer Name Policy Number Ind Rel

Amount Description Amount

Header Level Details (To Add Multiple Rows, Press 'Tab' key after completing a Row.)

GRP	ARC	ARC Description	Amount
▼	▼		

Add Another Payer

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
Claim Placement Header Level Fields				
54	S	54: Prior Payments:	9(8)V99	The total Insurance Paid from all previous payers.
N/A	S	00: CoPay	9(8)V99	The total CoPay paid from all previous payers.
COB / Deductible Header Details				
N/A	R	Sequence Number Code	X(1)	3) Defaults to 'P'. May add two additional prior payers, 'S' and 'T'.
N/A	S	Payer ID	X(80)	Optional Payer ID if known.
N/A	S	Payer Name	X(60)	Optional Payer Name if known.
N/A	S	Policy Number	X(50)	Optional Policy Number if known.
N/A	S	Ind Rel	9(2)	4) Optional Individual Relationship if known. Select from the drop-down.
N/A	R	(OI AMT PAID) Amount	9(8)V99	The total Insurance Paid by the payer denoted by the Sequence Number Code. It is acceptable to enter 0.00 if applicable.
N/A	S	GRP	X(2)	5) GRP (Claim Adjustment Group Code) if adjustment is made by the payer denoted by the Sequence Number Code.
N/A	S	ARC	X(8)	6) ARC (Adjustment Reason Code) if adjustment is made by the payer denoted by the Sequence Number

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
				Code.
N/A	DO	ARC Description	X(2000)	The ARC description is displayed after ARC code is chosen.
N/A	S	Amount	9(8)V99	The adjustment amount if adjustment is made by the payer denoted by the Sequence Number Code.

- 3) Sequence Number Code (Payer) - see Appendix A: Code Values.
- 4) Individual Relationship code - see Appendix A: Code Values.
- 5) GRP (Claim Adjustment Group Code) - see Appendix A: Code Values.
- 6) ARC (Adjustment Reason Code) - see Appendix A: Code Values.

Inpatient WebDDE Claim no COB

This is an example of an institutional inpatient WebDDE claim with no Coordination of Benefits. The participant only has CSHCS for insurance. Nothing is entered in claim header level fields 54: Prior Payments and 00: CoPay.

InPatient Claim

Please make sure all the values are entered correctly, to process your claim successfully.
Incomplete / Incorrect Claims will be rejected.

Provider Information

Provider NPI	Service Location	Provider ID
1063457380	1100 REID PKWY,RICHMOND,IN,47374-1157	55309
Provider Name	Billing Date (mm/dd/yyyy)	
REID HOSPITAL AND HEALTH CARE SERVICES	10/30/2020	
Provider Tax ID	350892672	

In Patient Claim Form UB04

Patient ID	Date Of Birth (mm/dd/yyyy)	First 3 letters of Last Name	Retrieve Patient Info
902119	01/01/2001	TES	
Patient Name	Sex	Insured Name	Patient Address
NOCOB2 TEST	M		444 N FOURTH STREET,MILFORD
Other Health Plan	03a: Patient Control Number	04: Type Of Bill	14: Admission Type
N	555902119	111	1
06a: From Date	06b: To Date	17: Discharge Status	
08/06/2020	08/08/2020	01	

Occurrence Code

31. Code	Date	32. Code	Date	33. Code	Date	34. Code	Date
42	08/08/2020		__/__/__		__/__/__		__/__/__
	__/__/__		__/__/__		__/__/__		__/__/__

47 Ln 23: Total Billed Amount:	54: Prior Payments:
4983.20	
00: CoPay	63: PA Number:
	9106871

Diagnosis Code

66: ICD Ind	67: Princ Dg	A	B	C	D	E	F	G	H	I
<input type="text" value="0"/>	<input style="border: 2px solid red;" type="text" value="E10.10"/>	<input type="text" value="E80.6"/>	<input type="text" value="Z79.4"/>	<input type="text" value="Z83.3"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
J	K	L	M	N	O	P	Q	69: Admin Dg		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="E10.10"/>		

74 Procedure Code

Principal Code	Principal Date	74a: Proc Cd 1	74a: Proc Date 1	74b: Proc Cd 2	74b: Proc Date 2
<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text"/>	<input type="text" value="__/__/__"/>
74c: Proc Cd 3	74c: Proc Date 3	74d: Proc Cd 4	74d: Proc Date 4	74e: Proc Cd 5	74e: Proc Date 5
<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text"/>	<input type="text" value="__/__/__"/>

Detail Lines

Line Number	42: Revenue Code	44: HCPCS Code	46: Service Units	47: Total Charges
1	<input type="text" value="111"/>	<input type="text"/>	<input type="text" value="2"/>	<input type="text" value="2821.04"/>
2	<input type="text" value="259"/>	<input type="text"/>	<input type="text" value="6"/>	<input type="text" value="41.70"/>
3	<input type="text" value="259"/>	<input type="text"/>	<input type="text" value="84"/>	<input type="text" value="19.16"/>
4	<input type="text" value="259"/>	<input type="text"/>	<input type="text" value="2"/>	<input type="text" value="92.46"/>
5	<input type="text" value="259"/>	<input type="text"/>	<input type="text" value="4"/>	<input type="text" value="19.02"/>
6	<input type="text" value="300"/>	<input type="text"/>	<input type="text" value="21"/>	<input type="text" value="728.49"/>
7	<input type="text" value="301"/>	<input type="text"/>	<input type="text" value="18"/>	<input type="text" value="947.08"/>
8	<input type="text" value="305"/>	<input type="text"/>	<input type="text" value="1"/>	<input type="text" value="101.59"/>
9	<input type="text" value="306"/>	<input type="text"/>	<input type="text" value="1"/>	<input type="text" value="212.66"/>

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Inpatient WebDDE COB Claim Header Level

This is an example of an institutional inpatient WebDDE claim with Coordination of Benefits at claim header level. There is one previous payer.

InPatient Claim

Please make sure all the values are entered correctly, to process your claim successfully.
Incomplete / Incorrect Claims will be rejected.

Provider Information

Provider NPI	Service Location	Provider ID
1306897335	7950 W JEFFERSON BLVD,FORT WAYNE,IN,46804-4140	52182
Provider Name		Billing Date (mm/dd/yyyy)
LUTHERAN HOSPITAL OF INDIANA		10/30/2020
Provider Tax ID		
351963748		

In Patient Claim Form UB04

Patient ID	Date Of Birth (mm/dd/yyyy)	First 3 letters of Last Name	Retrieve Patient Info
902117	01/01/2004	TES	
Patient Name	Sex	Insured Name	Patient Address
COB TEST	M	MOTHER TEST	222 N SECOND STREET,INDIANAPOLIS
Other Health Plan	03a: Patient Control Number	04: Type Of Bill	14: Admission Type
Y	555902117	111	2
06a: From Date	06b: To Date	17: Discharge Status	
03/14/2020	03/16/2020	01	

Occurrence Code

31. Code	Date	32. Code	Date	33. Code	Date	34. Code	Date
11	03/11/2020		__/__/__		__/__/__		__/__/__
	__/__/__		__/__/__		__/__/__		__/__/__

47 Ln 23: Total Billed Amount:	54: Prior Payments:
14105.20	5386.83
00: CoPay	63: PA Number:
	9106869

Diagnosis Code

66: ICD Ind	67: Princ Dg	A	B	C	D	E	F	G	H	I
0 ▾	E10.10	Z79.4	E86.0	Z88.0	Z83.3	Z91.19				
J	K	L	M	N	O	P	Q	69: Admin Dg		
								E10.10		

74 Procedure Code

Principal Code	Principal Date	74a: Proc Cd 1	74a: Proc Date 1	74b: Proc Cd 2	74b: Proc Date 2
	__/__/__		__/__/__		__/__/__
74c: Proc Cd 3	74c: Proc Date 3	74d: Proc Cd 4	74d: Proc Date 4	74e: Proc Cd 5	74e: Proc Date 5
	__/__/__		__/__/__		__/__/__

Detail Lines

Line Number	42: Revenue Code	44: HCPCS Code	46: Service Units	47: Total Charges
1	113		1	1907.85
2	203		1	4691.40
3	250		261	1776.10
4	258		5	1774.50
5	300		2	121.80
6	301		40	3669.75
7	305		3	163.80

COB / Deductible Details Clear All COB Data

Payer 1

Sequence Number Code
P

Payer ID: ONEHLTH Payer Name: ONE HEALTH PLAN Policy Number: Ind Rel: Child

Amount Description: OI AMT PAID Amount: 5386.83

Header Level Details (To Add Multiple Rows, Press 'Tab' key after completing a Row.)

GRP	ARC	ARC Description	Amount
Patient Responsibility	2	2> COINSURANCE AMOUNT	1346.72
Contractual Obligations	45	45> CHARGE EXCEEDS FEE !	7371.65

Add Another Payer

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Inpatient WebDDE COB Service Line Level

This example of an institutional inpatient WebDDE claim with Coordination of Benefits at service line level does not exist. CSHCS only allows an institutional inpatient WebDDE claim with Coordination of Benefits at the claim header level.

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Introduction Outpatient

The Indiana Department of Health, Children's Special Health Care Services WEB-Enabled Direct Data Entry (WebDDE) institutional claim mimics the NUBC UB-04 (CMS-1450) paper claim form.

CSHCS is a payer of last resort, so Coordination of Benefits (COB) is needed to pay a claim if there are prior payers. The Outpatient COB section provides further explanation.

Outpatient WebDDE Claim Form

OutPatient Claim

Please make sure all the values are entered correctly, to process your claim successfully.
Incomplete / Incorrect Claims will be rejected.

Provider Information

Provider NPI	Service Location	Provider ID
<input type="text"/>	<input type="text"/>	<input type="text"/>
Provider Name	Billing Date (mm/dd/yyyy)	
<input type="text"/>	<input type="text"/>	
Provider Tax ID	<input type="text"/>	

Out Patient Claim Form UB04

Patient ID	Date Of Birth (mm/dd/yyyy)	First 3 letters of Last Name	Retrieve Patient Info
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Patient Name	Sex	Insured Name	Patient Address
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other Health Plan	03e: Patient Control Number	04: Type Of Bill	16: Admission Type
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
06a: From Date	06b: To Date	17: Discharge Status	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Occurrence Code

31. Code	Date	32. Code	Date	33. Code	Date	34. Code	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

47 Ln 23: Total Billed Amount	54: Prior Payments
<input type="text"/>	<input type="text"/>
00: CoPay	63: PA Number
<input type="text"/>	<input type="text"/>

Diagnosis Code

66: ICD Ind	67: Princ Dg	67c: Dg Cd	67d: Dg Cd	67e: Dg Cd	67f: Dg Cd	67g: Dg Cd	67h: Dg Cd	67i: Dg Cd	67j: Dg Cd	67k: Dg Cd	67l: Dg Cd
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
67m: Dg Cd	67n: Dg Cd	67o: Dg Cd	67p: Dg Cd	67q: Dg Cd	67r: Dg Cd	67s: Dg Cd	67t: Dg Cd	69: Admtn Dg			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>			

Procedure Code

74: Princ Prc Cd	74c: Princ Prc Date	74e: Proc Cd 1	74f: Proc Date 1	74g: Proc Cd 2	74h: Proc Date 2
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
74i: Proc Cd 3	74j: Proc Date 3	74k: Proc Cd 4	74l: Proc Date 4	74m: Proc Cd 5	74n: Proc Date 5
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Detail Lines

Line Number	42: Revenue Code	44: HCPCS Code	44: Modifier	45: Service Date	46: Service Units	47: Total Charges	54: Prior Payment	00: CoPay
1				__/__/__				

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Provider Information and Billing Date

* **Note:** If the Provider NPI or Service Location does not exist in the CSHCS claims system, the claim cannot be continued. The provider needs to call the CSHCS Provider Relations phone number listed in the Contact Information section to establish this information. If the provider notices that the Service Location, Provider Name, or Provider Tax ID that is in the CSHCS claims system does not match the current provider information, the provider should also call CSHCS Provider Relations to have the information updated.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
56	R	Provider NPI	9(10)	Valid Provider NPI in CSHCS. This is the Service Facility NPI or Billing Provider NPI. If the Service Facility NPI is different from the Billing Provider NPI, the Service Facility NPI is used.
1	R	Service Location	X(158)	Drop-down select and display.
N/A	R	Provider ID	9(5) or 9(6)	Valid Provider ID in CSHCS; displays after Service Location is selected.
1	DO	Provider Name	X(100)	The CSHCS Provider Name is displayed.
5	DO	Provider Tax ID	9(9)	The CSHCS Provider Tax ID is displayed.
23 (Creation Date)	R	Billing Date	X(10)	MM/DD/YYYY; the billing date must be greater than or equal to the claim Date of Service End (To) Date and less than or equal to the current date.

Subscriber Detail

*** Note:** In the CSHCS claims system, the participant (patient) is the subscriber. If the participant does not exist in the CSHCS claims system, the claim cannot be continued. The provider needs to call the CSHCS Eligibility phone number listed in the Contact Information section to establish this information. If the provider notices that the Patient Name, Date of Birth, Sex, Patient Address, or Insured Name that is in the CSHCS claims system does not match the current provider information, the provider should also call CSHCS Eligibility to have the information updated.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/Type	Comments/Valid Values
60	R	Patient ID	9(6)	Valid Participant ID in CSHCS.
10	R	Date of Birth	X(10)	MM/DD/YYYY; participant's date of birth.
N/A	R	First 3 letters of Last Name	X(3)	First 3 letters of participant's last name.
8b	DO	Patient Name	X(95)	The CSHCS Participant Name is displayed.
11	DO	Sex	X(1)	The CSHCS Participant's Sex is displayed.
58	DO	Insured Name	X(95)	The CSHCS Insured Name for the participant is displayed.
9 a,b,c,d	DO	Patient Address	X(157)	The CSHCS Participant Address is displayed.

Claim Information

*** Note:** WebDDE validates diagnosis codes against the codes in our system database. Therefore, when entering claims, the diagnosis codes must be entered with the decimal point for diagnosis codes greater than three characters. The maximum pattern is 'XXX.XXXX'. If a claim is entered with a new diagnosis code that is not yet in our system database, WebDDE will still allow the claim to be submitted.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/Type	Comments/Valid Values
N/A	S	Other Health Plan	X(1)	Y, N, or not selected. This field is used for Coordination of Benefits (COB) with CSHCS as needed. See the Outpatient COB section for explanation.
3a	R	Patient Control Number	X(30)	Patient Control Number assigned by the provider of service's or supplier's accounting system.
4	R	Type of Bill	9(3)	Type of Bill.
14	R	Admission Type	9(3)	Admission Type drop-down.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
6	R	From Date	X(10)	MM/DD/YYYY; the Date of Service 'From' date must be greater than or equal to the participant's date of birth. It must also be less than or equal to the participant's date of death if applicable. It must also be less than or equal to the Date of Service 'To' date and less than or equal to the billed date.
6	R	To Date	X(10)	MM/DD/YYYY; the Date of Service 'To' date must be greater than or equal to the Date of Service 'From' date and less than or equal to the billed date.
17	R	Discharge Status	X(3)	Discharge Status.
Occurrence Code				
31a	S	Code	X(5)	First occurrence code is optional.
31a	S	Date	X(10)	MM/DD/YYYY; First occurrence code date is optional.
31b	S	Code	X(5)	Additional occurrence code reported.
31b	S	Date	X(10)	MM/DD/YYYY; Additional occurrence code date reported.
32a	S	Code	X(5)	Additional occurrence code reported.
32a	S	Date	X(10)	MM/DD/YYYY; Additional occurrence code date reported.
32b	S	Code	X(5)	Additional occurrence code reported.
32b	S	Date	X(10)	MM/DD/YYYY; Additional occurrence code date reported.
33a	S	Code	X(5)	Additional occurrence code reported.
33a	S	Date	X(10)	MM/DD/YYYY; Additional occurrence code date reported.
33b	S	Code	X(5)	Additional occurrence code reported.
33b	S	Date	X(10)	MM/DD/YYYY; Additional occurrence code date reported.
34a	S	Code	X(5)	Additional occurrence code reported.
34a	S	Date	X(10)	MM/DD/YYYY; Additional occurrence code date reported.
34b	S	Code	X(5)	Additional occurrence code reported.
34b	S	Date	X(10)	MM/DD/YYYY; Additional occurrence code date reported.
Occurrence Code				
47	R	Ln 23: Total Billed Amount:	9(8)V99	Total billed amount of all service line charges.
54	S	54: Prior Payments:	9(8)V99	This field is used for Coordination of Benefits (COB) with CSHCS as needed

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
				at the claim header level. See the Outpatient COB section for explanation.
N/A	S	00: CoPay	9(8)V99	This field is used for Coordination of Benefits (COB) with CSHCS as needed at the claim header level. See the Outpatient COB section for explanation.
63	S	PA Number:	9(7)	The CSHCS prior authorization obtained for the service(s) as needed.
Diagnosis Code				
66	R	ICD Ind	X(1)	0 or 9; defaults to 0. All claims are now ICD-10, so 0 is the default.
67	R	Princ Dg	X(8)	ICD-10 Principal Diagnosis is required.
67 A - Q	S	67a: Dg Cd through 67q: Dg Cd	X(8)	ICD-10 additional diagnosis codes reported.
69	R	Admin Dg	X(8)	ICD-10 Admitting Diagnosis is required.
Procedure Code				
74	S	Princ Pc Cd	X(8)	Principal Procedure Code.
74	S	Princ Pc Date	X(10)	MM/DD/YYYY; Principal Procedure Date.
74 a - e	S	Proc Cd (1 through 5)	X(8)	Additional Procedure Codes.
74 a - e	S	Proc Date (1 through 5)	X(10)	MM/DD/YYYY; Additional Procedure Dates.

Claim Detail Lines

* **Note:** Up to ninety-nine service lines may be entered for an outpatient claim.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
N/A	DO	Line Number	9(1) or 9(2)	Automatically increments as service lines are entered.
42	R	Revenue Code	9(6)	Revenue Code.
44	S	HCPCS Code	X(8)	HCPCS code value if applicable.
44	S	Modifier	X(2)	Modifier if applicable; up to four modifiers may be entered for the line.
45	R	Service Date	X(10)	MM/DD/YYYY; the Service Date must be greater than or equal to the participant's date of birth. It must also be less than or equal to the

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
				participant's date of death if applicable. It must also be less than or equal to the billed date.
46	R	Service Units	9(10)	Number of Service Units.
47	R	Total Charges	9(8)V99	Total billed amount for the service line. The sum of the service line charges must equal the Ln 23: Total Billed Amount.
N/A	S	54: Prior Payment	9(8)V99	This field is used for Coordination of Benefits (COB) with CSHCS as needed at the service line level. See the Outpatient COB section for explanation.
N/A	S	00: CoPay	9(8)V99	This field is used for Coordination of Benefits (COB) with CSHCS as needed at the service line level. See the Outpatient COB section for explanation.

Outpatient Coordination of Benefits (COB)

CSHCS is a payer of last resort, so Coordination of Benefits (COB) is needed to pay a claim if there are prior payers. The WebDDE system allows up to three prior payers. The COB information and/or adjustments will be entered at either the claim header level or the claim service line level but not both. The COB information must also match the claim information placement. If Insurance Paid and/or CoPay was entered at header level on the claim, then the COB information must also be entered at the claim header level. If Insurance Paid and/or Copay was entered at service line level on the claim, then the COB information must also be entered at the claim service line level.

Coordination of Benefits (COB) is controlled by answering the 'Other Health Plan' question. If there are no previous payers prior to CSHCS, the question may be answered with 'N' or left blank.

If there are previous payers prior to CSHCS, then the question should be answered with 'Y'. When the 'Y' is selected, a message will be displayed asking if the COB will be at the claim header level or the service line level. Select one of the options. Another message will be displayed confirming the selection, click 'OK'.

COB Details.

Enter all COB Fields in the COB Section below for
Successful Claim Submission. Please choose if the COB
Information you provide, is at Header Level or Line Level.



The image shows two blue buttons with white text. The first button is labeled 'Header Level' and the second button is labeled 'Line Level'. Both buttons have a slight shadow and rounded corners.

The appropriate COB section will appear at the bottom of the WebDDE claim form.

Outpatient Claim Header Level COB

COB / Deductible Details
Clear All COB Data

Payer 1

Sequence Number Code

Payer ID Payer Name Policy Number Ind Rel

Amount Description Amount

Header Level Details (To Add Multiple Rows, Press 'Tab' key after completing a Row.)

GRP	ARC	ARC Description	Amount
v	v		

Add Another Payer

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
Claim Placement Header Level Fields				
54	S	54: Prior Payments:	9(8)V99	The total Insurance Paid from all previous payers.
N/A	S	00: CoPay	9(8)V99	The total CoPay paid from all previous payers.
COB / Deductible Header Details				
N/A	R	Sequence Number Code	X(1)	3) Defaults to 'P'. May add two additional prior payers, 'S' and 'T'.
N/A	S	Payer ID	X(80)	Optional Payer ID if known.
N/A	S	Payer Name	X(60)	Optional Payer Name if known.
N/A	S	Policy Number	X(50)	Optional Policy Number if known.
N/A	S	Ind Rel	9(2)	4) Optional Individual Relationship if known. Select from the drop-down.
N/A	R	(OI AMT PAID) Amount	9(8)V99	The total Insurance Paid by the payer denoted by the Sequence Number Code. It is acceptable to enter 0.00 if applicable.
N/A	S	GRP	X(2)	5) GRP (Claim Adjustment Group Code) if adjustment is made by the payer denoted by the Sequence Number Code.
N/A	S	ARC	X(8)	6) ARC (Adjustment Reason Code) if adjustment is made by the payer denoted by the Sequence Number

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
				Code.
N/A	DO	ARC Description	X(2000)	The ARC description is displayed after ARC code is chosen.
N/A	S	Amount	9(8)V99	The adjustment amount if adjustment is made by the payer denoted by the Sequence Number Code.

Outpatient Claim Service Line Level COB

COB / Deductible Details
Clear All COB Data

Payer 1

Sequence Number Code

Payer ID Payer Name Policy Number Ind Rel

Amount Description Amount

Line Level Details (To Add Multiple Rows, Press 'Tab' key after completing a Row.)

Line Number	GRP	ARC	ARC Description	Amount
v	v	v		

Add Another Payer

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
Claim Placement Service Line Level Fields				
N/A	S	54: Prior Payment	9(8)V99	The total line Insurance paid from all previous payers.
N/A	S	00: CoPay	9(8)V99	The total line CoPay paid from all previous payers.
COB / Deductible Service Line Details				
N/A	R	Sequence Number Code	X(1)	3 Defaults to 'P'. May add two additional prior payers, 'S' and 'T'.
N/A	S	Payer ID	X(80)	Optional Payer ID if known.
N/A	S	Payer Name	X(60)	Optional Payer Name if known.
N/A	S	Policy Number	X(50)	Optional Policy Number if known.
N/A	S	Ind Rel	9(2)	4 Optional Individual Relationship if known. Select from the drop-down.
N/A	R	(OI AMT PAID) Amount	9(8)V99	The total Insurance Paid by the payer

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
				denoted by the Sequence Number Code. It is acceptable to enter 0.00 if applicable.
N/A	S	Line Number	9(2)	The claim line number being adjusted by the payer denoted by the Sequence Number Code.
N/A	S	GRP	X(2)	5) GRP (Claim Adjustment Group Code) if adjustment is made by the payer denoted by the Sequence Number Code.
N/A	S	ARC	X(8)	6) ARC (Adjustment Reason Code) if adjustment is made by the payer denoted by the Sequence Number Code.
N/A	DO	ARC Description	X(2000)	The ARC description is displayed after ARC code is chosen.
N/A	S	Amount	9(8)V99	The adjustment amount if adjustment is made by the payer denoted by the Sequence Number Code.

Outpatient WebDDE Claim no COB

This is an example of an institutional outpatient WebDDE claim with no Coordination of Benefits. The participant only has CSHCS for insurance. Nothing is entered in claim header level fields 54: Prior Payments and 00: CoPay. Nothing is entered in service line level 54: Prior Payment and 00: CoPay fields in Detail Lines section.

OutPatient Claim

Please make sure all the values are entered correctly, to process your claim successfully.
Incomplete / Incorrect Claims will be rejected.

Provider Information

Provider NPI 1689696148	Service Location 1100 MERCER AVE,PO BOX 151,DECATUR,IN,46733-2303	Provider ID 51134
Provider Name ADAMS MEMORIAL HOSPITAL		Billing Date (mm/dd/yyyy) 10/30/2020
Provider Tax ID 351470257		

Out Patient Claim Form UB04

Patient ID 902116	Date Of Birth (mm/dd/yyyy) 01/01/2005	First 3 letters of Last Name TES	Retrieve Patient Info
Patient Name NOCOB TEST	Sex F	Insured Name	Patient Address 111 N FIRST STREET,INDIANAPOLIS
Other Health Plan N	03a: Patient Control Number 555902116	04: Type Of Bill 131	14: Admission Type 3
06a: From Date 02/27/2020	06b: To Date 02/27/2020	17: Discharge Status 01	

Occurrence Code

31. Code	Date	32. Code	Date	33. Code	Date	34. Code	Date
11	02/27/2020		__/__/__		__/__/__		__/__/__
	__/__/__		__/__/__		__/__/__		__/__/__

47 Ln 23: Total Billed Amount: 13.35	54: Prior Payments:
00: CoPay	63: PA Number:

Diagnosis Code

66: ICD Ind	67: Princ Dg	67a: Dg Cd	67b: Dg Cd	67c: Dg Cd	67d: Dg Cd	67e: Dg Cd	67f: Dg Cd	67g: Dg Cd	67h: Dg Cd	67i: Dg Cd
<input type="text" value="0"/>	<input type="text" value="E11.9"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
67j: Dg Cd	67k: Dg Cd	67l: Dg Cd	67m: Dg Cd	67n: Dg Cd	67o: Dg Cd	67p: Dg Cd	67q: Dg Cd	69: Admin Dg		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="E11.9"/>		

Procedure Code

74: Princ Pc Cd	74: Princ Pc Date	74a: Proc Cd 1	74a: Proc Date 1	74b: Proc Cd 2	74b: Proc Date 2
<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text"/>	<input type="text" value="__/__/__"/>
74c: Proc Cd 3	74c: Proc Date 3	74d: Proc Cd 4	74d: Proc Date 4	74e: Proc Cd 5	74e: Proc Date 5
<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text"/>	<input type="text" value="__/__/__"/>

Detail Lines

Line Number	42: Revenue Code	44: HCPCS Code	44: Modifier	45: Service Date	46: Service Units	47: Total Charges	54: Prior Payment	00: CoPay
1	<input type="text" value="300"/>	<input type="text" value="36415"/>	<input type="text"/>	<input type="text" value="02/27/2020"/>	<input type="text" value="1"/>	<input type="text" value="13.35"/>	<input type="text"/>	<input type="text"/>

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Outpatient WebDDE COB Claim Header Level

This is an example of an institutional outpatient WebDDE claim with Coordination of Benefits at claim header level. There is one previous payer.

OutPatient Claim

Please make sure all the values are entered correctly, to process your claim successfully.
Incomplete / Incorrect Claims will be rejected.

Provider Information

Provider NPI	Service Location	Provider ID
<input type="text" value="1366407603"/>	<input type="text" value="11109 PARKVIEW PLAZA DR,FORT WAYNE,IN,46845-1701"/>	<input type="text" value="55794"/>
Provider Name	Billing Date (mm/dd/yyyy)	
<input type="text" value="PARKVIEW REGIONAL MEDICAL CENTER"/>	<input type="text" value="10/30/2020"/>	
Provider Tax ID		
<input type="text" value="350868085"/>		

Out Patient Claim Form UB04

Patient ID	Date Of Birth (mm/dd/yyyy)	First 3 letters of Last Name	Retrieve Patient Info
<input type="text" value="902117"/>	<input type="text" value="01/01/2004"/>	<input type="text" value="TES"/>	
Patient Name	Sex	Insured Name	Patient Address
<input type="text" value="COB TEST"/>	<input type="text" value="M"/>	<input type="text" value="MOTHER TEST"/>	<input type="text" value="222 N SECOND STREET,INDIANAPOLIS"/>
Other Health Plan	03a: Patient Control Number	04: Type Of Bill	14: Admission Type
<input type="text" value="Y"/>	<input type="text" value="555902117"/>	<input type="text" value="131"/>	<input type="text" value="3"/>
06a: From Date	06b: To Date	17: Discharge Status	
<input type="text" value="02/11/2020"/>	<input type="text" value="02/11/2020"/>	<input type="text" value="01"/>	

Occurrence Code

31. Code	Date	32. Code	Date	33. Code	Date	34. Code	Date
<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text"/>	<input type="text" value="__/__/__"/>
<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text"/>	<input type="text" value="__/__/__"/>

47 Ln 23: Total Billed Amount:	54: Prior Payments:
<input type="text" value="3451.36"/>	<input type="text" value="320.89"/>
00: CoPay	63: PA Number:
<input type="text"/>	<input type="text"/>

Diagnosis Code

66: ICD Ind	67: Princ Dg	67a: Dg Cd	67b: Dg Cd	67c: Dg Cd	67d: Dg Cd	67e: Dg Cd	67f: Dg Cd	67g: Dg Cd	67h: Dg Cd	67i: Dg Cd
0 ▾	I42.0	G47.01								
67j: Dg Cd	67k: Dg Cd	67l: Dg Cd	67m: Dg Cd	67n: Dg Cd	67o: Dg Cd	67p: Dg Cd	67q: Dg Cd	69: Admin Dg		
								I42.0		

Procedure Code

74: Princ Pc Cd	74: Princ Pc Date	74a: Proc Cd 1	74a: Proc Date 1	74b: Proc Cd 2	74b: Proc Date 2
	__/__/__		__/__/__		__/__/__
74c: Proc Cd 3	74c: Proc Date 3	74d: Proc Cd 4	74d: Proc Date 4	74e: Proc Cd 5	74e: Proc Date 5
	__/__/__		__/__/__		__/__/__

Detail Lines

Line Number	42: Revenue Code	44: HCPCS Code	44: Modifier	45: Service Date	46: Service Units	47: Total Charges	54: Prior Payment	00: CoPay
1	255			02/11/2020	40	507.36		
2	610	75561		02/11/2020	1	2944.00		

COB / Deductible Details Clear All COB Data

Payer 1

Sequence Number Code
P

Payer ID: ONEHLTH Payer Name: ONE HEALTH PLAN Policy Number: Ind Rel: Child

Amount Description: OI AMT PAID Amount: 320.89

Header Level Details: (To Add Multiple Rows, Press "Tab" key after completing a Row.)

GRP	ARC	ARC Description	Amount
Patient Responsibility	1	1> DEDUCTIBLE AMOUNT	2000.00
Patient Responsibility	2	2> COINSURANCE AMOUNT	80.22
Contractual Obligations	45	45> CHARGE EXCEEDS FEE !	1050.25

Add Another Payer

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Outpatient WebDDE COB Claim Service Line Level

This is an example of an institutional outpatient WebDDE claim with Coordination of Benefits at service line level. There is one previous payer.

OutPatient Claim

Please make sure all the values are entered correctly, to process your claim successfully.
Incomplete / Incorrect Claims will be rejected.

Provider Information

Provider NPI 1063457380	Service Location 1100 REID PKWY,RICHMOND,IN,47374-1157	Provider ID 55309
Provider Name REID HOSPITAL AND HEALTH CARE SERVICES	Billing Date (mm/dd/yyyy) 10/30/2020	
Provider Tax ID 350892672		

Out Patient Claim Form UB04

Patient ID 902117	Date Of Birth (mm/dd/yyyy) 01/01/2004	First 3 letters of Last Name TES	Retrieve Patient Info
Patient Name COB TEST	Sex M	Insured Name MOTHER TEST	Patient Address 222 N SECOND STREET,INDIANAPOLIS
Other Health Plan Y	03a: Patient Control Number 555902117	04: Type Of Bill 131	14: Admission Type 3
06a: From Date 07/03/2020	06b: To Date 07/22/2020	17: Discharge Status 01	

Occurrence Code

31. Code	Date	32. Code	Date	33. Code	Date	34. Code	Date
	__/__/__		__/__/__		__/__/__		__/__/__
	__/__/__		__/__/__		__/__/__		__/__/__

47 Ln 23: Total Billed Amount: 531.08	54: Prior Payments:
00: CoPay	63: PA Number: 9106870

Diagnosis Code

66: ICD Ind	67: Princ Dg	67a: Dg Cd	67b: Dg Cd	67c: Dg Cd	67d: Dg Cd	67e: Dg Cd	67f: Dg Cd	67g: Dg Cd	67h: Dg Cd	67i: Dg Cd
0 ▾	Q99.9	E71.440	R26.9							
67j: Dg Cd	67k: Dg Cd	67l: Dg Cd	67m: Dg Cd	67n: Dg Cd	67o: Dg Cd	67p: Dg Cd	67q: Dg Cd	69: Admin Dg		
								Q99.9		

Procedure Code

74: Princ Pc Cd	74: Princ Pc Date	74a: Proc Cd 1	74a: Proc Date 1	74b: Proc Cd 2	74b: Proc Date 2
	__/__/__		__/__/__		__/__/__
74c: Proc Cd 3	74c: Proc Date 3	74d: Proc Cd 4	74d: Proc Date 4	74e: Proc Cd 5	74e: Proc Date 5
	__/__/__		__/__/__		__/__/__

Detail Lines

Line Number	42: Revenue Code	44: HCPCS Code	44: Modifier	45: Service Date	46: Service Units	47: Total Charges	54: Prior Payment	00: CoPay
1	420	97110	GP	07/22/2020	3	285.33	196.60	
2	424	97162	GP	07/03/2020	1	245.75	228.26	

COB / Deductible Details Clear All COB Data

Payer 1

Sequence Number Code
P

Payer ID: ONEHLTH Payer Name: ONE HEALTH PLAN Policy Number: Ind Rel: Child

Amount Description: OI AMT PAID Amount: 424.86

Line Level Details (To Add Multiple Rows, Press 'Tab' key after completing a Row.)

Line Number	GRP	ARC	ARC Description	Amount
1	Patient Responsibility	2	2> COINSURANCE AMOUNT	49.15
2	Patient Responsibility	2	2> COINSURANCE AMOUNT	57.07

Add Another Payer

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Section 5: Dental Claims Instructions

Introduction Dental

The Indiana Department of Health, Children’s Special Health Care Services WEB-Enabled Direct Data Entry (WebDDE) dental claim mimics the ADA 2012 paper claim form.

CSHCS is a payer of last resort, so Coordination of Benefits (COB) is needed to pay a claim if there are prior payers. The Dental COB section provides further explanation.

Dental WebDDE Claim Form

Dental Claim

Please make sure all the values are entered correctly, to process your claim successfully.
Incomplete / Incorrect Claims will be rejected.

Type Of Transaction

Statement Of Actual Services Request For Predetermination/Preauthorization EPSDT / Title XIX

Provider Information

Provider NPI	Service Location	Provider ID
<input type="text"/>	<input type="text"/>	<input type="text"/>
Provider Name	Billing Date (mm/dd/yyyy)	
<input type="text"/>	<input type="text"/>	
Provider Tax ID	<input type="text"/>	

Dental Claim Form : ADA

Patient ID	Date Of Birth (mm/dd/yyyy)	First 3 letters of Last Name	Retrieve Patient Info	
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Patient Name	Sex	Insured Name	Patient Address	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
15: Other Health Plan	02: Prior Authorization Number	23: Patient Account Number	32: Total Fee	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
04: Other Coverage	40: Ortho Treatment	38: Place Of Treatment	25: Insurance Paid	00: CoPay
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
25a: Note (80 Characters Max)				
<input type="text"/>				

Dental Lines

Line Number	24: Procedure Date	27: Tooth	28: Surface	29: Procedure Code	31: Fee	Insurance Paid	CoPay
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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Header Information

Paper Claim Field	Usage	WebDDE Field Name	Field Length/Type	Comments/Valid Values
		Type of Transaction		
1.	R	Statement of Actual Services	X(1)	Submit actual services claim to CSHCS.
	N/A	Request for Predetermination/Preauthorization	X(1)	Please call CSHCS Preauthorization for PA instead of submitting a claim for preauthorization/predetermination.
	N/A	EPSDT / Title XIX	X(1)	CSHCS does not use.

Provider Information and Billing Date

* **Note:** If the Provider NPI or Service Location does not exist in the CSHCS claims system, the claim cannot be continued. The provider needs to call CSHCS Provider Relations phone number listed in the Contact Information section to establish this information. If the provider notices that the Service Location, Provider Name, or Provider Tax ID that is in the CSHCS claims system does not match the current provider information, the provider should also call CSHCS Provider Relations to have the information updated.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/Type	Comments/Valid Values
49.	R	Provider NPI	9(10)	Valid Provider NPI in CSHCS. This is the Service Facility NPI or Billing Provider NPI. If the Service Facility NPI is different from the Billing Provider NPI, the Service Facility NPI is used.
48.	R	Service Location	X(158)	Drop-down select and display.
N/A	R	Provider ID	9(5) or 9(6)	Valid Provider ID in CSHCS; displays after Service Location is selected.
48.	DO	Provider Name	X(100)	The CSHCS Provider Name is displayed.
51.	DO	Provider Tax ID	9(9)	The CSHCS Provider Tax ID is displayed.
53. (Date)	R	Billing Date	X(10)	MM/DD/YYYY; the billing date must be greater than or equal to the claim Procedure Date and less than or equal to the current date.

Subscriber Detail

*** Note:** In the CSHCS claims system, the participant (patient) is the subscriber. If the participant does not exist in the CSHCS claims system, the claim cannot be continued. The provider needs to call the CSHCS Eligibility phone number listed in the Contact Information section to establish this information. If the provider notices that the Patient Name, Date of Birth, Sex, Patient Address, or Insured Name that is in the CSHCS claims system does not match the current provider information, the provider should also call CSHCS Eligibility to have the information updated.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
15.	R	Patient ID	9(6)	Valid Participant ID in CSHCS.
13.	R	Date of Birth	X(10)	MM/DD/YYYY; participant's date of birth.
N/A	R	First 3 letters of Last Name	X(3)	First 3 letters of participant's last name.
12.	DO	Patient Name	X(95)	The CSHCS Participant Name is displayed.
14.	DO	Sex	X(1)	The CSHCS Participant's Sex is displayed.
5.	DO	Insured Name	X(95)	The CSHCS Insured Name for the participant is displayed.
12.	DO	Patient Address	X(157)	The CSHCS Participant Address is displayed.

Claim Information

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
N/A	S	11d: Other Health Plan	X(1)	Y, N, or not selected. This field is used for Coordination of Benefits (COB) with CSHCS as needed. See the Dental COB section for explanation.
2.	S	Prior Authorization Number	9(7)	The CSHCS prior authorization obtained for the service(s) as needed.
23.	S	Patient Account Number	X(15)	Patient Account Number assigned by the dentist's office to identify the patient.
32.	R	Total Fee	9(8)V99	Total billed amount of all service line charges.
4.	S	Other Coverage	X(1)	Y, N, or not selected.
40.	S	Ortho Treatment	X(1)	Y, N, or not selected.
38.	R	Place of Treatment	9(2)	1) Code value for professional claim.
35.	S	35b: Insurance Paid	9(8)V99	This field is used for Coordination of

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
				Benefits (COB) with CSHCS as needed at the claim header level. See the Dental COB section for explanation.
N/A	S	00: CoPay	9(8)V99	This field is used for Coordination of Benefits (COB) with CSHCS as needed at the claim header level. See the Dental COB section for explanation.
35.	S	Note	X(80)	Optional.

1) https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

WebDDE allows the following selections:

Code	Definition
11	Office
22	Outpatient Hospital
32	Nursing Facility
99	Other Place of Service

Claim Detail Lines

* **Note:** Up to fifty service lines may be entered for a dental claim.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
N/A	DO	Line Number	9(1) or 9(2)	Automatically increments as service lines are entered.
24.	R	Procedure Date	X(10)	MM/DD/YYYY; the Procedure Date must be greater than or equal to the participant's date of birth. It must also be less than or equal to the participant's date of death if applicable. It must also be less than or equal to the billed date.
27.	S	Tooth	X(2)	Tooth Number(s) or Letter(s).
28.	S	Surface	X(5)	Tooth Surface.
29.	R	Procedure Code	X(10)	Dental procedure code.
	R	Fee	9(8)V99	Total billed amount for the service line. The sum of the service line charges must equal the 32: Total Fee.
N/A	S	Insurance Paid	9(8)V99	This field is used for Coordination of Benefits (COB) with CSHCS as needed at the service line level. See the Dental COB section for explanation.

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
N/A	S	CoPay	9(8)V99	This field is used for Coordination of Benefits (COB) with CSHCS as needed at the service line level. See the Dental COB section for explanation.

Dental Coordination of Benefits (COB)

CSHCS is a payer of last resort, so Coordination of Benefits (COB) is needed to pay a claim if there are prior payers. The WebDDE system allows up to three prior payers. The COB information and/or adjustments will be entered at either the claim header level or the claim service line level but not both. The COB information must also match the claim information placement. If Insurance Paid and/or CoPay was entered at header level on the claim, then the COB information must also be entered at the claim header level. If Insurance Paid and/or Copay was entered at service line level on the claim, then the COB information must also be entered at the claim service line level.

Coordination of Benefits (COB) is controlled by answering the '11d: Other Health Plan' question. If there are no previous payers prior to CSHCS, the question may be answered with 'N' or left blank.

If there are previous payers prior to CSHCS, then the question should be answered with 'Y'. When the 'Y' is selected, a message will be displayed asking if the COB will be at the claim header level or the service line level. Select one of the options. Another message will be displayed confirming the selection, click 'OK'.

COB Details.

Enter all COB Fields in the COB Section below for
Successfull Claim Submission. Please choose if the COB
Information you provide, is at Header Level or Line Level.



The image shows two blue buttons with white text. The first button is labeled 'Header Level' and the second button is labeled 'Line Level'. Both buttons have a slight shadow and rounded corners.

The appropriate COB section will appear at the bottom of the WebDDE claim form.

Dental Claim Header Level COB

COB / Deductible Details
Clear All COB Data

Payer 1

Sequence Number Code

Payer ID Payer Name Policy Number Ind Rel

Amount Description Amount

Header Level Details (To Add Multiple Rows, Press 'Tab' key after completing a Row.)

GRP	ARC	ARC Description	Amount
v	v		

Add Another Payer

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
Claim Placement Header Level Fields				
35.	S	35b: Insurance Paid	9(8)V99	The total Insurance Paid from all previous payers.
N/A	S	00: CoPay	9(8)V99	The total CoPay paid from all previous payers.
COB / Deductible Header Details				
N/A	R	Sequence Number Code	X(1)	3) Defaults to 'P'. May add two additional prior payers, 'S' and 'T'.
N/A	S	Payer ID	X(80)	Optional Payer ID if known.
N/A	S	Payer Name	X(60)	Optional Payer Name if known.
N/A	S	Policy Number	X(50)	Optional Policy Number if known.
N/A	S	Ind Rel	9(2)	4) Optional Individual Relationship if known. Select from the drop-down.
N/A	R	(OI AMT PAID) Amount	9(8)V99	The total Insurance Paid by the payer denoted by the Sequence Number Code. It is acceptable to enter 0.00 if applicable.
N/A	S	GRP	X(2)	5) GRP (Claim Adjustment Group Code) if adjustment is made by the payer denoted by the Sequence Number Code.
N/A	S	ARC	X(8)	6) ARC (Adjustment Reason Code) if adjustment is made by the payer

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
				denoted by the Sequence Number Code.
N/A	DO	ARC Description	X(2000)	The ARC description is displayed after ARC code is chosen.
N/A	S	Amount	9(8)V99	The adjustment amount if adjustment is made by the payer denoted by the Sequence Number Code.

Dental Claim Service Line Level COB

COB / Deductible Details
Clear All COB Data

Payer 1

Sequence Number Code

Payer ID Payer Name Policy Number Ind Rel

Amount Description Amount

Line Level Details (To Add Multiple Rows, Press 'Tab' key after completing a Row.)

Line Number	GRP	ARC	ARC Description	Amount
v	v	v		

Add Another Payer

Paper Claim Field	Usage	WebDDE Field Name	Field Length/ Type	Comments/Valid Values
Claim Placement Service Line Level Fields				
N/A	S	Insurance Paid	9(8)V99	The total line Insurance paid from all previous payers.
N/A	S	CoPay	9(8)V99	The total line CoPay paid from all previous payers.
COB / Deductible Service Line Details				
N/A	R	Sequence Number Code	X(1)	3) Defaults to 'P'. May add two additional prior payers, 'S' and 'T'.
N/A	S	Payer ID	X(80)	Optional Payer ID if known.
N/A	S	Payer Name	X(60)	Optional Payer Name if known.
N/A	S	Policy Number	X(50)	Optional Policy Number if known.
N/A	S	Ind Rel	9(2)	4) Optional Individual Relationship if

Paper Claim Field	Usage	WebDDE Field Name	Field Length/Type	Comments/Valid Values
				known. Select from the drop-down.
N/A	R	(OI AMT PAID) Amount	9(8)V99	The total Insurance Paid by the payer denoted by the Sequence Number Code. It is acceptable to enter 0.00 if applicable.
N/A	S	Line Number	9(2)	The claim line number being adjusted by the payer denoted by the Sequence Number Code.
N/A	S	GRP	X(2)	5) GRP (Claim Adjustment Group Code) if adjustment is made by the payer denoted by the Sequence Number Code.
N/A	S	ARC	X(8)	6) ARC (Adjustment Reason Code) if adjustment is made by the payer denoted by the Sequence Number Code.
N/A	DO	ARC Description	X(2000)	The ARC description is displayed after ARC code is chosen.
N/A	S	Amount	9(8)V99	The adjustment amount if adjustment is made by the payer denoted by the Sequence Number Code.

Dental WebDDE Claim no COB

This is an example of a dental WebDDE claim with no Coordination of Benefits. The participant only has CSHCS for insurance. Nothing is entered in claim header level fields 35b: Insurance Paid and 00: CoPay. Nothing is entered in service line level Insurance Paid and CoPay fields in Detail Lines section.

Dental Claim

Please make sure all the values are entered correctly, to process your claim successfully.
Incomplete / Incorrect Claims will be rejected.

Type Of Transaction

Statement Of Actual Services
 Request For Predetermination/Preauthorization
 EPSDT / Title XIX

Provider Information

Provider NPI 1003947599	Service Location 705 RILEY HOSPITAL DR,RM 4205,INDIANAPOLIS,IN,46202-5109	Provider ID 103337
Provider Name UNIVERSITY PEDIATRIC DENTAL ASSN INC		Billing Date (mm/dd/yyyy) 10/29/2020
Provider Tax ID 352138723		

Dental Claim Form : ADA

Patient ID 902119	Date Of Birth (mm/dd/yyyy) 01/01/2001	First 3 letters of Last Name TES	Retrieve Patient Info
Patient Name NOCO2 TEST	Sex M	Insured Name	Patient Address 444 N FOURTH STREET,MILFORD
11d: Other Health Plan N	02: Prior Authorization Number	23: Patient Account Number 555902119	32: Total Fee \$ 436.00
04: Other Coverage N	40: Ortho Treatment N	38: Place Of Treatment 11	35b: Insurance Paid \$
00: CoPay \$			
35a: Note (80 Characters Max)			

Dental Lines

Line Number	24: Procedure Date	27: Tooth	28: Surface	29: Procedure Code	31: Fee	Insurance Paid	CoPay
1	4/22/2020	29		D2931	\$ 323.00	\$	\$
2	4/22/2020			D9230	\$ 81.00	\$	\$
3	4/22/2020			D0270	\$ 32.00	\$	\$

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Dental WebDDE COB Claim Header Level

This is an example of a dental WebDDE claim with Coordination of Benefits at claim header level. There is one previous payer.

Dental Claim

Please make sure all the values are entered correctly, to process your claim successfully.
Incomplete / Incorrect Claims will be rejected.

Type Of Transaction

Statement Of Actual Services Request For Predetermination/Preauthorization EPSDT / Title XIX

Provider Information

Provider NPI	Service Location	Provider ID
1568511582	3056 WEST STONES CROSSING RD, GREENWOOD, IN, 46143-6484 ▼	203227
Provider Name	Billing Date (mm/dd/yyyy)	
STACY JOHNSON	10/29/2020	
Provider Tax ID	352078923	

Dental Claim Form : ADA

Patient ID	Date Of Birth (mm/dd/yyyy)	First 3 letters of Last Name	Retrieve Patient Info	
902117	01/01/2004	TES		
Patient Name	Sex	Insured Name	Patient Address	
COB TEST	M	MOTHER TEST	222 N SECOND STREET, INDIANAPOLIS ^ ▼	
11d: Other Health Plan	02: Prior Authorization Number	23: Patient Account Number	32: Total Fee	
Y ▼		555902117	\$ 174.00	
04: Other Coverage	40: Ortho Treatment	38: Place Of Treatment	35b: Insurance Paid	00: CoPay
Y ▼	N ▼	11 ▼	\$ 124.00	\$ 50.00
35a: Note (80 Characters Max)				

Dental Lines

Line Number	24: Procedure Date	27: Tooth	28: Surface	29: Procedure Code	31: Fee	Insurance Paid	CoPay
1	10/05/2			D0120	\$ 45.00	\$	\$
2	10/05/2			D0272	\$ 40.00	\$	\$
3	10/05/2			D1120	\$ 60.00	\$	\$
4	10/05/2			D1208	\$ 29.00	\$	\$

COB / Deductible Details Clear All COB Data

Payer 1

Sequence Number Code

Payer ID: Payer Name: Policy Number: Ind Rel:

Amount Description: Amount:

Header Level Details (To Add Multiple Rows, Press 'Tab' key after completing a Row.)

GRP	ARC	ARC Description	Amount
Patient Responsibility	3	3> CO-PAYMENT AMOUNT	50.00

Add Another Payer

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Dental WebDDE COB Claim Service Line Level

This is an example of a dental WebDDE claim with Coordination of Benefits at service line level. There is one previous payer.

Dental Claim

Please make sure all the values are entered correctly, to process your claim successfully.
Incomplete / Incorrect Claims will be rejected.

Type Of Transaction

Statement Of Actual Services
 Request For Predetermination/Preauthorization
 EPSDT / Title XIX

Provider Information

Provider NPI <input type="text" value="1902025968"/>	Service Location <input type="text" value="124 N INDIANA ST,MOORESVILLE,IN,46158-1503"/>	Provider ID <input type="text" value="134990"/>
Provider Name <input type="text" value="STEPHANIELITZ"/>	Billing Date (mm/dd/yyyy) <input type="text" value="10/30/2020"/>	
Provider Tax ID <input type="text" value="371416626"/>		

Dental Claim Form : ADA

Patient ID <input type="text" value="902117"/>	Date Of Birth (mm/dd/yyyy) <input type="text" value="01/01/2004"/>	First 3 letters of Last Name <input type="text" value="TES"/>	Retrieve Patient Info
Patient Name <input type="text" value="COB TEST"/>	Sex <input type="text" value="M"/>	Insured Name <input type="text" value="MOTHER TEST"/>	Patient Address <input type="text" value="222 N SECOND STREET,INDIANAPOLIS"/>
11d: Other Health Plan <input type="text" value="Y"/>	02: Prior Authorization Number <input type="text"/>	23: Patient Account Number <input type="text" value="555902117"/>	32: Total Fee <input type="text" value="\$ 68.00"/>
04: Other Coverage <input type="text" value="Y"/>	40: Ortho Treatment <input type="text" value="N"/>	38: Place Of Treatment <input type="text" value="11"/>	35b: Insurance Paid <input type="text" value="\$"/>
00: CoPay <input type="text" value="\$"/>			
35a: Note (80 Characters Max) <input type="text"/>			

Dental Lines

Line Number	24: Procedure Date	27: Tooth	28: Surface	29: Procedure Code	31: Fee	Insurance Paid	CoPay
1	<input type="text" value="10/02/2020"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="D0140"/>	<input type="text" value="\$ 68.00"/>	<input type="text" value="\$ 6.52"/>	<input type="text" value="\$ 50.00"/>

COB / Deductible Details
Clear All COB Data

Payer 1

Sequence Number Code
P

Payer ID: ONEHLTH Payer Name: ONE HEALTH PLAN Policy Number: 902117890 Ind Rel: Child

Amount Description: OI AMT PAID Amount: 6.52

Line Level Details (To Add Multiple Rows, Press 'Tab' key after completing a Row.)

Line Number	GRP	ARC	ARC Description	Amount
1	Patient Responsibility	3	3> CO-PAYMENT AMOUNT	50.00
1	Patient Responsibility	2	2> COINSURANCE AMOUNT	1.63
1	Contractual Obligations	45	45> CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLO	9.85

Add Another Payer

Upload Related File
Scan all Necessary Pages into a Single PDF File for upload. (Max 50MB)

Browse

Clear File

Submit

Appendix A: Code Values

Sequence Number Code (Payer)

Code	Definition
P	Primary
S	Secondary
T	Tertiary

Individual Relationship Code

Code	Definition		Code	Definition
01	Spouse		39	Organ Donor
18	Self		40	Cadaver Donor
19	Child		53	Life Partner
20	Employee		G8	Other Relationship
21	Unknown			

GRP (Claim Adjustment Group Code)

Code	Definition
CO	Contractual Obligations
PR	Patient Responsibility
OA	Other Adjustments
PI	Payor Initiated Reductions

ARC (Adjustment Reason Code)

<https://x12.org/codes/claim-adjustment-reason-code>