



+*first*CONNECT

HEALTHCARE
+*first*
patients before paperwork

firstConnect Users Guide, April 2015 Edition

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Table of Contents

Preface: About <i>first</i>CONNECT	4
Chapter 1: Internet Settings	5
Chapter 2: Logging In	7
Logging In	
Reset Password	
Chapter 3: Menu Bar Options	10
Home	
Settings	
Logout	
Chapter 4: DDE	13
DDE Screen Captures	
Chapter 5: File Transfer	16
File Manager	
Reconciliation Manager	
Downloading Response Files	
Chapter 6: Medicare Eligibility	22
Viewing Previous Eligibility Reports	
Retrigger Report Request	
Status Types	
Saving and Printing Reports	
Viewing Eligibility Responses	
Chapter 7: All Payer Eligibility	33
Running the Eligibility Report	
Previous Eligibility Reports	
Saving and Printing Reports	
Viewing All Payer Eligibility Reports	
Eligibility Payer List	

About *first*CONNECT

Preface

HEALTHCARE *first* is providing connectivity to the Medicare Administrative Contractor (PGBA, CGS, NHIC, NGS). Once in the CMS (Centers for Medicare & Medicaid Services) system, if you have questions on how to use DDE (Direct Data Entry), you should refer to the CMS Direct Data Entry Manual.

If you don't already have a copy of the DDE manual it is located at:

[http://www.palmettogba.com/Palmetto/Providers.Nsf/files/DDE_Manual.pdf/\\$File/DDE_Manual.pdf](http://www.palmettogba.com/Palmetto/Providers.Nsf/files/DDE_Manual.pdf/$File/DDE_Manual.pdf)

A copy of the CMS HIPAA Eligibility Transaction System (HETS) UI User Guide can be located at:

<http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS-UI-User-Guide.pdf>

A copy of the Palmetto GBA Online Provider Services User Manual can be located at:

[http://www.palmettogba.com/Palmetto/Providers.nsf/files/OPS_UserManual.pdf/\\$File/OPS_UserManual.pdf](http://www.palmettogba.com/Palmetto/Providers.nsf/files/OPS_UserManual.pdf/$File/OPS_UserManual.pdf)

The HETS 271 transaction only provides HEALTHCARE *first* with the NPI number. We use the tool below to convert it to the Provider Name/Number. If, for any reason, your Provider Name or Number is not available, your NPI number will be listed under the Provider Number columns:

http://www.hipaaspace.com/Medical_Billing/Coding/National_Provider_Identifier/NPI_Number_Lookup.aspx

After the contract is finalized, Implementation will create your account, provide you with the login credentials, and walk you through how to use *first*CONNECT.

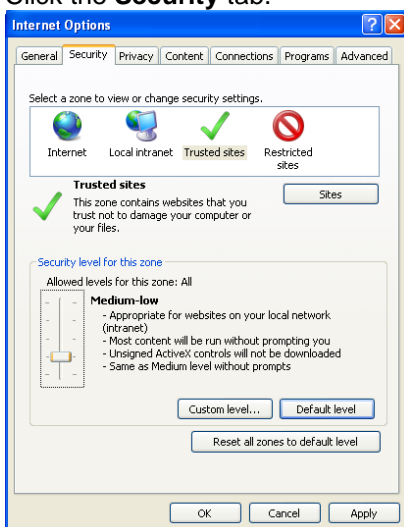
Internet Settings

Chapter 1

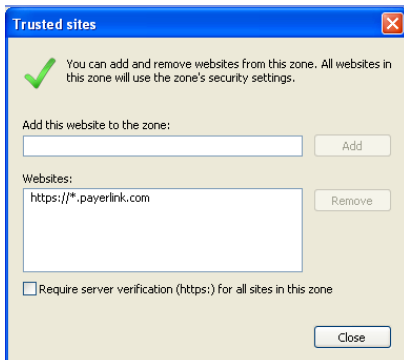
Settings may differ for certain browsers. Below are the instructions for Internet Explorer settings. These settings must be configured before accessing *firstCONNECT*.

To configure settings for *firstCONNECT* DDE (Direct Data Entry) access:

1. From the internet browser, click **Tools** then **Internet options**.
2. Click the **Security** tab.

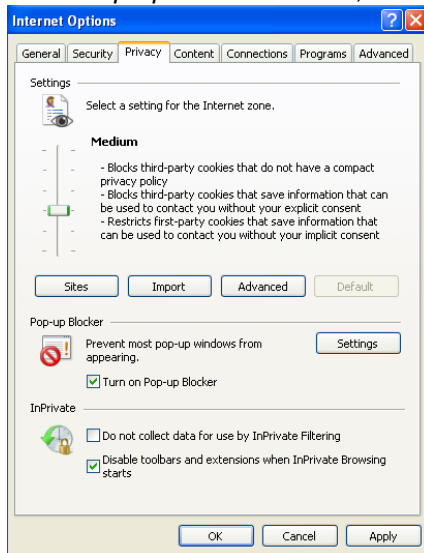


3. Click **Trusted Sites** (a green check mark should appear).
4. Click the **Default level** button.
5. Slide the slider bar on the left to Medium-low.
6. Click the **Sites** button. The following window will appear.

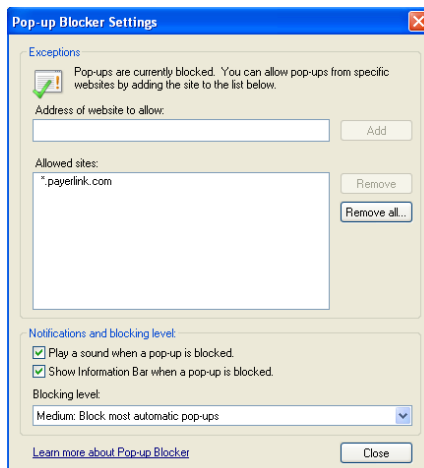


7. Type https://*.payerlink.com in the **Add this website to the zone:** box.

8. Click **Add** to add the site to the Trusted sites list. Make sure that the **Require server verification** checkbox is **unchecked**.
9. Click **Close**.
10. Click the **Privacy** tab in the *Internet Options* window.
11. In the *Pop-up Blocker* section, click the **Settings** button (if it is enabled).



12. In the *Pop-up Blocker Settings* window, type “*.payerlink.com” in the Address of website to allow: box.



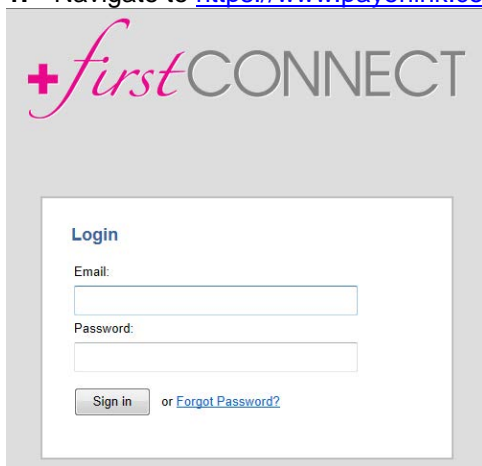
13. Click **Add**.
14. Click **Close**.
15. In the *Internet Options* window, click **Apply**.
16. Click **OK** to save all settings.
17. You may proceed to login.

Once you have contracted *first*CONNECT services, HEALTHCARE*first* Implementation will create your agency account and login information. A default password, “1Connect”, and a default security question, “What is your favorite sports team?” with the answer set as “Cardinals”, will be set up and e-mailed to each user at your agency. When a user logs in for the first time, both the default password and security question will need to be changed. Until your account is activated, you will not have access to the program. Once your account is activated, you will receive verification from Implementation.

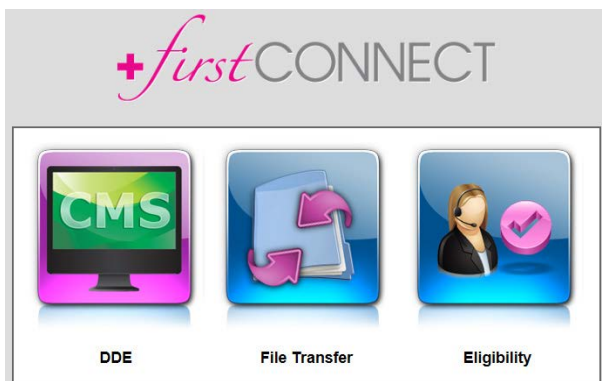
Logging In

To login to *first*CONNECT:

1. Navigate to <https://www.payerlink.com/PL/PTLogin.aspx>



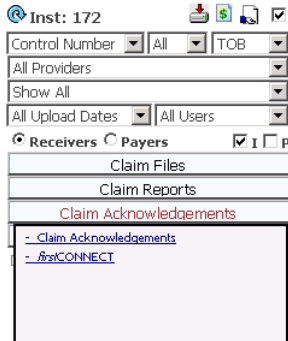
2. Enter the **Email** and **Password**.
3. Click **Sign In**.
4. The *first*CONNECT main menu screen will appear.



Enterprise Edition Users

To login to *first*CONNECT within Enterprise Edition:

1. From the Enterprise Edition main menu, go to **Accounts | Billing | Download Claims**.
2. The Account Management screen will appear.
3. Click **Claim Acknowledgements** in the Account Management screen.
4. A link to *first*CONNECT will appear on this screen. Click the ***first*CONNECT** link.



5. *first*CONNECT will open a new window in your browser.
6. Once you logout and close the *first*CONNECT window, or click on the Enterprise Edition window, you will return to the Enterprise Edition product.

Reset Password

If you forget your password, you can request to have the password reset.

To request a password reset:

1. From the login page at <https://www.payerlink.com/PL/PTLogin.aspx?type=logout>, click the **Forgot Password?** link.



The screenshot shows the 'Reset Password' form. At the top is the firstCONNECT logo. Below it is a white box with a blue header 'Reset Password'. Inside the box, there is an 'Email' label followed by a text input field. A green 'Submit' button is located at the bottom right of the box.

2. Enter your **Email** address.
3. Click **Submit**.
4. A screen will appear requesting you to **Answer Security Question**.



The screenshot shows the 'Answer Security Question' form. At the top is the firstCONNECT logo. Below it is a white box with a blue header 'Answer Security Question'. Inside the box, there is a 'Security Question' label followed by a dropdown menu showing 'What was your childhood nickname?'. Below that is a 'Security Answer' label followed by a text input field. A green 'Reset' button is located at the bottom right of the box.

5. Select the **Security Question** from the drop-down menu.
6. Enter your **Security Answer**.
7. Click **Reset**.

You will receive an email similar to the message below notifying you that your password has been reset. You will need to change the password after you login.

From: <noreply@payerlink.com>
Date: Mon, Mar 26, 2012 at 4:53 PM
Subject: PayerLink: Forgot Password Notification
To: dloftus73@gmail.com

Jane Doe,
Your password has been updated.
The temporary password is :

Wtsifd2QQJ

You will be asked to update this password once you log in


Menu Bar Options

Chapter 3

The Menu bar exists at the top of every screen in *firstCONNECT* and appears as follows:

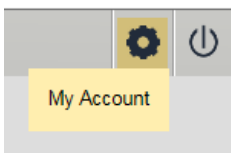


Home

The Home button () displays in the Menu Bar at the top-left of the screen throughout *firstCONNECT*. To return to the Home screen from any location in *firstCONNECT*, click the Home button. You will return to the Homepage, which contains options for the three functions of *firstCONNECT* (unless All Payer Eligibility has also been activated for the user account).



Settings

Account options are accessed by clicking  then selecting **My Account**.



Security

After logging in with the default password for the first time the password and security question will need to be changed:

1. On the main *firstCONNECT* screen, click  at the top-right of the screen then select **My Account**.
2. A new window will display and will default to **Security** (See image to the right).
3. Enter the **Old Password**.
4. Enter a **New Password** (The password must be 6 characters minimum and must contain 1 letter, 1 number, and is case-sensitive).
5. Enter the New Password again in the **Confirm** field.
6. Select a new **Security Question**.
7. Enter a new **Security Answer**.
8. Click **Update**. A window will appear notifying you that the information has been updated.
9. Click the  to the top-right to return to the Homepage.

Security Settings

Old Password

New Password

Confirm

Security Question

Security Answer

Settings

The **My Account** option in *Settings* includes default settings that can be changed per user preference for file transfers.

Set Default File Transfer Page



The selected setting determines which screen will open when you access File Transfer from the Home page in *firstCONNECT*. Two options are available:

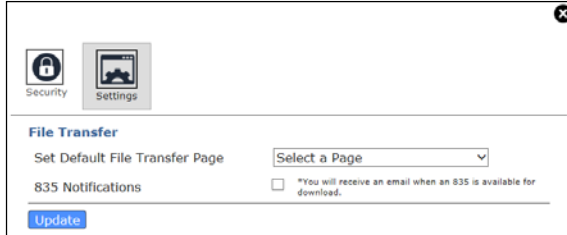
- **File Manager Page** – When selected, **File Transfer** will open to the **File Manager** page giving you quick access to download new 835 files.
- **Claim File Reconciliation Page** – When selected, **File Transfer** will open to the **Claim File Reconciliation** page displaying information for all claims that have been filed.



NOTE: Be aware that these setting change will not take effect until the user logs out then back in.

firstCONNECT is automatically set by default for **File Transfer** to open to the **File Manager** page. However, the first time that you access the **Claim File Reconciliation** page, a dialog will appear asking if you wish to make the **Claim File Reconciliation** page your default view. If you click “Yes” in the dialog, the **Claim File Reconciliation** page will be the default view when accessing **File Manager** going forward.

To change the default setting for your user login:

1. On the main *firstCONNECT* screen, click  at the top-right of the screen then select **My Account**.
2. Click the **Settings** Icon ().
3. The **Settings** window will display.





4. Click the arrow to the right of **Set Default File Transfer Page**.
5. Select the desired option, **File Manager Page** or **Claim File Reconciliation Page**.
6. Click . A window will appear, notifying you that the information has been updated.
7. Click the  to the top-right to return to the Homepage.

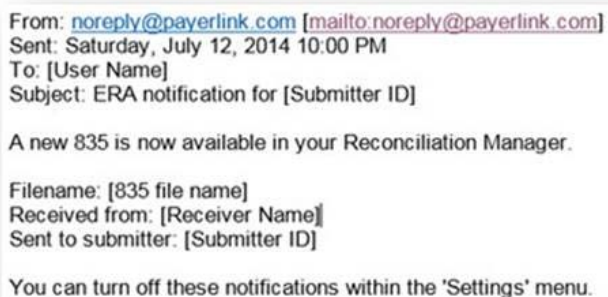
835 Notifications

When selected, a check will display in the box to the right and will trigger an email to be sent when a new 835 file is available for download. *firstCONNECT* is automatically set to default this option to NOT be selected.

To change the default setting for your user login:

1. On the main *firstCONNECT* screen, click  at the top-right of the screen then select **My Account**.
2. Click the box to the right of **835 Notifications** to select or deselect the option.
3. Click . A window will appear notifying you that the information has been updated.
4. Click Back to Home.

When an 835 file is available for download, you will receive an email similar to the following:



From: noreply@payerlink.com [mailto:noreply@payerlink.com]
Sent: Saturday, July 12, 2014 10:00 PM
To: [User Name]
Subject: ERA notification for [Submitter ID]

A new 835 is now available in your Reconciliation Manager.


Filename: [835 file name]
Received from: [Receiver Name]
Sent to submitter: [Submitter ID]

You can turn off these notifications within the 'Settings' menu.

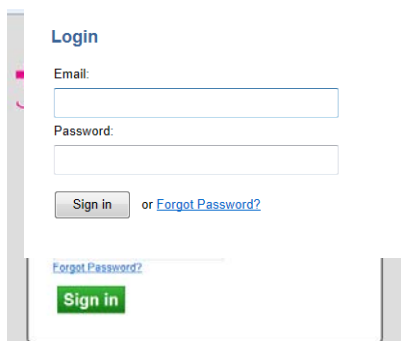
Logout

Logging Out from *first*CONNECT

To log out from *first*CONNECT:

1. Click  at the top-right of the screen.

After you logout, the following window will appear to notify you that were successfully logged out.



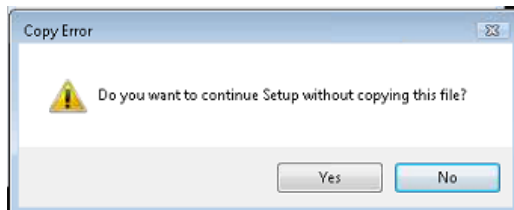
The screenshot shows the login interface for firstCONNECT. It features a 'Login' header, an 'Email' input field, a 'Password' input field, and a 'Sign in' button. A link for 'Forgot Password?' is also present. Below the main form, there is a separate section with a 'Forgot Password?' link and a green 'Sign in' button.

Logging Out from CMS

To log out from the CMS system:

1. Click **File** then select **Exit**.

In order to install the DDE software on your computer, you must either be an administrator for the computer or have an administrator log-in and install the software for you. If you do not have administrative rights to install software, you will receive the following error message:

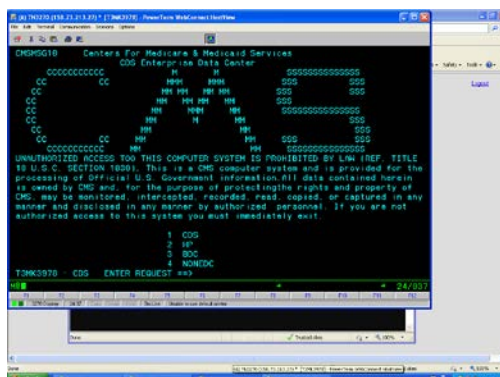


To access and install DDE:

1. On the main *firstCONNECT* screen click **DDE**.
2. A pop-up security warning about installing software will appear. Click **Install** to continue access to DDE. This message will only appear one time on the PC.



3. Wait as components are downloaded and installed. (This could take several minutes depending on the Internet connection speed.)
4. Access to the CMS DDE system should now be available.
5. Select 1 for PGBA or 2 for all other Medicare Administrative Contractors.



The DDE system will only allow one user to be logged in at a time. If you attempt to login when another user is already logged in you will receive an error message.



If Windows Firewall is enabled, the Ericom terminal program for access will need to be enabled – if notified by Windows. Click the **Windows Security Alert** button in the taskbar, at the bottom of the screen, and click **Unblock** in the window. This will remove any Windows Firewall notifications from popping up in the future.



DDE Screen Captures

DDE allows for the ability to capture screen shots which are stored in a single file and can be printed or saved to your computer. Screen captures are available until the DDE session ends, make sure to save screen captures before ending your session.

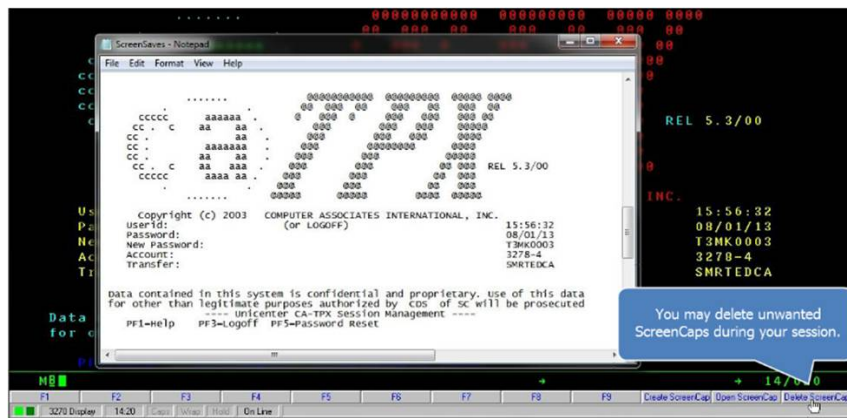
To create a screen capture, click **Create ScreenCap** near the bottom-right of the screen, as shown below. Screen captures will all be stored in a file.



To view, Print, or Save the screen capture from the stored file click **Open ScreenCap**, as shown below.



To delete the screen capture during the session, click **Delete ScreenCap**, as shown below.



File Transfer

Chapter 5

File Transfer is a component included in *firstCONNECT* and can take the place of the additional cost of using another vendor to upload billing claims to the Medicare Administrative Contractor (MAC).

As soon as claims are processed they are automatically sent to a File Transfer Queue. Files are transferred to and picked up from MACs in *firstCONNECT* every thirty minutes. After claims are sent to the File Transfer Queue, they will be transferred to the MAC on the next scheduled transfer. Likewise, inbound files (response files) will be received on the next scheduled system refresh. See below for a sample schedule outlining the timing of file transfers for various intermediaries. Files will be transferred or refreshed every thirty minutes based on this schedule.

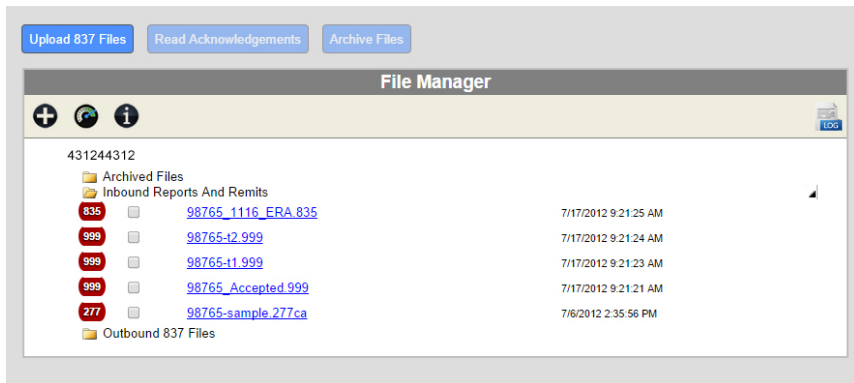
Transfer Schedule	PGBA/CGS	NGS/NHIC
06:00:00 (on the hour), 06:30:00, (on the half hour)	Send files	
06:10:00 (ten minutes after the hour), 06:40:00 (forty minutes after the hour)	Receive response files	
06:15:00 (15 minutes after the hour), 06:45:00 (45 minutes after the hour)		Send files
06:30:00 (thirty minutes after the hour), 07:00:00 (on the hour)		Receive response files


File Manager

The File Manager gives you access to manage all files including the ability to:

- Upload 837 Files
- Read Acknowledgements
- Archive Files
- Add Submitter
- Access Reconciliation Manager
- Access messages from Receivers

When the File Transfer default is set to File Manager Page (see page 11 for further details on File Transfer default) and the File Transfer button is clicked on the Home page, the File Manager screen will display.



If the File Transfer default is set to Claim File Reconciliation Page (see page 11 for further details on File Transfer default) you will need to click  at the top left of the screen to access the **File Manager** screen.

Upload 837 Files

Enterprise Edition Auto-Upload Users

As an Enterprise Edition client, all RAP/EOE claims that are generated after File Transfer has been activated will be automatically uploaded after claims are processed in the grid within Enterprise Edition. You will no longer need to save 837 files to your desktop if you were using another transfer vendor prior to *firstCONNECT*.

Manual Upload Users

For agencies not exclusively utilizing Enterprise Edition to generate claims, it is necessary to manually upload files from your prior software program until all admissions/patients are in Enterprise Edition. After claims are processed, 837 files will need to be uploaded to *firstCONNECT*.

To upload 837 files:

1. On the main *first*CONNECT screen, click the **File Transfer** button.
2. On the File Transfer screen, click **Upload 837 Files**.
3. A window will appear containing filters to browse for the applicable files.

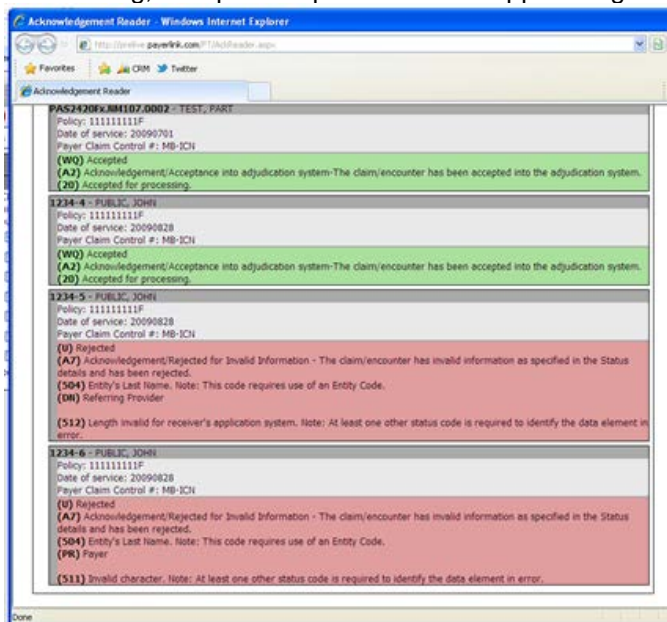


4. Select the applicable **Submitter ID** and **Claim Type**.
5. Click **Browse**.
6. Select the applicable file.
7. Click **Upload File**.

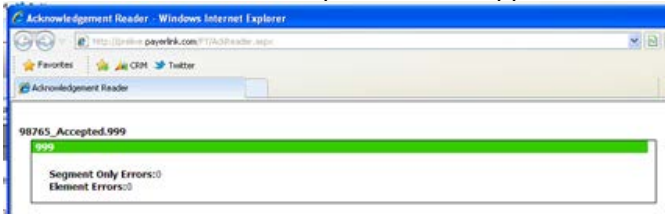
Read Acknowledgements

You will have the ability to retrieve and view the response files from *first*CONNECT. To view files:

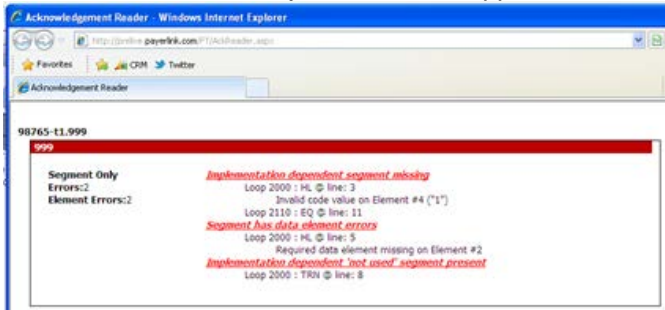
1. Expand the inbound folder to see a list of all response files.
2. Check the box next to each file that needs to be viewed. Only 277 and 999 files will automatically be available for viewing, 835 files must first be downloaded (See steps above for downloading 835 files).
3. Click **Read Acknowledgements** to view the response files.
4. The 277 Claim Status file will appear for review as seen below. Rejected claims will appear in red shading, accepted response files will appear in green shading.



- The 999 Claim Status accepted files will appear as shown below.




The 999 Claim Status rejected files will appear as shown below.

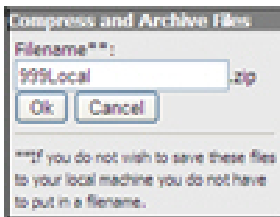


If you double click the inbound file itself from the File Manager screen without clicking the **Read Acknowledgements** button, the response file will open, however the format will not be readable. In order to read the response file you must click the **Read Acknowledgements** button.

Archive Files

Response files are never deleted from *firstCONNECT*. They will remain as visible current files in the inbound folder for 10 days following the receipt of the response file. After 10 days the response files will automatically be archived and will be available for viewing in the archived files. To access archived files from the Transaction Log:




- Click  to the right of Transaction Log.
- A calendar will appear. Select the log date to view.
- A list of transactions will appear.
- Additionally, response files can manually be archived by the user at any time during the 10 day period. To manually archive response files:
- Check the box to the left of the file to archive.
- Click Archive Files.
- A window will appear. If you do not want to compress the file, leave the filename blank. Click **OK**. If you want to compress the file enter a filename and click **OK**.




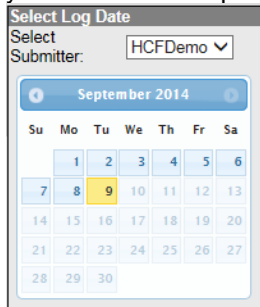
Archived response files will be available for viewing for all files that have been received through *first*CONNECT after a service is implemented.

File Manager Menu Buttons

Three buttons will display on the top-left of the screen:

-  – Add Submitter. When clicked a dialog will display in which you can enter new Submitter information to request activation for.
-  – Check on the status of your claim files. When clicked the **Claim File Reconciliation** page will display.
-  – Medicare System Messages. When clicked a window will display with any messages from Receivers.

At the top-right of the screen, an icon () will display. When clicked, a calendar will appear, allowing you to select the specific **Submitter** and **Log Date** to display data for.





Reconciliation Manager



The Reconciliation Manager will display information for claims that have been submitted, allowing you to quickly see the status of submitted claims.

When the File Transfer default is set to Claim File Reconciliation Page (see page 11 for further details on File Transfer default) and the File Transfer button is clicked on the Home page, the Claim File Reconciliation screen will display.

Claim File Reconciliation									
Receiver	837 Sent	Claims	Billed	999	277	Accepted	Rejected		
Payment recieved for 431244312 on date 7/15/2014 3:28:43 PM									
Payment recieved for 431244312 on date 7/15/2014 3:28:43 PM									
WPS	6/23/2014 1:08:59 PM	10	\$500.00	6/26/2014 4:32:19 PM	6/26/2014 4:31:54 PM	65	18	999	277
WPS	6/23/2014 1:08:59 PM	10	\$500.00	6/26/2014 4:40:35 PM				999	
WPS	6/23/2014 1:08:59 PM	10	\$500.00						
Payment recieved for 431244312 on date 6/23/2014 1:08:59 PM									
Payment recieved for 98765 on date 6/23/2014 1:08:59 PM									
Highmark	6/22/2014 12:06:45 PM								
Payment recieved for 431244312 on date 6/21/2014 1:05:59 PM									
Previous 1 Next									
								Late	Rejected

If the **File Transfer** default is set to **File Manager Page** (see page 11 for further details on File Transfer default), you will need to click  at the top-left of the screen to access the **Claim File Reconciliation** screen.

A file folder will display in the top-left corner of the screen. When  is clicked, you will return to the **File Manager** page.

The top-right corner of the screen will contain the option to **Show** or **Hide** details for each batch of files that was transferred. Additionally, the option to show or hide each individual batch of files is available by clicking  or  to expand or hide, respectively.

The **Claim File Reconciliation** screen will contain information regarding each batch of files that have been transferred.

Hidden batch files will display information regarding if the payment was received including the batch number, and date and time the payment was received.

Expanded batch files will contain the following:

- Receiver name
- Date and time the 837 file was transferred
- Number of claims included in the file that was transferred
- The amount that was billed
- The date and time the 999 file was transferred
- The date and time the 277 file was transferred
- Number of claims accepted
- Number of claims rejected
- Links to view the files

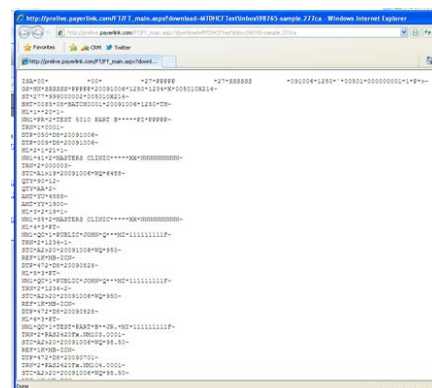
Files that were late will display with yellow shading in the applicable box. Files that were rejected will display with red shading in the applicable box.

Downloading Response Files

Response files are automatically stored and auto-archived in *firstCONNECT*. 999 and 277CA files will not need to be downloaded unless you want to store a copy of the files on your hard drive. ERN/835 files will not be able to be viewed in *firstCONNECT*. In **Settings**, you can select the option to receive an e-mail notification when 835 files are ready for download (See page 11 for further details). If you use Enterprise Edition and have ERA activated, you can import the file into Enterprise Edition. Follow the steps below to download files and then follow the normal steps to import the ERN/835 files into Enterprise Edition.

To download 835 files (or 999 and 277CA files if you wish to store them on your hard drive):

1. Expand the inbound folder to see a list of all response files.
2. Click the blue hyperlink for the file to be downloaded.
3. A File Download window will appear. Click **Open** or **Save**.
4. If you click **Open**, downloaded files will appear as shown in the image to the right.



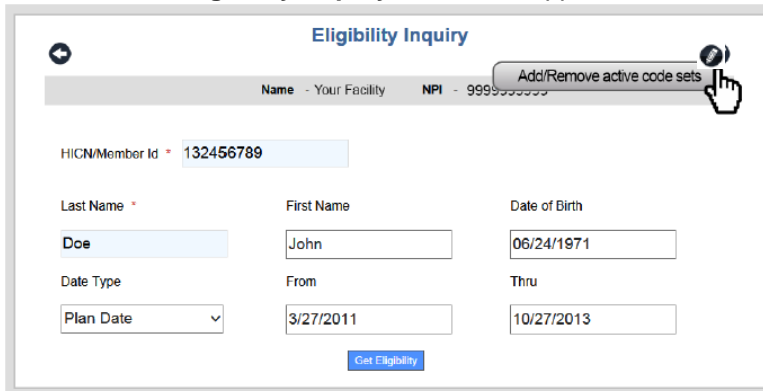
Medicare Eligibility

Chapter 6

firstCONNECT generates a 270 eligibility transaction request based off of the patient information entered in the Eligibility Inquiry screen. *firstCONNECT* then accesses CMS' HIPPA Eligibility Transaction System (HETS) which is available 24 hours a day, 7 days a week. CMS sends back a 271 Eligibility response file that *firstCONNECT* translates into an Eligibility report.

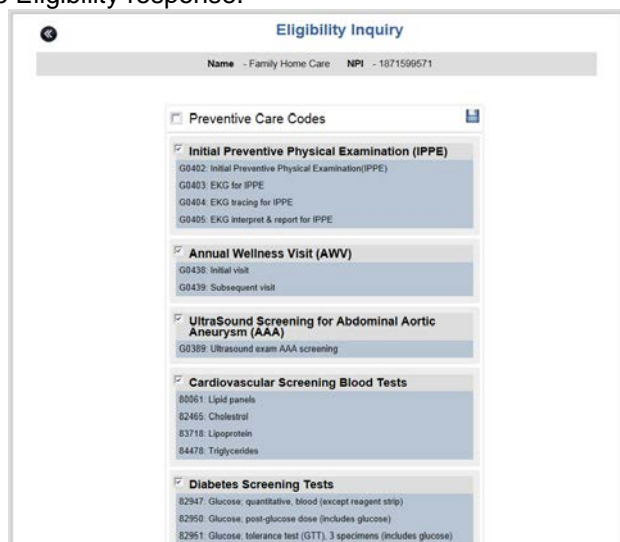
To access Eligibility:

1. On the main *firstCONNECT* screen, click the **Medicare Eligibility** module icon.
2. The **Medicare Eligibility Inquiry** screen will appear as shown below.




3. Type the **HICN/Member Id** (required field).
4. Type the **Last Name**, **First Name**, and **Date of Birth** (two of these three fields are required).
5. The **Date Type**, **From**, **Thru**, **Code 1**, **Code 2**, and **Code 3** fields are automatically set so that the maximum values/data are retrieved in the Eligibility response.
6. Click **Get Eligibility**.
7. The Eligibility response will appear in a new browser tab.

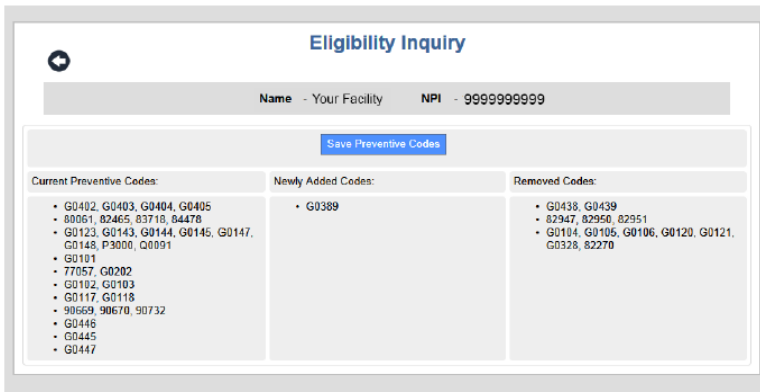
The *firstCONNECT* Eligibility module will give the user control over which Preventive Care code filters are used when requesting benefit information for selected services. These code sets can be accessed from the **Eligibility Inquiry** page by clicking on the pencil icon (🖋️) at the top right of the screen. The following screen will appear.



All Eligibility Inquiries will be set with default Preventive Care codes available in the 270 and 271 files. Only codes being used in the inquiry will appear in the file. Preventive Care codes can be customized as well, changing the default codes for the selected customer.

To edit Preventive Care codes:

1. Click  at the top-right of the Eligibility Inquiry screen.
2. To add codes to the inquiry, simply check the box next to the heading of the section of applicable codes to be added. To remove codes from the inquiry, simply uncheck the box next to the heading of the section of applicable codes to be removed.
3. After adjustments are completed, click **Save Preventive Codes** to continue.
4. Codes selected and saved will now be the default codes for the selected customer for all future Eligibility requests.
5. A screen will appear allowing the user to review the changes made on the previous screen, as shown below.



The screenshot shows the 'Eligibility Inquiry' screen with a header bar containing 'Name - Your Facility' and 'NPI - 9999999999'. Below the header is a 'Save Preventive Codes' button. The main content area is divided into three columns: 'Current Preventive Codes', 'Newly Added Codes', and 'Removed Codes'. Each column contains a list of codes with checkboxes next to them.


Current Preventive Codes:	Newly Added Codes:	Removed Codes:
<ul style="list-style-type: none"> G0402, G0403, G0404, G0405 80061, B2465, B3719, B4478 G0123, G0143, G0144, G0145, G0147, G0148, P3000, Q0091 G0101 77057, G0202 G0102, G0103 G0117, G0118 90669, 90670, 90732 G0446 G0445 G0447 	<ul style="list-style-type: none"> G0389 	<ul style="list-style-type: none"> G0438, G0439 82947, 82950, 82951 G0104, G0105, G0106, G0120, G0121, G0328, 82270

6. After reviewing the updated information, click **Save Preventive Codes**.
7. You will be returned to the Eligibility home page.

Viewing Previous Eligibility Reports

All Eligibility responses that have previously been pulled can be viewed.


To view previous Medicare Eligibility responses:


1. On the Eligibility Inquiry screen, click .
2. The Eligibility Manager screen will appear with a list of previous responses.

Eligibility Manager



Search by Member ID Select by Status: CMS Report Success

Name	Date of Birth	Member ID	Timestamp		
Baker	8/12/1935	156973596D	7/9/2013 9:56:34 AM		
Callaway	4/18/1940	639875698A	7/9/2013 9:56:16 AM		
Johns	4/25/1950	369785423D	6/6/2013 3:37:16 PM		
Lake	11/30/1932	968765238A	5/8/2013 1:13:58 PM		
Little	11/30/1943	369857215B	5/5/2013 2:22:13 PM		


3. Click  on the row of the response file that you wish to view.

4. If the Previous Responses list is long, you can click the **Select by Status** drop-down menu to filter the list to display only the status types that you wish to view (See below for further information on Status Types).
5. To go back to the Eligibility Inquiry screen, click .

Retrigger Report Request

All Eligibility Requests can be triggered from a previous request to generate a new Eligibility Report without re-entering all of the patient information.

To re-generate an Eligibility Report:

1. On the Eligibility Manager screen, click  on the row of the response file that you wish to re-generate.
2. The re-generated report will appear on a new browser tab on your screen. The report can be saved or printed from the screen that appears.

Status Types

Eligibility includes five response status types. These status types explain the type of response that was received in the report and allows you to filter previous responses by status.


The five status types include:

- **CMS Report Success** — Your Eligibility request was processed and successfully converted to a report.
- **Eligibility Entry Error** — One of the pieces of data you entered about the patient does not match what CMS has in the Common Working File.
- **Failed CMS Report** — Your Eligibility request was received, but there was an error converting it to a readable report.
- **Failed CMS Response** — Your Eligibility request was received from CMS, but there was an error retrieving the 271 response and no report was generated.
- **Eligibility Transaction Error** — No Eligibility 271 response was received due to an error from CMS.


Saving and Printing Reports

After you click **Get Eligibility** and the response appears on the screen, you will have the ability to save or print the response.

To save the report:

1. After the response report appears, two icons will appear to the top-right of the screen.
2. Click .
3. Various windows will pop up, depending on the browser. You may need to click **Save** and/or **Open** for the response to appear in a new tab.
4. The response will appear in a new browser tab.

To print the report:

1. After the response appears, two icons will appear to the top-right of the screen.
2. Click .
3. A print window will appear. Click **Print**.

Viewing Eligibility Responses

Eligibility responses that do not contain errors will contain several categories of information if they are entered, including the following:

Agency/User

The Agency/User section appears as follows:

Agency/User			
Agency:	ABC Home HEALTHCAREfirst	Provider:	111111
firstCONNECT User:	Jane Doe	Date/Time Requested:	5/31/2012 1:55 PM

Subscriber

The Subscriber section appears as follows:

Subscriber			
Name:	Johns, Elizabeth	Date of Birth:	7/29/1921
Gender:	F	HICN/Member Id:	496093871A

Eligibility

The Eligibility section appears as follows:

Eligibility			
Part A Effective Date:	7/1/1986	Part A Termination Date:	
Part B Effective Date:	7/1/1986	Part B Termination Date:	
Inactive Period Effective Date:		Inactive Period Effective Date:	
Beneficiary Address Line 1:	1234 West Ozark Avenue	ESRD Benefit Desc. Svc Type Code:	
Beneficiary Address Line 2:		ESRD Transplant DC Date:	
Beneficiary City:	Ozark	ESRD Effective Date:	
Beneficiary State:	MO		

Report Item	Description
Part A Effective Date	A date that indicates the start of eligibility for Medicare Part A benefits.
Part A Termination Date	A date that indicates the termination of eligibility for Medicare Part A Benefits. No date in this field means Medicare Part A eligibility has not terminated.
Part B Effective Date	A date that indicates the start of eligibility for Medicare Part B benefits.
Part B Termination Date	A date that indicates the termination of eligibility for Medicare Part B benefits. No date in this field means Medicare Part B eligibility has not terminated.
Inactive Period Effective Date	A date that indicates the start of an inactive period due to unlawful, deported, or incarcerated reasons.
Inactive Period Termination Date	A date that indicates the end of an inactive period due to unlawful, deported, or incarcerated reasons.
Beneficiary Address Line 1, Line 2	The address line of the subscriber (beneficiary), if available.

Beneficiary City	The city of the subscriber (beneficiary), if available.
Beneficiary State	The state of the subscriber (beneficiary), if available.
Beneficiary Zip	The zip code of the subscriber (beneficiary), if available.
ESRD Effective Date	The date that indicates the start of eligibility for ESRD services.
ESRD Benefit Desc. Svc Type Code	The Type of Dialysis (14 or 15) services that are being rendered.
ESRD Transplant DC Date	The Date the Transplant services were discharged.

Deductible

The Deductible section appears as follows:

Deductible			
Part B Deductible Year:	1/1/2012 – 12/31/2012	Part B Remaining Deductible Amount:	\$0
Blood Calendar year:	1/1/2012 – 12/31/2012	Blood Number of Units Remaining:	3
OT Cap Calendar year:	1/1/2012 – 12/31/2012	OT Cap Remaining Amount:	\$1880
PT & ST Cap Calendar year:	1/1/2012 – 12/31/2012	PT & ST Cap Remaining Amount:	\$1880
Pulmonary Rehab. Sessions Remaining (T):	72	Pulmonary Rehab. Sessions Remaining (P):	72
Cardiac Rehab. Sessions Remaining (T):	0	Cardiac Rehab. Sessions Remaining (P):	0
Int. Cardiac Rehab. Sessions Remaining (T):	0	Int. Cardiac Rehab. Sessions Remaining (P):	0

Report Item	Description
Part B Deductible Year	The calendar year associated with the remaining deductible amount.
Part B Remaining Deductible Amount	Medicare Part B remaining deductible amount associated with the calendar year indicated.
Blood Calendar Year	The calendar year associated with the remaining deductible amount.
Blood Number of Units Remaining	The Blood Deductible units remaining associated with the calendar year indicated.
OT Cap Calendar Year	The calendar year associated with the remaining capitation amount.
OT Cap Remaining Amount	Occupational Therapy remaining amount associated with the calendar year indicated.
PT & ST Cap Calendar Year	The calendar year associated with the remaining capitation amount.
PT & ST Cap Remaining Amount	Physical and Speech Therapy remaining amount associated with the calendar year indicated.
Pulmonary Rehab. Sessions Remaining (T)	The number of Pulmonary Rehabilitation sessions remaining for the Technical Component.
Pulmonary Rehab. Sessions Remaining (P)	The number of Pulmonary Rehabilitation sessions remaining for the Professional Component.
Cardiac Rehab. Sessions Remaining (T)	The number of Cardiac Rehabilitation sessions remaining for the Technical Component.

Cardiac Rehab. Session Remaining (P)	The number of Cardiac Rehabilitation sessions remaining for the Professional Component.
Int. Cardiac Rehab. Sessions Remaining (T)	The number of Intensive Cardiac Rehabilitation sessions remaining for the Technical Component.
Int. Cardiac Rehab. Sessions Remaining (P)	The number of Intensive Cardiac Rehabilitation sessions remaining for the Professional Component.

Part A Hospital/SNF

The Part A section contains all information for Medicare Part A plans and appears as follows:

Part A Hospital/SNF									
Plans:	Hospital				SNF				
	Full Days	\$per	Coin Days	\$per	Full Days	\$per	Coin Days	\$per	
2014	60	\$0.00	30	\$304.00	2014	20	\$0.00	80	\$152.00
2013	60	\$0.00	30	\$296.00	2013	20	\$0.00	80	\$148.00
2012	60	\$0.00	30	\$289.00	2012	20	\$0.00	80	\$144.50

Spells:	DOEBA	DOLBA	Full Rem.	Coin Rem.	Amount	DOEBA	DOLBA	Full Rem.	Coin Rem.	Amount
5/17/2013	5/18/2013	59 of 60	30 of 30	\$0.00	5/17/2013	5/18/2013	20 of 20	80 of 80	\$0.00	

Report Item	Description
Hospital Full Days	Number of full days spent in the hospital YTD under a Medicare Part A plan.
Hospital \$per	Dollar amount spent per full day spent in the hospital YTD under a Medicare Part A plan.
Hospital Coin Days	Number of Hospital days assessed coinsurance per benefit period under a Medicare Part A plan.
Hospital \$per	Dollar amount applied to Hospital coinsurance per benefit period under a Medicare Part A plan.
SNF Full Days	Number of full days spent in a skilled nursing facility under a Medicare Part A plan.
SNF \$per	Dollar amount spent per full day spent in a skilled nursing facility under a Medicare Part A plan.
SNF Coin Days	Number of SNF days assessed coinsurance per benefit period under a Medicare Part A plan.
SNF \$per	Dollar amount applied to SNF coinsurance per benefit period under a Medicare Part A plan.
DOEBA	The date of the earliest billing activity for the spell of illness.
DOLBA	The date of the latest billing activity for the spell of illness.
Full Rem.	Number of full days reimbursement was received for.
Coin Rem.	Number of days assessed coinsurance.
Amount	Full dollar amount of reimbursement.

Preventative

The Preventative section contains all preventative care and appears as follows:

Preventative		
Smoking Cessation Sessions Remaining: 8	Smoking Cessation Next Session Date:	
Prev. HCPCS Code G0439-Annual Wellness Visit (AWV) G0438-Annual Wellness Visit (AWV)	Prev. Next Professional Date 1/1/2011 1/1/2011	Prev. Next Technical Date 1/1/2011 1/1/2011

Report Item	Description
Smoking Cessation Sessions Remaining	Number of Smoking/Tobacco Cessation Counseling Sessions remaining for a subscriber.
Smoking Cessation Next Session Date	The next available begin date for Smoking/Tobacco Cessation Counseling Session program if there are no sessions in their current period.
Prev. HCPCS Code	A Healthcare Common Procedure Coding System (HCPCS) code.
Prev. Next Professional Date	The date a subscriber is next eligible for professional services associated with the indicated HCPCS code.
Prev. Next Technical Date	The date a subscriber is next eligible for technical services associated with the indicated HCPCS code.

Plan Coverage

The Plan Coverage section appears as follows:

Plan Coverage			
Enrollment Date :	1/1/2012	Term Date:	
Type:	Preferred Provider Organization (PPO)	Option:	MCO Bill Option Code C
Name	Humana Insurance Company	ID:	H0939 879
Address Line 1	1100 Insurance Blvd.	Telephone:	2120C, N402, (Hower 148)
Address Line 2:		Zip:	697586384
City:	St. Louis	Website	www.humana-medicare.com
State:	MO		

Report Item	Description
Enrollment Date	The date that indicates the start of enrollment to the coverage plan.
Type	A full plan description followed by Plan Type Code: HM — Health Maintenance Organization Medicare Non Risk HN — Health Maintenance Organization Medicare Risk IN — Indemnity PR — Preferred Provider Organization PS — Point of Service Part D — Pharmacy
Name	A descriptive name of the beneficiary's insurance coverage organization.

Address Line 1, 2	The Coverage Plan's Address lines.
City	The Coverage Plan's City Address.
State	The Coverage Plan's State Address.
Term Date	The date that indicates the termination of enrollment to the coverage. No date in this field means the plan enrollment has not terminated.
Option	The bill option code of the Plan Type. This field only applies to plan types HM, HN, IN, PPO, and PS. This field will not be displayed for Part D plan type.
ID	The contract number followed by the plan number (if on file).
Telephone	The Coverage Plan's Contract Telephone Number (if on file) displayed as XXX-XXX-XXXX.
Zip	The Coverage Plan's Zip Code.
Website	Contract Plan's website address that will provide information on the subscriber's insurance.

Medicare Secondary Payer

The Medicare Secondary Payer section will contain Secondary Payer information if there is any entered and appears as follows:

Medicare Secondary Payer	
Effective Date:	Address Line 1:
Termination Date:	Address Line 2:
Insurer Name:	City:
Policy Number:	State:
Type of Primary Insur:	Zip:
Report Item	Description
Effective Date	The date that indicates the start of the primary insurer's coverage.
Termination Date	The date that indicates the termination of the primary insurer's coverage. No date in this field means primary insurance coverage has not terminated.
Insurer Name	The name of the insurance company.
Policy Number	The primary insuring organization's policy number for the Medicare beneficiary.
Type of Primary Insurance	The type code and description of the Primary Insurance Plan: 12 — Medicare Secondary Working Aged Beneficiary or spouse with Employer group health plan 13 — Medicare Secondary End Stage Renal Disease Beneficiary in the 12 month coordination period with and Employer group health plan 14 — Medicare Secondary No-Fault insurance including auto is primary 15 — Medicare Secondary Workers Compensation

	16 — Medicare Secondary Public Health Service or other Federal Agency 41 — Medicare Secondary Black Lung 42 — Medicare Secondary Veteran's Administration 43 — Medicare Secondary Disabled Beneficiary under age 65 with Large Group Health Plan 47 — Medicare Secondary other liability insurance is primary WC — Workers Compensation Medicare Set aside arrangement.
Address Lines 1, 2	The address Line of the insurance company.
City	The city of the insurance company.
State	The state of the insurance company.
Zip	The Zip Code of the insurance company.

Home Health Certification

The Home Health Certification section appears as follows:

Home Health Certification			
Certification:	G0180	Certification Date:	1/4/2011
Re-Certification:	G0179	Re-Certification Date:	2/28/2012

Report Item	Description
Certification	The HCPCS code used when the subscriber became certified for home health care services.
Certification Date	The date the subscriber was certified to receive home health care services.
Re-Certification	The HCPCS code used when the Beneficiary became recertified for home health care services.
Re-Certification Date	The date the beneficiary was recertified to receive home health care services.

Home Health

The Home Health section appears as follows:

Home Health								
Start Date	End Date	DOEBA	DOLBA	Provider #	Provider Name	NPI #	Contractor #	Contractor Name
2/28/2012	4/27/2012	9/22/2014	10/23/2014	123401922	Other	383291928	44697	PGBA
12/30/2011	2/27/2012	12/31/2011	2/27/2012	291028192	Other	302392932	44697	PGBA

Report Item	Description
Start Date	The date the 60-day Home Health episode period started.
End Date	The date that the Home Health episode terminated.
DOEBA Date	The date of earliest billing activity for spell of illness.

DOLBA Date	The date of latest billing activity for spell of illness.
Provider #	Provider name and number, will show only the NPI if the Provider name is not available.
Contractor #	A display of the Contractor number.
Contractor Name	A display of the Contractor name.



If DOEBA and DOLBA dates are not available in the 271 Eligibility file retrieved, they will not be listed on the report. It is possible to have PPS period information with no DOEBA and DOLBA information.

Hospice

The Hospice section appears as follows:

Hospice				
Period	F2F	Start Date	Term Date	Revocation Code
3	Reqd	1/13/2015	3/13/2015	0 Not revoked, open spell
2		12/5/2013	2/17/2014	1 Revoked by notice of revocation

Hospice benefit periods since being covered by Medicare: 3

Report Item	Description
Period	The number of the Benefit Period.
F2F	Red will display if a Face to Face is required for the benefit period.
Start Date	The start date of a subscriber's elected period of Hospice coverage.
Term Date	The termination date of a beneficiary's elected Hospice coverage. No date in this field means the beneficiary's elected period of Hospice coverage has not terminated.
Provider #	Provider name and number, will show only the NPI if the Provider name is not available.
Revocation Code	Code indicating whether hospice coverage was terminated or not. "0" indicates continuing hospice coverage. "1", "2", or "3" indicates the hospice coverage was terminated (revoked). An explanation will display with the code.
Benefit Periods	The bottom of the report section displays data based on the total number of hospice periods the patient has had since being covered by Medicare.

Pharmacy (Part D)

The Pharmacy (Part D) section appears as follows and will only appear if the patient has a Pharmacy Part D plan:

Pharmacy (Part D)	
Enrollment Date: 8/1/2013	Disenrollment Date: 12/31/2013
Contract Number: H4590	Plan Number: 012
Plan Name: AETNA HEALTH, INC. (TX)	Plan Website: www.aetnamedicare.com
Plan Address: 2777 Stemmons Freeway Suite 300 Dallas, TX 753569440	Plan Phone: 8004451796



Any Hospice Benefit Periods that are older than twelve months, prior to the date that the report is run in *firstCONNECT*, will not be detailed in this section. Instead, they will simply be totaled with other Benefit Periods that fall into this date range and this amount will be listed (as seen in screenshot on previous page). This is because the Medicare HETS system (HIPAA Eligibility Transaction System) only returns detailed information for Benefit Periods that fall within the previous twelve months.

Report Item	Description
Enrollment Date	The date that indicates the start of enrollment to the coverage plan.
Disenrollment Date	The date that indicates the end of enrollment to the coverage plan.
Contract Number	The insurance company's Part D contract number.
Plan Number	The number of the beneficiary's Part D insurance plan.
Plan Name	A descriptive name of the beneficiary's insurance coverage organization.
Plan Website	The coverage plan's website address.
Plan Address	The coverage plan's mailing address.
Plan Phone	The coverage plan's telephone number.

No Data Available

If no data is available for a section, the section will appear as follows:

Medicare Secondary Payer
<i>No Medicare Secondary Payer data available</i>

All Payer Eligibility

Chapter 7

Similar to the *Medicare Eligibility* feature, *firstCONNECT* generates a 270 Eligibility Transaction Request based off of the patient information that is entered in the All Payer Eligibility screen. The *firstCONNECT* software then accesses a Payers Real-Time system through Emdeon, which is available 24 hours a day, 7 days a week. Emdeon then responds with a 271 Eligibility Response file that *firstCONNECT* then translates into an All Payer Eligibility Report.



For the **All Payer Eligibility** feature to become accessible from the *firstCONNECT* home screen, your agency must contact HEALTHCARE*first* to have the applicable permissions established.

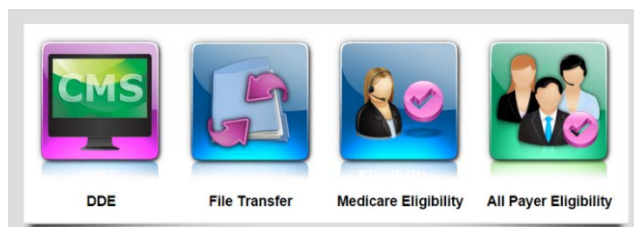
Running the Eligibility Report

To run an All Eligibility Report:

1. On the main *firstCONNECT* screen, click the **All Payer Eligibility** icon (See image to the right).
2. The All Payer Eligibility Inquiry screen will appear, prompting you to select the **Payer** (See image below and to the right). If you do not see a Payer in this list, please refer to the *Eligibility Payer List* section on page 37.
3. Type the HICN Number into the **Member Id** field (required).
4. Enter the applicable information into the fields, such as **Last Name**, **First Name**, and **Date of Birth**. Fields in yellow are required; each Payer is unique to what is required (See sample image below).

Member Id

Last Name



All Payer Eligibility
Eligibility for Medicaid and Commercial Payers

Select a Payer

- AARE
- Aetna
- Anthem Blue Cross California
- Arkansas Medicaid
- Blue Cross Blue Shield of Connecticut
- Blue Cross Blue Shield of New York (Empire)
- Blue Shield of California
- Blue Shield of Kentucky
- California Medicaid - Medi-Cal
- Excellus BlueCross BlueShield
- Fidelis
- Health Net
- MVP Health Plan of NY
- New York Medicaid
- North Carolina Medicaid
- Ohio Medicaid
- PARTNERSHIP HEALTH PLAN OF CALIFORNIA
- Pennsylvania Medicaid
- Universal American Family of Companies-American Progressive

Add Payer

Member Id: -1972644334

Date of Birth: [input field]


Thru: [input field]

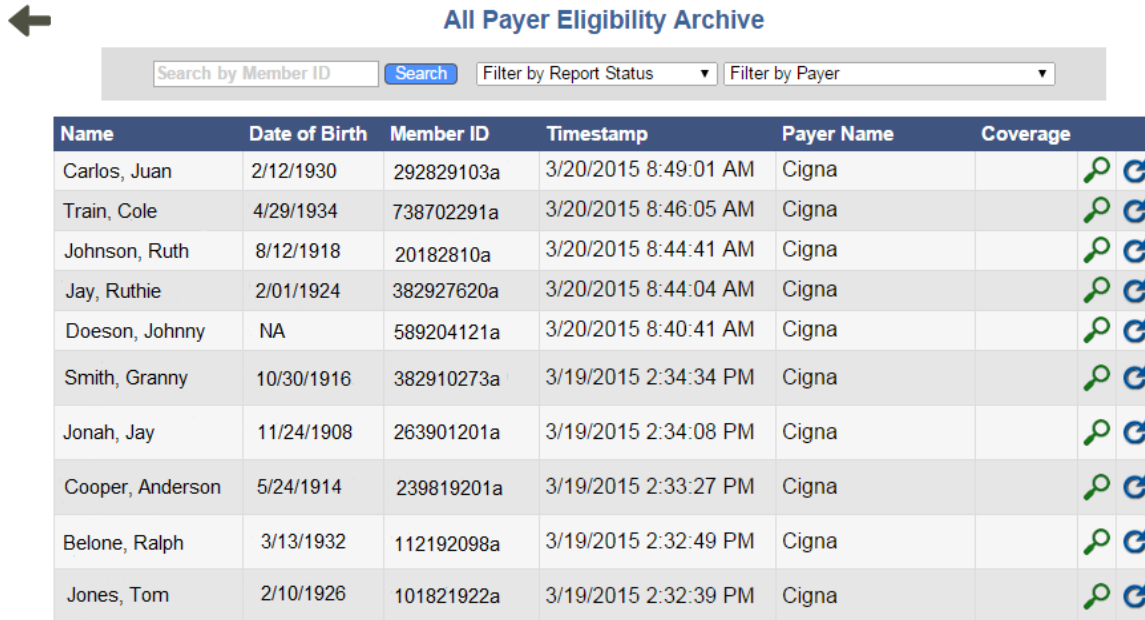
5. Though the user can manually alter these fields, the **Date Type**, **From**, and **Thru** fields are automatically defined so that the maximum values/data are retrieved in the Eligibility response.
6. Click **Get Eligibility**. The All Payer Eligibility response report will appear in a new browser tab.





















Previous Eligibility Reports



In addition to running new reports, users have the option to view any previous inquiry reports.

To view previous eligibility response reports:




1. From the *All Payer Eligibility* inquiry screen, click the **Previous Inquiries** icon () to the top-right of the window. The All Payer Eligibility Archive screen will automatically open, as seen in the image below.



Name	Date of Birth	Member ID	Timestamp	Payer Name	Coverage
Carlos, Juan	2/12/1930	292829103a	3/20/2015 8:49:01 AM	Cigna	 
Train, Cole	4/29/1934	738702291a	3/20/2015 8:46:05 AM	Cigna	 
Johnson, Ruth	8/12/1918	20182810a	3/20/2015 8:44:41 AM	Cigna	 
Jay, Ruthie	2/01/1924	382927620a	3/20/2015 8:44:04 AM	Cigna	 
Doeson, Johnny	NA	589204121a	3/20/2015 8:40:41 AM	Cigna	 
Smith, Granny	10/30/1916	382910273a	3/19/2015 2:34:34 PM	Cigna	 
Jonah, Jay	11/24/1908	263901201a	3/19/2015 2:34:08 PM	Cigna	 
Cooper, Anderson	5/24/1914	239819201a	3/19/2015 2:33:27 PM	Cigna	 
Belone, Ralph	3/13/1932	112192098a	3/19/2015 2:32:49 PM	Cigna	 
Jones, Tom	2/10/1926	101821922a	3/19/2015 2:32:39 PM	Cigna	 

2. Review the list and then click the magnifying glass icon () to open the previous inquiry report for the corresponding line item.
3. In case the list is too extensive, users can narrow search results by using the filtering options located above the grid:
 - a. Filter by Report Status:
 - i. **Eligibility Success** – Eligibility request was processed and successfully converted to a report file.
 - ii. **Eligibility Entry Error** – One of the pieces of data entered about the patient does not match what Emdeon has in the Common Working File.
 - iii. **Eligibility Transaction Error** – No Eligibility 271 response was received due to an error from Emdeon.
 - iv. **Failed Report** – Eligibility request was received from Emdeon, but there was an error retrieving the 271 response and no report file was generated.
 - v. **Failed Responses** – Your eligibility request was received from Emdeon, but there was an error retrieving the 271 response and no report was generated.
 - b. Filter by Payer – Select which specific Payer you wish to review results for.
4. To return to the All Payer Eligibility inquiry screen, click  in the top-left corner.


All previous eligibility requests can be triggered to generate a new eligibility report without re-entering all of the patient data. To generate an eligibility report:

1. On the *All Payer Eligibility Archive* screen (listing previous eligibility requests), click the refresh icon () to re-generate the report for the corresponding line item.
2. The report will then appear in a new browser tab, which can then be saved () or printed () using the corresponding icons to the top-right of the screen.


Saving and Printing Reports

As with the functionality in *Medicare Eligibility*, any report can be saved and/or printed in the same manner.

Saving or printing the report:

1. After clicking **Get Eligibility** on the *All Payer Eligibility* inquiry screen, the report will automatically appear in a new browser tab.
2. To the top-right of the screen will be two icons, click .
3. Different windows and/or prompts will appear, depending on the browser you are using. If necessary, click **Save** and/or **Open** for the report to appear in a new tab.

To print the report:

1. After clicking **Get Eligibility** on the *All Payer Eligibility* inquiry screen, the report will automatically appear in a new browser tab.
2. To the top-right of the screen will be two icons, click .
3. A print window will then appear. Click **Print**.

Viewing All Payer Eligibility Reports

Eligibility reports, that do **not** contain errors, contain several sets of data that are broken up into specific sections, which are covered in the following section:

Report Header

The image below shows what users can expect to see at the beginning of any given report, as long as all the corresponding data has been submitted.

ABC HEALTH INC ELIGIBILITY			
<small>Report ran by user: Davidson Home Care, Paula Murray, 1010101010, 3/16/2015</small>			
Name:	JONES SR, CARLOS P	Date of Birth:	2/11/1931
Gender:	123 COLCHESTER RD	Member Id:	MEABCDEF
Address:	COLUMBIA, AL	Plan Begin:	1/1/2015
		Eligibility Begin:	1/1/2014
Plan Number:	1234567	Service Date:	3/16/2015
Group Number:	ABC12345612345611	Active Coverage:	Yes
Plan Network Identification Number:	AL31		

¹Authorization Required ²Not In Network ³Limited to Facility

Eligibility and Coverage

The Eligibility and Coverage section appears as follows in the sample screenshot below:

Eligibility and Coverage				
Type	Coverage Level	Service Type	Coverage Desc.	
Primary Care Provider	Family	Health Benefit Plan Coverage		Preferred Provider Organization (PPO), PCP SELECTION NOT REQUIRED
Active Coverage	Family	Health Benefit Plan Coverage	ABC Medicare Plan PPO	Preferred Provider Organization (PPO), Medicare
Active Coverage	Family	Chiropractic, Dental Care, Emergency Services, Hospital, Hospital - Inpatient, Hospital - Outpatient, Mental Health, Pharmacy, Professional (Physician) Visit - Office, Urgent Care, Vision (Optometry)	ABC Medicare Plan PPO	

Patient Responsibility

The *Patient Responsibility* section appears as follows in the sample screenshot below:

Patient Responsibility				
Type	Coverage Level	Service Type	Amount	
Out of Pocket (Stop Loss)	Individual	Health Benefit Plan Coverage	\$2,500.00	
Out of Pocket (Stop Loss)	Individual	Health Benefit Plan Coverage	\$2,475.00 per Remaining	
Out of Pocket (Stop Loss)	Family	Health Benefit Plan Coverage	\$2,500.00	
Out of Pocket (Stop Loss)	Family	Health Benefit Plan Coverage	\$2,475.00 per Remaining	
Co-Insurance	Individual	Chiropractic	\$0.00	Chiro
Co-Payment	Individual	Chiropractic	\$20.00	Chiro, COPAY INCLUDED IN OOP, Facility OP Chiro, COPAY INCLUDED IN OOP
Co-Payment	Individual	Chiropractic	\$20.00 per Visit	Specialist Chiro Office Visits, COPAY INCLUDED IN OOP
Co-Insurance	Individual	Chiropractic	\$0.00	Facility IP Chiro, Facility OP Chiro, Specialist Chiro Office Visits, Specialist IP Chiro, Specialist OP Chiro
Co-Payment	Individual	Chiropractic ²	\$20.00	Facility OP Chiro, COPAY INCLUDED IN CATAS OOP
Co-Payment	Individual	Chiropractic ²	\$20.00 per Visit	Specialist Chiro Office Visits, COPAY INCLUDED IN CATAS OOP
Co-Insurance	Individual	Emergency Services	\$0.00	Emergency Room, Urgent Care Rider, Facility Emergency Urgent Care
Co-Payment	Individual	Emergency Services	\$65.00	Emergency Room, COPAY INCLUDED IN OOP, Waived if admitted, FAC EMERG MEDICAL TREATMENT, COPAY INCLUDED IN OOP, Waived if admitted

Limitations and Non-Covered Services

The *Limitations and Non-Covered Services* section appears as follows in the sample screenshot below:

Limitations and Non-Covered Services				
Type	Coverage Level	Service Type	Amount	
Limitations	Family	Chiropractic, Emergency Services, Hospital - Inpatient, Hospital - Outpatient, Professional (Physician) Visit - Office, Urgent Care	\$0.00	PCP OV Cost Share for any PCP
Limitations	Family	Emergency Services	\$0.00	Facility Emergency Urgent Care /Plan Ded Waived
Limitations	Family	Health Benefit Plan Coverage	\$0.00	Pre-cert required
Limitations	Family	Health Benefit Plan Coverage	\$0.00	INTEGRATED LIFETIME MAXIMUM
Limitations	Family	Health Benefit Plan Coverage ²	\$0.00	Pre-cert recommended
Benefit Description	Family	Health Benefit Plan Coverage ²	\$0.00	CATASTROPHIC

Other Information

It's likely that there will *not* be any applicable data that is pulled into this section of the report (see screenshot below), but there are several types of data that could be listed here – if applicable:

- Restricted data
- Managed care data
- Primary care provider data
- Eligibility contact information
- Additional Payer Information
- Benefit description
- Other source of data

Other Information

No other information found

Report Error

As mentioned previously, any report that is submitted must **not** contain errors or it will fail to complete. Any report that contains errors will populate a report similar to the sample screenshot below.

CIGNA HEALTHCARE ELIGIBILITY

Report ran by user: HAMPTON'S HOMECARE, INC., User Name: 12032702873, 3/24/2015

Name: COOPER, ANDERSON
Gender:
Address:

Date of Birth: 11/21/1934
Member Id: 282910
Active Coverage: **None**

¹Authorization Required ²Not In Network ³Limited to Facility

***** PLEASE REVIEW THE FOLLOWING ERRORS *****

Subscriber Errors

Request Valid: No
Reason for Rejection: **Invalid/Missing Subscriber/Insured ID. Verify HICN/Name and resubmit inquiry.**
Follow Up Action: Please Correct and Resubmit

Eligibility Payer List

Opening the Eligibility Payer List

To open the Eligibility Payer List:

1. Just as the prompt appears, when the *All Payer Eligibility* inquiry screen is first opened, click **Add Payer**, which is found directly below the list of Payers. Additionally, users can click the **Add New Payer** Icon (+) near the top-right of the *All Payer Eligibility* inquiry screen. The Eligibility Payer List will automatically open, as seen in the image below. If already on the inquiry screen (with a Payer selected), click the black arrow, to the bottom-right of the currently-selected Payer, which is located near the top-left of the inquiry window (See image above and to the right).



Payer Name	Payer ID	Payer State	Enrollment	Legacy
AARP	AARP			<input type="button" value="Add"/>
Aetna	00002			<input type="button" value="Add"/>
Aetna - Senior Products	AESSI			<input type="button" value="Add"/>
Alabama Medicaid	AID40	AL		<input type="button" value="Add"/>
Amerigroup	AMGRP			<input type="button" value="Add"/>
Anthem Blue Cross California	00039	CA		<input type="button" value="Add"/>
Arkansas Medicaid	AID26	AR		<input type="button" value="Add"/>
BCBS NEW MEXICO	BCNMC	NM		<input type="button" value="Add"/>
BCBS Rhode Island	BCRIC	RI		<input type="button" value="Add"/>
Blue Cross Blue Shield of Colorado	BCCOC	CO		<input type="button" value="Add"/>
Blue Cross Blue Shield of Connecticut	BCCTC	CT		<input type="button" value="Add"/>

2. Users can then review a cumulative list of potential Payers that can be added to their *firstCONNECT* account, which is set to display 25 Payers per page.

Understanding the Eligibility Payer List

firstCONNECT's interface makes interacting with the Eligibility Payer List simple, regardless if users are looking to add a Payer to their account, searching to see if a specific Payer is available from the list, or if they're looking to access an enrollment form (for Payers that require enrollment).

Document Status

Users can identify what status any given Payer has by simply looking in the *Payer Name* column. Except for those that are simply listed (no status), Payers can have one of three status types:

- Active – This Payer is currently included on this user account's list for inquiries.
- Requested – The user has requested an enrollment form and administrators are currently awaiting the completed form via fax/e-mail (for Payers that require enrollment).
- Processing – Administrators have received the completed enrollment form and the Payer is currently in a pending status while it is being processed.

NOTE: Payers that require an enrollment form to be processed are designated with an Adobe .pdf icon in the **Enrollment** column (See image to the bottom-right).

Legacy

While some Payers could still require legacy data in the 270 request, we have yet to encounter one requested by a client. If a new Payer requires legacy data, this column is where the data is populated.

Filtering List Items

Several features allow the user to view, sort, and differentiate between Payers. For instance, as seen in the image below, you'll notice that several documents have been designated with a status type, depending on how the user has interacted with those items.

As mentioned, each page lists up to 25 Payers. Users can also navigate between pages of results using the numbered hierarchy, which can be found directly below the list of Payers (See image below).


Users can also choose to filter the list results:

- **Filter by State** – Using the drop-down menu to the top-left, users can filter the list by any of the 50 U.S. states.
- **Filter by Status** – By toggling any of the four buttons to the top-right, users can filter the list according to status.

NOTE: If a button is filled in with color then the list is currently displaying these status types. status types.

- **Filter by Search** – Using the textbox near the top of the screen, users can search for a specific Payer name or Payer ID by entering the criteria and clicking **Search** (or by pressing **Enter** on the keyboard).


Eligibility Payer List

Payer Name	Payer ID	Payer State	Enrollment	Legacy
AARP	Active	AARP		
Aetna	Active	00002		
Aetna - Senior Products	AESSI			Add
Alabama Medicaid	AID40	AL		Add
Amerigroup	AMGRP			Add
Anthem Blue Cross California	Active	00039	CA	
Arkansas Medicaid	Active	AID26	AR	
BCBS NEW MEXICO	BCNMC	NM		Add
BCBS Rhode Island	BCRIC	RI		Add
Blue Cross Blue Shield of Colorado	BCCOC	CO		Add
Blue Cross Blue Shield of Connecticut	Active	BCCTC	CT	
Blue Cross Blue Shield of Florida	00267	FL		Add
Blue Cross Blue Shield of Georgia	00151	GA		Add
Blue Cross Blue Shield of Illinois	BCILC	IL		Add
Blue Cross Blue Shield of Louisiana	00083	LA		Add
Blue Cross Blue Shield of Maryland (CareFirst)	BCMDC	MD		Add
Blue Cross Blue Shield of Massachusetts	00139	MA		Add
Blue Cross Blue Shield of Michigan	Requested	BCMII	MI	
Blue Cross Blue Shield of Minnesota	00269	MN		Add
Blue Cross Blue Shield of Missouri	Processing	BCMOC	MO	

Previous 1 2 3 4 5 ... Next

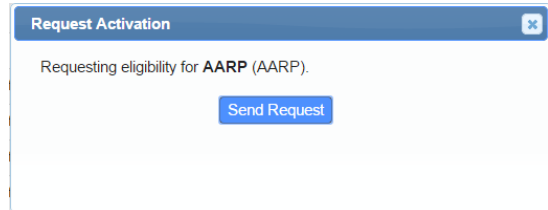
Adding a Payer

The method for adding a Payer is similar for those that do or do *not* require enrollment. Essentially, for Payers that do require enrollment, users must fill out a form and send it to one of the methods of contact listed on the Request Activation prompt (Refer to “Enrollment Payers” section below).

For both scenarios, start by simply clicking  on the row corresponding to the Payer you wish to add.

Non-Enrollment Payers


Payers that do **not** require enrollment will be prompted to confirm this selection (See sample image to the right). Click **Send Request**. The Payer will automatically be granted an “Active” status on the Eligibility Payer List and a “Payer successfully added” notification will appear at the top of the screen.



A dialog box titled "Request Activation" with a close button (X) in the top right corner. The text inside reads "Requesting eligibility for AARP (AARP)." Below the text is a blue button labeled "Send Request".

Enrollment Payers

Payers that **do** require enrollment will be prompted to confirm this selection (See sample image to the left and below). Click **Download Enrollment Form**. The browser will then automatically open the .pdf form in a separate tab. The Payer will automatically be granted a “Requested” status on the Eligibility Payer List”.



A dialog box titled "Request Activation" with a close button (X) in the top right corner. The text inside reads "Enrollment is required for Blue Cross Blue Shield of Pennsylvania - Highmark. Please download the enrollment form below and email it to impgroup@healthcarefirst.com or fax it to 1-866-924-7395." Below the text is a red icon and the text "Enrollment Details". At the bottom is a blue button labeled "Download Enrollment Form".

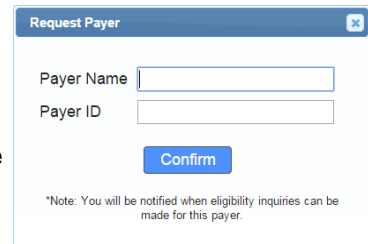
Users should then complete the downloaded form, by whatever means is most convenient, then either e-mail or fax the form to HEALTHCARE *first* via one of the contact methods that are listed on the Request Activation Prompt. Once the form has been received, it will be acknowledged by granting the Payer a “Processing” status in the list, which will be pending until the form has been approved.

ATTENTION: Please be aware that every Payer that requires enrollment for all payer eligibility utilizes a distinct form so it is not an option to provide customized instruction on filling out the forms in this guide. We advise users to follow instructions printed on the custom forms and reach out to the organization via contact information listed on the forms if any issues arise.

Requesting a Payer

If a specific Payer cannot be found in the Eligibility Payer List and a user would like it to be added to their *first*CONNECT account, they can submit a request for the Payer to be added. At the bottom of any screen, while in the Eligibility Payer List, is an informative section (See image below).

Within this informative section, click [here](#) to open the Request Payer prompt (see image to the right). Simply enter the Payer Name and Payer ID then click **Confirm** to submit the request. A representative will then contact you once the request has been received.



A dialog box titled "Request Payer" with a close button (X) in the top right corner. It contains two input fields: "Payer Name" and "Payer ID". Below the fields is a blue button labeled "Confirm". At the bottom, there is a note: "*Note: You will be notified when eligibility inquiries can be made for this payer."

NOTE: Only the Payer Name is required to request a Payer. As long as your Payer supports Real-Time 270/271 through Emdeon, we will be able to find the correct Payer ID.

If enrollment is required for the payer, please download the enrollment form and email it to impgroup@healthcarefirst.com or fax it to 1-866-924-7395. Don't see your payer in the list? Click [here](#) to request a new payer.

To view a cumulative list of *all* existing Payers, follow the URL listed below then click on the **Eligibility, Claims Status & Referrals** tab and select either **View List** or **Download List**.

<https://access.emdeon.com/PayerLists/>