



Provider Portal Quick Start Guide

There are multiple ways that you can upload documentation or attachments on the CareSource Provider Portal. This document provides instructions for submitting information for the following scenarios.

You can click the link to navigate directly to the relevant section of the document.

- [Submit a retro-authorization](#)
- [Submit hospital medical records or consent forms for denied claims](#)
- [Submit hospital medical records or consent forms proactively for claims](#)
- [File a claim dispute with supporting documentation](#)
- [File a claim appeal with supporting documentation](#)

In addition to this guide, please refer the following, as needed:

- The Provider Manual that is available on CareSource.com for each plan, which outlines claim submission timely filing information. The Provider Manual may be found at **CareSource.com** > Providers > Tools & Resources > [Provider Manual](#).
- Appeal information, such as when and how to file a dispute or an appeal, is also located on **CareSource.com** > Providers > Provider Portal > [Provider Appeals](#).



SUBMIT A RETRO AUTHORIZATION

Retro authorizations will only be approved when the service meets **all** of the following requirements:

- The service is directly related to another service for which prior approval has already been obtained and that has already been performed;
- The new service was not known to be needed at the time the original prior authorized service was performed; **and**
- The need for the new service was revealed at the time the original authorized service was performed.

Unless the member is transitioning and qualifies under the retroactive coverage requirements, all of the above criteria must be met to qualify for a retro authorization review.

Guidelines for submitting a retro authorization:

- If a member had an active coordination of benefits (COB) on the DOS, no prior authorization is required, as the rules of the primary insurance are followed.
- If you are submitting a retro authorization through the Portal and a COB is showing but wasn't active on the DOS, the Provider Portal may block the authorization from being done. For this scenario, please fax the prior authorization with a note indicating the COB was not active on the requested DOS.
- Submit a retro authorization 30 calendar days from the DOS or the date of discharge.

To enter a retro authorization, complete the following steps:

1. From the **Providers** menu, select **Prior Authorization and Notifications**.
2. Click the **Medical (Inpatient & Outpatient)** tab.
3. Click the appropriate tab to enter the member's CareSource ID, Medicaid ID, or Member Info (name and date of birth).
4. Enter the **Start Date of Service** and click **Search**.
5. Click the **COB Information** tab and verify if the member has other insurance.

NOTES:

- The Portal may block retro authorizations from being submitted if the COB was not active on the DOS but is now active.
 - If the member has other insurance, select **Add COB Information**, then complete and submit the form.
6. If neither of the two scenarios above apply, click **Verified** to continue the retro authorization.
 7. Select the **Inpatient** or **Outpatient** authorization type.
 8. Complete the required form fields, then click continue.
 9. If prompted, complete clinical indications, upload supporting documentation and submit authorization.



SUBMIT MEDICAL RECORDS FOR DENIED CLAIMS

A new **Document Upload** tab is available on the **Claims Detail** view when a claim is denied due to certain missing attachments. Use this option to upload documentation instead of submitting an appeal or corrected claim.

To upload documentation for a denied claim, do the following:

1. From the left hand **Claims** menu, click **Claim Information and Attachments**. Locate the claim using one of the search criteria available on the **Claim Information and Attachments** page.
2. Click the **View Detail** link for the denied claim.
3. On the **Document Upload** tab, review the reason the claim was denied and then upload the appropriate documentation. The file size is limited to 100 MB.

Claim Detail

General Information	
Claim #:	14141414141414141414
Date Received:	9/25/2019
Adjusted From Claim #:	=
Total Amount Charged:	\$1,760.00
Adjusted To Claim #:	=
Total Patient Responsibility:	\$0.00
Original Claim #:	=
Total Amount Paid:	\$744.91
Patient Account #:	14141414141414141414
Processed Date:	10/16/2019
Check Number:	14141414141414141414

Claim Detail

List View | Table View | **Document Upload** | Attached Documents

Denial Reason: ESC - Disallow; consent form required

Upload the signed member consent form related to the denied claim.
File sizes must be limited to 100 MB.
Only files of types: tsmg, png, tiff, jpeg, tdt, pdf, xls, xlsx, doc and docx may be uploaded.

Files Uploaded:

4. Complete the required fields (marked with a red asterisk).
5. Add **Notes** if needed.
6. Click **Submit Documents**.

NOTES:

- Submitted documentation will be reviewed according to documented guidelines.
- The documents that are uploaded will be available on the **Attached Documents** tab approximately a half hour after they are uploaded.
- Submit records that directly correspond and support the billed services that were denied. Submitting an entire medical record versus documents related to a specific stay or visit could delay the processing turnaround time.



SUBMIT MEDICAL RECORDS PROACTIVELY FOR CLAIMS

If you need to submit medical records for a new claim, you can do so using the **Claim Information and Attachments** page. The attachments will be matched with member's corresponding claim so that the claim can be processed successfully.

To upload a medical records, do the following:

1. From the left hand **Claims** menu, click **Claim Information and Attachments** to perform a search to locate the specific member for whom you want to upload the records.

Claim Information and Attachments

Please select one of the following search methods and enter the requested information to check the status of any claim you have submitted in the last 24 months. We update our claim status daily.

Claim Information and Attachments

Cardsource id Medicaid id Member info Claim number Patient number Check number External Reference number

Medicaid id: 12345678900

Member(s) have related Claims information

Search

2. In the **Claim Summary** section, click the **Claim Attachment** tab.

NOTES:

- a. If the member does not have existing claims, this tab opens by default.
- b. If you want to submit attachments for a denied claim, click the **View Details** link for the specific claim and follow the instructions to [Error! Reference source not found.](#)

Claim Summary

Claims Claim Attachment

Use the Claim Attachment functionality to submit supporting documentation for claims.

NOTE: It is best to submit your claim number along with your documentation if possible. If you do not provide your claim number with your attachment, your attachment will apply only to claims received **after** the receipt date of the attachments. For example, an attachment uploaded on 3/1/2020 will systematically apply to claims received by CareSource on or after 3/1/2020. It will not apply to claims received prior to 3/1/2020.

To upload attachments applicable to a previously submitted claim, you must enter the corresponding claim number when submitting the attachment to ensure systematic alignment.

File sizes must be limited to 100 MB.
Only files of types: bmp, png, gif, jpeg, txt, pdf, xls,xlsx, doc, docx may be uploaded.

Files Uploaded:

patient_number.png

Delete Selected

3. Click **Choose File** to locate the attachment. The file size is limited to 100 MB.

Submit records that directly correspond and support the billed services. Submitting an entire medical record versus documents related to a specific claim could delay the processing turnaround time.



4. Enter the **Service Date** for the claim.

NOTES:

- The member must be eligible for the selected date of service to continue with the attachment.
- If you are including a claim number with the attachment, the date of service must match what is on the claim.
- If the claim is for a service with a date range, enter the first date that appears on the claim.

Claims | Claim Attachment

Use the Claim Attachment functionality to submit supporting documentation for claims.

NOTE: It is best to submit your claim number along with your documentation if possible. If you do not provide your claim number with your attachment, your attachment will apply only to claims received **after** the receipt date of the attachments. For example, an attachment uploaded on 3/1/2020 will systematically apply to claims received by CareSource on or after 3/1/2020. It will not apply to claims received prior to 3/1/2020.

To upload attachments applicable to a previously submitted claim, you must enter the corresponding claim number when submitting the attachment to ensure systematic alignment.

File sizes must be limited to 100 MB.
Only files of types: .bmp, .png, .tiff, .jpeg, .txt, .pdf, .xls, .xlsx, .doc and .docx may be uploaded.

Files Uploaded

patient_number.png

Delete Selected

Claim Attachment Form

Member CareSource ID: 1000000000

Service Date: * Required

Submission Reason: --Select Reason-- * Required

Claim Number:

Provider Contact Email: * Required

Notes:

Cancel Submit Documents

5. Select the appropriate **Submission Reason**.

6. Enter the **Claim Number**, if available.

7. Enter your contact information and any applicable notes.

8. Click **Submit Documents**.

NOTE: If you submit documentation for a claim and do not indicate the specific claim number for which the documentation applies, the documentation will apply **only** to claims received **after** the receipt date of the medical records. For example, documentation uploaded on 1/6/2020 will systematically apply to claims received by CareSource on or after 1/6/2020. It will not apply to claims received prior to 1/6/2020. **To upload documentation applicable to a previously submitted claim, you must enter the corresponding claim number when submitting the attachment to ensure systematic alignment.**



FILE A CLAIM DISPUTE WITH SUPPORTING DOCUMENTATION

Review the reasons and timeframes for submitting a dispute below based upon the specific plan.

Submit a dispute for the following reasons	
GA Medicaid	<ul style="list-style-type: none">• Claim underpayment
Timeframe to submit a dispute	
GA Medicaid	<ul style="list-style-type: none">• A dispute must be submitted within 90 calendar days of the payment date on the claim.

NOTE:

- CareSource is currently unable to receive dental appeals or disputes through the Provider Portal. If you need to submit an appeal or dispute involving a dental claim, please mail or fax your submission.

The following should not be submitted as a dispute:

- If you are responding to a denied authorization that required medical necessity review, please submit an appeal.
- If you are submitting a request due to overpayment, please submit a claim recovery request.
- If your claim was denied due to a missing consent form, please upload the consent form.
- If your hospital claim was denied due to missing medical records, upload the medical records.
- For **GA Medicaid**: If you are responding to a denied claim, please submit an appeal.

To submit a dispute, do the following:

1. From the left hand **Claims** menu, click **Disputes**.
2. Locate the claim for which you want to submit a dispute.
3. Complete the appropriate information and upload an attachment (up to 100 MB) if needed. Required fields are marked with a red asterisk. At a minimum, the dispute must include:
 - Sufficient information to identify the claims in dispute
 - A statement of why you believe a claim adjustment is needed (enter in the **Notes** field)
 - Pertinent documentation to support the adjustment

A screenshot of the CareSource 'Submit Dispute' web form. The form is titled 'Submit Dispute' and has a 'Check Status' tab. It includes a 'Claim ID' field with the value '299246202000'. The 'Dispute Type' is a dropdown menu currently set to 'Please Select'. The 'Issue Category' is 'Claim Dispute Medical'. There is a 'Provider Contact Name' field. A 'Notes' text area is present. The 'Attachments' section contains instructions: 'Please select a file using browser and click an Upload button for verification. Once all the files are uploaded, click Submit Dispute button to continue.' Below this is a 'Choose File / No file chosen' button, a blue 'Upload' button, and a red error message: 'File size must be limited to 100 MB.'. A 'Files Uploaded' list is empty. At the bottom are three buttons: 'Cancel Dispute', 'Cancel', and 'Submit Dispute'.

4. Click **Submit Dispute**.

NOTES:

- You can return to the **Disputes** page to check status of your appeal using the **Claim ID** or **Dispute ID** that was generated when you submitted the dispute.
- Dispute acknowledgement and decision letters for GA Medicaid can be located on the **Provider Documents** page.



FILE A CLAIM APPEAL WITH SUPPORTING DOCUMENTATION

Review the reasons and timeframes for submitting an appeal below based upon the specific plan.

Submit an appeal for the following reasons	
GA Medicaid	<ul style="list-style-type: none"> • Claim appeals - Disagreement with decision of a processed claim. • Clinical appeals - To request reconsideration of a medical necessity decision. (Cannot be submitted via portal at this time)
Timeframe to submit an appeal	
GA Medicaid	<ul style="list-style-type: none"> • Claim appeal – 30 calendar days from the date the adverse action, denial of payment, remittance advice or initial review determination was mailed to you. • Clinical appeal – 60 calendar days from the date of denial (member written consent required).

NOTES

- CareSource is currently unable to receive clinical appeals, dental appeals or disputes through the Provider Portal. If you need to submit an appeal involving a prior authorization denial or a dental claim, or a dispute involving a dental claim, please mail or fax your submission.
- If you believe a claim processed incorrectly due to incomplete, incorrect or unclear information, you should submit a corrected claim through the claim submission process. You do not need to file an appeal. Corrected claims submitted with the appeal will not be accepted.
 - Examples where you may need to submit a corrected claim include but are not limited to:
 - Your claim denied due to needing a consent form
 - Your claim denied due to needing medical records
- The Provider Manual that is available on CareSource.com for each plan, which outlines claim submission timely filing information. The Provider Manual may be found at **CareSource.com** > Providers > Tools & Resources > [Provider Manual](#).
- Appeal information, such as when and how to file a dispute or an appeal, is also located on **CareSource.com** > Providers > Provider Portal > [Provider Appeals](#).



To submit an appeal, do the following:

1. From the left hand **Claims** menu, click **Appeals**.
2. Locate the claim for which you want to submit an appeal.
3. Select the appropriate **Appeal Type**.
4. Complete the remaining required information (marked with a red asterisk).

The screenshot shows the 'Open Appeal' form. At the top, there are two buttons: 'Submit Appeal' and 'Check Status'. Below these, there is a 'Claim ID' field with a value of '0000000000'. The 'Appeal Type' is a dropdown menu set to 'Please Select'. The 'Appeal Reasoning' section has two questions: 'Did your claim deny due to lack of authorization?' and 'Are you appealing the denial of authorization for services?'. Each question has radio buttons for 'Yes' and 'No'. Below these is a 'Notes' text area. The 'Attachments' section has a note: 'Please select a file using browser and click on upload button to upload. Once an file has been uploaded, you'll submit appeal to get review.' and a 'Choose File' button. There is an 'Upload' button and a red asterisk indicating a required field. The 'File Uploaded' section has a text area. At the bottom, there are three buttons: 'Cancel', 'Submit Appeal', and 'Back to Claims'.

5. Enter the reason for the appeal and any other applicable information in the **Notes** box.
6. You can upload an attachment, up to 100 MB, that is necessary for your appeal.
7. Click **Submit Appeal**.

NOTES:

- You can return to the **Appeals** page to check status of your appeal using the **Claim ID** or **Appeal ID** that was generated when you submitted the appeal.
- Appeal acknowledgement and decision letters for GA Medicaid claims can be located on the **Provider Documents** page.

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