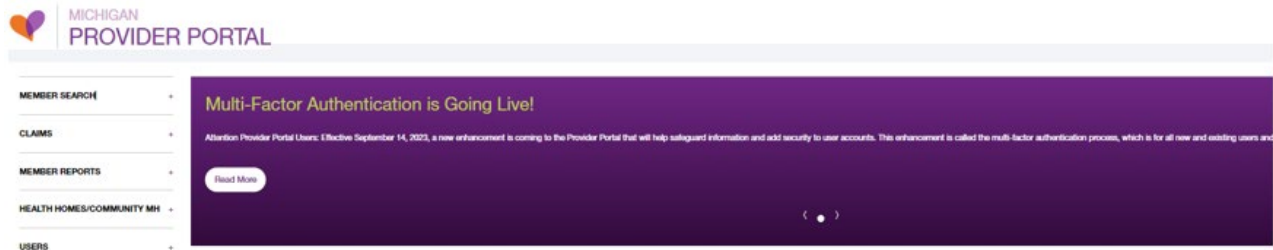




## HAP CARESOURCE PROVIDER PORTAL

The HAP CareSource Provider Portal is a key self-service tool for our providers and defines how our providers engage with us. The HAP CareSource Provider Portal is a secure, encrypted online tool available for any provider serving our members. Providers will need to be registered on the HAP Provider Portal to use the HAP CareSource Provider Portal.



### PROVIDER FEEDBACK

Provider satisfaction with the portal is a key metric that we monitor closely. We have implemented a feedback loop where we elicit provider feedback, gather that feedback into key enhancement themes, and then build a thoughtful, enhancement roadmap that delivers new features that our providers find useful. The enhancements are released iteratively throughout the year and target highly requested items.

We place satisfaction surveys directly on the portal to capture feedback about your overall experience with completing your daily tasks.

### MEMBER ELIGIBILITY

The portal enables quick access to relevant member information, such as member eligibility and enrollment, including a member's primary language information and any other special communication needs.

By going to Member Search > Member Eligibility, providers can search for member eligibility using one of the search options, or search for multiple members at a time. Providers can easily export and print member data as needed. Providers can also access a member's case management plan and submit a request to update case management information.



Member Eligibility

CareSource Id Medicaid Id Member Info Case Number Multiple CareSource Ids Multiple Medicaid Ids

CareSource ID  Member is eligible for service on the specified date

Date of Service

**Member Information**

<b>Member Name:</b>		<b>Address:</b>	
<b>CareSource Id:</b>		<b>County of Residence:</b>	
<b>Medicaid Id:</b>		<b>County of Eligibility:</b>	
<b>Case Number:</b>		<b>Phone:</b>	
<b>Gender:</b>		<b>Date of Birth:</b>	
<b>Member Profile:</b>	Not Available for this Member <a href="#">Member Profile Report Definitions</a>	<b>Relationship to Subscriber:</b>	
<b>Original Effective Date:</b>		<b>Program Details:</b>	Not a coordinated services member
<b>Program:</b>		<b>Member Eligibility Date</b>	
<b>Member Alerts:</b>	1. No ambulatory or preventive care visits recorded.	<b>Span Last Updated:</b>	

---

<b>Primary Care Provider (PCP):</b>		<b>Phone:</b>	
<b>NPI #:</b>			
<b>Case Manager:</b>		<b>Case Manager Phone</b>	
		<b>Member</b>	

---

**Member Aid Category:**  
Working Disabled, >150% FPL

**Language Preference:**  
English

**Alternate Communication Format Needed:**  
Large Print

**Subscriber Information**

**Member Covered Benefits Summary**

**Member Dental & Vision Services History**

## MEMBER PROFILE

The Member Profile supports coordinated member care between the member's primary care provider (PCP) and other care coordinators by providing access to comprehensive patient medical information in one convenient location. The data in the Member Profile can be used to offer coordinated, streamlined care for patients.

- Patient demographics
- Primary Care Provider information
- Prior prescribing information
- Historical diagnoses
- Patient-specific quality metrics (such as mammography screening, A1C value, and more)



- Prior hospital admissions
- Emergency room visits
- Specialist visits
- Case management activity

Member Eligibility


CareSource Id	Medicaid Id	Member Info	Case Number	Multiple CareSource Ids	Multiple Medicaid Ids
---------------	-------------	-------------	-------------	-------------------------	-----------------------

CareSource ID  Member is eligible for service on the specified date

Date of Service

[Search](#)

**Member Information**

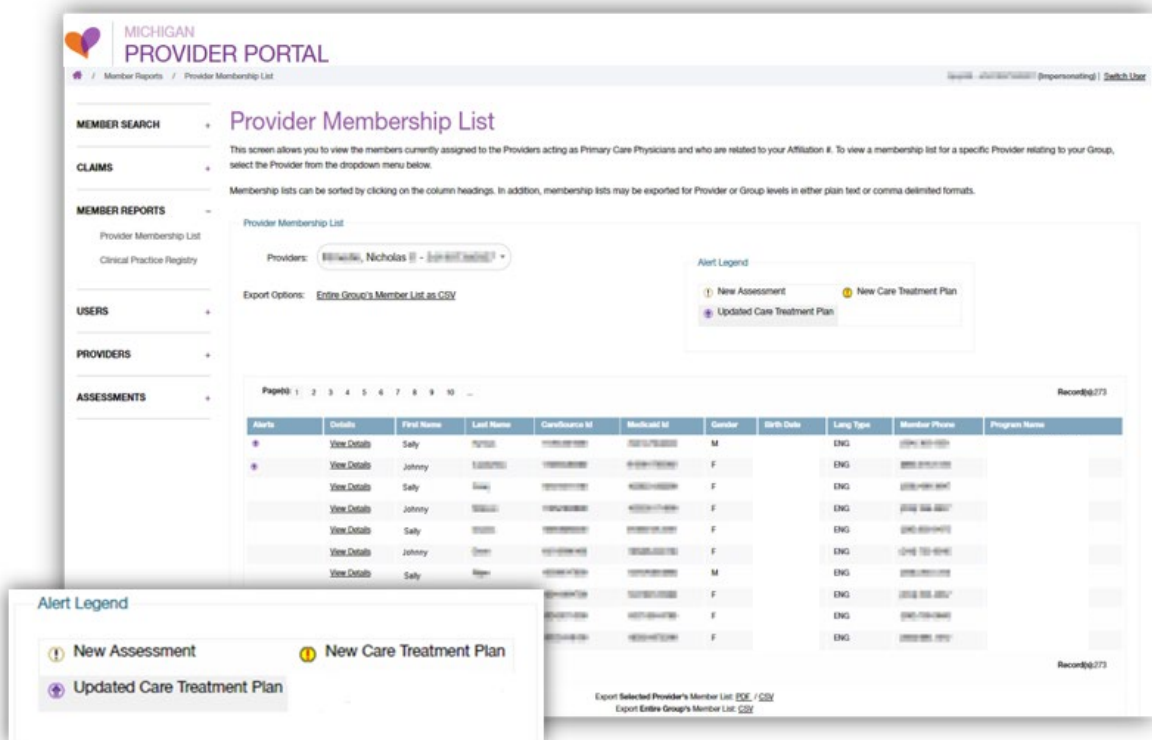
Member Name:	Address:
CareSource Id:	County of Residence:
Medicaid Id:	County of Eligibility:
Case Number:	Phone:
Gender:	Date of Birth:
<b>Member Profile:</b> <a href="#">Click To View</a>  <a href="#">Member Profile Report Definitions</a>	Relationship to Subscriber:
Original Effective Date:	Program Details:
Program:	Member Eligibility Date Span Last Updated:
Language Preference:	Alternate Communicat
Special Communication Needs:	
Member Aid Category:	
Primary Care Provider (PCP):	Phone:
NPI #:	
Case Manager:	Case Manager Phone Number:

## PROVIDER MEMBERSHIP LIST

The Provider Membership List allows providers to view the members currently assigned to the Providers acting as PCPs and who are related to their Affiliation Number. The list can be sorted by a specific provider related to a group or for the entire group's member list. Membership lists can be sorted by clicking on a column heading and/or exported in either plain text or comma delimited formats. Access the Provider Membership List from the Member Reports left-hand menu.

Alerts that display on the Provider Membership List remain for 90 days from the triggering event. Events include:

- **New Assessment.** The member has a new health risk assessment available for review.
- **New Care Treatment Plan.** The member has a new care treatment plan that can be reviewed/acknowledged.
- **Updated Care Treatment Plan.** The member has an updated care treatment plan that can be reviewed/acknowledged.



**MICHIGAN PROVIDER PORTAL**

Member Reports / Provider Membership List

## Provider Membership List

This screen allows you to view the members currently assigned to the Providers acting as Primary Care Physicians and who are related to your Affiliation #: To view a membership list for a specific Provider relating to your Group, select the Provider from the dropdown menu below.

Membership lists can be sorted by clicking on the column headings. In addition, membership lists may be exported for Provider or Group levels in either plain text or comma delimited formats.

Provider Membership List

Providers:  -

Export Options: [Entire Group's Member List as CSV](#)

Alert Legend

- New Assessment
- New Care Treatment Plan
- Updated Care Treatment Plan

Alerts	Details	First Name	Last Name	CareSource M	Medicaid M	Gender	Birth Date	Ling Type	Member Phone	Program Name
	<a href="#">View Details</a>	Sally	NYST	XXXXXXXXXX	XXXXXXXXXX	M		ENG	(248) 810-1000	
	<a href="#">View Details</a>	Johnny	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	F		ENG	(248) 810-1000	
	<a href="#">View Details</a>	Sally	XXXX	XXXXXXXXXX	XXXXXXXXXX	F		ENG	(248) 810-1000	
	<a href="#">View Details</a>	Johnny	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	F		ENG	(248) 810-1000	
	<a href="#">View Details</a>	Sally	XXXX	XXXXXXXXXX	XXXXXXXXXX	F		ENG	(248) 810-1000	
	<a href="#">View Details</a>	Johnny	XXXX	XXXXXXXXXX	XXXXXXXXXX	F		ENG	(248) 810-1000	
	<a href="#">View Details</a>	Sally	XXXX	XXXXXXXXXX	XXXXXXXXXX	F		ENG	(248) 810-1000	
	<a href="#">View Details</a>	Johnny	XXXX	XXXXXXXXXX	XXXXXXXXXX	F		ENG	(248) 810-1000	
	<a href="#">View Details</a>	Sally	XXXX	XXXXXXXXXX	XXXXXXXXXX	M		ENG	(248) 810-1000	
	<a href="#">View Details</a>	Johnny	XXXX	XXXXXXXXXX	XXXXXXXXXX	F		ENG	(248) 810-1000	
	<a href="#">View Details</a>	Sally	XXXX	XXXXXXXXXX	XXXXXXXXXX	F		ENG	(248) 810-1000	
	<a href="#">View Details</a>	Johnny	XXXX	XXXXXXXXXX	XXXXXXXXXX	F		ENG	(248) 810-1000	
	<a href="#">View Details</a>	Sally	XXXX	XXXXXXXXXX	XXXXXXXXXX	F		ENG	(248) 810-1000	

Export Selected Provider's Member List: [CSV](#) / [CSV](#)  
Export Entire Group's Member List: [CSV](#)

## CLINICAL PRACTICE REGISTRY

The HAP CareSource Clinical Practice Registry (CPR) is an online tool available to health partners to identify and prioritize needed health care services, screening, and tests for HAP CareSource members. The CPR is easy to access via the secure HAP CareSource Provider Portal on the Member Reports tab.

- **Identify gaps in care:** View preventive service history and easily identify HEDIS® (Healthcare Effectiveness Data and Information Set) gaps in care to discuss during appointments.
- **Holistically address patient care:** Receive alerts when HAP CareSource members need tests or screenings, review member appointment histories and view their prescriptions.
- **Improve clinical outcomes:** Easily sort HAP CareSource members into actionable groups for population management.
- **Attributed as PCP via Claims** – Indicates the member is attributed to a provider based on claims data. This type of attribution generally means the member has attributable claims history and is engaged with this provider or provider group.
- **Attributed as PCP via Self-Selection** – Indicates the member has selected a PCP for assignment and is attributed to their self-selected provider. This type of attribution generally means the member has no attributable claims history.
- **Assigned as PCP** – Indicates the member is attributed to their geographically assigned provider. This type of attribution generally means the member has no attributable claims history.





## CLAIMS STATUS/CLAIM DETAIL

The [Claim Information](#) feature allows providers to review necessary claim information including payment information with check number, process, and adjustment reason of how the claim was reviewed, and more.

Claim status is updated daily on the HAP CareSource Provider Portal. Providers can check claims that were submitted for the previous 24 months. Search options include Member ID number, member name and date of birth or claim number, patient number, check number and external reference number, or a custom date range. Claim information can be found on the Claims > Claim Information and Attachments page.

Highlights of the Claim Details include:

- [Process Reason](#) – Claim clinical edits
- [Adjustment Reason](#)
- [Remittance Reason](#)
- [Authorization Number](#) – The related authorization, if applicable.
- [Disallowed Amount](#) – The disallowed amounts on the claim and line items.
- [Rendering Provider Name](#) – The rendering provider on the claim.

### Claim Detail

General Information			
Claim #:		Date Received:	
Adjusted From Claim #:		Total Amount Charged:	
Adjusted To Claim #:		Total Patient Responsibility:	
Original Claim #:		Total Amount Paid:	
Patient Account #:		Processed Date:	
		Check Number:	
		Adjustment Amount:	
		Remaining Balance Due:	

Claim Detail

List View
Table View
Dispute
Post Service Appeal
Related Documents
Recovery Request

Line Number: 1			
Status:	Processed	Date of Service:	3/21/2022
Amount Charged:	\$77.00		
Process Reason:	z11 - This claim line is being disallowed because the procedure code has been deleted. - Procedure Code 99201 has been deleted as of 12/31/2020.		
Adjustment Reason:	181 - Procedure code was invalid on the date of service.		
Remittance Reason:	N56 - Procedure code billed is not correct/valid for the services billed or the date of service billed.		
Procedure:	99201 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused exam	Patient Responsibility:	\$0.00
Diagnosis:	S1290XS - Fracture of neck, unspecified, sequela	Amount Paid:	\$0.00
Place of Service:	On Campus - Outpatient Hospital	Recovery Amount:	\$0.00



## CLAIMS SUBMISSION

The option to submit a claim via the HAP CareSource Provider Portal will be for Date of Service Oct. 1, 2023 or later. This can be found on the Claims > Online Claim Submission page.

The screenshot shows the "Online Claims Submission" page in the HAP CareSource Provider Portal. At the top, there is a breadcrumb trail: Home / Member Search / Member File Upload. The main header area includes a "MEMBER SEARCH" link with a plus sign and the page title "Online Claims Submission". On the left, a "CLAIMS" menu is expanded, listing options: Online Claim Submission, Claim Information and Attachments, Rejected Claims, Real Time Claims, Payment History, Recovery Request, Disputes, and Post Service Appeals. The main content area is titled "Online Claims Submission" and contains a "Member Search" section. This section has a "Search by ID" field with the value "1010101010", a "MemberID" dropdown menu, and a "Start Date of Service" field with a calendar icon. Below these fields are "Search" and "Reset" buttons.



## DISPUTES AND APPEALS

Providers can easily submit Disputes or Post Service Claim Appeals while viewing a claim on the Portal on the Claims tab. As part of the submission process, additional information or documentation can be submitted up to 100 MB. Using the reference number that is provided upon submissions, providers can check the appeal status and review acknowledgement and decision letters associated to the appeal.

**MEMBER SEARCH**

**CLAIMS**

- Online Claim Submission
- Claim Information and Attachments
- Rejected Claims
- Payment History
- Recovery Request
- Disputes
- Post Service Appeals

### Post Service Appeals

Payment information for overturned appeals will be displayed on the EOP following appeal decision.

Is this a corrected claim? Corrected claims need to be faxed to (937) 224-3388 or mailed to P.O. Box 8730, Dayton, Ohio 45401-8730.

**CareSource is required to submit all information utilized to make a decision in an appeal to the state as well as the member or their authorized representative upon the member's request of the next level of the appeal process. The member or the authorized representative may also request the documentation used in making the appeal determination.**

Appeals

**Submit Appeal** | Check Status

Claim ID: 1908044478

Appeal Type: Authorization Denial (Medical)

Note: Pursuant to Ohio Revised Code 5160.24 & 1791.02, to qualify for a retrospective review the service must be directly related to another service for which prior authorization was already obtained and has been performed. The required recipient does not directly relate to previously received prior authorization, so therefore this request cannot be authorized. Retrospective reviews must and cannot be reviewed on Appeal.

Authorization Number:

Do you have a completed Member Consent form?  Yes  No

Attachments: Please select a file using Browse and click on Upload button for verification. Once all of the files are uploaded, click Submit Appeal button to continue.  
 No file chosen

Files Uploaded:

Expedited treatment based on member's condition:  Yes  No

Reason for appeal/issue and desired outcome:

### Disputes

You file a claim payment dispute for a claim underpayment, a partially or fully denied claim or for an adverse claim payment decision.

If the dispute is for an overpayment, please submit a [claim recovery request](#).

Disputes

**Submit Dispute** | Check Status

Claim ID: 1908044478

Dispute Type: Please Select

Issue Category: Claim Dispute Medical

Provider Contact Name:

Notes:

Attachments: Please select a file using Choose File. Once all of the files are uploaded, click Submit Dispute button to continue.  
 No file chosen  
**File sizes must be limited to 100 MB.**  
Files Uploaded:





## PRE-SERVICE APPEALS

Providers can submit pre-service appeals while viewing a denied authorization on the portal. As part of the submission process, additional information or documentation can be submitted up to 100 MB. Using the reference number that is provided upon submissions, providers can check the appeal status and review acknowledgement and decision letters associated to the appeal.

### Pre Service Authorization Appeals

Impersonate Provider ID:

Receipt Method: Please Select ▾

Received Date:

Received Time:

---

Appeal Type: Authorization Denial-Medical ▾

Do you have a completed Member Consent form?  Yes  No

### Reference #:

Reference #:	04181812200		
Description:	Inpatient Elective		
Place Of Service:	21 Inpatient Hospital		
Submitting Provider:	Baylor Scott & White Medical Center		
Requesting/Ordering Provider:	Baylor Scott & White Medical Center Hospital/Acute Care F		
Servicing/Rendering Provider:			
Facility:	Baylor Scott & White Medical Center Hospital/Acute Care F		
<b>Member Information</b>			
Member Name:			
CareSource Id:	18181812200		
Birth Date:	1/1/1978		
Gender:	Male		
<b>Admission Event</b>			
Diagnosis Code:	F13.129 Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified; M22 Disorder of patella		
Procedure:	97120 Tx,1 Area,30 Min,Ea;iontophoresis; 99304 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A		
<b>Line #1</b>			
Requested Received Date:	4/13/2022 10:00:00 AM	Requested Days:	1
Start Date of Service:	4/13/2022	Authorized Days:	0
End Date of Service:	4/14/2022	Status:	Denied



## DISPUTE AND APPEAL LETTERS

Providers can easily access Disputes or Post Service Claim Appeal acknowledgement and decision letters on the HAP CareSource Provider Portal from three locations:

- While checking the status of the dispute or appeal
- While viewing the associated claim
- From the Provider Documents page

The image displays two screenshots of the HAP CareSource Provider Portal. The left screenshot shows the 'Post Service Appeals' page, which includes a sidebar with navigation options like 'MEMBER SEARCH', 'CLAIMS', 'MEMBER REPORTS', 'USERS', 'PROVIDERS', and 'ASSESSMENTS'. The main content area has a 'Post Service Appeals' header and a search form with fields for 'Providers', 'Claim ID', 'Appeal ID', and 'Member Number', along with a 'Search' button. Below the form is a table with columns: Documents, Received, Member Name, Member ID, Claim ID, Appeal ID, Method, Status, Decision, and Closed. The table contains one record for a document received on 01/31/2022.

The right screenshot shows the 'Disputes' page, which has a similar search form with fields for 'Providers', 'Claim ID', 'Dispute ID', and 'Member Number', and a 'Search' button. Below the form is a table with columns: Documents, Received, Member Name, Member ID, Claim ID, Dispute ID, and Status. The table contains one record for a document received on 02/29/2022.



## PRIOR AUTHORIZATION SUBMISSION

The HAP CareSource Provider Portal allows providers to submit an inpatient or outpatient prior authorization request and receive an automatic approval for over 200 procedure codes. Through the Providers > Prior Authorizations and Notifications page, providers can enter clinical details and receive a decision on the authorization within seconds in addition to an authorization reference number. Cite Auto Authorization matches the entered procedure and diagnosis information to the integrated clinical criteria and policies to display for the provider to complete that is required for the authorization to be processed. A determination is then made within seconds and given to the provider based on the selected clinical criteria. If a submitted authorization is pending and requires additional clinical information, providers may use the HAP CareSource Provider Portal to update the authorization and attach documentation.

Prior Authorization and Notifications

The screenshot shows the 'Medical (Inpatient & Outpatient)' tab selected in a navigation bar. Below the tab are several input fields: 'Provider ID' with an 'Impersonate' button, 'CareSource ID', and 'Start Date of Service' with a calendar icon. A 'Search' button is located at the bottom. A warning message states: 'An authorization or notification is not a guarantee of payment, but is based on medical necessity, as determined when the claim is received for processing. For Physician Administered Pharmacy Codes, please [click here](#) to complete your Prior Authorization.'

The 'Authorization Request' form includes the following sections:

- Select Care Setting:** Radio buttons for 'Inpatient' and 'Outpatient' (selected).
- Select Category:** A dropdown menu showing 'Outpatient Services'.
- Select Type of Prior Authorization Request:** A dropdown menu showing 'Outpatient Services Other'.
- Will service be performed in a Facility? \*** Radio buttons for 'Yes' and 'No'.
- Requesting/Ordering Provider Information:** A search field with a dropdown for 'Provider Name' and a text input field, marked as '\* Required'.
- Servicing/Rendering Provider Information:** A checkbox for 'Same As Requesting/Ordering'.
- If unable to locate the physician please use the facility.** A search field with a dropdown for 'Provider Name' and a text input field, marked as '\* Required'.



## PRIOR AUTHORIZATION STATUS

Providers can check status of a prior authorization, make updates to an existing prior authorization, and view related letters.

Recent Prior Authorizations ^

Page(s): 1 2 Record(s):11

Details	Authorization Number	Member ID	Description	Service Start Date	Status
<a href="#">View Details   Update</a>			Inpatient Elective		Pending Decision
<a href="#">View Details   Update</a>			Outpatient Elective		Fully Approved
<a href="#">View Details   Update</a>			Outpatient Elective		Fully Approved
<a href="#">View Details   Update</a>			Inpatient Elective		Fully Approved
<a href="#">View Details   Update</a>			Inpatient Elective		Pending Decision
<a href="#">View Details   Update</a>			Inpatient Emergency		Pending Decision
<a href="#">View Details   Update</a>			Inpatient Emergency		Pending Decision
<a href="#">View Details</a>			Outpatient Elective		Pending Decision
<a href="#">View Details</a>			Outpatient Elective		Pending Decision
<a href="#">View Details</a>			Outpatient Elective		Pending Decision

Page(s): 1 2 Record(s):11

Prior Authorization and Notifications

Medical (Inpatient & Outpatient) | Newborn Delivery Notification | BOT | Observation | **Status**

ES:

Marketplace and Medicaid lines of business only. To check the status of a previously submitted Physician Administered Pharmacy Prior Authorization, [click here](#)

Member ID | Medicaid ID | Member Info | Authorization Number | **Facility**

Select the facility: In State Hospital - 222222222 \* Authorization(s) found

Start Date: 10/1/2021

End Date: 10/18/2021

[Search](#)

Page(s): 1 Record(s):30

Details	Authorization Number	Member ID	Member First Name	Member Last Name	Gender	Birth Date	Description	Service Start Date	Service End Date	Actual Discharge Date	Status
<a href="#">View Details   Update   Letters</a>		118880000	Jenifer	Blak	F	10/1/1988	Inpatient Elective	10/16/2021	10/19/2021		Pending Decision
<a href="#">View Details   Update   Letters</a>		1001340000	Diana	Blanco	M	01/11/1982	Inpatient Elective	10/16/2021	10/19/2021		Pending Decision
<a href="#">View Details   Update   Letters</a>		1100940000	Bliss	Bohler	F	2/20/2000	Inpatient Elective	10/17/2021	10/18/2021		Pending Decision
<a href="#">View Details   Update   Letters</a>		1100940000	Caroline	Bohler	F	01/20/2002	Inpatient Elective	10/16/2021	10/17/2021		Pending Decision
<a href="#">View Details   Update   Letters</a>		1008400000	Thomas	Bohler	M	01/18/2007	Inpatient Elective	10/15/2021	10/16/2021		Pending Decision
<a href="#">View Details   Update   Letters</a>		118880000	Shelby	Blak	F	01/10/1989	Inpatient Elective	10/14/2021	10/15/2021		Pending Decision

MI-MED-P-2309301