



Claim Entry on Provider Express

The detailed overview of the Long Form:

- **COB Claims**
- **Corrected Claims**
- **Claim Adjustments**

Topics Covered on the Long Form

Step 1 of Claim Entry : Page 3

Step 2 of Claim Entry:

- Filing COB / Secondary Claims – Page 4 - 9**
- Claim Level Attachments: Notes & Paperwork – Page 10**
- Patient & Provider sections: Page 11**
- Service Information: Corrected claim & Other attributes – Page 12**
- Line Level Attachments: Paperwork, Notes & COB – Page 13 & 14**
- Final Step of 2 – Page 15**

Step 3 & 4 of Claim Entry: Page 16

Claim Entry – Long Form - Step 1

Claim Entry | Claim Inquiry | My Submitted Claims | My Submitted Adjustments

Claim Entry Step 1 of 4

★ Required

Federal Tax ID★ Select Provider★

Supervisory Protocol ⓘ
 Yes
 No

Types of Claim★
 Mental Health / Substance Use Disorder / ABA
 EAP

Will the claim include any of these?★
 Yes - COB details
- Claim Notes / Paperwork attachments
- Date Span Billing
 No

← Select Yes here to start the Long Form

My Patients | Member ID Search | Name / DOB Search | Authorization Number

1 record Show 25 per page Page 1 of 1

Clear All Filters

Select One	First Name ^	Last Name ^	Member ID	Birth Date	State
<input checked="" type="radio"/>					CA

Proceed to Step 2

- Select a Federal tax ID if there is more than one on file
- Select Provider name if you are logged in as a group.
- If the provider selected is supervising a rendering protocol, click yes
- Choose the type of claim: Mental health / Substance Use / ABA or EAP services.
- Select Yes If your claim requires any of the items listed to launch the Long Form:
 - COB Details
 - Claim Notes / Paperwork Attachments
 - Date Span Billing
- After you have searched for and selected the member, click on the “Proceed to Step 2” button.

Please Note: Throughout this form all required fields are highlighted in orange and are easily recognizable

Long Form - Step 2 – Another Health Plan

Optum Provider Express

Claim Entry | Claim Inquiry | My Submitted Claims | My Submitted Adjustments

Elig & Benefits | Claims | Auths | Appeals | My Practice Info | More

Claim Entry Step 2 of 4

← Return to Step 1

*Required

Patient Information				Insured Information			
Patient Name	DOB	Address	Telephone	ID Number	Insured Name	Address	Telephone
							516-633-1007
Is there another health benefit plan?				Group Number	Insurance Plan Name	Employer Group Name	
<input checked="" type="radio"/> Yes <input type="radio"/> No					United Behavioral Health		
Relationship to Insured							
Self - 01							

Other Insured				Coordination of Benefits		
First Name	Middle Initial	Last Name *	Member ID *	Claim Adjudication Date	COB Payer Paid Amount	Remaining Patient Liability
						0.00
Group Number	Date of Birth	Gender	Relationship to Insured *			
		Select	Select			
Payer ID *	Payer Name *	Insurance Type *	Reason for Medicare is Secondary			
		Select	Select			

Medicare Outpatient Adjudication			
Payable Percent	Payable Amount	Non-payable Amount	Remark Code
Remark Code	Remark Code	Remark Code	Remark Code

The Long Form displays a claim similar to the Short Form which pre-populates the Patient and Insured's information.

Select "Yes" if there is another health plan. Additional fields will then be displayed to support entry of data needed for COB claim filing including:

- Other Insured
- Coordination of Benefits
- Medicare Outpatient adjudication
- COB Claim Adjustments

Please note: By filling in these sections, the primary EOB/statement does NOT need to be submitted separately.

Long Form - Step 2 – COB Details – Other Insured

Patient Information

Patient Name: [Redacted] DOB: [Redacted] Address: [Redacted] Telephone: [Redacted]

Is there another health benefit plan?
 Yes No

Relationship to insured: Self - 01

Other Insured ←

First Name: [Redacted] Middle Initial: [Redacted] Last Name*: [Redacted] Member ID*: [Redacted]

Group Number: [Redacted] Date of Birth: [Redacted] (mm/dd/yyyy) Gender: [Select] Relationship to Insured*: [Select]

Payer ID*: [Redacted] Payer Name*: [Redacted] Insurance Type*: [Select] Reason for Medicare is Secondary: [Select]

For all COB claims, the Other Insured section must be filled out

Payer ID is typically a 5 digit # used for electronic claim submission (but can be any other identifying number specific to that insurance)

Insurance Type has a dropdown of many options

Long Form - Step 2 – COB Details – Coordination of Benefits

Insured Information			
ID Number	Insured Name	Address	Telephone
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Group Number	Insurance Plan Name	Employer Group Name	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Coordination of Benefits ⓘ		
Claim Adjudication Date	COB Payer Paid Amount	Remaining Patient Liability
<input type="text"/> mm/dd/yyyy	<input type="text"/>	0.00

Medicare Outpatient Adjudication ⓘ			
Payable Percent	Payable Amount	Non-payable Amount	Remark Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Remark Code	Remark Code	Remark Code	Remark Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

The Coordination of Benefits section details payment info from the primary insured and would be found on the primary EOB/PRA:

- Claim Adjudication Date (date claim was paid)
- COB Payer Paid Amount (amount paid by the primary insurance – if nothing paid, then this should be left blank or listed as 0.00)
- Remaining Patient Liability (auto-populates from amount(s) entered in the COB Claim Adjustments section)

Long Form - Step 2 – COB Details – Medicare Outpatient Adjudication

The screenshot shows two main sections of a form. The top section is titled 'Coordination of Benefits' and contains three fields: 'Claim Adjudication Date' (with a calendar icon and 'mm/dd/yyyy' placeholder), 'COB Payer Paid Amount' (empty text box), and 'Remaining Patient Liability' (displaying '0.00'). The bottom section is titled 'Medicare Outpatient Adjudication' and contains eight fields arranged in two rows. The top row has 'Payable Percent', 'Payable Amount', 'Non-payable Amount', and 'Remark Code'. The bottom row has four 'Remark Code' fields. A yellow arrow points to the 'Medicare Outpatient Adjudication' title.

If the Insurance Type is Medicare, this section needs to be completed with information found on the Medicare EOB

Primary claims that have been processed through Medicare need to have additional information provided:

- Payable percent (if one is indicated)
- Payable amount
- Non-payable amount
- Remark Codes

Long Form - Step 2 – COB claim Adjustments – Claim Level

COB Claim Adjustments ⓘ
If you have more than one Claim Adjustment click the 'Add' button to the right.

Group Code: CO-Contractual Obligations
Reason Code:
Adjustment Amount:
Quantity:

Add

Notes Claim Levels ⓘ
Reference Code: Reference Text:
Supervising Provider:

COB Claim Adjustments is the last section for COB that needs to be filled out whether at a Claim Level (completed in the upper section of the form- shown here) or at a Line Level (completed for each line entered in the Service Info section at the bottom of the form). Filing adjustments at a Claim Level is most effective when there is only one DOS on the claim, or if all adjustment reasons and amounts are the same.

This section is used to identify the unpaid portion of the claim, which come from the primary EOB. When filing COB claim adjustments, you have the option to file them at a Claim Level or at a Line Level.

- **Group Code (dropdown values)**
 - CO – Contractual Obligation**
 - CR – Correction and Reversals**
 - OA – Other Adjustments**
 - PI – Payer Initiated Reduction (non-allowed)**
 - PR – Patent Responsibility (copy, coinsurance, deductibles)**
- **Reason Code (reason amount was not paid) This code should be on the primary EOB but this field has a type ahead feature which makes them easy to lookup**
- **Adjustment Amount (the amount not covered by the Primary Payer)**
- **Quantity**
- **Clicking on Add will allow multiple adjustments to be entered if that is necessary.**

Long Form - Step 2 – COB claim Adjustments – Claim Level

When filing COB Claim Adjustments at the Claim Level:

Use one line per reason code and for different dates of service, otherwise the claim will reject

Use one line for same reason and same date of service, add up all amounts and note the quantity (example shown below is for same reason code and same date of service)

IMPORTANT: All claim adjustments plus COB Payer paid amounts entered on a claim must equal the Total Charges on the claim.

COB Claim Adjustments ⓘ
If you have more than one Claim Adjustment click the 'Add' button to the right.

INCORRECT

Group Code PR-Patient Responsibility	Reason Code 15	Adjustment Amount 50.00	Quantity 1
Group Code PR-Patient Responsibility	Reason Code 15	Adjustment Amount 25.00	Quantity 1

Add

COB Claim Adjustments ⓘ
If you have more than one Claim Adjustment click the 'Add' button to the right.

CORRECT

Group Code PR-Patient Responsibility	Reason Code 15	Adjustment Amount 75.00	Quantity 2
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Add

Long Form - Step 2 –Notes & Paperwork – Claim Level

The screenshot displays two main sections of the form. The top section, 'Notes Claim Levels', includes a 'Reference Code' dropdown menu and a 'Reference Text' input field. The bottom section, 'Paperwork Attachment Claim Level', includes a 'Report Type Code' dropdown menu, a 'Report Transmission Code' dropdown menu, and a 'Report Control Number' input field. To the right of these sections are two provider information blocks: 'Supervising Provider' with 'First Name' and 'Last Name' fields, and 'Referring Provider' with 'First Name' and 'Middle Initial' fields. Two yellow arrows point to the headers of the 'Notes Claim Levels' and 'Paperwork Attachment Claim Level' sections.

Please Note: Paperwork attachments cannot be attached to the claim itself via Provider Express.

This section is only used to note that paperwork is available and/or forthcoming via the transmission method noted.

Other options on the Long Form at the Claim Level include:

Notes at the Claim Level – notate information related to this claim

- Choose one of the four Reference Codes (Additional Information • Certification Narrative • Goals, Rehabilitation Potential, or Discharge Plans • Diagnosis Description)
- Then add text in the Reference Text field with the necessary information.

Paperwork Attachment at the Claim Level – where you can note specific paperwork that was/will be sent separately

- Select Report Code Type (Examples: Plan of Treatment or Progress Reports)
- Choose the Report Transmission Code from the dropdown list (how the paperwork will be sent)
- Enter the Report control number found on the actual report (so it can be referenced and matched up to the correct claim)

There are also fields for notes and paperwork available under the Service Info section for **Line Level entries**.

Long Form - Step 2 – Patient & Provider sections

Paperwork Attachment Claim Level ⓘ Report Type Code Select ▾ Report Transmission Code Select ▾ Report Control Number <input type="text"/>	Referring Provider First Name <input type="text"/> Middle Initial <input type="text"/> Last Name <input type="text"/> NPI <input type="text"/>
Patient ← Patient Control Number ⓘ <input type="text"/> Signature* On File ▾ Patient or Authorized Person's signature to authorize release of medical or other information necessary to process this claim and to pay any benefits according to the assignment listed on this claim. Signature* On File ▾ Insured or Authorized Person's signature to authorize payment of benefits to the undersign provider of services on this claim.	Provider ← Federal Tax ID <input type="text"/> Accept Assignment? <input checked="" type="radio"/> Yes <input type="radio"/> No Service Address* ⓘ <input type="text"/> + Add Address Signature of Rendering Provider <input type="text"/> Rendering Provider NPI <input type="text"/> Rendering Provider Taxonomy <input type="text"/> Pay to Provider <input type="text"/> Billing NPI* <input type="text"/> Billing Taxonomy <input type="text"/>
Service Information	

Patient section:

Patient control number - The unique number assigned to your patient in your practice management system (Not a required field)

Signatures – Patient & Insured or Authorized person's signature, the default is 'On File'

Provider section:

All fields are pre-populated in this section, most are editable

Be sure that the correct Service Address is chosen

Long Form - Step 2 – Service Information

Claim Frequency- The default of Original is already chosen claim but you can choose Corrected or Void claim.

To submit a Corrected or Void claim, you will need to enter the Claim Number found on the claim record in our system. The claim number will also be reported on the paper remittance advice or electronic 835 file.

Type ahead fields are recognizable by the ... dots in the end of the field and are used throughout the Claim Entry steps so you can easily search for and find the correct code.

As you tab through the Service Information, be sure to complete all required fields (highlighted in orange)

In the Service Information section these fields are type ahead fields:

- Diagnosis code
- Place of Service
- Procedure code
- Modifiers

Service Information

Claim Frequency Original

Authorization Number

Diagnosis code or nature of illness or injury*

1. F23 - Brief psychotic disorder 2. ... 3. ... 4. ... 5. ... 6. ...

Re: F20.2 - Catatonic schizophrenia

From: F22 - Delusional disorder

Outside Labs? Yes No

Charges

Actions		Dates of Service (mm/dd/yyyy)		Modifiers							
Copy	Clear	From*	To	Place of Service*	Procedure Code*	1	2	3	4	1	2
		...	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Click on Copy to easily copy the claim line above onto the next line

Click Clear to remove a service line

Long Form - Step 2 – Line Level Paperwork, Notes and COB

To the right of each line of service are three Line Level options:

- PWK = Paperwork
- NTE = Notes
- COB = Coordination of benefits

To attach any of these items at a line level you will need to click on the arrow below the option to display the additional fields that need to be completed.

Claim Frequency Original **Diagnosis code or nature of illness or injury***

1. Z63.31 2. ... 3. ... 4. ... 5. ... 6. ...

[+More Than 6?](#)

Authorization Number **Related hospitalization dates** **Outside Labs?**

From: **To:** Yes No

Charges

Actions		Dates of Service (mm/dd/yyyy)		Place of Service*	Procedure Code*	Modifiers				Diagnosis Codes						Charges*	Unit*	Line Level Options		
Copy	Clear	From*	To			1	2	3	4	1	2	3	4	5	6			PWK	NTE	COB
		03/01/2022		11	H0001	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	105.00	1			
				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		1			
				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		1			
				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		1			
				<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		1			

Add Claim Line

Long Form - Step 2 – Line Level Paperwork, Notes and COB

Service Information

Claim Frequency Original

Diagnosis code or nature of illness or injury*

1. F23 2. ... 3. ... 4. ... 5. ... 6. ...

Authorization Number

Related hospitalization dates

From: mm/dd/yyyy To: mm/dd/yyyy

Outside Labs? Yes No

Charges

Paperwork information is already attached in this example

Actions		Dates of Service (mm/dd/yyyy)		Place of Service*	Procedure Code*	Modifiers				Diagnosis Codes						Charges*	Unit*	PWK	NTE	COB
Copy	Clear	From*	To			1	2	3	4	1	2	3	4	5	6					
<input type="checkbox"/>	<input type="checkbox"/>	04/01/2022		11	90832					<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	75.00	1	<input checked="" type="checkbox"/>		

NTE (Claims Notes)

Please click on the Save & Close button to save your changes.

Note reference code*

Additional Information a

Note reference text*

Save And Close

<input type="checkbox"/>	<input type="checkbox"/>									<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		1			
<input type="checkbox"/>	<input type="checkbox"/>									<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		1			
<input type="checkbox"/>	<input type="checkbox"/>									<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		1			
<input type="checkbox"/>	<input type="checkbox"/>									<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		1			

Add Claim Line

Total Claim Charge \$75.00

Total Adjustment \$0.00


Patient Paid Amount \$0.00

- Click on the Save and Close button to save and attach the additional information
- More than one item per line can be added
- In this example, the user is also adding Notes to the same service line

Long Form - Step 2 - Final Step

When all required & additional fields are completed, Click on the Preview button



Service Information

Claim Frequency  Diagnosis code or nature of illness or injury*











1. 2. 3. 4. 5. 6.

[+More Than 6?](#)


Authorization Number

Related hospitalization dates
From:  To: 

Outside Labs?
 Yes No
Charges

Actions		Dates of Service (mm/dd/yyyy)		Place of Service*	Procedure Code*	Modifiers 				Diagnosis Codes 						Charges*	Unit*	PWK	NTE	COB
Copy	Clear	From*	To			1	2	3	4	1	2	3	4	5	6					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="03/30/2022"/> 	<input type="text" value=""/> 	<input type="text" value="11"/>	<input type="text" value="90832"/>	<input type="text" value="..."/>	<input type="text" value="..."/>	<input type="text" value="..."/>	<input type="text" value="..."/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="75.00"/>	<input type="text" value="1"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/> 	<input type="text" value=""/> 	<input type="text" value="..."/>	<input type="text" value="..."/>	<input type="text" value="..."/>	<input type="text" value="..."/>	<input type="text" value="..."/>	<input type="text" value="..."/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="text" value="1"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/> 	<input type="text" value=""/> 	<input type="text" value="..."/>	<input type="text" value="..."/>	<input type="text" value="..."/>	<input type="text" value="..."/>	<input type="text" value="..."/>	<input type="text" value="..."/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="text" value="1"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/> 	<input type="text" value=""/> 	<input type="text" value="..."/>	<input type="text" value="..."/>	<input type="text" value="..."/>	<input type="text" value="..."/>	<input type="text" value="..."/>	<input type="text" value="..."/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/>	<input type="text" value="1"/>	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>

Total Claim Charge Total Adjustment Patient Paid Amount



Claim Entry – Long Form Step 3 & 4

- ✓ Step 3 Click on Submit after reviewing the basic information on the claim
- ✓ Step 4 Receive confirmation message

The image shows two screenshots of the Optum Provider Express web application. The top screenshot is 'Claim Entry Step 3 of 4' and the bottom screenshot is 'Claim Entry Step 4 of 4'.

Step 3 of 4: The page displays 'Provider Information' and 'Diagnosis Information'. The 'Submit' button is highlighted with a red box.

Step 4 of 4: The page displays a green confirmation message: 'The claim was successfully submitted with Confirmation Number 1224749677.' Below this, there is a table of claim details and a 'Total Claim Charge' of \$190.00. A yellow arrow points to the 'Enter Another Claim' button.

Provider Information:

Tax ID	NPI	Rendering Taxonomy
[REDACTED]	[REDACTED]	[REDACTED]

Diagnosis Information:

Diagnosis Code
F06.33 K72.01

Patient Information:

Relationship to Insured
Self-01

Insured Information:

ID Number
[REDACTED]

Table of Claim Details:

Date(s) of Service	Place of Service	Procedure Code(s)	Modifier(s)	Charges	Units
03/08/2022-	12	90791	1P	75.00	1
03/10/2022-	10	90792	93	115.00	1

Total Claim Charge: \$190.00

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