

# Web Portal Overview

## New Provider Portal Features!



Your Extended Family.

mhtxportal2015

**Please Note:** All the Member IDs, Names, and any Data in this Demo are fictitious. Only TEST data was used and does **NOT** represent any Molina Member information.

# Accessing From the Molina Public Website

<http://www.MolinaHealthcare.com>

The screenshot shows the Molina Healthcare website homepage. At the top, it says "Showing Information For Texas" with a "Change" button, "English" language selection, and "Type Size: - +" controls. The Molina Healthcare logo is on the left, and a search bar with a "Go" button and "Sign In" / "Register" buttons are on the right. A navigation menu includes "Home", "Become a Member", "Find a Doctor or Pharmacy", "Staying Healthy", "Members", and "About Molina". The main content area features a "My Molina" section with the text "Manage your health care with My Molina" and a list of services: "Change your doctor", "Check your eligibility", and "Get a new Member ID Card". A "Sign Up" button is below this list. Below the main content is a "How can we help you?" section with three buttons: "I'd Like to Become a Molina Member", "I'm a Molina Member", and "I'm a Health Care Professional". A callout box points to the "I'm a Health Care Professional" button with the text "Select I'm a Health Care Professional". At the bottom, there is a "Quick Tools for Molina Members" section.

# Accessing From the Molina Public Website

This information is for Doctors and Health Care Professionals only.

Select any Line of Business

[Medicaid Professionals Click Here](#)

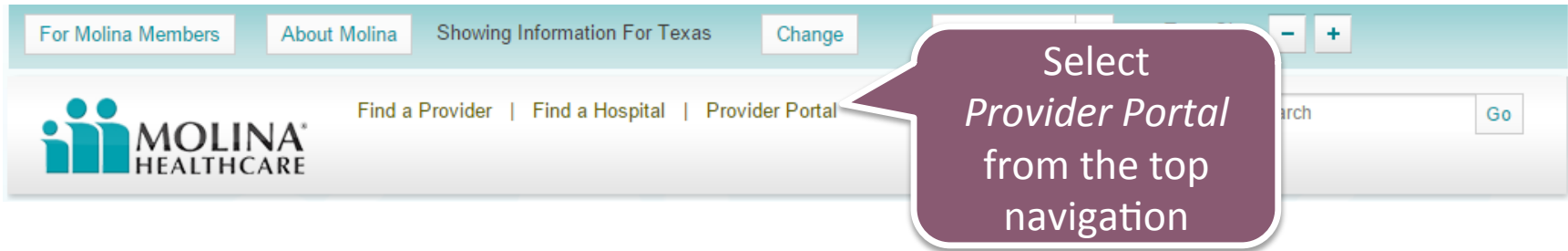
[Medicare Professionals Click Here](#)

[Dual Options Professionals Click Here](#)

[Marketplace Professionals Click Here](#)

[I am not a healthcare professional](#)

# Accessing From the Molina Public Website



The link to the Provider Portal is accessible for all Lines of Business

# Accessing via Direct Link

<https://Provider.MolinaHealthcare.com/>

## Welcome to the Web Portal

The Web Portal is a secure area that provides multiple services now available to all Molina Providers. In the Web Portal you will be able to do the following:

- Check member eligibility and benefits
- Search and manage your service request/authorizations
- Search and manage claims
- View other information helpful to you

Register today to access our on-line services. A video will guide you through the easy on-line registration process.

## Provider Self Services

User ID:  \*  
Password:   
[Accept & Login](#)  
[Forgot Password?](#)

[New Provider Registration](#)  
[Request Access for new user \*\*New!\*\*](#)  
[Minimum System Requirements](#)  
[View FAQs](#)  
[Contact Us](#)  
For technical assistance with this website please call [\(866\) 449-6848](tel:8664496848)

ACKNOWLEDGEMENT OF TERMS OF USE: Use of Molina Healthcare, Inc.'s Provider Online Access Program ("E-Access") is subject to the terms and conditions of the Provider Online User Agreement. Use of E-Access is limited to only Authorized Users designated by a Provider, who has executed the Provider Online User Agreement. Authorized User acknowledges that as an agent of said Provider s/he is bound by the terms of the Provider Online User Agreement. HIPAA COMPLIANCE: Authorized User will comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). PRIVACY AND SECURITY

## Provider Self Services

Log in using specific *User ID and Password*

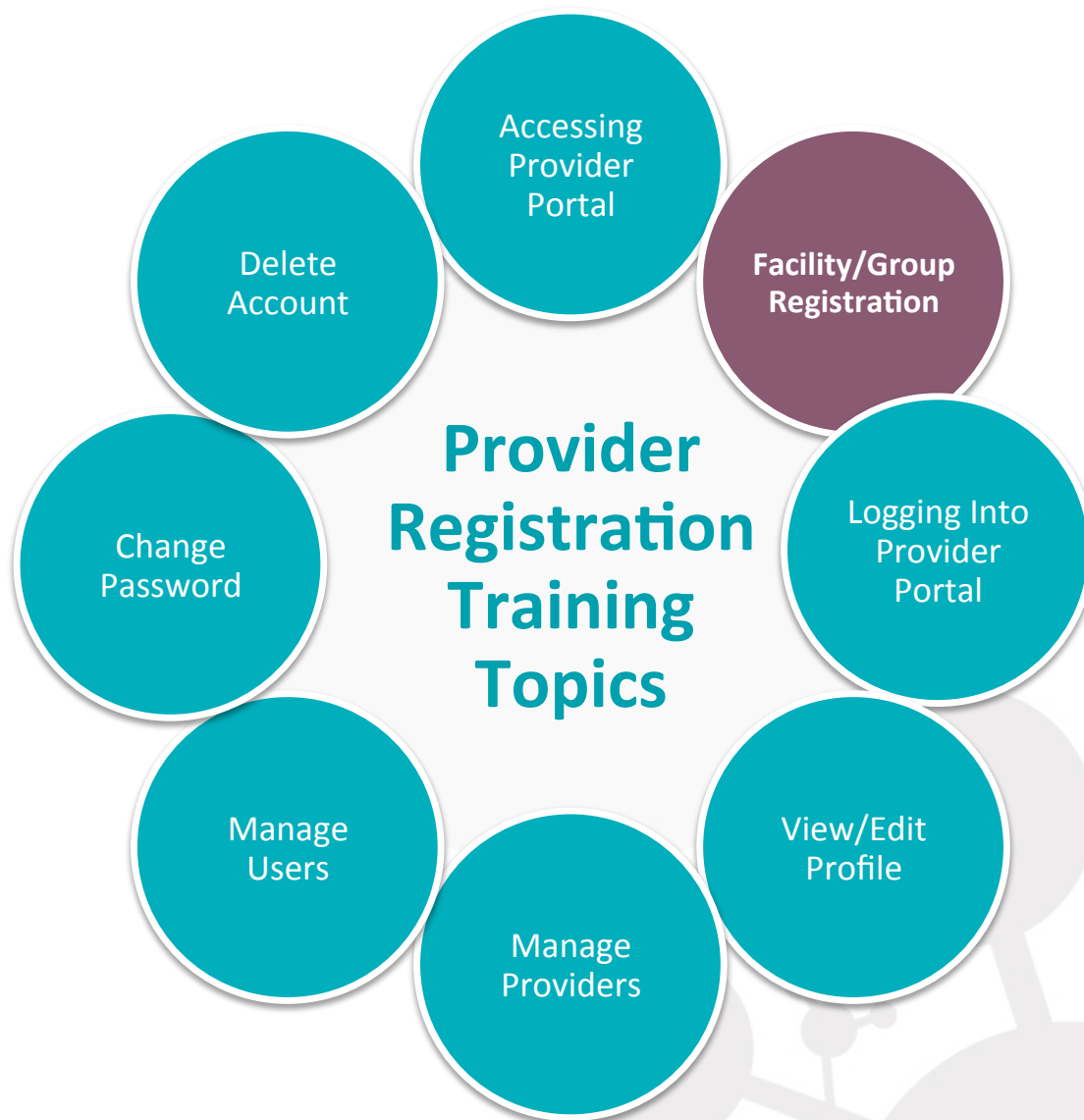


Web Portal Overview



# Provider Registration







## Welcome to the Web Portal

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Register today to access our on-line services. A video will guide you through the easy on-line registration process.

### Provider Self Services

User ID:   
Password:   
[Accept & Login](#)  
[Forgot Password](#)

To register, click  
New Provider  
Registration

[New Provider Registration](#)  
[Request Access for new user \*\*New!\*\*](#)  
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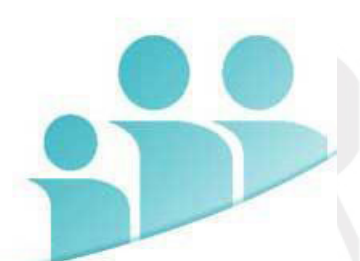
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## Provider Self Services



Web Portal Overview



### Admin User Responsibility

Before creating your account, please note that you will be responsible for the following:

- Managing all additional users added to the account which includes:
  - Inviting New Users
  - Assigning User Roles
  - De-Linking Users
  - Linking Users Accounts as needed
- Perform mandatory periodic reviews validating the accuracy

To continue with registration, click [here](#)

To exit click [here](#)

For more information about Molina's Provider Self-Services ePortal, visit the [FAQs](#) section

Click here to  
proceed

**Please note: The first account created is automatically the Admin User account.**

**The Admin User account provides access to all Web Portal functionality and is responsible for management of all other users under the account.**

Welcome to the Provider Registration Page

Please Click "Take a Tour" to see a video walk through of the registration process

[Take A Tour](#)

If you have any questions about the registration process, Please visit our [FAQ](#)

[FAQ](#)

**Provider Information**

Are you registering for: \*  Medicare  Other Lines of Business [?](#)  [?](#)

\* Tax Identification Number:  [?](#)

\* Molina Provider ID:  [?](#)

Provider Type: \*

Individual Physician

Facility / Group

**Facility/Group** type is designed for payto accounts and is not limited to provider types can register using their Molina Provider ID. Some, who are using both a Tax ID and a Molina Provider ID. If you are going to be submitting requests/authorizations on behalf of a provider group, you would register as Facility/Group, instead of an Individual Physician.

[Next](#) [Cancel](#)

Choose your Line of Business and Provider Type

Select the between Medicare or Other Lines of Business. If you select Other Lines of Business, please select State from dropdown menu.

Select a Provider Type (Facility/Group) A description for each Provider Type will appear depending on which one is selected.

Welcome to the Provider Registration Page

Please Click "Take a Tour" to see a video walk through of the registration process

[Take A Tour](#)

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[FAQ](#)

#### Provider Information

Are you registering for:\*

Medicare

Other Lines of Business ?

Select State ?

Provider Type: \*

Individual Physician

Facility / Group

\* Tax Identification Number:  ?

\* Molina Provider ID:  ?

**Facility/Group** type is designed for payto accounts and is no provider types can register using their Molina Provider ID. Some using both a Tax ID and a Molina Provider ID. If you are going requests/authorizations on behalf of a provider group, you wo Physician.

Fill out Tax ID Number and Molina Provider ID

[Next](#) [Cancel](#)

Contact your local provider services representative if you do not know your Molina provider ID.

**Authentication Details**

First Name:  \* User ID:  ?

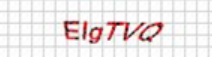
Last Name:  [Check Availability](#)

\* Email:  \* Password:  ?

\* Confirm Email:  \* Confirm Password:


Test

\* Security Questions:  Enter answers in the corresponding fields:

\* Enter the code shown in the Text box:    ?

This input is to verify whether you are a human visitor and to prevent automated spam submissions

I accept [Provider Online User Agreement](#) ?



The Authentication Details section appears after inputting the appropriate information for the Provider Information. All fields in the Authentication Details sections are *required*.

Welcome to the Provider Registration Page

Please Click "Take a Tour" to see a video walk through of the registration process

[Take A Tour](#)

If you have any questions about the registration process, Please visit our [FAQ](#)

**Provider Information**

Are you registering for:  Medicare  Other Lines of Business  Tax Identification Number:  Molina Provider ID:

Provider Type:  Individual Physician  Facility / Group

**Registered Successfully**

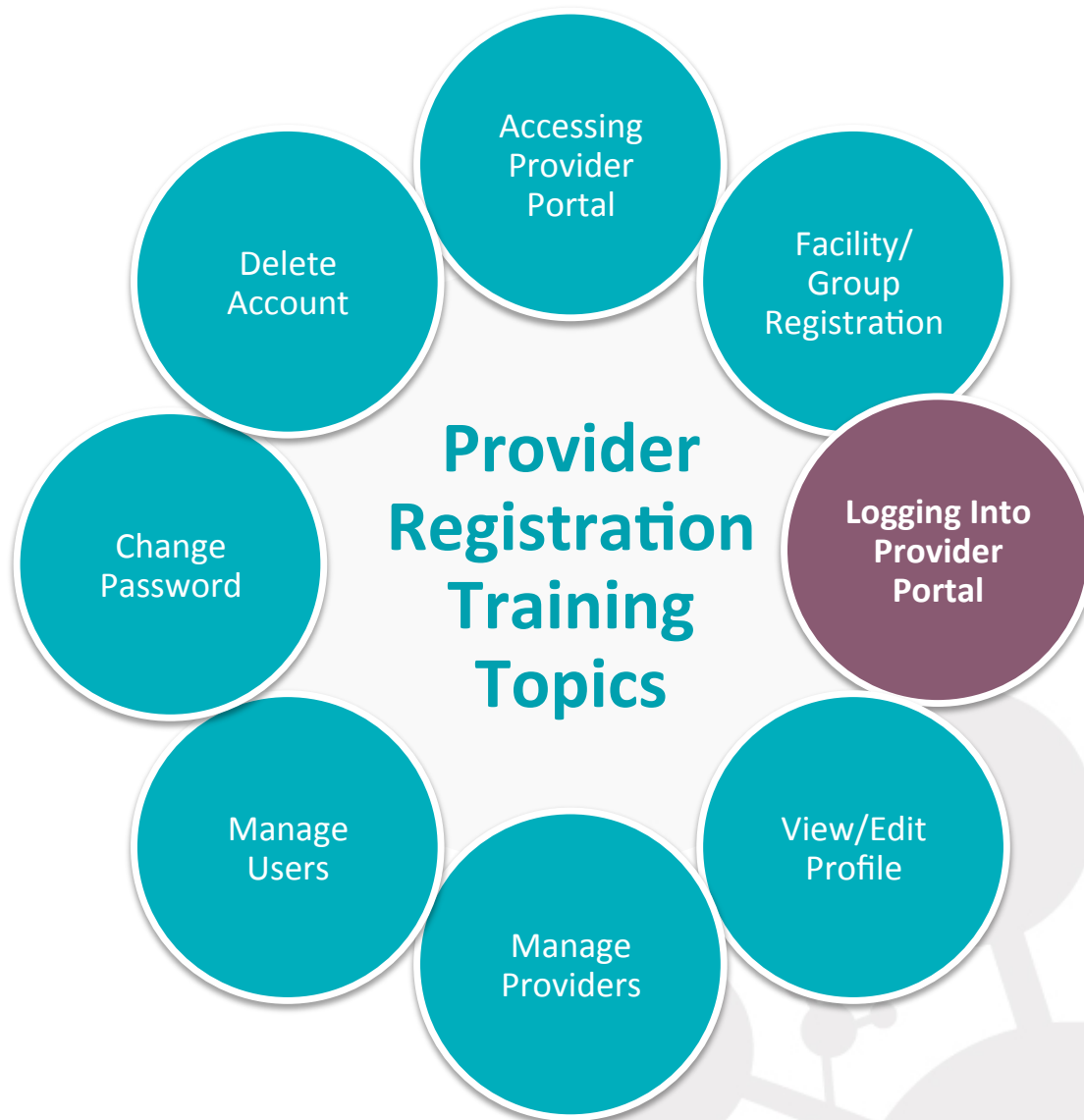
An activation link has been sent to your registered email address. In order to activate this account, please click the link in the email to successfully complete the registration process. For security purposes your browser window will be closed once clicked on "Close".

**NOTE:** The activation link in your email will be valid for ONLY 3 days.

[Close](#)

[Cancel](#)

Go to the e-mail that was provided during the registration process to your activate Molina provider portal account. After closing the message window you will be sent to the Provider Services Login Page.



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## Provider Self Services

Login with User ID and Password



Web Portal Overview





### Provider Portal

Member Eligibility

▶ Claims

▶ Service Request/Authorization

HEDIS Profile **New!**

▶ Member Roster

Reports

Links

Forms

▶ Account Tools

### Messages and Announcements

You have (0) new messages

You have (3) announcements

### Recent Activity

You have 0 Service Request Authorizations in the last 30 days

You have 0 claims in the last 30 days

### My Favorites [Edit](#)

 Member Eligibility	 Create Professional Claims
 Claims Download Report	 Claims Status Inquiry
 Service Request/Authorization..	 Clear Coverage
 Create Institutional Claim	 HEDIS Profile

### Quick Member Eligibility Search

Search by Member ID

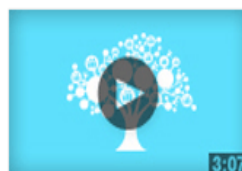
#### What's New



Medicare is available for Member eligibility searches, Service/Request authorization Inquiry and Claim Status inquiry. Please click [Contact Molina](#) to locate the Molina

medicare member services telephone number.

#### Video



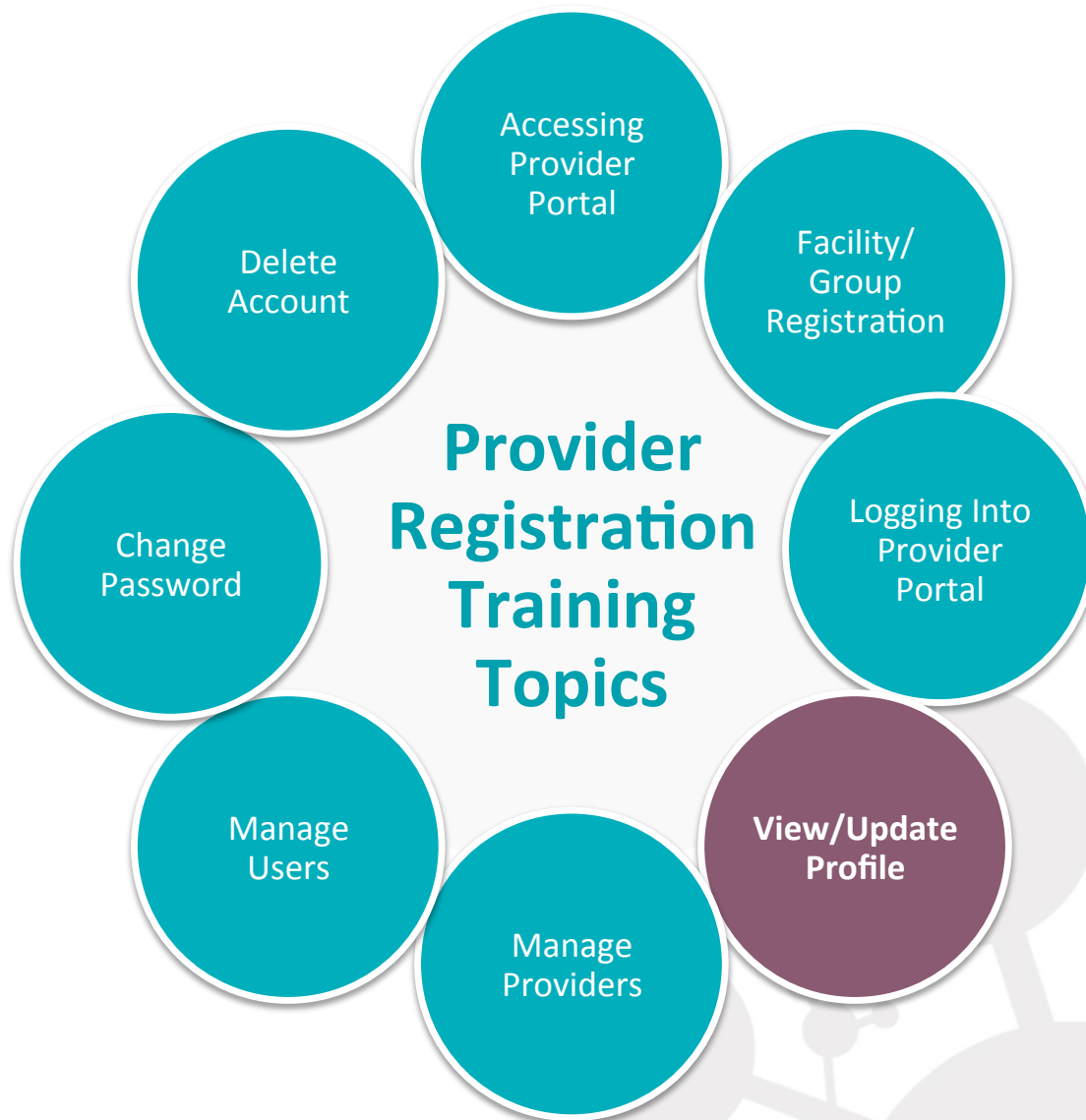
Take a tour at our new Provider Self Services!

#### Poll

Do you like our new look?

- Yes
- No
- None
- NA

[See Responses](#)



- Provider Portal**
- Member Eligibility
- ▶ Claims
- ▶ Service Request/Authorization
- HEDIS Profile **New!**
- ▶ Member Roster
- Reports
- Links
- Forms
- Account Tools
  - Change Password
  - View/Update Profile
  - Manage Users
  - Delete Account
  - Manage Providers

### Messages and Announcements

You have (0) new messages

You have (16) announcements

### Recent Activity

You have 0 Service Request Authorizations in the last 30 days

You have 0 claims in the last 30 days

### My Favorites [Edit](#)

- Member Eligibility
- Create Professional Claims
- Claims Download Report
- Claims Status Inquiry
- Service Request/Authorization
- Clear Coverage
- Create Institutional Claim
- HEDIS Profile

### Quick Member Eligibility Search

Search by Member ID

### What's New

Medicare is available for Member eligibility searches, Service/Request authorization Inquiry and Claim Status inquiry. Please click [Contact Molina](#) to locate the Molina Medicare member services telephone number.

### Video

3:07

Take a tour at our new Provider Self Services!

### Poll

Do you like our new look?

Yes  
 No  
 None  
 NA

[See Responses](#)

Select View/Update Profile

My Profile

General Information			
Name:	Web PortalTester	Title:	
Status:	Active	Credential Status:	
Provider Type:	AMBULATORY HEALTH CARE FACILITIES	Federal Tax ID:	123456789
License Number:		License Effective Date:	
License Termination Date:		Ethnicity:	NO ETHNICITY
Date Of Birth:		Gender:	
Specialty			
	Specialty Type		Specialty
AMBULATORY SURGICAL CENTER		PRIMARY	
Languages			
	Language Code		Description
Contact Information			
Mailing Address			
Address 1:	12345 MAIN STREET	Address 2:	
State:	CA	City:	LONG BEACH
County:	LOS ANGELES	Zip:	90801
Email:	WebPortal@MolinaHealthcare.com		
Physical Address			
Address 1:	12345 MAIN STREET	Address 2:	
State:	CA	City:	LONG BEACH
County:	LOS ANGELES	Zip:	90801
Phone Numbers			
Primary Phone Number:	<a href="#">555-555-5555</a>	Mobile Number:	
Secondary Phone Number:			
Account Self Services			
Secret Questions		Answers	
In which city you were born?		Test	
What is your mother's maiden name?		Test	
In what city or town was your first job?		Test	

Edit

To update your profile, select Edit

Update any information in any editable field. If the field that you need to edit is not open to change, please contact your local provider services representative.

**My Profile**

**General Information**

Name:	Web Portal Tester	Title:	
Status:	Active	Credential Status:	
Provider Type:	AMBULATORY HEALTH CARE FACILITIES	Federal Tax ID:	123456789
License Number:		License Effective Date:	
License Termination Date:		Ethnicity:	NO ETHNICITY
Date Of Birth:		Gender:	

**Specialty**

Specialty Type	Specialty
AMBULATORY SURGICAL CENTER	PRIMARY

**Languages**

Language Code	Description

**Contact Information**

**Mailing Address**

Address 1: *	12345 Main Street	Address 2:	
State:	CA	City:	LONG BEACH
County: *	LOS ANGELES	Zip: *	90801
Email: *	WebPortal@MolinaHealthcare.com		

**Physical Address**

Address 1:	12345 Main Street	Address 2:	
State:	CA	City:	LONG BEACH
County:	LOS ANGELES	Zip:	90801

**Phone Numbers**

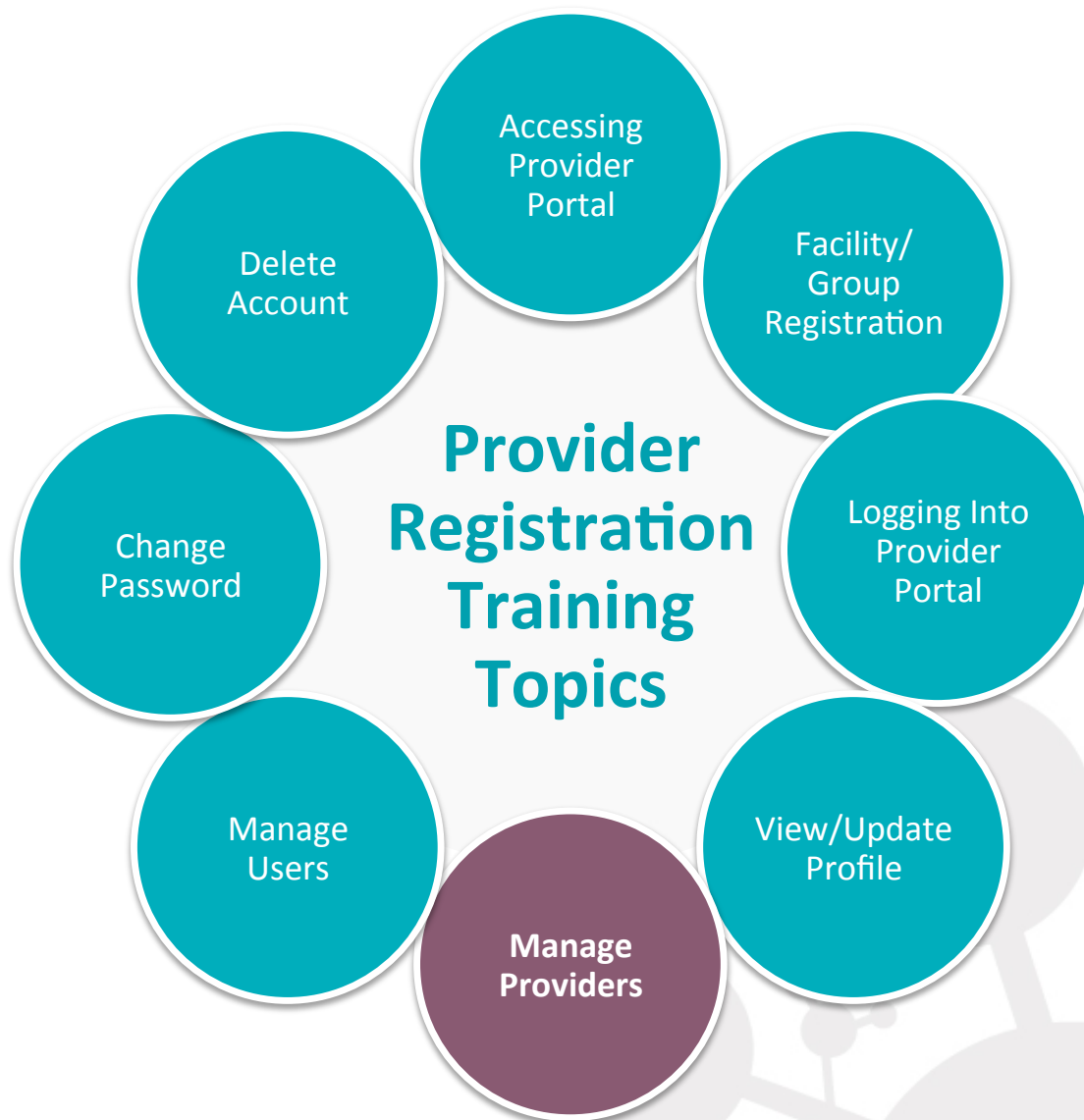
Primary Phone Number:	3616645291	Mobile Number:	
Secondary Phone Number:			

**Account Self Services \***

Secret Questions	Answers
In which city you were born?	test1
What was your childhood nickname?	test2
What is your oldest cousin's first and last name?	test3

**Save** **Cancel**

Select Save after updating your profile



Provider Portal	Messages and Announcements	Recent Activity	My Favorites <span style="float: right;"><a href="#">Edit</a></span>			
<ul style="list-style-type: none"> <li>Member Eligibility</li> <li>▶ Claims</li> <li>▶ Service Request/Authorization</li> <li>HEDIS Profile <span style="color: red;">New!</span></li> <li>▶ Member Roster</li> <li>Reports</li> <li>Links</li> <li>Forms</li> <li style="background-color: #009688; color: white;">▶ Account Tools             <ul style="list-style-type: none"> <li>Change Password</li> <li>View/Update Profile</li> <li>Manage Users</li> <li>Delete Account</li> <li>Manage Providers</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li> You have (0) new messages</li> <li> You have (16) announcements</li> </ul>	<ul style="list-style-type: none"> <li> You have 0 Service Request Authorizations in the last 30 days</li> <li> You have 0 claims in the last 30 days</li> </ul>	<ul style="list-style-type: none"> <li> Member Eligibility</li> <li> Create Professional Claims</li> <li> Claims Download Report</li> <li> Claims Status Inquiry</li> <li> Service Request/Authorization...</li> <li> Clear Coverage</li> <li> Create Institutional Claim</li> <li> HEDIS Profile</li> </ul>			
<h3 style="margin: 0;">Quick Member Eligibility Search</h3> <div style="border: 1px solid #ccc; padding: 5px; display: flex; align-items: center;"> <input style="width: 80%; border: none;" type="text" value="Search by Member ID"/> <input style="width: 10%; border: none; background-color: #009688; color: white; margin-left: 5px;" type="button" value="Go"/> </div>						
<table border="0" style="width: 100%;"> <tr> <td style="width: 33%; vertical-align: top;"> <h4 style="margin: 0;">What's New</h4> <p style="font-size: small; margin: 0;">Medicare is available for Member eligibility searches, Service/Request authorization inquiry and Claim Status inquiry. Please click <a href="#">Contact Molina</a> to locate the Molina Medicare member services telephone number.</p> </td> <td style="width: 33%; vertical-align: top;"> <h4 style="margin: 0;">Video</h4> <div style="text-align: center;"> <p style="font-size: x-small; margin: 0;">3:07</p> </div> <p style="font-size: x-small; margin: 0;">Take a tour at our new Provider Self Services!</p> </td> <td style="width: 33%; vertical-align: top;"> <h4 style="margin: 0;">Poll</h4> <p style="font-size: x-small; margin: 0;">Do you like our new look?</p> <p style="font-size: x-small; margin: 0;"> <input type="radio"/> Yes  <input type="radio"/> No  <input type="radio"/> None  <input type="radio"/> NA         </p> <p style="font-size: x-small; margin: 0; text-align: right;"> <input type="button" value="Vote"/> <a href="#">See Responses</a> </p> </td> </tr> </table>				<h4 style="margin: 0;">What's New</h4> <p style="font-size: small; margin: 0;">Medicare is available for Member eligibility searches, Service/Request authorization inquiry and Claim Status inquiry. Please click <a href="#">Contact Molina</a> to locate the Molina Medicare member services telephone number.</p>	<h4 style="margin: 0;">Video</h4> <div style="text-align: center;"> <p style="font-size: x-small; margin: 0;">3:07</p> </div> <p style="font-size: x-small; margin: 0;">Take a tour at our new Provider Self Services!</p>	<h4 style="margin: 0;">Poll</h4> <p style="font-size: x-small; margin: 0;">Do you like our new look?</p> <p style="font-size: x-small; margin: 0;"> <input type="radio"/> Yes  <input type="radio"/> No  <input type="radio"/> None  <input type="radio"/> NA         </p> <p style="font-size: x-small; margin: 0; text-align: right;"> <input type="button" value="Vote"/> <a href="#">See Responses</a> </p>
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Select Manage Providers

After you fill out the Tax ID Number and Provider ID, click Add.

Host Admin(s):   
Other Lines Of Business State: WA

**Registered Providers**

Tax ID Number	Provider ID	NPI #	Provider Name	Other Lines Of Business	Molina Status	
123456789	QMP000000000000	1111111111	Web Portal Tester	Other Lines Of Business	Active	Delete
<input type="text" value="123456789"/>	<input type="text" value="QMP111111111111"/>	<input type="text"/>		<input type="text" value="Other Lines Of Business"/>		Add



Host Admin(s):

Other Lines Of Business State: WA

**Registered Providers**

Tax ID Number	Provider ID	NPI #	Provider Name	Program	Molina Status	
123456789	QMP000000000000	1111111111	Web Portal Tester	Other Lines Of Business	Active	<a href="#">Delete</a>
123456789	QMP111111111111		Web Portal Tester _ Long Beach	Other Lines Of Business	Active	<a href="#">Delete</a>
<input type="text"/>	<input type="text"/>	<input type="text"/>		MEDICARE		<a href="#">Add</a>

When you are finished adding Providers, click Submit

123456789 - Other Lines of Business - xxx0000 - Web Portal Tester

Welcome, Admin User : WebPortal2014 [Log Out](#)

Dec 22 2014 3:03:57 PM

[Search](#) [FAQ](#) [Training](#) [Contact Molina](#)

### Recent Act

You have 0 S

You have 0 cl

There should now be a drop down menu with your providers

### My Favorites

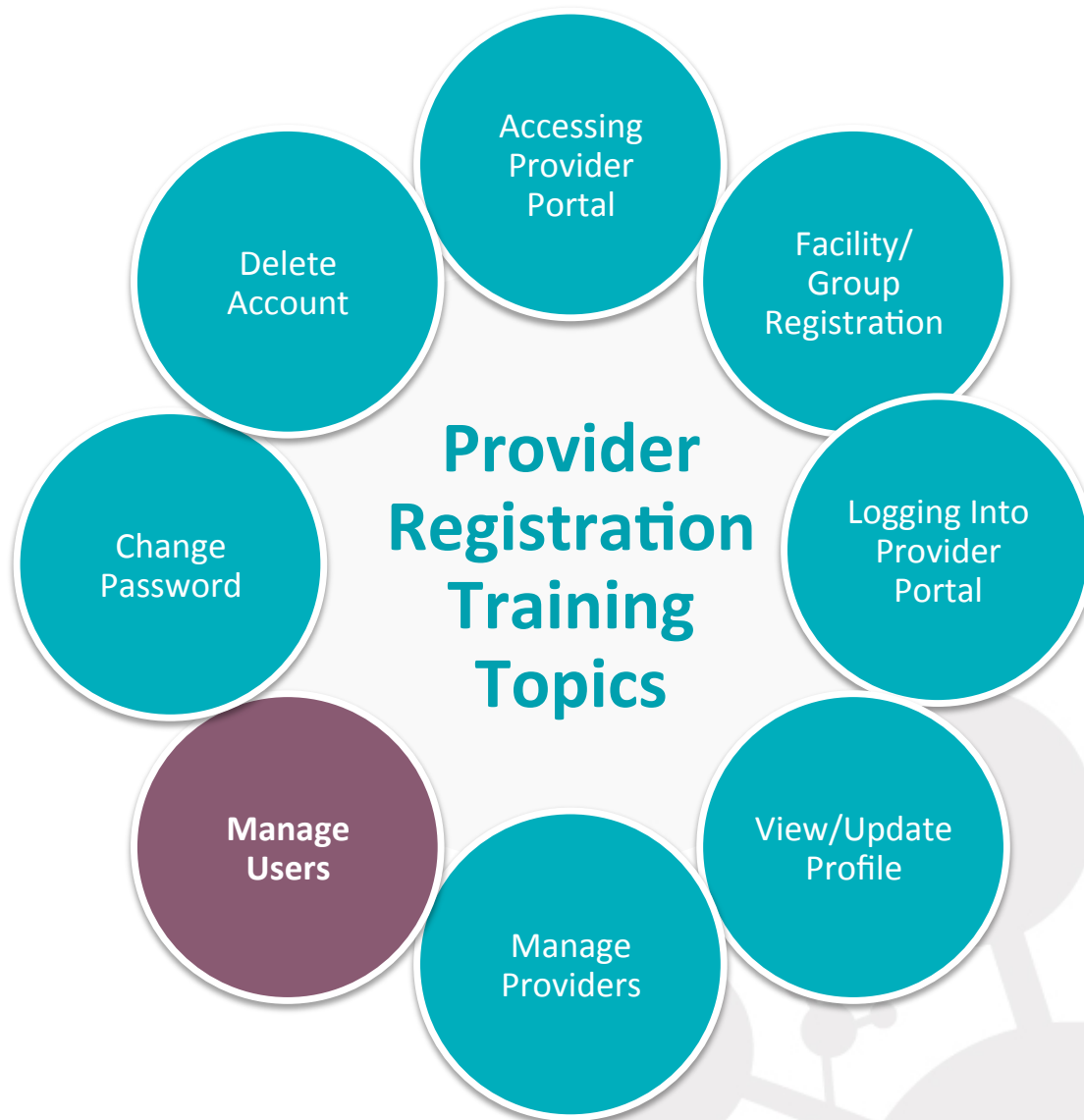
[Edit](#)

- Member Eligibility
- Create Professional Claims
- Claims Download Report
- Claims Status Inquiry

### Eligibility Search

[Go](#)

### Poll



Select Invite Users

**Welcome to  
Provider Services**  
Manage Users

**Filter Users**

- Administrator(0)
- Locked(0)
- Active(0)


**Go**

**Host Admin(s)**  
WebPortal2014

**Manage Users**

No sub users exist, please invite users to join your group.

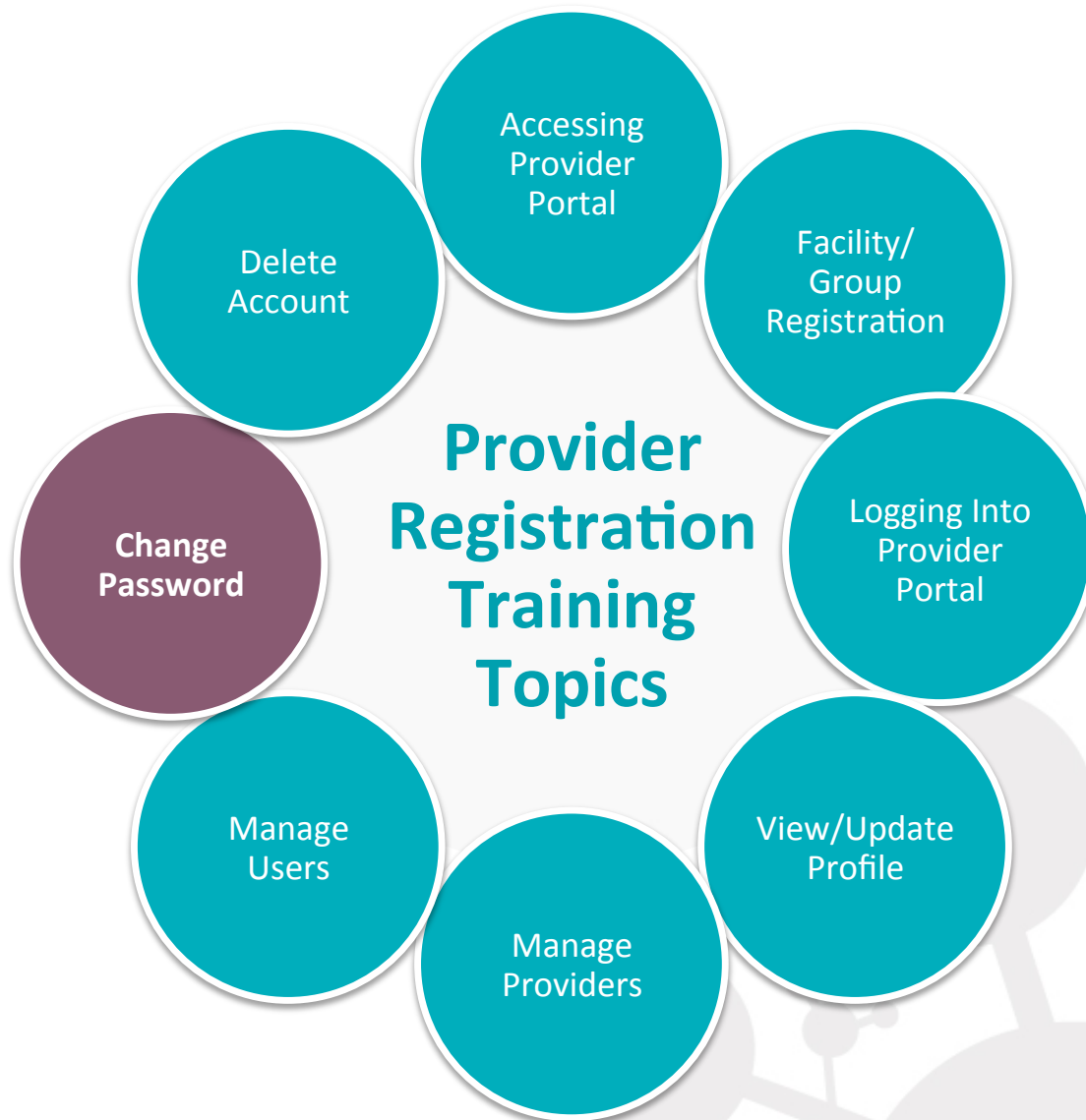
**Find My User**

User ID:  Email Address:  Date Created:    
(mm/dd/yyyy) **Search** **Clear**

**Invite Users**

**View Invitations** **View Access Requests**





- Provider Portal**
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- ▶ Service Request/Authorization
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- ▶ Member Roster
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### Quick Member Eligibility Search

Search by Member ID

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### Video

3:07

Take a tour at our new Provider Self Services!

### Poll

Do you like our new look?

Yes  
 No  
 None  
 NA

[See Responses](#)

Select Change Password

### Change Password

User ID: WebPortal2014

Current Password: \*

New Password: \*  12 Characters Max. 12 Character(s) Remaining

Confirm Password: \*

Password Rules:

Must have at least 8 and no more than 12 characters in the password.

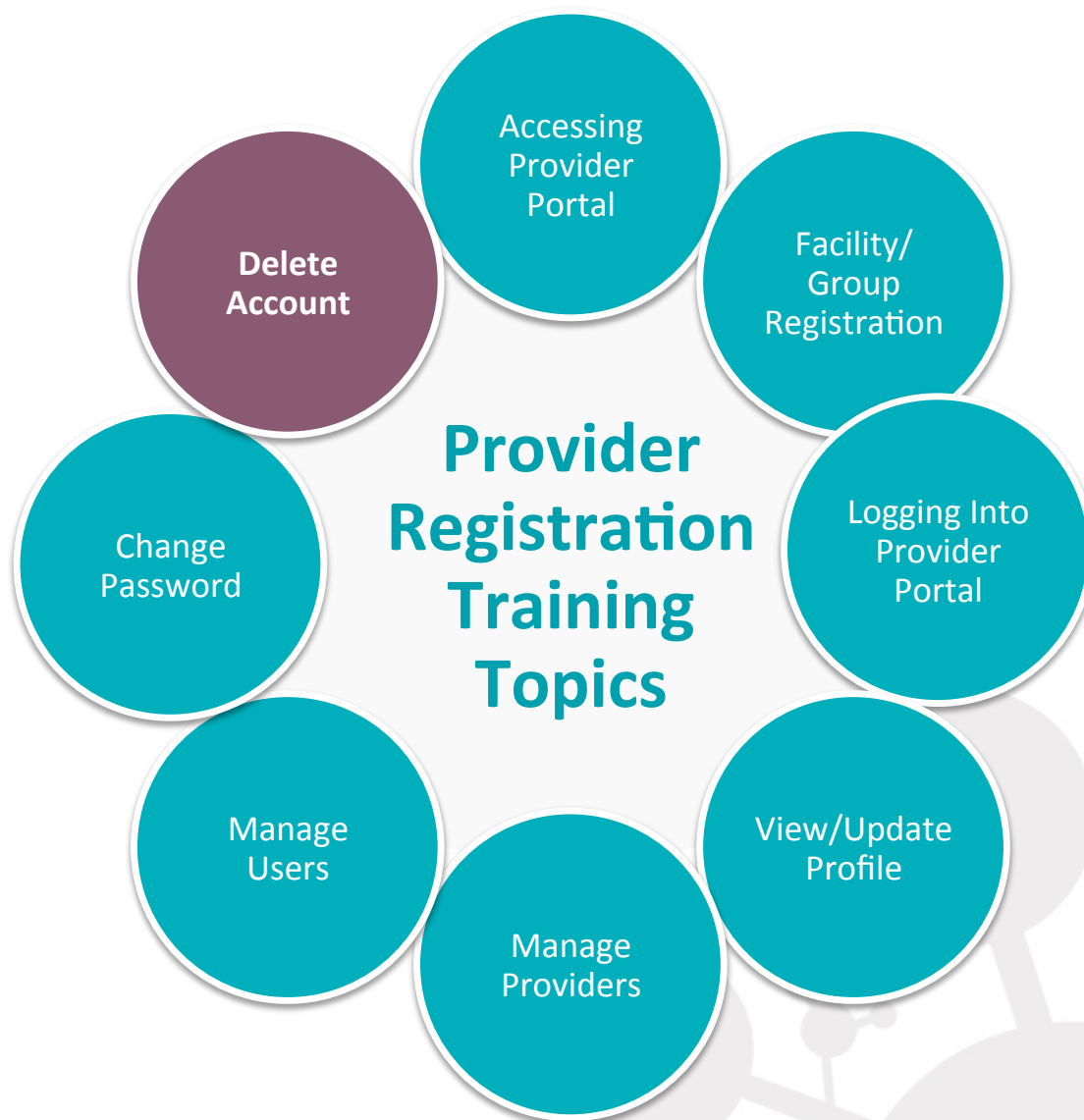
Must contain at least one uppercase and lowercase letter,

Must have at least one number

Password cannot contain partial User ID, first name or last name

Fill in the required fields and select Submit





### Provider Portal

- Member Eligibility
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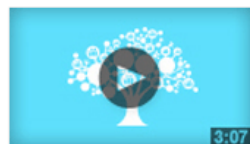
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Take a tour at our new Provider Self Services!

#### Poll

Do you like our new look?

- Yes
- No
- None
- NA

[See Responses](#)

Select Delete Account

### Delete Provider Self Services Account

To continue with account deletion, click the button below.

**Delete Account** **Cancel**

Select Delete Account

If a host admin is deleted, all linked users will lose access.  
If an admin or linked account is deleted, only that account will lose access

#### Delete Provider Self Services Account

To continue with account deletion, click the button below.

#### Confirmation

You are about to delete your account! Your session will be terminated and you will be redirected to the login page!. Press OK to continue.

Select Ok to delete account

# Member Eligibility



Your Extended Family.

# Member Eligibility

Member/Eligibility Inquiry provides the options to search by Member ID or Full Name and Date of Birth.

- Click Search to initiate the search.
- Click Clear to remove any data entered.

Search eligibility as of  (mmddyyyy)

**Member Search** Enter Member ID or First and Last Name and Date of Birth.

**Member ID:**

**First Name:**  **Last Name:**

**Date of Birth:**   
(mmddyyyy)

**Search Options**

**Gender:**

**Zip Code:**

**Line of Business:**

# Member Search by Member ID

1. Enter the Subscriber's Member ID.
2. Click Search. The Member Eligibility and Benefits page displays.

Search eligibility as of  (mmddyyyy)

---

**Member Search** Enter Member ID or First and Last Name and Date of Birth.

**Member ID:**

**First Name:**  **Last Name:**

**Date of Birth:**   
(mmddyyyy)

---

**Search Options**

**Gender:**

**Zip Code:**

**Line of Business:**

---

# Member Search by Name/Date of Birth

1. Enter the Member's First Name and/or Last Name, and the Date of Birth.

Search eligibility as of  (mmddyyyy)

**Member Search** Enter Member ID or First and Last Name and Date of Birth.

Member ID:

First Name:  Last Name:

Date of Birth:   
(mmddyyyy)

**Search Options**

Gender:

Zip Code:

Line of Business:

2. Click Search. The Member Eligibility And Benefits page displays.



# Multiple Members Found

If any search results in multiple matches the page will display a message and highlight the fields that differentiate the members. You may select/enter any of the highlighted fields and do a search again. The following illustrates an example of the display of multiple member found search.

- *Enter Zip Code and/or select a Line of Business to see member details*

**Member Search** Enter Member ID or First and Last Name and Date of Birth.

Member ID:

First Name:  Last Name:

Date of Birth:   
(mmddyyyy)

**Search Options**

Gender:

Zip Code:

Line of Business:

Your search has returned more than one result, enter optional information for the record you are requesting then press Submit again.

# Member Eligibility and Benefits page

The Member Information, Enrollment Information, and Primary Care Provider are displayed.

- Click any closed tab to display more detail information.
- Click on tabs to view and hide information.

**You Are Here: Member Information** [Help](#)

[Back to Member Eligibility Inquiry](#) Eligibility Information is current as of 09/23/2011 01:44 AM

Alerts Exist: HEDIS Alerts Member currently enrolled No enrollment restrictions

---

**Member Information**

<b>Name:</b>	<b>Member #:</b>
<b>Date of Birth:</b>	<b>Gender:</b>
<b>Mailing Address:</b>	<b>Home #:</b>
	<b>Alternative #:</b>
	<b>Mobile #:</b>
	<b>Email ID:</b>

---

**+ Additional Member Information** Expand to view Additional Member Information

---

**+ ALERTS** Expand to view ALERTS

---

**Enrollment Information** As of search date Today

<b>Enrollment Plan:</b>	Member has no current enrollment restrictions
<b>Enrollment Status:</b>	Member has no other Insurance
<b>Enrollment Effective Date:</b>	View <a href="#">Member Benefit Handbook</a>
<b>Enrollment Term Date:</b>	View <a href="#">Benefit Co-Pay Summary Amount</a>
<b>Rate Code:</b>	
<b>Health Plan ID:</b>	
<b>Subscriber ID:</b>	

---

**+ Enrollment History** Expand to view Enrollment History

---

**- Primary Care Provider Information** Collapse to hide Primary Care Provider Information

<b>Provider Name:</b>	<b>IPA/Group Name:</b>
<b>Provider NPI:</b>	<b>IPA/Group Effective Date:</b>
<b>Provider Specialty:</b>	
<b>Effective Date with Member:</b>	
<b>Service Location:</b>	

---

**+ PCP History** Expand to view PCP History

---

**+ IPA/Group Information** Expand to view IPA/Group Information

---

**+ IPA/Group History** Expand to view IPA/Group History

Alerts Exist: HEDIS Alerts Member currently enrolled No enrollment restrictions

[Member Information](#)

<b>Name:</b>	<b>Member #:</b>
<b>Date of Birth:</b>	<b>Gender:</b>
<b>Mailing Address:</b>	<b>Home #:</b>
	<b>Alternative #:</b>
	<b>Mobile #:</b>
	<b>Email ID:</b>

[- Additional Member Information](#) Collapse to hide Additional Member Information

**Primary Language Spoken:** ENGLISH **Ethnicity:** NO ETHNICITY

[- ALERTS](#) Collapse to hide ALERTS

**HEDIS Alert:** **Adult Access to Preventive/Ambulatory Health Services** 07/01/2011  
MISSING SERVICE documentation needed: Office Visit

**Notification:** Notify member to contact Molina

[Enrollment Information](#) As of search date Today

<b>Enrollment Plan:</b>	Member has no current enrollment restrictions
<b>Enrollment Status:</b>	
<b>Enrollment Effective Date:</b>	Member has no other Insurance
<b>Enrollment Term Date:</b>	
<b>Rate Code:</b>	View <a href="#">Member Benefit Handbook</a>
<b>Health Plan ID:</b>	View <a href="#">Benefit Co-Pay Summary Amount</a>
<b>Subscriber ID:</b>	

[- Enrollment History](#) Collapse to hide Enrollment History

There are no history records

[- Primary Care Provider Information](#) Collapse to hide Primary Care Provider Information

<b>Provider Name:</b>	<b>IPA/Group Name:</b>
<b>Provider NPI:</b>	<b>IPA/Group Effective Date:</b>
<b>Provider Specialty:</b>	
<b>Effective Date with Member:</b>	
<b>Service Location:</b>	

[- PCP History](#) Collapse to hide PCP History

There are no history records

[- IPA/Group Information](#) Collapse to hide IPA/Group Information

<b>Group Name:</b>	<b>NPI #:</b>
<b>Mailing Address:</b>	<b>Phone #:</b>
<b>Physical Address:</b>	<b>Phone #:</b>

**Last Contract Effective Date:**

[- IPA/Group History](#) Collapse to hide IPA/Group History

There are no history records

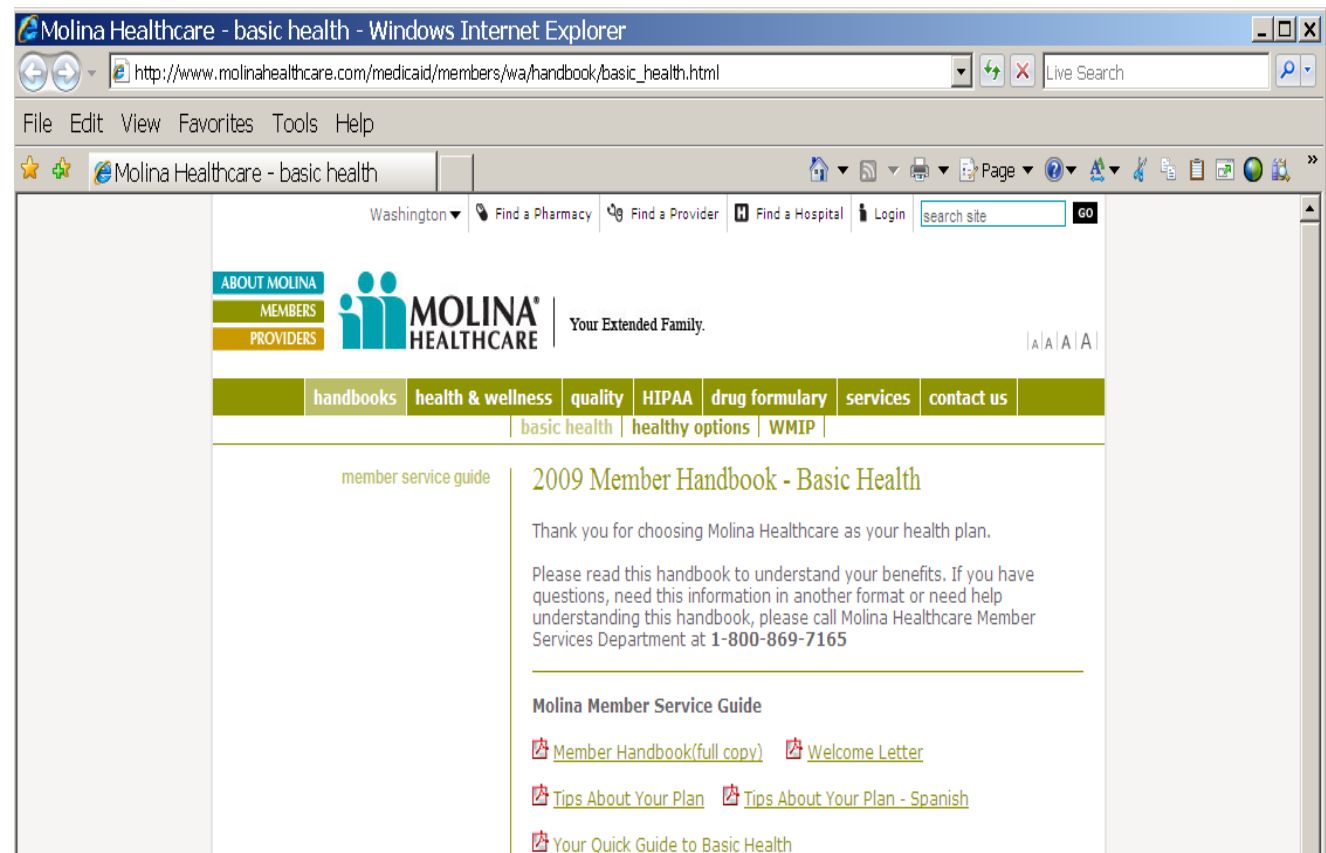
- *If alerts exist they will display on the top yellow alert bar*
- *Click Member Benefit Handbook to access the member's handbook.*
- *Click view Benefit Co-Pay Summary Amount to display the member's co-pay, coinsurance and deductible.*
- *Click Back to go to the previous page.*

# Member Eligibility and Benefits (cont.)

The member's handbook is displayed for their benefit plans.

Click the displayed link to view the Member Handbook.

Click X to close the page.



The screenshot shows a Windows Internet Explorer browser window displaying the Molina Healthcare website. The address bar shows the URL: [http://www.molinahealthcare.com/medicaid/members/wa/handbook/basic\\_health.html](http://www.molinahealthcare.com/medicaid/members/wa/handbook/basic_health.html). The page content includes the Molina Healthcare logo, navigation tabs for 'handbooks', 'health & wellness', 'quality', 'HIPAA', 'drug formulary', 'services', and 'contact us'. The main content area is titled '2009 Member Handbook - Basic Health' and contains the following text:

member service guide

## 2009 Member Handbook - Basic Health

Thank you for choosing Molina Healthcare as your health plan.

Please read this handbook to understand your benefits. If you have questions, need this information in another format or need help understanding this handbook, please call Molina Healthcare Member Services Department at 1-800-869-7165

---

**Molina Member Service Guide**

- [Member Handbook\(full copy\)](#)
- [Welcome Letter](#)
- [Tips About Your Plan](#)
- [Tips About Your Plan - Spanish](#)
- [Your Quick Guide to Basic Health](#)

# Member Eligibility – Print Function

Click Print on the Member Eligibility Details page to display a printable PDF document.



## Member Eligibility and Benefits Inquiry Response Report

Requested Eligibility Inquiry Date: 02-05-2009  
 Entity: GASTRO DIGESTIVE MEDICAL GROUP  
 Date of Inquiry: Thursday, February 5, 2009  
 Time of Inquiry: 09:40:54

Member Eligibility and Benefits	
Member Name: JONES, EDWIN C	Member Number: MMM123000000000F
Date of Birth: 01/01/1900	Gender: M
Street Address: CREST DR	City: ENCIN
State CA	Zip:
Home Phone: 4334334333	

Enrollment Restrictions			
Enrollment Status	Start Date	End Date	
Disenrollment from the Health Plan	10/1/2007	10/31/2007	
Eligibility Information			
Plan ID	Plan Description	Plan Effective Date	Plan Termination Date
QMXBP7539	San Diego Medicaid	11/1/2008	
QMXBP7539	San Diego Medicaid	1/1/2006	10/31/2007
QMXBP7528	HEALTHY FAMILIES	6/1/2005	10/31/2005

PCP / PMP									
Name	Provider Speciality	Effective Date	Term Date	Street Address	City	State	Zip	Phone	NPI Number
MENDENHALL, ANNA K	Pediatrics	11/1/2008		285 N EL CAMINO REAL STE 114	ENCINITAS	CA	92024	7604364511	1639140650
BALCH, STEVEN A	Pediatrics	3/1/2006	10/31/2007	285 N EL CAMINO REAL STE 114	ENCINITAS	CA	92024	7604364511	1003887027
MENDENHALL, ANNA K	Pediatrics	1/2/2006	2/28/2006	285 N EL CAMINO REAL STE 114	ENCINITAS	CA	92024	7604364511	1639140650
RUBENSTEIN, STUART I	Pediatrics	1/1/2006	1/1/2006	12395 EL CAMINO REAL 219	SAN DIEGO	CA	92130	8587931011	1689633844
RUBENSTEIN, STUART I	Pediatrics	7/1/2005	10/31/2005	12395 EL CAMINO REAL 219	SAN DIEGO	CA	92130	8587931011	1689633844
MENDENHALL, ANNA K	Pediatrics	6/1/2005	6/30/2005	285 N EL CAMINO REAL STE 114	ENCINITAS	CA	92024	7604364511	1639140650

Group / IPA				
Name	Address	City	State	Zip
CHILDRENS PRIMARY CARE MED GRP	3860 CALLE FORTUNADA STE 200	SAN DIEGO	CA	92123
CHILDRENS PRIMARY CARE MED GRP	3860 CALLE FORTUNADA STE 200	SAN DIEGO	CA	92123
CHILDRENS PRIMARY CARE MED GRP	3860 CALLE FORTUNADA STE 200	SAN DIEGO	CA	92123
CHILDRENS PRIMARY CARE MED GRP	3860 CALLE FORTUNADA STE 200	SAN DIEGO	CA	92123
CHILDRENS PRIMARY CARE MED GRP	3860 CALLE FORTUNADA STE 200	SAN DIEGO	CA	92123
CHILDRENS PRIMARY CARE MED GRP	3860 CALLE FORTUNADA STE 200	SAN DIEGO	CA	92123



# Claims



Your Extended Family.  
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# Training Breakdown

- [Create a Professional Claim](#)
- [Create an Institutional Claim](#)
- [Open Saved Claims](#)
- [Claims Status Inquiry](#)
- [Correct/Void a Claim](#)
- [Create/Manage Templates](#)
- [Download Exported Claim File](#)

**Note:** All the Member IDs, Member Names, and Any Member Data in this Demo are fictitious. Only TEST data was used and does **NOT** represent any actual person or actual Member ID #



The Claims menu provides you with the following options:

- Claim Status Inquiry
  - Create Professional Claim (CMS1500)
  - Create Institutional Claim (UB04)
  - Open Saved Claims
  - Create/Manage Claims Templates
  - Export Claims Report to Excel
- Export Claims Report to Excel

\*Please Note: You may also view recent claims by selecting View your recent Claims

The screenshot shows the Molina Healthcare Provider Self Services portal. The top navigation bar includes the Molina Healthcare logo, the text 'Provider Self Services', and a user greeting 'Welcome, Admin User: webportal' with a 'Log Out' link. The date and time 'Feb 09 2015 9:33:11 AM' are also displayed. Below the navigation bar, there are four main sections: 'Provider Portal', 'Messages and Announcements', 'Recent Activity', and 'My Favorites'. The 'Provider Portal' section contains a list of options, with 'Claims' highlighted by a red box. The 'Recent Activity' section contains a link 'Click here to view your recent Claims' also highlighted by a red box. The 'Messages and Announcements' section shows 'You have (274) new messages' and 'You have (16) announcements'. The 'My Favorites' section contains icons for 'Member Eligibility', 'Claim Status Inquiry', 'Create Professional Claims', 'Claims Download Report', 'Service Request/Authorization', 'Create Service Request/Authorization', 'Clear Coverage', and 'Create Institutional Claim'. The 'Quick Member Eligibility Search' section has a search box for 'Search by Member ID' and a 'Go' button. The 'What's New' section mentions Medicare availability. The 'Coming Soon!' section lists upcoming features like 'Batched Claims' and 'Create Claims Templates'. The 'Poll' section asks 'Do you like our new look?' with 'Yes' and 'No' options and a 'Vote' button.



**Provider Portal**

Member Eligibility

▼ **Claims**

Claims Status Inquiry

Create Professional Claim (CMS 1500)

Create Institutional Claim (UB04)

Open Saved Claims

Create/Manage Claims Template

Export Claims Report to Excel

▶ Service Request/Authorization

▶ Member

HEDIS Profile **New!**

Reports



Links

Forms

▶ Account Tools

**Messages and Announcements** You have (274) new messages You have (16) announcements

Select *Create Professional Claim (CMS 1500)*

**Recent Activity** [Click here to view your recent Service Request/Authorizations](#) [Click here to view your recent Claims](#)**Member Eligibility Search**

Search by member ID

Go

**What's New**

Medicare is available for Member Eligibility Searches, Service/Request Authorization Inquiry and Claim Status Inquiry. Please click [Contact Molina](#) to locate the Molina Member/Provider Services telephone numbers.

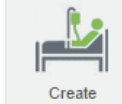
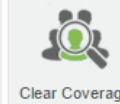
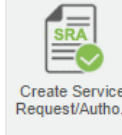
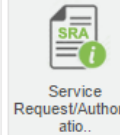
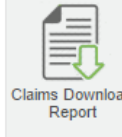
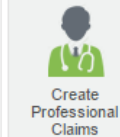
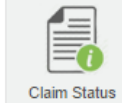
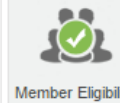
**Coming Soon !**

Claims will have new functionality coming in March!

- Batched Claims
- Create Claims Templates
- Correct Claims
- Add Attachments to Claims

**Poll**

Do you like our new look?

 Yes No[Vote](#)[See Responses](#)**My Favorites** [Edit](#)

The Professional Claim form includes three tabs. Start with Member tab.

Next >> Save for Later Cancel

**Member** **Provider** **Summary** \*\* Required Field [Help](#) [FAQ](#)

Create Claim  Correct Claim  Void Claim

Search by Last name, first name and Date of Birth. If you dont know the ID search by Last name,First name and Date of Birth using

Advanced Search

First Name: \*  DOB: \*   
(mm/dd/yyyy)

Service To Date: \*   
(mm/dd/yyyy)

**Insured's Information**

Last Name:  First Name:  Middle Initial:   
DOB:  Sex:   
Address1:  Address2:   
City:  State:  Zip Code:   
Payor Name: MHC TX Program Name:  Payor ID: 00-1111111

**Patient Information**

Note: If there are no dependents for the Insured, Patient Relationship will be prepopulated as "Self".

Patient Relationship to Insured: 18-Self

**Other Insurance**

Is there another benefit plan? \*  Yes  No

**Patient Conditions**

Is patient's condition related to the following? (check all that apply)

Employment  Another Party Responsible  Other Accident  
 Auto Accident Place(State):\*

Are there any patient condition dates that need to be entered? (eg :Last menstruation, X-ray,immunization,etc..)  Yes  No

**Verify Required Information**

Patient Account Number:\*

Member Authorized Assignment of Benefit:\*  Yes  No Provider Assignment code:

Release of Information:\*

Prior Authorization Number:

Next >> Save for Later Cancel

Next >> Save for Later Cancel

**Member** **Provider** **Summary** \*\* Required Field [Help](#) [FAQ](#)

What would you like to do?  Create Claim  Correct Claim  Void Claim

**Eligibility Check**  
 Enter the insured's ID or their last name, first name and Date of Birth. If you dont know the ID search by Last name,First name and Date of Birth using Advance Search .

Insured's ID Number: \*  Advanced Search  
 OR  
 Last Name: \*  First Name: \*  DOB: \*   
(mm/dd/yyyy)  
 AND  
 Service From Date: \*  (mm/dd/yyyy) Service To Date: \*  (mm/dd/yyyy)

**Insured's Information**

Last Name:  First Name:  Middle Initial:   
 DOB:  Sex:   
 Address1:  Address2:   
 City:  State:  Zip Code:   
 Payor Name:  MHC TX Program Name:  Payor ID:  00-1111111

**Patient Information**

Note: If there are no dependents for the Insured, Patient Relationship will be prepopulated as "Self".

Patient Relationship to Insured:  18-Self

**Other Insurance**

Is there another benefit plan? \*  Yes  No

**Patient Conditions**

Is patient's condition related to the following? (check all that apply)

Employment  Another Party Responsible  Other Accident  
 Auto Accident Place(State):\*  Select

Are there any patient condition dates that need to be entered? (eg.Last menstruation, X-ray,immunization,etc..)  Yes  No

**Verify Required Information**

Patient Account Number:\*   
 Member Authorized Assignment of Benefit:\*  Yes  No Provider Assignment code:  Select  
 Release of Information:\*  Select  
 Prior Authorization Number:

Next >> Save for Later Cancel

Once you fill in the required fields, the Insured's Information should auto-populate

Please Note: All required field are noted with a red asterisk (\*)

Next >> Save for Later Cancel

**Member** **Provider** **Summary** \*\* Required Field [Help](#) [FAQ](#)

What would you like to do?  Create Claim  Correct Claim  Void Claim

**Eligibility Check**

Enter the insured's ID or their last name, first name and Date of Birth. If you dont know the ID search by Last name,First name and Date of Birth using Advance Search .

Insured's ID Number: \*  Advanced Search

OR

Last Name: \*  First Name: \*  DOB: \*   
(mm/dd/yyyy)

AND

Service From Date: \*    Service To Date: \*     
(mm/dd/yyyy) (mm/dd/yyyy)

**Insured's Information**

Last Name:  First Name:  Middle Initial:

DOB:  Sex:

Address1:  Address2:

City:  State:  Zip Code:

Payor Name:  MHC TX Program Name:  Payor ID:  00-11111111

**Patient Information**

Note: If there are no dependents for the Insured, Patient Relationship will be prepopulated as "Self".

Patient Relationship to Insured:  18-Self

**Other Insurance**

Is there another benefit plan? \*  Yes  No

**Patient Conditions**

Is patient's condition related to the following? (check all that apply)

Employment  Another Party Responsible  Other Accident

Auto Accident Place(State):\*  Select

Are there any patient condition dates that need to be entered? (eg:Last menstruation, X-ray,immunization,etc..)  Yes  No

**Verify Required Information**

Patient Account Number:\*

Member Authorized Assignment of Benefit:\*  Yes  No Provider Assignment code:  Select

Release of Information:\*  Select

Prior Authorization Number:

Next >> Save for Later Cancel

Enter the Patient's Relationship to Insured. For most coverage, Patient Relationship to Insured defaults to "Self".

Please Note: All required field are noted with a red asterisk (\*)

Next >> Save for Later Cancel

**Member** **Provider** **Summary** \*\* Required Field [Help](#) [FAQ](#)

What would you like to do?  Create Claim  Correct Claim  Void Claim

**Eligibility Check**

Enter the insured's ID or their last name, first name and Date of Birth. If you dont know the ID search by Last name,First name and Date of Birth using Advance Search .

Insured's ID Number: \*  Advanced Search

OR

Last Name: \*  First Name: \*  DOB: \*   
(mm/dd/yyyy)

AND

Service From Date: \*          
(mm/dd/yyyy)

Service To Date: \*          
(mm/dd/yyyy)

**Insured's Information**

Last Name:  First Name:  Middle Initial:

DOB:  Sex:

Address1:  Address2:

City:  State:  Zip Code:

Payor Name: MHC TX Program Name:  Payor ID: 00-1111111

**Patient Information**

Note: If there are no dependents for the Insured, Patient Relationship will be prepopulated as "Self".

Patient Relationship to Insured: 18-Self

**Other Insurance**

Is there another benefit plan? \*  Yes  No

**Patient Conditions**

Is patient's condition related to the following? (check all that apply)

Employment  Another Party Responsible  Other Accident

Auto Accident Place(State):\*

Are there any patient condition dates that need to be entered? (eg.Last menstruation, X-ray,immunization,etc..)  Yes  No

**Verify Required Information**

Patient Account Number:\*

Member Authorized Assignment of Benefit:\*  Yes  No Provider Assignment code:

Release of Information:\*

Prior Authorization Number:

Next >> Save for Later Cancel

Enter information for other insurance, if applicable.

Note: If "Yes" is selected and this is a Secondary claim, you must attach EOB and update the COB line level information in the Provider Tab claim line.

Please Note: All required field are noted with a red asterisk (\*)

Next >> Save for Later Cancel

**Member** **Provider** **Summary** \*\* Required Field [Help](#) [FAQ](#)

What would you like to do?  Create Claim  Correct Claim  Void Claim

**Eligibility Check**

Enter the insured's ID or their last name, first name and Date of Birth. If you dont know the ID search by Last name,First name and Date of Birth using Advance Search .

Insured's ID Number: \*  Advanced Search

OR

Last Name: \*  First Name: \*  DOB: \*   
(mm/dd/yyyy)

AND

Service From Date: \*    Service To Date: \*     
(mm/dd/yyyy) (mm/dd/yyyy)

**Insured's Information**

Last Name:  First Name:  Middle Initial:

DOB:  Sex:

Address1:  Address2:

City:  State:  Zip Code:

Payor Name: MHC TX Program Name:  Payor ID: 00-1111111

**Patient Information**

Note: If there are no dependents for the Insured, Patient Relationship will be prepopulated as "Self".

Patient Relationship to Insured: 18-Self

**Other Insurance**

Is there another benefit plan? \*  Yes  No

**Patient Conditions**

Is patient's condition related to the following? (check all that apply)

Employment  Another Party Responsible  Other Accident

Auto Accident Place(State):\*

Are there any patient condition dates that need to be entered? (eg.Last menstruation, X-ray,immunization,etc..)  Yes  No

**Verify Required Information**

Patient Account Number:\*

Member Authorized Assignment of Benefit:\*  Yes  No Provider Assignment code:

Release of Information:\*

Prior Authorization Number:

Next >> Save for Later Cancel

Select all that apply. If there are any other dates known or related to the patient's condition, enter them as appropriate.

Please Note: All required field are noted with a red asterisk (\*)



Next >>

Save for Later Cancel

- Member
- Provider
- Summary

\*- Required Field [Help](#) [FAQ](#)

What would you like to do?  Create Claim  Correct Claim  Void Claim

### Eligibility Check

Enter the insured's ID or their last name, first name and Date of Birth. If you dont know the ID search by Last name,First name and Date of Birth using Advance Search .

Insured's ID Number: \*

OR

Last Name: \*  First Name: \*  DOB: \*   
(mm/dd/yyyy)

AND

Service From Date: \*        
(mm/dd/yyyy)

Service To Date: \*        
(mm/dd/yyyy)

### Insured's Information

Last Name:  First Name:  Middle Initial:

DOB:  Sex:

Address1:  Address2:

City:  State:  Zip Code:

Payor Name:  MHC TX Program Name:  Payor ID:  00-1111111

### Patient Information

Note: If there are no dependents for the Insured, Patient Relationship will be prepopulated as "Self".

Patient Relationship to Insured:  18-Self

### Other Insurance

Is there another benefit plan? \*  Yes  No

### Patient Conditions

Is patient's condition related to the following? (check all that apply)

Employment  Another Party Responsible  Other Accident

Auto Accident Place(State):\*  Select

Are there any patient condition dates that need to be entered? (eg.Last menstruation, X-ray,immunization,etc..)  Yes  No

### Verify Required Information

Patient Account Number:\*

Member Authorized Assignment of Benefit:\*  Yes  No Provider Assignment code:  Select

Release of Information:\*  Select

Prior Authorization Number:

Next >>

Save for Later Cancel

Enter the required information to release patient information

Please Note: All required field are noted with a red asterisk (\*)

Next >>

Save for Later Cancel

Member Provider Summary

\*- Required Field Help FAQ

What would you like to do?  Create Claim  Correct Claim  Void Claim

Eligibility Check

Enter the insured's ID or their last name, first name and Date of Birth. If you dont know the ID search by Last name,First name and Date of Birth using Advance Search .

Insured's ID Number: \* [ ] Advanced Search
OR
Last Name: \* [ ] First Name: \* [ ] DOB: \* [ ] (mm/dd/yyyy)
AND
Service From Date: \* [ ] (mm/dd/yyyy) Service To Date: \* [ ] (mm/dd/yyyy)

Insured's Information

Last Name: [ ] First Name: [ ] Middle Initial: [ ]
DOB: [ ] Sex: [ ]
Address1: [ ] Address2: [ ]
City: [ ] State: [ ] Zip Code: [ ]
Payor Name: MHC TX Program Name: [ ] Payor ID: 00-11111111

Patient Information

Note: If there are no dependents for the Insured, Patient Relationship will be prepopulated as "Self".

Patient Relationship to Insured: 18-Self

Other Insurance

Is there another benefit plan? \*  Yes  No

Patient Conditions

Is patient's condition related to the following? (check all that apply)

Employment  Another Party Responsible  Other Accident

Auto Accident Place(State):\* [ Select ]

Are there any patient condition dates that need to be entered? (eg :Last menstruation, X-ray,immunization,etc..)  Yes  No

Verify Required Information

Patient Account Number:\* [ ]
Member Authorized Assignment of Benefit:\*  Yes  No Provider Assignment code: [ Select ]
Release of Information:\* [ Select ]
Prior Authorization Number: [ ]

Next >>

Save for Later Cancel

Please Note: All required field are noted with a red asterisk (\*)

Upon completion of the required fields, select Next >>

If you have more than one Billing Provider, a drop down list will appear. Once you make a selection, it will auto-populate the information.

<< Previous Next >> Save for Later Cancel

**Member** **Provider** **Summary** Help FAQ

Select a Billing Provider Information

Billing Provider: MOLINA HEALTH CENTER

Last Name: MOLINA HEALTH CENTER First Name: Middle Initial: TIN: 123456789 NPI: 1111111111  
 Address1: 000 MAIN ST Address2: City: LONG BEACH State: CA Zip Code: 90801

Provider Information

Rendering Provider: MOLINA HEALTH CENTER

NPI: 1111111111 Last Name: MOLINA HEALTH CENTER First Name: Middle Initial: Zip Code: 90801

+ Add another type of provider

Facility Information

Select one:  Service Location  Facility  Independent Lab

Diagnosis Code

Remove	DX No.	Diagnosis Code	Diagnosis Description
<input type="checkbox"/>	1		
<input type="checkbox"/>	2		

+ Add more Diagnosis Code

Claim Line Details \*

(Remove)	Service From Date	Service To Date	Place of Service	Emergency	Procedure Code	Modifier	Diagnosis Code Reference	Charges	Units of Measurement	Quantity	EPSDT	Family Plan	More Details
1				No					Select	0.00	No	No	More Details
2				No					Select	0.00	No	No	More Details

Drug Information

NDC Number: Prescription Date:

Drug Information

NDC Number: Prescription Date:

+ Add more Claim Lines

Supporting Information

Type of Attachment: Select

File: Choose File No file chosen Upload

Supported file formats are PDF, TIF, JPG, BMP and GIF. Upload 1 file at a time. Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

Comments

Remarks:

256 Characters Max. 256 characters remaining.

Total Amount

Total Charge: Total Paid: Balance Due:

<< Previous Next >> Save for Later Cancel

Please Note: All required field are noted with a red asterisk (\*)

If there is more than one Rendering Provider, a drop down list will appear. Once you make a selection, it will auto-populate the information.

<< Previous Next >> Save for Later Cancel

**Member** **Provider** **Summary** Help FAQ

Select a Billing Provider Information

Billing Provider: MOLINA HEALTH CENTER

Last Name: MOLINA HEALTH CENTER First Name: Middle Initial: TIN: 123456789 NPI: 1111111111  
 Address1: Address2: City: LONG BEACH State: CA Zip Code: 90801  
 000 MAIN ST

Provider Information

Rendering Provider: MOLINA HEALTH CENTER

NPI: 1111111111 Last Name: MOLINA HEALTH CENTER First Name: Middle Initial: Zip Code: 90801

+ Add another type of provider

Facility Information

Select one:  Service Location  Facility  Independent Lab

Diagnosis Code

Remove	DX No.	Diagnosis Code	Diagnosis Description
<input type="checkbox"/>	1		
<input type="checkbox"/>	2		

+ Add more Diagnosis Code

Claim Line Details \*

(Remove)	Service From Date	Service To Date	Place of Service	Emergency	Procedure Code	Modifier	Diagnosis Code Reference	Charges	Units of Measurement	Quantity	EPSTD	EPSTD Family Plan	More Details
<input type="checkbox"/>				No					Select	0.00	No	No	More Details
<input type="checkbox"/>				No					Select	0.00	No	No	More Details

Drug Information

NDC Number: Prescription Date:

Drug Information

NDC Number: Prescription Date:

+ Add more Claim Lines

Supporting Information

Type of Attachment: Select

File: Choose File No file chosen Upload

Supported file formats are PDF, TIF, JPG, BMP and GIF. Upload 1 file at a time.  
 Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

Comments

Remarks:

256 Characters Max. 256 characters remaining.

Total Amount

Total Charge: Total Paid: Balance Due:

<< Previous Next >> Save for Later Cancel

Please Note: All required field are noted with a red asterisk (\*)

<< Previous Next >> Save for Later Cancel

**Member** **Provider** **Summary** Help FAQ

Select a Billing Provider Information

Billing Provider: MOLINA HEALTH CENTER

Last Name: MOLINA HEALTH CENTER First Name: Middle Initial: TIN: 123456789 NPI: 1111111111  
 Address1: 000 MAIN ST Address2: City: LONG BEACH State: CA Zip Code: 90801

Provider Information

Rendering Provider: MOLINA HEALTH CENTER

NPI: 1111111111 Last Name: MOLINA HEALTH CENTER First Name: Middle Initial: Zip Code: 90801

+ Add another type of provider

Facility Information

Select one:  Service Location  Facility  Independent Lab

Diagnosis Code

Remove	DX No.	Diagnosis Code	Diagnosis Description
<input type="checkbox"/>	1		
<input type="checkbox"/>	2		

+ Add more Diagnosis Code

Claim Line Details \*

(Remove)	Service From Date	Service To Date	Place of Service	Emergency	Procedure Code	Modifier	Diagnosis Code Reference	Charges	Units of Measurement	Quantity	EPSDT	Family Plan	More Details
<input type="checkbox"/>	1			No					Select	0.00	No	No	More Details
<input type="checkbox"/>	2			No					Select	0.00	No	No	More Details

Drug Information

NDC Number: Prescription Date:

Drug Information

NDC Number: Prescription Date:

+ Add more Claim Lines

Supporting Information

Type of Attachment: Select

File: Choose File No file chosen Upload

Supported file formats are PDF, TIF, JPG, BMP and GIF. Upload 1 file at a time.  
 Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

Comments

Remarks:

256 Characters Max. 256 characters remaining.

Total Amount

Total Charge: Total Paid: Balance Due:

<< Previous Next >> Save for Later Cancel

If there is a Service Location affiliated with the Provider, you may select it in the list under Service Location. If it is a Facility or Independent Lab, please manually enter all necessary information.

Please Note: All required field are noted with a red asterisk (\*)

<< Previous Next >> Save for Later Cancel

**Member** **Provider** **Summary** Help FAQ

Select a Billing Provider Information

Billing Provider: MOLINA HEALTH CENTER

Last Name: MOLINA HEALTH CENTER First Name: Middle Initial: TIN: 123456789 NPI: 1111111111  
 Address1: 000 MAIN ST Address2: City: LONG BEACH State: CA Zip Code: 90801

Provider Information

Rendering Provider: MOLINA HEALTH CENTER

NPI: 1111111111 Last Name: MOLINA HEALTH CENTER First Name: Middle Initial: Zip Code: 90801

+ Add another type of provider

Facility Information

Select one:  Service Location  Facility  Independent Lab

Diagnosis Code

Remove	DX No.	Diagnosis Code	Diagnosis Description
<input type="checkbox"/>	1	<input type="text"/>	
<input type="checkbox"/>	2	<input type="text"/>	

+ Add more Diagnosis Code

Claim Line Details \*

(Remove)	Service From Date	Service To Date	Place of Service	Emergency	Procedure Code	Modifier	Diagnosis Code Reference	Charges	Units of Measurement	Quantity	EPSDT	Family Plan	More Details
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	No	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Select	0.00	No	No	More Details
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	No	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Select	0.00	No	No	More Details

Drug Information

NDC Number:  Prescription Date:

Drug Information

NDC Number:  Prescription Date:

+ Add more Claim Lines

Supporting Information

Type of Attachment:  Select

File:  No file chosen

Supported file formats are PDF, TIF, JPG, BMP and GIF. Upload 1 file at a time.  
 Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

Comments

Remarks:

256 Characters Max. 256 characters remaining.

Total Amount

Total Charge:  Total Paid:  Balance Due:

<< Previous Next >> Save for Later Cancel

You must enter at least one Diagnosis Code. If not known, click on magnifying glass icons to search for the appropriate code.

Please Note: All required field are noted with a red asterisk (\*)

<< Previous Next >> Save for Later Cancel

**Member** **Provider** **Summary** Help FAQ

**Select a Billing Provider Information**

Billing Provider: MOLINA HEALTH CENTER

Last Name: MOLINA HEALTH CENTER First Name: Middle Initial: TIN: 123456789 NPI: 1111111111  
 Address1: 000 MAIN ST Address2: City: LONG BEACH State: CA Zip Code: 90801

**Provider Information**

Rendering Provider: MOLINA HEALTH CENTER

NPI: 1111111111 Last Name: MOLINA HEALTH CENTER First Name: Middle Initial: Zip Code: 90801

+ Add another type of provider

**Facility Information**

Select one:  Service Location  Facility  Independent Lab

**Diagnosis Code**

Remove	DX No.	Diagnosis Code	Diagnosis Description
<input type="checkbox"/>	1		
<input type="checkbox"/>	2		

+ Add more Diagnosis Code

**Claim Line Details \***

(Remove)	Service From Date	Service To Date	Place of Service	Emergency	Procedure Code	Modifier	Diagnosis Code Reference	Charges	Units of Measurement	Quantity	EPSDT	Family Plan	More Details
<input type="checkbox"/>	1			No					Select	0.00	No	No	More Details
<input type="checkbox"/>	2			No					Select	0.00	No	No	More Details

**Drug Information**

NDC Number: Prescription Date:

**Drug Information**

NDC Number: Prescription Date:

+ Add more Claim Lines

**Supporting Information**

Type of Attachment: Select  
 File: Choose File No file chosen Upload

Supported file formats are PDF, TIF, JPG, BMP and GIF. Upload 1 file at a time.  
 Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

**Comments**

Remarks:

256 Characters Max. 256 characters remaining.

**Total Amount**

Total Charge: Total Paid: Balance Due:

<< Previous Next >> Save for Later Cancel

Service Dates should auto-populate from the Member tab. Fill in the additional required information.

Please Note: All required field are noted with a red asterisk (\*)

<< Previous Next >> Save for Later Cancel

**Member** **Provider** **Summary** Help FAQ

**Select a Billing Provider Information**

Billing Provider: MOLINA HEALTH CENTER

Last Name: MOLINA HEALTH CENTER First Name: Middle Initial: TIN: 123456789 NPI: 1111111111  
 Address1: Address2: City: LONG BEACH State: CA Zip Code: 90801  
 000 MAIN ST

**Provider Information**

Rendering Provider: MOLINA HEALTH CENTER

NPI: 1111111111 Last Name: MOLINA HEALTH CENTER First Name: Middle Initial: Zip Code: 90801

+ Add another type of provider

**Facility Information**

Select one:  Service Location  Facility  Independent Lab

**Diagnosis Code**

Remove	DX No.	Diagnosis Code	Diagnosis Description
<input type="checkbox"/>	1		
<input type="checkbox"/>	2		

+ Add more Diagnosis Code

**Claim Line Details \***

(Remove)	Service From Date	Service To Date	Place of Service	Emergency	Procedure Code	Modifier	Diagnosis Code Reference	Charges	Units of Measurement	Quantity	EPSTD	Family Plan	More Details
<input type="checkbox"/>				No					Select	0.00	No	No	More Details
<input type="checkbox"/>				No					Select	0.00	No	No	More Details

**Drug Information**

NDC Number: Prescription Date:

**Drug Information**

NDC Number: Prescription Date:

+ Add more Claim Lines

**Supporting Information**

Type of Attachment: Select  
 File: Choose File No file chosen Upload  
 Supported file formats are PDF, TIF, JPG, BMP and GIF. Upload 1 file at a time.  
 Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

**Comments**

Remarks:   
 256 Characters Max. 256 characters remaining.

**Total Amount**

Total Charge: Total Paid: Balance Due:

<< Previous Next >> Save for Later Cancel

These sections are available to upload supporting documentation or add comments and remarks. If an attachment is submitted, it is required to fill in the *Type of Attachment*.

Please Note: All required field are noted with a red asterisk (\*)



<< Previous Next >> Save for Later Cancel

**Member** **Provider** **Summary** Help FAQ

**Select a Billing Provider Information**

Billing Provider: MOLINA MEDICAL CENTER

Last Name: MOLINA MEDICAL CENTER First Name: Middle Initial: TIN: 123456789 NP1: 000000000  
 Address1: Address2: City: SAN ANTONIO State: Zip Code: 78224  
 0000 E MAIN ST TX

**Provider Information**

Select a Rendering Provider: Select

NPI: Last Name: First Name: Middle Initial: Zip Code:

+ Add another type of provider

**Facility Information**

Select one:  Service Location  Facility  Independent Lab

**Diagnosis Code**

Remove	DX No.	Diagnosis Code	Diagnosis Description
	* 1		
	2		

+ Add more Diagnosis Code

**Claim Line Details \***

(Remove)	Services From Date	To Date	Place of Service	Emergency	Procedure Code	Modifier	Diagnosis Code Reference	Charges	Units of Measurement	Quantity	EPSTD	Family Plan	More Details
* 1				No					Select	0.00	No	No	More Details
2				No					Select	0.00	No	No	More Details

**Drug Information**

NDC Number: Prescription Date:

**Supporting Information**

Type of Attachment: Select

File: Choose File No file chosen Upload

Upload files only when you want to submit a claim or add supporting documents to the claim in adjudication. Supported file formats are PDF, TIF, JPG, BMP and GIF. Upload 1 file at a time. Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

**Comments**

Remarks:  256 Characters Max. 256 characters remaining.

**Amount**

Charge: 0 Total Paid: 0 Balance Due: 0

<< Previous Next >> Save for Later Cancel

Please Note: All required field are noted with a red asterisk (\*)

Upon completion of the required fields, select Next >>

[Print](#)
[Save for Later](#)
[Submit](#)
[Save For Batch](#)
[Cancel](#)

[Member](#)
[Provider](#)
[Summary](#)
[Help](#)
[FAQ](#)

Collapse All

**Member Summary** Edit

**Insured Information**

Insured's ID: Service From Date: Last Name: Middle Initial: Sex: Address2: State: Payor Name: MHC TX Payor ID: 20-1494502	Service To Date: First Name: DOB: Address1: City: Zip Code: Program Name: Another Health Benefit Plan: No
---	--

**Patient Information** Edit

Patient Relationship to Insured: Last Name: Middle Initial: Sex: Address1: City: Zip Code:	First Name: DOB: Address2: State:
--	--

**Patient Condition** Edit

Auto Accident: No Employment: No Another Party Responsible: No	Place(State): Other Accident: No
--	-------------------------------------

**Required Information** Edit

Patient Account Number: Provider Assignment Code: Select Prior Authorization Number:	Member Authorized Assignment of Benefits: Yes Release of Information:
--	--

---

**Provider Summary** Edit

**Billing Provider Information**

Last Name/Facility Name: Middle Initial: Address1: City: Zip Code:	First Name: NPI: Address2: State: TIN:
--	--

**Rendering Provider Information** Edit

Last Name: Middle Initial: ZipCode:	First Name: NPI:
---	---------------------

**Facility Information** Edit

Facility Type: Address1: City: Zip Code:	Address2: State:
---	---------------------

**Diagnosis Code** Edit

Principal Diagnosis Code: \_\_\_\_\_ Diagnosis Description \_\_\_\_\_

**Claim Line Details**

Service Line	Service From Date	Service To Date	Place of Service	Emergency	Procedure Code	Modifier				Diagnosis Code Reference				
						1	2	3	4	1	2	3		

**Comments**

Remarks: \_\_\_\_\_

**Total Amount**

Total Charge: 0      Total Paid: 0

[Print](#)
[Save for Later](#)
[Submit](#)
[Save For Batch](#)
[Cancel](#)

Select *Submit* to submit your claim

[Print](#) [Save for Later](#) [Submit](#) [Save For Batch](#) [Cancel](#)

[Member](#) [Provider](#) [Summary](#) [Help](#) [FAQ](#)

Collapse All

**Member Summary** [Edit](#)

**Insured Information**

Insured's ID:	Service To Date:
Service From Date:	First Name:
Last Name:	DOB:
Middle Initial:	Address1:
Sex:	City:
Address2:	Zip Code:
State:	Program Name:
Payor Name: MHC TX	Another Health Benefit Plan: No
Payor ID: 20-1494502	

**Patient Information** [Edit](#)

Patient Relationship to Insured:	First Name:
Last Name:	DOB:
Middle Initial:	Address2:
Sex:	State:
Address1:	
City:	
Zip Code:	

**Patient Condition** [Edit](#)

Auto Accident: No	Place(State):
Employment: No	Other Accident: No
Another Party Responsible: No	

**Required Information** [Edit](#)

Patient Account Number:	Member Authorized Assignment of Benefits: Yes
Provider Assignment Code: Select	Release of Information:
Prior Authorization Number:	

---

**Provider Summary** [Edit](#)

**Billing Provider Information**

Last Name/Facility Name:	First Name:
Middle Initial:	NPI:
Address1:	Address2:
City:	State:
Zip Code:	TIN:

**Rendering Provider Information** [Edit](#)

Last Name:	First Name:
Middle Initial:	NPI:
ZipCode:	

**Facility Information** [Edit](#)

Facility Type:	Address2:
Address1:	State:
City:	
Zip Code:	

**Diagnosis Code** [Edit](#)

Principal Diagnosis Code:  Diagnosis Description

**Claim Line Details**

Service Line	Service From Date	Service To Date	Place of Service	Emergency	Procedure Code	Modifier	Diagnosis Code Reference	Charge
						1 2 3 4	1 2 3 4	

**Comments**

Remarks:

**Total Amount**

Total Charge: 0 Total Paid: 0

[Print](#) [Save for Later](#) [Submit](#) [Save For Batch](#) [Cancel](#)

Select *Save for Batch* to be able to submit more than 1 claim at the same time

[Print](#) [Save for Later](#) [Submit](#) [Save For Batch](#) [Cancel](#)

[Member](#) [Provider](#) [Summary](#) [Help](#) [FAQ](#)

Collapse All

**Member Summary** [Edit](#)

**Insured Information**

Insured's ID: Service From Date: Last Name: Middle Initial: Sex: Address2: State: Payor Name: MHC TX Payor ID: 20-1494502	Service To Date: First Name: DOB: Address1: City: Zip Code: Program Name: Another Health Benefit Plan: No
---	--

**Patient Information** [Edit](#)

Patient Relationship to Insured: Last Name: Middle Initial: Sex: Address1: City: Zip Code:	First Name: DOB: Address2: State:
--	--

**Patient Condition** [Edit](#)

Auto Accident: No Employment: No Another Party Responsible: No	Place(State): Other Accident: No
--	-------------------------------------

**Required Information** [Edit](#)

Patient Account Number: Provider Assignment Code: Select Prior Authorization Number:	Member Authorized Assignment of Benefits: Yes Release of Information:
--	--

---

**Provider Summary** [Edit](#)

**Billing Provider Information**

Last Name/Facility Name: Middle Initial: Address1: City: Zip Code:	First Name: NPI: Address2: State: TIN:
--	--

**Rendering Provider Information** [Edit](#)

Last Name: Middle Initial: ZipCode:	First Name: NPI:
---	---------------------

**Facility Information** [Edit](#)

Facility Type: Address1: City: Zip Code:	Address2: State:
---	---------------------

**Diagnosis Code**

Principal Diagnosis Code:  Diagnosis Description

**Claim Line Details**

Service Line	Service From Date	Service To Date	Place of Service	Emergency	Procedure Code	Modifier			
						1	2	3	4

**Comments**

Remarks:

**Total Amount**

Total Charge: 0      Total Paid: 0

[Print](#) [Save for Later](#) [Submit](#) [Save For Batch](#) [Cancel](#)

Select *Save for Later* to save your claim as an incomplete claim

If you Select *Print*, you can print the claim summary

Your Claim has been Successfully submitted. Please note the Claim ID for Future Reference.  
Claim ID: 12345678901

<< Previous

Print Save for Later Submit Save For Batch Cancel

Member Provider Summary

[Help](#) [FAQ](#)

Claim ID: 12345678901

Collapse All

Member Summary

Insured Information

Edit

Upon Successful Single Submission; a message will appear with the Claim ID number.

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> PICA <span style="float: right;"><input type="checkbox"/> PICA</span>									
1. MEDICARE <input checked="" type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)</small>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>123456789</b>							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>SMITH, JOHN</b>				3. PATIENT'S BIRTH DATE MM DD YY <b>01 01 1990</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>SMITH, JOHN</b>			
5. PATIENT'S ADDRESS (No., Street) <b>000 MAIN ST,</b>				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) <b>000 MAIN ST,</b>			
CITY <b>EAST SAINT LOUIS</b>		STATE <b>IL</b>		CITY <b>EAST SAINT LOUIS</b>		STATE <b>IL</b>		ZIP CODE TELEPHONE (Include Area Code) <b>62205 ( )</b>	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		9. EMPLOYMENT? (Current or Previous) Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER <b>MHC IL</b>		a. INSURED'S DATE OF BIRTH MM DD YY <b>01 01 1990</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10d. RESERVED FOR LOCAL USE		b. EMPLOYER'S NAME OR SCHOOL NAME <b>Integrated Care Program</b>		c. INSURANCE PLAN NAME OR PROGRAM NAME <b>Integrated Care Program</b>	
c. INSURANCE PLAN NAME OR PROGRAM NAME PROGRAM NAME		PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary for payment of government benefits either to myself or to the party who accepts assignment.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED _____ DATE _____		SIGNED _____ DATE _____		SIGNED _____ DATE _____		SIGNED _____ DATE _____		SIGNED _____ DATE _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO <b>0</b>		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>650</b> 3. _____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. <b>1</b>		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE ICD-9-CM-3		C. CPT/HCPCS		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER		E. DIAGNOSIS POINTER	
F. \$ CHARGES		G. DATES OF FROM MM DD YY TO MM DD YY		H. FROM MM DD YY TO MM DD YY		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1 <b>02 10 2015 02 10 2015 21 N 1000F 1 25.00 2.00 N NPI</b>									
2 _____									
3 _____									
4 _____									
5 _____									
6 _____									
25. FEDERAL TAX I.D. NUMBER <b>00000000</b>		26. PATIENT'S ACCOUNT NO. <b>123456789</b>		27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE <b>\$ 25.00</b>		29. AMOUNT PAID <b>\$ 0.00</b>	
30. BALANCE DUE <b>\$ 25.00</b>		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # <b>MOLINA MEDICAL CENTER                  000 MAIN ST, LONG BEACH, CA, 90801</b>		a. <b>1111111111</b> b.	
SIGNED _____ DATE _____		SIGNED _____ DATE _____		SIGNED _____ DATE _____		SIGNED _____ DATE _____		SIGNED _____ DATE _____	

Print Claim Summary

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)





Provider Portal	Messages and Announcements	Recent Activity	My Favorites <a href="#">Edit</a>
<a href="#">Member Eligibility</a>	You have (274) new messages You have (16) announcements	<a href="#">Click here to view your recent Service Request/Authorizations</a> <a href="#">Click here to view your recent Claims</a>	Member Eligibility Claim Status Inquiry
<b>Claims</b>	<h3>Quick Member Eligibility Search</h3> <input type="text" value="Member ID"/> <input type="button" value="Go"/>		
<a href="#">Claims Status Inquiry</a>	<b>What's Coming Soon!</b> We have new functionality coming in - Create Claims Templates - Correct Claims - Add Attachments to Claims	<b>Poll</b> Do you like our new look? <input type="radio"/> Yes <input type="radio"/> No <input type="button" value="Vote"/> <a href="#">See Responses</a>	Create Professional Claims Claims Download Report
<a href="#">Create Professional Claim (CMS 1500)</a>			Service Request/Authorization Create Service Request/Authorization
<a href="#">Create Institutional Claim (UB04)</a>			Clear Coverage Create Institutional Claim
<a href="#">Open Saved Claims</a>			
<a href="#">Create/Manage Claims Template</a>			
<a href="#">Export Claims Report to Excel</a>			
<a href="#">Service Request/Authorization</a>			
<a href="#">Member</a>			
<a href="#">HEDIS Profile <b>New!</b></a>			
<a href="#">Reports</a>			
<a href="#">Links</a>			
<a href="#">Forms</a>			
<a href="#">Account Tools</a>			

Select *Create Institutional Claim (UB04)*



The Institutional Claim form includes three tabs. Start with Member tab.

UB-04 Facility Claim

Member Provider Summary

Next Save For Later Cancel

(Fields marked with \* are required fields) [Help](#) [FAQ](#)

Correct Claim  Void Claim

Advanced Search

First Name:  Date of Birth:  (mm/dd/yyyy)

Statement To Date:  (mm/dd/yyyy)

Last Name:  First Name:  Middle Initial:

Insured's ID:  DOB:  Sex:

Address1:  Address2:

City:  State:  Zip Code:

Insured Group Number:  Employer Name:

**Patient Information** NOTE: If Patient is the insured, Patient information will be automatically populated

Patient Relationship to Insured:

**Other Insurance**

Is there another Health Benefit Plan?  Yes  No

Type of Bill:

**Patient Conditions**

Patient Condition related to: Employment  Yes  No Auto Accident  Yes  No Other Accident  Yes  No

Admission Date:  (mm/dd/yyyy) Admission Type:  Admission Source:

Admission Hour:  (0 - 23) Discharge Hour:  (0 - 23) Status:

Condition Code:  [Add Another Condition Code](#)

Occurrence Codes:  Occurrence Date:  (mm/dd/yyyy) [Add Another Occurrence Code](#)

Occurrence Span Codes:  Occurrence Span From:  (mm/dd/yyyy) Occurrence Span To:  (mm/dd/yyyy) [Add Another Occurrence Span Code](#)

Value Code:  Amount(\$):  [Add Another Value Code](#)

Next Save For Later Cancel

Once you fill in the required fields, the Insured's Information should auto-populate

**UB-04 Facility Claim**

Member | Provider | Summary

Next Save For Later Cancel

(Fields marked with \* are required fields) [Help](#) [FAQ](#)

What would you like to do?  Create Claim  Correct Claim  Void Claim

**Eligibility Check**  
Enter the insured's ID or Last Name, First Name, Date of Birth and also Statement Date(s)

Insured's ID: \*  **Advanced Search**

OR

Last Name:  First Name:  Date of Birth:  (mm/dd/yyyy)

AND

Statement From Date: \*  (mm/dd/yyyy) Statement To Date: \*  (mm/dd/yyyy)

**Insured's Information**

Last Name:  First Name:  Middle Initial:

Insured's ID:  DOB:  Sex:

Address1:  Address2:

City:  State:  Zip Code:

Insured Group Number:  Employer Name:

**Patient Information** NOTE: If Patient is the insured, Patient information will be automatically populated

Patient Relationship to Insured: \*

**Other Insurance**

Is there another Health Benefit Plan?  Yes  No

Type of Bill: \*

**Patient Conditions**

Patient Condition related to:  Employment  Yes  No  Auto Accident  Yes  No  Other Accident

Admission Date: \*  (mm/dd/yyyy) Admission Type:  Admission

Admission Hour: \*  (0 - 23) Discharge Hour:  (0 - 23)

Condition Code:  **Add Another Condition Code**

Occurrence Codes:  Occurrence Date:  (mm/dd/yyyy) **Add Another Occurrence Code**

Occurrence Span Codes:  Occurrence Span From:  (mm/dd/yyyy) Occurrence Span To:  (mm/dd/yyyy) **Add Another Occurrence Span Code**

Value Code:  Amount(\$):  **Add Another Value Code**

Next Save For Later Cancel

Please Note: All required field are noted with a red asterisk (\*)

Enter the Patient's Relationship to Insured. For most coverage, Patient Relationship to Insured defaults to "Self".

**UB-04 Facility Claim**

Member | **Provider** | Summary

Next Save For Later Cancel

(Fields marked with \* are required fields) [Help](#) [FAQ](#)

What would you like to do?  Create Claim  Correct Claim  Void Claim

**Eligibility Check**  
Enter the insured's ID or Last Name, First Name, Date of Birth and also Statement Date(s)

Insured's ID:\*  **Advanced Search**

OR

Last Name:  First Name:  Date of Birth:  (mm/dd/yyyy)

AND

Statement From Date:\*  (mm/dd/yyyy) Statement To Date:\*  (mm/dd/yyyy)

**Insured's Information**

Last Name:  First Name:  Middle Initial:

Insured's ID:  DOB:  Sex:

Address1:  Address2:

City:  State:  Zip Code:

Insured Group Number:  Employer Name:

**Patient Information** NOTE: If Patient is the insured, Patient information will be automatically populated

Patient Relationship to Insured:\*

**Other Insurance**

Is there another Health Benefit Plan?  Yes  No

Type of Bill\*

**Patient Conditions**

Patient Condition related to: Employment  Yes  No Auto Accident  Yes  No Other Accident  Yes  No

Admission Date:  (mm/dd/yyyy) Admission Type:  Admission

Admission Hour:  (0 - 23) Discharge Hour:  (0 - 23)

Condition Code:  **Add Another Condition Code**

Occurrence Codes:  Occurrence Date:  (mm/dd/yyyy) **Add Another Occurrence Code**

Occurrence Span Codes:  Occurrence Span From:  (mm/dd/yyyy) Occurrence Span To:  (mm/dd/yyyy) **Add Another Occurrence Span Code**

Value Code:  Amount(\$):  **Add Another Value Code**

Next Save For Later Cancel

Please Note: All required field are noted with a red asterisk (\*)

UB-04 Facility Claim

Member Provider Summary

Next Save For Later Cancel

(Fields marked with \* are required fields) [Help](#) [FAQ](#)

What would you like to do?  Create Claim  Correct Claim  Void Claim

**Eligibility Check**  
 Enter the insured's ID or Last Name, First Name, Date of Birth and also Statement Date(s)

Insured's ID: \*

OR

Last Name:  First Name:  Date of Birth:  (mm/dd/yyyy)

AND

Statement From Date: \*  (mm/dd/yyyy) Statement To Date: \*  (mm/dd/yyyy)

**Insured's Information**

Last Name:  First Name:  Middle Initial:

Insured's ID:  DOB:  Sex:

Address1:  Address2:

City:  State:  Zip Code:

Insured Group Number:  MHC TX Employer Name:

**Patient Information** NOTE: If Patient is the insured, Patient information will be automatically populated

Patient Relationship to Insured:  18-Self

**Other Insurance**

Is there another Health Benefit Plan?  Yes  No

Type of Bill:

**Patient Conditions**

Patient Condition related to: Employment  Yes  No Auto Accident  Yes  No Other Accident  Yes  No

Admission Date:  (mm/dd/yyyy) Admission Type:  Select Admission

Admission Hour:  (0 - 23) Discharge Hour:  (0 - 23)

Condition Code:

Occurrence Codes:  Occurrence Date:  (mm/dd/yyyy)

Occurrence Span Codes:  Occurrence Span From:  (mm/dd/yyyy) Occurrence Span To:  (mm/dd/yyyy)

Value Code:  Amount(\$):

Next Save For Later Cancel

Enter information for other insurance, if applicable.

Note: If "Yes" is selected and this is a Secondary claim, you must submit Prior Payment and Estimated Amount Due in Provider Tab

Please Note: All required field are noted with a red asterisk (\*)

Member Provider Summary

Next Save For Later Cancel

(Fields marked with \* are required fields) [Help](#) [FAQ](#)

What would you like to do?  Create Claim  Correct Claim  Void Claim

**Eligibility Check**

Enter the insured's ID or Last Name, First Name, Date of Birth and also Statement Date(s)

Insured's ID: \*

OR

Last Name:  First Name:  Date of Birth:  (mm/dd/yyyy)

AND

Statement From Date: \*  (mm/dd/yyyy) Statement To Date: \*  (mm/dd/yyyy)

**Insured's Information**

Last Name:  First Name:  Middle Initial:

Insured's ID:  DOB:  Sex:

Address1:  Address2:

City:  State:  Zip Code:

Insured Group Number:  Employer Name:

**Patient Information** NOTE: If Patient is the insured, Patient information will be automatically populated

Patient Relationship to Insured:

**Other Insurance**

Is there another Health Benefit Plan?  Yes  No

Type of Bill:

**Patient Conditions**

Patient Condition related to:  Employment  Yes  No  Auto Accident  Yes  No  Other Accident

Admission Date:  (mm/dd/yyyy) Admission Type:  Admission

Admission Hour:  (0 - 23) Discharge Hour:  (0 - 23)

Condition Code:

Occurrence Codes:  Occurrence Date:  (mm/dd/yyyy)

Occurrence Span Codes:  Occurrence Span From:  (mm/dd/yyyy) Occurrence Span To:  (mm/dd/yyyy)

Value Code:  Amount(\$):

Next Save For Later Cancel

Enter the Type of Bill you are submitting. If not known, click on magnifying glass icons to search for the appropriate code.

Please Note: All required field are noted with a red asterisk (\*)

UB-04 Facility Claim

Member Provider Summary

Next Save For Later Cancel

(Fields marked with \* are required fields) [Help](#) [FAQ](#)

What would you like to do?  Create Claim  Correct Claim  Void Claim

**Eligibility Check**  
 Enter the insured's ID or Last Name, First Name, Date of Birth and also Statement Date(s)

Insured's ID: \*

OR

Last Name:  First Name:  Date of Birth:  (mm/dd/yyyy)

AND

Statement From Date: \*  (mm/dd/yyyy) Statement To Date: \*  (mm/dd/yyyy)

**Insured's Information**

Last Name:  First Name:  Middle Initial:

Insured's ID:  DOB:  Sex:

Address1:  Address2:

City:  State:  Zip Code:

Insured Group Number:  Employer Name:

**Patient Information** NOTE: If Patient is the insured, Patient information will be automatically populated

Patient Relationship to Insured:

**Other Insurance**

Is there another Health Benefit Plan?  Yes  No

Type of Bill:

**Patient Conditions**

Patient Condition related to: Employment  Yes  No Auto Accident  Yes  No Other Accident  Yes  No

Admission Date:  (mm/dd/yyyy) Admission Type:

Admission Hour:  (0 - 23) Discharge Hour:  (0 - 23)

Condition Code:

Occurrence Codes:  Occurrence Date:  (mm/dd/yyyy)

Occurrence Span Codes:  Occurrence Span From:  (mm/dd/yyyy) Occurrence Span To:  (mm/dd/yyyy)

Value Code:  Amount(\$):

Next Save For Later Cancel

Enter the Admission Date, Hour, Type, Source, and Status. If known, enter additional information relation to the patient's condition.

Please Note: All required field are noted with a red asterisk (\*)

UB-04 Facility Claim

Member Provider Summary

Next Save For Later Cancel

(Fields marked with \* are required fields) [Help](#) [FAQ](#)

What would you like to do?  Create Claim  Correct Claim  Void Claim

**Eligibility Check**  
Enter the insured's ID or Last Name, First Name, Date of Birth and also Statement Date(s)

Insured's ID: \*

OR

Last Name:  First Name:  Date of Birth:  (mm/dd/yyyy)

AND

Statement From Date: \*  (mm/dd/yyyy) Statement To Date: \*  (mm/dd/yyyy)

**Insured's Information**

Last Name:  First Name:  Middle Initial:

Insured's ID:  DOB:  Sex:

Address1:  Address2:

City:  State:  Zip Code:

Insured Group Number: MHC TX Employer Name:

**Patient Information** NOTE: If Patient is the insured, Patient information will be automatically populated

Relationship:  18-Self

**Patient Conditions**

Patient Condition related to: Employment  Yes  No Auto Accident  Yes  No Other Accident  Yes  No

Admission Date:  (mm/dd/yyyy) Admission Type:  Admission Date:

Admission Hour:  (0 - 23) Discharge Hour:  (0 - 23)

Condition Code:

Occurrence Codes:  Occurrence Date:  (mm/dd/yyyy)

Occurrence Span Codes:  Occurrence Span From:  (mm/dd/yyyy) Occurrence Span To:  (mm/dd/yyyy)

Value Code:  Amount(\$):

Next Save For Later Cancel

Please Note: All required field are noted with a red asterisk (\*)

Upon completion of the required fields, select Next

If you have more than one Billing Provider, a drop down list will appear

**UB-04 Facility Claim**

Member **Provider** Summary

Previous Next Save For Later Cancel

(Fields marked with \* are required fields) [Help](#) [FAQ](#)

**Billing Provider Information**

Billing Provider:

Last Name  First Name  Middle Initial  TIN  NPI  Provider ID

Address1  Address2

City  State  Zip Code  Phone Number  Fax Number

**Claim Information**

Type of Bill\*  Patient Control Number  Medical Record Number  Document Control Number

(Remove)	Revenue Code*	Revenue Code Description:	HCPCS/HIPPS Rate Codes/HCPCS Modifiers:	NDC:	Service Date*	Service Units*	Total Charges*	Non-Covered Charges:
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> (mm/dd/yyyy)	<input type="text"/>	<input type="text"/>	<input type="text"/>

+ Add another Claim Line

Assignment of Benefits\*  Release Of Information\*

Treatment Authorization Code  **Add Another Authorization Code**

Diagnosis Code(s) (DX) and POA Indicators

Principal DX	POA	Other DX	POA	Other DX	POA
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Add Another Diagnosis Code**

Admit Diagnosis\*  Patient Reason For Visit Code  **Add Another Patient Reason for Visit Code**

Prospective Payment System Code (PPS Code)

External Cause of Injury (ECI) Code and POA Indicators

ECI	POA
<input type="text"/>	<input type="text"/>

**Add Another ECI code**

Principal Procedure Date  (mm/dd/yyyy) Principal Procedure Code  **Add Another Procedure Code**

**Physician Information**

**Attending Physician\***

NPI\*  First Name\*  Last Name\*  Secondary Qualifier  Physician

Select Physician Type

NPI  First Name  Last Name  Qualifier  Physician

**Supporting Information**

Type of Attachment:

File:  Browse... Upload

Upload files only when you want to submit a claim or add supporting documents to the claim in adjudication. Supported file formats are PDF, TIF, JPG, BMP and GIF. Upload 1 file at a time. Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

**Remarks**

Clinical Notes or Comments: 256 character Max

256 characters remaining.

Previous Next Save For Later Cancel

Please Note: All required field are noted with a red asterisk (\*)



Enter all mandatory fields. Use the magnifying glass next to the field to search when an item is unknown. Add additional lines or information as needed.

**UB-04 Facility Claim**

Member Provider Summary Previous Next Save For Later Cancel

(Fields marked with \* are required fields) [Help](#) [FAQ](#)

**Billing Provider Information**

Billing Provider: Select

Last Name First Name Middle Initial TIN NPI Provider ID  
 Address1 Address2  
 City State Zip Code Phone Number Fax Number

**Claim Information**

Type of Bill\* Patient Control Number Medical Record Number Document Control Number

(Remove) Revenue Code: Revenue Code Description: HCPCS/HIPPS Rate Codes/HCPCS Modifiers: NDC: Service Date: (mm/dd/yyyy) Service Units: Total Charges: Non-Covered Charges:

1 [magnifying glass] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

+ Add another Claim Line

Assignment of Benefits: Select Release Of Information: Select

Treatment Authorization Code Add Another Authorization Code

Diagnosis Code(s) (DX) and POA Indicators  
 Principal DX POA Other DX POA Other DX POA  
 [magnifying glass] [Select] [?] [magnifying glass] [Select] [?] [magnifying glass] [Select] [?] [magnifying glass] [Select] [?]

Add Another Diagnosis Code

Admit Diagnosis: Patient Reason For Visit Code  
 [magnifying glass] [magnifying glass] Add Another Patient Reason for Visit Code

Prospective Payment System Code (PPS Code)

External Cause of Injury (ECI) Code and POA Indicators  
 ECI POA  
 [magnifying glass] [Select] [?] Add Another ECI code

Principal Procedure Date Principal Procedure Code  
 [magnifying glass] (mm/dd/yyyy) [magnifying glass] Add Another Procedure Code

**Physician Information**

Attending Physician\*

NPI\* First Name\* Last Name\* Secondary Qualifier Physician  
 [ ] [ ] [ ] [Select] [ ]

Select Physician Type Select

NPI First Name Last Name Qualifier Physician  
 [ ] [ ] [ ] [Select] [ ]

**Supporting Information**

Type of Attachment: Select

File: [Browse] Upload

Upload files only when you want to submit a claim or add supporting documents to the claim in adjudication. Supported file formats are PDF, TIF, JPG, BMP and GIF. Upload 1 file at a time. Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

**Remarks**

Clinical Notes or Comments: 256 character Max

[ ] 256 characters remaining.

Previous Next Save For Later Cancel

Please Note: All required field are noted with a red asterisk (\*)

UB-04 Facility Claim

Member Provider Summary

(Fields marked with \* are required fields) [Help](#) [FAQ](#)

**Billing Provider Information**

Billing Provider: Select

Last Name First Name Middle Initial TIN NPI Provider ID

Address1 Address2

City State Zip Code Phone Number Fax Number

**Claim Information**

Type of Bill\* Patient Control Number Medical Record Number Document Control Number

(Remove)	Revenue Code*	Revenue Code Description:	HCPCS/HIPPS Rate Codes/HCPCS Modifiers:	NDC:	Service Date*	Service Units*	Total Charges*	Non-Covered Charges:
1					(mm/dd/yyyy)		0	0

+ Add another Claim Line

Assignment of Benefits\* Select Release Of Information\* Select

Treatment Authorization Code Add Another Authorization Code

Diagnosis Code(s) (DX) and POA Indicators

Principal DX POA Other DX POA Other DX POA Add Another Diagnosis Code

Other DX POA Other DX POA

Admit Diagnosis\* Patient Reason For Visit Code Add Another Patient Reason for Visit Code

Prospective Payment System Code (PPS Code)

External Cause of Injury (ECI) Code and POA Indicators ECI POA Add Another ECI code

Principal Procedure Date Principal Procedure Code Add Another Procedure Code

**Physician Information**

Attending Physician\*

NPI\* First Name\* Last Name\* Secondary Qualifier Physician

Select Physician Type Select

NPI First Name Last Name Qualifier Physician

**Supporting Information**

Type of Attachment: Select

File: Browse Upload

Upload files only when you want to submit a claim or add supporting documents to the claim in-adjudication. Supported file formats are PDF, TIF, JPG, BMP and GIF. Upload 1 file at a time. Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

**Remarks**

Clinical Notes or Comments: 256 character Max

256 characters remaining.

Previous Next Save For Later Cancel

Enter the Attending Physician's information. You can also include additional physician types.

Please Note: All required field are noted with a red asterisk (\*)

UB-04 Facility Claim

Member Provider Summary

(Fields marked with \* are required fields) [Help](#) [FAQ](#)

**Billing Provider Information**

Billing Provider:

Last Name  First Name  Middle Initial  TIN  NPI  Provider ID

Address1  Address2

City  State  Zip Code  Phone Number  Fax Number

**Claim Information**

Type of Bill\*  Patient Control Number  Medical Record Number  Document Control Number

(Remove)	Revenue Code*	Revenue Code Description:	HCPCS/HIPPS Rate Codes/HCPCS Modifiers:	NDC:	Service Date*	Service Units*	Total Charges*	Non-Covered Charges:
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> (mm/dd/yyyy)	<input type="text"/>	<input type="text"/>	<input type="text"/>

+ Add another Claim Line

Assignment of Benefits\*  Release Of Information\*

Treatment Authorization Code  Add Another Authorization Code

Diagnosis Code(s) (DX) and POA Indicators

Principal DX	POA	Other DX	POA	Other DX	POA
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Add Another Diagnosis Code

Admit Diagnosis\*  Patient Reason For Visit Code  Add Another Patient Reason for Visit Code

Prospective Payment System Code (PPS Code)

External Cause of Injury (ECI) Code and POA Indicators

ECI	POA
<input type="text"/>	<input type="text"/>

Add Another ECI code

Principal Procedure Date  (mm/dd/yyyy) Principal Procedure Code  Add Another Procedure Code

**Physician Information**

Attending Physician\*

NPI\*  First Name\*  Last Name\*  Secondary Qualifier  Physician

Select Physician Type

NPI  First Name  Last Name  Qualifier  Physician

**Supporting Information**

Type of Attachment\*

File:  Browse... Upload

Upload files only when you want to submit a claim or add supporting documents to the claim in adjudication. Supported file formats are PDF, TIF, JPG, BMP and GIF. Upload 1 file at a time. Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

**Remarks**

Clinical Notes or Comments: 256 character Max

256 characters remaining.

Previous Next Save For Later Cancel

Supporting Information is available to upload supporting documentation or add comments and remarks. If an attachment is submitted, it is required to fill in the *Type of Attachment*.

Please Note: All required field are noted with a red asterisk (\*)

UB-04 Facility Claim

Member Provider Summary

Previous Next Save For Later Cancel

(Fields marked with \* are required fields) [Help](#) [FAQ](#)

### Billing Provider Information

Billing Provider:

Last Name  First Name  Middle Initial  TIN  NPI  Provider ID

Address1  Address2

City  State  Zip Code  Phone Number  Fax Number

### Claim Information

Type of Bill\*  Patient Control Number\*  Medical Record Number  Document Control Number

(Remove)	Revenue Code*	Revenue Code Description:	HCPCS/HIPPS Rate Codes/HCPCS Modifiers:	NDC:	Service Date*	Service Units*	Total Charges*	Non-Covered Charges:
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> (mm/dd/yyyy)	<input type="text"/>	<input type="text"/>	<input type="text"/>

+ Add another Claim Line

Assignment of Benefits\*  Release Of Information\*

Treatment Authorization Code  Add Another Authorization Code

Diagnosis Code(s) (DX) and POA Indicators

Principal DX	POA	Other DX	POA	Other DX	POA
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Add Another Diagnosis Code

Admit Diagnosis\*  Patient Reason For Visit Code  Add Another Patient Reason for Visit Code

Prospective Payment System Code (PPS Code)

ECI Code and POA Indicators

ECI	POA
<input type="text"/>	<input type="text"/>

Add Another ECI code

Principal Procedure Code  Add Another Procedure Code

First Name\*  Last Name\*  Secondary Qualifier  Physician ID

Select Physician Type

NPI  First Name  Last Name  Qualifier  Physician ID

### Supporting Information

Type of Attachment\*

File:  Browse... Upload

Upload files only when you want to submit a claim or add supporting documents to the claim in-adjudication. Supported file formats are PDF, TIF, JPG, BMP and GIF. Upload 1 file at a time. Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

### Remarks

Clinical Notes or Comments: 256 character Max

characters remaining.

Previous Next Save For Later Cancel

Please Note: All required field are noted with a red asterisk (\*)

Upon completion of the required fields, select Next

Expand All

Help FAQ

Member Summary

Eligibility Check

Insured's ID Number:		
Last Name:	First Name:	DOB:
Statement From Date:		Statement To Date:

Insured's Information

Last Name:	First Name:	Middle Initial:
Insured's ID:	DOB:	Sex:
Address 1:		Address 2:
City:	State:	Zip Code:
Insured Group Number: HHC TX	Employer Name:	

Type of Bill

Type of Bill:
---------------

Admission Conditions

Employment:	AutoAccident:	OtherAccident:
Admission Date:	Admission Source:	Admission Type:
Admission Hour:	Discharge Hour:	Status:
Condition Code:		
Occurrence Code:	Occurrence Date:	
Occurrence Span Code:	Occurrence Span From:	Occurrence Span To:
Value Code:	Amount(\$):	

Provider Summary

Billing Provider Information

Billing Provider:		
Last Name:	First Name:	Middle Name:
DOB:	NPI:	Provider ID:
Address 1:		Address 2:
State:	Phone Number:	Fax Number:

Claim Information

Type of Bill:	Patient Control Number:	Medical Record Number:	Document Control Number:					
Revenue Codes								
Claim Lines	Revenue Codes	Revenue Code Descriptions	HCPCS/NPPS Rate Codes/HCPCS Modifiers	NDC	Service Dates	Service Units	Total Charges	Non-Covered Charges
1							0	0
Assignment of Benefits:		Release Of Information:						
Treatment Authorization Code(s) :								
Diagnosis Code(s) ; PCA Indicator :								
Patient reason for visit Codes								
Admit Diagnosis :		Patient Reason For Visit Code :						
Prospective Payment System Code (PPS Code):								
ECI Codes								
External Cause of Injury (ECI) Codes ; PCA Indicator :								
Procedure Codes								
Principal Procedure Code:		Principal Procedure Date:			Principal Procedure Code:			

Physician Information

Physician Type	First Name	Last Name
Attending Physician		

Remarks

Remarks
---------

Select *Submit* to submit your claim

UR-04 Facility Claim

Member    Provider    Summary

Expand All    Print    Previous    Save For Later    Submit    Save For Batch    Cancel    Help FAQ

### Member Summary

**Eligibility Check** Edit

Insured's ID Number: \_\_\_\_\_  
 Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Statement From Date: \_\_\_\_\_ Statement To Date: \_\_\_\_\_

**Insured's Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Insured's ID: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Address 1: \_\_\_\_\_ Address 2: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Insured Group Number: HMC TX Employer Name: \_\_\_\_\_

**Type of Bill**

Type of Bill: \_\_\_\_\_

**Admission Information**

Employment: \_\_\_\_\_ AutoAccident: \_\_\_\_\_ OtherAccident: \_\_\_\_\_  
 Admission Date: \_\_\_\_\_ Admission Source: \_\_\_\_\_ Admission Type: \_\_\_\_\_  
 Admission Hour: \_\_\_\_\_ Discharge Hour: \_\_\_\_\_ Status: \_\_\_\_\_  
 Condition Code: \_\_\_\_\_  
 Occurrence Code: \_\_\_\_\_ Occurrence Date: \_\_\_\_\_  
 Occurrence Span Code: \_\_\_\_\_ Occurrence Span From: \_\_\_\_\_ Occurrence Span To: \_\_\_\_\_  
 Value Code: \_\_\_\_\_ Amount(\$): \_\_\_\_\_

### Provider Summary

**Billing Provider Information** Edit

Billing Provider: \_\_\_\_\_  
 Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
 Title: \_\_\_\_\_ NPI: \_\_\_\_\_ Provider ID: \_\_\_\_\_  
 Address 1: \_\_\_\_\_ Address 2: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Claim Information**

Type of Bill: \_\_\_\_\_ Patient Control Number: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_ Document Control Number: \_\_\_\_\_

**Revenue Codes**

Claim Lines	Revenue Codes	Revenue Code Descriptions	HCPCS/NPPES Rate Codes/HCPCS Modifiers	NDC	Service Dates	Service Units	Total Charges	Non-Covered Charges
1							0	0

Assignment of Benefits: \_\_\_\_\_ Release Of Information: \_\_\_\_\_  
 Treatment Authorization Code(s): \_\_\_\_\_  
 Diagnosis Code(s) ; PCA Indicator: \_\_\_\_\_  
 Patient reason for visit Codes: \_\_\_\_\_  
 Admit Diagnosis: \_\_\_\_\_ Patient Reason For Visit Code: \_\_\_\_\_  
 Prospective Payment System Code (PPS Code): \_\_\_\_\_  
 ECI Codes: \_\_\_\_\_  
 External Cause of Injury (ECI) Codes ; PCA Indicator: \_\_\_\_\_  
 Procedure Codes: \_\_\_\_\_  
 Principal Procedure Code: \_\_\_\_\_ Principal Procedure Date: \_\_\_\_\_

**Physician Information**

Physician Type	First Name	Last Name	NPI
Attending Physician			

**Remarks**

Remarks: \_\_\_\_\_

Print    Previous    Save For Later    Submit    Save For Batch    Cancel

Select *Save for Batch* to be able to submit more than 1 claim at the same time

UR-04 Facility Claim

Member    Provider    Summary

Expand All    Print    Previous    Save For Later    Submit    Save For Batch    Cancel    Help FAQ

### Member Summary

**Eligibility Check** Edit

Insured's ID Number: \_\_\_\_\_  
 Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Statement From Date: \_\_\_\_\_ Statement To Date: \_\_\_\_\_

**Insured's Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
 Insured's ID: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Address1: \_\_\_\_\_ Address2: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Insured Group Number: HMC TX Employer Name: \_\_\_\_\_

**Type of Bill**

Type of Bill: \_\_\_\_\_

**Admission Conditions**

Employment: \_\_\_\_\_ AutoAccident: \_\_\_\_\_ OtherAccident: \_\_\_\_\_  
 Admission Date: \_\_\_\_\_ Admission Source: \_\_\_\_\_ Admission Type: \_\_\_\_\_  
 Admission Hour: \_\_\_\_\_ Discharge Hour: \_\_\_\_\_ Status: \_\_\_\_\_  
 Condition Codes: \_\_\_\_\_  
 Occurrence Codes: \_\_\_\_\_ Occurrence Date: \_\_\_\_\_  
 Occurrence Span Codes: \_\_\_\_\_ Occurrence Span From: \_\_\_\_\_ Occurrence Span To: \_\_\_\_\_  
 Value Codes: \_\_\_\_\_ Amount(\$): \_\_\_\_\_

### Provider Summary

**Billing Provider Information** Edit

Billing Provider: \_\_\_\_\_  
 Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
 Title: \_\_\_\_\_ NPI: \_\_\_\_\_ Provider ID: \_\_\_\_\_  
 Address 1: \_\_\_\_\_ Address 2: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Claim Information**

Type of Bill: \_\_\_\_\_ Patient Control Number: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_ Document Control Number: \_\_\_\_\_

Claim Lines	Revenue Codes	Revenue Code Descriptions	HCPCS/NPPES Rate Codes/HCPCS Modifiers	NDC	Service Dates	Service Units	Total Charges	Non-Covered Charges
1							0	0

Assignment of Benefits: \_\_\_\_\_ Release Of Information: \_\_\_\_\_  
 Treatment Authorization Code(s): \_\_\_\_\_  
 Diagnosis Code(s) / ICD Indicator: \_\_\_\_\_  
 Patient reason for visit Codes: \_\_\_\_\_  
 Admit Diagnosis: \_\_\_\_\_ Patient Reason For Visit Code: \_\_\_\_\_  
 Prospective Payment System Code (PPS Code): \_\_\_\_\_  
 ECI Codes: \_\_\_\_\_  
 External Cause of Injury (ECI) Codes / ICD Indicator: \_\_\_\_\_  
 Procedure Codes: \_\_\_\_\_  
 Principal Procedure Date: \_\_\_\_\_

**Physician Information**

Physician Type	First Name	Last Name
Attending Physician		

**Remarks**

Remarks: \_\_\_\_\_

Print    Previous    Save For Later    Submit    Save For Batch    Cancel

Select *Save for Later* to save your claim as an incomplete claim

Your Claim has been Successfully submitted. Please note the Claim ID for Future Reference.  
Claim ID: 12345678912

UB-04 Facility Claim

Member

Provider

Summary

Claim ID: 12354678912

Expand All

+ Member Summary

If you Select *Print*, you can print the claim summary

Print

Previous

Save For Later

Submit

Save For Batch

Cancel

Upon Successful Single Submission; a message will appear with the Claim ID number.

[Help](#) [FAQ](#)



Print Claim Summary

1. MOLINA HEALTH CENTER 900 MAIN ST CA LONG BEACH 90801		3. PAT. CNTRL # 123456789		4. TYPE OF BILL 0212	
5. PATIENT NAME SMITH JILL A		6. PATIENT ADDRESS LONG BEACH		7. STATEMENT COVERED PERIOD 01/06/2015 - 01/07/2015	
8. PATIENT NAME SMITH JILL A		9. PATIENT ADDRESS LONG BEACH		10. STATEMENT COVERED PERIOD 01/06/2015 - 01/07/2015	
11. BIRTHDATE 03/06/1982		12. SEX F		13. ADMISSION DATE 01/06/2015	
14. TYPE P		15. SRC 2		16. DHR 03	
17. STAT 03		18. COND CODES 22 23 24		19. CA 0100	
20. OCCURRENCE DATE 01/06/2015		21. OCCURRENCE DATE 01/06/2015		22. OCCURRENCE DATE 01/06/2015	
23. OCCURRENCE DATE 01/06/2015		24. OCCURRENCE DATE 01/06/2015		25. OCCURRENCE DATE 01/06/2015	
26. OCCURRENCE DATE 01/06/2015		27. OCCURRENCE DATE 01/06/2015		28. OCCURRENCE DATE 01/06/2015	
29. OCCURRENCE DATE 01/06/2015		30. OCCURRENCE DATE 01/06/2015		31. OCCURRENCE DATE 01/06/2015	
32. OCCURRENCE DATE 01/06/2015		33. OCCURRENCE DATE 01/06/2015		34. OCCURRENCE DATE 01/06/2015	
35. OCCURRENCE DATE 01/06/2015		36. OCCURRENCE DATE 01/06/2015		37. OCCURRENCE DATE 01/06/2015	
38. RESPONSIBLE PARTY NAME AND ADDRESS		39. VALUE CODES AMOUNT		40. VALUE CODES AMOUNT	
41. VALUE CODES AMOUNT		42. VALUE CODES AMOUNT		43. VALUE CODES AMOUNT	
44. REV CD		45. DESCRIPTION		46. HCPCS / RATE / ICD	
47. SERV DATE		48. SERV UNITS		49. TOTAL CHARGES	
50. NON-COVERED CHARGES		51. ACCIDENT STATE		52. STATE	
53. PAYER NAME		54. HEALTH PLAN ID		55. REL INFO	
56. PRIOR PAYMENTS		57. EST. AMOUNT DUE		58. NPI	
59. INSURED'S NAME		60. F REL		61. INSURED'S UNIQUE ID	
62. GROUP NAME		63. INSURANCE GROUP NUMBER		64. EMPLOYER NAME	
65. TREATMENT AUTHORIZATION CODES		66. DOCUMENT CONTROL NUMBER		67. EMPLOYER NAME	
68. DX		69. ICD		70. ICD	
71. ADMIT DEX		72. PATIENT REASON DEX		73. PPS CODE	
74. PRINCIPAL PROCEDURE CODE		75. OTHER PROCEDURE CODE		76. ATTENDING NPI	
77. OTHER PROCEDURE CODE		78. OTHER PROCEDURE CODE		79. OTHER NPI	
80. OTHER PROCEDURE CODE		81. OTHER PROCEDURE CODE		82. OTHER NPI	
83. OTHER PROCEDURE CODE		84. OTHER PROCEDURE CODE		85. OTHER NPI	
86. OTHER PROCEDURE CODE		87. OTHER PROCEDURE CODE		88. OTHER NPI	
89. OTHER PROCEDURE CODE		90. OTHER PROCEDURE CODE		91. OTHER NPI	
92. OTHER PROCEDURE CODE		93. OTHER PROCEDURE CODE		94. OTHER NPI	
95. OTHER PROCEDURE CODE		96. OTHER PROCEDURE CODE		97. OTHER NPI	
98. OTHER PROCEDURE CODE		99. OTHER PROCEDURE CODE		100. OTHER NPI	





### Provider Portal

Member Eligibility

#### Claims

Claims Status Inquiry

Create Professional Claim (CMS 1500)

Create Institutional Claim (UB04)

Open Saved Claims

Create/Manage Claims Template

Export Claims Report to Excel

▶ Service Request/Authorization

▶ Member

HEDIS Profile **New!**

Reports

Links

Forms

▶ Account Tools

### Messages and Announcements

You have (274) new messages

You have (16) announcements

### Recent Activity

[Click here to view your recent Service Request/Authorizations](#)

[Click here to view your recent Claims](#)

### My Favorites [Edit](#)

Member Eligibility

Claim Status Inquiry

Create Professional Claims

Claims Download Report

Service Request/Authorization

Create Service Request/Authorization

### Quick Member Eligibility Search

Search by Member ID

Select *Open Saved Claims*

#### Coming Soon !

Claims will have new functionality coming in...  
- Search!  
- Matched Claims  
- Create Claims Templates  
- Correct Claims  
- Add Attachments to Claims

#### Poll

Do you like our new look?

- Yes
- No

The *Open Saved Claims* page includes:

- Ready to Batch Claims
- Incomplete Claims

The *Open Saved Claims* page includes:

- Ready to Batch: Claims that were *Saved for Batch*
- Incomplete Claims: Claims that were *Saved for Later*

### Saved Claim Details

Status:

Claim Type:

From:

Search

Cancel

### Ready to Batch

Select	Member Name	Tracking Number	Claim Type	Service From Date	Service To Date
<input type="checkbox"/>	SMITH, JOHN	TN0000000000	Professional	01/05/2015	01/05/2015
<input type="checkbox"/>	SMITH, JOHN	TN0000000001	Institutional	07/31/2012	09/07/2012

Page  of   per page Showing 1-2 of 2

Edit

Submit

Delete

### Incomplete Claims

Select	Member Name	Tracking Number	Claim Type	Service From Date	Service To Date
<input type="checkbox"/>		TN0000000002	Professional	01/05/2015	01/05/2015
<input type="checkbox"/>	SMITH, JOHN	TN0000000003	Institutional	01/05/2015	01/05/2015

Page  of   per page Showing 1-2 of 2

Edit

Delete

You can search Saved Claims by

- Status
- Claim Type
- Service Dates

**Saved Claim Details**

Status:

Claim Type:

From :

Service Date To :

**Ready to Batch**

Select	Member Name	Tracking Number	Claim Type	Service From Date	Service To Date
<input type="checkbox"/>	SMITH, JOHN	TN0000000000	Professional	01/05/2015	01/05/2015
<input type="checkbox"/>	SMITH, JOHN	TN0000000001	Institutional	07/31/2012	09/07/2012

**Incomplete Claims**

Select	Member Name	Tracking Number	Claim Type	Service From Date	Service To Date
<input type="checkbox"/>		TN0000000002	Professional	01/05/2015	01/05/2015
<input type="checkbox"/>	SMITH, JOHN	TN0000000003	Institutional	01/05/2015	01/05/2015

## Saved Claim Details

Status: 
 Claim Type: 
 Service Date From:  To:

### Ready to Batch

Select	Member Name	Tracking Number	Claim Type	Service From Date	Service To Date
<input type="checkbox"/>	SMITH, JOHN	TN0000000000	Professional	01/05/2015	01/05/2015
<input type="checkbox"/>	SMITH, JOHN		Institutional	07/31/2012	09/07/2012

Select the *Member Name* to view member details

### Incomplete Claims

Select	Member Name	Tracking Number	Claim Type	Service From Date	Service To Date
<input type="checkbox"/>		TN0000000002	Professional	01/05/2015	01/05/2015
<input type="checkbox"/>	SMITH, JOHN	TN0000000003	Institutional	01/05/2015	01/05/2015

## Saved Claim Details

Status:

Claim Type:

Service Date

From :   
mm/dd/yyyy

To :   
mm/dd/yyyy

Search

Cancel

## Ready to Batch

Select	Member Name	Tracking Number	Claim Type	Service From Date	Service To Date
<input type="checkbox"/>	SMITH, JOHN	TN0000000000	Professional	01/05/2015	01/05/2015
<input type="checkbox"/>	SMITH, JOHN	TN0000000001		07/31/2012	09/07/2012

Showing 1-2 of 2

Select the *Tracking Number* to view or submit the claim

Edit

Submit

Delete

## Incomplete Claims

Select	Member Name	Tracking Number	Claim Type	Service From Date	Service To Date
<input type="checkbox"/>		TN0000000002	Professional	01/05/2015	01/05/2015
<input type="checkbox"/>	SMITH, JOHN	TN0000000003	Institutional	01/05/2015	01/05/2015

Showing 1-2 of 2

Edit

Delete

## Saved Claim Details

Status:  Claim Type:  Service Date  
From:  To:

## Ready to Batch

Select	Member Name	Tracking Number	Claim Type	Service From Date	Service To Date
<input checked="" type="checkbox"/>	SMITH, JOHN	TN0000000000	Professional	01/05/2015	01/05/2015
<input checked="" type="checkbox"/>	SMITH, JOHN	TN0000000001	Institutional	07/31/2012	09/07/2012

Page 1 of 1 10 per page Showing 1-2 of 2

## Incomplete Claims

Select	Member Name	Tracking Number	Claim Type	Service From Date	Service To Date
<input type="checkbox"/>		TN0000000002	Professional		
<input type="checkbox"/>	SMITH, JOHN	TN0000000003	Institutional		

Page 1 of 1 10 per page

You can select one or more *Ready to Batch* claims to submit or delete



## Saved Claim Details

Status:

Claim Type:

Service Date

From :

To :

### Ready to Batch

Select	Member Name	Tracking Number	Claim Type	Service From Date	Service To Date
<input checked="" type="checkbox"/>	SMITH, JOHN	TNO	Claims Saved Batch Process	01/05/2015	01/05/2015
<input checked="" type="checkbox"/>	SMITH, JOHN	TNO		07/31/2012	09/07/2012

2 claim(s) have been submitted for claim processing

Showing 1-2 of 2

### Incomplete Claims

Select	Member Name	Tracking Number	Claim Type	Service From Date	Service To Date
<input type="checkbox"/>			Professional	01/05/2015	01/05/2015
<input type="checkbox"/>			Institutional	01/05/2015	01/05/2015

Showing 1-2 of 2

Upon Successful Batch Submission; a pop up will appear verifying that they were submitted.

## Saved Claim Details

Status:

Claim Type:

From :   
mm/dd/yyyy

Service Date  
To :   
mm/dd/yyyy

Search

Cancel

## Ready to Batch

Select	Member Name	Tracking Number	Claim Type	Service From Date	Service To Date
<input type="checkbox"/>	SMITH, JOHN	TN0000000000	Professional	01/05/2015	01/05/2015
<input checked="" type="checkbox"/>	SMITH, JOHN	TN0000000001	Institutional	07/31/2012	09/07/2012

Page 1 of 1 | 10 per page | Showing 1-2 of 2

Edit

Submit

Delete

## Incomplete Claims

Select	Member Name	Tracking Number	Claim Type	Service From Date	Service To Date
<input type="checkbox"/>		TN0000000002	Professional		
<input type="checkbox"/>	SMITH, JOHN	TN0000000003	Institutional		

Page 1 of 1 | 10 per page | Showing 1-2 of 2

You can select one *Ready to Batch* claim to edit, submit or delete

## Saved Claim Details

Status:

Claim Type:

Service Date

From :

To :

Search

Cancel

## Ready to Batch

Select	Member Name	Tracking Number	Claim Type	Service From Date	Service To Date
<input type="checkbox"/>	SMITH, JOHN	TN0000000000	Professional	01/05/2015	01/05/2015
<input type="checkbox"/>	SMITH, JOHN	TN0000000001	Institutional	07/31/2012	09/07/2012

Page  of   per page Showing 1-2 of 2

Edit

Submit

Delete

## Incomplete Claims

Select	Member Name	Tracking Number	Claim Type	Service From Date	Service To Date
<input checked="" type="checkbox"/>		TN0000000002	Professional	01/05/2015	01/05/2015
<input type="checkbox"/>	SMITH, JOHN	TN0000000003	Institutional	01/05/2015	01/05/2015

Page  of   per page Showing 1-2 of 2

Edit

Delete

You can select one or more *Incomplete Claims* to delete, but you can only edit one claim at a time



**Provider Portal**

Member Eligibility

▼ **Claims**

Claims Status Inquiry

Create Professional Claim (CMS 1500)

Create Institutional Claim (UB04)

Open Saved Claims

Create/Manage Claims Template

Export Claims Report to Excel

▶ Service Request/Authorization

▶ Member



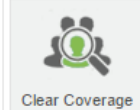
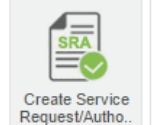
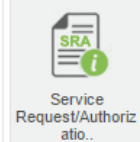
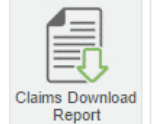
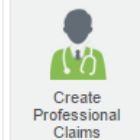
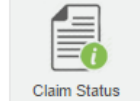
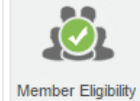
HEDIS Profile **New!**

Reports

Links

Forms

▶ Account Tools

**Messages and Announcements** You have (274) new messages You have (16) announcements**Recent Activity** [Click here to view your recent Service Request/Authorizations](#) [Click here to view your recent Claims](#)**My Favorites** [Edit](#)

Select *Claims Status Inquiry*

**Member Eligibility Search**

Member ID

Go

**What's New**

Medicare is available for Member Eligibility Searches, Service/Request Authorization Inquiry and Claim Status Inquiry. Please click [Contact Molina](#) to locate the Molina Member/Provider Services telephone numbers.

**Coming Soon !**

Claims will have new functionality coming in March!

- Batched Claims
- Create Claims Templates
- Correct Claims
- Add Attachments to Claims


**Poll**

Do you like our new look?

- Yes
- No

[Vote](#)[See Responses](#)

## Claims Inquiry


Information on Claims accepted into the adjudication system is current as of Jan 18 2015 12:06:58 PM PST 


### Search


Claim Type:  Search Options:  Claim Status:


### Optional Search Criteria

Enter optional criteria to narrow your search

Received Date: From:  

To:  

Date of Service From:  

To:  

Patient Control No:

NPI:

Claim No:

Gender:

Claims Status:

Search


Clear

Cancel

Select *Claim Type* and search by any of the following:

- Member Name/DOB
- Member Number
- Tracking Number
- Claim Status

## Claims Inquiry

Information on Claims accepted into the adjudication system is current as of Jan 18 2015 12:06:58 PM PST 



### Search


Claim Type:  Search Options:  Claim Status:



- Claim Status
- Member Name/DOB
- Member Number
- Tracking Number
- Claim Status


### Optional Search Criteria

Enter optional criteria to narrow your search

Received Date: From:   To:  

To:  

Date of Service From:   To:  

To:  

Patient Control No:

NPI:

Claim No:

Gender:

Claims Status:

Search

Clear

Cancel

Upon completion of the required search criteria, select *Search*

## Claims Inquiry

**Please Note: If more than 100 claims are found, only the first 100 will be shown. Please narrow your criteria.**

Search

Claim Type:  Search Options:  Claim Status:

Optional Search Criteria

Enter optional criteria to narrow your search

Received Date: From:  To:   
mm/dd/yyyy mm/dd/yyyy

Date of Service From:  To:   
mm/dd/yyyy mm/dd/yyyy

Patient Control No:

Claim No:

Claims Status:

NPI:

Gender:

Your search information found more than 100 claims. The first one hundred claims are displayed. If you are looking for a particular claim, narrow your search by adding additional criteria.


## Claims Found

Claim ID	Member Name	Total Charged Amount(\$)	Service Date From	Service Date To	Received Date	Status	Claim Type	Attachments
12345678901	GRAINGER, HERMIONE	283.00	02/06/2013	02/06/2013	02/18/2013	Paid	PROFESSIONAL	No
12345678901	POTTER, HARRY	643.00	01/24/2013	01/24/2013	02/01/2013	Paid	PROFESSIONAL	No
12345678901	WEASLEY, CHARLES	94.00	01/14/2013	01/14/2013	01/22/2013	Paid	PROFESSIONAL	No
12345678901	WEASLEY, RONALD	330.00	01/16/2013	01/16/2013	01/25/2013	Paid	PROFESSIONAL	No
12345678901	WEASLEY, RONALD	645.00	03/12/2012	03/12/2012	06/08/2012	Paid	PROFESSIONAL	No

Showing 1-5 of 100  per page Page 1 of 20



## Claims Inquiry


Information on Claims accepted into the adjudication system is current as of Jan 12 2015 06:41:22 PM PST 


### Search


Claim Type:  Search Options:  Claim Status:


### Optional Search Criteria

Enter optional criteria to narrow your search

Received Date: From:    
mm/dd/yyyy

To:    
mm/dd/yyyy

Date of Service From:    
mm/dd/yyyy

To:    
mm/dd/yyyy

Patient Control No:

NPI:

Gender:

Claim

Select a *Claim ID* to see the details

Your search information is used to filter the claims displayed. If you are looking for a particular claim, narrow your search by adding additional criteria.

## Claims Found

Claim ID	Member Name	Total Charged Amount(\$)	Service Date From	Service Date To	Received Date	Status	Claim Type	Attachments
12345678901	GRAINGER, HERMIONE	283.00	02/06/2013	02/06/2013	02/18/2013	Paid	PROFESSIONAL	No
12345678901	POTTER, HARRY	643.00	01/24/2013	01/24/2013	02/01/2013	Paid	PROFESSIONAL	No
12345678901	WEASLEY, CHARLES	94.00	01/14/2013	01/14/2013	01/22/2013	Paid	PROFESSIONAL	No
12345678901	WEASLEY, RONALD	330.00	01/16/2013	01/16/2013	01/25/2013	Paid	PROFESSIONAL	No
12345678901	WEASLEY, RONALD	645.00	03/12/2012	03/12/2012	06/08/2012	Paid	PROFESSIONAL	No

Showing 1-5 of 100  per page Page 1 of 20

## Claims Inquiry

[Print Claim Summary](#)

[Back](#)

Information on Claims accepted into the adjudication system is current as of Jan 12 2015 06:41:22 PM PST

### Search

Claim Type:  Search Options:  Claim Status:

### Optional Search Criteria

Enter optional criteria to narrow your search

Received Date: From:  To:  Date of Service From:  To:

Patient Control No:

NPI:

Claim No:

Gender:

Claims Status:

[Search](#)

[Clear](#)

[Cancel](#)

## Claim Details

### General Information

Member Name:POTTER, HARRY	Claim Number:12345678901
Claim Status Category:	Claim Status Effective:1/24/2013
Claim Header Status:Paid	Billed Amount(\$):643.00
Rendering Provider Name:DUMBLEDORE, ALBUS	Check Number:
Rendering Provider NPI: 0000000000	Service Date From:01/24/2013
Check Paid Date:02/12/2013	Patient Control Number:1111111111
Service Date To:01/24/2013	Amount Paid(\$):247.05

### Claim Line Items

Claim Line	Service From Date	Service To Date	Rev Code	HCPCS/Service Code	Procedure code Modifiers	Units	Billed Amt	Paid Amt	Deductible	Co-Insurance	Member Copay	Line Status Effective	Status	Remit Message
1	01/24/2013	01/24/2013		68530		1	549.00	204.65	0.00	0.00	0.00	1/24/2013	Paid	
2	01/24/2013	01/24/2013		99213		1	94.00	42.40	0.00	0.00	0.00	1/24/2013	Paid	

Showing 1-2 of 2

per page

Page 1 of 1

[Save As Template](#)

[Appeal Claim](#)

[Void Claim](#)

[Correct Claim](#)

[View Diagnosis Code](#)

[Print Claim Summary](#)

[Back](#)

## Claims Inquiry

[Print Claim Summary](#)

[Back](#)

Information on Claims accepted into the adjudication system is current as of Jan 12 2015 06:41:22 PM PST

### Search

Claim Type:  Search Options:  Claim Status:

### Optional Search Criteria

Enter optional criteria to narrow your search

Received Date: From:    
mm/dd/yyyy

To:    
mm/dd/yyyy

Date of Service From:    
mm/dd/yyyy

To:    
mm/dd/yyyy

Patient Control No:

NPI:

Claim No:

Gender:

Claims Status:

[Search](#)

[Clear](#)

[Cancel](#)

## Claim Details

### General Information

Member Name: POTTER, HARRY

Claim Number: 12345678901

Claim Status Category:

Claim Status Effective: 1/24/2013

Claim Header Status: Paid

Rendering Provider Name: DUMBLEDORE, ALBUS

Rendering Provider NPI: 0000000000

Check Paid Date: 02/12/2013

Service Date To: 01/24/2013

### Claim Line Items

Claim Line	Service From Date	Service To Date	Rev Code	HCPCS/Service Code	Deductible	Co-Insurance	Member Copay	Line Status Effective	Status	Remit Message			
1	01/24/2013	01/24/2013		68530	1	549.00	204.65	0.00	0.00	0.00	1/24/2013	Paid	
2	01/24/2013	01/24/2013		99213	1	94.00	42.40	0.00	0.00	0.00	1/24/2013	Paid	

Select *Save as Template* to create a template from this claim

Showing 1-2 of 2

per page

Page 1 of 1

[Save As Template](#)

[Appeal Claim](#)

[Void Claim](#)

[Correct Claim](#)

[View Diagnosis Code](#)

[Print Claim Summary](#)

[Back](#)

## Claims Inquiry

Print Claim Summary Back

Information on Claims accepted into the adjudication system is current as of Jan 12 2015 06:41:22 PM PST ?

### Search

Claim Type: CMS-1500-Professional Search Options: Claim Status Claim Status: All

### Optional Search Criteria

Enter optional criteria to narrow your search

Received Date: From: mm/dd/yyyy To: mm/dd/yyyy Date of Service From: mm/dd/yyyy To: mm/dd/yyyy

Patient Control No:

Claim No:

Claims Status: All

### Add Template

Template Name: \* WebPortal021915

Template Description:

Save

Cancel

Search

Clear

Cancel

## Claim Details

### General Information

Member Name: POTTER, HARRY

Claim Status Category:

Claim Header Status: Paid

Rendering Provider Name: DUMBLEDORE, ALBUS

Rendering Provider NPI: 0000000000

Check Paid Date: 02/12/2013

Service Date To: 01/24/2013

Amount(\$): 643.00

Number:

01/24/2013

111111111111

247.05

### Claim Line Items

Claim Line	Service From Date	Service To Date	Rev Code	HCPCS/Service Code	Deductible	Co-Insurance	Member Copay	Line Status Effective	Status	Remit Message
1	01/24/2013	01/24/2013		68530	0.00	0.00	0.00	1/24/2013	Paid	
2	01/24/2013	01/24/2013		99213	0.00	0.00	0.00	1/24/2013	Paid	

Select Save

Showing 1-2 of 2

10

per page

Page 1 of 1

Save As Template

Appeal Claim

Void Claim

Correct Claim

View Diagnosis Code

Print Claim Summary

Back

## Claims Inquiry

Template Added Successfully

You can view Saved Templates in the [Create/Manage Templates](#) Page

[Print Claim Summary](#) [Back](#)

System is current as of Jan 12 2015 06:41:22 PM PST

Search

Claim Type:  Search Options:

Optional Search Criteria

Enter optional criteria to narrow your search

Received Date: From:  To:  Date of Service From:  To:

Patient Control No:  NPI:

Claim No:  Gender:

Claims Status:

[Search](#) [Clear](#) [Cancel](#)

## Claim Details

### General Information

Member Name: POTTER, HARRY  
 Claim Status Category:  
 Claim Header Status: Paid  
 Rendering Provider Name: DUMBLEDORE, ALBUS  
 Rendering Provider NPI: 0000000000  
 Check Paid Date: 02/12/2013  
 Service Date To: 01/24/2013

Claim Number: 12345678901  
 Claim Status Effective: 1/24/2013  
 Billed Amount(\$): 643.00  
 Check Number:  
 Service Date From: 01/24/2013  
 Patient Control Number: 11111111111  
 Amount Paid(\$): 247.05

### Claim Line Items

Claim Line	Service From Date	Service To Date	Rev Code	HCPCS/Service Code	Procedure code Modifiers	Units	Billed Amt	Paid Amt	Deductible	Co-Insurance	Member Copay	Line Status Effective	Status	Remit Message
1	01/24/2013	01/24/2013		68530		1	549.00	204.65	0.00	0.00	0.00	1/24/2013	Paid	
2	01/24/2013	01/24/2013		99213		1	94.00	42.40	0.00	0.00	0.00	1/24/2013	Paid	

Showing 1-2 of 2  per page Page 1 of 1

[Save As Template](#) [Appeal Claim](#) [Void Claim](#) [Correct Claim](#) [View Diagnosis Code](#) [Print Claim Summary](#) [Back](#)

## Claims Inquiry

[Print Claim Summary](#) [Back](#)

Information on Claims accepted into the adjudication system is current as of Jan 12 2015 06:41:22 PM PST

### Search

Claim Type:  Search Options:  Claim Status:

### Optional Search Criteria

Enter optional criteria to narrow your search

Received Date: From:  To:  Date of Service From:  To:

Patient Control No:  NPI:   
 Claim No:   
 Claims Status:

**Claims Appeals are ONLY available in Texas**

[Search](#) [Clear](#) [Cancel](#)

## Claim Details

### General Information

Member Name: SMITH, JILL  
 Claim Status Category:  
 Claim Header Status: Paid  
 Rendering Provider Name: LOWE, ROB  
 Rendering Provider NPI: 0000000000  
 Check Paid Date: 07/19/2013  
 Service Date To: 06/25/2013

Claim Number: 1111111111  
 Claim Status Effective: 06/25/2013  
 Billed Amount(\$): 643.00  
 Check Number:  
 Service Date From: 06/25/2013

### Claim Line Items

Claim Line	Service From Date	Service To Date	Rev Code	HCPCS/Service Code	Procedure	Co-Insurance	Member Copay	Line Status Effective	Status	Remit Message
1	06/25/2013	06/25/2013		68530		0.00	0.00	06/25/2013	Paid	
2	06/25/2013	06/25/2013		99213		0.00	0.00	06/25/2013	Paid	

Showing 1-2 of 2  per page Page 1 of 1

Select Appeal Claim to appeal a Paid/Denied claims

[Save As Template](#) [Appeal Claim](#) [Void Claim](#) [Correct Claim](#) [View Diagnosis Code](#) [Print Claim Summary](#) [Back](#)

## Provider Complaint/Appeal Request Form

### Instructions for filling a complaint/appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit.
3. The completed form will be submitted to Molina Healthcare of Texas to Provider Complaints & Appeals. We will send a written acknowledgement of your request. It will be mailed to you within three (3) working days after the request is received.

Provider's Name:	<input type="text" value="LOWE, ROB"/>	NPI:	<input type="text" value="0000000000"/>	Federal ID:	<input type="text" value="123456789"/>
Request Type:	<input type="radio"/> Complaint <input checked="" type="radio"/> Appeal	Participation Status:	<input checked="" type="radio"/> Contract <input type="radio"/> Non - Contracted		
Claim Number:	<input type="text" value="1111111111"/>	Date of Service:	<input type="text" value="06/25/2013"/>	Total Charges:	<input type="text" value="643.00"/>
			mm/dd/yyyy		
Address:	<input type="text" value="000 MAIN ST"/>	City/State/Zip:	<input type="text" value="DALLAS, TX, 75206"/>		
Contact Person:	<input type="text"/>	Phone:	<input type="text"/>		
Member's ID:	<input type="text" value="123456789"/>	Member Name:	<input type="text" value="SMITH, JILL"/>	Date of Birth:	<input type="text" value="11/11/1911"/>
					mm/dd/yyyy
Specific Issue(s):	Please state all details relating to your request including names, dates and places. Attach all supporting materials below to support your request.				
	<input type="text"/>				

### Supporting Information

Attachments: Attach copies of any records you wish to submit below

Attachment:

File:  No file chosen

Upload files only when you want to add supporting documents to the claim appeal. Upload 1  
Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not

After entering the necessary information the notification and all supporting documents that were uploaded will be delivered. Printing the claims summary will be covered next.

Fill out all the information and select *Submit*

Name:  Date:

I agree that the information provided is true and correct. If someone else is completing this form for me, by checking this box I am giving my consent for the person named above to submit on my behalf.

# Claims Inquiry

[Print Claim Summary](#) [Back](#)

Information on Claims accepted into the adjudication system is current as of Mar 25 2015 01:30:07 PM PST

Search  
Claim Type:  Search Options:  Claim Status:

### Optional Search Criteria

Enter optional criteria to narrow your search

Received Date: From:  To:   
mm/dd/yyyy mm/dd/yyyy  
Date of Service From:  To:   
mm/dd/yyyy mm/dd/yyyy

Patient Control No:   
Claim No:   
NPI:   
Claims Status:

If a claim's Header Status is Pending/In Process or In-adjudication you can submit an attachment via the Claims Details screen

## Claim Details

### General Information

Member Name: SMITH, JILL  
Claim Status Category:  
Claim Header Status: In adjudication  
Rendering Provider Name: LOWE, ROB  
Rendering Provider NPI: 0000000000  
Check Paid Date:  
Service Date To: 03/09/2015  
Claim Status: Pending/In Process  
Billed Amount: 51.36  
Check Number:  
Service Date From: 03/09/2015  
Patient Control Number: 1111111111  
Amount Paid(\$): 51.36

### Claim Line Items

Claim Line	Service From Date	Service To Date	Rev Code	HCPCS/Service Code	Procedure code Modifiers	Units	Billed Amt	Paid Amt	Deductible	Co-Insurance	Member Copay	Line Status Effective	Status	Remit Message
1	03/09/2015	03/09/2015	0450	99282	25	1	505.80	51.36	0.00	0.00	0.00	3/9/2015	Paid	

Showing 1-1 of 1  per page Page 1 of 1

[Save As Template](#) [Appeal Claim](#) [Void Claim](#) [Correct Claim](#) [View Diagnosis Code](#) [Print Claim Summary](#) [Back](#)

### Attachments

Type of Attachment:

File:  No file chosen [Upload](#)

Supported file formats are PDF, TIF, JPG, BMP and GIF. Upload 1 file at a time.  
Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

[Submit Attachments](#) [Cancel](#)





### Provider Portal

Member Eligibility

#### Claims

Claims Status Inquiry

Create Professional Claim (CMS 1500)

Create Institutional Claim (UB04)

Open Saved Claims

Create/Manage Claims Template

Export Claims Report to Excel

▶ Service Request/Authorization

▶ Member

HEDIS Profile **New!**

Reports

Links

Forms


▶ Account Tools

### Messages and Announcements

 You have (274) new messages


 You have (16) announcements


### Recent Activity


 [Click here to view your recent Service Request/Authorizations](#)


 [Click here to view your recent Claims](#)


### My Favorites [Edit](#)


 Member Eligibility


 Claim Status Inquiry


 Create Professional Claims

 Claims Download Report

 Service Request/Authorization

 Create Service Request/Authorization

 Coverage

 Create Institutional Claim

### Quick Member Eligibility Search

Search by Member ID

#### What's New

Medicare is available for Member Eligibility Searches, Service/Request Authorization Inquiry and Claim Status Inquiry. Please click [Contact Molina](#) to locate the Member/Provider Services telephone numbers.

#### Coming Soon !

Claims will have new functionality coming in March!  
- Batched Claims

#### Poll

Do you like our new look?

Yes

There are two ways to Correct or Void a claim

- Within Create Professional or Institutional Claim
- Within a Claims Details page

Correct Claims via Create Professional Claim (CMS 1500) & Create Institutional Claim (UB04)

Next >>

Member

Provider

Summary

What would you like to do?  Create Claim  Correct Claim  Void Claim

Prior Claim ID#: \*

### Eligibility Check

Enter the insured's ID or their last name  
Advance Search .

Select *Correct Claim* and enter a previously opened claim. Select *Enter*.

How the ID search by Last name, First name and Date of Birth using

Insured's ID Number: \*

OR

Last Name: \*

First Name: \*

DOB: \*   
(mm/dd/yyyy)

AND

Service From Date: \*    
(mm/dd/yyyy)

Service To Date: \*    
(mm/dd/yyyy)

### Insured's Information

Last Name:

First Name:

Middle Initial:

DOB:

Sex:

## Claims Inquiry

**Correct Claims via the Claims Details Page**

[Print Claim Summary](#)   [Back](#)

The adjudication system is current as of Jan 12 2015 06:41:22 PM PST

Search

**Claim Type:** CMS-1500-Professional   **Search Options:** Claim Status   **Claim Status:** All

Optional Search Criteria

Enter optional criteria to narrow your search

**Received Date:** From:  To:   
mm/dd/yyyy                      mm/dd/yyyy

**Date of Service** From:  To:   
mm/dd/yyyy                      mm/dd/yyyy

**Patient Control No:**                       **NPI:**

**Claim No:**                                       **Gender:** Select

**Claims Status:** All

[Search](#)   [Clear](#)   [Cancel](#)

## Claim Details

### General Information

Member Name: SMITH, JILL	Claim Number: 1111111111
Claim Status Category:	Claim Status Effective: 06/25/2013
Claim Header Status: Paid	Billed Amount(\$): 643.00
Rendering Provider Name: LOWE, ROB	Check Number:
Rendering Provider NPI: 0000000000	Service Date From: 06/25/2013
Check Paid Date: 07/19/2013	Patient Control Number: 1111111111
Service Date To: 06/25/2013	Amount Paid(\$): 247.05

### Claim Line Items

Claim Line	Service From Date	Service To Date	Rev Code	HCPCS/Service Code	Procedure code Modifiers	Units	Billed	Member Copay	Line Status Effective	Status	Remit Message
1	06/25/2013	06/25/2013		68530		1	549	0.00	06/25/2013	Paid	
2	06/25/2013	06/25/2013		99213		1	94.00	0.00	06/25/2013	Paid	

Showing 1-2 of 2   10 per page                      Page 1 of 1

**Select Correct Claim**

[Save As Template](#)   [Appeal Claim](#)   [Void Claim](#)   [Correct Claim](#)   [View Diagnosis Code](#)   [Print Claim Summary](#)   [Back](#)

Next >>

Save for Later

Save as Template

Cancel

Member

Provider

Summary

\*- Required Field [Help](#) [FAQ](#)

What would you like to do?  Create Claim  Correct Claim  Void Claim

Prior Claim ID#: \*

### Eligibility Check

Enter the insured's ID or their last name, first name and Date of Birth. If you dont know the ID search by Last name,First name and Date of Birth using Advance Search .

Insured's ID Number: \*

OR

Last Name: \*

First Name: \*

DOB: \*   
(mm/dd/yyyy)

AND

Service From Date: \*    
(mm/dd/yyyy)

Service To Date: \*    
(mm/dd/yyyy)

### Insured's Information

Last Name:

First Name:

DOB:

Sex:

Address1:

Address2:

The claim will auto-fill with the details

Select *Save for Later* to save the claim as an incomplete claim

<< Previous

Print

Save for Later

Save as Template

Submit

Save For Batch

Cancel

Member

Provider

Summary

[Help](#) [FAQ](#)

Collapse All

Member Summary

Insured Information

Edit

Insured's ID: 123456789123  
Service From Date: 06/26/2013  
Last Name: SMITH  
Middle Initial:

Service To Date: 06/25/2013  
First Name: JILL  
DOB: 10/11/2012

Select *Save as Template* to save the original claim as a template.

<< Previous

Print

Save for Later

Save as Template

Submit

Save For Batch

Cancel

Member

Provider

Summary

[Help](#) [FAQ](#)

Collapse All

Member Summary

Insured Information

Edit

Insured's ID: 123456789123  
Service From Date: 06/26/2013  
Last Name: SMITH  
Middle Initial:

Service To Date: 06/25/2013

Please Note: If you *Save as Template*, your original claim will not be corrected

Select *Save for Batch* to submit the corrected claim in a batch

<< Previous

Print

Save for Later

Save as Template

Submit

Save For Batch

Cancel

Member

Provider

Summary

[Help](#) [FAQ](#)

Collapse All

Member Summary

Insured Information

Edit

Insured's ID: 123456789123  
Service From Date: 06/26/2013  
Last Name: SMITH  
Middle Initial:

Service To Date: 06/25/2013  
First Name: JILL  
DOB: 10/11/2012



Select *Submit* to submit the claim

<< Previous

Print

Save for Later

Save as Template

Submit

Save For Batch

Cancel

Member

Provider

Summary

[Help](#) [FAQ](#)

Collapse All

Member Summary

Insured Information

Edit

Insured's ID: 123456789123  
Service From Date: 06/26/2013  
Last Name: SMITH  
Middle Initial:

Service To Date: 06/25/2013  
First Name: JILL  
DOB: 10/11/2012

Your Claim has been Successfully submitted. Please note the Claim ID for Future Reference.  
Claim ID: 12345678901

<< Previous

Print

Save for Later

Save as Template

Submit

Save For Batch

Cancel

Member

Provider

Summary

[Help](#) [FAQ](#)

Claim ID: 12345678901

Collapse All

Member Summary

Insured Information

Upon Successful Single Submission; a message will appear with a new Claim ID number.

Edit

Service To Date: 06/25/2013  
First Name: JILL  
DOB: 10/11/2012

## Void Claims via Create Professional Claim (CMS 1500) & Create Institutional Claim (UB04)

Next >>

Save for Later Cancel

Member

Provider

Summary

\* - Required Field [Help](#) [FAQ](#)

What would you like to do?  Create Claim  Correct Claim  Void Claim

Prior Claim ID#: \*  Enter

### Eligibility Check

Enter the insured's ID or their last name, first name and Date of Birth using Advance Search .

Insured's ID Number: \*

OR

Select *Void Claim* and enter a previously opened claim. Select *Enter*.

## Claims Inquiry

Void Claims via the Claims Details Page

Print Claim Summary Back

The adjudication system is current as of Jan 12 2015 06:41:22 PM PST

Search

Claim Type: CMS-1500-Professional Search Options: Claim Status Claim Status: All

Optional Search Criteria

Enter optional criteria to narrow your search

Received Date: From: mm/dd/yyyy To: mm/dd/yyyy Date of Service From: mm/dd/yyyy To: mm/dd/yyyy

Patient Control No: NPI: Gender: Select

Claim No: Claims Status: All

Search Clear Cancel

## Claim Details

### General Information

Member Name: SMITH, JILL  
 Claim Status Category:  
 Claim Header Status: Paid  
 Rendering Provider Name: LOWE, ROB  
 Rendering Provider NPI: 0000000000  
 Check Paid Date: 07/19/2013  
 Service Date To: 06/25/2013

Claim Number: 1111111111  
 Claim Status Effective: 06/25/2013  
 Billed Amount(\$): 643.00

Select Void Claim

### Claim Line Items

Claim Line	Service From Date	Service To Date	Rev Code	HCPCS/Service Code	Proced Mod	Chargeable	Co-Insurance	Member Copay	Line Status Effective	Status	Remit Message
1	06/25/2013	06/25/2013		68530		0.00	0.00	0.00	06/25/2013	Paid	
2	06/25/2013	06/25/2013		99213		94.00	0.00	0.00	06/25/2013	Paid	

Showing 1-2 of 2 10 per page Page 1 of 1

Save As Template Appeal Claim Void Claim Correct Claim View Diagnosis Code Print Claim Summary Back

Next >>

Cancel

Member

Provider

Summary

\* - Required Field [Help](#) [FAQ](#)

What would you like to do?  Create Claim  Correct Claim  Void Claim

Prior Claim ID#: \*

The claim will auto-fill with the details

### Eligibility Check

Enter the insured's ID or their last name, first name and Date of Birth. If you dont know the ID search by Last name,First name and Date of Birth using Advance Search .

Insured's ID Number: \*

OR

Last Name: \*

First Name: \*

DOB: \*   
(mm/dd/yyyy)

AND

Service From Date: \*  (mm/dd/yyyy)

Service To Date: \*  (mm/dd/yyyy)

### Insured's Information

Last Name:

First Name:

Middle Initial:

Select *Submit* to void the claim

<< Previous

Print

Submit

Cancel

Member

Provider

Summary

[Help](#) [FAQ](#)

Collapse All

Member Summary

Insured Information

Insured's ID: 123456789123  
Service From Date: 06/25/2013  
Last Name: SMITH  
Middle Initial:  
Sex: Female

Service To Date: 06/25/2013  
First Name: JILL  
DOB: 10/11/2012  
Address1: 000 MAIN ST

<< Previous

Print

Save for Later

Save as Template

Submit

Save For Batch

Cancel

Member

Provider

Summary

[Help](#) [FAQ](#)

Collapse All

Member Summary

Insured Information

Insured's ID:	123456789123
Service From Date:	06/26/2013
Last Name:	SMITH
Middle Initial:	

**Web Portal**

Are you sure you want to void Claim ID# 11111111111?

Yes No

Select Yes to void the claim

Your Claim has been Successfully submitted. Please note the Claim ID for Future Reference.  
Claim ID: 12345678901

<< Previous

Member

Provider

Summary

[Help](#) [FAQ](#)

Claim ID: 11111111111

Collapse All

Member Summary

Insured Information

Insured's ID: 12345678912  
Service From Date: 06/26/2013  
Last Name: SMITH

Web Portal

The Claim ID: 11111111111 has been successfully submitted to void Claim ID:12345678901.

Do you wish to use the previous claim's information to create your new claim?

Yes

No

Upon Successful submission; a message will appear with a new Claim ID number.

You also have the opportunity to use the information to create a new claim





## Create/Manage Claims Template

### Manage and Use Templates

Select	Claim Type	Template Name	Template Description
<input type="checkbox"/>	CMS1500-Professional	Testing020115	
<input type="checkbox"/>	CMS1500-Professional	CMS1500021915	
<input type="checkbox"/>	CMS1500-Professional	WebPortal021215	
<input type="checkbox"/>	CMS1500-Professional	WebPortal021215v1	
<input type="checkbox"/>	CMS1500-Professional	WebPortal021215v2	
<input type="checkbox"/>	CMS1500-Professional	Tester021615	
<input type="checkbox"/>	CMS1500-Professional	WebPortal021915	

Page 1 of 1    10 per page    Showing 1-7 of 7

[Create](#)   [Load](#)   [Delete](#)

You can create a claim template via;

- Claim Inquiry Details
- Corrected/Voided Claims
- Create/Manage Claims

## Create/Manage Claims Template

### Manage and Use Templates

Select	Claim Type	Template Name	Template Description
<input type="checkbox"/>	CMS1500-Professional	Testing020115	
<input type="checkbox"/>	CMS1500-Professional	CMS1500021915	
<input type="checkbox"/>	CMS1500-Professional	WebPortal021215	
<input type="checkbox"/>	CMS1500-Professional	WebPortal021215v1	
<input type="checkbox"/>	CMS1500-Professional	WebPortal021215v2	
<input type="checkbox"/>	CMS1500-Professional	Tester021615	
<input type="checkbox"/>	CMS1500-Professional	WebPortal021915	

Page 1 of 1    10 per page    Showing 1-7 of 7

[Create](#)   [Load](#)   [Delete](#)

To create a claims template select *Create*

## Create/Manage Claims Template

### Manage and Use Templates

Select	Claim Type	Template Name	Template Description
<input type="checkbox"/>	CMS1500-Professional	Testing020115	
<input type="checkbox"/>	CMS1500-Professional	CMS1500021915	
<input type="checkbox"/>	CMS1500-Professional	WebPortal021215	
<input type="checkbox"/>	CMS1500-Professional	WebPortal021215v1	
<input type="checkbox"/>	CMS1500-Professional		
<input type="checkbox"/>	CMS1500-Professional		
<input type="checkbox"/>	CMS1500-Professional		

Page 1 of 1 | 10 per page | Showing 1-7 of 7

**Add Template**

Professional     Institutional

Choose the type of claim you want to open and select *Create*

Next >>

Save as Template

Cancel

Member

Provider

Summary

Field [Help](#) [FAQ](#)

What would you like to do?  Create Claim  Correct Claim  Void Claim

A blank claim will appear. You will have the option to *Save as Template*

### Eligibility Check

Enter the insured's ID or their last name, first name and Date of Birth. If you dont know the ID search by Last name,First name and Date of Birth using Advance Search .

Insured's ID Number: \*

Advanced Search

OR

Last Name: \*

First Name: \*

DOB: \*   
(mm/dd/yyyy)

AND

Service From Date: \*    
(mm/dd/yyyy)

Service To Date: \*    
(mm/dd/yyyy)

### Insured's Information

Last Name:

First Name:

Middle Initial:

DOB:

Sex:

Address1:

Address2:

City:

State:

Zip Code:

Payor Name: MHC OH

Program Name:

Payor ID: 20-0750134

### Patient Information

Note: If there are no dependents for the Insured, Patient Relationship will be prepopulated as "Self".

Patient Relationship to Insured: \* 18-Self

### Other Insurance

Next >>

Save as Template

Cancel

Member

Provider

Summary

\* - Required Field [Help](#) [FAQ](#)

What would you like to do?  Create Claim  Correct Claim  Void Claim

### Eligibility Check

Enter the insured's ID or their last name, first name and Date of Birth. [Advance Search](#).

Insured's ID Number: \*

OR

Last Name: \*

AND

Service From Date: \*    
(mm/dd/yyyy)

### Add Template

Template Name: \*

Template Description:

Save

Cancel

Select *Save* and you will be redirected back to the Create/Manage Templates page

### Insured's Information

Last Name:

DOB:

Address1:

City:

Payor Name:

Middle Initial:

Zip Code:

Payor ID:

### Patient Information

Note: If there are no dependents for the Insured, Patient Relationship will be prepopulated as "Self".

Patient Relationship to Insured: \*

### Other Insurance

## Create/Manage Claims Template

### Manage and Use Templates

Select	Claim Type	Template Name	Template Description
<input type="checkbox"/>	CMS1500-Professional	Testing020115	
<input type="checkbox"/>	CMS1500-Professional	CMS1500021915	
<input type="checkbox"/>	CMS1500-Professional	WebPortal021215	
<input type="checkbox"/>	CMS1500-Professional	WebPortal021215v1	
<input type="checkbox"/>	CMS1500-Professional	WebPortal021215v2	
<input type="checkbox"/>	CMS1500-Professional	Tester021615	
<input type="checkbox"/>	CMS1500-Professional	WebPortal021915	
<input type="checkbox"/>	CMS1500-Professional	Professional01	

Page 1 of 1    10 per page    Showing 1-8 of 8

Create

Load

Delete

The template you created will appear in the list





### Provider Portal

- Member Eligibility
- Claims**
  - Claims Status Inquiry
  - Create Professional Claim (CMS 1500)
  - Create Institutional Claim (UB04)
  - Open Saved Claims
  - Create/Manage Claims Template
  - Export Claims Report to Excel**
- Service Request/Authorization
- Member
  - HEDIS Profile **New!**
  - Reports
  - Links
  - Forms
- Account Tools

### Messages and Announcements

- You have (274) new messages
- You have (16) announcements

### Recent Activity

- [Click here to view your recent Service Request/Authorizations](#)
- [Click here to view your recent Claims](#)

### My Favorites [Edit](#)

- Member Eligibility
- Claim Status Inquiry
- Create Professional Claims
- Claims Download Report
- Service Request/Authorization
- Create Service Request/Authorization
- Clear Coverage
- Create Institutional Claim

### Quick Member Eligibility Search

Search by Member ID

#### What's New

Medicare is available for Member Eligibility Search

#### Coming Soon !

Claims will have new functionality coming in

- Claims
- Claims Templates
- Claims Attachments to Claims

#### Poll

Do you like our new look?

Yes

No

[See Responses](#)

*Select Export Claims Report to Excel*

To Export a Claim to Excel, enter Service Dates in the required fields below and click "Search". You can enter dates for claims beyond 12 months and receive your report as little as 10 minutes. To retrieve your Exported Claim Record, go to the Homepage.

#### Claims Export To Excel

\* - Required Field 

Information on historical claims data is current as of 3/22/2015

Service Date From :\*   Service Date To :\*    
mmddyyyy mmddyyyy

Click Search to Export Claims  
You will receive an email notification once your Exported Claim Record has been completed.

Choose your Service Dates and select Search

**Claims Export To Excel**

Your request has been submitted successfully! You will be notified via email when your report has been completed.

You will receive a successful submission message and in due time a confirmation email that your report is available.

## Provider Portal

Member Eligibility

▶ Claims

▶ Service Request/Authorization

▶ Member

HEDIS Profile

Reports

Links

Forms

▶ Account Tools

Successfully! You will be notified via email when your report has been completed.

Select *Reports* once you receive the confirmation email

The report should be available in the *Downloadable Claims Reports* Section

#### Downloadable Claims Reports

File Name	Service From Date	Service To Date	Generated Date
*****1759_02-25-2015_03-25-2015	02/25/2015	03/25/2015	03/25/2015

[View more Claim files](#)

\* Displays the last 30 days' most recent 5 Claim files based on Date of Service

#### Affiliation List

<a href="#">Affiliation List - PDF</a>
<a href="#">Affiliation List - EXCEL</a>

**If you have any additional questions, please email  
[WebPortal@MolinaHealthcare.com](mailto:WebPortal@MolinaHealthcare.com).**

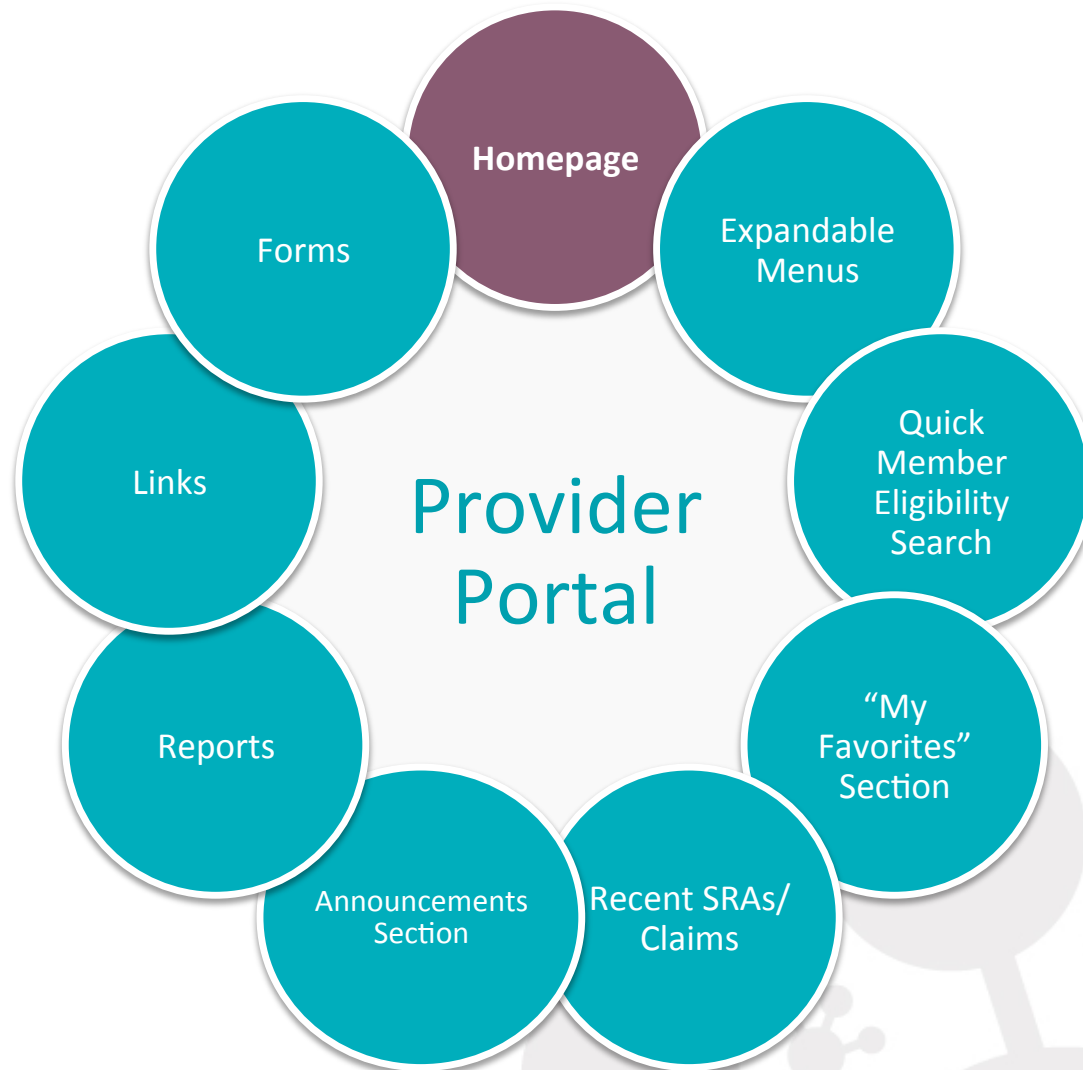
# Updates to Portal

1/1/2015 New Look to the Same Portal



Your Extended Family.

143





# Provider Portal 2014

[Home](#) [Member Eligibility](#) [Claims](#) [Service Request/Authorization](#) [Provider Search](#) [HEDIS Profile \*\*New!\*\*](#) [Member Roster](#) [Download](#) [Account Tools](#) [Logout](#)

## Newsletter

[Medicaid Newsletter](#)

[Marketplace Newsletter](#)

## Messages

✉ [210](#) New Message(s)

📄 [Health Alert! What you need to know about Ebola](#)

**Starting January 1, 2015** Clear Coverage will be phased into Molina's Provider Network throughout 2015. Clear Coverage is a web-based application that offers providers the ability to enter a prior authorization service request electronically and receive immediate authorization for specific services, such as diagnostic imaging, outpatient surgical procedures and DME, if the request meets clinical criteria.

📄 [MMP Provider Training Material](#)

📄 [HHSC Letter to Providers about ACA PCP Rate Increase](#)

📄 [Texas PreService Auth Codification Guide 2013](#)

📄 [Frequently Asked Questions about Home Health and LTSS Reimbursement Effective, September 1, 2013](#)

📄 [Personal Attendant Services Rates Effective September 1, 2013](#)

📄 [Frequently Asked Questions about Home Health and LTSS Reimbursement 90% to 100% Effective, July 1, 2013](#)

📄 [Frequently Asked Questions about Home Health and LTSS Reimbursement 100% Effective, July 1, 2013](#)

📄 [Corrected Claims](#)

📄 [Expedited Credentialing](#)

📄 [New CHIP ID Number](#)

📄 [...](#)

## Welcome WEB PORTAL TESTER

- [Contact Molina](#)
- [View FAQs](#)
- [What's New!](#)
- [Training Materials](#)

## Forms

- [LCD's and NCD's](#)
- [State Billing Guidelines](#)
- [Prior Authorization Guide 7/1/2013](#)
- [Prior Authorization Pre-Service Review Guide 01/01/2014](#)
- [Marketplace Provider Forms](#)
- [Prior Authorization Pre-Service Review Guide for Market Place- January 1, 2014](#)
- [Day Activity and Health Services Rates Effective September 1, 2013](#)
- [Early Childhood Intervention Services \(ECI\) & Non-ECI Behavioral Health Services FAQs](#)
- [New Cognitive Rehabilitation](#)

# Provider Portal 2015



- Provider Portal**
- Member Eligibility
- ▶ Claims
- ▶ Service Request/Authorization
- HEDIS Profile **New!**
- ▶ Member Roster
- Reports
- Links
- Forms
- ▶ Account Tools

### Messages and Announcements

You have (0) new messages

You have (16) announcements

### Recent Activity

You have 0 Service Request Authorizations in the last 30 days

You have 0 claims in the last 30 days


### My Favorites [Edit](#)

- Member Eligibility
- HEDIS Profile
- Claims Status Inquiry
- Member Roster
- Forms
- Create Professional Claims
- Create Service Request/Author..

### Quick Member Eligibility Search


Search by Member ID

### What's New



Medicare is available for Member eligibility searches, Service/Request authorization Inquiry and Claim Status inquiry. Please click [Contact Molina](#) to locate the molina medicare member services telephone number.

### Video



Take a tour at our new Provider Self Services!

### Poll

Do you like our new look?

- Yes
- No
- None
- NA

[See Responses](#)

- Provider Portal
- Member Eligibility
- Claims
- Service Request/Authorization
- HEDIS Profile **New!**
- Member Roster
- Reports
- Links
- Forms
- Account Tools

### Messages and Announcements

You have (0) new messages

You have (16) announcements

### Recent Activity

You have 0 Service Request Au

You have 0 claims in the last 30

### My Favorites


[Edit](#)

- HEDIS Profile
- Member Roster
- Forms
- Create Professional Claims
- Create Service Request/Autho..

### Quick Member Eligibility Search


Search by Member ID  [Go](#)

### What's New



Medicare is available for Member eligibility searches, Service/Request authorization Inquiry and Claim Status inquiry. Please click [Contact Molina](#) to locate the molina medicare member services telephone number.

### Video



3:07

Take a tour at our new Provider Self Services!

### Poll

Do you like our new look?

Yes



No

None

NA

[Vote](#) [See Responses](#)

A Poll functionality was added to allow Provider feedback

Provider Portal	Messages and Announcements	Recent Activity	My Favorites <a href="#">Edit</a>
<ul style="list-style-type: none"> <li>Member Eligibility</li> <li>▶ Claims</li> <li>▶ Service Request/Authorization</li> <li>HEDIS Profile <span style="color: red;">New!</span></li> <li>▶ Member Roster</li> <li>Reports</li> <li>Links</li> <li>Forms</li> <li>▶ Account Tools</li> </ul>	<ul style="list-style-type: none"> <li> You have (0) new messages</li> <li> You have (16) announcements</li> </ul>	<ul style="list-style-type: none"> <li> You have 0 Service Request Authorizations in the last 30 days</li> <li> You have 0 claims in the last 30 days</li> </ul>	<ul style="list-style-type: none"> <li> Member Eligibility</li> <li> HEDIS Profile</li> <li> Claims Status Inquiry</li> <li> Member Roster</li> <li> Forms</li> <li> Create Professional Claims</li> <li> Create Service Request/Autho..</li> </ul>
<h3>Quick Member Eligibility Search</h3> <div style="border: 1px solid white; padding: 5px; display: flex; justify-content: space-between;"> <input type="text" value="Search by Member ID"/> <span>Go</span> </div>			
<div style="display: flex; justify-content: space-between;"> <div style="width: 25%;"> <h4>What's New</h4>  <p>Medicare is available for Member eligibility searches, Service/Request authorization Inquiry and Claim Status Inquiry. Please click <a href="#">Contact Molina</a> to locate the molina medicare member services telephone number.</p> </div> <div style="width: 25%;"> <h4>Video</h4>  <p>Take a tour at our new Provider Self Services!</p> </div> <div style="width: 25%;"> <h4>Poll</h4> <p>Do you like our new look?</p> <p> <input type="radio"/> Yes  <input type="radio"/> No  <input type="radio"/> None  <input type="radio"/> NA                 </p> <p><a href="#">Vote</a> <a href="#">See Responses</a></p> </div> </div>			

The *What's New* section will provide the latest information to users

- Provider Portal**
- Member Eligibility
- ▶ Claims
- ▶ Service Request/Authorization
- HEDIS Profile **New!**
- ▶ Member Roster
- Reports
- Links
- Forms
- ▶ Account Tools

### Messages and Announcements

- You have (0) new messages
- You have (16) announcements

### Authorizations

Authorizations in the last 30 days

0 days


[Go](#)

A Video section to update users on new information or to provide trainings on new functionalities

### My Favorites [Edit](#)


- Member Eligibility
- HEDIS Profile
- Claims Status Inquiry
- Member Roster
- Forms
- Create Professional Claims
- Create Service Request/Author...

### What's New



Medicare is available for Member eligibility searches, Service/Request authorization Inquiry and Claim Status inquiry. Please click [Contact Molina](#) to locate the Molina Medicare member services telephone number.

### Video



3:07

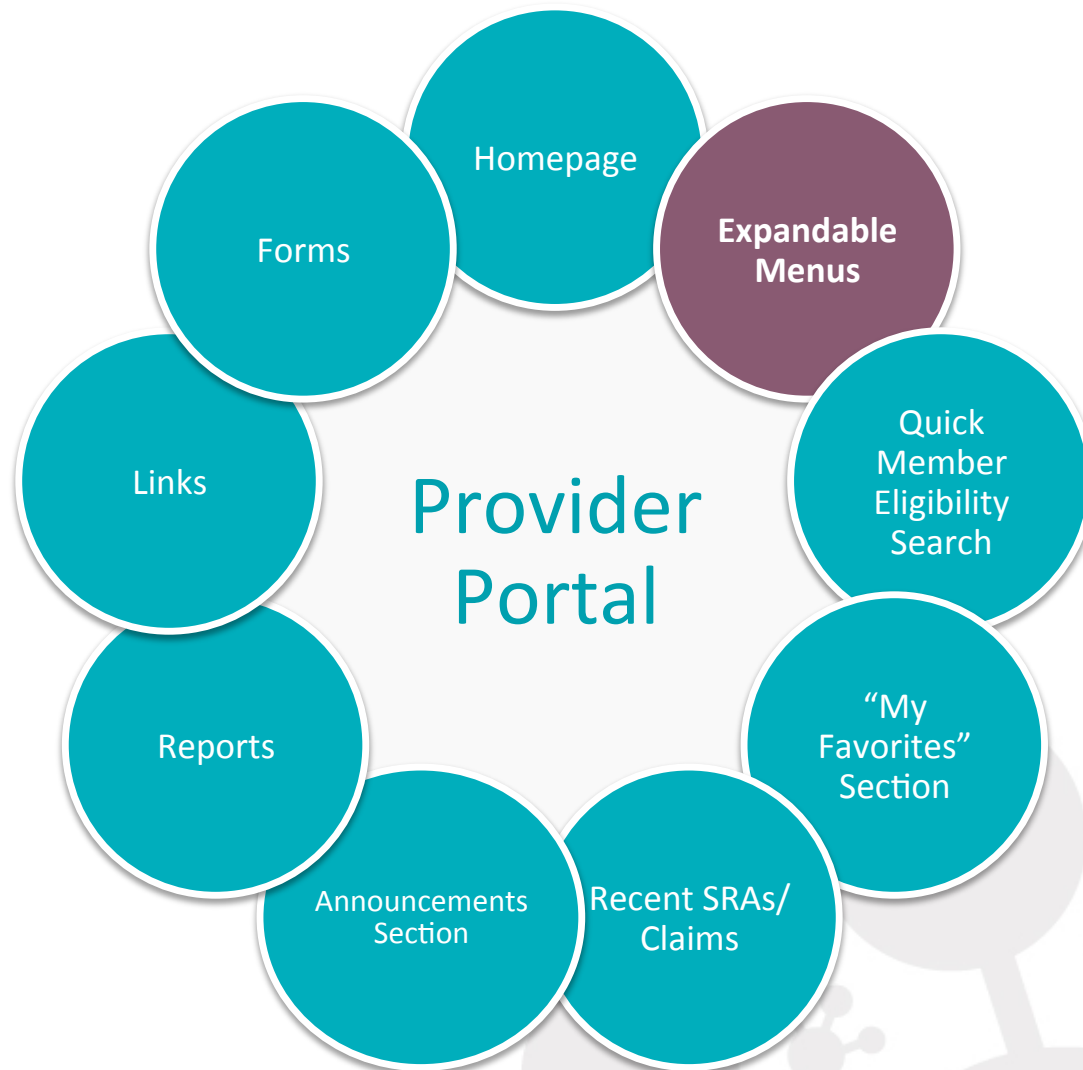
Take a tour at our new Provider Self Services!

### Poll

Do you like our new look?

- Yes
- No
- None
- NA

[Vote](#) [See Responses](#)



Select the teal triangle to expand for more detailed pages

Welcome, Admin User : webportaltest [Log Out](#)  
Dec 23 2014 5:07:25 PM  
Home Provider Search FAQ Training Contact Molina

Provider Self Services

Messages and Announcements

- You have (0) new messages
- You have (16) announcements

Recent Activity

- You have 0 Service Request Authorizations in the last 30 days
- You have 0 claims in the last 30 days


My Favorites [Edit](#)

- Member Eligibility
- HEDIS Profile
- Claims Status Inquiry
- Member Roster
- Forms
- Create Professional Claims
- Create Service Request/Auto...


Quick Member Eligibility Search

Search by Member ID

What's New

 Medicare is available for Member eligibility searches, Service/Request authorization Inquiry and Claim Status inquiry. Please click [Contact Molina](#) to locate the molina medicare member services telephone number.

Video

 3:07

Take a tour at our new Provider Self Services!

Poll

Do you like our new look?

- Yes
- No
- None
- NA

[See Responses](#)

### Provider Portal

- Member Eligibility
- Claims
  - Claims Status Inquiry
  - Create Professional Claim (CMS 1500)
  - Create Institutional Claim (UB04)
  - Open Incomplete Claim
  - Export Claims Report to Excel
- Service Request/Authorization
- HEDIS Profile **New!**
- Member Roster
- Reports
- Links
- Forms
- Account Tools

### Messages and Announcements

### Recent Activity

### My Favorites [Edit](#)

- You have 0 Service Request Authorizations in the last 30 days
- You have 0 claims in the last 30 days

 Member Eligibility	 HEDIS Profile
 Claims Status Inquiry	 Member Roster
 Forms	 Create Professional Claims
 Create Service Request/Author..	

The navigation will expand showing sub-topics

### Member Eligibility Search

Member ID

#### What's New

Medicare is available for Member eligibility searches, Service/Request authorization Inquiry and Claim Status inquiry. Please click [Contact Molina](#) to locate the molina medicare member services telephone number.

#### Video

3:07

Take a tour at our new Provider Self Services!

#### Poll

Do you like our new look?

- Yes
- No
- None
- NA

[See Responses](#)



Reminder: Member Eligibility information is updated every 30 minutes

Eligibility searches are limited to Provider's state of business, except for Medicare which is available for all states. For eligibility questions, please contact [Molina Member Services](#)

NOTE - Eligibility verification is not a guarantee of payment.



**Member Search**

Enter Member ID or First and Last Name and Date of Birth.

Member ID:

or

First Name:  Last Name:

Date of Birth:   
(mmddyyyy)

**Search Options**

Gender:

Zip Code:

Line of Business:

To see member eligibility from certain date enter date here:  (mmddyyyy)

[Help](#)  
Eligibility Information is current as of Oct 16 2014 04:30:09 PM PST

When you navigate away from the homepage, the menu bar minimizes to the left side of the screen

Remind  
informa  
minutes

Eligibili  
Provide  
for Med  
states.  
contact

NOTE -  
guaran

To navigate to  
another page  
select the white  
arrow

Enter Member ID or First and Last Name and Date of Birth.

[Help](#)  
Eligibility Information is current as of Oct 16 2014 04:30:09 PM PST

Member ID:

or

First Name:  Last Name:

Date of Birth:   
(mmdyyyy)

Search Options

Gender:

Zip Code:

Line of Business:

To see member eligibility from certain date enter date here:  (mmdyyyy)

Search for Member

Clear All



The left navigation will appear

### Provider Portal

Member Eligibility

▶ Claims

▶ Service Request/Authorization

HEDIS Profile **New!**

▶ Member Roster

Reports

Links

Forms

▶ Account Tools



**Member Search** Enter Member ID or First and Last Name and Date of Birth.

**Member ID:**

or

**First Name:**

**Last Name:**

**Date of Birth:**

(mmddyyyy)

#### Search Options

**Gender:**

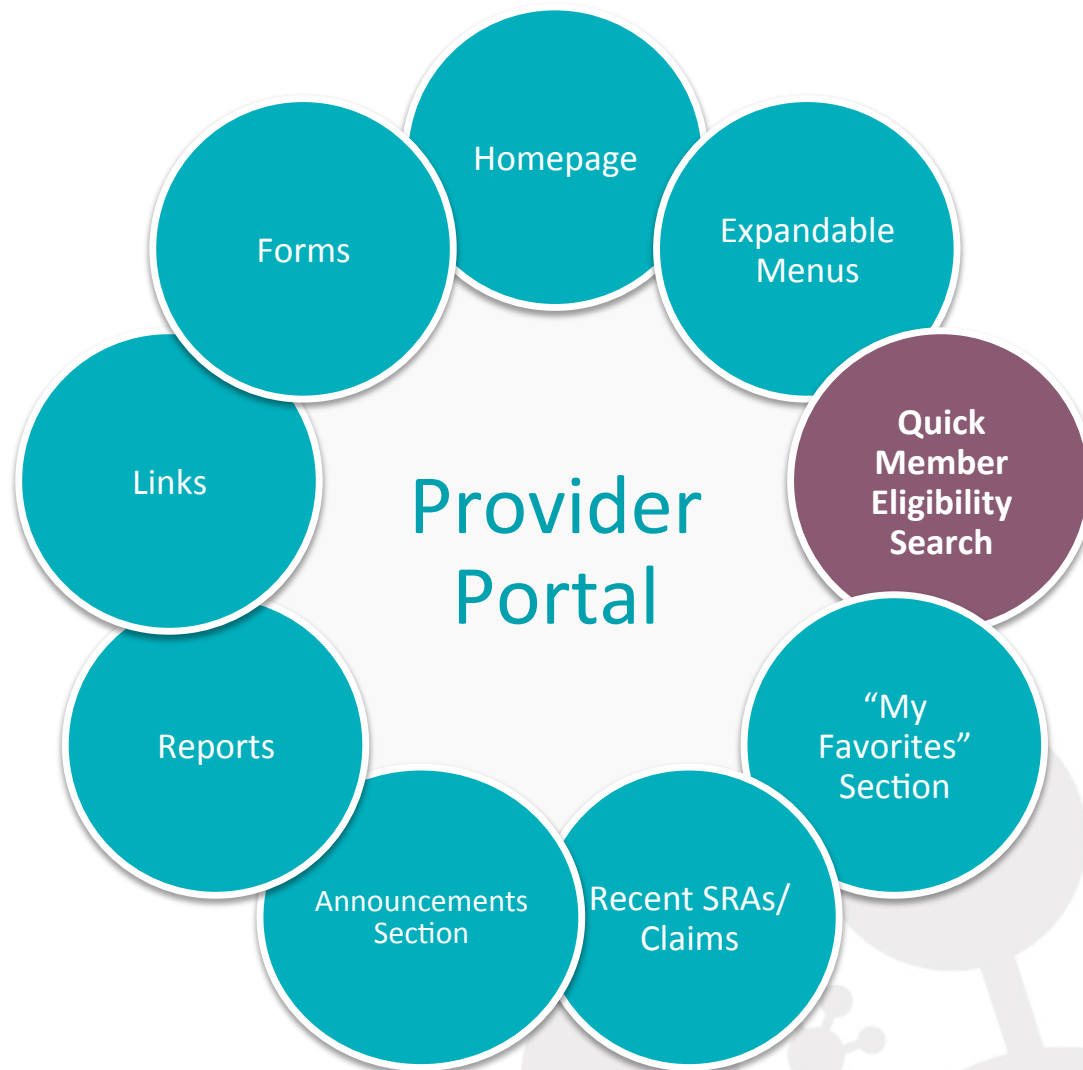
**Zip Code:**

**Line of Business:**

To see member eligibility from certain date enter date here:  (mmddyyyy)

Search for Member

Clear All



- Member Eligibility
- ▶ Claims
- ▶ Service Request/Authorization
- HEDIS Profile **New!**
- ▶ Member Roster
- Reports
- Links
- Forms
- ▶ Account Tools

### Messages and Announcements

You have (0) new messages

You have (16) announcements

### Recent

You have...

You have... last 30 days

- ### Favorites
- Member Eligibility
  - HEDIS Profile
  - Claims Status Inquiry
  - Member Roster
  - Forms
  - Create Professional Claims
  - Create Service Request/Author...

Input a Member's ID into the *Quick Member Eligibility Search*

### Quick Member Eligibility Search

Search by Member ID

### What's New

Medicare is available for Member eligibility searches, Service/Request authorization Inquiry and Claim Status inquiry. Please click **Contact Molina** to locate the molina medicare member services telephone number.

### Video

3:07

Take a tour at our new Provider Self Services!

### Poll

Do you like our new look?

Yes

No

None

NA

[See Responses](#)

## Member Eligibility Details

### Quick View

- ✓ Member is currently enrolled
- ✓ No Missed Services
- ✓ No enrollment restrictions

### Member Information

Member ID: 000000000  
Enrollment Plan: STAR  
Enrollment Status: ACTIVE  
Enrollment Effective Date: 05/01/2014  
Enrollment Termination Date:

### Quick Links

- [Print](#)
- [Submit Professional Claim](#)
- [Claim Status](#)
- [Submit Service Request/Authorization](#)
- [Service Request / Authorization Inquiry](#)

#### Member Details

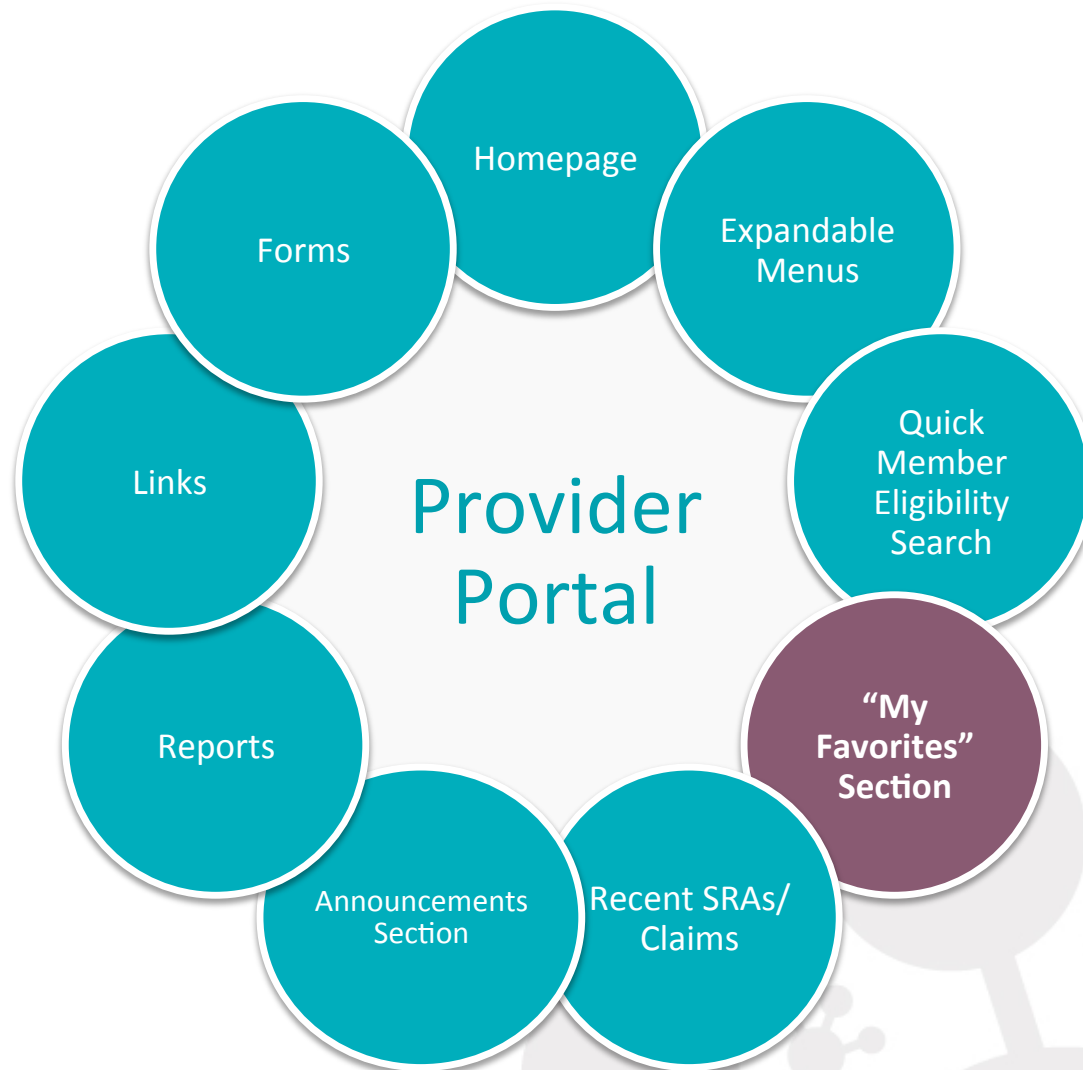
#### Member Health Record

[Member Information](#) • [Enrollment Information](#) • [Primary Care Provider Information](#) • [IPA/Group Information](#) • [History](#)

**Name:** SMITH, JOHN R  
**Date of Birth:** 06/08/2006  
**Mailing Address:** 123 MAIN ST, FREER, TX, 78357  
**Member #:** 000000000  
**Gender #:** Male  
**Home #:**  
**Alternative #:**  
**Mobile #:**  
**Email ID:**

New Quick View sections were added to find information faster

[+ Additional Member Information](#) Expand to view Additional Member Information



Select *Edit* to customize your Favorites

**MOLINA HEALTHCARE** Provider Self Services Log Out 2014 5:07:25 PM Home Provider Search FAQ Training Contact Molina

<b>Provider Portal</b> <ul style="list-style-type: none"><li>Member Eligibility</li><li>▶ Claims</li><li>▶ Service Request/Authorization</li><li>HEDIS Profile <b>New!</b></li><li>▶ Member Roster</li><li>Reports</li><li>Links</li><li>Forms</li><li>▶ Account Tools</li></ul>	<b>Messages and Announcements</b> <ul style="list-style-type: none"><li> You have (0) new messages</li><li> You have (16) announcements</li></ul>	<b>Recent Activity</b> <ul style="list-style-type: none"><li> You have 0 Service Request Authorizations in the last 30 days</li><li> You have 0 claims in the last 30 days</li></ul>	<b>My Favorites</b> <span>Edit</span> <ul style="list-style-type: none"><li> Member Eligibility</li><li> HEDIS Profile</li><li> Claims Status Inquiry</li><li> Member Roster</li><li> Forms</li><li> Create Professional Claims</li><li> Create Service Request/Authoro..</li></ul>
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**Quick Member Eligibility Search**

**What's New**

Medicare is available for Member eligibility searches, Service/Request authorization Inquiry and Claim Status Inquiry. Please click [Contact Molina](#) to locate the molina medicare member services telephone number.

**Video**

3:07  
Take a tour at our new Provider Self Services!

**Poll**

Do you like our new look?

- Yes
- No
- None
- NA

[See Responses](#)

You can customize your own menu items for easy access to your most used functionalities right on the home screen.



### Provider Portal

- Member Eligibility
- ▶ Claims
- ▶ Service Request/Authorization
- HEDIS Profile **New!**
- ▶ Member Roster
- Reports
- Links
- Forms
- ▶ Account Tools

### Messages and Announcements



### What's New



medicare number.

### Recent Activity

st 30 days

### My Favorites [Edit](#)

 Member Eligibility	 HEDIS Profile
 Claims Status Inquiry	 Member Roster
 Forms	 Create Professional Claims
 Create Service Request/Author...	

#### Edit My Favorites

##### Available Favorites:

- Service Request/Authorization Inquiry
- Create Institutional Claim
- Claims Download Report

##### Selected:

- Member Eligibility
- HEDIS Profile
- Claims Status Inquiry
- Member Roster
- Forms
- Create Professional Claims
- Create Service Request/Authorizations

You can select up to 8 favorites:

Choose up to 8 of your most-used functionalities

### Provider Portal

- Member Eligibility
- ▶ Claims
- ▶ Service Request/Authorization
- HEDIS Profile **New!**
- ▶ Member Roster
- Reports
- Links
- Forms
- ▶ Account Tools

### Messages and Announcements

You have 1 message

You have 1 announcement

#### What's New

medicare number.

### Recent Activity

st 30 days

### My Favorites [Edit](#)

- Member Eligibility
- HEDIS Profile
- Claims Status Inquiry
- Member Roster
- Forms
- Create Professional Claims
- Create Service Request/Author.

### Edit My Favorites

Available Favorites:

- Claims Download Report
- Forms
- HEDIS Profile

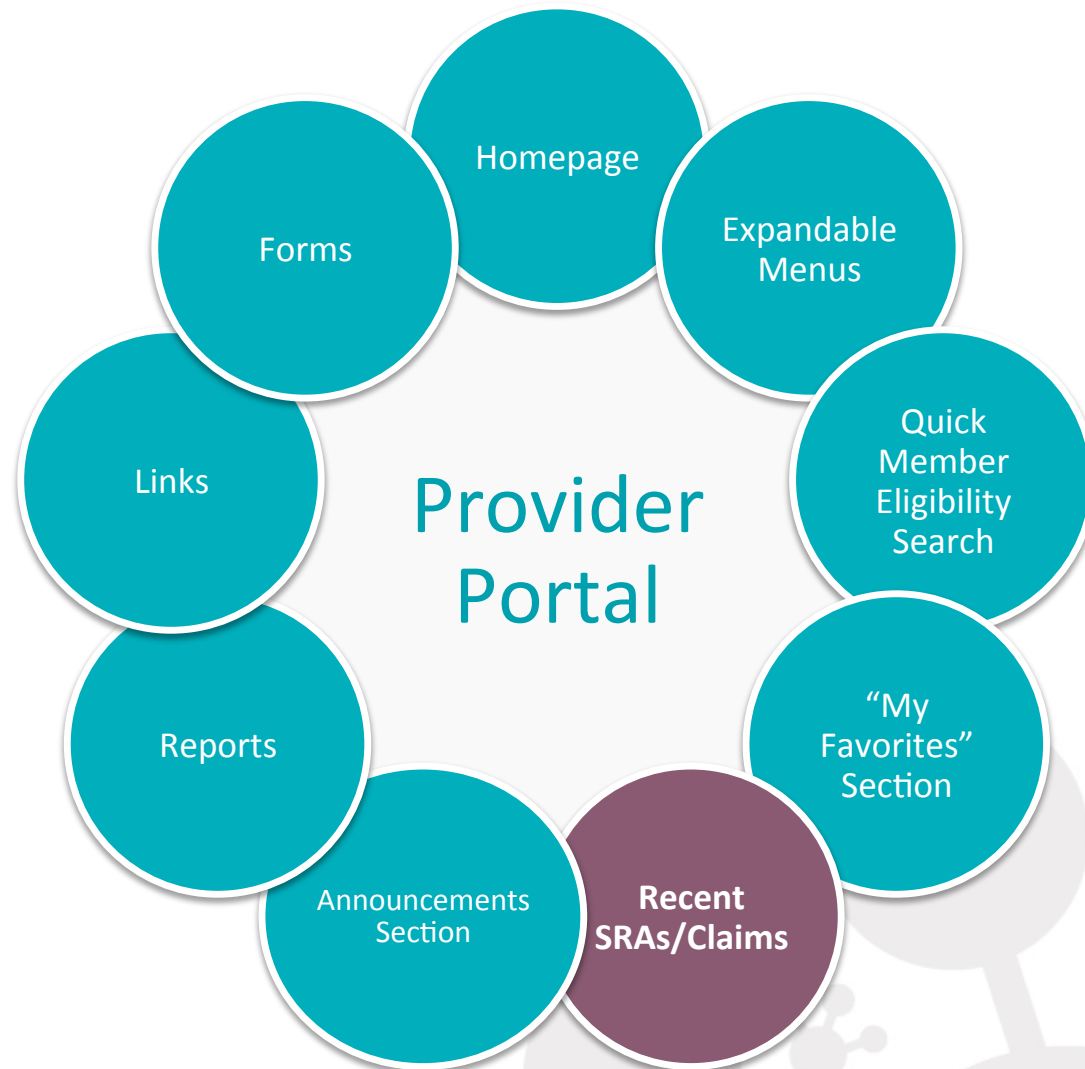
Selected:

- Member Eligibility
- Create Professional Claims
- Create Institutional Claim
- Claims Status Inquiry
- Service Request/Authorization Inquiry
- Create Service Request/Authorizations
- Member Roster

\* You can select up to 8 favorites:

[Save](#)

Don't forget to Save!



- Provider Portal**
- Member Eligibility
- ▶ Claims
- ▶ Service Request/Authorization
- HEDIS Profile **New!**
- ▶ Member Roster
- Reports
- Links
- Forms
- ▶ Account Tools

### Messages and Announcements

- You have (0) new messages
- You have (16) announcements

### Recent Activity

- You have 0 Service Request Authorizations in the last 30 days
- You have 0 Claims in the last 30 days

### My Favorites [Edit](#)

- Member Eligibility
- HEDIS Profile
- Claims Status Inquiry
- Member Roster
- Forms
- Create Professional Claims
- Create Service Request/Author...

### Quick Member Eligibility Search

Search by Member ID

### What's New

Medicare is available for Member eligibility searches, Service/Request authorization Inquiry and Claim Status inquiry. Please click [Contact Molina](#) to locate the molina medicare member services telephone number.

### Video

Take a tour at our new Provider Services!

Select a link to see the most *Recent Activity* regarding Service Request Authorizations and/or Claims

Once the link is selected you will be taken to a screen showing Authorizations and Claims

[Back to Home Page](#)

**Recent Service Requests/Authorizations\***

Show

You have no Service Requests/Authorizations in the last 30 days based on the Submission Date.

[View more Service Requests/Authorizations](#)

\* Displays the last 30 days' most recent Service Requests/Authorizations based on Submission Date

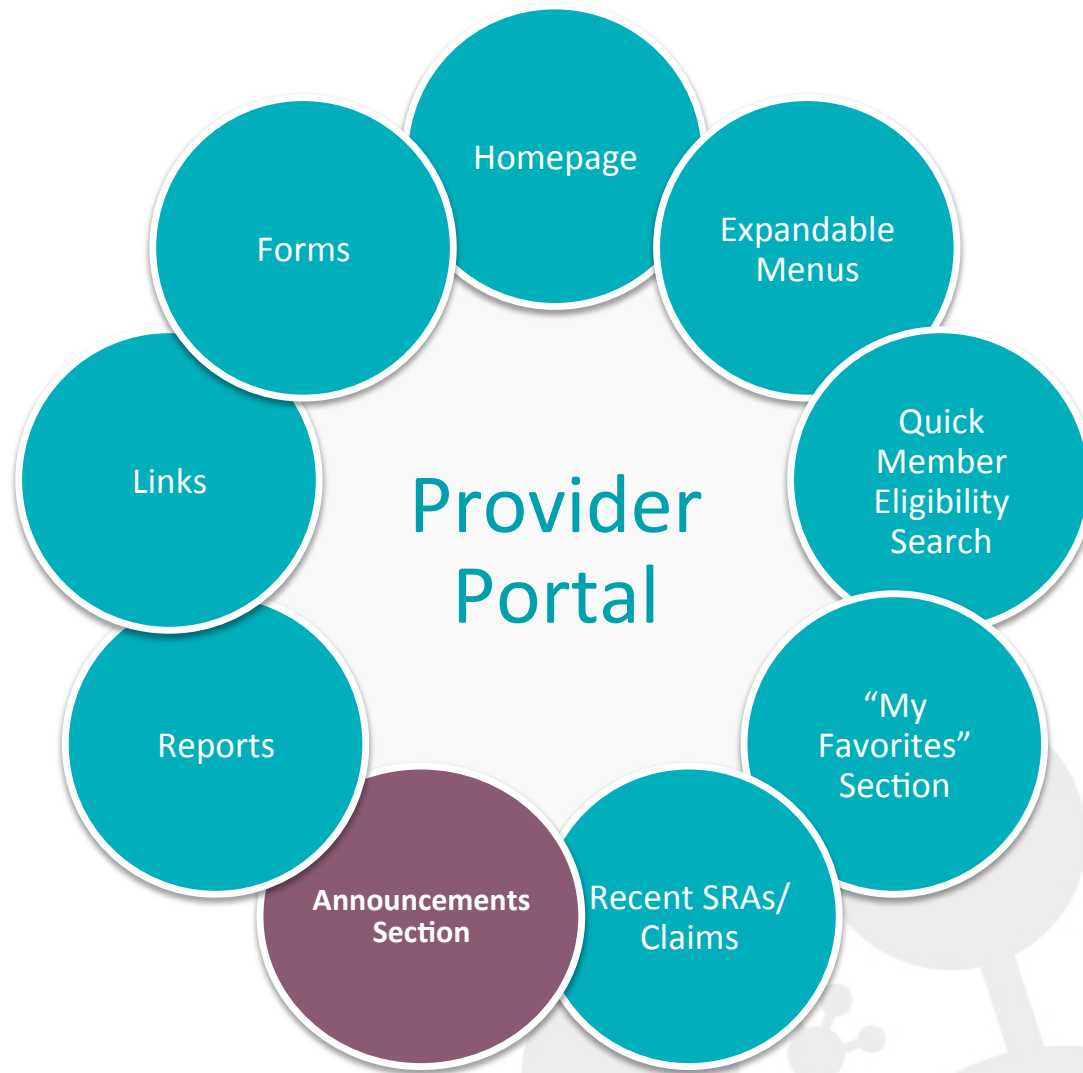
**Recent Claims \***

You have no claims in the last 30 days based on the Received Date.

[View more Claims](#)

[Print](#)

\* Displays the last 30 days' most recent Claims based on Received Date



- Provider Portal**
- Member Eligibility
- ▶ Claims
- ▶ Service Request/Authorization
- HEDIS Profile **New!**
- ▶ Member Roster
- Reports
- Links
- Forms
- ▶ Account Tools

### Messages and Announcements

You have (0) new messages

You have (16) announcements

### Recent Activity

You have 0 Service Request Authorizations in the last 30 days

You have 0 claims in the last 30 days

### My Favorites [Edit](#)

- Member Eligibility
- HEDIS Profile
- Claims Status Inquiry
- Member Roster
- Forms
- Create Professional Claims
- Create Service Request/Author...

### Quick Member Eligibility Search

Member ID  [Go](#)

**Wh**  
medic  
numb

3:07

ur at our new Provider Self

ces!

### Poll

Do you like our new look?

- Yes
- No
- None
- NA

[Vote](#) [See Responses](#)


When there are new **Announcements** they will be displayed here for easy access

The most recent announcements will be displayed.

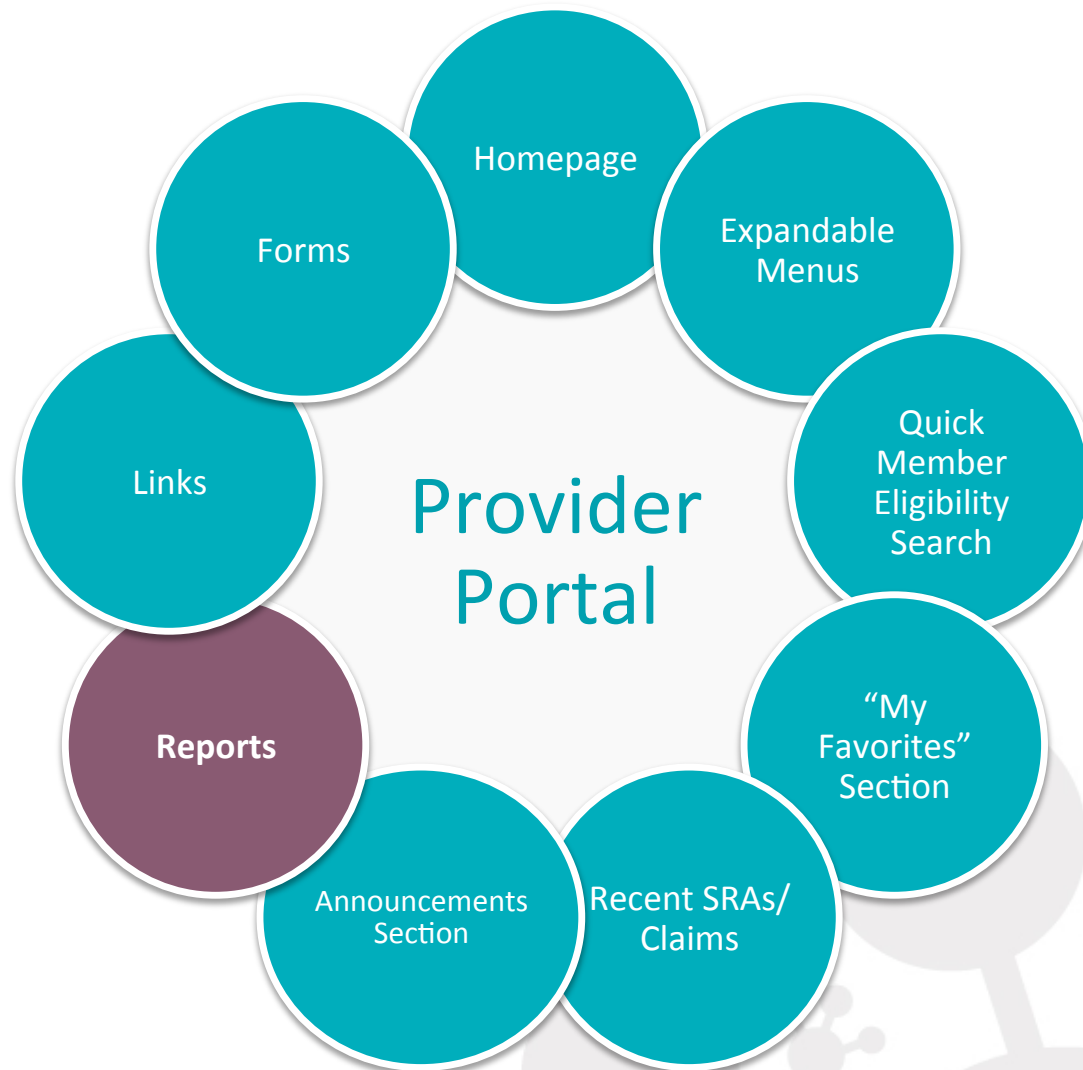
## Announcements

-  [Health Alert What you need to know about Ebola](#)
-  [Frequently Asked Questions about Home Health and LTSS Reimbursement Effective, September 1, 2013](#)
-  [Personal Attendant Services Rates Effective September 1, 2013](#)
-  [Frequently Asked Questions about Home Health and LTSS Reimbursement 90% to 100% Effective, July 1, 2013](#)
-  [Frequently Asked Questions about Home Health and LTSS Reimbursement 100% Effective, July 1, 2013](#)
-  [Corrected Claims](#)
-  [Expedited Credentialing](#)
-  [New CHIP ID Number](#)
-  [Service Coordination Updates](#)
-  [Spell-of-Illness Limitation to Apply to STAR+PLUS Clients Effective September 1, 2013](#)
-  [Early Childhood Intervention Services \(ECI\) & Non-ECI Behavioral Health Services FAQs](#)
-  [New Cognitive Rehabilitation Therapy Benefits for HCBS STAR+PLUS waiver members only - Effective March 1, 2014](#)

**Export a Claims Report to Excel beyond 12 months and receive your report in as little as ten minutes! To access click Claims then Export Claims Report to Excel.**

-  [HHSC Letter to Providers about ACA PCP Rate Increase](#)





Provider Portal	Messages and Announcements	Recent Activity	My Favorites <a href="#">Edit</a>
<ul style="list-style-type: none"><li>Member Eligibility</li><li>▶ Claims</li><li>▶ Service Request/Authorization</li><li>HEDIS Profile <b>New!</b></li><li>▶ Member Roster</li><li>Reports</li><li>Links</li><li>Forms</li><li>▶ Account To</li></ul>	<ul style="list-style-type: none"><li> You have (0) new messages</li><li> You have (16) announcements</li></ul>	<ul style="list-style-type: none"><li> You have 0 Service Request Authorizations in the last 30 days</li><li> You have 0 claims in the last 30 days</li></ul>	<ul style="list-style-type: none"><li> Member Eligibility</li><li> HEDIS Profile</li><li> Claims Status Inquiry</li><li> Member Roster</li><li> Forms</li><li> Create Professional Claims</li><li> Create Service Request/Auto..</li></ul>

### Quick Member Eligibility Search

#### What's New

Medicare is available for Member eligibility searches, Service/Request authorization Inquiry and Claim Status Inquiry. Please click [Contact Molina](#) to locate the Molina member services telephone

#### Video

Take a tour at our new Provider Self Services!

#### Poll

Do you like our new look?

- Yes
- No
- None
- NA

[See Responses](#)

Select Reports from the left navigation

This option allows to access previously downloaded reports.

Reports will be shown here

#### Downloadable Claims Reports

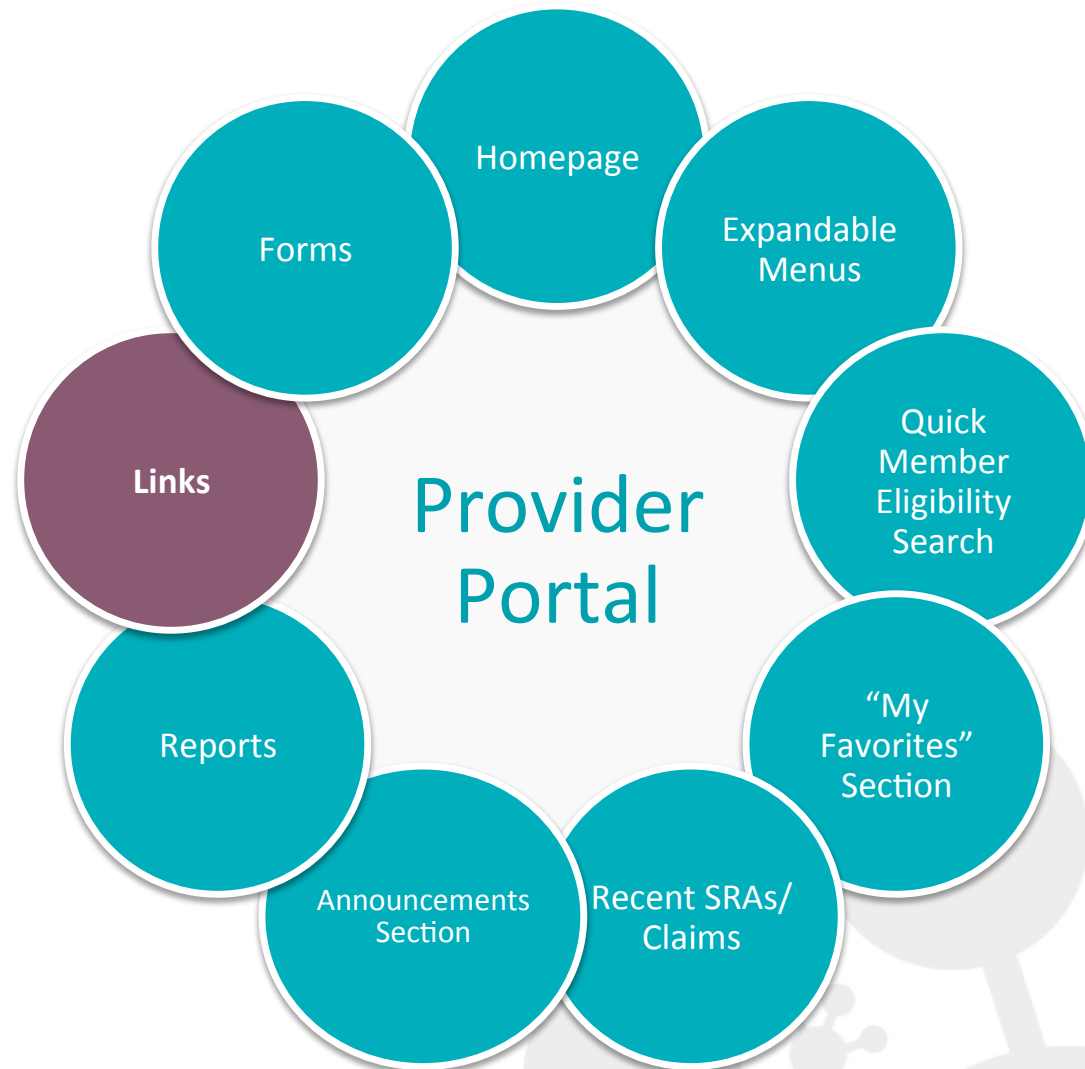
File Name	Service From Date	Service To Date	Generated Date
*****9022_08-01-2014_12-11-2014	08/01/2014	12/11/2014	12/22/2014

[View more Claim files](#)

\* Displays the last 30 days' most recent 5 Claim files based on Date of Service

#### Affiliation List

[Affiliation List - PDF](#)  
[Affiliation List - EXCEL](#)



- Provider Portal
- Member Eligibility
- Claims
- Service
- HEDIS
- Member
- Reports
- Links
- Forms
- Account Tools

Select *Links* from the left navigation

### Messages and Announcements

You have (0) new messages

You have (16) announcements

### Recent Activity

You have 0 Service Request Authorizations in the last 30 days

You have 0 claims in the last 30 days

### My Favorites [Edit](#)

- Member Eligibility
- HEDIS Profile
- Claims Status Inquiry
- Member Roster
- Forms
- Create Professional Claims
- Create Service Request/Author..

### Quick Member Eligibility Search

Search by Member ID  [Go](#)

### What's New

Medicare is available for Member eligibility searches, Service/Request authorization Inquiry and Claim Status inquiry. Please click [Contact Molina](#) to locate the molina medicare member services telephone number.

### Video

3:07

Take a tour at our new Provider Self Services!

### Poll

Do you like our new look?

- Yes
- No
- None
- NA

[Vote](#) [See Responses](#)

## Links

[Emdeon WebConnect Batch Claims](#)

[Emdeon WebConnect Batch Claims](#)

[Find a Pharmacy](#)

[HIPAA 5010](#)

[Marketplace Newsletter](#)

[Medicaid Newsletter](#)

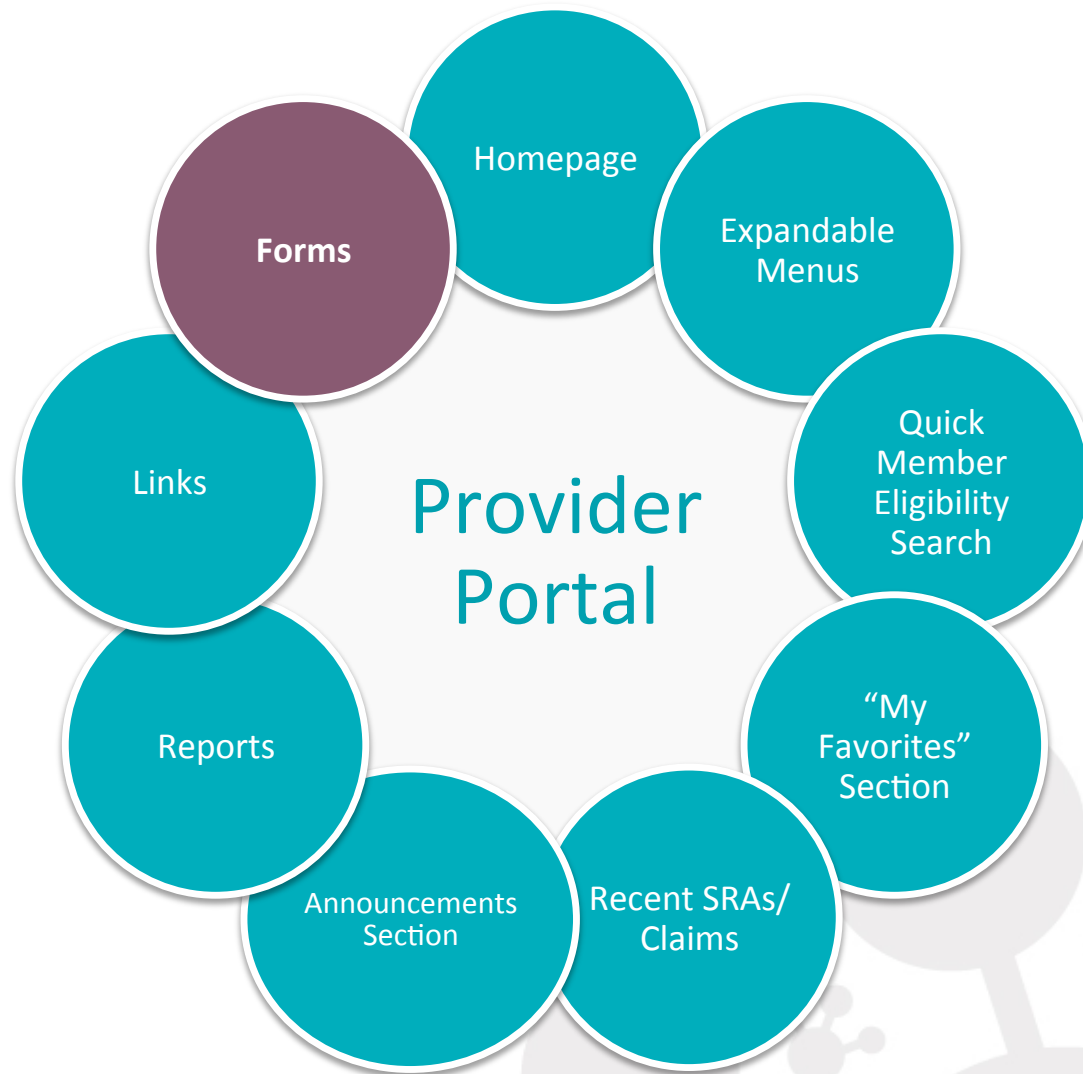
[Nurse Advice Reports](#)

[Outpatient Pharmacy Prior Authorization Request Login](#)

[Outpatient Pharmacy Prior Authorization Request Registration](#)

[ProviderNet Remittance EFT](#)

This page will display a list of the most commonly used links.



Provider Portal	Messages and Announcements	Recent Activity	My Favorites <a href="#">Edit</a>
<ul style="list-style-type: none"><li>Member Eligibility</li><li>▶ Claims</li><li>▶ Service Request/Authorization</li><li>HEDIS Profile <b>New!</b></li><li>▶ Member Roster</li><li>Reports</li><li>Links</li><li>Forms</li><li>▶ Account Tools</li></ul>	<ul style="list-style-type: none"><li> You have (0) new messages</li><li> You have (16) announcements</li></ul>	<ul style="list-style-type: none"><li> You have 0 Service Request Authorizations in the last 30 days</li><li> You have 0 claims in the last 30 days</li></ul>	<ul style="list-style-type: none"><li> Member Eligibility</li><li> HEDIS Profile</li><li> Claims Status Inquiry</li><li> Member Roster</li><li> Forms</li><li> Create Professional Claims</li><li> Create Service Request/Author...</li></ul>

### Quick Member Eligibility Search

care is available for per eligibility searches, ce/Request authorization y and Claim Status y.Please click Contact Molina to locate the molina medicare member services telephone number.

#### Video

3:07

Take a tour at our new Provider Self Services!

#### Poll

Do you like our new look?

- Yes
- No
- None
- NA






















[See Responses](#)

Select Forms from the left navigation



This page will display a list of the most commonly used forms.

## Forms

-  Provider Information
-  LCD's and NCD's
-  State Billing Guidelines
-  Marketplace Provider Forms
-  Provider Communications
-  Prior Authorization Guide 7/1/2013
-  ACUTE MHT\_CHIP\_JEFFPO
-  ALL MHT\_ePORTAL\_PMO
-  MHT\_SS+\_ACUTEPO
-  Revised LTSS Provider Orientation
-  Import\_claims
-  Molina WebConnect Self Enrollment
-  WebConnect create\_claims instructions
-  HHSC Letter to Providers about ACA PCP Rate Increase
-  Texas PreService Auth Codification Guide 2013
-  Frequently Asked Questions about Home Health and LTSS Reimbursement Effective, September 1, 2013
-  Frequently Asked Questions about Home Health and LTSS Reimbursement 90% to 100% Effective, July 1, 2013
-  Frequently Asked Questions about Home Health and LTSS Reimbursement 100% Effective, July 1, 2013
-  Corrected Claims
-  Expedited Credentialing
-  New CHIP ID Number
-  Service Coordination Updates
-  Spell-of-Illness Limitation to Apply to STAR+PLUS Clients Effective September 1, 2013
-  Personal Attendant Services Rates Effective September 1 ,2013
-  Prior Authorization Pre-Service Review Guide 01/01/2014
-  Prior Authorization Pre Service Review Guide for Market Place- January 1. 2014

**For any questions please contact your provider  
services representative by calling  
1-855-322-4080  
or emailing  
[mhtxproviderservices@molinahealthcare.com](mailto:mhtxproviderservices@molinahealthcare.com).**