TEXMEDCONNECT

ACUTE USER GUIDE

TMHP
Texas Medicaid & Healthcare Partnership
A STATE MEDICAID CONTRACTOR

v2023_0512

Contents

Overview

The TexMedConnect Acute Care application is accessed online on the Texas Medicaid & Healthcare Partnership (TMHP) website at tmhp.com.

TexMedConnect is a free, online claims submission application provided by TMHP. Acute care providers can use TexMedConnect to verify client eligibility, submit claims and appeals, use Claim Status Inquiry (CSI) to check the status of claims, and view Remittance and Status (R&S) Reports.

TexMedConnect requires a National Provider Identifier (NPI) and does not support the Texas Provider Identifier (TPI).

TexMedConnect:

- Delivers an integrated, web-based application.
- Provides a stable and secure environment for claims submission.
- Provides accessibility from any computer with internet access.

TexMedConnect supports the following Health Insurance Portability and Accountability Act (HIPAA) - compliant transaction types along with their corresponding electronic file numbers:

- Eligibility Request 270
- Eligibility Response 271
- Claim Status Inquiry 276
- Electronic Remittance and Status (ER&S) Reports 835
- Dental Claims 837D
- Institutional Claims 837I
- Professional Claims 837P
- Long Term Care (LTC) Claims

Note: All transaction types except 276 apply for LTC transactions through TexMedConnect.

Requirements

TexMedConnect is a web-based application and requires internet capabilities as follows:

- Internet service provider (ISP)
- Internet browser such as Microsoft Edge® or Google Chrome®

A broadband connection is recommended but not required.

Support

TMHP offers support for TexMedConnect technical issues, training, and claims questions.

Technical Support

Contact the TMHP Electronic Data Interchange (EDI) Help Desk at 888-863-3638 for technical issues. The TMHP EDI Help Desk provides technical assistance with troubleshooting TexMedConnect and TMHP EDI Gateway system issues.

Contact your system administrator for assistance with modem, hardware, internet connectivity, or phone-line issues.

Training Support

The TMHP EDI Help Desk does not provide training; however, training is available through your TMHP provider relations representative.

TMHP has two contact centers that provide information about your provider relations representative and other information.

For Medicaid and Family Planning information, call the TMHP Contact Center at 800-925-9126.

For CSHCN Services Program information, call the TMHP CSHCN Services Program Contact Center at 800-568-2413.

Claims Support

For answers to questions about Medicaid and Family Planning electronic or paper claims, providers can call the TMHP Contact Center at 800-925-9126.

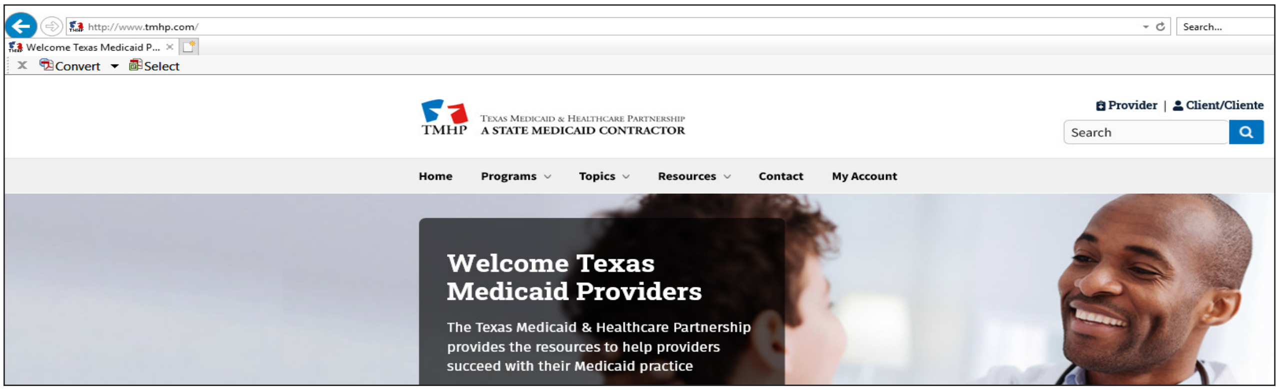
For answers to questions about CSHCN Services Program claims, providers can call the TMHP CSHCN Services Program Contact Center at 800-568-2413.

Logging in to TexMedConnect

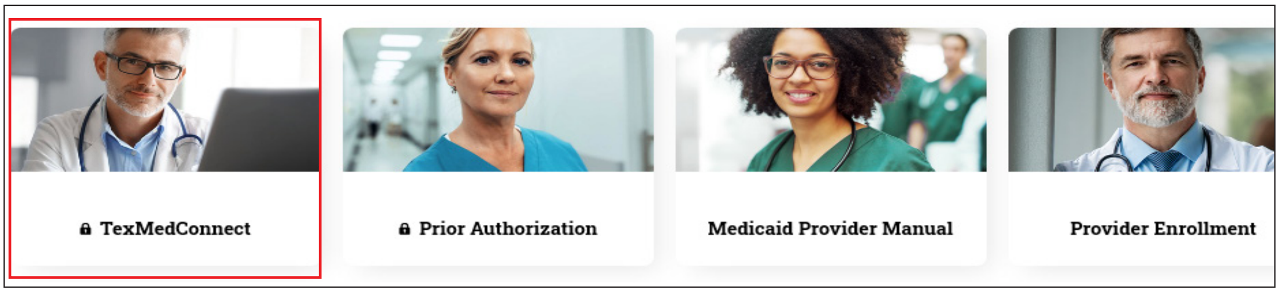
To use TexMedConnect, you must already have an account on the TMHP website. If you do not have an account, set one up using the information provided in the TMHP Website Security Provider Training Manual.

Take the following steps after you have an account for the TMHP website:

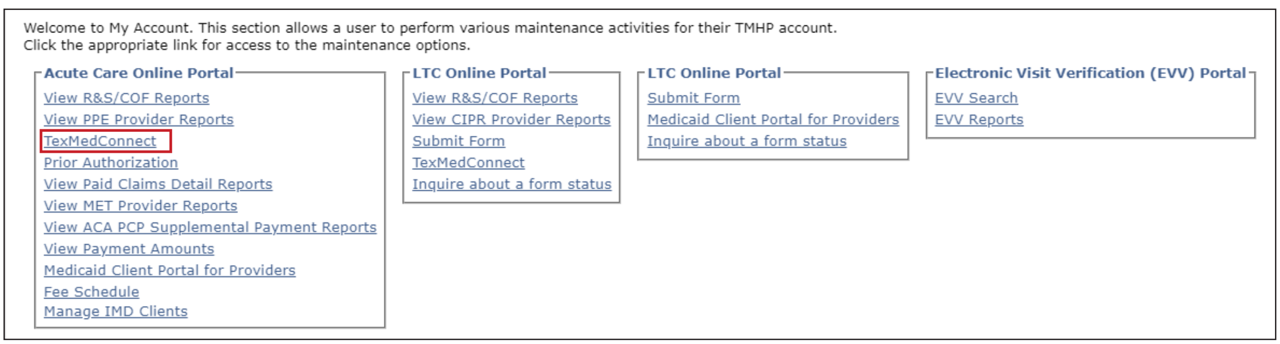
1) Access the TMHP website at tmhp.com.



2) Click **TexMedConnect**. Enter your user name and password.



3) The My Account page will open to display website features you have access to. Click **TexMedConnect**.



Navigation Panel

Menu options for acute care providers are located under Acute Care in the left navigation panel. Access privilege determines which options are displayed. Select the option from the navigation panel that you would like to perform.

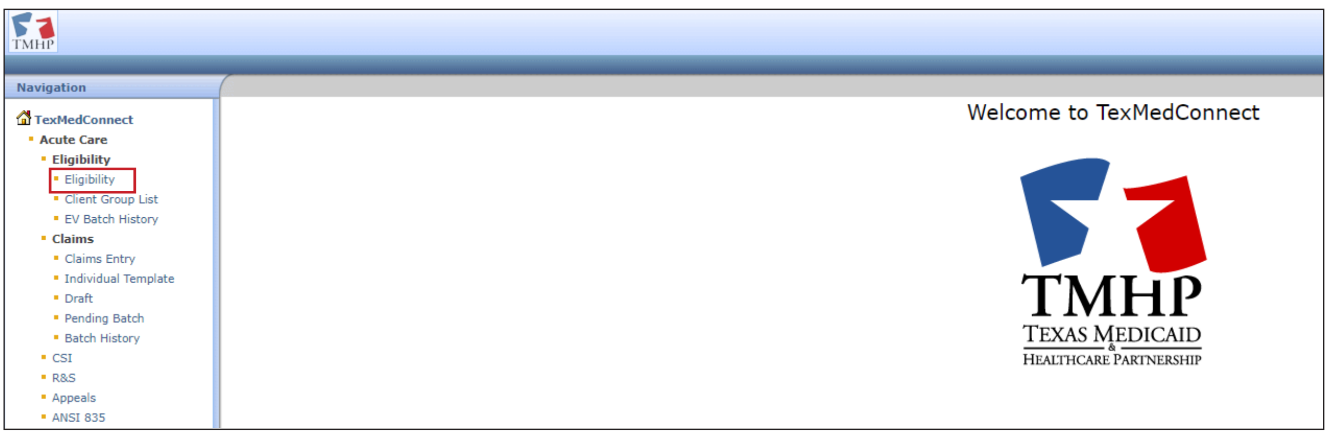
Eligibility

You have the ability to verify a client's eligibility, create a list of clients for whom you would like to verify eligibility, and create eligibility batch reports by NPI or API.

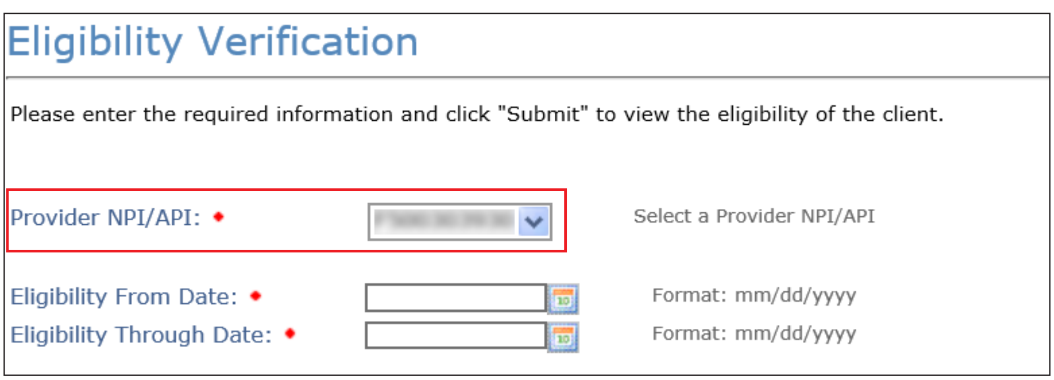
Eligibility Verification (EV)

To verify a client's eligibility, follow these steps:

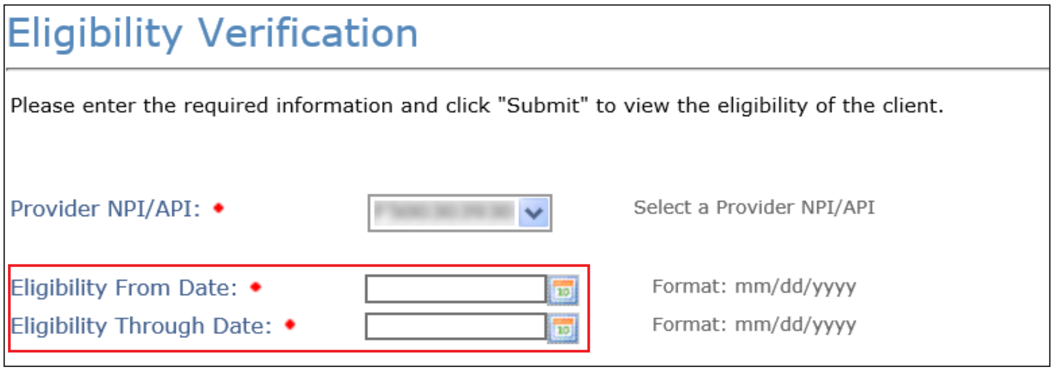
1) Click **Eligibility** from the navigation panel.



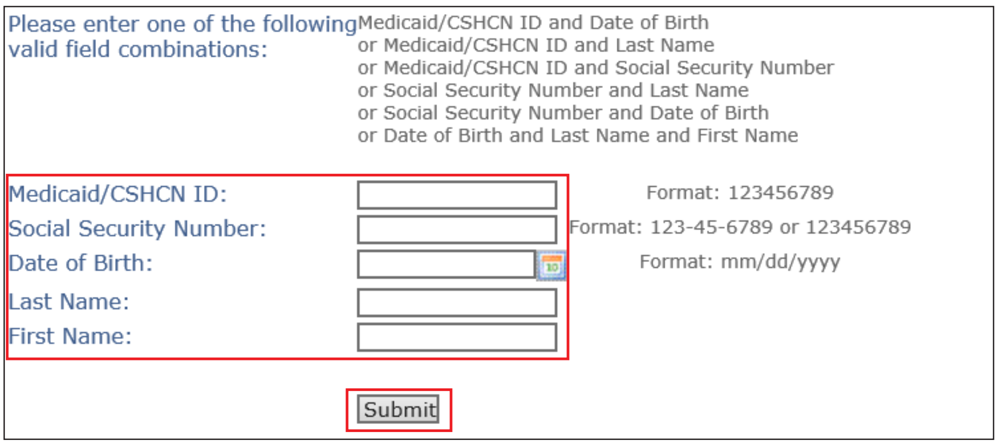
2) Use the Provider NPI/API drop-down list to select an NPI or API.



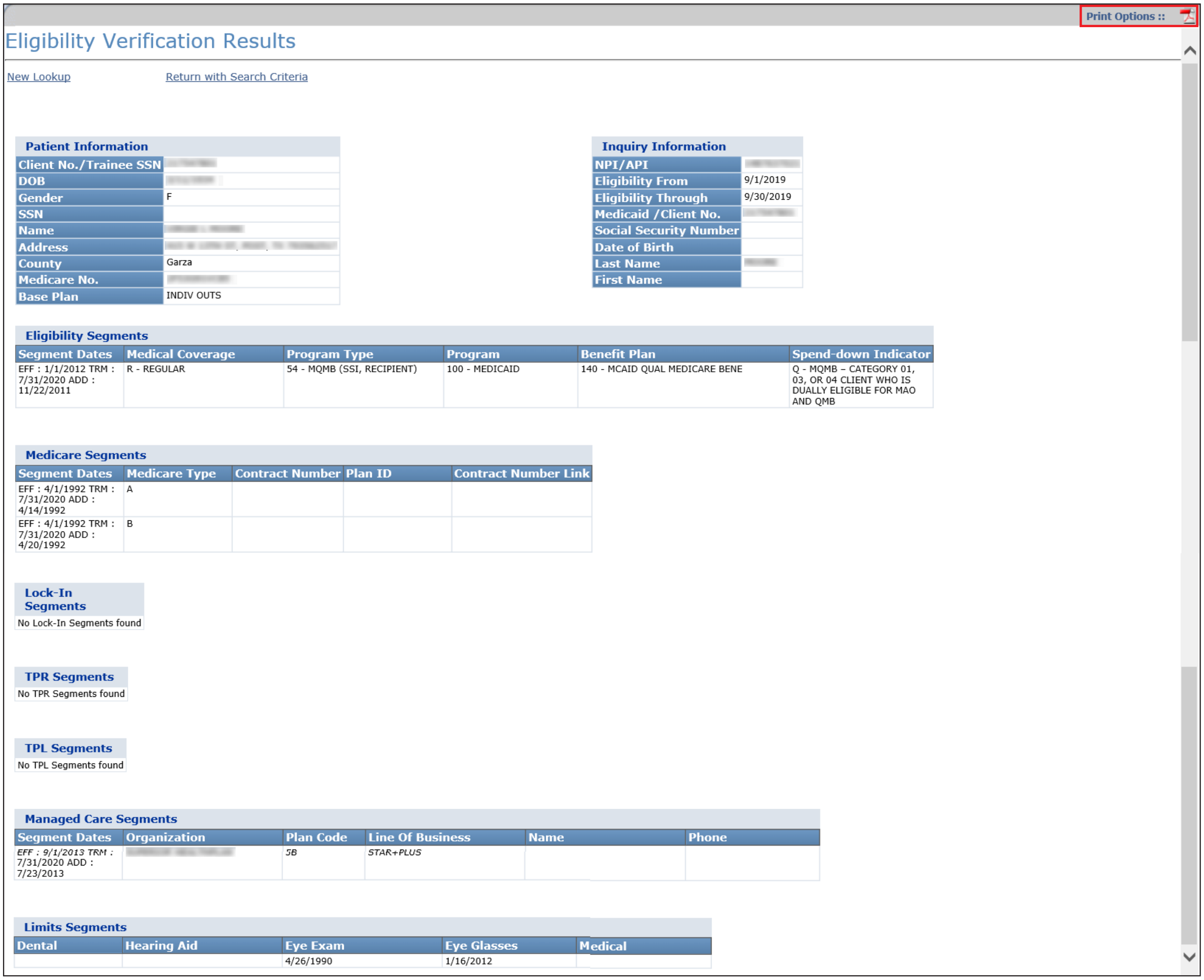
3) Enter an Eligibility From Date and Eligibility Through Date manually, or use the calendar icon.



4) You must also enter information in the Medicaid/CSHCN ID field or Social Security Number field and either the Date of Birth, Last Name, or First Name field. Click **Submit**.



5) Eligibility verification results appear. Click the PDF icon in the top right corner of the Eligibility Verification Results page to view and print results.



Print Options ::

Eligibility Verification Results

New Lookup   Return with Search Criteria

Patient Information	
Client No./Trainee SSN	[illegible]
DOB	[illegible]
Gender	F
SSN	
Name	[illegible]
Address	[illegible]
County	Garza
Medicare No.	[illegible]
Base Plan	INDIV OUTS

Inquiry Information	
NPI/API	[illegible]
Eligibility From	9/1/2019
Eligibility Through	9/30/2019
Medicaid /Client No.	[illegible]
Social Security Number	
Date of Birth	
Last Name	[illegible]
First Name	

Eligibility Segments

Segment Dates	Medical Coverage	Program Type	Program	Benefit Plan	Spend-down Indicator
EFF : 1/1/2012 TRM : 7/31/2020 ADD : 11/22/2011	R - REGULAR	54 - MQMB (SSI, RECIPIENT)	100 - MEDICAID	140 - MCAID QUAL MEDICARE BENE	Q - MQMB – CATEGORY 01, 03, OR 04 CLIENT WHO IS DUALLY ELIGIBLE FOR MAO AND QMB

Medicare Segments

Segment Dates	Medicare Type	Contract Number	Plan ID	Contract Number Link
EFF : 4/1/1992 TRM : 7/31/2020 ADD : 4/14/1992	A			
EFF : 4/1/1992 TRM : 7/31/2020 ADD : 4/20/1992	B			

Lock-In Segments

No Lock-In Segments found

TPR Segments

No TPR Segments found

TPL Segments

No TPL Segments found

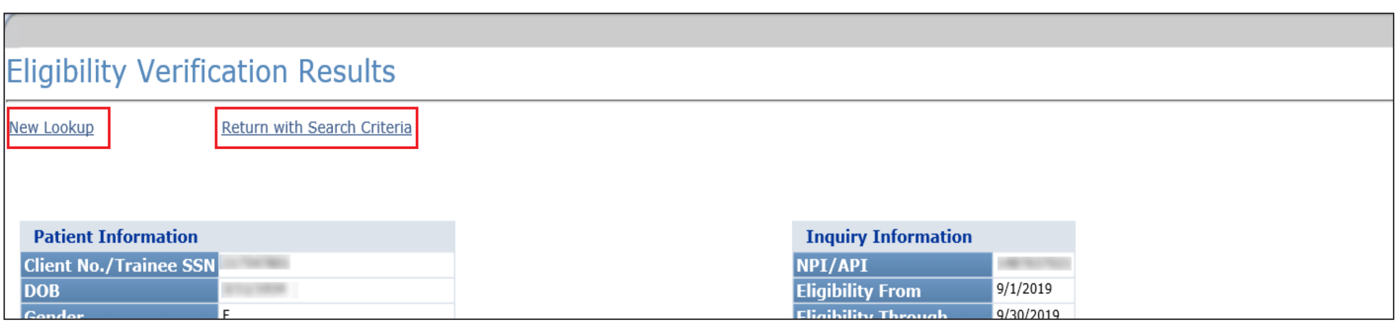
Managed Care Segments

Segment Dates	Organization	Plan Code	Line Of Business	Name	Phone
EFF : 9/1/2013 TRM : 7/31/2020 ADD : 7/23/2013	[illegible]	5B	STAR+PLUS		

Limits Segments

Dental	Hearing Aid	Eye Exam	Eye Glasses	Medical
		4/26/1990	1/16/2012	

6) Click **New Lookup** to return to the Eligibility Verification screen. Click **Return with Search Criteria** to return to the Eligibility Verification screen with the last search criteria in the fields.



Eligibility Verification Results

New Lookup   Return with Search Criteria

Patient Information	
Client No./Trainee SSN	[illegible]
DOB	[illegible]
Gender	F

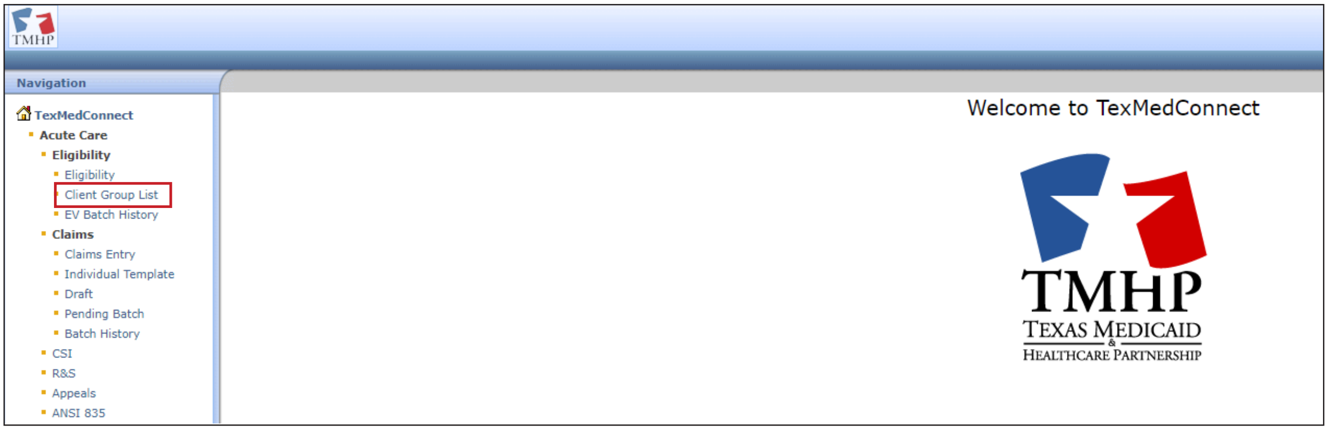
Inquiry Information	
NPI/API	[illegible]
Eligibility From	9/1/2019
Eligibility Through	9/30/2019

Client Group List

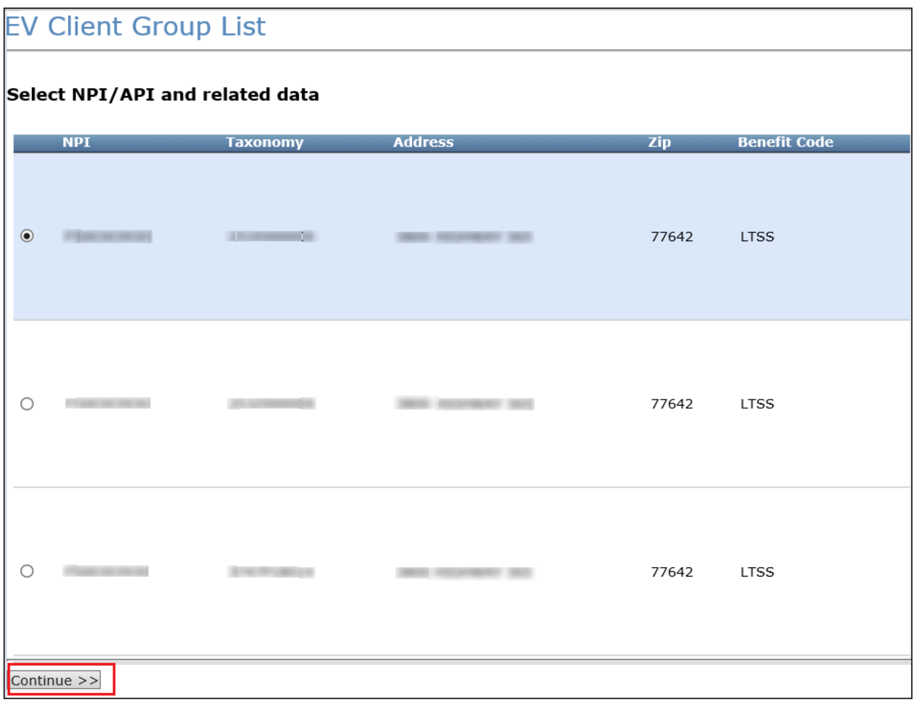
The client group list allows you to create a list of clients for whom you would like to verify eligibility. You can create up to 100 groups for each NPI or API. Each client group can contain up to 250 clients.

To verify eligibility through the client group list, follow these steps:

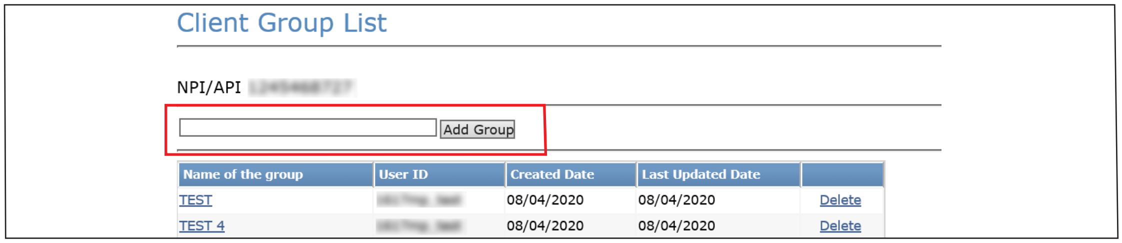
1) Click **Client Group List** on the navigation panel.



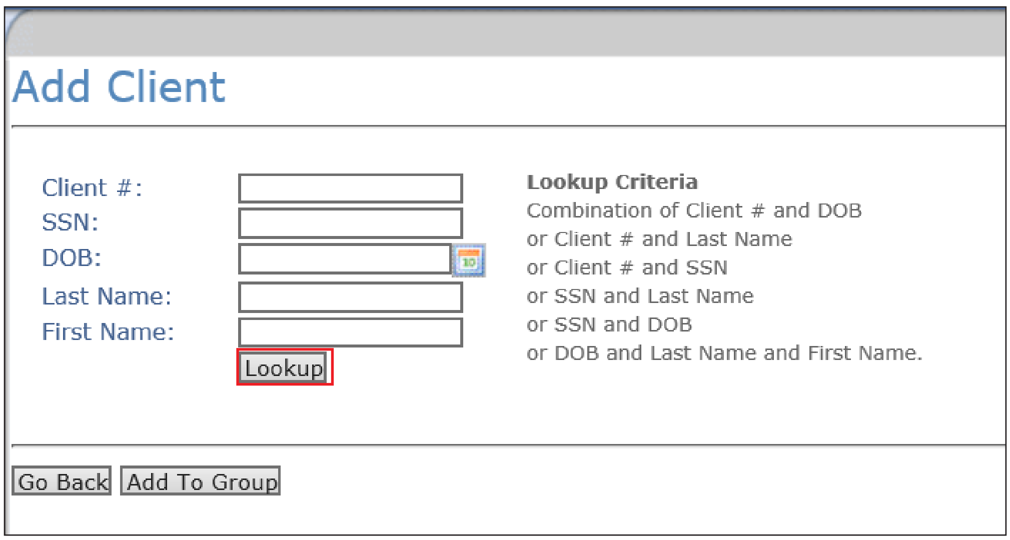
2) Select the NPI or API on the EV Client Group List screen. Click **Continue**.



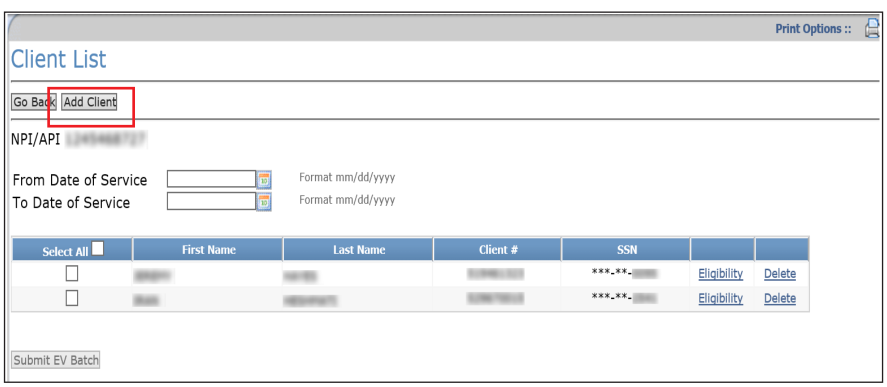
3) The Client Group List screen appears. You can click the name of the group to view the client list, or you can click **Delete** to remove an existing client group list. You can also type a group name and click **Add Group** to create a new client group list.



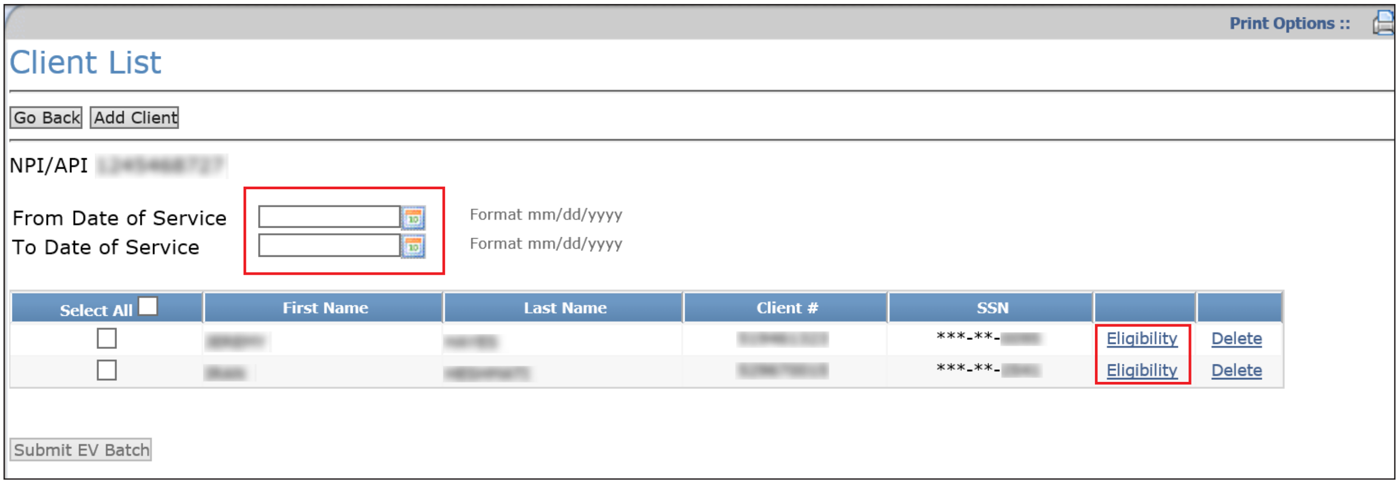
4) To add a client to the group, enter a Client number or Social Security number and date of birth, last name, or first name. Click **Lookup**. Then, click **Add To Group**.



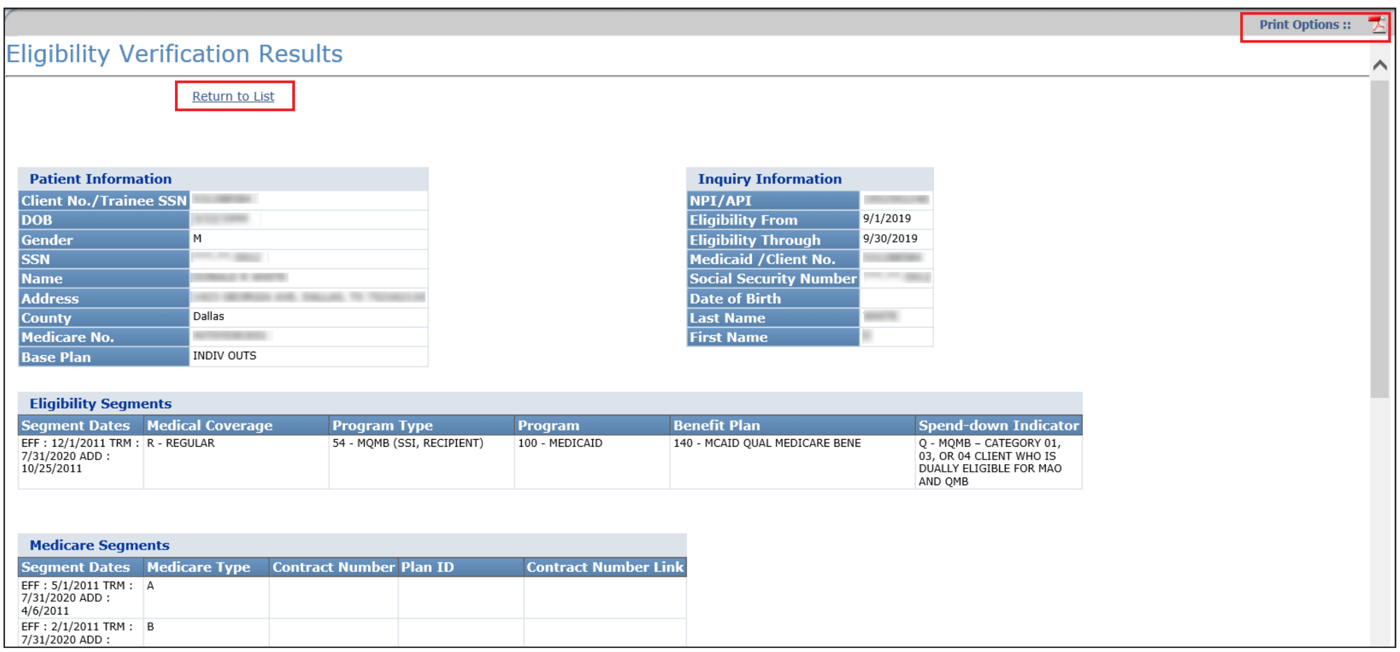
5) Click **Add Client** to add more clients to the group.



6) Enter a date range in the From Date of Service and To Date of Service fields manually, or use the calendar icon. Click **Eligibility** to view the Eligibility Verification Results page.

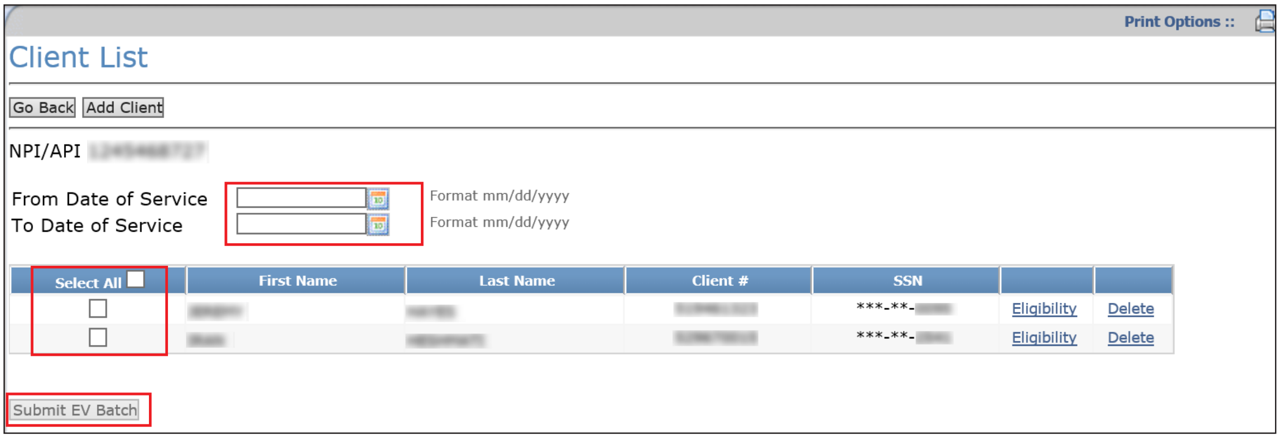


7) The eligibility verification results appear. Click the PDF icon in the top right corner of the Eligibility Verification Results page to view and print the results. Click **Return to List** to return to the Client List screen.



8) To submit an eligibility report for one or more clients in a client group list to batch, enter a date range in the From Date of Service and To Date of Service fields manually, or use the calendar icon. Click individual check boxes to select clients for a batch report, or click **Select All** to create a batch report for all members of the client

group list. Click **Submit EV Batch**.

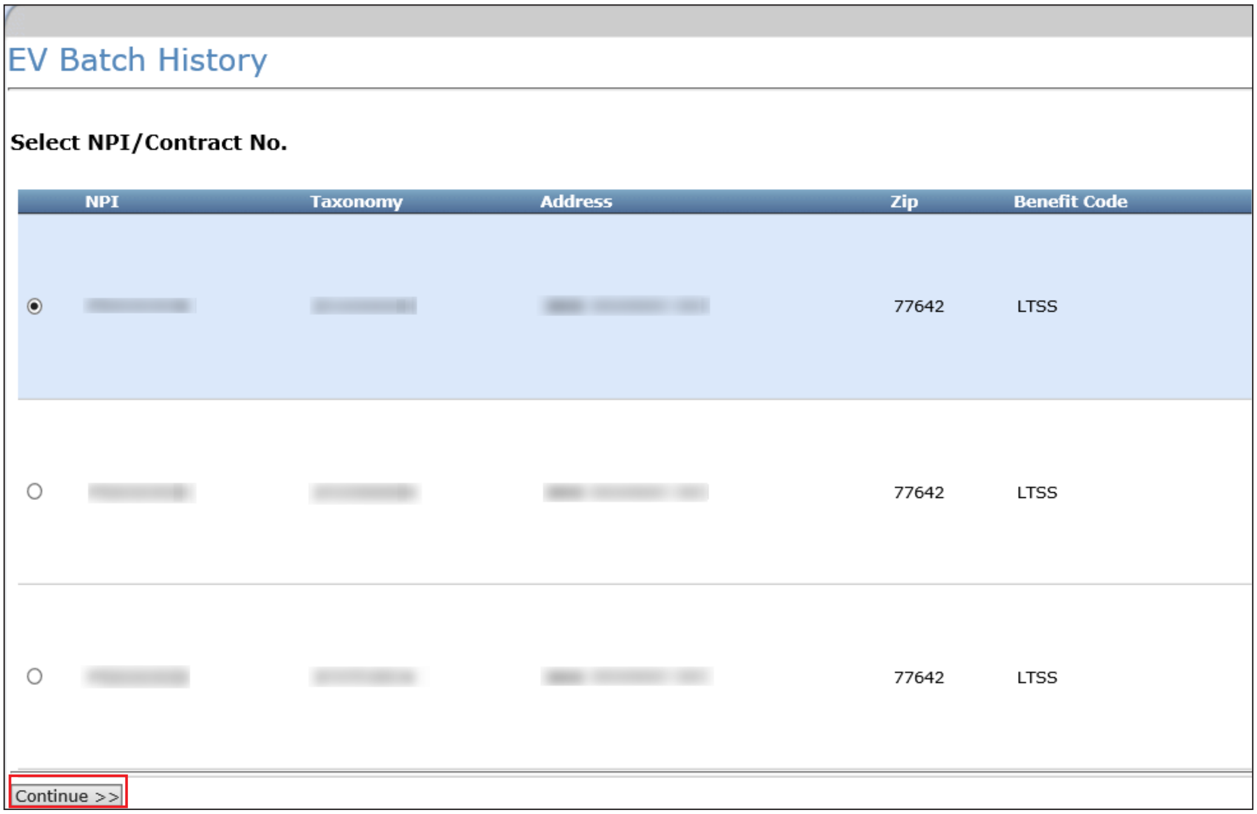


EV Batch History

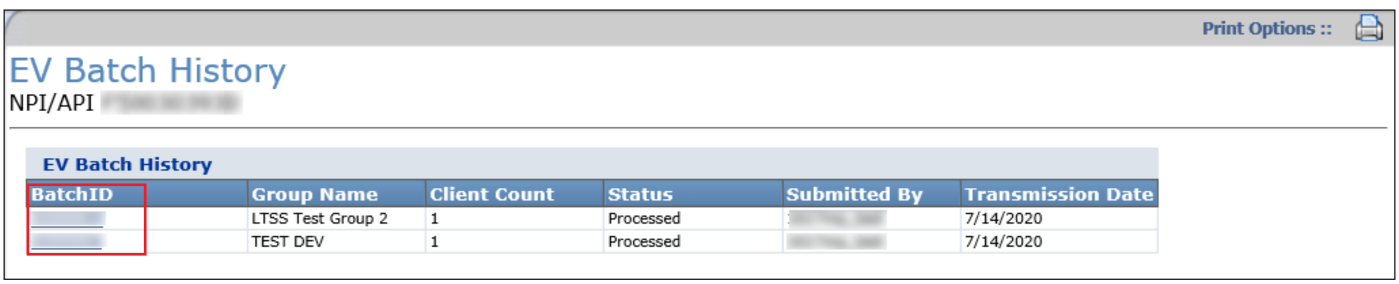
To view eligibility batch reports, follow these steps:

1) Click **EV Batch History** from the navigation panel.

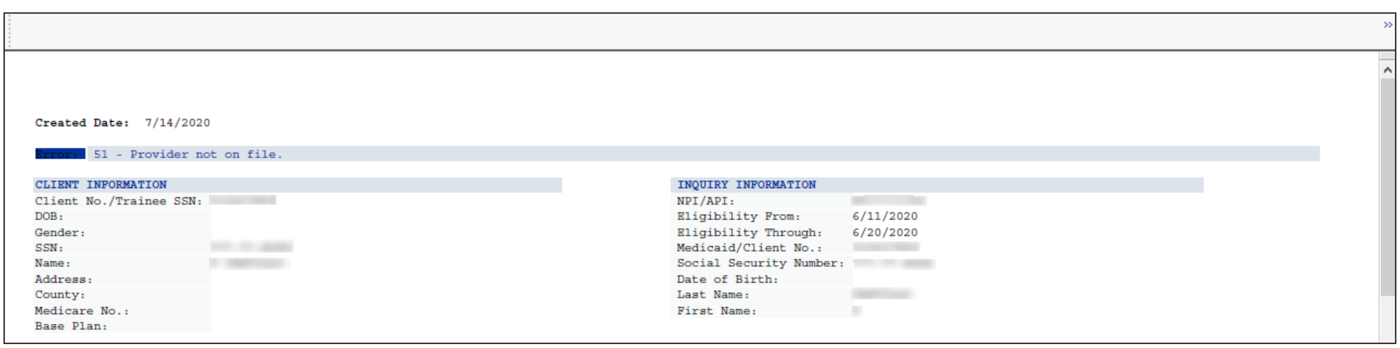
2) Select an NPI or API on the EV Batch History screen. Click **Continue**.



3) Click a **Batch ID** to review the eligibility report results. The report opens in a new browser window in PDF format.



4) Use your browser print functions to print the report results. Click **X** on the browser tab to close the report and return to the EV Batch History results screen for the selected NPI or API.



Claims Submission

To submit an individual claim, you must select a valid NPI and related data before entering the Claims Entry screen.

You can submit the following claims:

- 020 (Professional, Ambulance, Vision, and Medical Transportation Program)
- 021 (Dental)
- 023 (Outpatient)
- 040 (Inpatient)
- 056 (HHSC Family Planning Program [DFPP])
- 058 (Family Planning Title XIX)

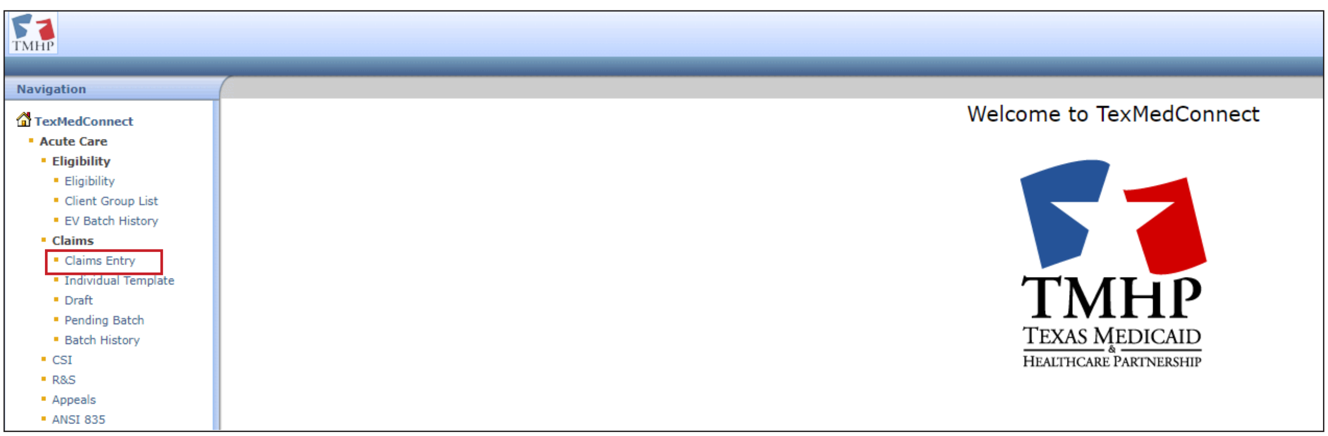
After choosing the appropriate claim type, entering the optional client number, and selecting the next appropriate action, you are directed to the Claims Main screen where the required data can be entered on the available tabs for the selected claim type.

After the claim is completed, you can choose to submit the claim from the Other Insurance tab. After doing so, you will receive any explanation of benefits (EOBs) that may apply or an Internal Control Number (ICN) if the claim has submitted successfully. You also can save an incomplete claim as a draft or save an individual claim as a template.

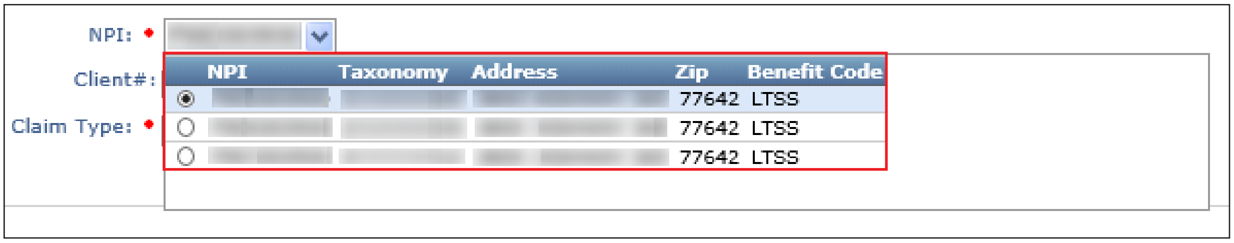
Claims Entry

To enter the details of a claim, follow these steps:

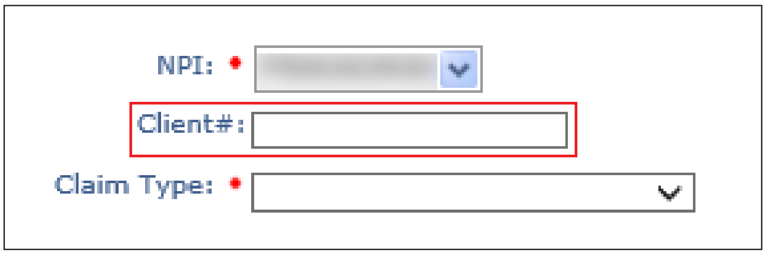
1) Click **Claims Entry** from the navigation panel.



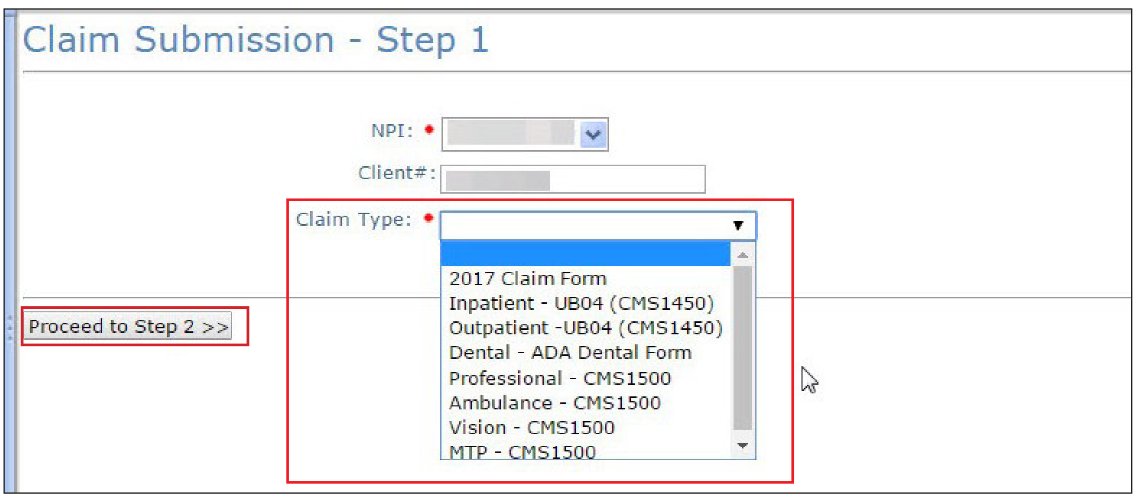
2) Use the NPI drop-down list to select an NPI or API. A list of NPIs or APIs and related data (such as taxonomy, physical address, and benefit code selections) are displayed based on the user's access.



3) Enter the client number for the claim (optional). The client number is the Medicaid ID number. When a client number is entered, the system populates most of the required fields on the Client tab. If you do not enter the client number, you must enter all required fields manually on the Client tab.



4) Use the Claim Type drop-down menu to select the claim type you are submitting. Click **Proceed to Step 2**.



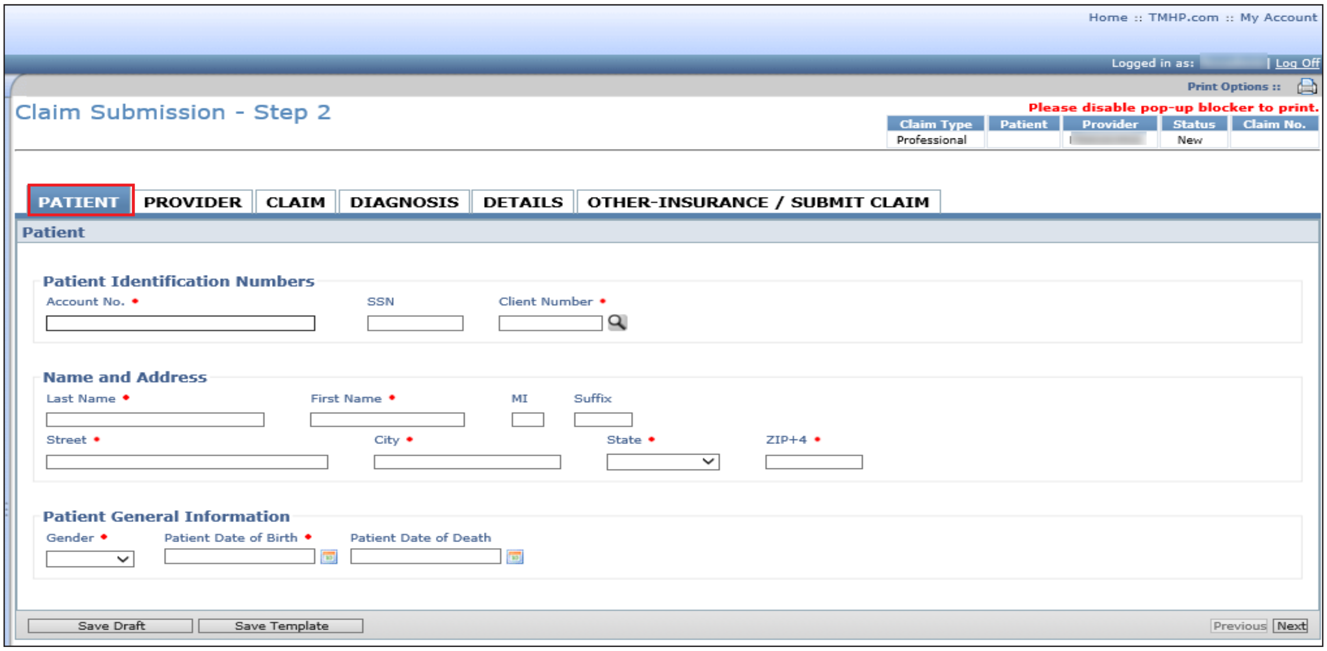
Professional Claim

When the Professional claim type is chosen from drop-down menu, the Claims Entry screen appears for the chosen type. Required fields (indicated by a red dot) must be completed on each tab. If you entered the client number on the Claims Entry screen, many of these fields are prepopulated but can still be edited.

You can use the Next and Previous buttons on each tab to save claim data and move through the claims entry steps.

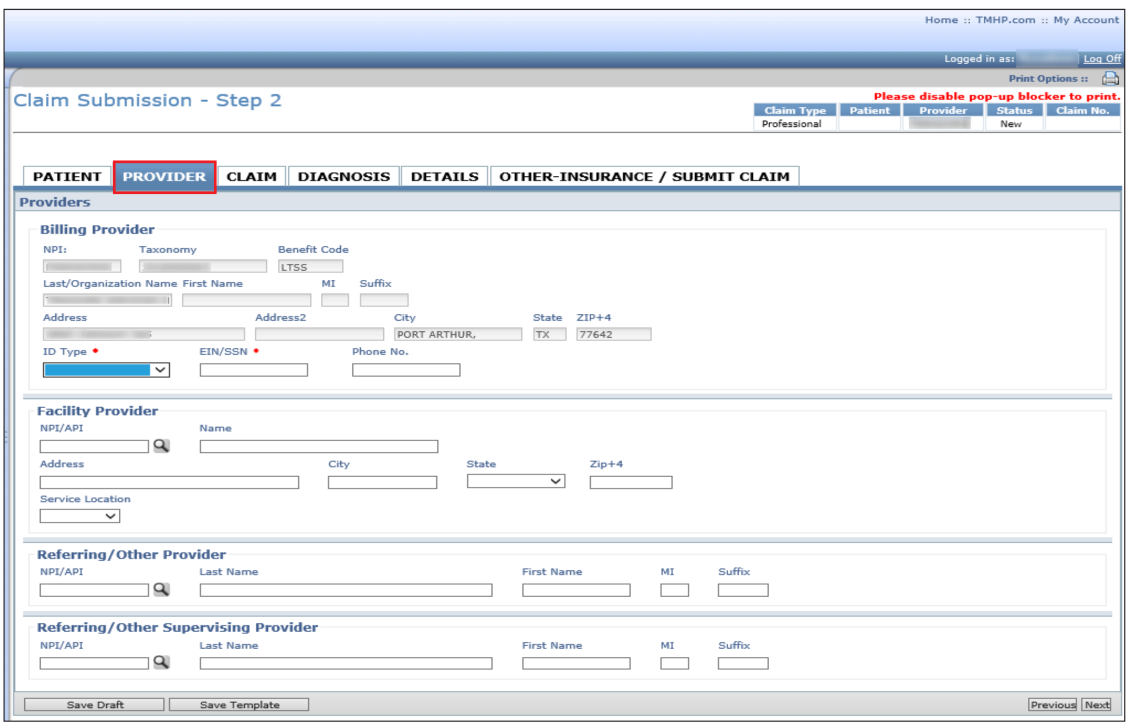
Patient Tab

On the Patient tab, complete all required fields. Make sure to enter a nine-digit ZIP code in the ZIP+4 field.



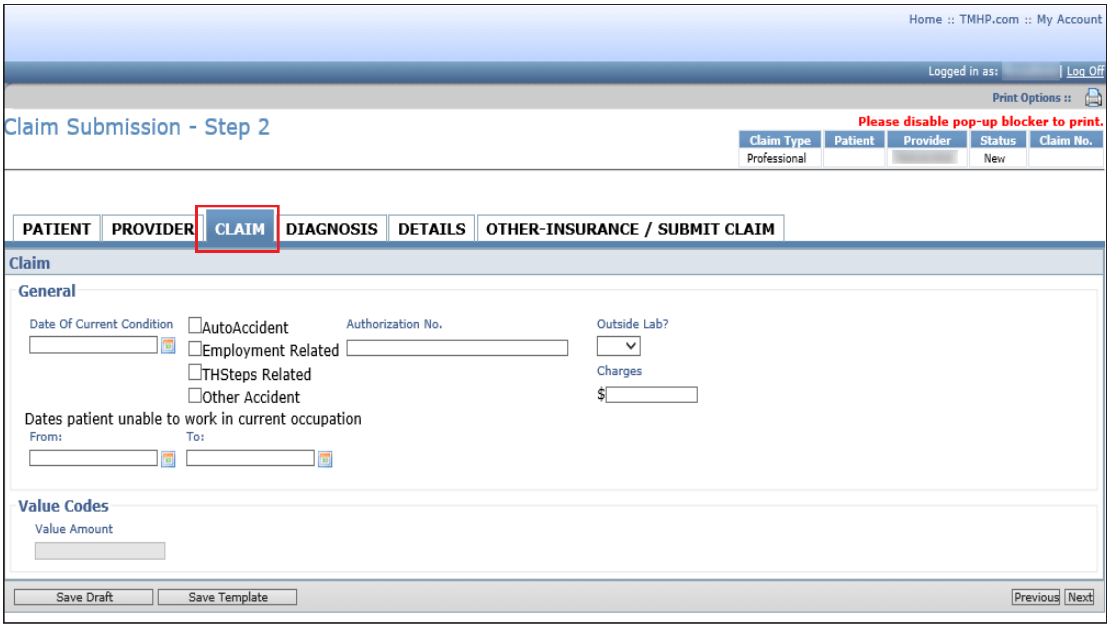
Provider Tab

On the Provider tab, complete all required fields. Some billing provider fields prepopulate. All other required data (such as ID Type) must be entered manually.



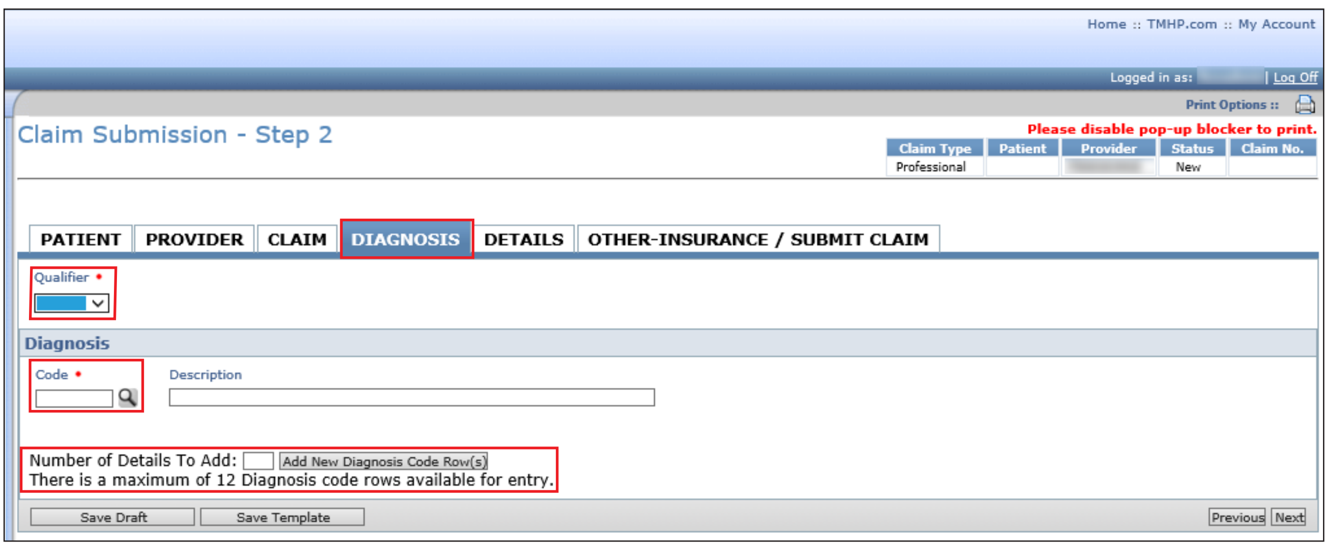
Claim Tab

On the Claim tab, complete all required fields when applicable.



Diagnosis Tab

On the Diagnosis tab, complete all required fields.



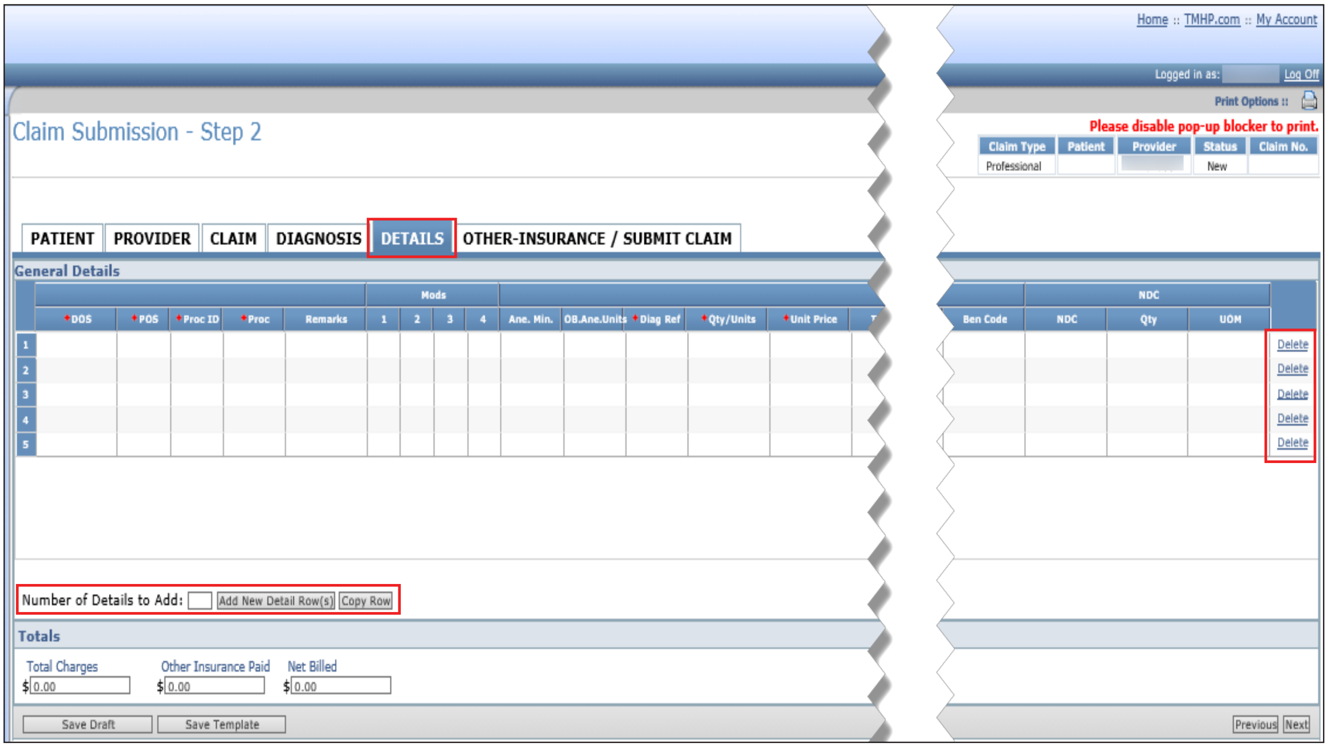
Use the Qualifier drop-down list to select International Statistical Classification of Diseases and Related Health Problems (ICD-9) or ICD-10 to ensure that the correct ICD diagnosis code is found in the Code lookup field. The qualifier selected must be valid for the diagnosis code entered based on the date of services.

Input the diagnosis code to the highest degree of specificity. Click the magnifying glass icon to look up the code description.

To add additional diagnosis code rows, enter a number (up to 12) in the **Number of Details To Add** field and click **Add New Diagnosis Code Row(s)**.

Details Tab

On the Details tab, complete all required fields.



The Total Charges on each row are automatically calculated based on the Qty/Units x Unit Price. It is important to note that, for Electronic Visit Verification (EVV) claims, the units on the EVV claim must match the units on the EVV transactions for the date of service, or the claim will be denied.

Consult the current HHSC published list of EVV services to know which services are set to bypass the EVV06 claims units match edit. In the list, find your service. Go to the Units Matched During EVV Claims Matching column to determine whether the units on the EVV claim must match the units on the EVV visit transactions for that service.

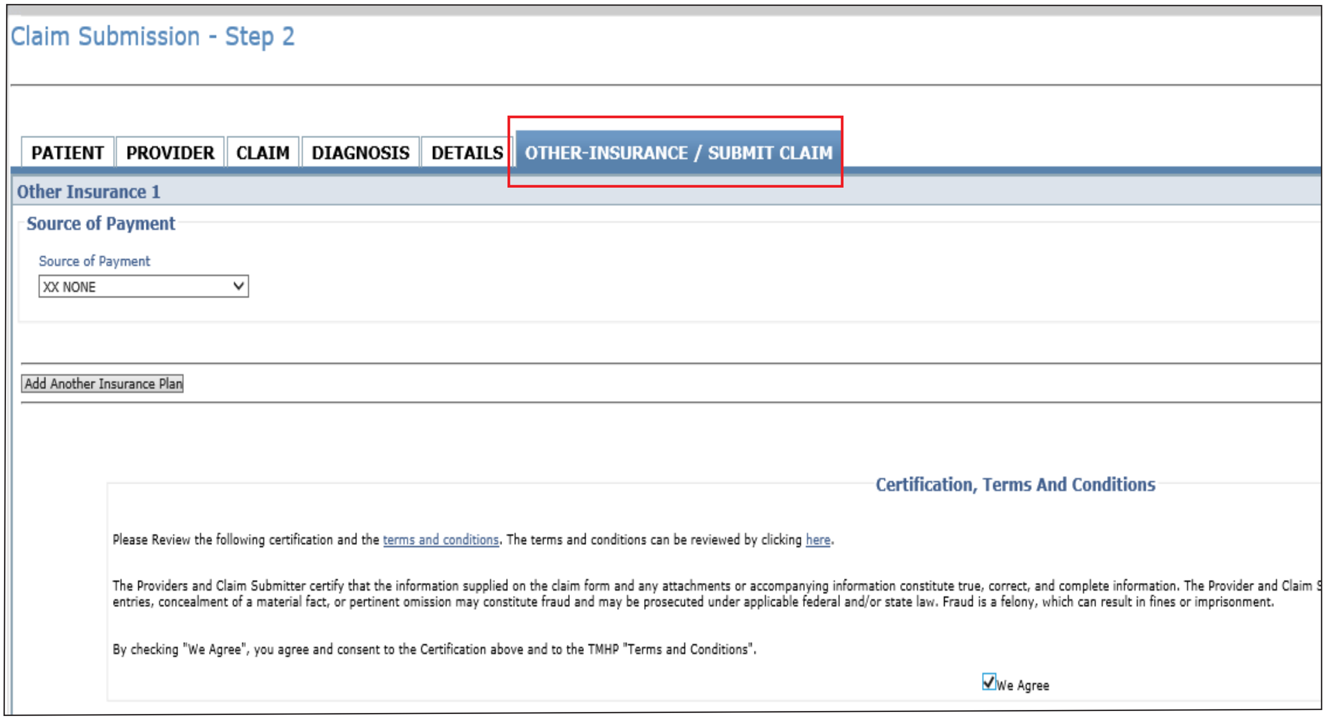
Additionally, the total charges at the bottom of the screen are automatically calculated, based on the Total Charges for each row entered.

To add additional detail rows, enter the **Number of Details To Add** (up to 28) and click **Add New Detail Row(s)**. To duplicate a detail row, click on the row number and click **Copy Row**.

Click **Delete** in the far right column to remove a row.

Other-Insurance/Submit Claim Tab

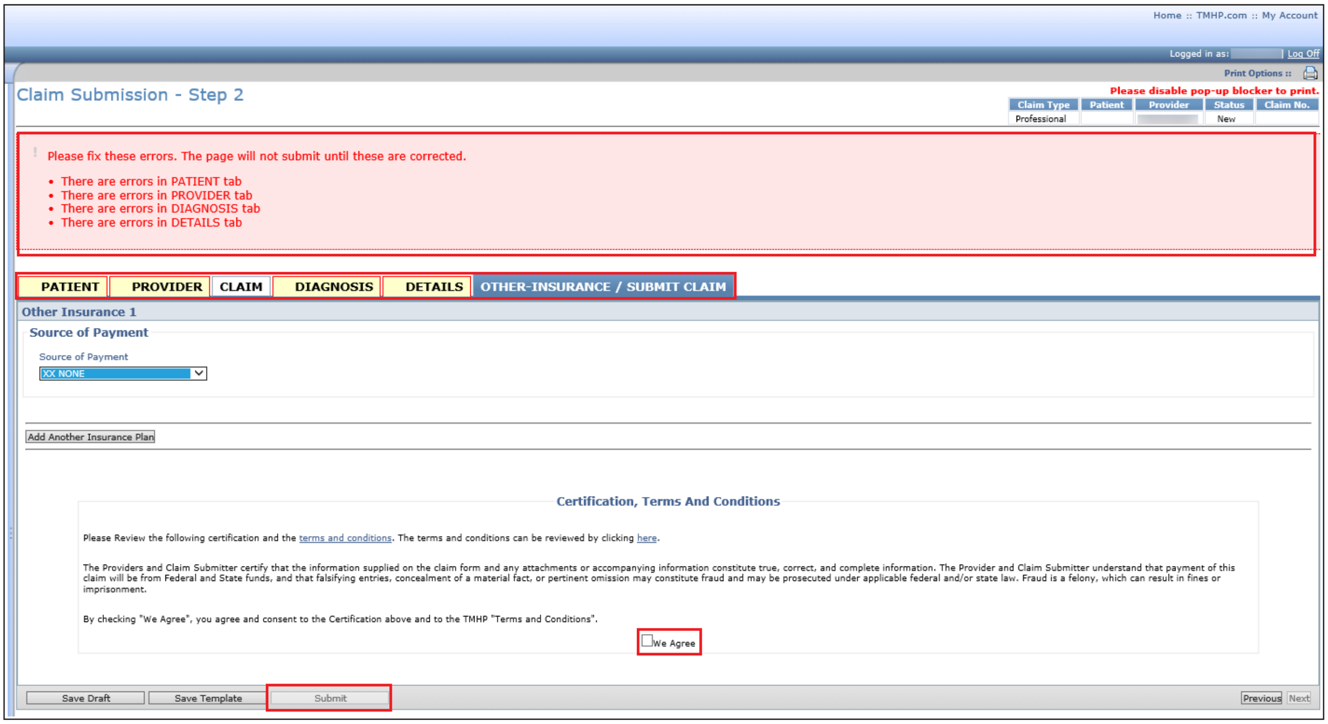
On the Other-Insurance/Submit Claim tab, you can select an option from the **Source of Payment** drop-down list. Enter insurance information into all required fields. Click **Add Another Insurance Plan** to enter information on new insurance that is not on file.



After reviewing the Certification, Terms, And Conditions section, check **We Agree** to enable the Submit button.

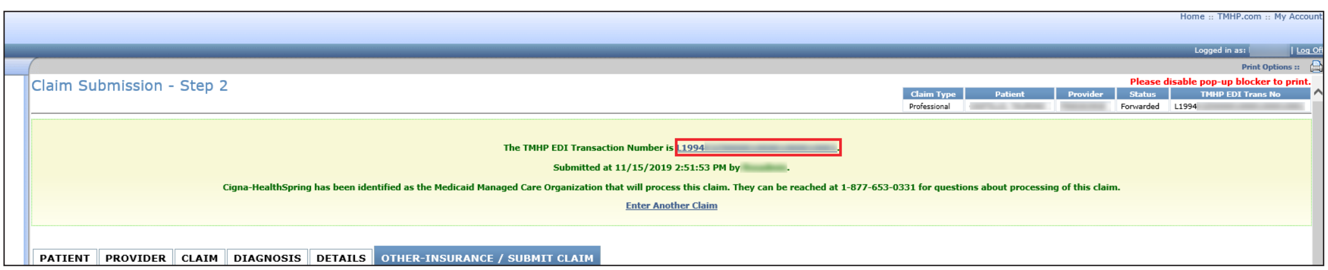
Click **Submit** to have the claim information automatically verified by TexMedConnect.

If there is any missing or invalid information, an error message will display the location of the error. Click each tab to view the error message detailing fields that must be corrected. The claim will not submit until the errors are corrected.



After you have corrected all errors return to the Other-Insurance/Submit Claim tab. Read the Certification, Terms And Conditions section, then check the **We Agree box**. Click **Submit** to submit the claim.

When the claim has been successfully submitted, a message indicating the claim was submitted successfully will be displayed and assign the Internal Control Number (ICN) for the claim. The ICN is a clickable link that will open the Claim Status Inquiry (CSI) screen and display the status of the claim.



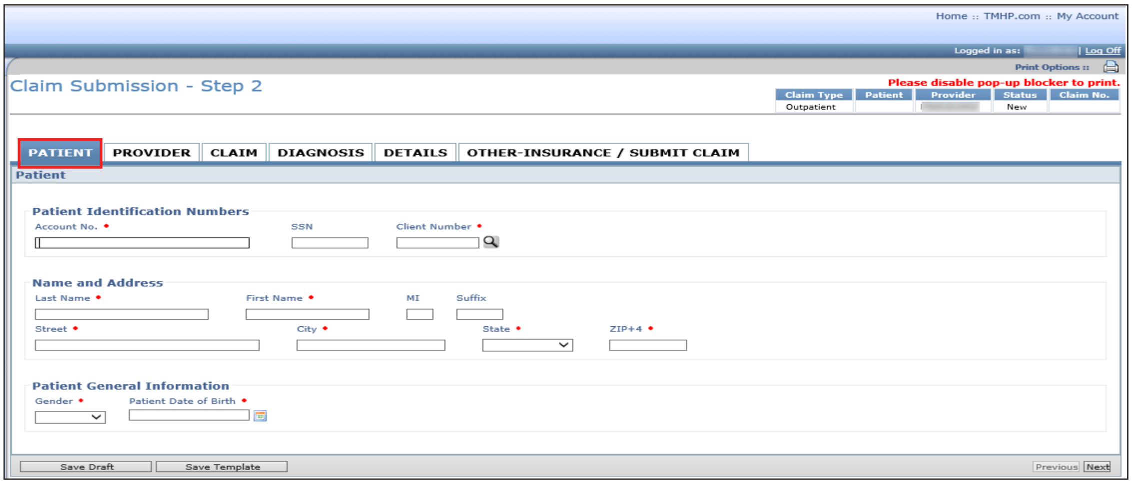
Outpatient Claim

The Claims Entry screen appears for an Outpatient claim type. Required fields (indicated by a red dot) must be completed on each tab. If you entered the client number on the Claims Entry screen, many of these fields are prepopulated but can still be edited.

Use the Next and Previous buttons at the bottom of each tab to save claim data and move through the claims entry steps.

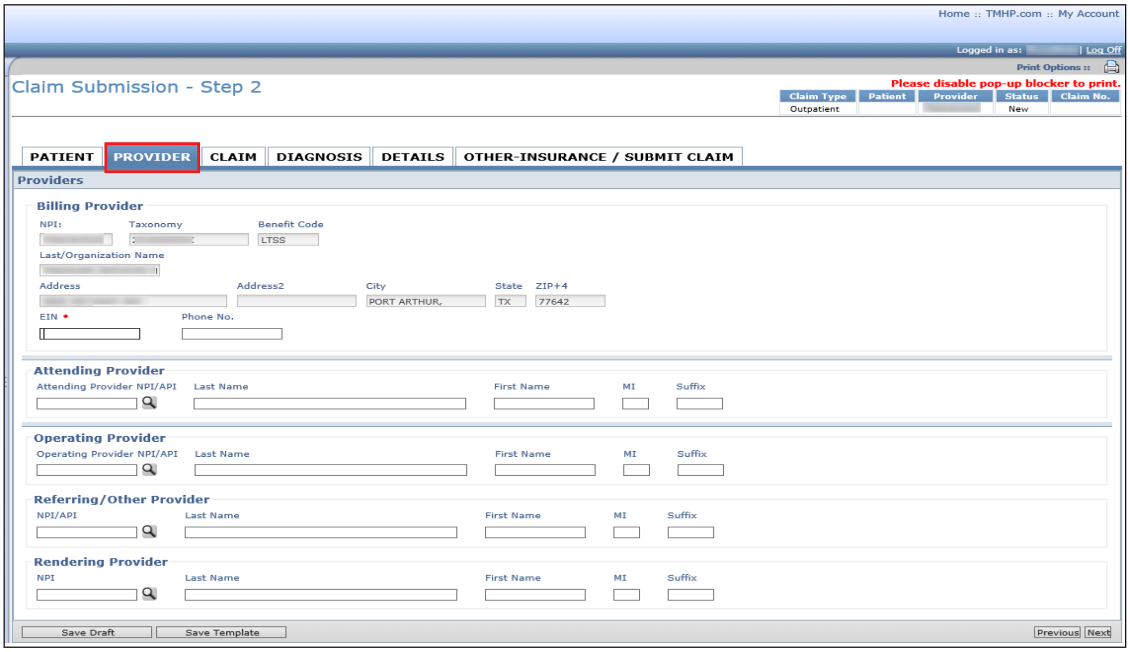
Patient Tab

On the Patient tab, complete all required fields.



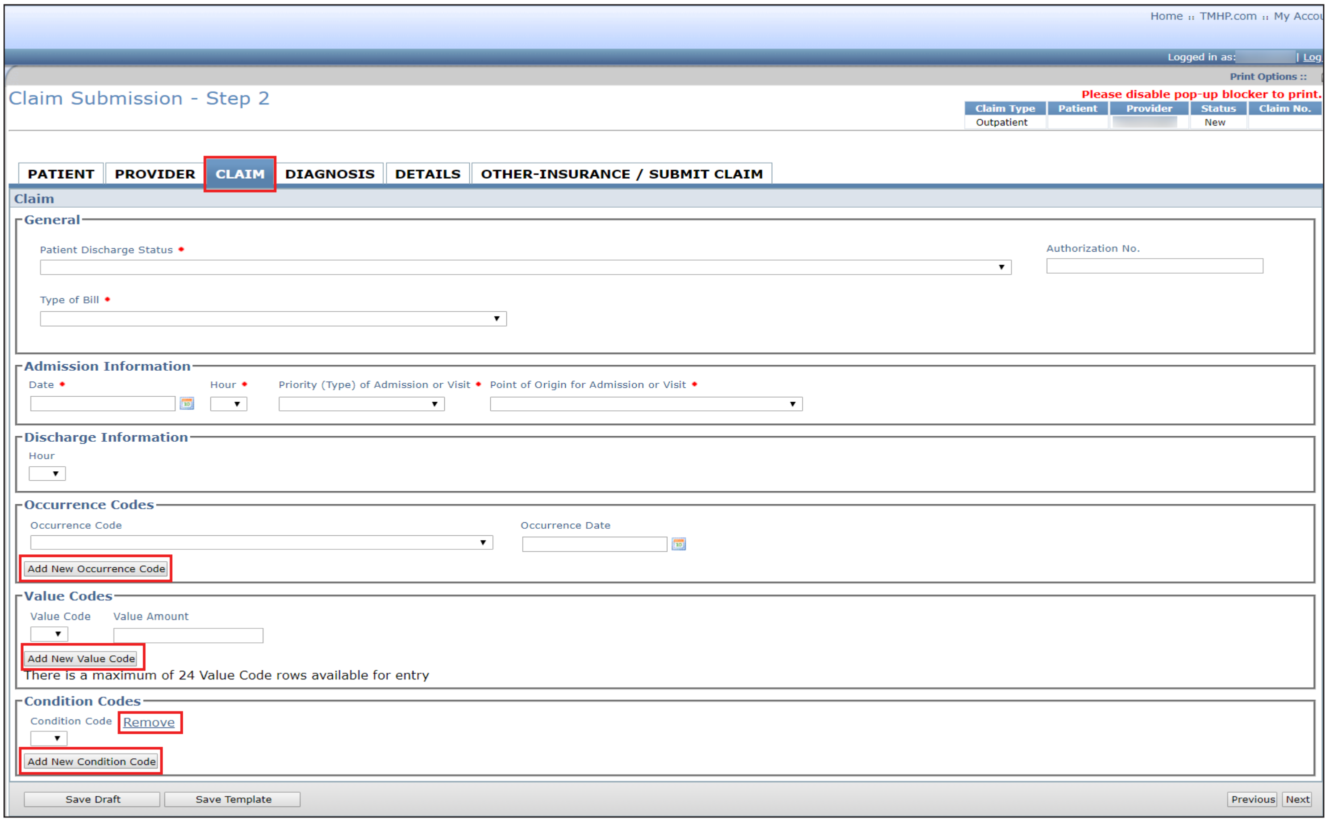
Provider Tab

On the Provider tab, complete all required fields. Some billing provider fields prepopulate. All other required data (such as ID Type) must be entered manually.



Claim Tab

On the Claim tab, complete all required fields.



To add occurrence code rows, click **Add New Occurrence Code**. There is a maximum of four occurrence code rows.

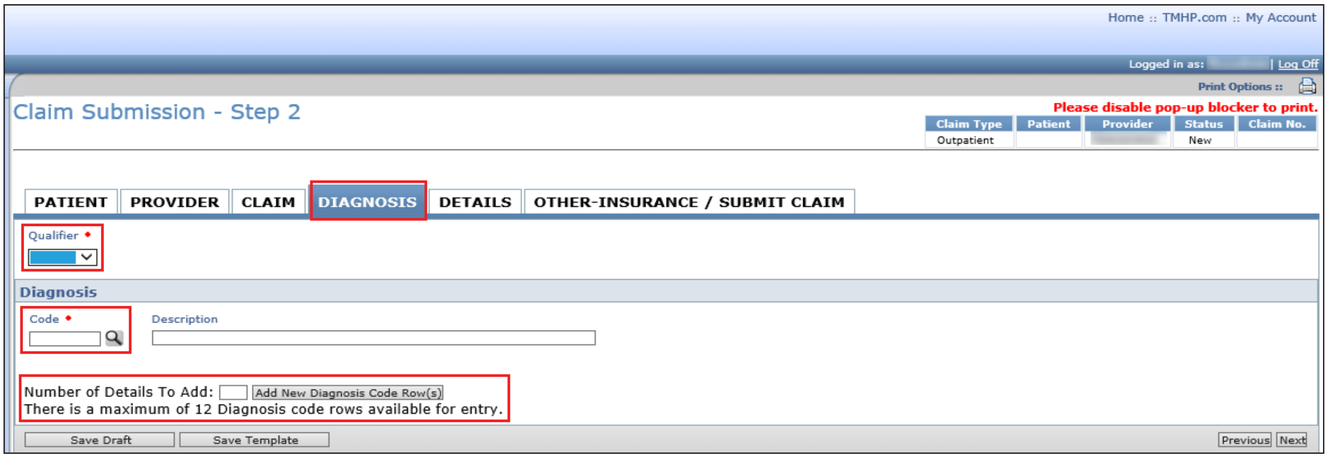
To add value code rows, click **Add New Value Code** (up to 24 rows) and click **Add New Diagnosis Code Row(s)**.

To add condition codes, click **Add New Condition Code**.

To delete any added rows, click **Remove**.

Diagnosis Tab

On the Diagnosis tab, complete all required fields.



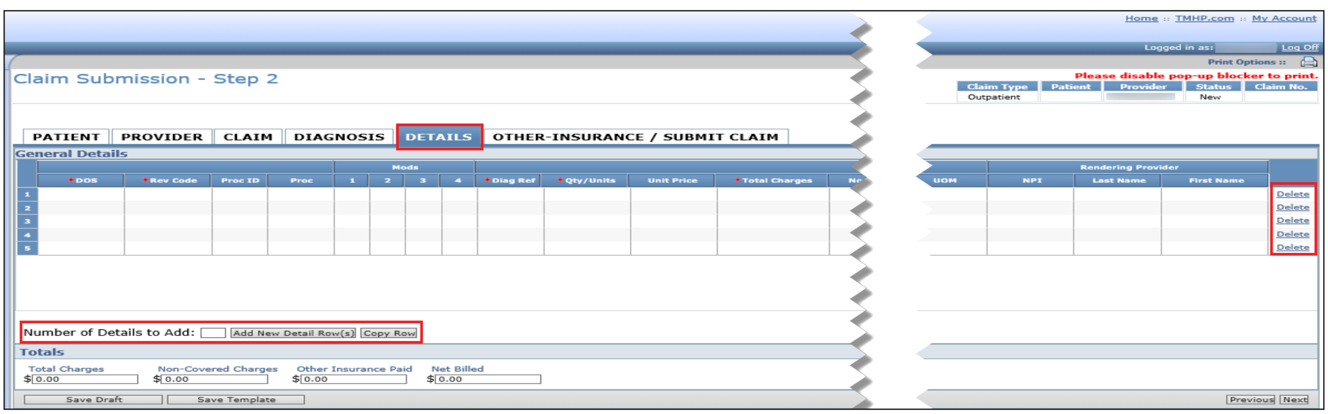
Use the Qualifier drop-down list to select ICD-9 or ICD-10 to ensure that the correct ICD diagnosis code is found in the Code lookup field. The qualifier selected must be valid for the diagnosis code entered based on the date of services.

Input the diagnosis code to the highest degree of specificity. Click the magnifying glass icon to look up the code description.

To add additional diagnosis code rows, enter the **Number of Details To Add** (up to 12) and click **Add New Diagnosis Code Row(s)**.

Details Tab

On the Details tab, complete all required fields.



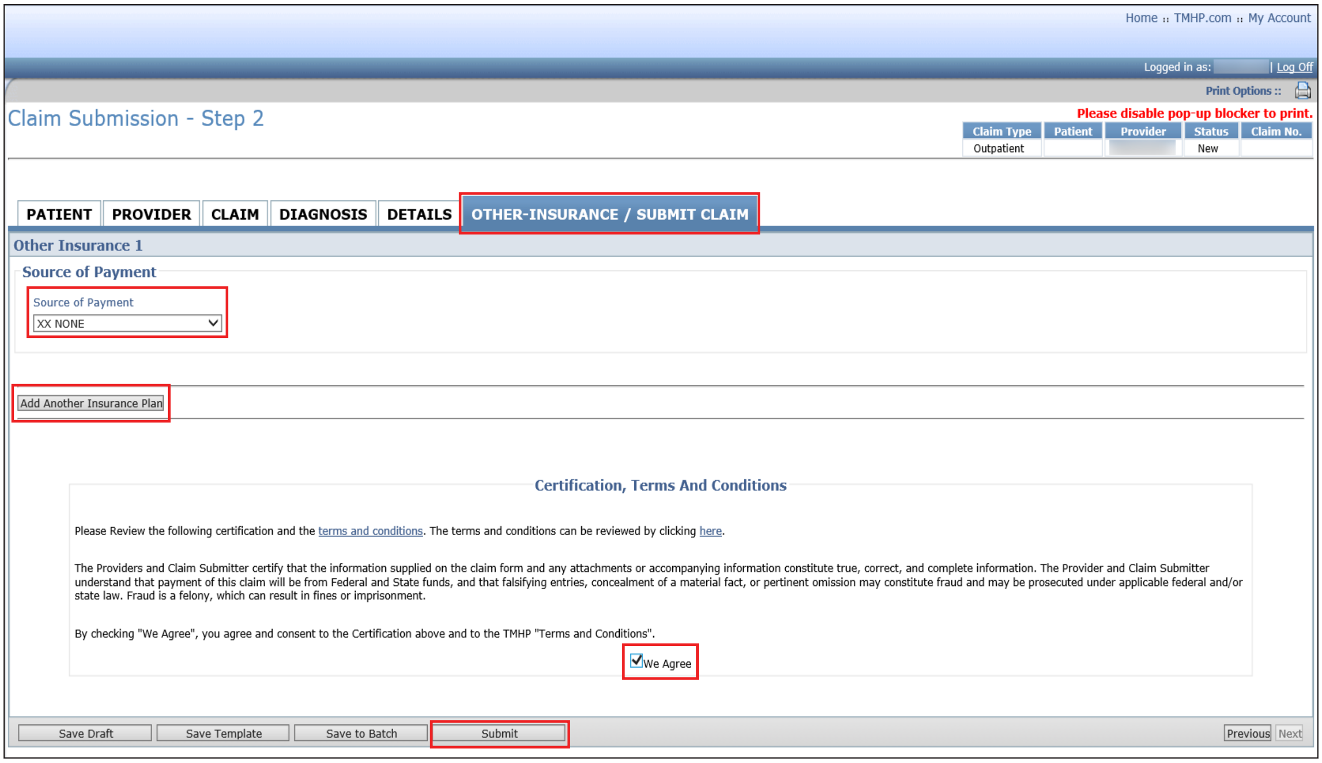
The Total Charges on each row are automatically calculated based on the Qty/Units x Unit Price. It's important to note that, for EVV claims, the units on the EVV claim must match the units on the EVV transactions for the date of service, or the claim will be denied. Additionally, the Total Charges at the bottom of the screen are automatically calculated based on the total charges for each row entered.

To add additional detail rows, enter the **Number of Details To Add** (up to 28) and click **Add New Detail Row(s)**. To duplicate a detail row, click on the row number, and click **Copy Row**.

To remove a row, click **Delete** in the far right column.

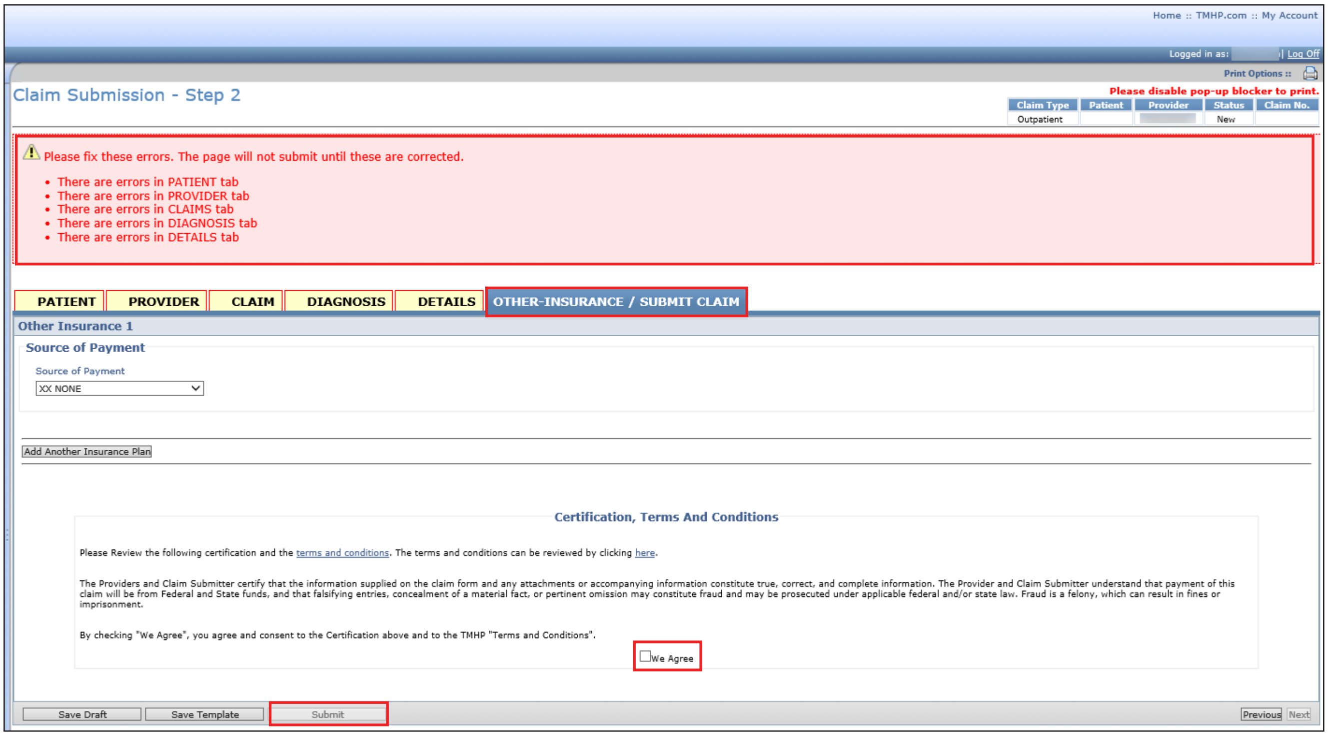
Other-Insurance/Submit Claim Tab

On the Other-Insurance/Submit Claim tab, you can select an option from the **Source of Payment** drop-down list. Enter insurance information into all required fields. Click **Add Another Insurance Plan** to enter information on new insurance that is not on file.



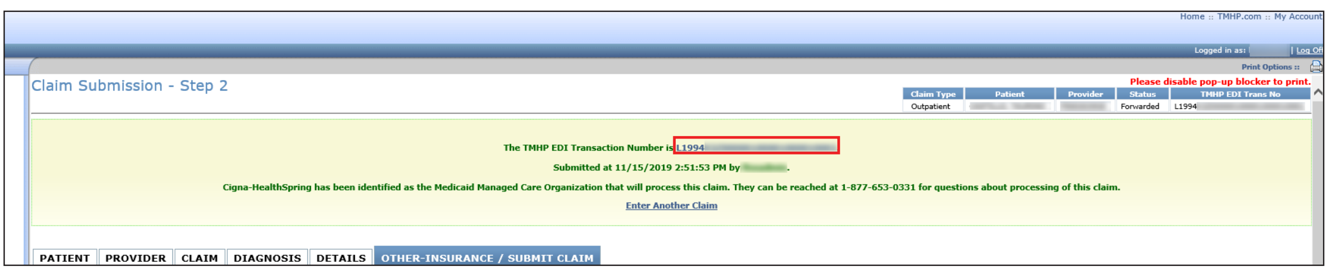
After reviewing the Certification, Terms, And Conditions section, check **We Agree** to enable the Submit button.

Click **Submit** to have the claim information automatically verified by TexMedConnect. If there is any missing or invalid information, an error message will display the location of the error. Click each tab to view the error message detailing fields that must be corrected. The claim will not submit until the errors are corrected.



After you have corrected all errors, return to the Other-Insurance/Submit Claim tab. Read the Certification, Terms And Conditions, then check the **We Agree box**. Click **Submit** to submit the claim.

When the claim has been successfully submitted, a message indicating that the claim was submitted successfully will be displayed and assign the Internal Control Number (ICN) for the claim. The ICN is a clickable link that will open the Claim Status Inquiry (CSI) screen and display the status of the claim.



Saving Claims

Claims cannot be submitted until all required information has been entered correctly. If information has been entered incorrectly or is missing, a message screen will display to indicate the fields with errors. Once all required fields have been completed, four choices are available for processing:

- **Save Draft** – Adds claim to the draft list for later completion
- **Save Template** – Adds claim to the template list for quicker claims creation in the future

- **Save to Batch** – Adds claim to the pending claims list for batch submission
- **Submit** – Submits one claim at a time

Note: After a claim is submitted, an ICN is generated.

Saving as a Draft

Incomplete claims can be saved in a draft status for later submission. To save a claim as a draft, follow these steps:

1) Click **Save Draft**.

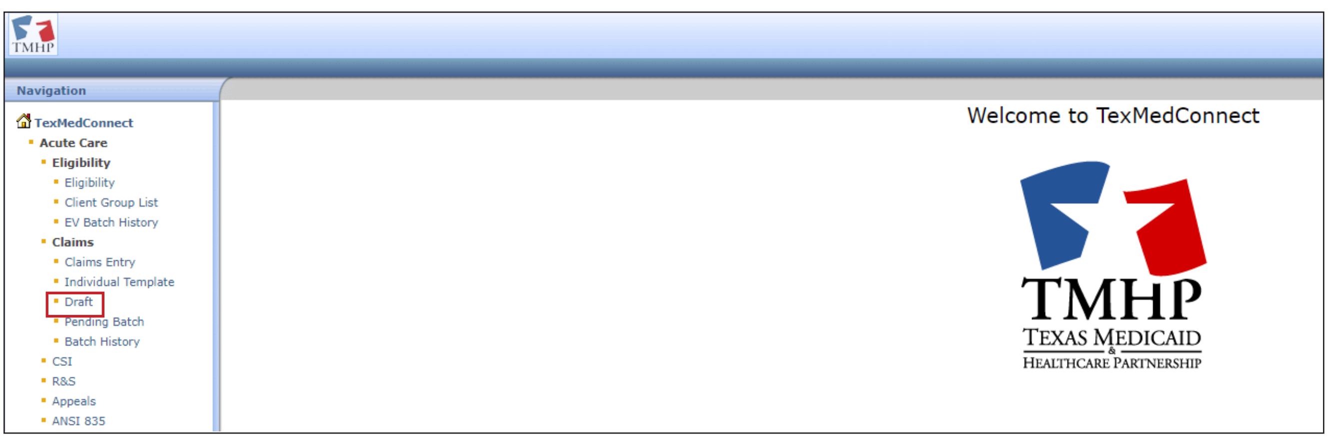
2) Enter a draft name in the blank field that appears. The draft name can include both numbers and letters.

3) Click **Save** to save the draft for later completion.

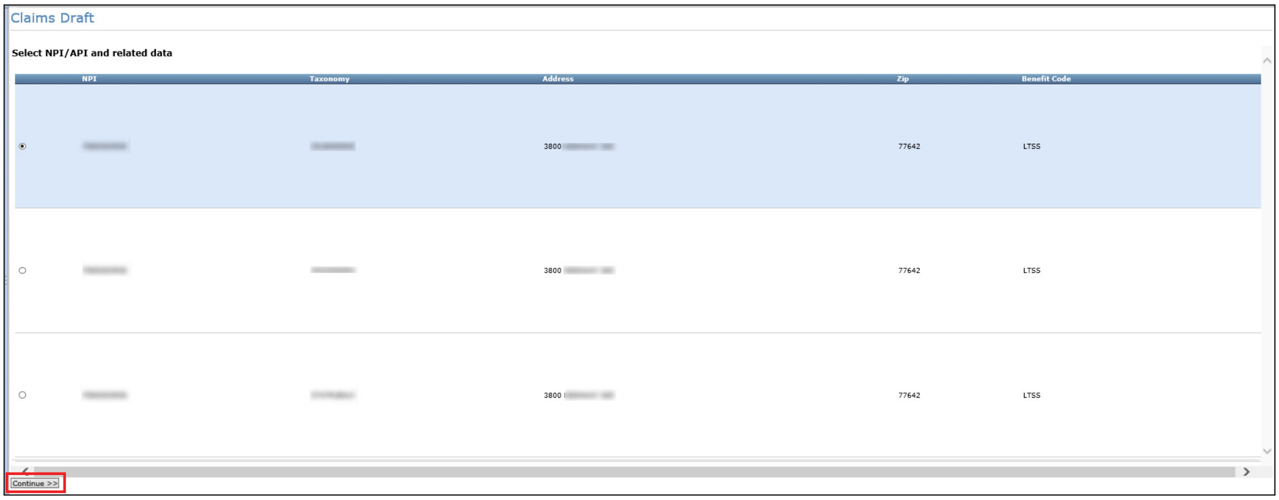
Viewing Draft Claims

A list of NPIs and APIs and related data appear in the Claims Draft screen. Once a draft is submitted, it is removed from the draft list. Additionally, drafts are removed if they are not submitted within 45 days. A maximum of 50 drafts can be created for each NPI or API number. Drafts are displayed by NPI or API. To view a list of draft claims, follow these steps:

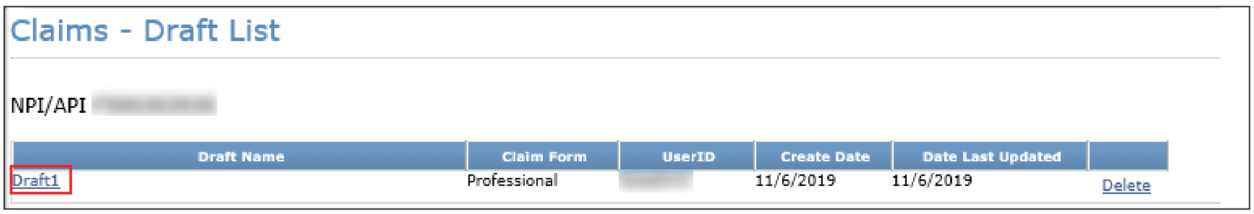
1) Click **Draft** in the left navigation panel.



2) Select the NPI or API on the Claims Draft screen. Click **Continue**.



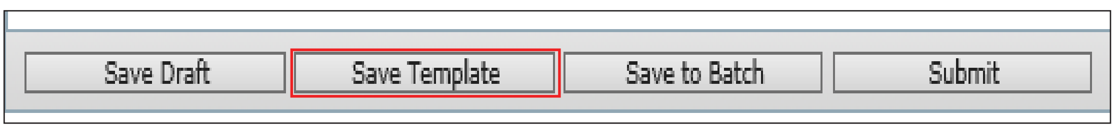
3) Click on a draft name to continue working on it. Drafts can be sorted by clicking column headers.



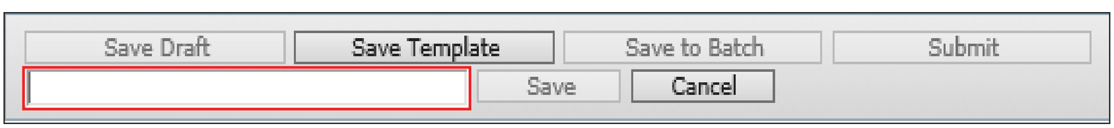
Saving Claims as Templates

To save time submitting claims in the future, you can save an individual claim as a template. Follow these steps to save a claim as a template:

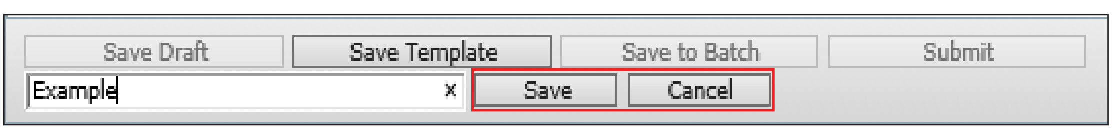
1) Click **Save Template**.



2) Enter a template name in the blank field that appears.



3) Click **Save** to save the template. Click **Cancel** to close the template name field.

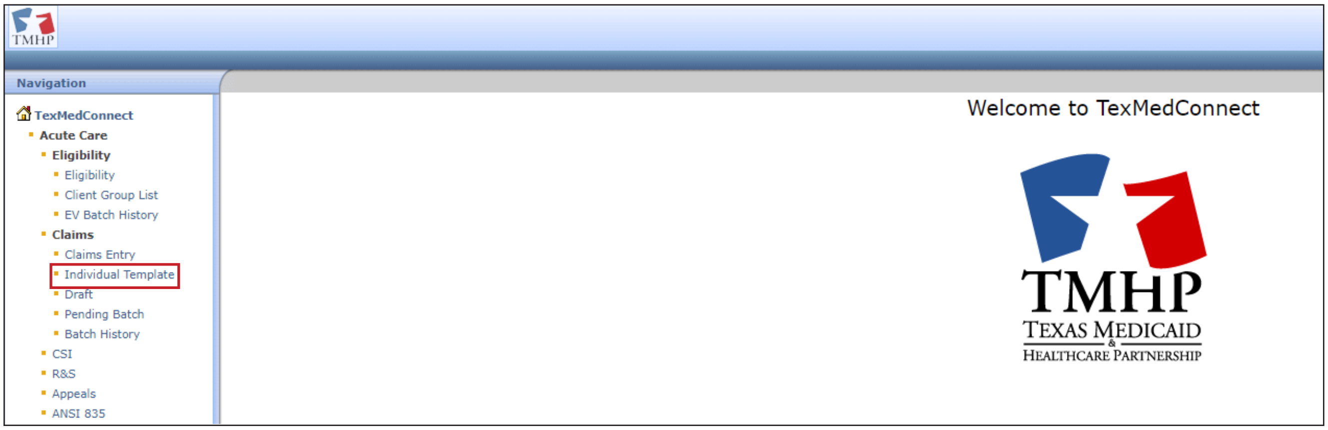


4) The claim is saved to the Individual Template screen for later completion.

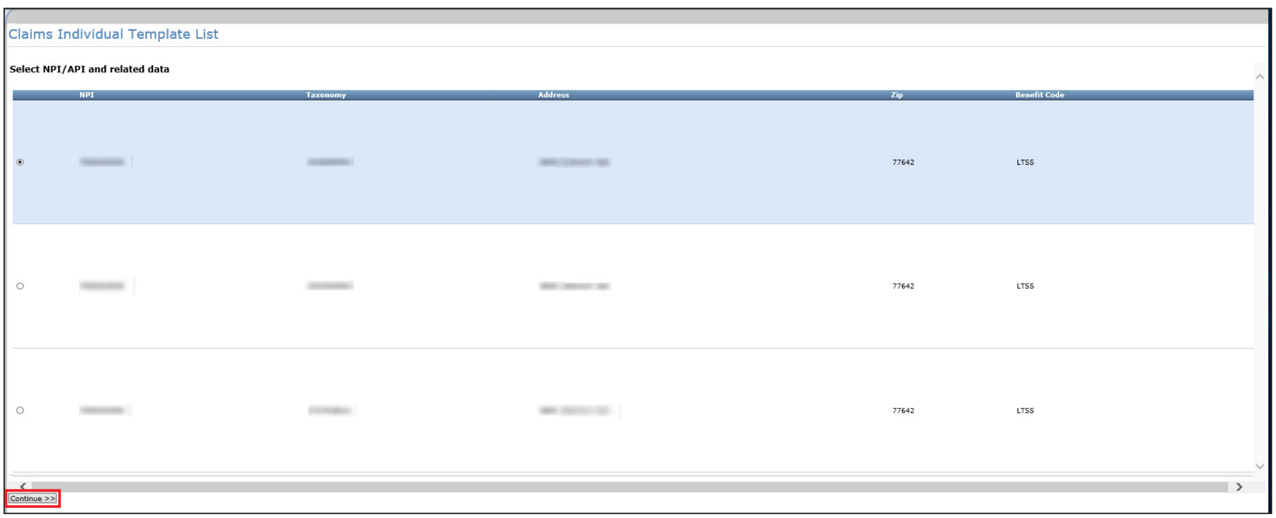
Viewing Individual Templates

A list of NPIs and APIs and related data appear in the Claims Individual Template List screen. Templates are displayed by NPI or API. Templates do not disappear when used, but they are removed when they are not used for 90 days. A maximum of 1000 individual claim templates can be created for each NPI or API number. To view a list of individual templates:

1) Click **Individual Template** in the left navigation panel.



2) Select the NPI or API on the Claims Individual Template List screen. Click **Continue**.



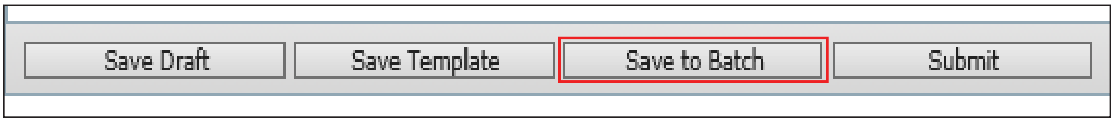
3) Click on a template name to continue working on a claim. Templates can be sorted by clicking column headers.

Saving as a Batch

You can save a claim to batch, which creates a pending batch list that is maintained until you submit the batch. One batch can contain up to 250 claims. Claims from Draft, Templates, or claims currently being created can be saved to a pending batch. After 45 days, pending batches that have not been submitted are deleted. You can view or edit claims in a pending batch before submission.

To save a claim to batch, follow these steps:

1) Click **Save to Batch**.

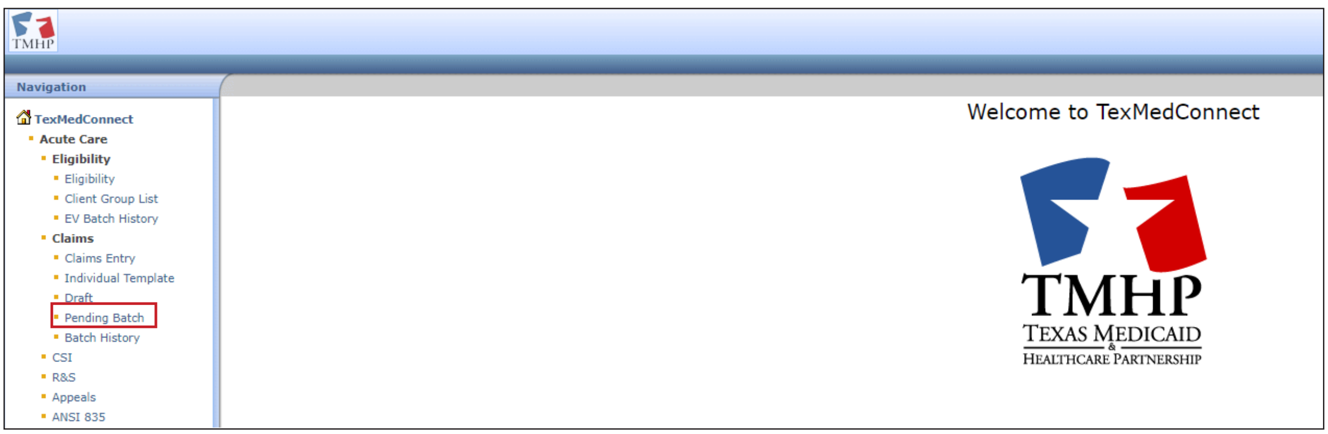


2) After you click **Save to Batch**, the system will take you back to the Claims Entry screen.

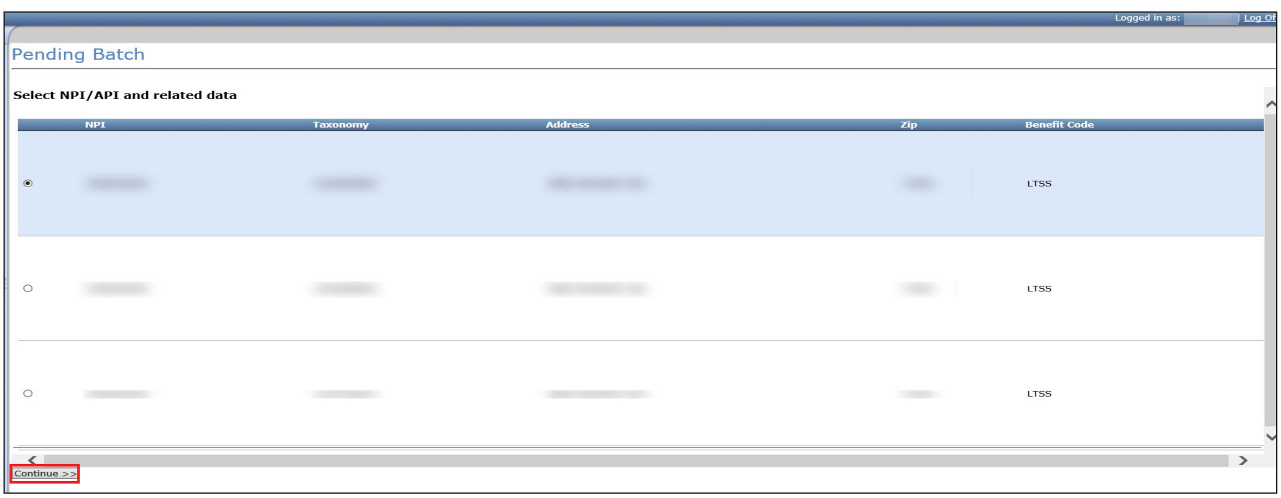
Submitting a Pending Batch

The pending batch list displays claims that are ready to be submitted. To submit a batch of pending claims, follow these steps:

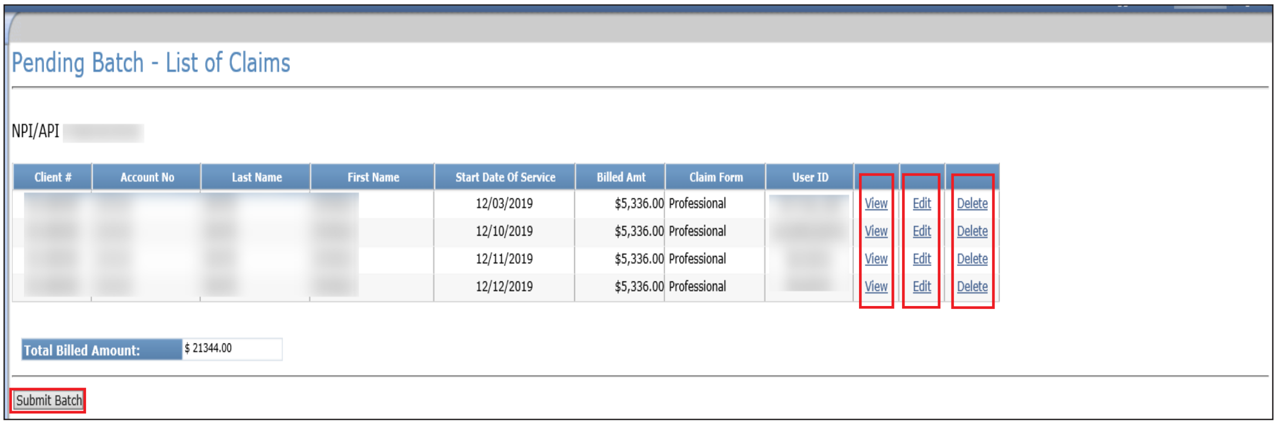
1) Click **Pending Batch** in the left navigation panel.



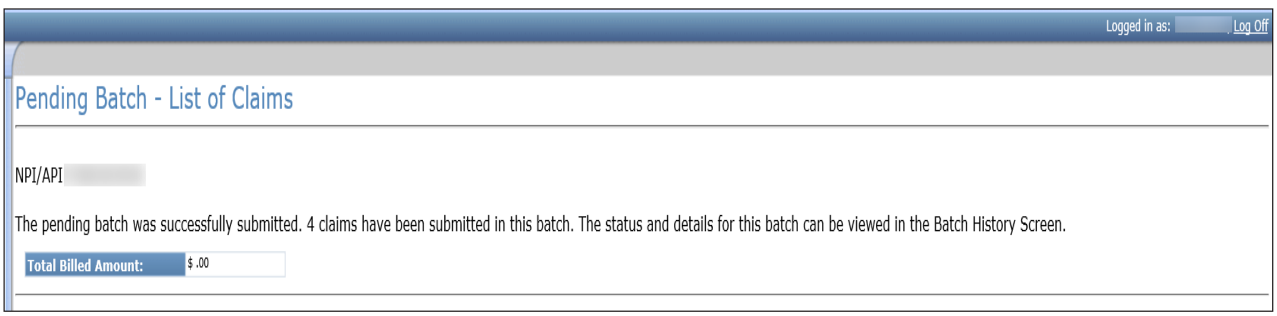
2) Select the NPI or API in the Select NPI/API and related data list, then click **Continue**.



3) Click **View** to view pending claim detail. Click **Edit** to make changes to the pending claim. Click **Delete** to delete the pending claim.
Click **Submit Batch** when all pending claims displayed are ready to be submitted. All claims in the batch will be submitted, even if they were created by other users under the same NPI.



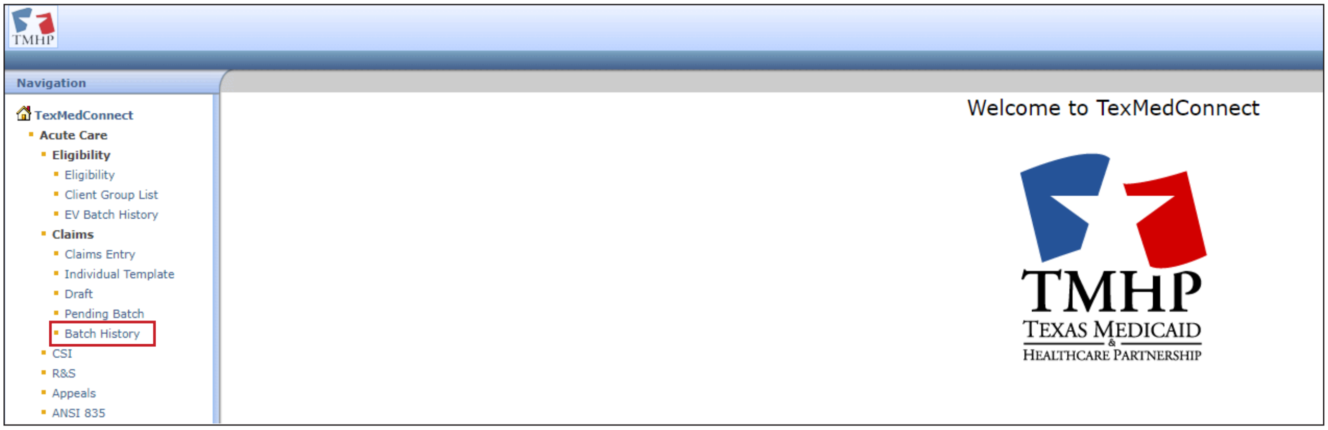
4) A confirmation appears when the batch is submitted.



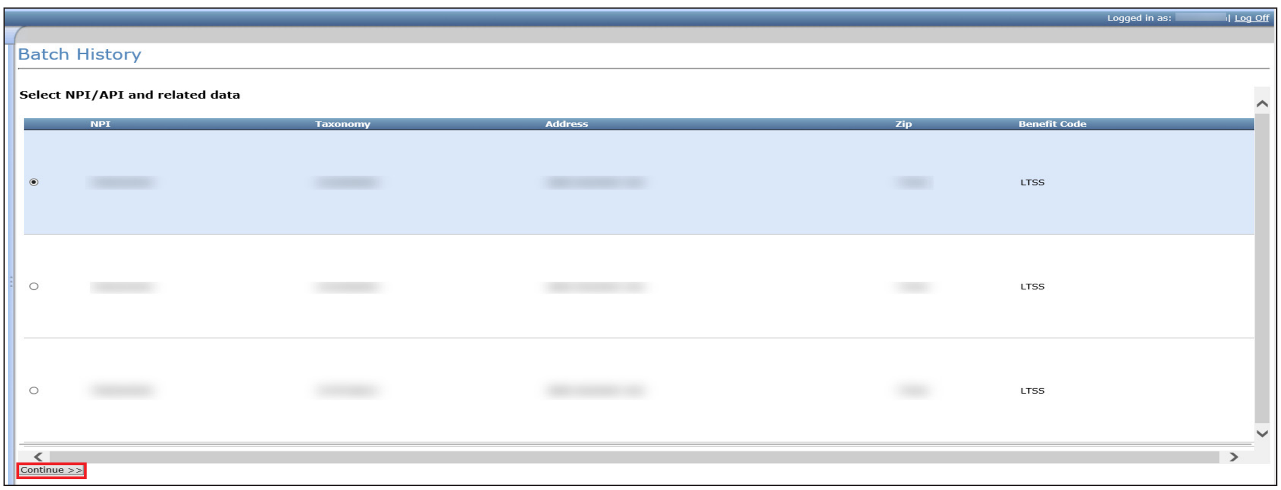
Batch History

You can view the history of submitted claim batches for the previous 120 days. Batches that are more than 120 days old are automatically deleted from the history. To view a batch history, follow these steps:

1) Click **Batch History** in the left navigation panel.

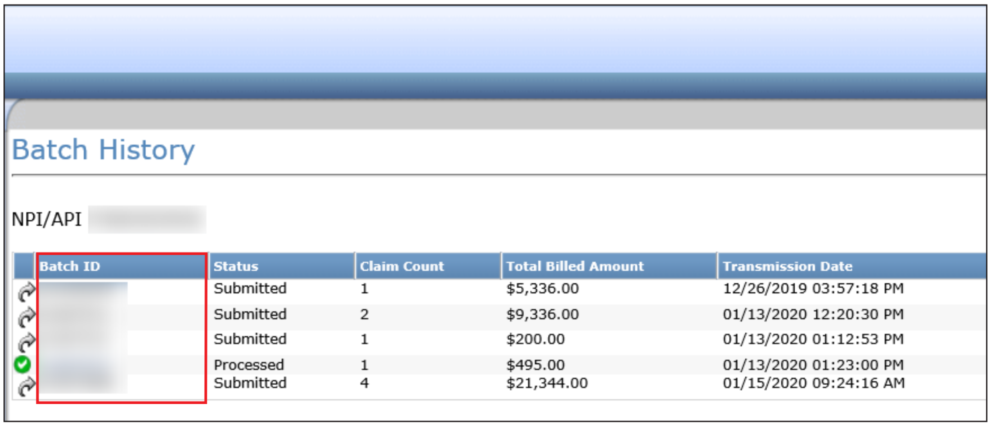


2) Select the NPI or API in the **Select NPI/API and related data** list, then click **Continue**.



3) A Batch History list appears for the NPI/API that was selected. Batch IDs are assigned a *Submitted* status or a *Processed* status. A *Submitted* status indicates that the user has submitted the batch, but it has not been forwarded to the payer. A *Processed* status indicates that the batch has been processed by the system and forwarded to the payer. A *Submitted* status will change to *Processed* status within 24 hours. Contact the EDI Help Desk at 888-863-3638 if the batch remains in *Submitted* status for over 24 hours.

4) Click a **Batch ID** in *Processed* status to view the list of claims in that batch.



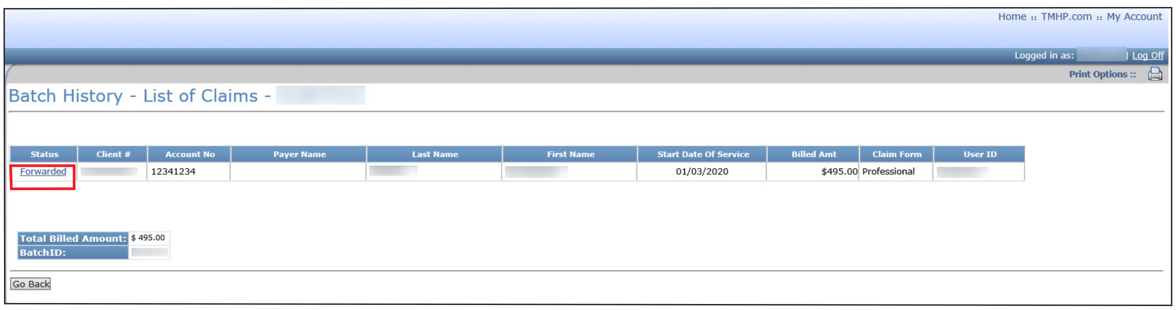
Batch History

NPI/API

Batch ID	Status	Claim Count	Total Billed Amount	Transmission Date
	Submitted	1	$5,336.00	12/26/2019 03:57:18 PM
	Submitted	2	$9,336.00	01/13/2020 12:20:30 PM
	Submitted	1	$200.00	01/13/2020 01:12:53 PM
	Processed	1	$495.00	01/13/2020 01:23:00 PM
	Submitted	4	$21,344.00	01/15/2020 09:24:16 AM

5) A list of claims for the Batch ID appears. Claims are in a *Forwarded*, *Accepted*, or *Rejected* status. *Forwarded* claims have been sent to the payer, but have not been accepted or rejected. *Accepted* claims have been accepted by the payer. *Rejected* claims have been rejected by the payer.

6) Clicking the **Status** link will take you to additional details on the CSI Search Details screen.



Home :: TMHP.com :: My Account

Logged in as: | Log Off

Print Options ::

Batch History - List of Claims -

Status	Client #	Account No	Payer Name	Last Name	First Name	Start Date Of Service	Billed Amt	Claim Form	User ID
Forwarded		12341234				01/03/2020	$495.00	Professional	

Total Billed Amount:	$ 495.00
BatchID:	

Go Back

7) Click **Go Back** to return to the list of claims.

Batch History - List of Claims -

Status	Client #	Account No	Payer Name	Last Name	First Name	Start Date Of Service	Billed Amt
Forwarded		12341234				01/03/2020	$495

Total Billed Amount:	$ 495.00
BatchID:	

Go Back

Claim Status Inquiry (CSI)

The Claim Status Inquiry (CSI) function allows you to determine the status of processed claims. Three years of claims history are available. Claims meeting the search criteria are displayed on the CSI Search Results screen. The system returns a maximum of 250 results, and you can determine the claim status for those claims. You have two options for conducting a CSI search:

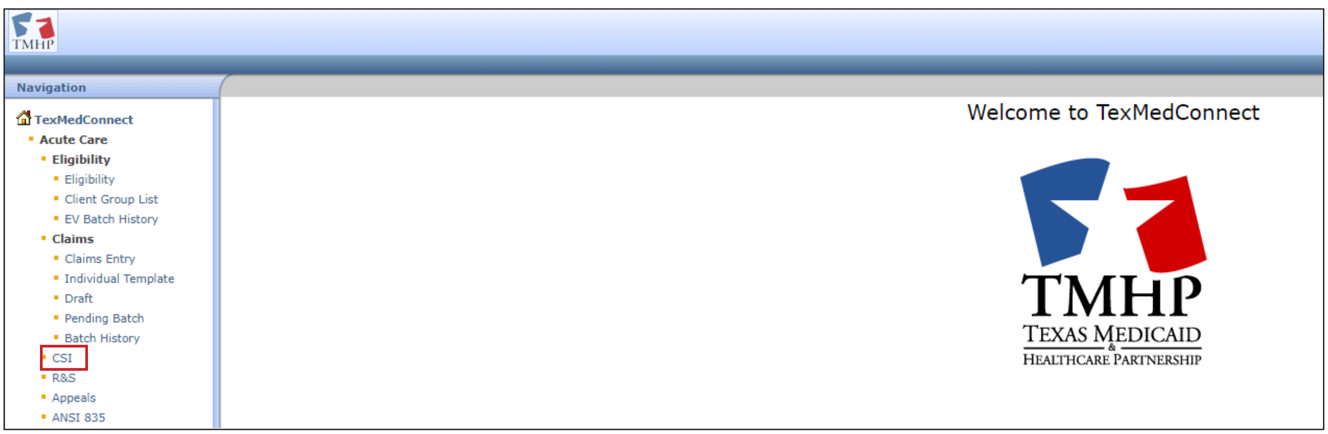
- By claim number
- By a valid NPI/API and related data, including from date of service (FDOS) and through date of service (TDOS)

When searching by NPI/API/FDOS/TDOS, the following conditions apply:

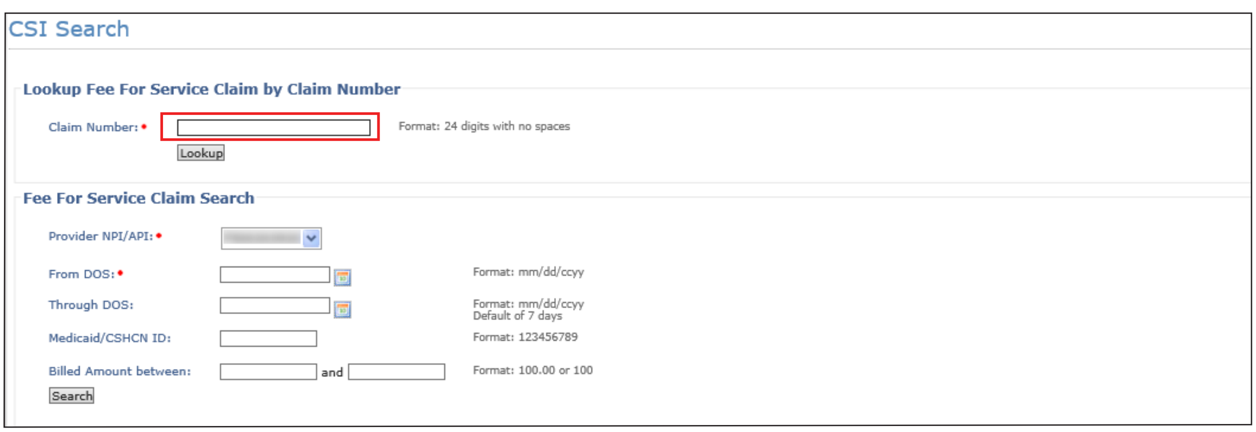
- The dates cannot define a length of time greater than 30 days.
- The FDOS cannot go back more than 36 months from the current date.
- If the FDOS is entered but the TDOS is not provided, the default value of seven days (from the FDOS date) auto-populates in the TDOS field.

To perform a claim status inquiry, follow these steps:

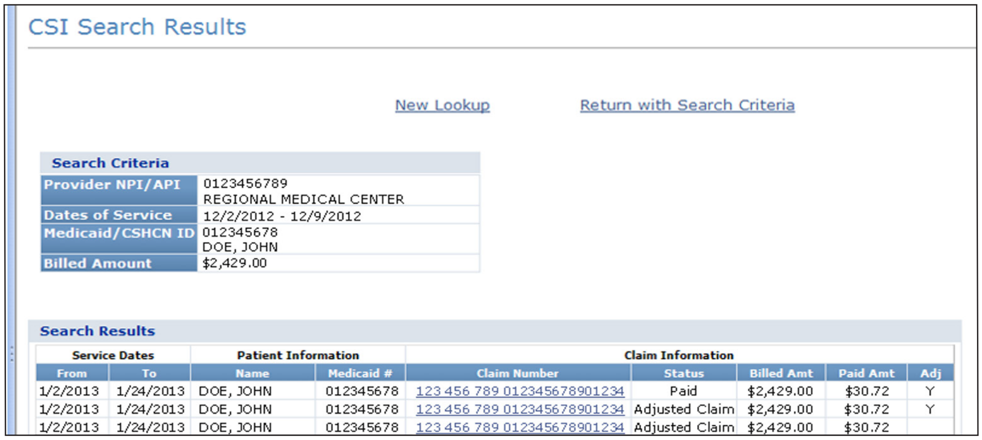
1) Click **CSI** in the left navigation panel.



2) Enter a claim number. Click **Lookup**. If you do not know the claim number, enter other claim information and click **Search**.



3) The CSI Search Results screen displays. If the search does not locate the desired claim, narrow the search criteria to produce a more specific match. A maximum of 50 claims at a time can be displayed on the Search Results screen. To display more claims that match the search criteria, click **Next**.



4) To display the details of a specific claim, click the claim number. The claim details for the selected claim appear on the CSI Search Details screen. The information displayed on the Details screen is the same information available on the R&S Report.

Fee-for-Service Claims Appeals

The following claims may not be appealed through TexMedConnect (refer to the *Texas Medicaid Provider Procedures Manual* (TMPPM) for detailed appeals information):

- Claims that require supporting documentation (e.g., operative report, medical records, home health, hearing aid, and dental X-rays)
- Diagnosis-related group (DRG) assignment
- Medicare crossovers
- Claims listed as pending or in process with explanation of pending status (EOPS) messages
- Claims denied as past filing deadline except when retroactive eligibility deadlines apply
- Claims denied as past the payment deadline
- Claims with quantity billed changes in the claims details
- Claims that are the result of a mass adjustment

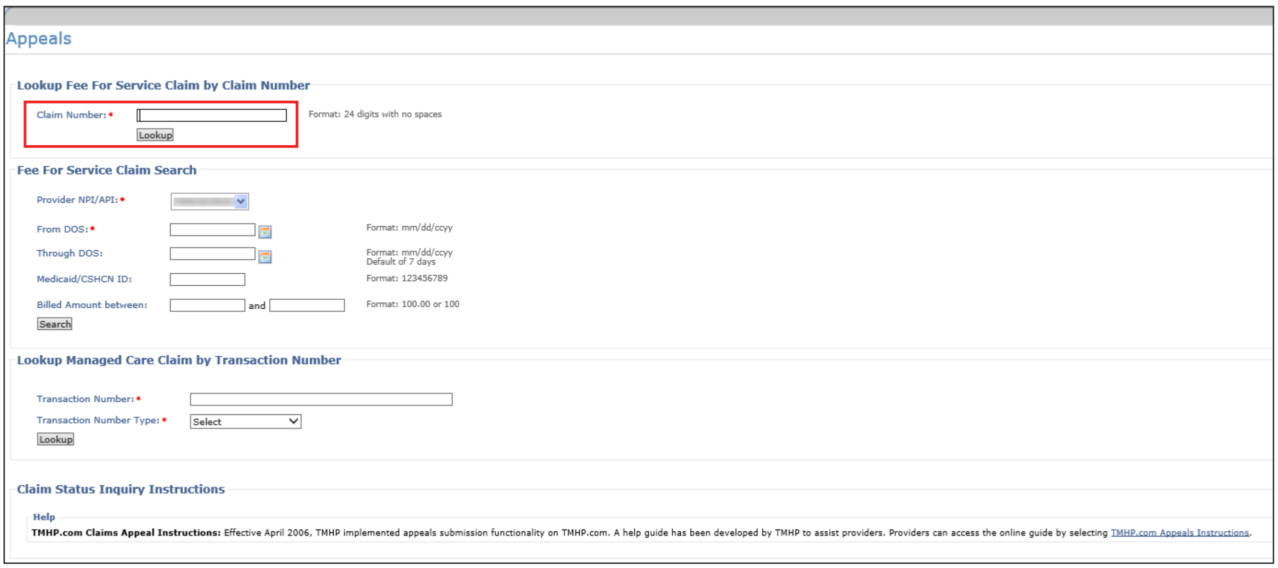
Claims with a finalized status, such as *Denied* or *Paid*, can be appealed directly from TexMedConnect.

NOTE: MCOs may refer to Appeals as Corrections, Adjustments, or Updates.

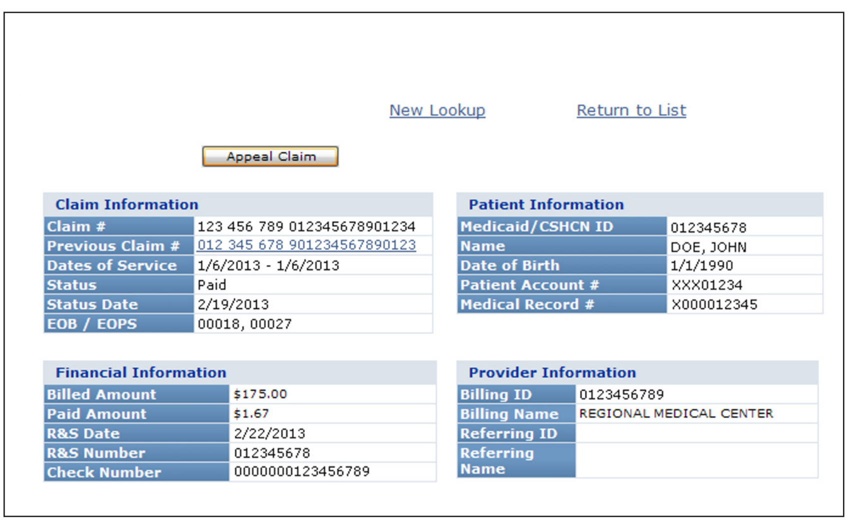
To appeal a claim, follow these steps:

1) Click **Appeals** in the left navigation panel.

2) Enter the claim number and click **Lookup** or select an NPI/API, enter claim information, and click **Search**.



3) CSI search details appear if a match is found. Click **Appeal Claim** to begin the appeal process. Most fields populate with the claim information. You can modify the claim information for the appeals.



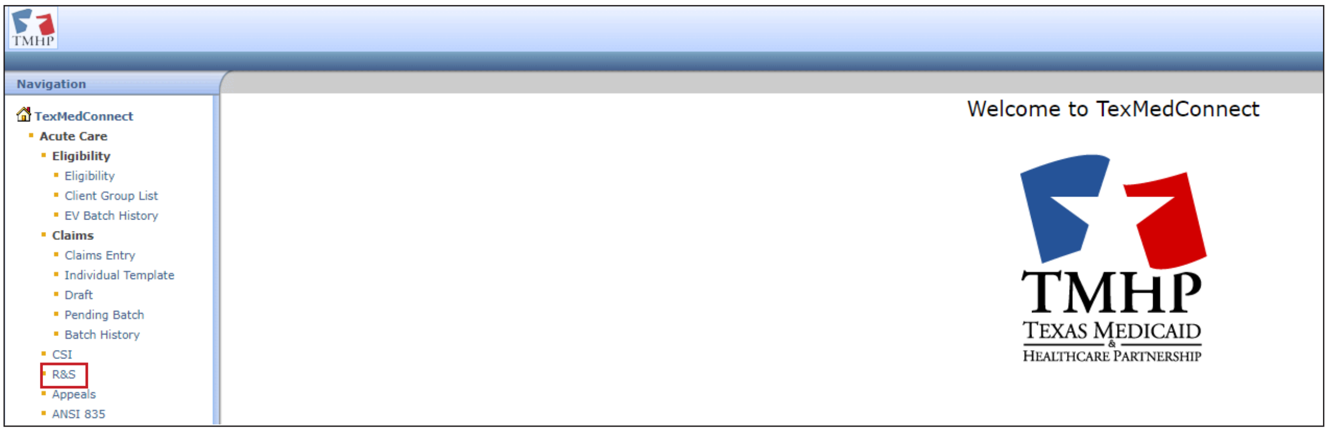
Remittance and Status (R&S) Reports

The R&S function on the navigation panel has two options:

- PDF – Displays the Portable Document Format (PDF) version of the R&S Report
- ANSI 835 – Allows the download of the American National Standards Institute (ANSI) 835 version of the R&S Report for providers that use third-party billing software or third-party billing agents

Viewing the PDF Version

To view the R&S Report PDF, click **R&S** on the navigation panel. Click any R&S Report to view the PDF.



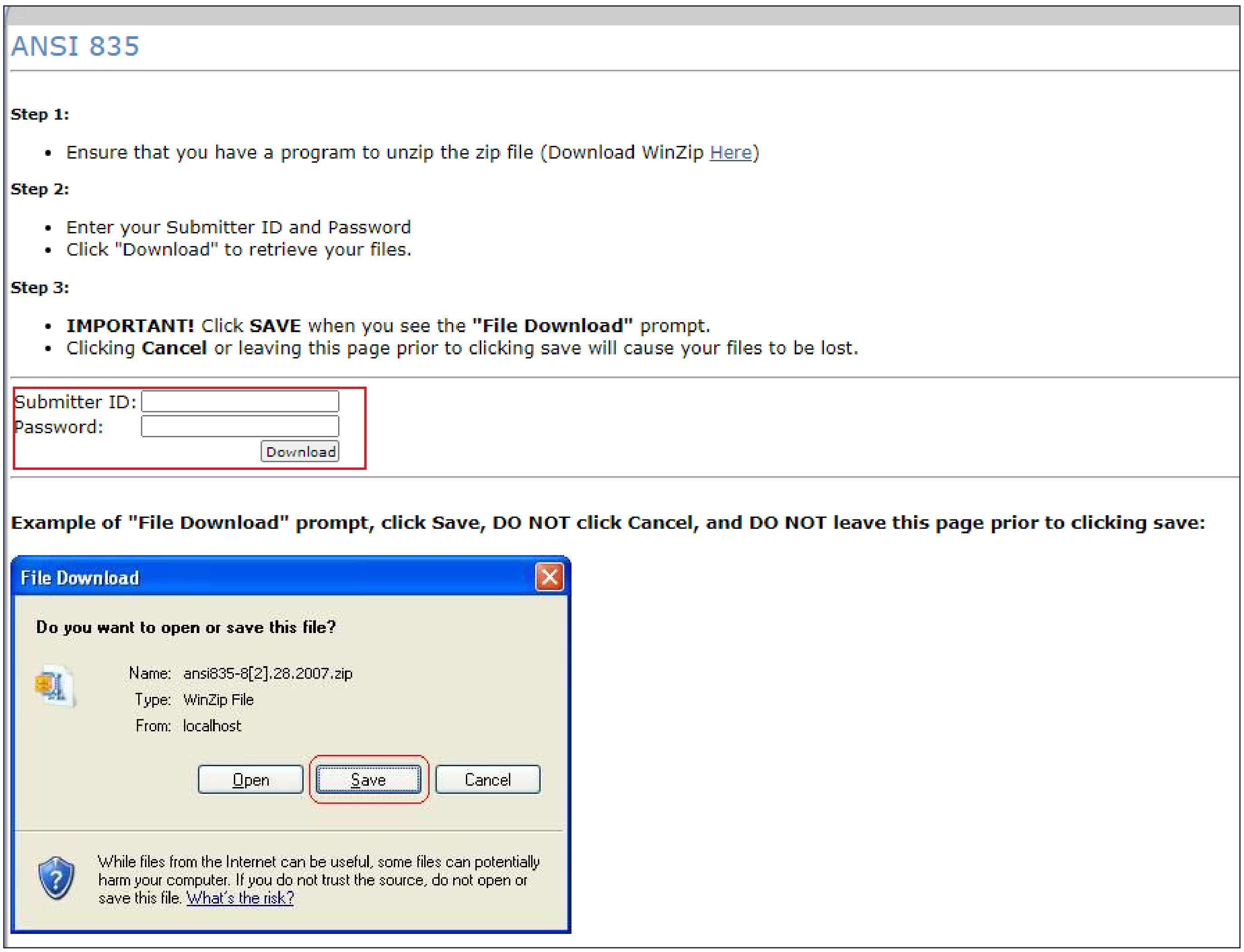
Downloading the ANSI 835 Version

You can access the ANSI 835 version of nonpending Electronic Remittance and Status (ER&S) Reports and pending ER&S Reports using a submitter ID and password. To obtain a submitter ID or for help with a forgotten password, call the TMHP EDI Help Desk at 888-863-3638.

To download the ANSI 835 version of the R&S Report, follow these steps:

1) Click **ANSI 835** from the navigation panel to access the FTP site.

2) Enter the Submitter ID you were issued and password. Click **Download**.



Note: A companion guide containing information about file formats is available on tmhp.com on the EDI page.