



Medicaid Provider How-To Guide

Registering for Secure, Self-Service Web Access

WellCare of Florida, Inc./HealthEase of Florida, Inc. (the Plan) understands that having access to the right tools can help participating providers and their staff streamline day-to-day administrative tasks. Two free services that the Plan offers to assist with those routine tasks are the Provider Portal and Payformance's Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA) services. For more information on the benefits of registering for secure, self-service web access, refer to the *Provider Resource Guide*.

To Register for the Provider Portal

There are two types of users: **administrative users** and **sub-accounts**. **Administrative users** oversee additional website users (**sub-accounts**) in their practice or department.

Create a New Account by Registering

Administrative users can register on www.wellcare.com by selecting *Not Registered? Sign Up Today!* on the *Providers* tab. You will need the following to register:

- Plan-issued Provider ID number (located in your welcome packet or on your Explanation of Payment);
- Primary address ZIP code (the ZIP code submitted on your credentialing packet); and
- Tax Identification Number (TIN).

Create a new account using the *Sign Up Here* link that appears on the home page. Select the *Register Here* link on the top right side of the following page. This will direct you to the *Provider Registration* form.

Identify Yourself & Tell Us About Yourself

Complete the registration form by submitting your Provider ID, ZIP code and TIN. Please note that your Plan-issued Provider ID appears in your welcome packet and on your Explanation of Payment copies. Please provide us with information regarding your organization and users.

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Create a Username

Create a username and select a security question and answer. A confirmation page will be displayed. Print this page for your records. Within 24 hours of registration, you will receive an e-mail with a temporary password that will expire in 30 days. Use this password to log on to the website and create a password of your preference. Be sure to keep your username and password for future reference.

Need Assistance?

For questions on Web registration, or to reset your password, contact Provider Services at the number listed on your Quick Reference Guide.

To Register for Payformance's Electronic Funds Transfer at PaySpan Health

Create a New Account by Registering

New users must first contact Payformance to request a registration code. Call 1-877-331-7154 or email providersupport@payspanhealth.com. Payformance will then mail instructions on how to register online.

Once you receive your code, you can register at www.payspanhealth.com by selecting the *Secure Registration* button. You will need the following to register:

- Your Vendor/Provider Identification Number (PIN) and Tax Identification Number (TIN);
- A valid e-mail address;
- An account name (to identify the receiving account);
Note: Providers typically use the account name to specify the payee designation. Each payee will have a separate registration code and can therefore have a separate receiving account established. The same routing and account number can be used for multiple receiving accounts.
- Bank routing number; and
- Account number.

Enter Your Registration Code

Enter the registration code you received from Payformance. If you need your registration code, please contact Payformance. Please see the *Contacting Us* section of the *Provider Resource Guide* for specific contact information.

Follow the Prompts

Follow all prompts and complete the required registration information questions. It is important you provide an account name to identify the receiving account. See *Create a New Account by Registering* for more information.

Verify Successful Registration

Your e-mail address will become the username when logging in to PaySpan Health. After completing your registration, you will receive an e-mail from PaySpan Health. In a few days, you will need to verify with your bank that a small deposit has been made by Payformance. This deposit amount will be used to confirm your electronic payments are properly set up. The deposit does not need to be returned to Payformance.

Need Assistance?

For questions on PaySpan registration, contact the PaySpan Provider Support Team. Please see the *Contacting Us* section of the *Provider Resource Guide* for specific contact information.

Verifying Member Eligibility

Prior to rendering services, providers should verify the member's eligibility via one of the methods below. The following information is needed to verify eligibility:

- Provider ID;
- Member identification number; and
- Member name (last, first);
- Member date of birth.

Via Provider Portal (www.wellcare.com)

Registered users may log on and go to the Eligibility portlet, enter the member's identification number and click *Show Eligibility Co-pay* OR click *Look Up Member*.

Fill in the last name, first name and date of birth fields and click *Find Members*. Choose *Member* from the list that appears below and click *OK*. Eligibility and co-pay information for the member will appear. You may print this information.

Via Provider Services Interactive Voice Response (IVR)

Contact Provider Services at the phone number listed on your state-specific Quick Reference Guide. The system will ask for the member's name and ID number. Follow the prompts to complete the request.

Via a Provider Services Customer Service Representative

Contact Provider Services at the phone number listed on your Quick Reference Guide. A representative will request the member's name and date of birth as well as the name of the office, your Provider ID number and the name of the staff person making the request. The representative will then provide the effective date of coverage and current PCP on file. Co-pay and benefit information is also available upon request.

Requesting an Authorization

Providers must obtain prior authorizations for certain services and procedures. The Plan also highly encourages providers to submit authorization requests for global obstetric services through the Provider Portal. For details regarding services that require authorization and how to go about submitting one, please refer to your Quick Reference Guide. For more information on standard and expedited authorization requests, refer to the *Provider Resource Guide*.

The following information, at a minimum, is generally requested for all authorizations:

- Member name;
- Member identification number;
- Provider ID and NPI number or name of the treating physician;
- Facility ID and NPI number or name where services will be rendered (when appropriate);
- Provider and/or facility fax number;
- Date(s) of service;
- Diagnosis and diagnostic codes; and
- CPT codes.

Via Provider Portal (www.wellcare.com)

Registered users may log on and click on *Submit Authorization* under the *Authorizations* heading. Or you can select the *Authorizations* tab at the top of the page and from there, click on the *Authorization Request* link. Enter your name and Provider ID number and follow the prompts.

For global obstetric services (prenatal notifications), be sure to select the appropriate type of request (*Outpatient*) and the place of service. Then follow the prompts. Please note that authorization requests for pre-planned C-sections and other elective inpatient surgeries may also be submitted online. You may review a summary of your authorization request on the right side of the screen to ensure the information is correct.

For all authorizations, please supply your phone and fax numbers. You can attach up to 10 clinical files, or you can provide any relevant clinical information supporting the request by typing the information into the text box. Please note that your ability to view the request via Provider Portal inquiry may be delayed until a final disposition has been determined. As a result, you may receive our fax response prior to seeing the determination online.

*Note: If you are not a registered user, follow the instructions under **To Register for the Provider Portal**.*

Via Fax

Complete the appropriate notification or authorization form for the type of care needed. Forms can be found online at www.wellcare.com in the *Provider Resources* area. You may also contact your Provider Relations representative to obtain a copy.

Complete every section of the form to prevent any delays in processing. Then fax the form to the appropriate fax number provided on your Quick Reference Guide and include any supporting documentation.

Via Phone

EMERGENT OR URGENT AUTHORIZATIONS ONLY

Emergent or urgent requests should only be submitted when following the standard timeframe could seriously jeopardize the member's life or health. Requests for expedited authorization will receive a determination within 72 hours.

Contact Provider Services at the phone number listed on your Quick Reference Guide to request an expedited authorization.

Please note:

Authorization/Certification determinations are made based on medical necessity and appropriateness, and reflect the application of the Plan's review criteria guidelines. Once you complete each authorization request, you can download or print a summary report for your records.

Authorizations are valid for the time noted on each authorization response. The Plan may grant multiple visits under one authorization when a plan of care shows medical necessity for this request. Failure to obtain the necessary prior authorization from the Plan could result in a denied claim. Authorization does not guarantee payment. All services or procedures are subject to benefit coverage, limitations and exclusions as described in applicable plan coverage guidelines.

Checking Authorization Status Online

The Plan encourages you to check the status of your authorization requests online via our secure website at www.wellcare.com.

Simply log in and access the *Check Authorization Status* area. For the *Find By* menu, filter your search criteria by *Provider ID* or *Member ID*.

In the *Provider ID* or *Member ID* box (depending on the option chosen above), enter the appropriate number. Please note that you can click *Look Up Provider* or *Look Up Member* if you do not know the ID number.

Select one of the service date ranges from within the drop-down box or enter any 30-day date range in the *From* option.

Click the *Find Authorizations* button. The results are displayed at the bottom of the screen.

Filing a Claim

Claims, both paper and electronic, should include all necessary, complete, correct and compliant data including:

- Current CPT and ICD-9 (or its successor) codes;
- TIN;
- NPI numbers; and
- Provider and/or practice name(s) matching the W-9 initially submitted to the Plan.

The Plan encourages providers to submit claims electronically via **Electronic Data Interchange (EDI) or Direct Data Entry (DDE)**. This is less costly than billing with paper and, in most instances, results in quicker claims processing.

Electronic Claims – EDI

Providers should follow the HIPAA transaction and code set requirements as found in the National Electronic Data Interchange Transaction Set Implementation Guides that are available at www.wpc-edi.com. EDI claims should:

- Be in the ANSI ASC X12N format, version 4010A, or effective **January 1, 2012**, version 5010;
- Be on the nationally accepted 837 file format;
- **Include Payer ID 14163 on claims submissions; and**
- **As applicable, include Payer ID number 59354 on claims encounter submissions.**

Fee-For-Service Clearinghouse Submitters

All Fee-for-Service (FFS) providers and provider vendors must send claims through a clearinghouse. The Plan is contracted with RelayHealth, a division of McKesson, as our sole source clearinghouse to manage EDI connectivity between the Plan and our providers. **The Plan only accepts electronic claims through RelayHealth.**

If your vendor (i.e., practice management system, billing service or clearing house) is not connected to RelayHealth, we strongly encourage you to contact them directly and request that they establish this **FREE** connection. Upon confirmation from your vendor of continued electronic claims submission to the Plan via RelayHealth, no further action is necessary.

If you have any questions regarding submission of EDI transactions directly through RelayHealth, refer to your Quick Reference Guide for contact information for providers and vendors.

Real Time Services

Availity, Med Data, RelayHealth and Emdeon provide real-time Eligibility (270/271) and Claim Status (276/277) services.

Electronic Claims – Direct Data Entry (DDE)

Via www.wellcare.com

Registered users can log on and directly enter professional and/or institutional claims and encounters into the Provider Portal. Once logged on, select the *Claims* tab, and then click on *Claims Submission (single)*. Follow the prompts to complete your individual claims or encounters submission.

Via MD-Online

Online by registering at www.mdol.com/wellcare. Once logged on, follow the prompts to complete your individual or batch claims encounters submissions.

Paper Claims

The Plan follows the Centers for Medicare & Medicaid Services' (CMS) guidelines for paper claim submissions. Since **October 28, 2010**, the Plan accepts only the original "red claim" form for claims and encounter submissions. The Plan no longer accepts handwritten, faxed or replicated claims forms.

For more information on claims submissions, clean claims, timely filing guidelines and encounter data submission, refer to the *Claims* section of the Provider Manual, which can be accessed at www.wellcare.com/Provider/ProviderManuals.

For further instructions for both paper and EDI claim submission, including access to the EDI Companion Guides, visit www.wellcare.com/Provider/ClaimsUpdates.

The Plan's EDI team can be contacted at EDI-Master@wellcare.com.

For information regarding corrected claims or checking the status of a claim, please refer to the Provider Manual.

Encounters Submission

Delegated vendors and providers are required to submit encounters. Encounters may be submitted electronically via:

- The Plan's preferred clearinghouse, RelayHealth;
- The Plan's Secure FTP (SFTP) process; or
- The Plan's Direct Data Entry (DDE)

Secure File Transfer Protocol (SFTP)

Refer to the Plan's ANSI ASC X12 837I, 837P and, 837D Health Care Claim/Encounter Institutional, Professional and Dental Guides for detailed instructions on how to submit encounters electronically using SFTP. The Companion Guides are located on our website at www.wellcare.com/Provider/ClaimsUpdates.

For more information on submitting encounters through our preferred clearinghouse, contact RelayHealth. Refer to your Quick Reference Guide for contact information. For more information on submitting encounters via DDE, refer to page 5 of this guide.

Strategic National Implementation Process (SNIP)

All claims and encounter transactions submitted via paper, direct data entry (DDE) or electronically will be validated for transaction integrity/syntax based on the SNIP guidelines. The SNIP validations used by the Plan are available on our website at www.wellcare.com/Provider/ClaimsUpdates and in the EDI Companion Guides, which may be a helpful resource to share with your billing vendor or clearinghouse.

Checking Claim Status Online

The Plan encourages you to check the status of your claims online via our secure website at www.wellcare.com.

Simply log in and access the *Check Claims Status* area. For the *Find By* menu, filter your search criteria by *Provider ID*, *Member ID* or *Claim Number*.

In the *Provider ID/Member ID/Claim Number* box (depending on the option chosen above), enter the appropriate number. Please note that you can click *Look Up Provider* or *Look Up Member* if you do not know the ID number.

Select one of the service date ranges from within the drop-down box or enter any 30-day date range in the *From* option.

Click the *Check Claim Status* button. The claim results are displayed at the bottom of the screen.

Filing an Appeal

Authorization-related and non-authorization-related claims may be denied. For examples, refer to the *Provider Resource Guide*.

The Plan encourages providers to first contact our Provider Services team to resolve any issues that may arise before initiating the appeals process. To file an appeal, refer to your Quick Reference Guide for applicable addresses and fax numbers. The Plan will process and finalize an appealed claim to a paid or denied status within 30 calendar days of receipt of the appealed claim.

Contacting Us

The Plan's and our vendors can be contacted in a variety of ways. Refer to your *Provider Resource Guide* and/or your Quick Reference Guides for contact information.

