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SmartCare

Provider Direct Claim Entry
User Manual

September 30, 2026

www.ceicmh.org

This guide includes instructions for contracted providers to enter claims directly into CMHA-CEI's Electronic Health Record (EHR) system. It also includes a review of other information that providers can view within the SmartCare EHR.

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Access to Smart Care

How to Obtain a User Account

To obtain a user account to log into SmartCare and enter claims, each user/employee must contact Providersupport@ceicmh.org to obtain the External Provider Access Request Form. **Please do not share your user name or password with anyone.** Below is a copy of the information that must be completed in order for access to be granted.

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EXTERNAL PROVIDER

ACCESS REQUEST FORM INSTRUCTIONS

In order to be granted access to SmartCare, CMHA-CEI's Electronic Health Record, the attached External Provider User Request must be completed. The External Provider Access Administrator Request may also be required. Please complete the form(s) based on the following information:

External Provider User Request

Each user/employee that will be logging into SmartCare must have this form completed by an Authorized Representative (or an Access Administrator as explained below).

An ***Authorized Representative*** is an individual authorized to sign and/or act on behalf of your organization.

External Provider Access Administrator Request

If the Authorized Representative would like to delegate the responsibility of completing the External Provider User Request(s), the Authorized Representative may choose to complete this form to designate an Access Administrator. The Access Administrator will then have the authority to complete and sign External Provider User Request(s).

*Please note, any External Provider User Request returned to CMHA-CEI that does not have the signature of the appropriate Authorized Representative or the signature of the designated Access Administrator, will be rejected and access will not be granted.

Completed forms must be returned to providersupport@ceicmh.org. For any questions regarding the completion or submission of the attached forms, please contact providersupport@ceicmh.org or (517) 346-8306.

Following submission of the form(s), each new user will receive an email titled, "Security Agreement for CMHA-CEI EHR" with instructions to accept CMHA-CEI's security policy and enable the new account.

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EXTERNAL PROVIDER ACCESS ADMINISTRATOR REQUEST FORM

TYPE OF REQUEST: NEW CHANGE TERMINATE

DATE OF REQUEST: _____

PROVIDER/ORGANIZATION NAME(S): _____

_____

ACCESS ADMINISTRATOR FIRST NAME: _____

ACCESS ADMINISTRATOR LAST NAME: _____

ACCESS ADMINISTRATOR EMAIL ADDRESS: _____

ACCESS ADMINISTRATOR PHONE NUMBER: _____

ACCESS ADMINISTRATOR TITLE/ROLE: _____

WILL ACCESS ADMINISTRATOR REQUIRE SYSTEM ACCESS? YES NO

WILL ACCESS ADMINISTRATOR REQUIRE CLINICAL REVIEW? YES NO

If yes, reason: _____

WILL ACCESS ADMINISTRATOR BE SUBMITTING 837 FORMAT CLAIM FILES? YES NO

The intent of this request form is to monitor who is accessing client information which is protected under HIPAA laws. By utilizing the Provider Access System, you agree to notify Community Mental Health Authority of Clinton, Eaton, and Ingham Counties immediately upon termination of an employee with access to this system.

Any request forms submitted without the proper Authorized Representative's / Access Administrator's signature will be rejected.

_____ _____

Authorized Representative Printed Name **Date**

_____

Authorized Representative Signature

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EXTERNAL PROVIDER USER REQUEST

TYPE OF REQUEST: NEW CHANGE TERMINATE

DATE OF REQUEST: _____

PROVIDER/ORGANIZATION NAME(S): _____

_____

USER FIRST NAME: _____

USER LAST NAME: _____

USER EMAIL ADDRESS: _____

USER PHONE NUMBER: _____

USER TITLE/ROLE: _____

WILL USER REQUIRE CLINICAL REVIEW? YES NO

If yes, reason: _____

WILL USER BE SUBMITTING 837 FORMAT CLAIM FILES? YES NO

The intent of this request form is to monitor who is accessing client information which is protected under HIPAA laws. By utilizing the Provider Access System, you agree to notify Community Mental Health Authority of Clinton, Eaton, and Ingham Counties immediately upon termination of an employee with access to this system.

Any request forms submitted without the proper Authorized Representative's / Access Administrator's signature will be rejected.

_____ _____

Authorized Representative/Access Administrator Printed Name **Date**

_____

Authorized Representative/Access Administrator Signature

Access Issues

If you are having difficulty logging into the SmartCare system (have forgotten your password and/or disabled your account, etc) please contact Provider Support for assistance:

EMAIL: providersupport@ceicmh.org

TELEPHONE: (517) 346-8306, Chelsea Park
(517) 346-7160, Annette Pepper

Getting Started

Logging In To Streamline

SmartCare supports the use of **Google Chrome**. Please make sure you are always running the SmartCare application in **Chrome** before contacting Provider Support if you are experiencing any issues logging in.

Please enter the URL into your **Chrome** browser window to access SmartCare:
https://streamline.ceicmh.org/smartcare/

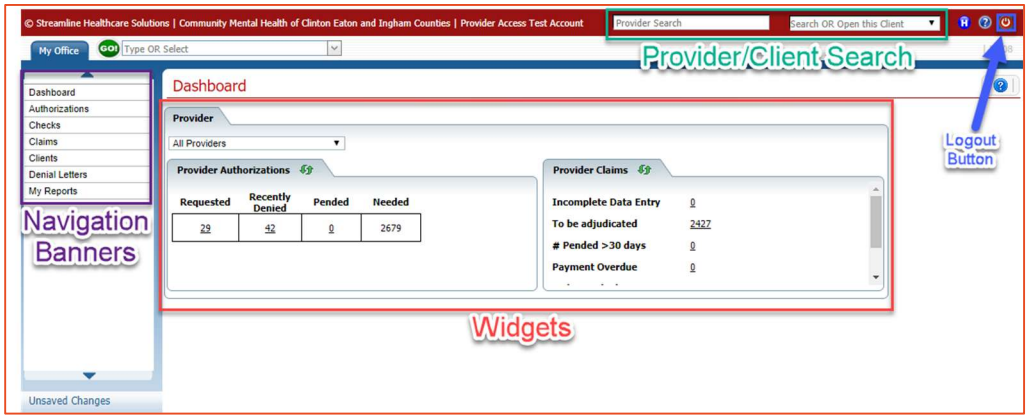


General Navigation

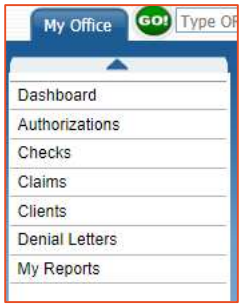
After you have successfully logged into SmartCare, the first screen you will see is the Dashboard.

The main section of the dashboard contains widgets, which provide quick access to important information about your claims. For detailed information regarding what widgets are available and their uses, please see the *Widgets* section below.

SmartCare screens have a common header with 2 search fields. The left search field is for ***Provider Search***, the right drop-down is for ***Client*** searches. Also, to the right is a small red circle to log out of your current session.



The navigation banners on the left side of the screen will take you to various screens used for direct claim entry.



Locating a Client

From the My Office banner:

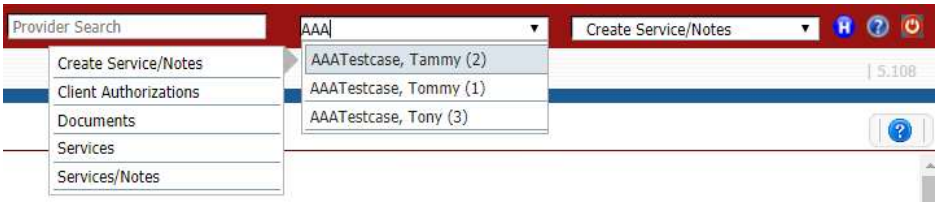
1. Choose Clients from the menu under the My Office tab on the left side of the screen.



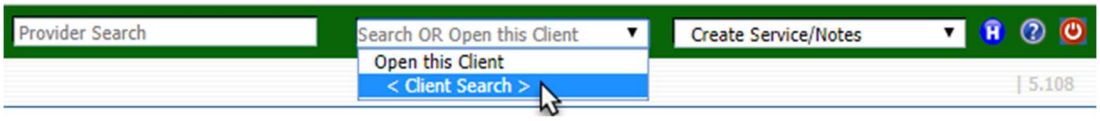
2. On the client list, find the client you want to enter a claim for and click on the client name. Only the clients actively associated with your organization will be visible to you. If, for any reason, you do not see a client that you expect to see on this screen, please attempt the searches described in the next two sections.

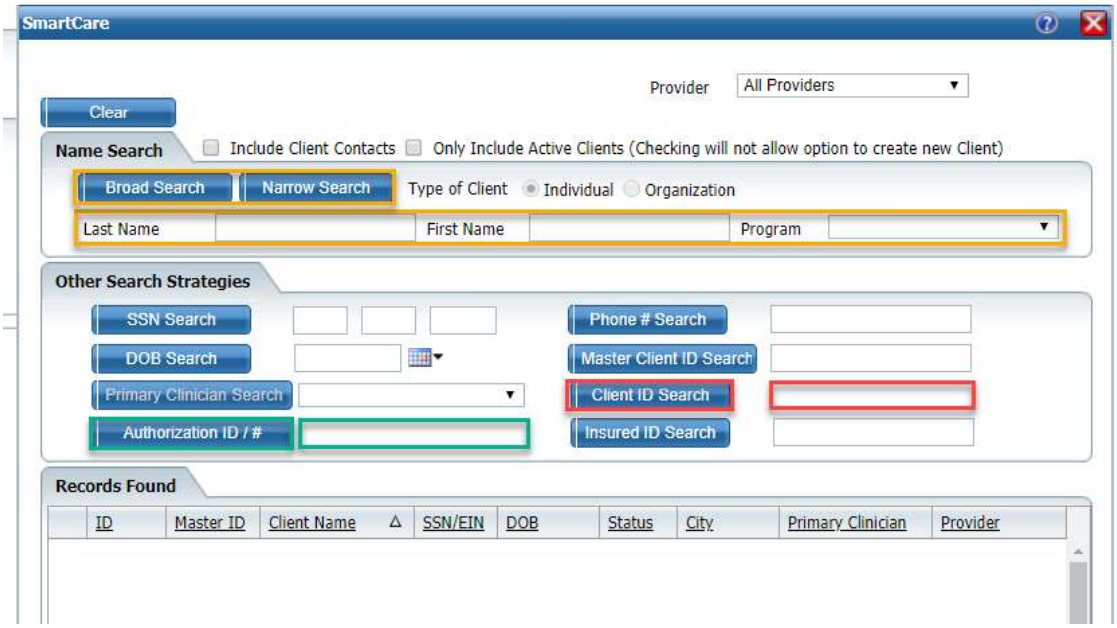
From the 'Search OR Open this Client' box:

1. If the client is active, you can type the client's 'last name, first name' or enter the client's ID number into this search box. If there are multiple results, click on the name of the client you wish to view to launch the client tab.



2. You can also click on the drop-down arrow in the search field and select *<Client Search>*, this will launch the SmartCare search window.





a. You may search for the client by entering your choice of search information and then clicking the corresponding search button next to the information you've entered. Client Search will only use the search criteria for the box next to the button you click. If you type in first name, last name and client id, then click 'Client ID Search', the system will only search by client ID, ignoring the first and last names.

b. From the Records Found list of found clients below, choose the radio button next to the client you want to select and then click 'Select'.

c. **IMPORTANT: If for any reason you are unable to view a client you think you should have access to, please contact Provider Network Support at providersupport@ceicmh.org.**

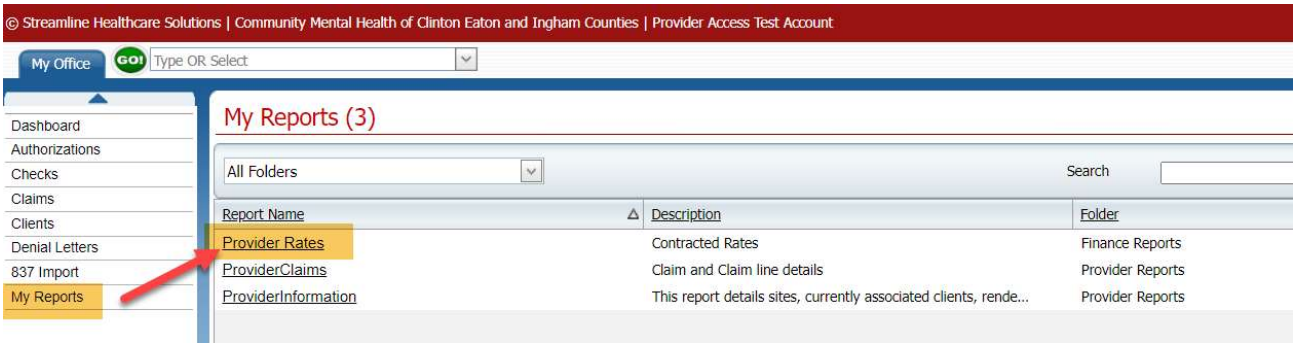
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Viewing Contract Rates Report

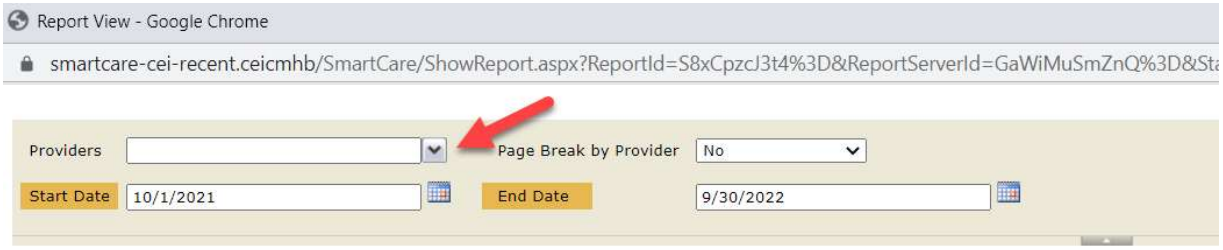
There are two ways providers can view their contract rates that have been entered in Streamline.

My Office > My Reports

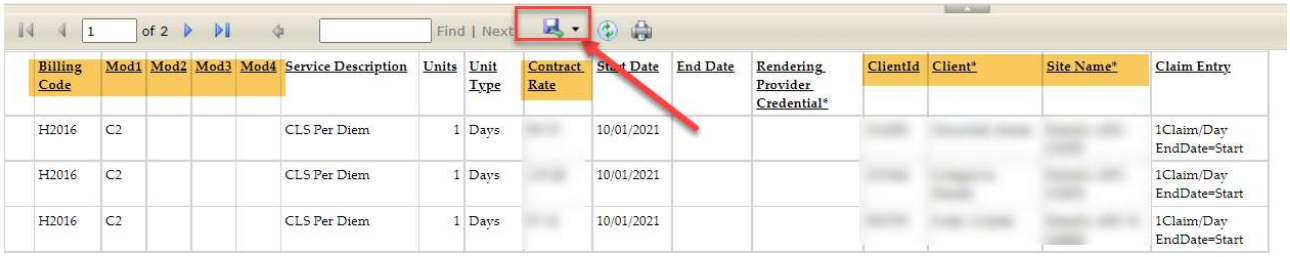
1. Click on the **Provider Rates Report**



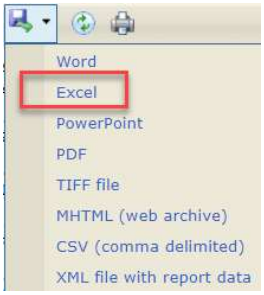
2. Select your Provider Name from the drop-down and enter the Start and End dates for the current fiscal year. Click on the View Report icon on the top right corner of the report.



3. The report will provide you will all approved Billing Codes, Modifiers (which must be entered in the order listed), Service Description, Units, Start and End Date (if applicable), client information and Site ID



4. Click on the drop-down arrow next to the Export Icon to download a copy of this report to Excel. When saving this report, we recommend to "save as" an Excel Spreadsheet:



View Rates by Provider Search

This search option for contract rates is sometimes easier if you are just looking for an individual consumer's rate. This option also allows you to download the information to an Excel file which may be a little easier to format and extract information for some providers.

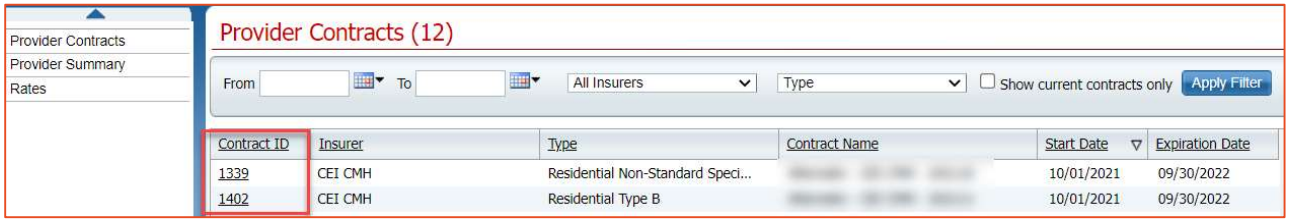
1. Enter your Provider name in the Provider Search field and select to open up a new tab with your provider information.



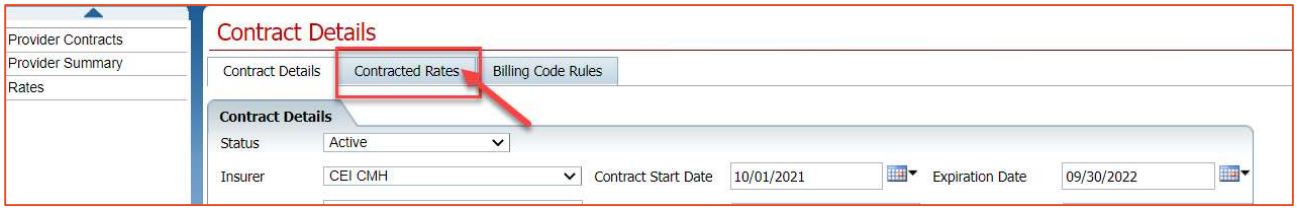
2. Click on ***Provider Contracts***



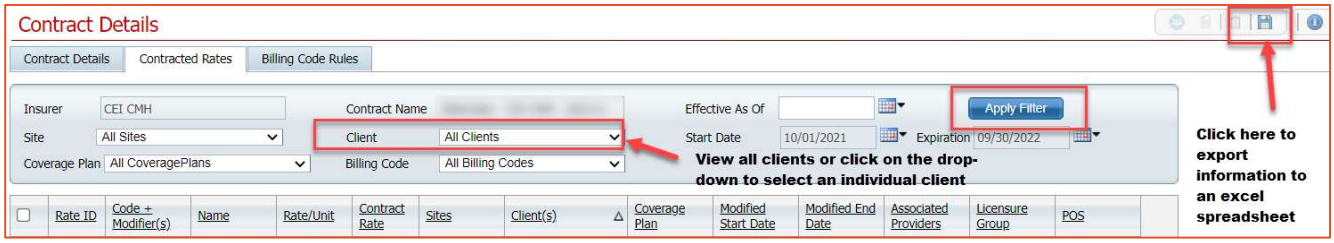
3. Click on the Contract ID number that is underlined for the current fiscal year to open and view the contract rates. NOTE: Some providers may have more than one active contract as shown in the example below:



4. Click on the Contracted Rates Tab



5. In the Contract Details tab, you can filter by All Clients, or select an individual client from the drop-down arrow and apply filter to see rates for only that consumer. NOTE: This information can also be exported to an Excel spreadsheet.

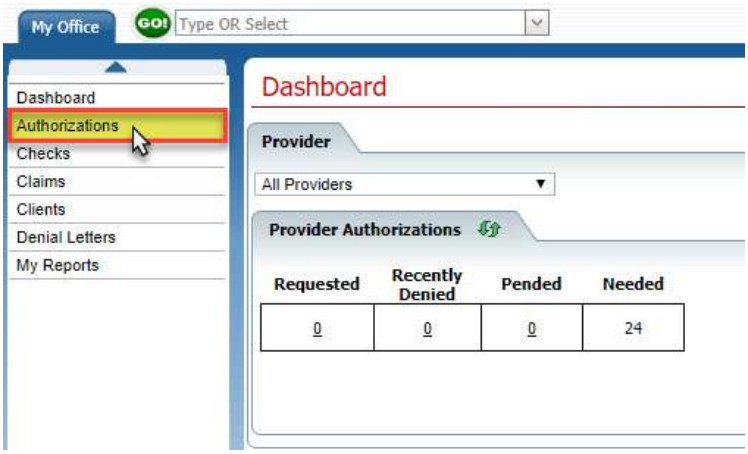


Viewing Client Authorizations Report

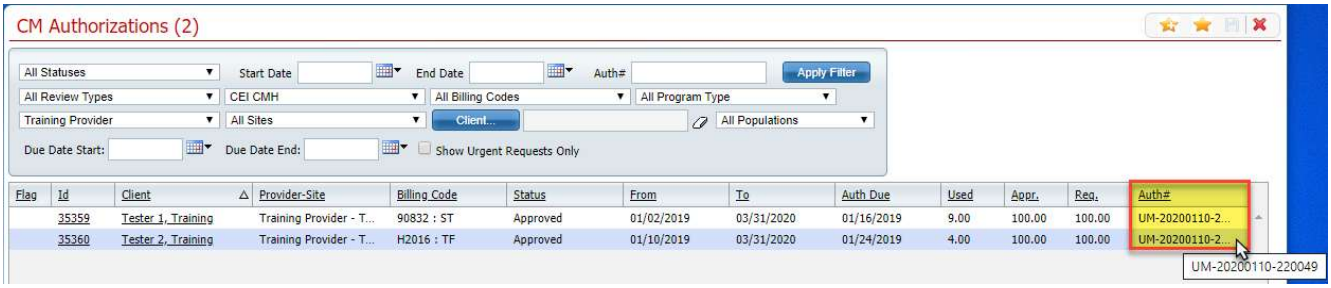
There are two ways you can view client authorizations. Authorizations can be viewed through the ***My Office > Authorizations*** or through the ***Client Record > Authorizations***. Before you begin entering a claim, you must first verify that the authorization has been entered, and what site it has been entered under. **IMPORTANT NOTE**: Authorizations and contract rates must be entered in the same site in order for claims to process correctly.

My Office > Authorizations

1. From the My Office tab, select the Authorizations banner. This will launch the CM Authorizations screen.



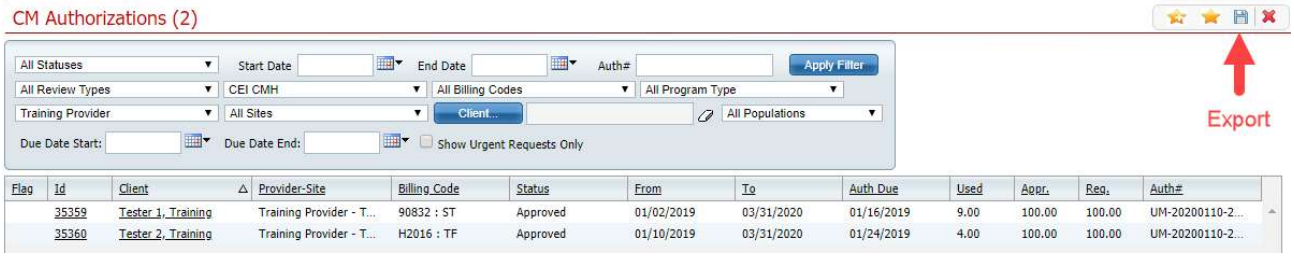
2. Your organizations active authorizations should populate when the screen loads. If they do not, make sure the filters are set to the correct date range and the other filter attributes are not excluding the clients you are looking for. If you have confirmed the filter settings and are still not seeing client authorizations you are expecting to see, work with the client's case manager.



3. If you are unable to view a consumer's authorizations in Smart Care, please contact Provider Network Support at providersupport@ceicmh.org.

4. You also have the ability to export the information on this screen to an Excel spreadsheet for your convenience.

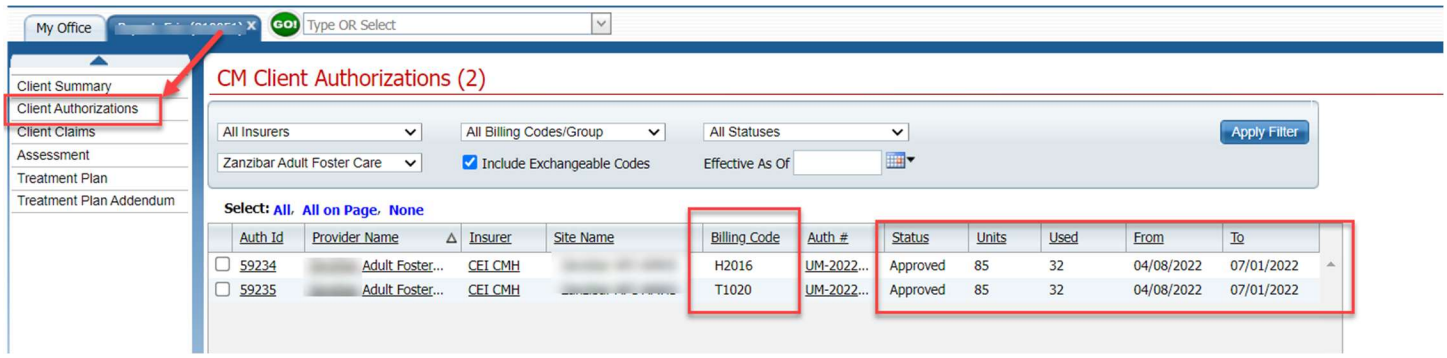
   a. Set the filters to view the authorizations you want to export
   b. Click on the export button in the top right of the authorization screen



   c. This will begin the download of an excel file.
   d. Open the file to view the detail of the client authorizations. Note: This information can be saved for reference. We recommend saving the file as an Excel Workbook.

From Client Record

Once you have opened the client record, click on the banner to the left labeled 'Client Authorizations' to view authorizations entered. From this view you can view all authorizations, or click on the drop-down arrow in the box labeled 'All Billing Codes Group' to select a specific billing code (if desired).

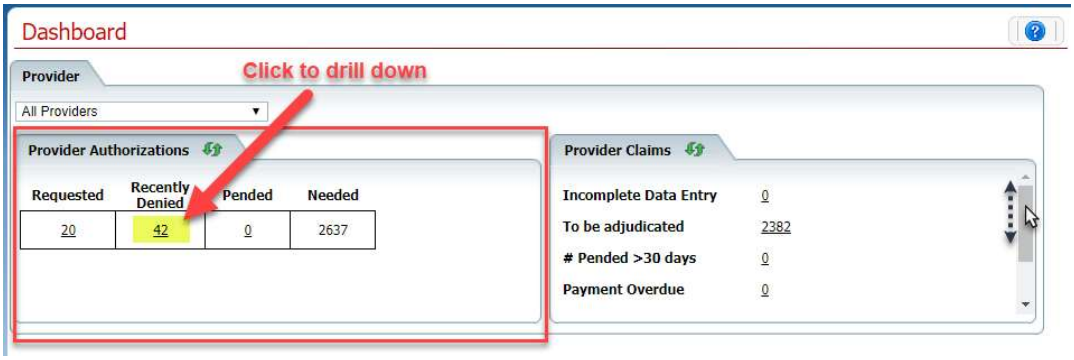


If you notice a gap in the authorization dates or available units left, please refer to the ***Guide on Who to Direct Inquiries To*** at the end of this manual. You may also reach out to providersupport@ceicmh.org for assistance.

Widgets

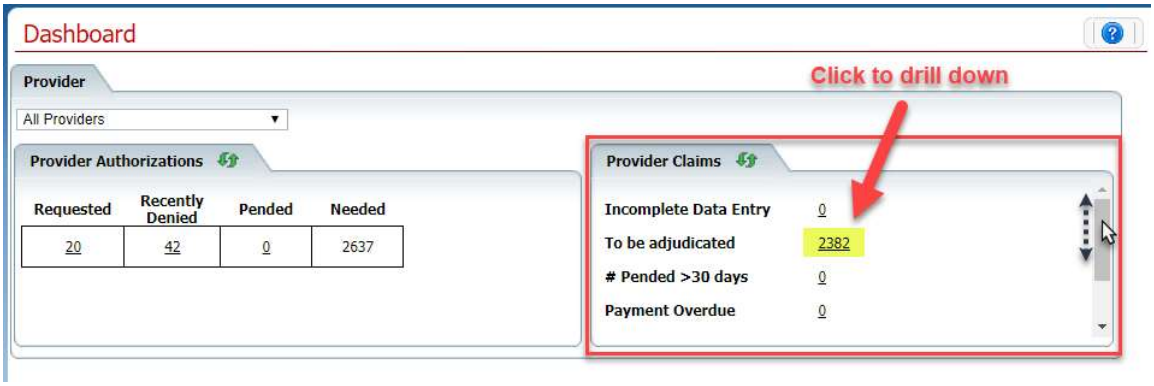
Provider Authorizations

The Provider Authorizations widget provides the user with a snap shot view of the Authorizations in the system by provider site. If applicable, please ensure you have selected the correct site from the Provider drop down list on the widget. To drill down and get more detailed information, click on the underlined metric you are interested in to navigate to a list of the authorizations with the corresponding status. To refresh the widget, click the green arrows button next to the title of the widget.



Provider Claims Widget

The Provider Claims widget provides the user with a snap shot view of the submitted claims in the system by provider site. If applicable, please ensure you have selected the correct site from the Provider drop down list on the widget. To drill down and get more detailed information, click on the underlined metric you are interested in to navigate to a list of the claims with the corresponding status. To refresh the widget, click the green arrows button next to the title of the widget. It is important to note, unlike the Provider Authorizations widget, there is a scroll bar on the right side of the widget, which allows you to scroll down to view additional information.



Entering A Claim

Creating a New Claim

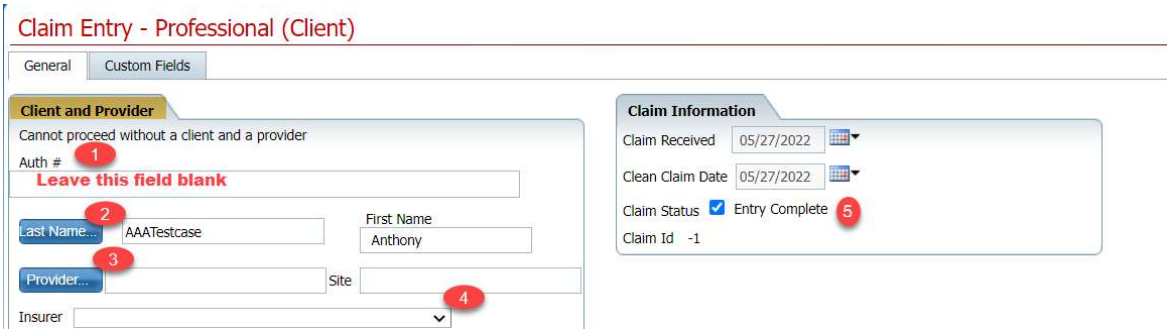
When you select a client, it opens to the Client Claims screen. If you have navigated away from this screen, you can get back to it by selecting the Claims menu option in the My Office banner.)

On the client claims screen, click the **PP** (Professional Provider) button in the top right corner. **NOTE: Do not use the 'I' or 'PI' claim forms as these are for institutional (hospital) claims only.**

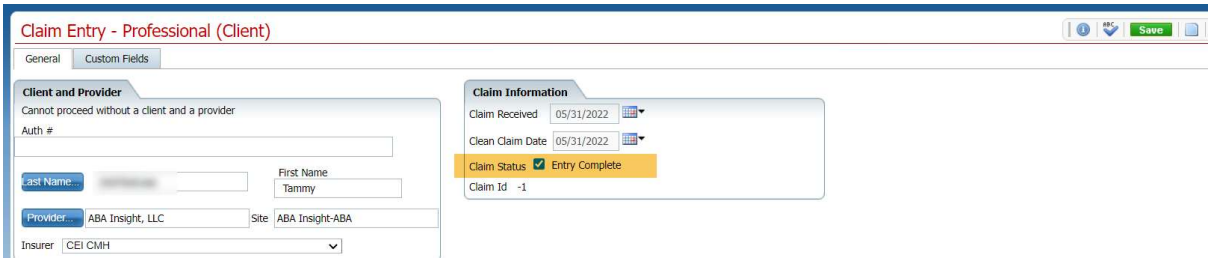


There are basically three (3) sections on the professional claim that you will need to enter information.

Client and Provider information

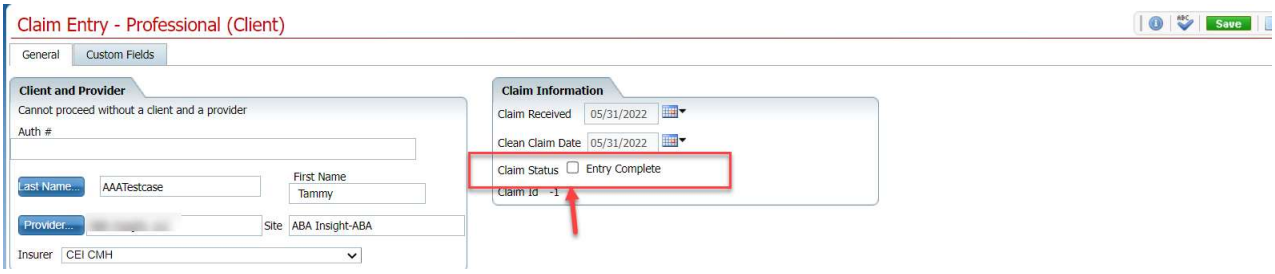


1. **Auth #** - This field should be left blank. It is important to note, however, if you have more than one site, you will want to make sure there is an authorization entered and note the specific site the authorization is created under.
2. **Client name** – The client name will auto-populate to the claim when you open through the client record.
3. **Provider** – Click on the Provider button to select your organization name and site where the authorization and rates have been entered. Some providers may have only one site to choose from, while others may have multiple sites. It is important to know which site to use in order to ensure the claims are processed correctly.
4. **Insurer -** Click on the drop-down arrow to select CEI CMH.
5. **Claim Status -** When you create a new Claim Form the claim status is marked as 'Entry Complete.' Once the claim has been saved it is ready to be processed (Adjudicated).



If you uncheck this box prior to hitting the Save button, your claim will have a status of 'Entry Incomplete' and cannot be processed for payment until you check the box to show complete and save the claim. **PLEASE NOTE**:

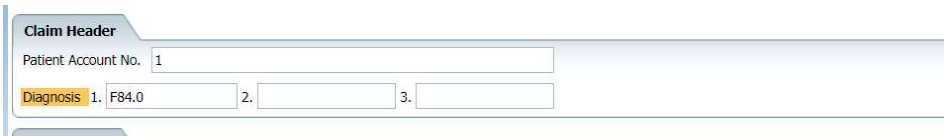
If you are entering multiple claim lines on the same claim form, please keep in mind that you cannot mark the claim as 'complete' the claim until **all** claim lines are ready to be processed.



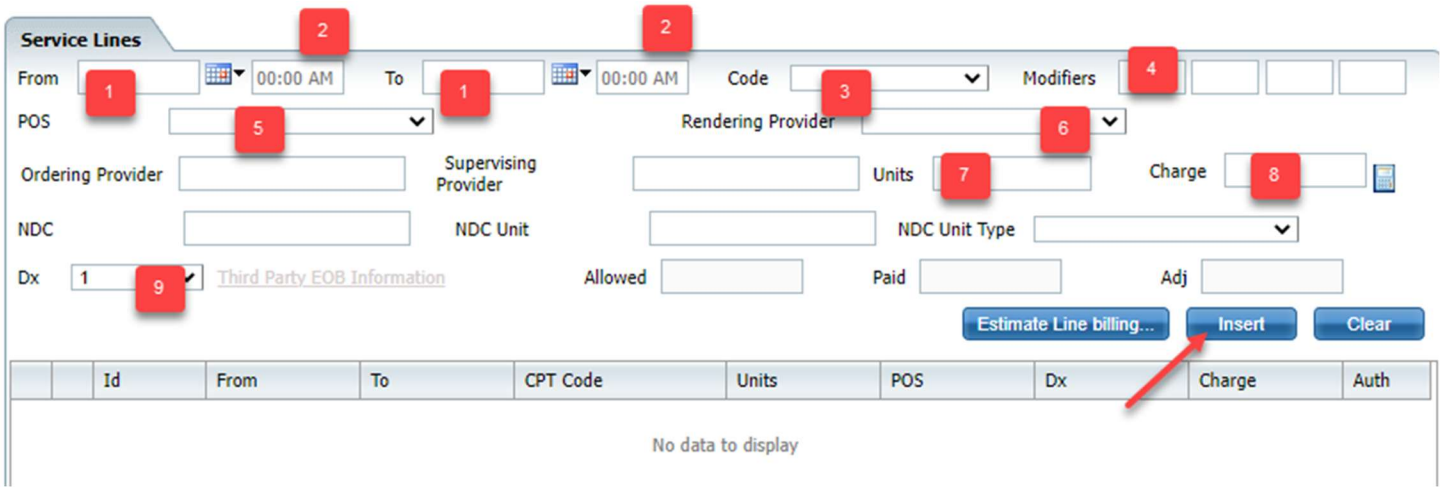
More detailed information on *Claim Statuses* is found in the *Working Claims* section of this guide.

Claim Header

This section automatically populates the diagnosis code(s) that are needed in order to save the claim. If this section is blank, you will need to contact Provider Support for assistance at providersupport@ceicmh.org before proceeding.



Entering Individual Claim Lines for Services Provided

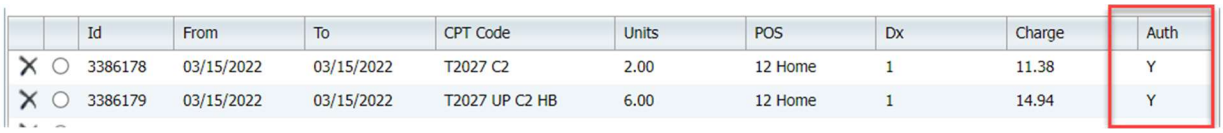


When entering claims, complete the following information as numbered above:

1. Start by entering the date of service in the 'From' field. The 'To' field will auto-populate based on the 'From' field.
2. Enter the start and end times for the service you are billing. If the code you are billing is a one **(1) unit per day** code, you do not need to enter anything in these fields.
3. Enter the billing Code and select it from the drop-down once populated. If you do not select the code from the drop-down, it may affect the information from populating correctly in the claim.
4. Enter the appropriate modifier(s), if necessary. Please refer to the contract rates for the correct modifiers as they must be entered in the order as shown in the contract rates.
5. Enter the Place of Service (POS).
6. Rendering provider information is not required for most direct-entry providers. This field is, however, required for certain billing codes provided for autism services. If you are an ABA provider that is required to enter this information on the claim lines, Provider Support Services will provide you with information and instructions on specific billing codes that do require this information.
7. The number of units are auto-populated based on the From and To dates and Start/Stop times entered.
8. The charge amount is also auto-populated based on the billing code, modifiers, number of Units and contracted rate. If the charge is not calculating correctly, please verify the following information:
    a. Check the contract to see if the billing code and modifier combinations are in the contract and that they have been entered in the proper order on the claim line.
    b. Check the times entered for the 15 minute per unit billing codes to be sure the claim is calculating the correct number of units. **Do not manually override the calculated charge amount**. If the number of units does not calculate correctly based on the service times entered, you may need to adjust the number of units you are billing and the system will update the charge amount accordingly.
    c. **If no charge is populating,** this usually means there is no contract rate in the system or you have selected the wrong Provider/Site for the billing code. **Do not save the claim** at this point. You will need to reach out to Provider Support Services at providersupport@ceicmh.org for assistance.

9. Dx (Diagnosis) is auto-populated on the claim based on the client's treatment plan.
    a. If a diagnosis does not auto-populate, you will need to reach out to Provider Network Support for assistance. The diagnosis code will then need to be manually entered on the first claim that is entered for the consumer. After the first claim is entered and saved, future diagnoses will auto-populate on claims.
    b. **If you are entering more than one billing code per claim, please make sure to "SAVE" the claim before proceeding with the new billing code. Failure to do so may result in the diagnosis code not auto-populating on the claim line**.

Once the service information has been entered as outlined above for each claim line, click the **Insert** button to add the claim line to the list below. NOTE: If there is a valid authorization for the service entered, the 'Auth' column will have a "Y". If a "N" is displayed, please verify that an authorization has been entered for the consumer.



		Id	From	To	CPT Code	Units	POS	Dx	Charge	Auth
X	○	3386178	03/15/2022	03/15/2022	T2027 C2	2.00	12 Home	1	11.38	Y
X	○	3386179	03/15/2022	03/15/2022	T2027 UP C2 HB	6.00	12 Home	1	14.94	Y

You will need to reach out to the program or case manager for assistance with the authorization if any of the following circumstances apply:

a. No authorization exists or there is a gap in the end date and start date of a new authorization.
b. The authorization was not entered under the correct site for the contracted rate(s).
c. The units available on the authorization have all been used.

If you are unsure as to who to reach out to, please contact Provider Support.

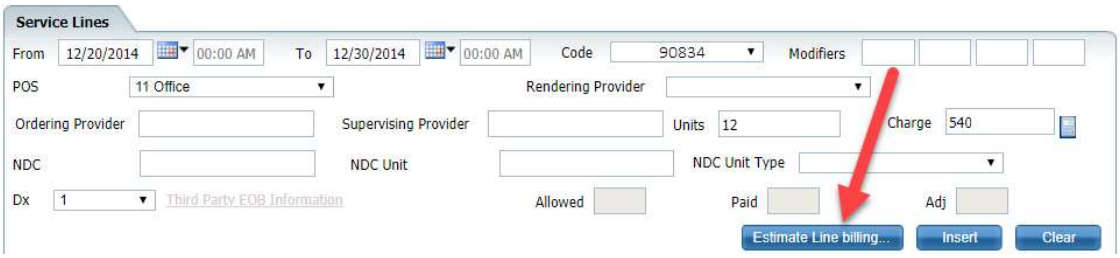
Once all claim lines have been entered on the claim, Save the claim information. Finance-claims will process all claims that are in an "entry complete" status on a weekly basis.

Entering Claim Lines for a "Date Range"

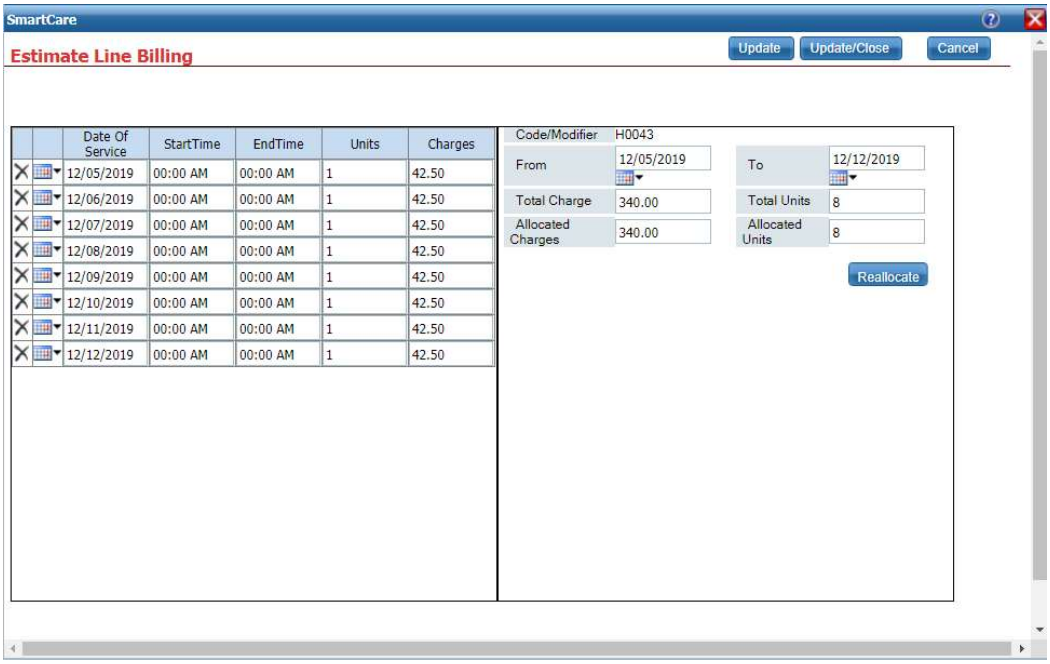
If you are manually entering claims into the system and you are entering services for the same billing code but for multiple days, there is a tool you can use to make entry easier. The tool is called ***Estimate Line Billing***.

1. In the Service Lines section of the claim form:
    a. Enter the 'From' and 'To' Dates which are the start date and the end date to indicate the time frame for which you are entering services.
    b. Enter the code and modifiers that will be billed for all of the services. NOTE: To use this tool, all services must have the same billing code and modifier(s).
    c. Enter the Place of Service (POS).
    d. Enter the total number of units to be billed for the time frame.
    e. Tab through the charge field to populate the total charges for all dates of service that have been entered.

f. Click on the ***Estimate Line Billing*** icon.



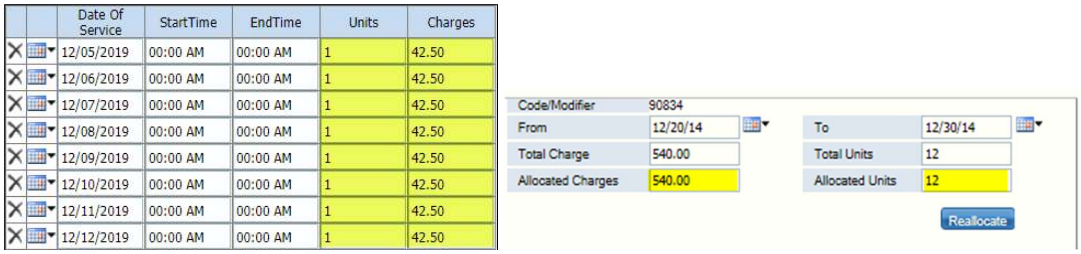
The ***Estimate Line Billing*** pop up window will display. The system will use the total units and total charge amount to break out each date of service on a separate line. Please verify that the number of units and charges calculated correctly. If everything looks correct, click on the ***Update/Close*** button in the top right corner.



NOTE: The following information can be updated in the Estimate Line Billing pop-up:

- You can delete a specific date of service if needed by clicking on the black "X" next to the date of service to remove the charge for that date.

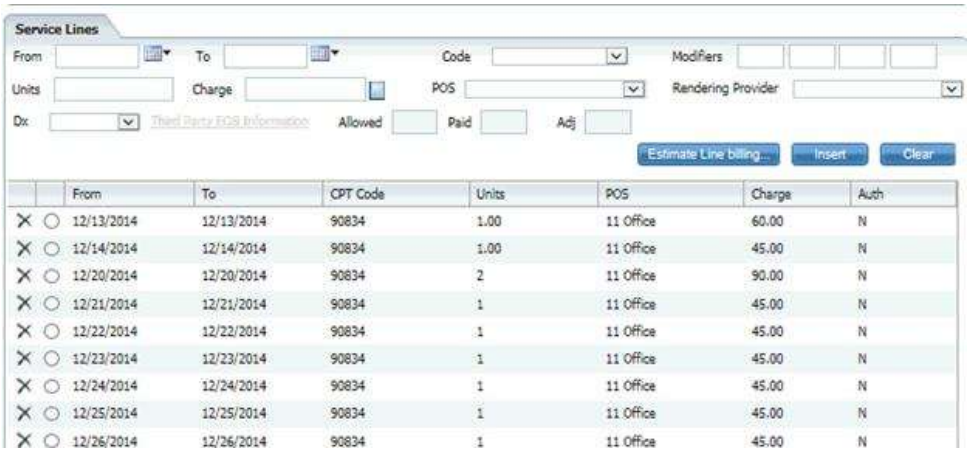
- If you are billing for a code that is paid in 15 min increments, you can modify the StartTime and EndTime if needed. You will need to make sure that the appropriate number of units are reflected for each date of service and verify that the charge amount has updated correctly.



		Date Of Service	StartTime	EndTime	Units	Charges
✕	▦	12/05/2019	00:00 AM	00:00 AM	1	42.50
✕	▦	12/06/2019	00:00 AM	00:00 AM	1	42.50
✕	▦	12/07/2019	00:00 AM	00:00 AM	1	42.50
✕	▦	12/08/2019	00:00 AM	00:00 AM	1	42.50
✕	▦	12/09/2019	00:00 AM	00:00 AM	1	42.50
✕	▦	12/10/2019	00:00 AM	00:00 AM	1	42.50
✕	▦	12/11/2019	00:00 AM	00:00 AM	1	42.50
✕	▦	12/12/2019	00:00 AM	00:00 AM	1	42.50

As changes are made, the ***Allocated Charges*** and ***Allocated Units*** fields will update to reflect the new amount you have entered. The Total Charge and Total Units are the original amounts you started with. If a mistake is made and you want to start over, click on the "Reallocate" button to reset all the values back to the original ones entered.

g. Once you click the Update/Close button, a claim line for each date of service will be created as follows. Click the **Save** button in the top right corner to save your claim.



		From	To	CPT Code	Units	POS	Charge	Auth
✕	○	12/13/2014	12/13/2014	90834	1.00	11 Office	60.00	N
✕	○	12/14/2014	12/14/2014	90834	1.00	11 Office	45.00	N
✕	○	12/20/2014	12/20/2014	90834	2	11 Office	90.00	N
✕	○	12/21/2014	12/21/2014	90834	1	11 Office	45.00	N
✕	○	12/22/2014	12/22/2014	90834	1	11 Office	45.00	N
✕	○	12/23/2014	12/23/2014	90834	1	11 Office	45.00	N
✕	○	12/24/2014	12/24/2014	90834	1	11 Office	45.00	N
✕	○	12/25/2014	12/25/2014	90834	1	11 Office	45.00	N
✕	○	12/26/2014	12/26/2014	90834	1	11 Office	45.00	N

Entering Third Party Payment (EOB) Information for Billable Autism Services

CMHA-CEI is the payor of last resort. As a result, Third Party EOB (Explanation of Benefits) information is required for a claim to pass adjudication when CMHA-CEI is not the primary payer. The following steps must be followed, even if a consumer has private insurance but their policy does not include coverage for autism services. Please feel free to reach out to Finance-Claims@ceicmh.org if you have any questions about entering this information on the claim.

Dual Insurance: Provider is required to determine if the Consumer is dually insured, prior to submitting claims to Payor and at a minimum monthly. In instances when the Consumer has dual insurance (i.e., Blue Cross and Medicaid), the Provider must bill the commercial insurance first. Medicaid shall always be the Payor of last resort. It is the Provider's responsibility to follow all insurance rules and collect directly from the primary insurance. To qualify for any Medicaid benefit, Consumer must be receiving services through the CMH where services are being authorized, and the Provider must first obtain the Authorization Form from the Payor. The Provider must notify the Payors in writing that the Consumer is dually insured. This should occur prior to ABA treatment beginning under the BHT benefit. If requirements are met as described, the Provider must submit the actual Explanation of Benefits ("EOBs") from the primary insurance to the Payor in order to receive consideration of payment through Medicaid. The Medicaid benefit will only reimburse the Provider up to the primary insurance allowed amount or agreed upon contractual rate indicated in this contract, whichever is the less amount. The Provider may not seek nor accept additional or supplemental payment from the Consumer, their family, or other representative when the Consumer is enrolled in the BHT benefit. The Provider must notify the Payor of any changes to the Consumer's primary insurance at any time during treatment

APPLIED BEHAVIORAL ANALYSIS CONTRACT #FY27ABA-1

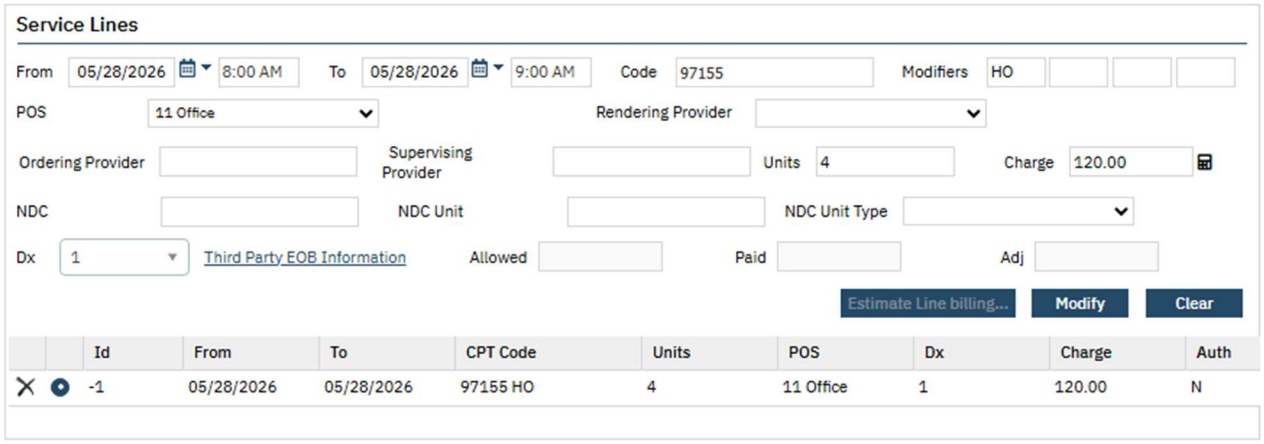
When the amount paid by insurance on the EOB is less than our contracted rate:

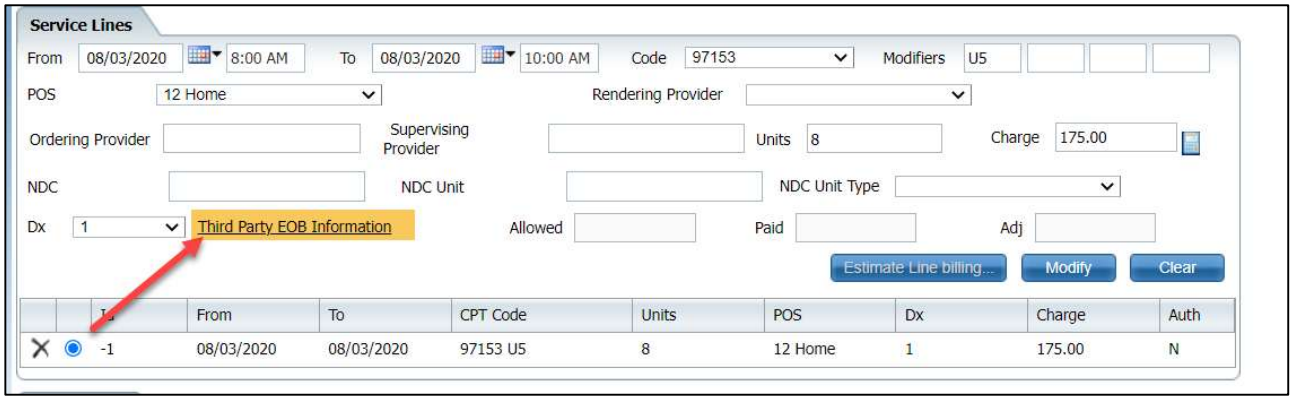
1. After you have entered the claim line information, tab through the charge field, then select "insert" and save.
2. Click on the radio button next to the claim line ID number, and then click on the Third Party EOB Information (see example below).
3. In the pop-up window for ***Claim Entry Payment and Adjustment***, click on the drop-down arrow in the "Payer" box and select the correct insurance.
4. Tab through to the "Previous Payment" box and enter the paid amount as shown on the EOB then select Save. **DO NOT** enter any additional information in the other boxes at this time.

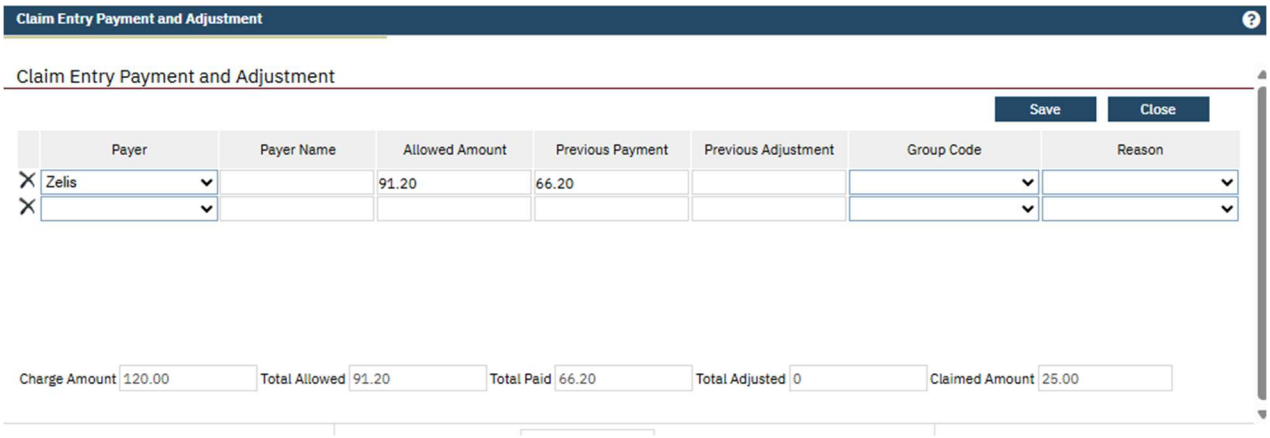
Example:

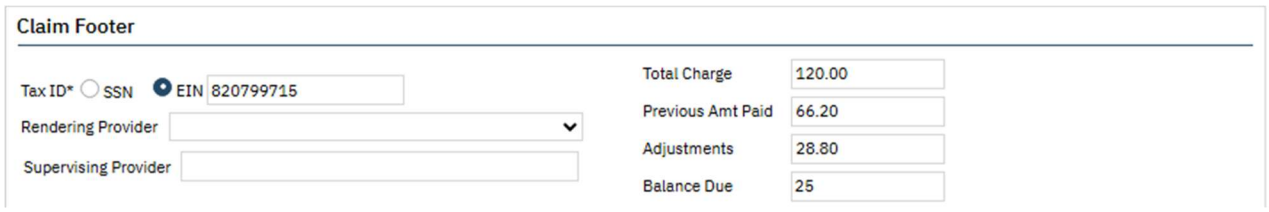
- Our contracted rate is $120.00;
- Private insurance allowed amount is $91.20
- Private insurance paid $66.20
- Balance due to provider should reflect $25.00
- **IMPORTANT NOTE:** If the commercial insurance **paid the same amount as our contracted rate**, the Balance Due to the provider should reflect $0. CMHA-CEI cannot pay more than our contracted rate.

DATE OF SERVICE	DIAG CODE	PROCEDURE CODE AND MODIFIERS	UNITS	BILLED AMOUNT	ALLOWED AMOUNT	DISALLOW/ CONTRACTUAL ADJUSTMENT	EXPLANATION			MEMBER COPAY/ DEDUCTIBLE	ADDITIONAL MEMBER LIABILITY	RISK/ WITHHOLD	OTHER CARRIER LIABILITY	PAID AMOUNT
							BCN CODE	Reason Code	Remark Code					
5/28/2026	F84.0	97155 HO	4	$91.20	$91.20	$0.00				$25.00	$0.00	$0.00	$0.00	$66.20


Service Lines
From 05/28/2026 8:00 AM To 05/28/2026 9:00 AM Code 97155 Modifiers HO
POS 11 Office Rendering Provider
Ordering Provider Supervising Provider Units 4 Charge 120.00
NDC NDC Unit NDC Unit Type
Dx 1 Third Party EOB Information Allowed Paid Adj
Estimate Line billing... Modify Clear
Id From To CPT Code Units POS Dx Charge Auth
-1 05/28/2026 05/28/2026 97155 HO 4 11 Office 1 120.00 N


Service Lines
From 08/03/2020 8:00 AM To 08/03/2020 10:00 AM Code 97153 Modifiers U5
POS 12 Home Rendering Provider
Ordering Provider Supervising Provider Units 8 Charge 175.00
NDC NDC Unit NDC Unit Type
Dx 1 Third Party EOB Information Allowed Paid Adj
Estimate Line billing... Modify Clear
From To CPT Code Units POS Dx Charge Auth
-1 08/03/2020 08/03/2020 97153 U5 8 12 Home 1 175.00 N


Claim Entry Payment and Adjustment
Claim Entry Payment and Adjustment
Save Close
Payer Payer Name Allowed Amount Previous Payment Previous Adjustment Group Code Reason
Zelis 91.20 66.20
Charge Amount 120.00 Total Allowed 91.20 Total Paid 66.20 Total Adjusted 0 Claimed Amount 25.00


Claim Footer
Tax ID* SSN EIN 820799715
Rendering Provider
Supervising Provider
Total Charge 120.00
Previous Amt Paid 66.20
Adjustments 28.80
Balance Due 25

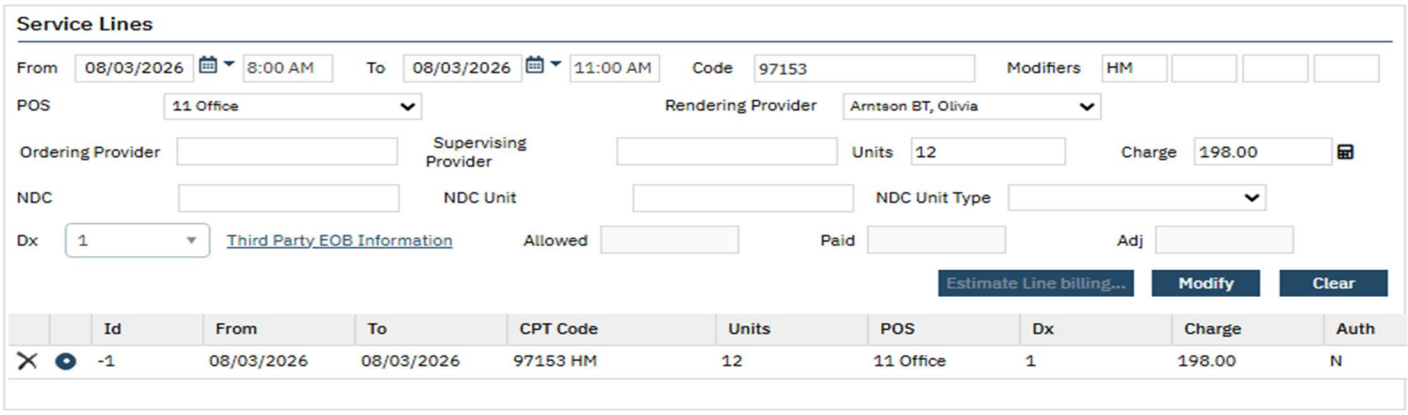
When the "allowed amount" on the EOB is more than our contracted rate:

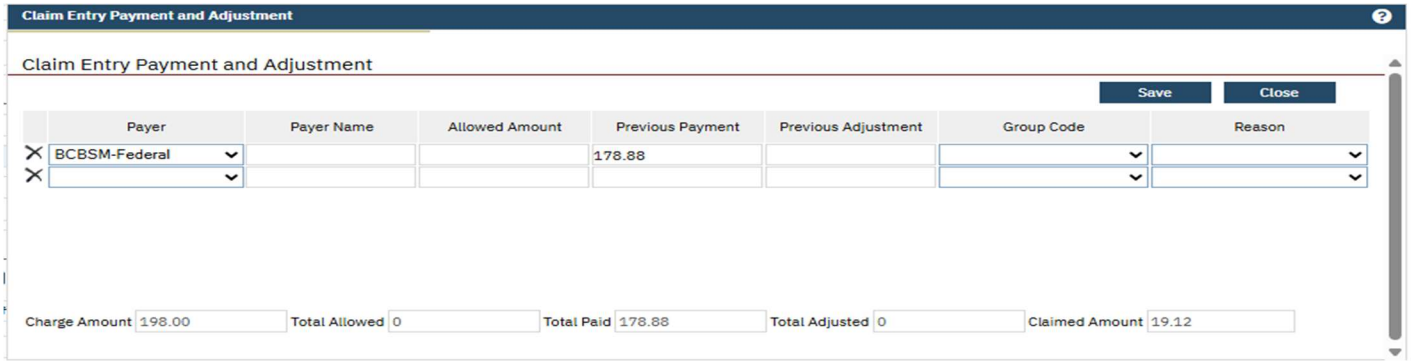
1. Enter the claim line
2. The charge amount will automatically populate the contract rate, tab through then select insert and save
3. Click on the circle in front of claim ID and then click on ***Third Party EOB Information***
4. Click on Payer and select correct insurance
5. Tab to previous payment and enter the amount paid by insurance then tab through (Do not enter any additional information in the other boxes), select save and then select modify
6. Select save in the top right corner
7. Proceed with the next claim line

EOB Example:

- Our contracted rate is $198.00;
- Private insurance allowed amount (Negotiated Amount) is $218.88
- Private insurance paid $178.88
- Balance due to provider should reflect $19.12

SERVICE DATES	PL	SERVICE CODE	NUM SVCS	SUBMITTED CHARGES	NEGOTIATED AMOUNT	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
08/03/20	11	97153	12.0	300.00	218.88	40.00					40.00	178.88



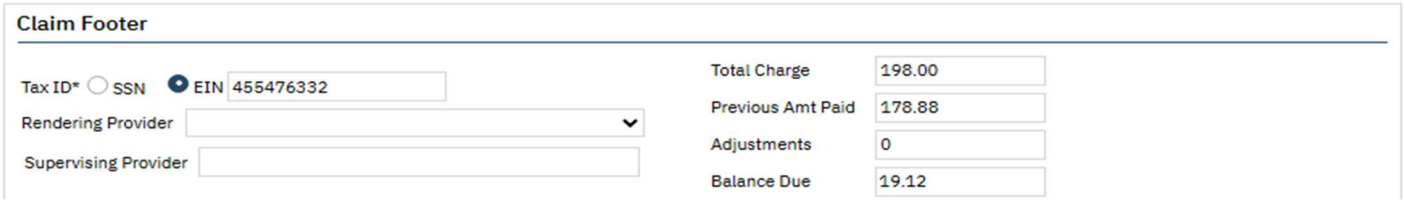


When the "allowed amount" on the EOB is more than our contracted rate, and primary paid in full, please complete the following steps below:

1. Enter the claim line then tab through to the charge field
2. Override the charge amount to reflect the allowed amount on EOB, tab through then select insert and save
3. Click on the circle in front of the claim ID and then click on ***Third Party EOB Information***
4. Click on payer and select the correct insurance
5. Tab to previous payment and enter the amount paid by insurance then tab through (Do not enter any additional information in the other boxes), select save and then select modify
6. Select save in the top right corner
7. Proceed with the next claim line

Please note that the "Allowed Amount" verbiage on EOB's can vary (examples below):
•Negotiated Amount
•Covered Expense
•Supp Info (AMT) with a B6 Code: AMT CODE(S): B6 = Allowed – Actual

Supporting documentation (notes, EOB's, etc.) must be sent via email to ABAassessments@ceicmh.org or by uploading to Dropbox.



Provider Resources including the Direct Claim Entry Manual can be found on our website:
https://www.ceicmh.org/for-providers/provider-resource-library.html#service-163070985135614131

Supporting Documentation

Some providers are required to submit supporting documentation. Please reference your contract for information on this topic and where to submit supporting documentation, if required. All claims entered that require supporting documentation are placed in a "Claim Line Under Review" status and will not be processed (adjudicated) for payment until documentation has been received and verified by the Program. Once information has been reviewed, the Program will release the claims for processing. Finance-Claims Department is unable to release a claim line from under review without the Program's approval.

Client privacy and the security of their record is of the utmost importance. When sending supporting documentation, please ensure that you are emailing them in a secure fashion. If your agency does not have access to a secure email platform you may use CMHA-CEI's secure portal (Zix). Please refer to the Miscellaneous section of this manual for more information on secure emails through Zix or Provider Support Services at providersupport@ceicmh.org.

Claim Submission and Adjudication Process

After a provider has entered claims for a client, Finance-Claims performs a process called adjudication. Claims are adjudicated on a weekly basis and this process scrubs each claim line against a series of validation rules. If the submitted claim passes all of those validations rules, the claim status will update from 'Entry Complete' to 'Approved.'

If a claim fails the validation rules, it will go into a "To Be Worked" denied status. Direct Entry Providers are responsible for monitoring their own claims that are in a 'To Be Worked' status. Please refer to the following 'Denial Reasons' that require your attention:

- All authorized units have already been used
- Authorization cannot be found for some date(s) of service
- Authorization for this claim is pended
- Billing code is not in the Contract
- Billing code not associated with the Member's Plan
- Billing Code rate in contract is less than claimed amount
- Billing code requires Authorization but one does not exist
- Billing code requires end date to equal start date on a claim line
- Billing Code Unit Frequency exceeds Contract Rules
- Billing Code/Revenue Code is not in the Contract
- Claim line exceeds units remaining on Authorization
- Contracted rate is less than the claimed amount
- Diagnosis not entered on claim
- Invalid billing code
- Invalid date(s) of service or number of units
- Invalid diagnosis list
- Member is not eligible for any Plan
- More than one rate was found for this claim line
- Multiple providers exceed the Billing Code Standard Allowed Units
- No contract exists for claimed date of service
- No rate can be found for this claim line
- Overlapping Time for Multiple Providers for the same billing code
- Rendering provider is required for this service
- Same Claim line exists
- Specified rendering provider is not associated with the contract
- Specified rendering provider is not associated with the provider
- Spenddown not met for period covering date of service
- The date of service occurred before the date the monthly deductible was met

Once the problem has been identified and corrected, Providers and/or their billing staff will need to revert the claims back to an entry complete status for editing and reprocessing. Refer to the section on '**Working Claims**' for more detail.

The following denial reasons cannot be corrected without Program approval or the assistance of Finance-Claims

- Documentation is incomplete
- Documentation/corrections not received by due date
- Duplicate claim
- Incorrect client billed
- Incorrect Cost Center/Site billed
- Provider billed in error
- Provider not credentialed
- Rendering provider is not credentialed
- Specified Rendering Provider is not associated with the Provider
- Contract amount cap has been reached
- Claim includes discharge day
- Associated plan is pending
- No contract exists for claimed date of service
- No rate can be found for this claim line
- Claim was received after the period mentioned in the Contract
- Specified Rendering Provider is not associated with the Contract
- Contract Billing Code amount cap has been reached
- Claimed amount exceeds remaining Contact Billing Code amount cap
- Claimed amount exceeds remaining Contact amount cap
- Spenddown not met for period covering date of service
- Dates of service not fully covered
- Waiting for Plan's EOB
- The date of service occurred before the date the monthly deductible was met
- Claim line's approved amount is over budget
- Activity claim line cannot be adjudicated without an associated bundle claim line
- Bundle claim line does not have the correct associated claim lines to bill

Working Claims

All Direct Entry providers are responsible for reviewing their claim statuses on a regular basis. Claims that are in a "To Be Worked" status have been processed and denied because the claim line(s) did not pass the system without error. Providers must review the denial reasons to determine what needs to be corrected and who to reach out to for assistance if needed. Any questions you may have in regarding this topic, can be directed to Finance-Claims@ceicmh.org

Understanding Claim Statuses

In this section you will find explanations of the statuses that are applied to claim lines throughout the SmartCare Claims Process. Providers will use these statuses to determine the outcome of the adjudication process and work their claims.

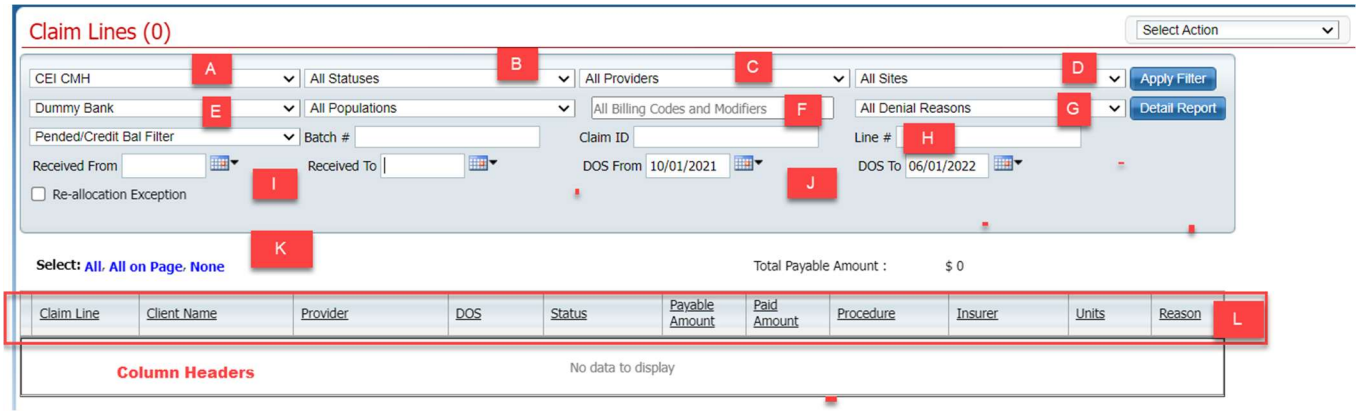
Status	Explanation
Entry Incomplete	Entry Incomplete status denotes the "Entry Complete" box has NOT been checked on the claim entry form. Claims will not be adjudicated or paid while in this status.
Entry Complete	Claim Lines with the status of Entry Complete have the "Entry Complete" box checked on the claim entry form and the claim is ready to be adjudicated (as long as the "Do Not Adjudicate" box is NOT checked on the claim line) and should process during the next adjudication process. A claim MUST be in this status if you need to make a change to a claim line.
Approved	Claim Lines with the status of Approved have gone through the adjudication process and met all the requirements to be paid. Claims in this status will be paid during the next claims payment cycle.
Denied	Denied statuses that cannot be corrected will include: Duplicate, incorrect provider/site, provider billed in error, wrong consumer/patient. Do not use this status if you are looking to see if there are claims that need to be worked so they can be reprocessed for payment. Please refer to the "To Be Worked" denied status below.
To Be Worked	Claim Lines in a Denied status that have gone through the adjudication process and are missing one or more requirements for payment. The system will indicate the reason(s) for denial which may include one or more of the following: billing code requires authorization, partially approved, overlapping times, no rate can be found, billing code in contract is less than claimed amount. Providers will need to work on these claims to correct the identified issues to get the claim to approve for payment. These claims must be reverted back to Entry Complete status once the errors have been corrected in order to make the necessary changes.
Partially Approved	Partially Approved status means the claim has gone through the adjudication process, has met all the requirements to be paid but is not paying the full charged amount in the claim. The reason for this is usually due to the charge amount being greater than the contracted amount with the provider. It could also mean that the units on the authorization have all been used. Claims in this status will not be paid until the next claims payment cycle in order to allow providers to look into the reason for partially approved.
Pended	Pended status means the claim has been through the adjudication process but was not approved/partially approved because of missing information. This claim will NOT be paid. The primary reason for a pended claim is the provider has not included third party payment information for the claim and/or the provider did not check "Previous Payer EOB Received" checkbox after entering the third-party payer information in the claim line. Spenddowns are automatically pended and will be manually adjudicated/completed.
Paid	Claim Lines with the status of Paid have been through the adjudication process, have been approved or partially approved. It has also been through the payment process and a check/EFT has been processed or in the processing of being issued to the provider. Claims are processed and paid/deposited on a weekly basis (every Friday).
Void	If a claim was entered in error and it is not able to be corrected, it may be voided. The system treats a voided claim as if it were never entered.

Reviewing/Monitoring Entered Claims

1. To view all submitted claims, select 'Claims' banner under the My Office tab on the left side of the screen. This will take you to the Claim Lines page.



2. In the Claim lines page, you will need to select your desired. These filters are also available in the Client Claims screen.



   a. **Insurer** – please select 'CEI CMH'
   b. **All Statuses** – Providers have the option to view claims based on the status of the claim(s). Once you have selected a status, click on the 'Apply Filter' button in the top right corner for results. Below is a complete description of each claim status that is available for you to select. The statuses we have highlighted in red are the most common filters that will be used: by most providers:
      - **All Statuses** - selecting this status will give you all claim lines, regardless of status. Be careful when using this status that your date range is not too large as it may take a long time to return data or you may even time out and not get any data returned. Also, you are not able to apply some mass functions (such as revert, mark re-adjudicate, or unmark Needs to be worked) using the appropriate icon when in this status;
      - **Entry Incomplete –** this means the "Entry Complete" box has NOT been checked on the claim entry form. Claims in this status WILL NOT be adjudicated or paid;
      - **Entry Complete –** this means the "Entry Complete" box was checked on the claim entry form and the claim is ready to be adjudicated;
      - **Approved –** this means the claim has gone through the adjudication process and has met all the requirements to be paid. Claims in this status will be paid during the next claims payment cycle;

- **Denied –** this means the claim has gone through the adjudication process and has been denied. Please note, this status includes ALL claim denials, including claims that have been hard denied are in 'final status' that cannot be reverted and reprocessed without contacting Finance-Claims. Please refer to the 'To Be Worked' status below for claims that need to be worked in order to be reprocessed for payment.
- **Partially Approved –** this means the claim has gone through the adjudication process, has met all the requirements to be paid but is not paying the full charged amount in the claim. The reason for this is usually due to the charge amount being greater than our contracted amount with the provider, or it could mean that the number of authorized units has been exhausted. Claims in this status will be paid during the next claims payment cycle;
- **Paid –** this means the claim has been through the adjudication process, was approved or partially approved, has been through the payment process and a check/EFT has been (or will be) issued to the provider;
- **Pended –** this means the claim has been through the adjudication process but was not approved/partially approved because it requires manual review and approval by Finance-Claims.
- **Void** – Voided claims can be viewed but cannot be edited or reprocessed.
- **To be Adjudicated** – This status is the same as 'Entry Complete';
- **To be Paid** – This status is the same as 'Approved';
- **Approved and Partially Approved** – pulls claim lines with either approved or partially approved statuses;
- **Denied and Partially Approved** – pulls all claim lines with either denied or partially approved statues;
- **To re-adjudicate** – This status is not used at CEICMH
- **Do Not Adjudicate** – pulls claim lines that have "Do Not Adjudicate" checkbox checked in the claim line. This status is not used at CEICMH;
- **To be Worked** – This status shows all claims that the provider needs to work to correct issues so approval and payment can be made. The system will indicate the reason(s) for denial. You will need to work on these claims to correct the identified issues prior to reverting the claims back to an 'Entry Complete' status for re-adjudication.
- **Payment Overdue** – not applicable for providers – do not use;
- **Denial Letters Not Sent** – not applicable for providers – do not use.

c. **All Providers** – providers are limited to only their provider option. If your provider name does not display appropriate, click on the drop to select or re-select;
d. **All Sites** – providers with multiple sites will have the option for All Sites or individual sites;
e. **All Bank Accounts** – This should automatically default to 'Dummy Bank';
f. **All Billing Codes and Modifiers** – Selection is not necessary, however, you may choose to select a billing code/modifier combination to further reduce your results;
g. **All Denial Reasons** – Selection not necessary, however, you may choose to select a specific denial reason to further reduce your results while working claims. Click on the down arrow button next to the box to see your options to choose from;
h. **Line #** - This refers to a specific Claim Line #. Use this filter if you want to look at a specific claim line;

i. **Received From and Received To** – This will auto-populate with dates and may affect your search results. We recommend that you delete the dates from these fields;
j. **DOS From and DOS To –** use this date to set the start date of services to be included in the returned data;
k. Once results have been applied, you have the option to select a desired claim line, multiple lines, or you can use the blue hyperlinks to review **All, All on Page or None**
l. Once results have been applied, you can click on a column heading to group by patient (alphabetical), or sort by DOS (ascending or descending), Procedure Code (ascending or descending) or Reason (of denial alphabetically). Anything displayed under the results that is underlined is a link to open the claim line/claim entry form or client record.

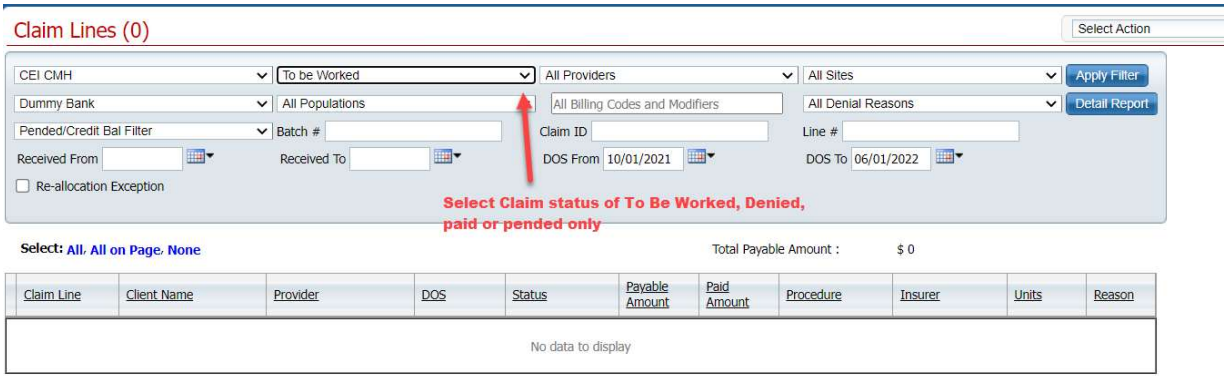
Reverting Claims Back to 'Entry Complete' for Editing

Before you can modify a claim line that has already been processed (adjudicated) and is currently in a '***To Be Worked, Denied***, ***Paid*** or a ***Pended'*** status, the claim line(s) must be reverted back to an "***Entry Complete***" status. This section explains how to revert a single claim line or multiple claim lines at one time.

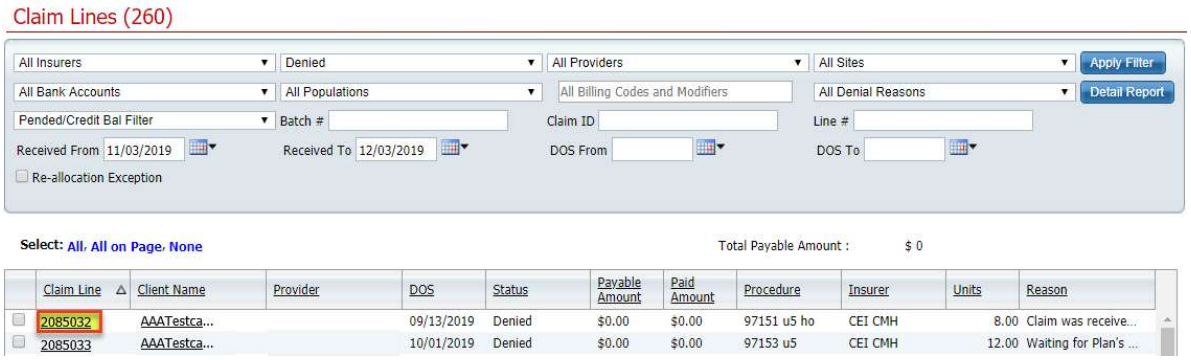
Claims that are in an "***Approved or Partially Approved***" status should **NEVER** be reverted as this may cause issues with the payment process and cause delays in payments. **If an error is found while a claim is in a status of "Approved or Partially Approved", please contact Finance-Claims for assistance at finance-claims@ceicmh.org**

Reverting a Single Claim Line

1. Set filters as needed to identify claims that need to be reverted.



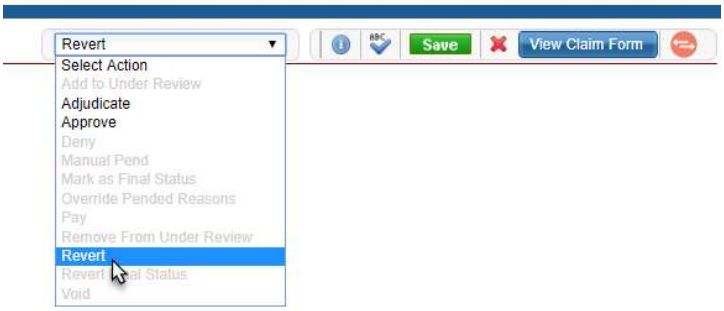
2. In the results grid, under Claim Line Id, click on the claim line number you want to work. This will launch the Claim Line Detail screen.



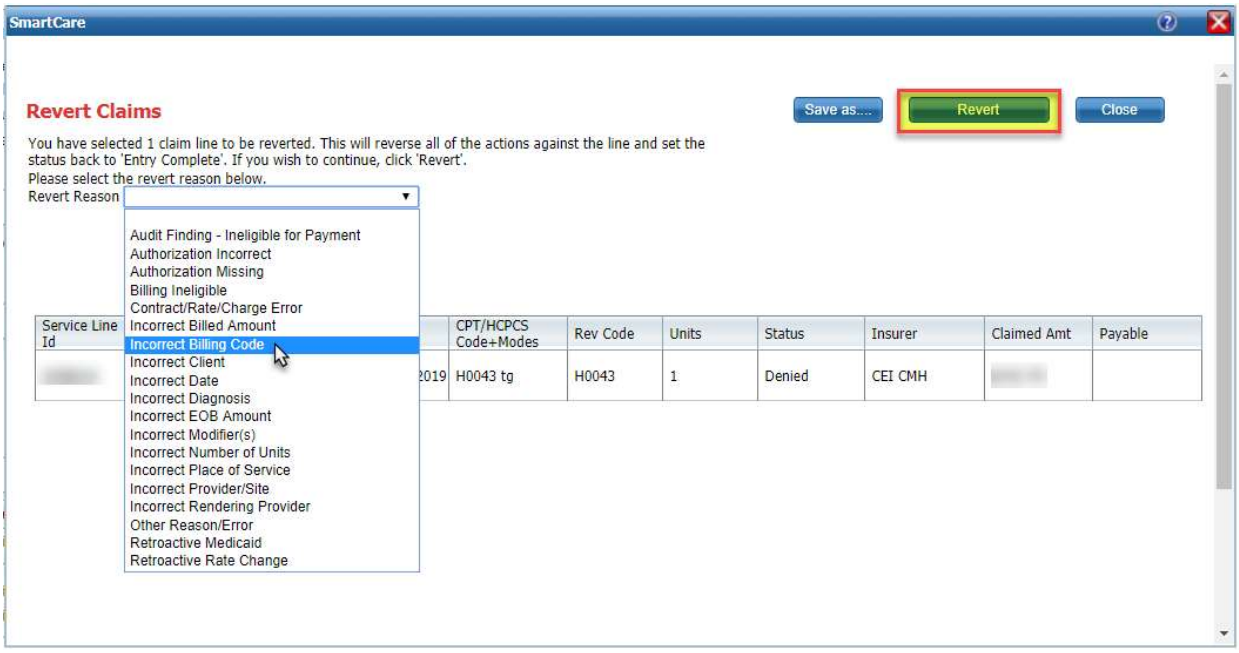
3. Confirm that you have selected the Claim Line you want to revert. If not, hit the X on the banner to navigate back to the Claim Lines List page.



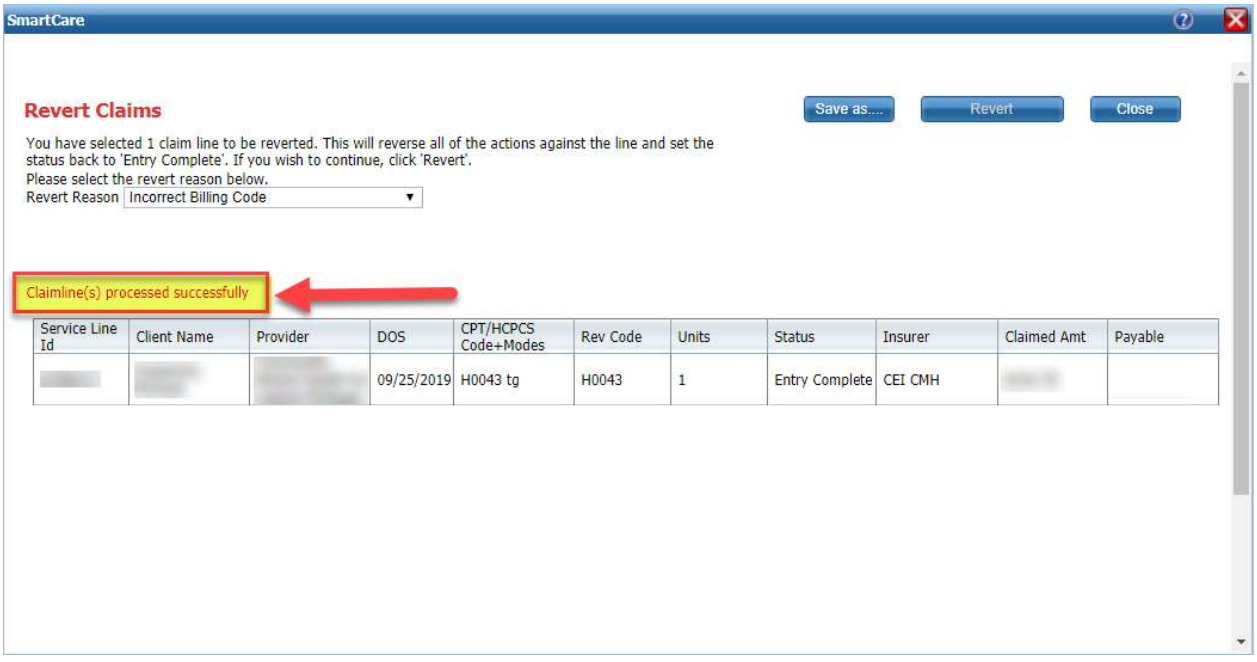
4. Use the Action drop down and select 'Revert.' If the claim line doesn't meet the requirements to be reverted, this selection will be grayed out.



5. The Revert Claims pop-up will display. Make the applicable selection on the revert reason drop down and click the revert button.

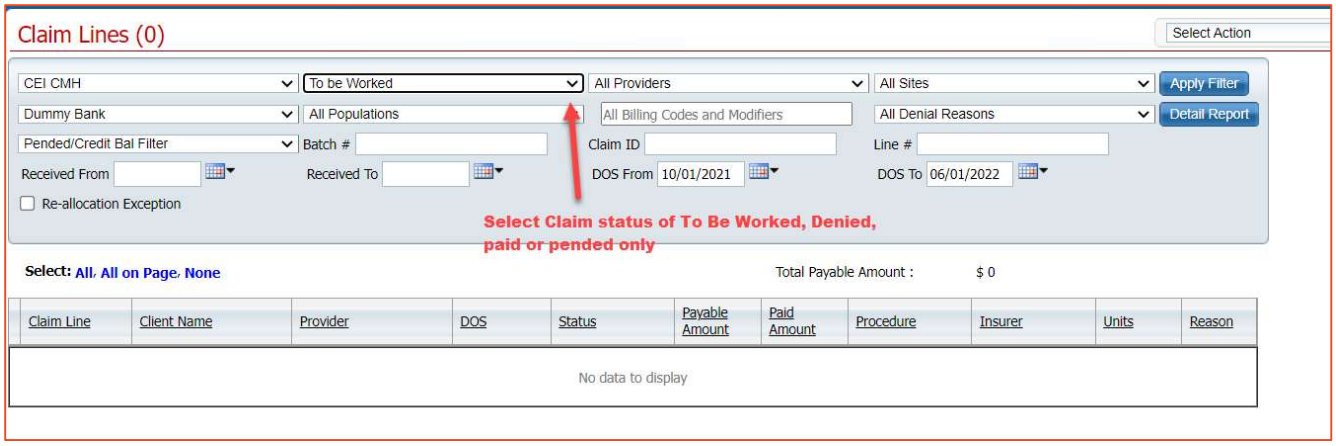


6. After clicking the Revert button, you will receive a message, "*Claimline(s) processed successfully*" and the status will update to Entry Complete.



Reverting More Than One Claim Line Back to "Entry Complete" for Editing

1. Set filter to "To Be Worked" status.

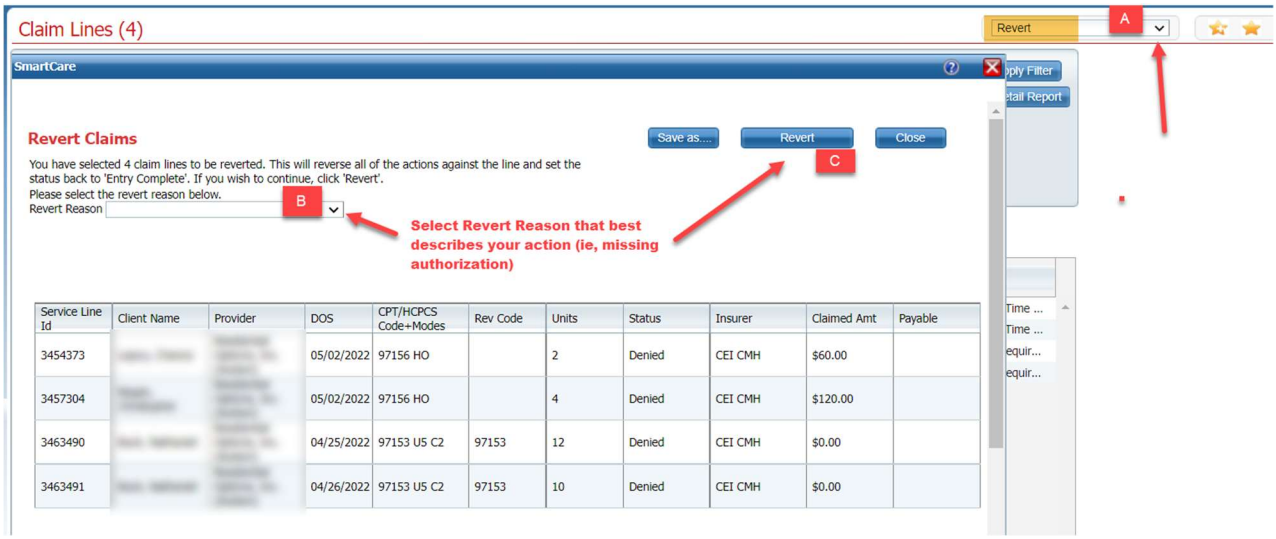


2. Select the claim lines you want to revert. You may do this by selecting "All", "All on Page", "None" or selecting the checkbox next to each claim line number.



3. Using the Selection Action box on the top right corner of the screen, select the following:

   a. Select Revert. The Revert Claims pop-up screen will appear and all selected claim lines will be displayed. Review that the correct claim lines have been selected before proceeding to Step B.



   b. Click on the drop-down arrow to select the Revert Reason. If desired, you can use the 'Save As' button if you want to download the claims lines being reverted to an Excel for record keeping purposes.

   c. If you have not selected the correct claims to revert, use the 'Close' button to return to the claim lines screen and begin step 3 again. If all claim lines selected are appropriate, click 'Revert'. You will receive a message "Claimline(s) processed successfully" and the status will update to Entry Complete. Close the pop-up window.

Modifying a Claim Line

Claim lines can only be modified for the following reasons:

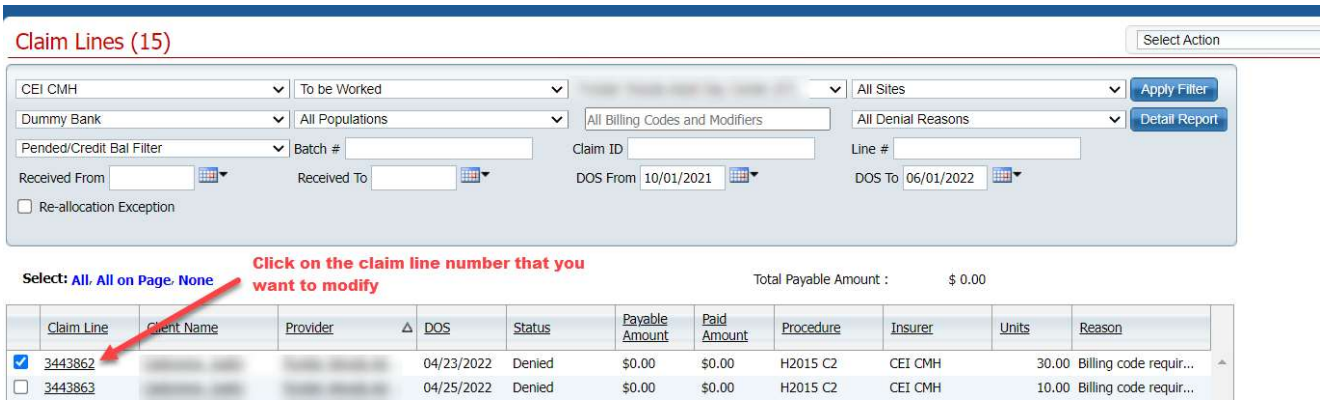
- Incorrect date of service.
- Incorrect times
- Incorrect procedure code and/or modifier
- Incorrect POS (place of service)
- Incorrect diagnosis code pointer on a claim line. NOTE: Depending upon the number of diagnosis codes pre-populated on a claim, the diagnosis pointer number(s) must match each claim line in order for the claim to process appropriately.
- Incorrect number of units

Please notify Finance-claims@ceicmh.org if any of the following errors have been made as these cannot be corrected and the claim line(s) will need to be hard denied before a new claim is entered:

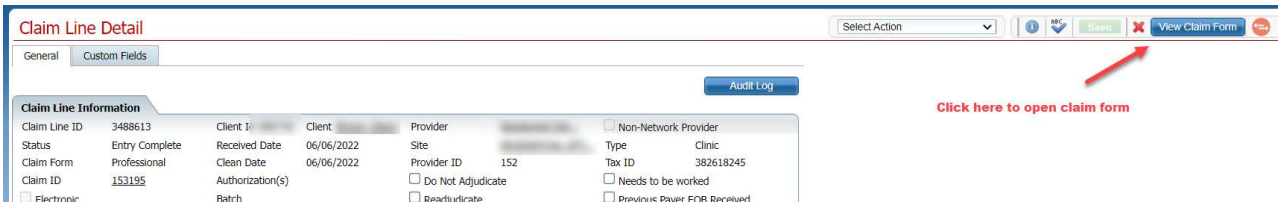
- Incorrect Provider/Site entered on the claim.
- Incorrect client was billed in error.
- Duplicate claim(s) were entered in error.
- Service claim dates that have been billed in error that have already been processed for payment.

All claim lines must be in an 'Entry Complete' status before you can edit information on the claim line. See the *Reverting Claims* section of this user guide for the detailed steps of that process for claims that have already been processed and are in a 'To Be Worked or Paid' status.

1. Select the claim line you want to edit, click on the claim line number that is underlined in order to Open the Claim Line Detail screen.

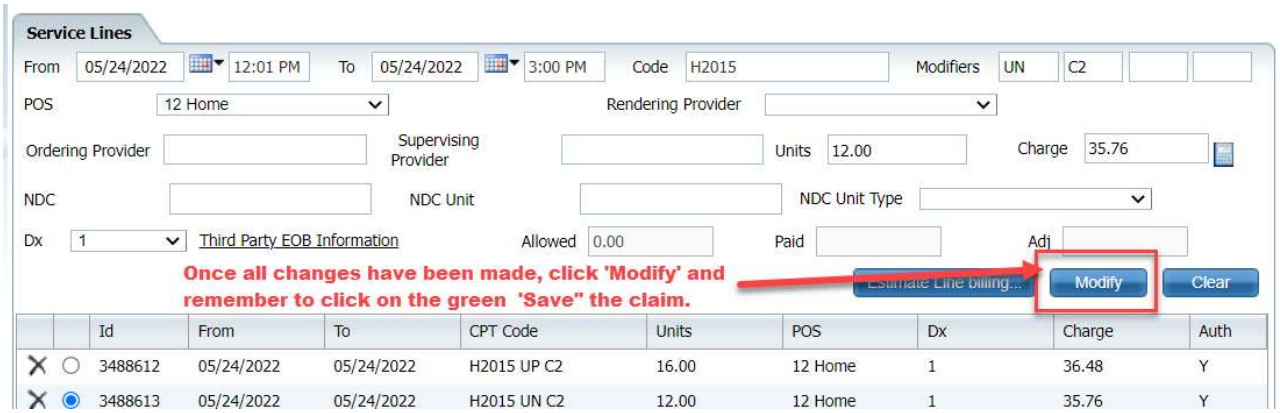


2. Click the “View Claim Form” button found in the top right banner of your screen.



3. The Claim Entry Professional screen will open. This is the screen used to enter the claim initially.

4. From the Claim Entry screen, select the radio button of the Claim Line you want to edit. The service line information for the selected service line will now populate the Service Lines section of the form. Make the necessary changes and click the “Modify” button to update the claim form with your changes.



5. Verify the changes that were made are reflected in the claim line information below.

6. When you have completed the changes to the individual claim lines, click the green “Save” icon at the top right of the Claim Entry Professional Screen. Click on the red ‘X’ to close the claim entry screen.



Voiding a Claim

Direct Entry Providers should not be ‘voiding’ claims that have been entered and saved in SmartCare. If a claim is in an ‘entry complete’ status and has not been processed (adjudicated), individual claim lines entered in error can be deleted from the claim. If the entire claim needs to be removed, contact Finance-Claims@ceicmh.org so the entire claim can be deleted from the system.

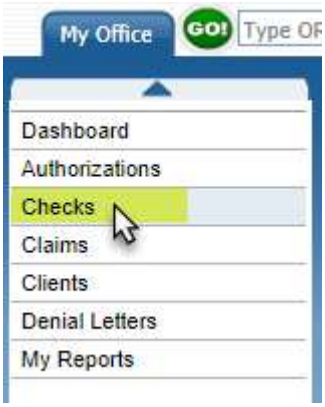
Claims that have been entered and processed, should never be voided. Processed claims entered in error will need to be hard denied by Finance-Claims staff. Please direct all questions concerning this topic to Finance-Claims@ceicmh.org.

Reviewing Check Payment Details

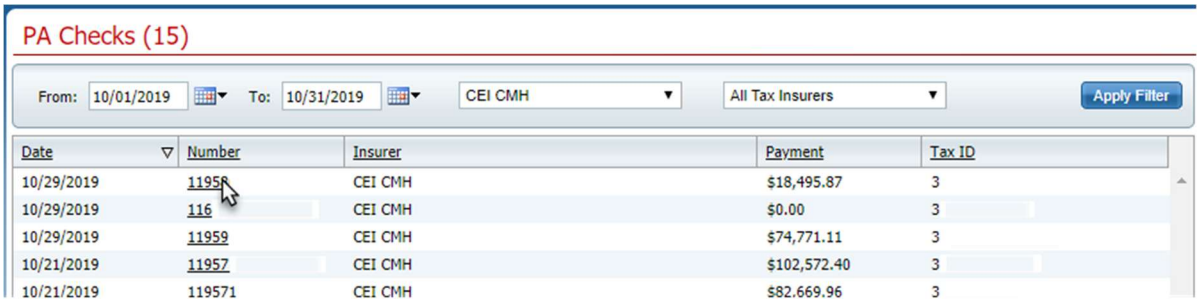
Viewing and Exporting Check Details

CMHA-CEI does not pay providers out of the SmartCare system. Claims are processed through the SmartCare system and then the data is transferred to our accounts payable system. The check number in the SmartCare system will match the check number/EFT providers receive from CMHA-CEI. The total amount paid and the details of each check/EFT can be found in the My Office banner/Checks in SmartCare. **IMPORTANT: CMHA-CEI <u>does not</u> send out Remittance Advice statements to providers using Direct Claim Entry.**

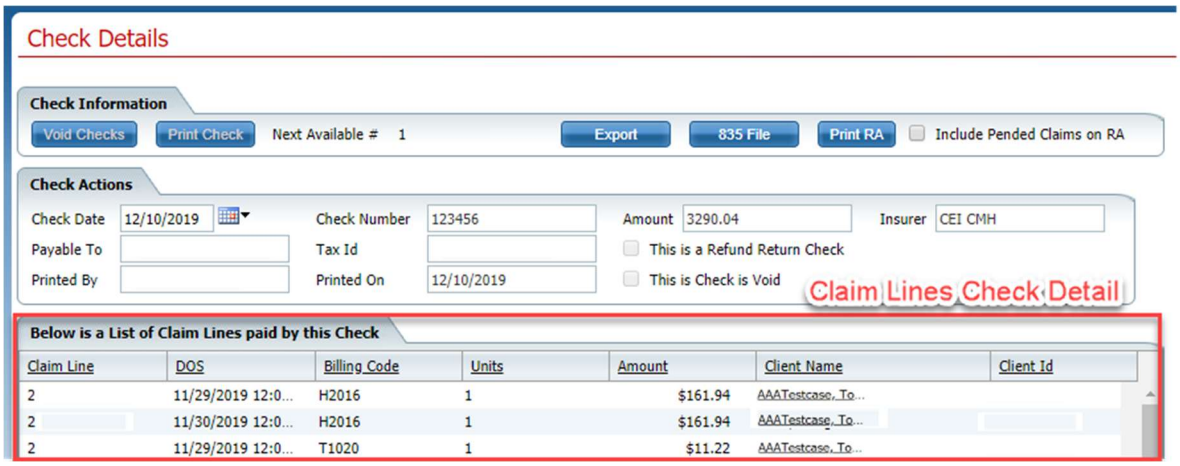
To view this information, click on **Checks** from the navigation banner.



1. This will take you to the PA Checks List screen. Find check issue date that you want to view and double-click on the underlined check number you want to view information on.



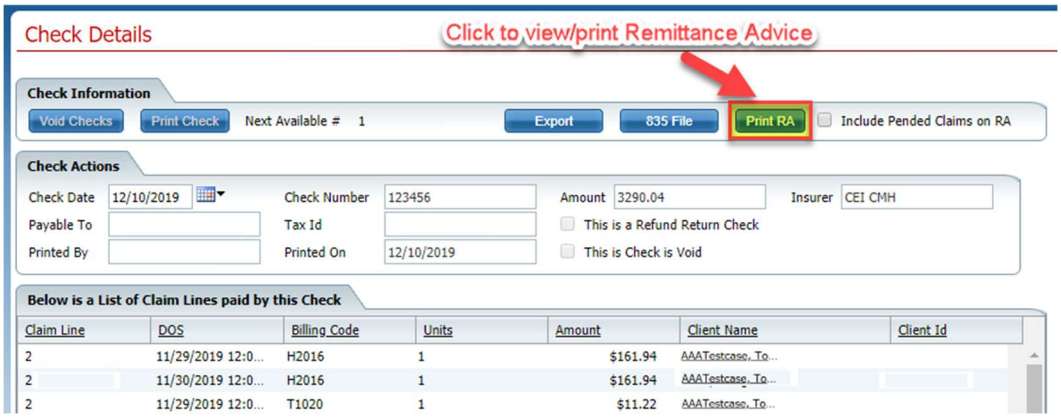
2. This will launch the Check Details screen. This screen provides claim line and client detail for the claims payed on a specific check. Click on the ***Export*** button to download a copy of the check details to an excel spreadsheet.



3. Once you have downloaded the check details to an excel spreadsheet, you can filter the document headers which will allow you to drill down more specifically into the check details either by client, billing codes or specific sites (if you have more than one site in your provider group) in order to post your payments to the appropriate consumer and/or locations within your organization.

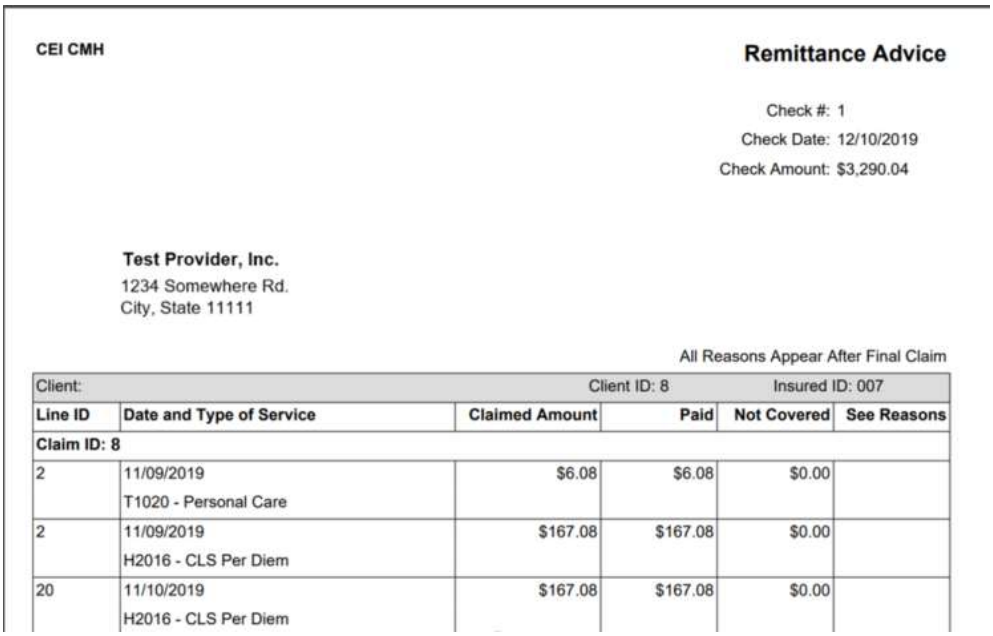
A	B	C	D	E	F	G	H	L	M	N	O	Q	R	S	T	V	AA
Claim Line	DOS	Billing Code	Units	Amount	ClientName	ClientId	Modifier1	CheckId	Insurer	Provider	TaxId	PayeeName	CheckNumber	CheckDate	Memo	CheckAmount	ProviderSiteInformation
5068910	11/25/2024 12:00:00 AM	97155	2	$ 34.40	Client #1	xxxxxx	HO	26189	CEI CMH				1245097	3/31/2025 10:06:10 AM		2622.66	Provider Site 1
5199551	2/5/2025 12:00:00 AM	97153	8	$113.12	Client 2	xxxxxx		26189	CEI CMH				1245097	3/31/2025 10:06:10 AM		2622.66	Provider Site 2
5199552	2/10/2025 12:00:00 AM	H2016	1	$155.54	Client 3	xxxxxx		26189	CEI CMH				1245097	3/31/2025 10:06:10 AM		2622.66	Provider Site 3
5199561	2/21/2025 12:00:00 AM	T1020	1	$ 70.70	Client 3	xxxxxx		26189	CEI CMH				1245097	3/31/2025 10:06:10 AM		2622.66	Provider Site 3

4. To print a PDF version of the remittance advice statement, click on the Print RA button. NOTE: This information cannot be filtered or modified and is not recommended for account reconciliation purposes.



5. The Remittance Advice will launch in a new pop-up window.

    - Claim lines are grouped by client but claim payments are not sub-totaled.
    - If the claim is only partially approved, the amount denied will appear under the column 'Not Covered' and a reason code will appear in the 'See Reasons' column which is printed at the bottom of the Remittance Advice.



CEI CMH

Remittance Advice

Check #: 1
Check Date: 12/10/2019
Check Amount: $3,290.04

Test Provider, Inc.
1234 Somewhere Rd.
City, State 11111

All Reasons Appear After Final Claim

Client:		Client ID: 8		Insured ID: 007	
Line ID	**Date and Type of Service**	**Claimed Amount**	**Paid**	**Not Covered**	**See Reasons**
Claim ID: 8					
2	11/09/2019 T1020 - Personal Care	$6.08	$6.08	$0.00	
2	11/09/2019 H2016 - CLS Per Diem	$167.08	$167.08	$0.00	
20	11/10/2019 H2016 - CLS Per Diem	$167.08	$167.08	$0.00	

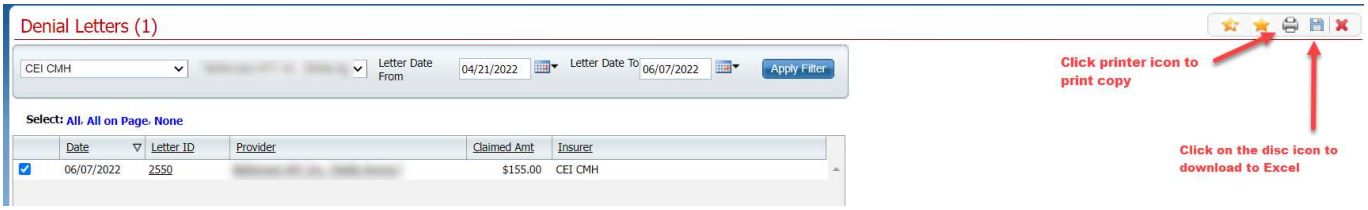
Claim Denial Letters

Access to the SmartCare system gives providers the ability to view/print their organization's denial letters, on demand. **IMPORTANT: CMHA-CEI does not mail Denial Letters to providers using Direct Claim Entry.**

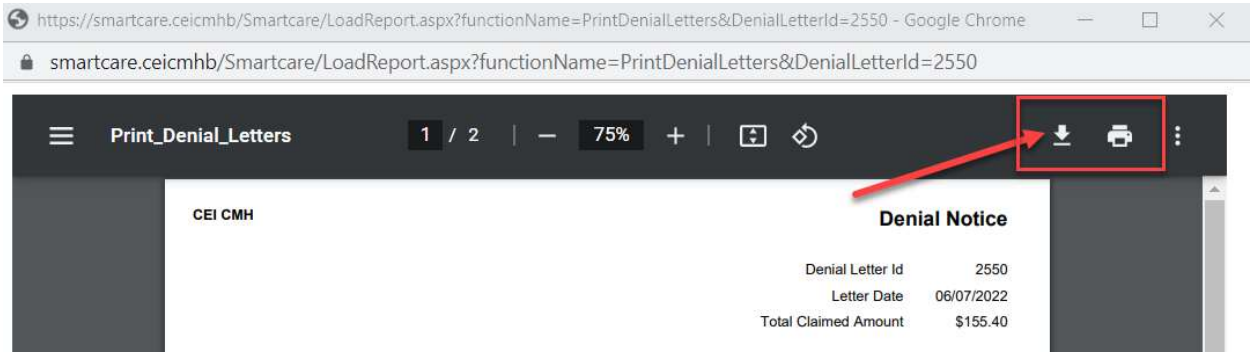
1. Click on Denial Letters from the Navigation Banner.



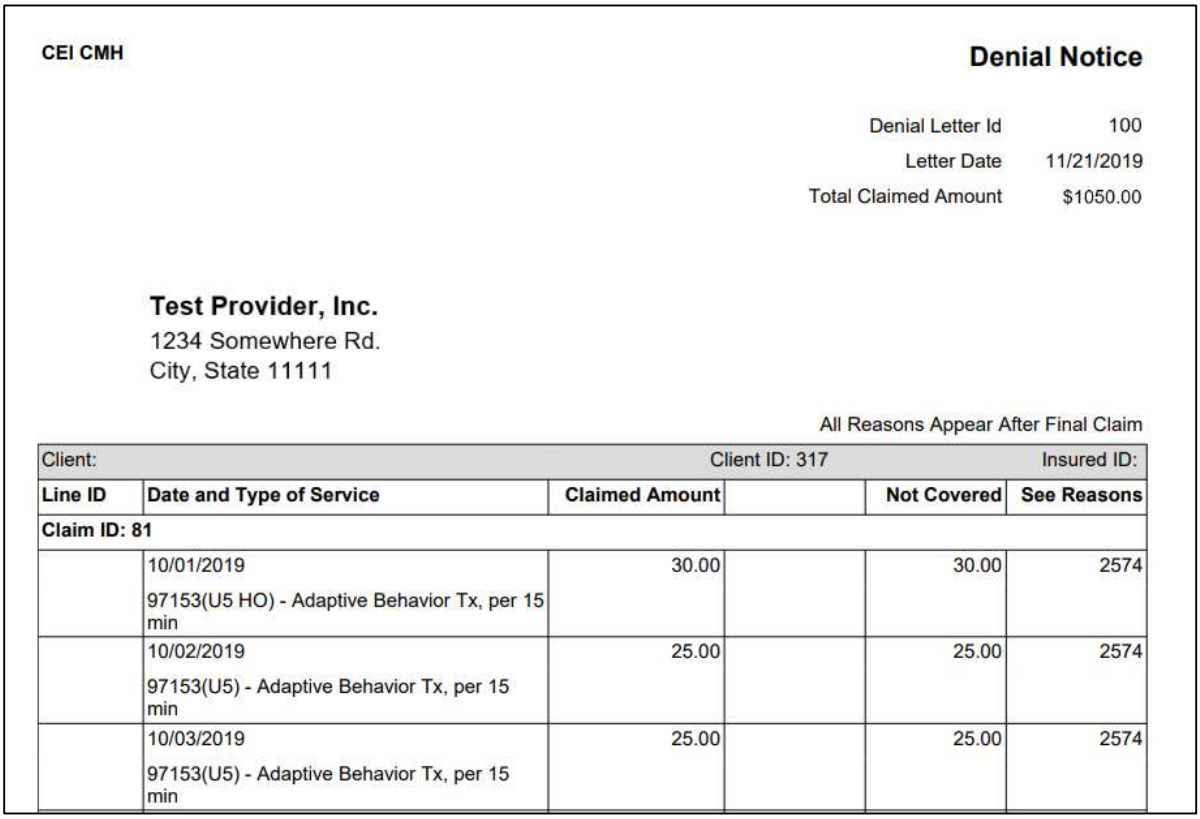
2. This will launch the Denial Letters screen. Use the filters section to limit the number of results returned. Once you have found the letter you are working, click on the corresponding number in the Letter ID field. This will take you to the Denial Letter Detail screen.



- Click on the disc icon in the top right corner if you prefer to download the details to an Excel Workbook.
- Click on the printer icon in the top right corner to print a copy of the letter. The drop-down icon will print to a PDF document, the printer icon will send to your default printer.



3. This opens the actual Denial Letter in a new pop-up window which give you the option of either downloading the letter to a PDF document or printing a copy of the denial letter.



CEI CMH

Denial Notice

Denial Letter Id	100
Letter Date	11/21/2019
Total Claimed Amount	$1050.00

Test Provider, Inc.
1234 Somewhere Rd.
City, State 11111

All Reasons Appear After Final Claim

Client:		Client ID: 317			Insured ID:
Line ID	**Date and Type of Service**	**Claimed Amount**		**Not Covered**	**See Reasons**
Claim ID: 81					
	10/01/2019 97153(U5 HO) - Adaptive Behavior Tx, per 15 min	30.00		30.00	2574
	10/02/2019 97153(U5) - Adaptive Behavior Tx, per 15 min	25.00		25.00	2574
	10/03/2019 97153(U5) - Adaptive Behavior Tx, per 15 min	25.00		25.00	2574

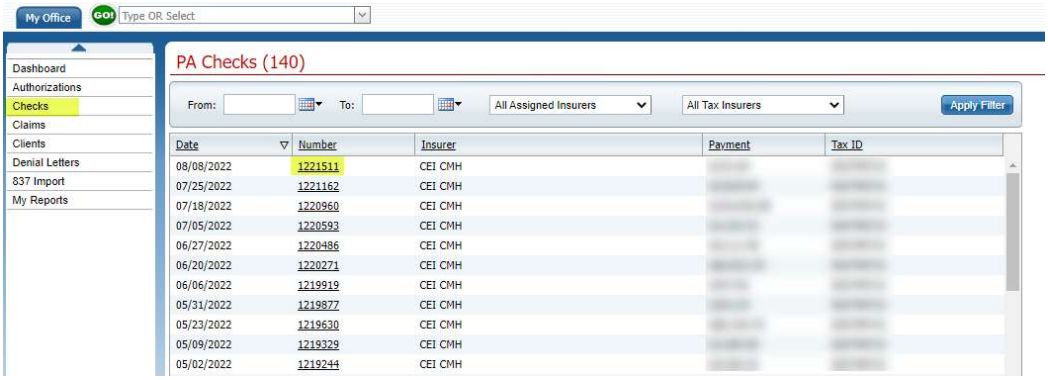
Miscellaneous Information

Electronic 837 Claims Submission

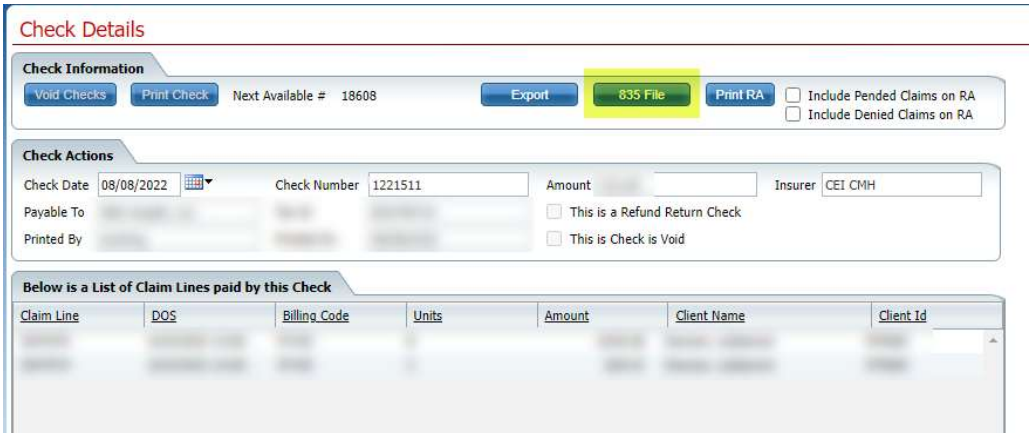
If you are interested in submitting claims electronically, please contact Provider Network Support at providersupport@ceicmh.org for additional information.

Electronic 835 Payments

You can download the 835 Remittance Advice. On the 'My Office' tab in Smart Care, click on 'Checks'. Once on the PA Checks screen, select the check by clicking on the underlined number.



From the Check Details screen, click on the blue box labeled, '835 File'.



It will ask you where you want to save it. Select a location and Save. It can now be opened and reviewed. For any further questions, please contact Provider Network Support at providersupport@ceicmh.org for additional information.

Sending Protected Health Information (PHI) Via Email

Client privacy and the security of their record is of the utmost importance. When emailing any protected health information (PHI) to CMHA-CEI, whether it is supporting documentation or a question about a specific client, it **MUST** be sent using a secure email platform. If your agency doesn't have access to a secure email platform you may use CMHA-CEI's secure portal, Zix.

For complete instructions on how to access Zix, copy and paste the following link to your browser: https://web1.zixmail.net/s/e?b=ceicmh



1. Enter the email address you used to create your Zix account during direct claim entry registration process. This is the same email address CMHA-CEI has on file for your claim entry account.
2. Enter the password you created during direct claim entry registration process.
3. Click Sign In to access Zix.
4. If you forgot the password you assigned at registration, click the Reset button to start the password reset process.
5. If you haven't previously created an account with Zix, click the Register button to start the account creation process.

Once logged in, Zix works similarly to any other web based email client except emails are encrypted from point to point. If you have any issues with logging into or using Zix, please email helpdesk@ceicmh.org.

Troubleshooting - Common Questions and Problems

Below is a list of some of the most common problems that may occur and who you can reach out to for assistance:

Authorizations Missing

If you have questions concerning an authorization that has been entered or is missing, please reach out to Providersupport@ceicmh.org or reference the ***Guide on Who to Direct Inquiries To***.

Charges Not Calculating Correctly on a Claim

If the charge amount is not calculating properly, or not populating at all, check to ensure that the consumer rates have been entered in the contract for the code you are billing and the effective dates for the rates. Billing codes and modifiers must be entered in the exact order as shown in the contract rates.

Authorizations must be entered under the same provider/site as the contract rates. If this information does not match, you will need to reach out to Providersupport@ceicmh.org to determine which site is correct.

Unable to Modify Claim Status Information from "Entry Incomplete" to "Entry Complete"

In order to modify the Claim Status, **all** claim lines must have a status of Entry Complete. Any claim lines that have been adjudicated and are in a 'Paid, Denied or To Be Worked' status MUST first be reverted. Please contact Finance-Claims@ceicmh.org for assistance.

Can Multiple Claims Lines be edited at the same time?

Multiple claim lines can be entered at one time using the "estimate Line" billing option, however, SmartCare does not allow users to modify multiple claim lines at one time. To edit a claim, you must first click on a claim line ID number and go to the View Claim Form where you can click on the radio button next to each claim line to be updated. Do not forget to click Modify and Save after edits are done.

If you revert a claim that has previously been paid, the system will apply the credit to the next claim to be paid.

Unable to Access a Client

If you are unable to see a client on the PA Clients List, try the other two search options. If all three options fail to return the client you are searching for, contact Provider Support at providersupport@ceicmh.org.

If you are not able to see a client on the PA Clients List, but the client shows up using one of the other two search methods, check the date range on the Client Authorization to ensure this document is current then contact Provider Support.

Below is a list of some of the most common questions that you have. Please refer to our ***Guide on Who to Direct Inquiries To*** for these types of questions, as well as other problems that may arise.

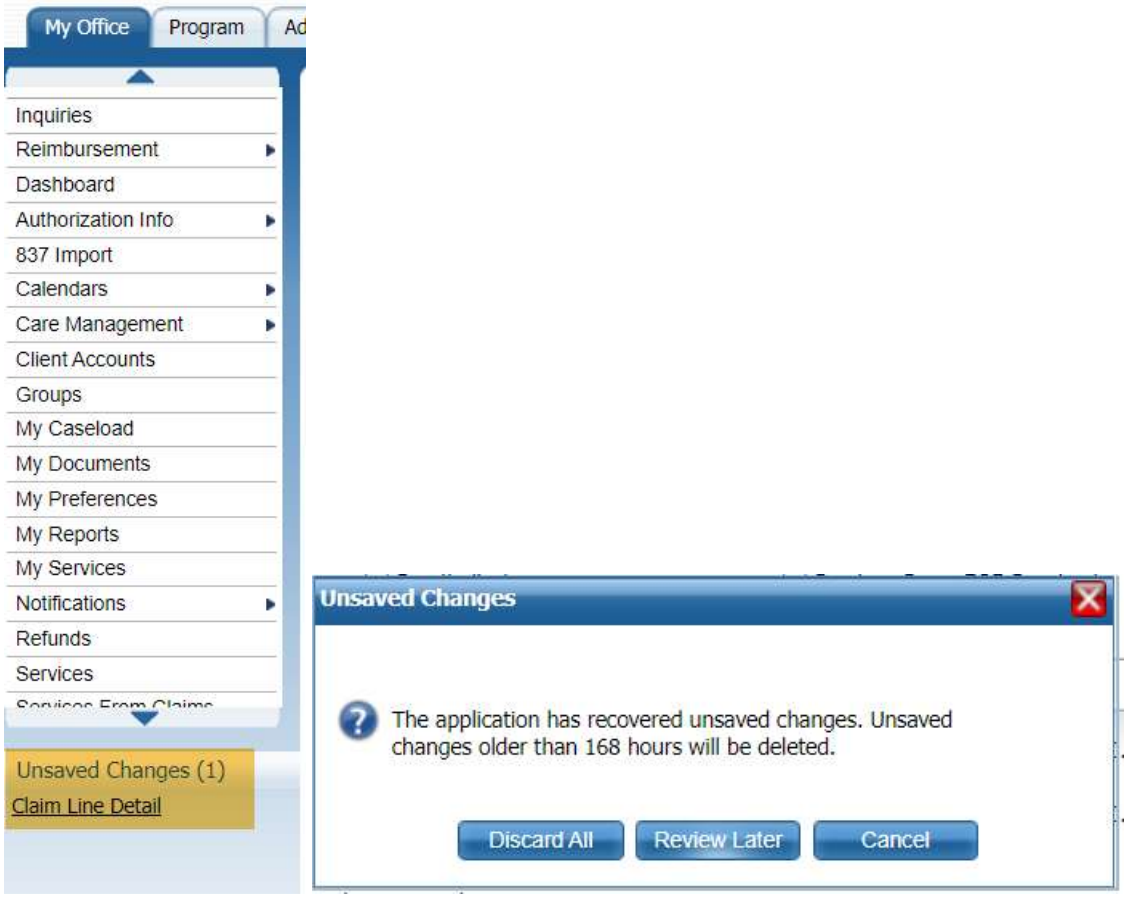
Can you revert a paid claim line?

A paid claim can be reverted if an error was made but provider's should contact Finance-Claims@ceicmh.org for assistance prior to performing this function as it could impact checks that are in the process of being paid. If a claim is reverted and reprocessed for a 'take-back' of money, the system will automatically deduct the credit balance from the provider's next scheduled payment.

Unsaved Changes

If you are working on a claim but have not 'Saved' the information, the information you have entered will appear below the area labeled Unsaved Changes on your dashboard. Smart Care stores this information in a temporary holding area until the claim is either saved or discarded. If you try to close out of Smart Care before saving your claim information, you will get a pop-up warning for Unsaved Changes where you can choose to 'Discard All, Review Later or Cancel'.

- If you select 'Cancel' you can click on the link displayed below the Unsaved Changes to open, review and save the claim line information.
- If you select 'Review Later' Smart Care will save those changes which you can then review the next time you log into Smart Care.
- If you select 'Discard All' none of the information entered will be saved.



The best practice is to save your work regularly and to click 'Save' before changing screens.

Who to Direct Claim Inquiries To

Please refer to the **Guide on Who to Direct Claim Inquiries To** that is published on the CEI-CMH website under Provider Resources to print a copy of this guide. This guide was created to assist you identifying the correct department/staff member(s) to reach out to for the various questions that you may have. If you are uncertain as to who to ask for assistance, please feel free to contact Finance-Claims@ceicmh.org or Providersupport@ceicmh.org and someone will be happy to assist you.