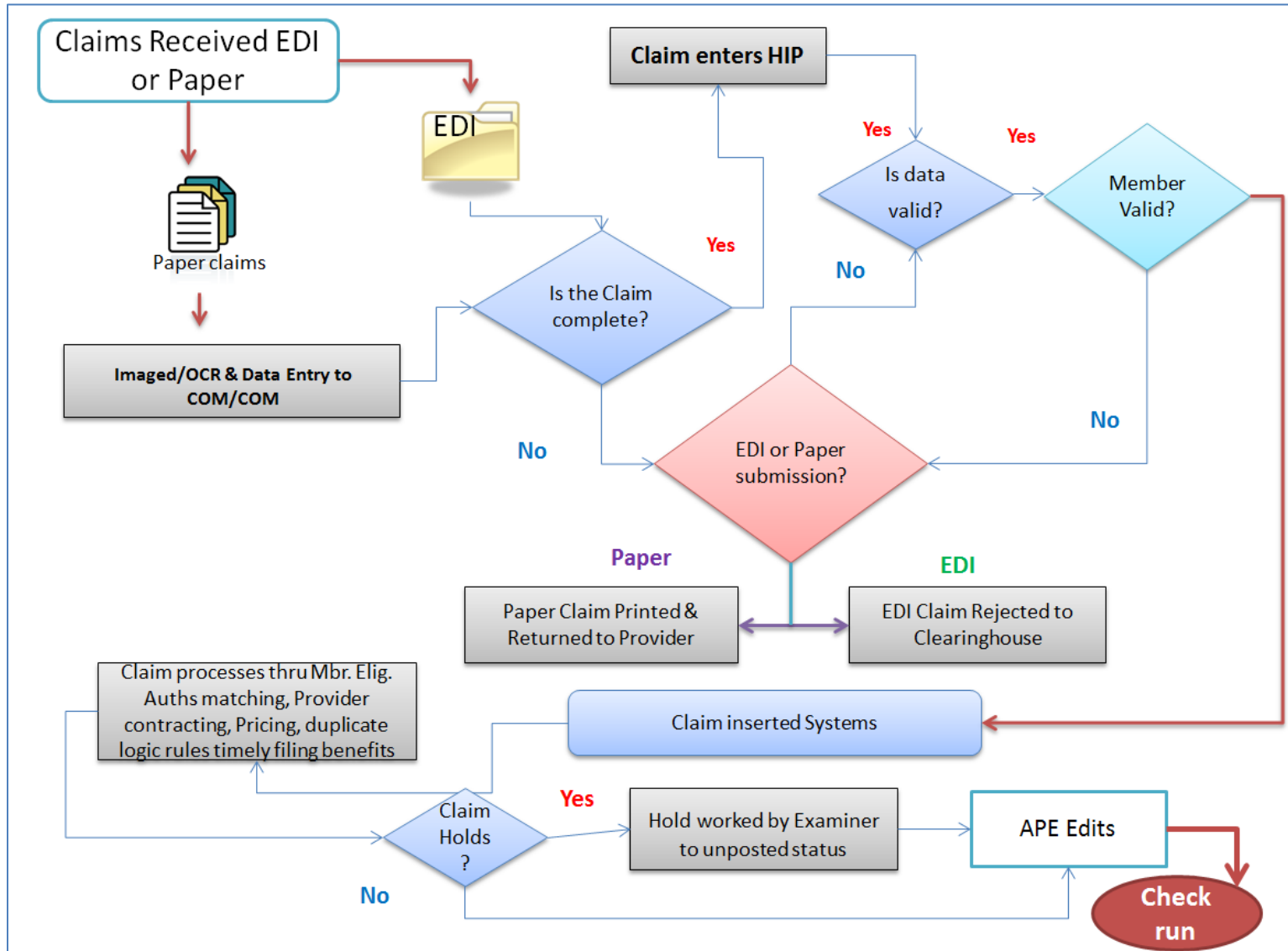


HealthMAPS Provider Portal Training Guide:

High Level Claim Flow Chart



To Begin Entering Claims:

1. Log into the HealthMAPS Provider Portal at <https://mychpw.chpw.org/en/provider>.
2. On Left Margin – Choose “Claims” drop down menu and select either:
 - Submit Professional Claim
 - OR-
 - Submit Institutional Claim
3. Choose **Create a New Batch** or use an **existing New Batch** that hasn't been submitted yet if you wish to add another claim to that batch prior to batch submission. A batch can consist of one or more claims. You can submit more than one claim, but you are not required to.

Submit Professional Claims

Welcome CHPW Provider

Submit a Professional Claim

[Create a new batch](#)

Batch & Claims

Submitted Batch [New Batch](#)

15 Batches

Quick search a batch by Batch Number

Batch Number	Entered Claims	Date Submitted	Batch Status	Actions
100237719	4	11/05/2018	New	Delete
100237755	1	11/12/2018	New	Delete
100237775	1	11/14/2018	New	Delete
100237795	1	11/15/2018	New	Delete
100237797	0	11/15/2018	New	Delete
100237803	0	11/15/2018	New	Delete

Choosing an existing batch that hasn't been submitted; example:

Submit Professional Claims Welcome CHPW Provider

New Batch #100237719 Back to Batch List

* Fields are required

Batch Submit Date: 11/19/2018 Total Claims Entered: 4 Form Name: HCFA-1500

[New Claim](#) [Corrected / Replacement Claim](#) [Voided / Cancelled Claim](#)

<input type="checkbox"/>	Batch Record #	No. of claim lines	Total Amount Billed	Notes
<input type="checkbox"/>	1	1	\$100	
<input type="checkbox"/>	2	0	\$0	
<input type="checkbox"/>	3	1	\$25	
<input type="checkbox"/>	4 <small>New</small>	1	\$360	Copy of Claim#1802230AV2958177

Showing 1 - 4 of 4 Claims 5 Per Page 1

Delete Claim(s)

Batch Record #5

* Submission Code

New Batch Corrected / Replacement Claim Voided / Cancelled Claim

Original Reference Number


Member Information ^

Appeals and Grievances Disputes Call Toll Free:
1 (206) 521-8830, 1 (800) 440-1561 or 1 (866) 418-1009.
For IMC and BHSO Only in Clark and Skamania Counties
Fax: (206) 613-8984 (routine)
Fax: (206) 613-8983 (urgent)



You may also send a secure message to CHPW Customer Service department using the envelop icon above or by selecting secure messages from the left navigation menu.

Email: Appealsgrievances@chpw.org
(mailto: Appealsgrievances@chpw.org)

4. Member Information



- Insured's ID Number – please enter the Member's CHPW eight digit subscriber ID number or click on the  icon to use the Search menu.
- Click on the radio button to Select Member Search Results. The members Name, DOB, Address, City, State, Zip, and Plan information will auto-populate.
- Enter Patient Control Number which is the number you've assigned the member as their patient ID. The space provided is Alphanumeric to accommodate your unique patient control numbering system.

Insured Info

* Insured's ID Number 	* Patient Control Number 
<input type="text"/>	<input type="text"/>
<input type="button" value="Search"/>	
* Patient's relationship to Insured	* Select Type of Health Insurance applicable to this claim
<input checked="" type="radio"/> Self	<input checked="" type="radio"/> Medicaid <input type="radio"/> Medicare

Note: selecting the Member Search Results will auto-populate the Patient's relationship to "Self" and whether the member is Medicaid or Medicare.

- If you have a Prior Authorization Number for this member please enter it in the indicated field:

State Washington 	Zipcode 98274	Phone # <input type="text"/>
Policy Group or FECA Number  HRSA	Insurance Plan Name or Program Name APPLE HEALTH - FAMILY	Prior Authorization Number <input type="text"/>

5. Provider Information

- Search by Billing Provider NPI and select Provider Search Result
- Provider Name, Address, City, State and Zip Code will auto-populate.
- Please ensure you type in the Billing Provider Federal Tax ID (TIN) and Federal Taxonomy ID

Provider Information

Set Default Values

* Billing Provider NPI [?](#)

* Billing Provider FED. Tax ID # [?](#)

Billing Provider Taxonomy ID [?](#)

Billing Provider Name

First Name	Middle Name	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>

- Please provide your contact name and phone number:

State

Zip Code

Phone #

Contact name [?](#)

- If your Pay to address is either a PO box or Lock box, fill out the address fields:

If Pay to address is either a PO box or Lock box. Use below address fields

PO Box/Lock Box

City

State

Zip Code

- If the servicing provider is the same as the billing provider select “Yes” if not, please fill out the Servicing Provider information:

* Is the servicing provider the same as the billing provider? [?](#)
 Yes No

Servicing Provider NPI [?](#) Servicing Provider Taxonomy ID [?](#)

Servicing Provider Name

First Name	Middle Name	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>

Address 1 (No. Street) Address 2 (Suite) City

State Zip Code Phone #

* Release information Certification [?](#)
 Yes No

* Assignment of Benefit Certification [?](#)
 Yes No

* Accept Assignment [?](#)
 Yes No

* Signature of Physician or Supplier on file? [?](#)
 Yes No

- Please enter the Referring Provider information **if applicable**:

Referring Physician NPI		
<input type="text"/>		<input type="button" value="🔍"/>
Referring Physician Name		
First Name	Middle Name	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Address 1 (No. Street)	Address 2 (Suite)	City
<input type="text"/>	<input type="text"/>	<input type="text"/>
State	Zip Code	Phone #
<input type="text" value="Select"/> <input type="button" value="▼"/>	<input type="text"/>	<input type="text"/>

6. Claim Information

- Please provide the Claim Header information NOTE – Claim Header Information and Claim Detail Information are both clickable tabs.
- **Total Amount Billed** will be auto-populated when Claim Detail Info is completed.

Claim Information

Claim Header Information | Claim Details Info.

* Were the services provided emergency related?
 Yes No

Total Amount Billed
\$0.00

* From Date of Service

Through Date of Service

* Place of Service

* Diagnosis 1

Claim Note 1

Only 12 diagnosis codes allowed.

If this button is not clicked, the claim data will be lost.

Note: before leaving the claim form make sure to click on **“Save Claim Data”** or you will need to re-enter the data.

Note that the Claim Detail information has a field for the NDC. The **NDC** must be included for all outpatient medications/injections and consist of **11 digits with no spaces or hyphens**, in the 5-4-2 format.

^
Claim Information

Claim Header Information
Claim Details Info.

* CPT/HCPCS Q

1st Modifier Q

3rd Modifier Q

* Amount Billed

* Outside Lab Charges?
 Yes No

National Drug Code

 Q

Drug Unit Count

Drug Unit

 ▼

* Diagnosis Reference +

2nd Modifier Q

4th Modifier Q

Patient Paid Amount +

* \$ Charges

Prescription Number
 None Pharmacy Prescription Number Link Sequence

* Days Or Units

Add Line Item

From Date of Service	Through Date of Service	Diagnosis 1	Place of Service	CPT/HCPCS	Diagnosis Reference	1st Modifier	Days Or Units	Amount Billed	Outside Lab Charges	Total Claim Line Amount	Actions
Total Amount Billed									\$ 0		

← Previous

If you need to come back to edit the claim prior to submitting batch, you can do so by clicking on the underlined number under Batch Record # at top of claim form.

New Batch #100237719

* Fields are required

Batch Submit Date
11/19/2018

Total Claims Entered
6

Form Name
HCFA-1500

[New Claim](#) [Corrected / Replacement Claim](#) [Voided / Cancelled Claim](#)

<input type="checkbox"/>	Batch Record #	No. of Claim Lines	Total Amount Billed	Notes
<input type="checkbox"/>	1		\$100	
<input type="checkbox"/>	2	0	\$0	
<input type="checkbox"/>	3	1	\$25	
<input type="checkbox"/>	4	1	\$360	Copy of Claim#1802230AVZ 58177
<input type="checkbox"/>	5	1	\$150	

Showing 1 - 5 of 6 Claims

[1](#) [2](#) [>](#) [>>](#)

Delete Claim(s)

Batch Record #7

* Submission Code

Original Reference Number

New Batch Corrected / Replacement Claim Voided / Cancelled Claim

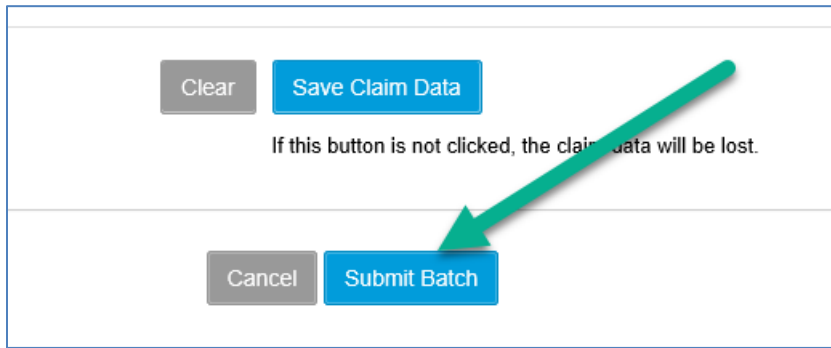
Appeals an

1 (206) 521
For IMC an
Fax: (206)
Fax: (206)

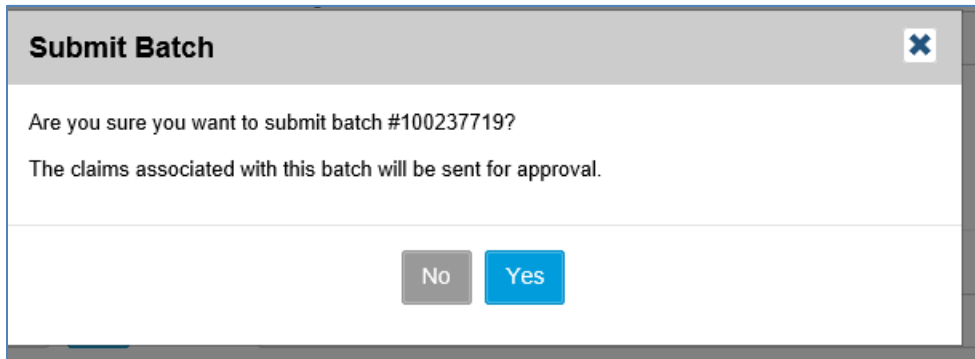
You may al
envelop icc

Email: App
(mailto: App

When you are ready to submit your batch of claims, click on "Submit Batch"

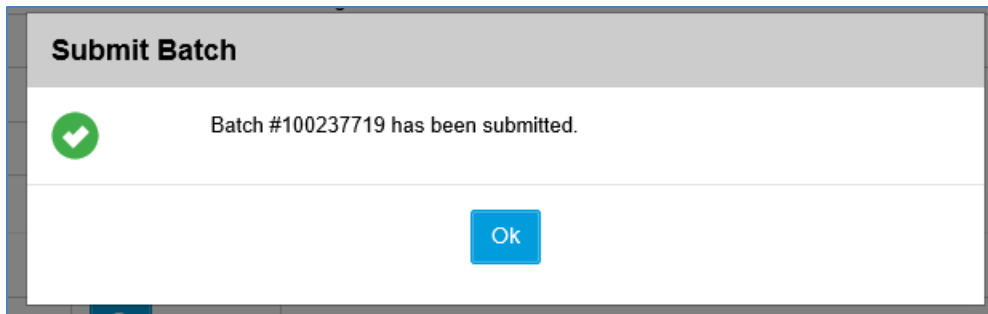


You'll be asked if you're sure you want to submit:



Click "Yes" to Submit or "No" to return to creating/editing your batch.

After you click "Yes" to submit your batch you will receive confirmation it has been submitted. Click Ok.



The process will take you back to the Batch & Claims screen where you'll see your Batch number has been submitted, with the Number of Claims within your batch and the Submission date.

Submit Professional Claims Welcome CHPW Provider

Submit a Professional Claim Create a new batch

Batch & Claims

Submitted Batch New Batch

16 Batches

Quick search a batch by Batch number

Batch Number	Entered Claims	Date Submitted	Batch Status
100237719	6	11/19/2018	Submitted
100237734	1	11/09/2018	Generated
100237740	1	11/10/2018	Generated
100237790	4	11/15/2018	Generated
100237791	1	11/15/2018	Generated

