PCW Institutional Outpatient Claim Submission via iCare Provider Portal

Log on to iCare Provider Portal Provider Portal

From the menu on the left side select **Claims**, next select **create claim**, (see screen shot 1)

Next select **member name** (enter member last name , first name, date of birth or member Medicaid id) click on **search**, (This will bring up the members name) verify your member is correct, click **next**

Claim Type (Required) select **Institutional Outpatient Claim**, click **next**.

Provider Information
Select the claim type, provider name, and the service address.
Select Claim Type (Required) = **Institutional Outpatient Claim**

Type of Bill
Click next , Facility Type (Required) – 32 Home Health Services

Frequency 4 – options
01 – Admit through Discharge
02 – First Interim Claim
03 – Continuing Interim Claim
04 – Last Interim Claim

Statement From Date and Statement To Date
MM/DD/YYYY through **MM/DD/YYYY**

Admission Details
Admission Date (the date the member started care) enter **MM/DD/YYYY**

Admission Hour
Select Admission time 00 to 18

Type of Admission
Select Options 1 to 9

Admission Sources
Select Options 0 to 9 or C to F

Discharge Details
Discharge Date (the though date on claim) enter **MM/DD/YYYY**

Discharge Hour (Required)
Select Discharge time 00 to 18

Discharge Status (Required)
Select Options 0 to 11 or 30

Select the ICD type & primary Diagnosis Code to enter service details.

ICD Type (Required)
Select – ICD 10

Primary Diagnosis Code (Required)
Enter valid IDC10 for the member

POA Indicator (*not a required field)
Present on Admission (POA) – means the primary diagnosis was present at the time admission occurs
Select Yes, No, Unknown, Clinically Undetermined or Exempt

Accept Assignment check box
indicate whether you agree (or is required by law) to accept the Medicare-approved amount as full payment for covered services

Service Line 1
Date of Service From Date and Date of Service To Date
MM/DD/YYYY through **MM/DD/YYYY**

Revenue Code
Enter - room and board Rev (example: 0570)

CPT/HCPCS
Enter valid code, must be a 5 digit/character code.

- T1019

Enter Modifiers
Example, U3 or KX

Units (Required)
Enter – number of units/days

Unit Type (Required)
Select unit type = Days

Charge (Required)

Calculate – Rev code rates x number of days – Enter Charge amount

Click **+ Add Service Line** to submit additional charges

Once the fields are complete on each service line, click View Estimate

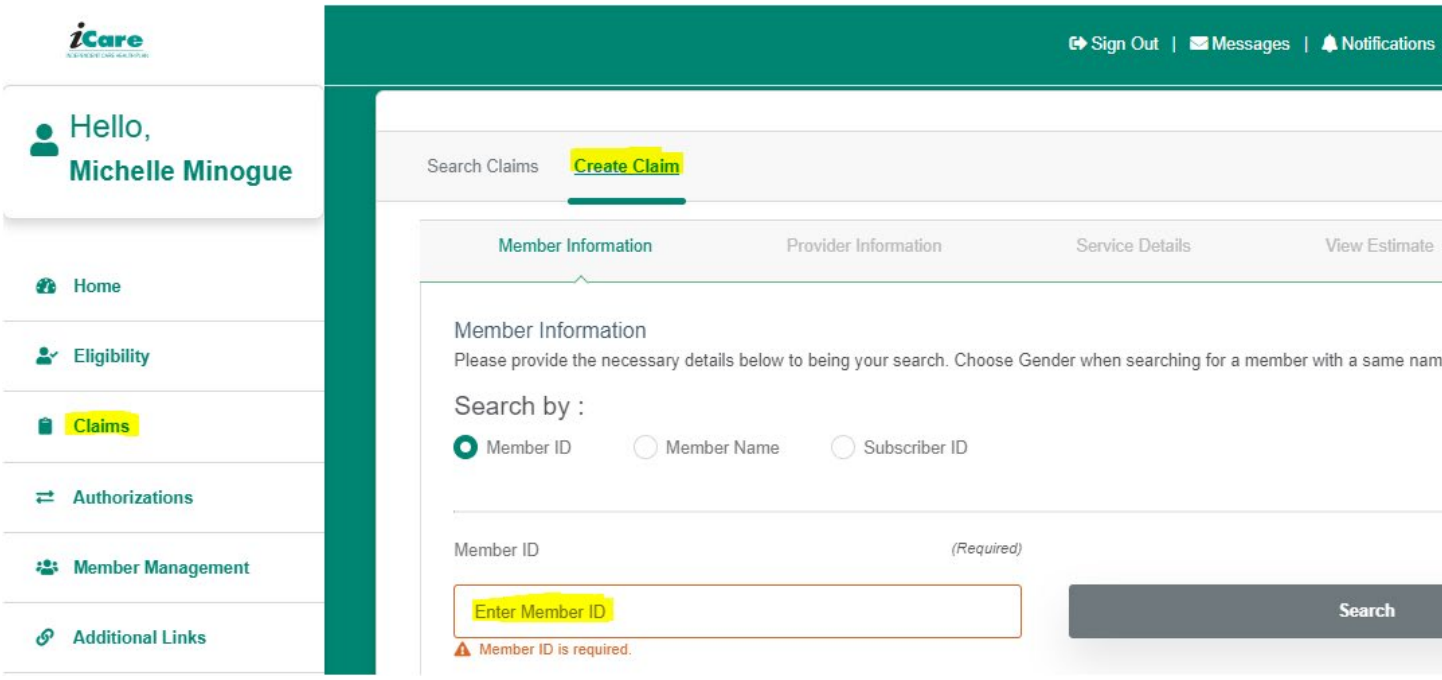
Next
Confirm Claims Service Line is correct. Next Submit Claim

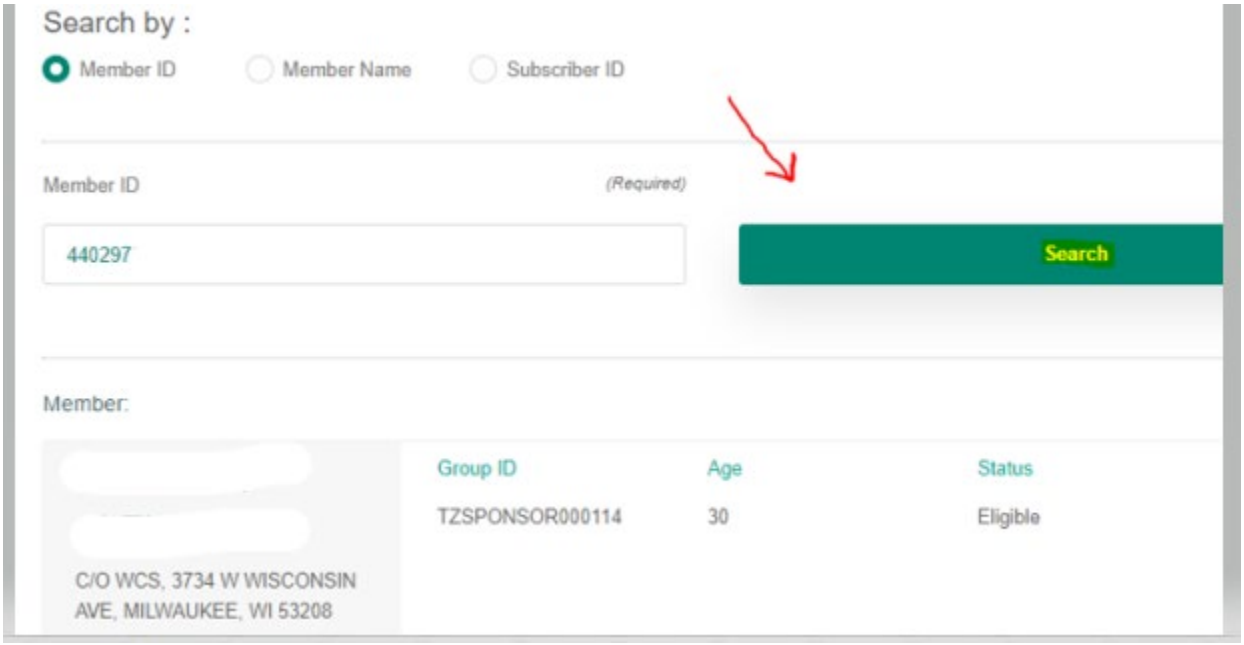
Please be sure to review your claim to ensure accuracy. Any corrected claims will need to be submitted on the hard copy UB04 claim form.

Corrected Claims

Follow the above instructions to submit a claim. But, use the following Frequency in the Statement Summary

Frequency 06 – adjustment of a prior claim (make changes to a paid claim)
Frequency 07 – Replacement of a prior claim (make changes to a denied claim)




Search by :
Member ID
Member Name
Subscriber ID
Member ID
(Required)
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Member:
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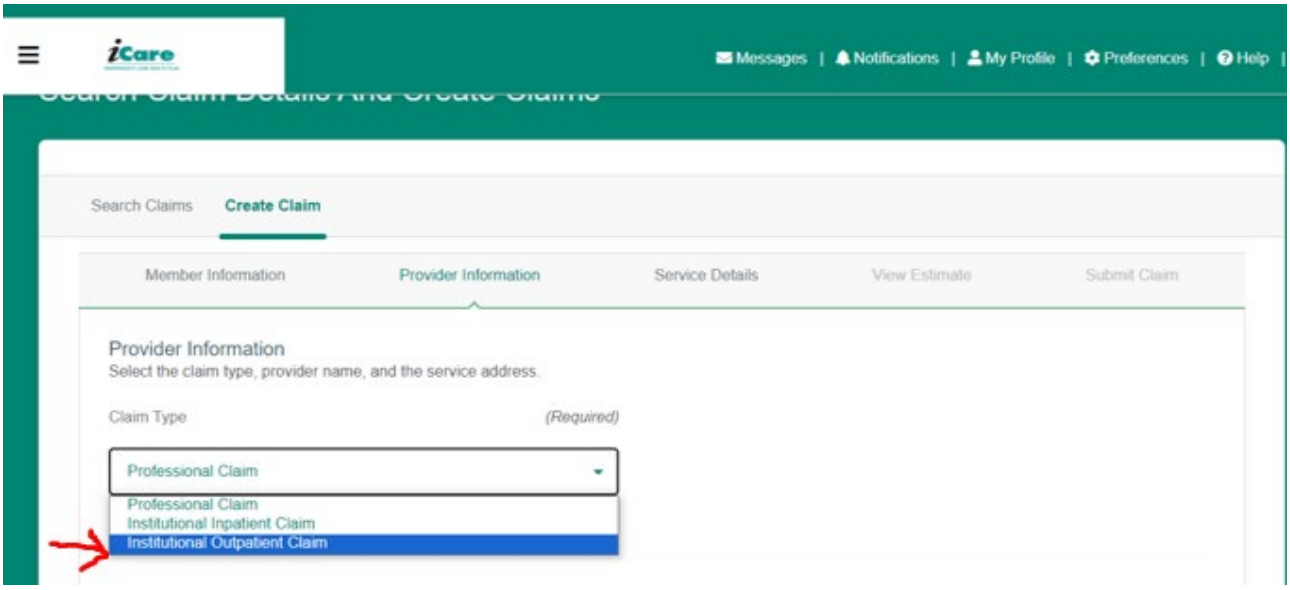
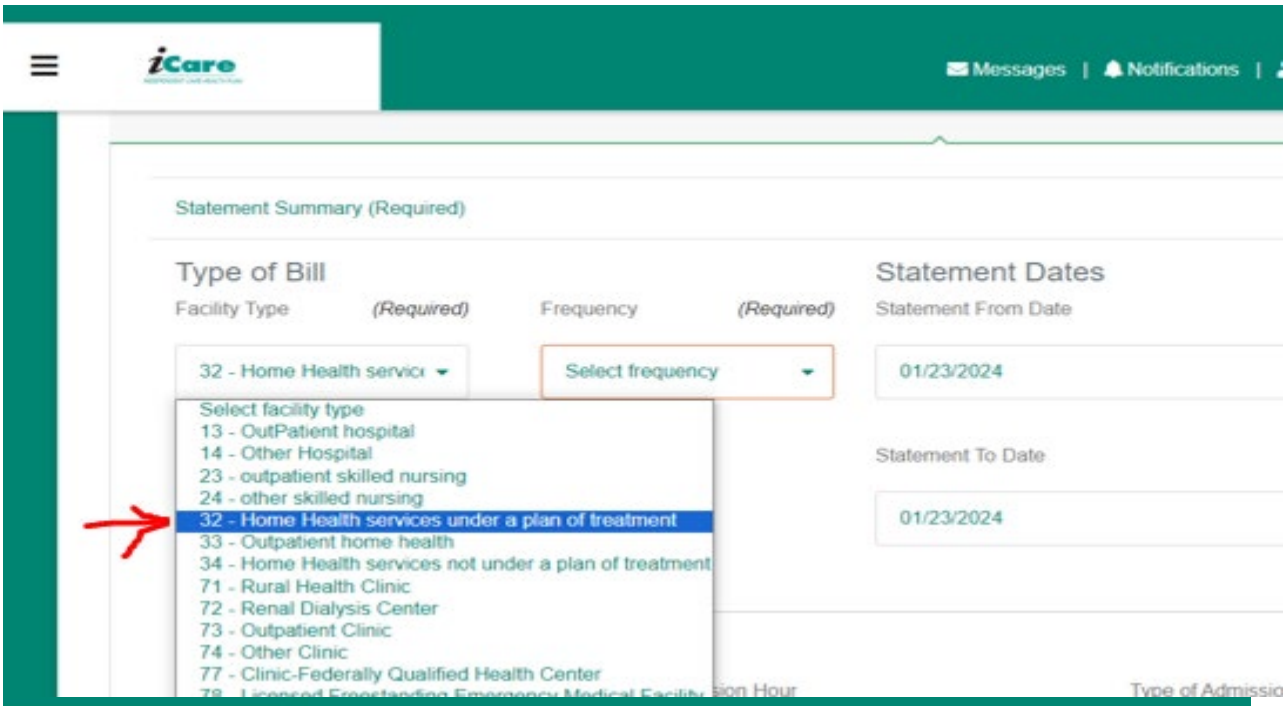
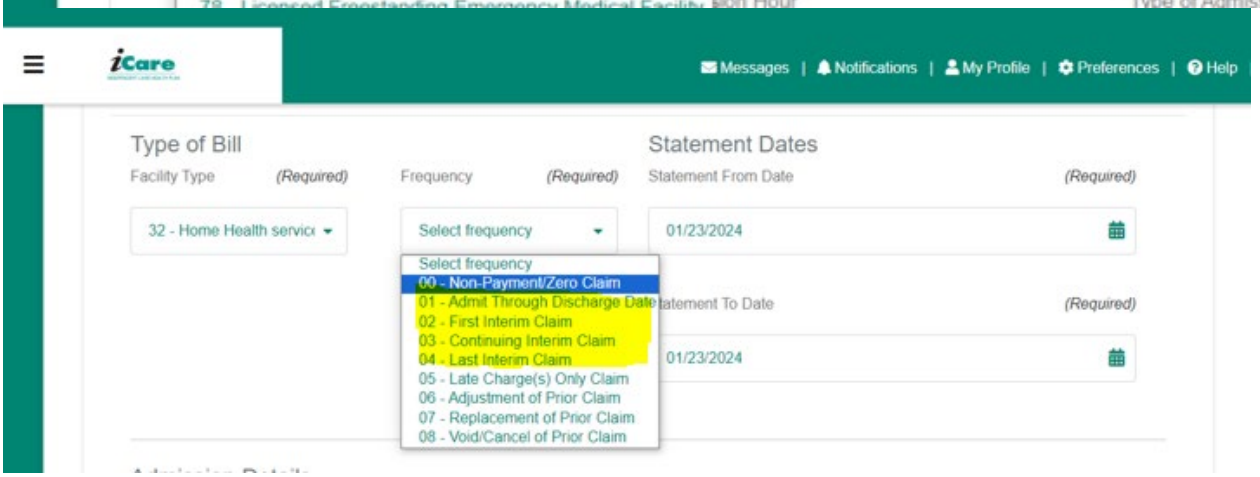
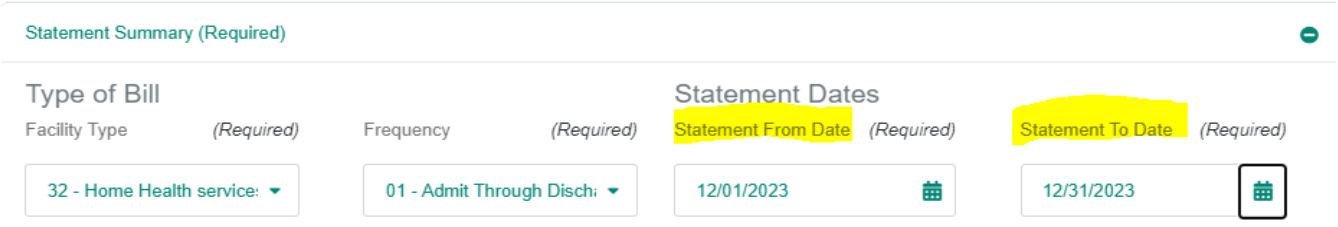
Eligible
C/O WCS, 3734 W WISCONSIN AVE, MILWAUKEE, WI 53208


iCare
Messages
Notifications
My Profile
Preferences
Help
Search Claims
Create Claim
Member Information
Provider Information
Service Details
View Estimate
Submit Claim
Provider Information
Select the claim type, provider name, and the service address.
Claim Type
(Required)
Professional Claim
Professional Claim
Institutional Inpatient Claim
Institutional Outpatient Claim


iCare
Messages | Notifications |
Statement Summary (Required)
Type of Bill
Facility Type (Required)
Frequency (Required)
Statement Dates
Statement From Date
32 - Home Health servic
Select frequency
01/23/2024
Select facility type
13 - OutPatient hospital
14 - Other Hospital
23 - outpatient skilled nursing
24 - other skilled nursing
32 - Home Health services under a plan of treatment
33 - Outpatient home health
34 - Home Health services not under a plan of treatment
71 - Rural Health Clinic
72 - Renal Dialysis Center
73 - Outpatient Clinic
74 - Other Clinic
77 - Clinic-Federally Qualified Health Center
Statement To Date
01/23/2024

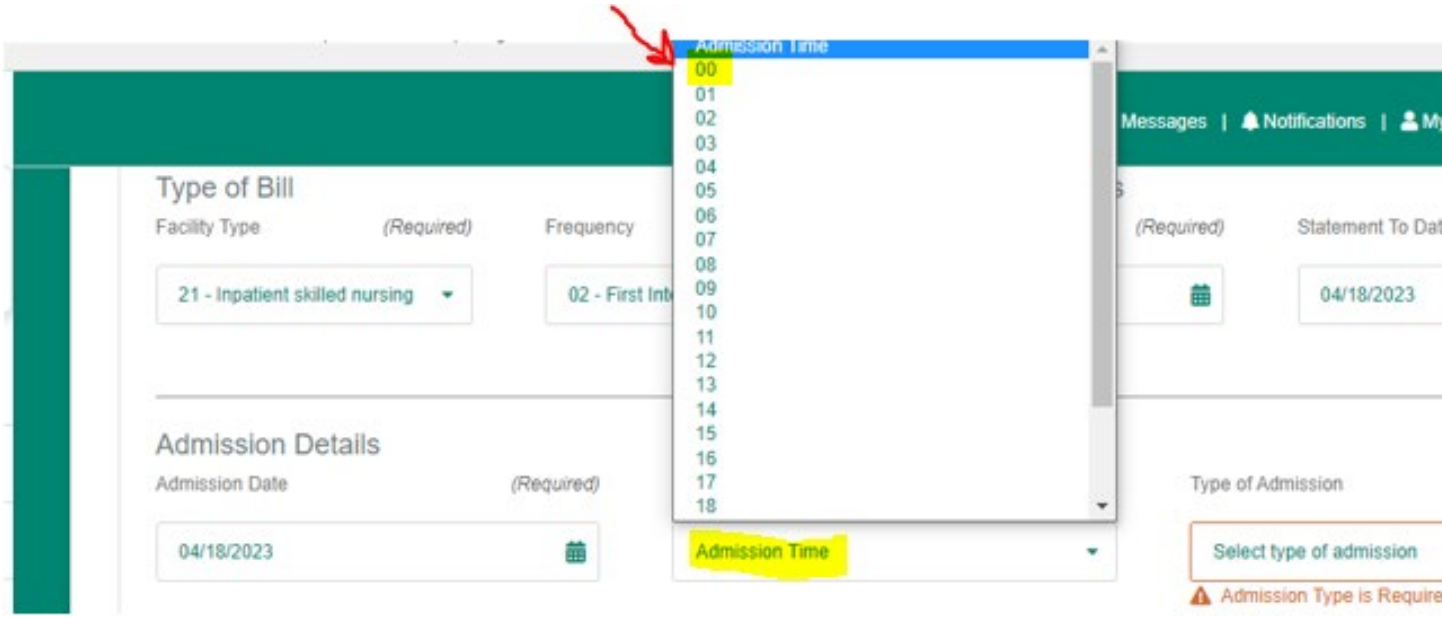

iCare
Messages | Notifications | My Profile | Preferences | Help
Type of Bill
Facility Type (Required)
Frequency (Required)
Statement Dates
Statement From Date (Required)
32 - Home Health servic
Select frequency
01/23/2024
Select frequency
00 - Non-Payment/Zero Claim
01 - Admit Through Discharge Date
02 - First Interim Claim
03 - Continuing Interim Claim
04 - Last Interim Claim
05 - Late Charge(s) Only Claim
06 - Adjustment of Prior Claim
07 - Replacement of Prior Claim
08 - Void/Cancel of Prior Claim
Statement To Date (Required)
01/23/2024


Statement Summary (Required)
Type of Bill
Facility Type (Required)
Frequency (Required)
Statement Dates
Statement From Date (Required)
Statement To Date (Required)
32 - Home Health service
01 - Admit Through Disch
12/01/2023
12/31/2023

Admission Details

Admission Date *(Required)* | Admission Hour *(Required)* | Type of Admission

04/18/2023 | 17 | Select type of admission



Admission Details

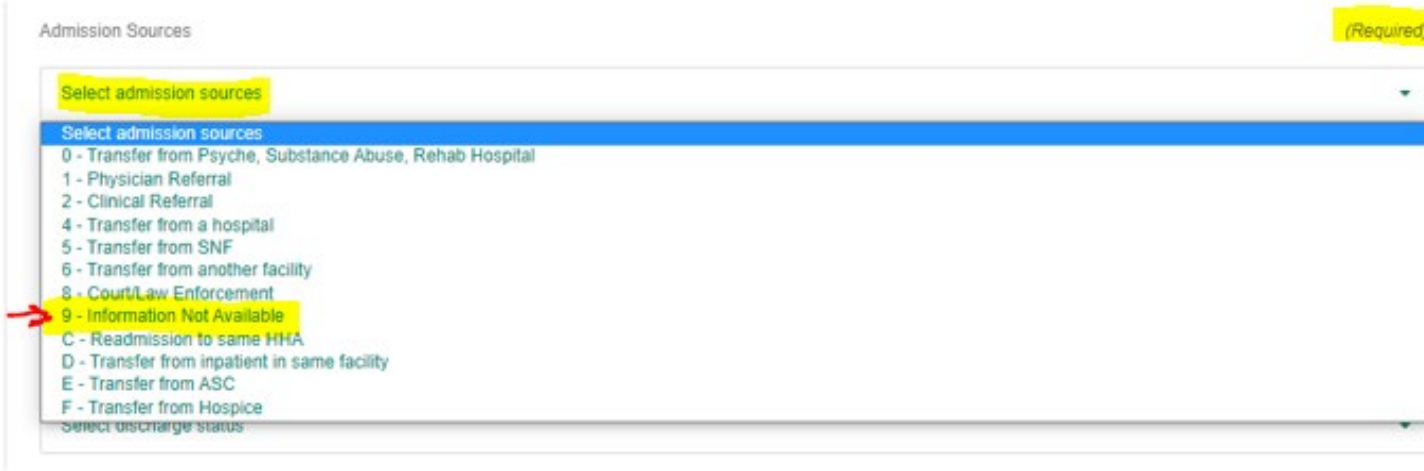
Admission Date *(Required)* | Admission Hour *(Required)* | Type of Admission *(Required)*

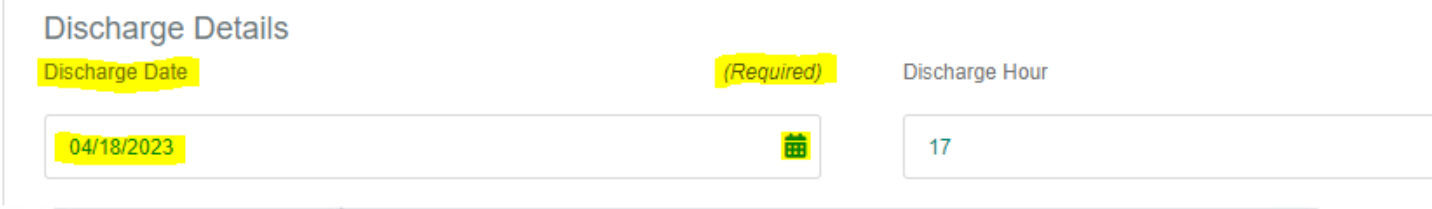
04/18/2023 | Admission Time | Select type of admission

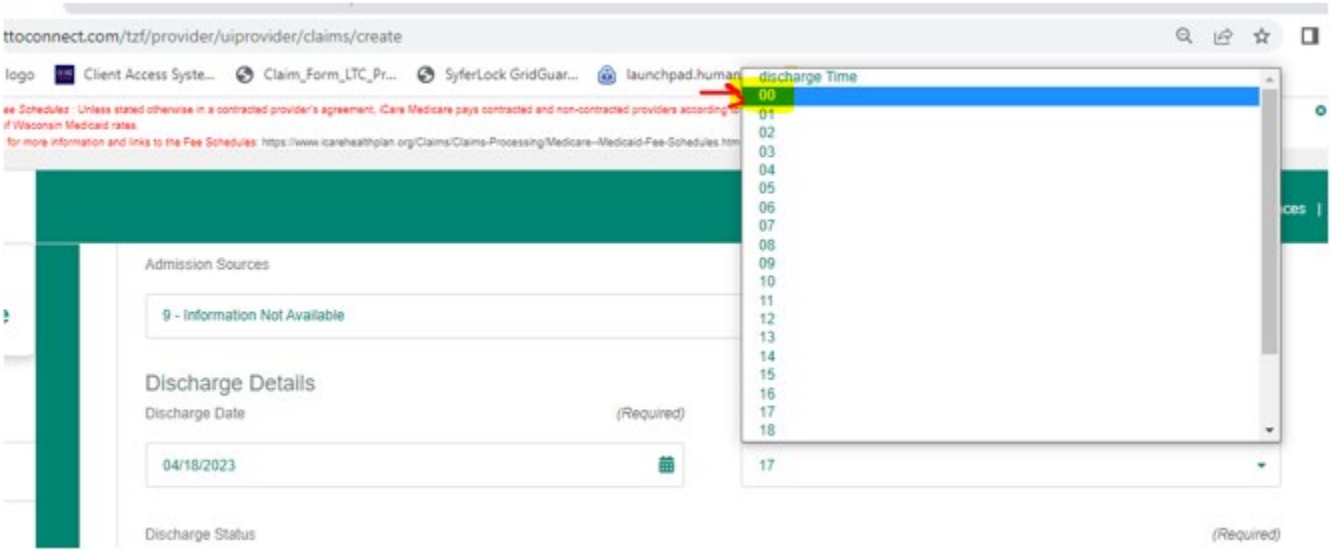
Select type of admission
1 - Emergency
2 - Urgent
3 - Elective
4 - Newborn
5 - Trauma Center
9 - Information Not Available

Admission Sources

Select admission sources


Admission Sources
(Required)
Select admission sources
Select admission sources
0 - Transfer from Psyche, Substance Abuse, Rehab Hospital
1 - Physician Referral
2 - Clinical Referral
4 - Transfer from a hospital
5 - Transfer from SNF
6 - Transfer from another facility
8 - Court/Law Enforcement
9 - Information Not Available
C - Readmission to same HHA
D - Transfer from inpatient in same facility
E - Transfer from ASC
F - Transfer from Hospice


Discharge Details
Discharge Date
(Required)
Discharge Hour
04/18/2023
17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Claim_Form_LTC_Pr...
SyferLock GridGuar...
launchpad.human
discharge Time
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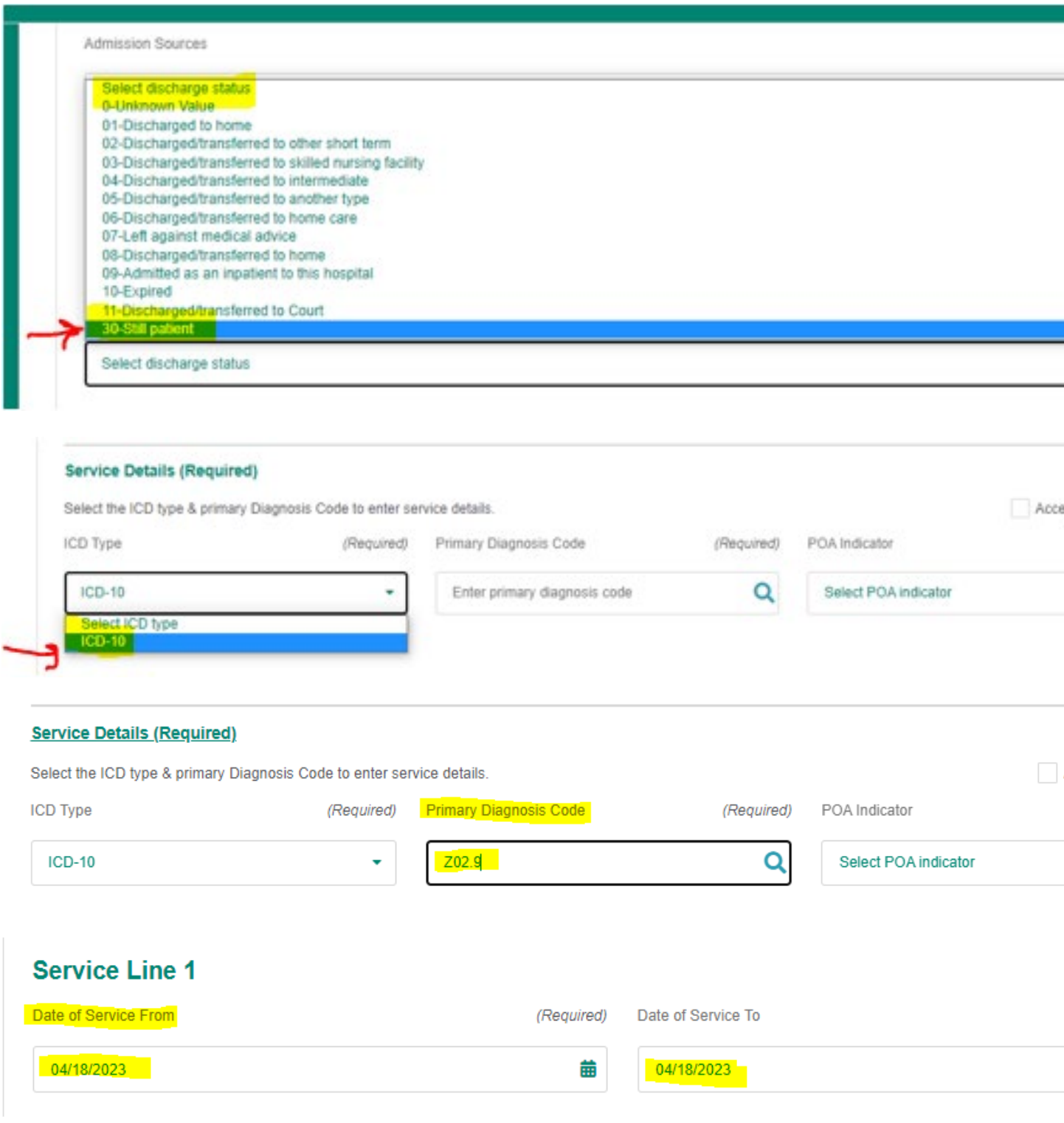
18
Admission Sources
9 - Information Not Available
Discharge Details
Discharge Date
(Required)
04/18/2023
17
Discharge Status
(Required)



Enter KX Modifier for Live In Workers ONLY

Service Line 1

Add Service Line

Date of Service From *(Required)* 01/23/2024

Date of Service To *(Required)* 01/23/2024

Revenue Code *(Required)* 0570

CPT / HCPCS *(Required)* T1019

Modifiers KX

NDC Code: Enter NDC code

Units *(Required)*: 1

Unit Type *(Required)*: Units

Charge *(Required)*: $ 0.00