

## 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)

The screenshot displays the iCare web portal interface. On the left is a navigation sidebar with the iCare logo at the top, followed by a user greeting: "Hello, Michelle Minogue". Below the greeting are menu items: Home, Eligibility, Claims (highlighted in yellow), Authorizations, Member Management, and Additional Links. The main content area is titled "Create Claim" and features a search bar with "Search Claims" and "Create Claim" buttons. Below the search bar are four tabs: "Member Information" (selected), "Provider Information", "Service Details", and "View Estimate". The "Member Information" section contains the text: "Member Information Please provide the necessary details below to being your search. Choose Gender when searching for a member with a same nam". Underneath is a "Search by :" section with three radio button options: "Member ID" (selected), "Member Name", and "Subscriber ID". A "Member ID" input field is present with the label "(Required)" and a placeholder "Enter Member ID" (highlighted in yellow). A "Search" button is located to the right of the input field. A red warning icon and the text "Member ID is required." are displayed below the input field.

Search by :



Member ID     Member Name     Subscriber ID

Member ID (Required)

440297

Search

Member:

	<b>Group ID</b>	<b>Age</b>	<b>Status</b>
	TZSPONSOR000114	30	Eligible
C/O WCS, 3734 W WISCONSIN AVE, MILWAUKEE, WI 53208			



**icare**

Messages | Notifications | My Profile | Preferences | Help

Search Claims Details and Create Claims

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**

Statement Summary (Required)

**Type of Bill**

Facility Type (Required)      Frequency (Required)

32 - Home Health service      Select frequency

**Statement Dates**

Statement From Date: 01/23/2024

Statement To Date: 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
- 78 - Licensed Free-standing Emergency Medical Facility

Statement Summary (Required)

**Type of Bill**

Facility Type (Required)      Frequency (Required)

32 - Home Health service      Select frequency

**Statement Dates**

Statement From Date: 01/23/2024

Statement To Date: 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 Summary (Required)

**Type of Bill**

Facility Type (Required)      Frequency (Required)

32 - Home Health service:      01 - Admit Through Dischi:

**Statement Dates**

Statement From Date (Required): 12/01/2023

Statement To Date (Required): 12/31/2023

## Admission Details

Admission Date

(Required)

Admission Hour

(Required)

Type of Admission

04/18/2023



17



Select type of admission

Admission Time

- 00
- 01
- 02
- 03
- 04
- 05
- 06
- 07
- 08
- 09
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18

Type of Bill

Facility Type (Required) Frequency

21 - Inpatient skilled nursing 02 - First Int

Admission Details

Admission Date (Required)

04/18/2023

Admission Time

Select type of admission

Admission Type is Required

## Admission Details

Admission Date

(Required)

Admission Hour

(Required)

Type of Admission

(Required)

04/18/2023



Admission Time



Select type of admission

Admission Sources

Select admission sources

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

(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

ttoconnect.com/tzf/provider/ui/provider/claims/create

logo Client Access System... Claim\_Form\_LTC\_Pr... SyferLock GridGuar... launchpad.human...  
ee Scheduler - Unless stated otherwise in a contracted provider's agreement, Care Medicare pays contracted and non-contracted providers according to...  
if Wisconsin Medicaid rates.  
for more information and links to the Fee Schedules: <https://www.carehealthplan.org/Claims/Claims-Processing/Medicare-Medicaid-Fee-Schedules.htm>

Admission Sources

9 - information Not Available

Discharge Details

Discharge Date

(Required)

04/18/2023



Discharge Status

(Required)

- discharge Time
- 00
  - 01
  - 02
  - 03
  - 04
  - 05
  - 06
  - 07
  - 08
  - 09
  - 10
  - 11
  - 12
  - 13
  - 14
  - 15
  - 16
  - 17
  - 18



Admission Sources

Select discharge status

- 0-Unknown Value
- 01-Discharged to home
- 02-Discharged/transferred to other short term
- 03-Discharged/transferred to skilled nursing facility
- 04-Discharged/transferred to intermediate
- 05-Discharged/transferred to another type
- 06-Discharged/transferred to home care
- 07-Left against medical advice
- 08-Discharged/transferred to home
- 09-Admitted as an inpatient to this hospital
- 10-Expired
- 11-Discharged/transferred to Court
- 30-Still patient

Select discharge status

Service Details (Required)

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

ICD Type

(Required)

Primary Diagnosis Code

(Required)

POA Indicator

ICD-10

Select ICD type

ICD-10

Enter primary diagnosis code

Select POA indicator

Service Details (Required)

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

ICD Type

(Required)

Primary Diagnosis Code

(Required)

POA Indicator

ICD-10

Z02.9

Select POA indicator

Service Line 1

Date of Service From

(Required)

Date of Service To

04/18/2023

04/18/2023

Enter KX Modifier for Live In Workers ONLY



## Service Line 1

+ Add Service Line

Date of Service From

(Required)

Date of Service To

(Required)

01/23/2024



01/23/2024



Revenue Code

(Required)

CPT / HCPCS

(Required)

Modifiers

0570



T1019



KX

NDC Code

Units

(Required)

Unit Type

(Required)

Charge

(Required)

Ambul

Enter NDC code



1

Units

\$ 0.00

NDC Code

Units

(Required)

Unit Type

(Required)

Charge

(Required)

Ambul

Enter NDC code



1

Units

\$ 0.00

Select unit type

Units

Minutes

Days

NDC Code

Units

(Required)

Unit Type

(Required)

Charge

(Required)

An

Enter NDC code



1

Units

\$ 1.00