

LTC Residential 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 Inpatient Claim**, click **next**.

Provider Information

Select the claim type, provider name, and the service address.

Select Claim Type (Required) = **Institutional Inpatient Claim**

Type of Bill

Click next , Facility Type (Required) 21- Inpatient skilled nursing

*note this facility type with the closet match to a residential facility for UB04 submissions

Frequency 3 – options

01 – Admit through Discharge

02 – First Interim Claim

03 – Continuing Interim Claim

04 – Last Interim Claim

When entering the above Facility Type and Frequency, they will be converted as follows for residential facility/AFH

21 01 will be: 861 – Respite Services

21 02 will be: 862 – First claim for Client

21 03 will be: 863 – Continuous claim for Client

21 04 will be: 864 – Last claim for Client

Statement From Date and Statement To Date

MM/DD/YYYY through **MM/DD/YYYY**

Admission Details

Admission Date (the date the member came to your facility) enter **MM/DD/YYYY**

Admission Hour

Select – admission time = **00**

Type of Admission

Select – 9 – Information Not Available

Admission Sources

Select – 9 – Information Not Available

Discharge Details

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

Discharge Hour (Required)

Select – discharge time = **00**

Discharge Status (Required)

Select – discharge status = 30 – Still patient

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

ICD Type (Required)

Select – ICD 10

Primary Diagnosis Code (Required)

Enter – Z02.9

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: 0120)

CPT/HCPCS (previously referred to as HIPAA)

Enter the code that is approved on your Service Request, it must be a 5 digit/character code.

- If a CPT/HCPCS is not provided, use only the Revenue code

Modifier

- Enter a comma between modifiers when entering more than one modifier.

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 LTC Residential 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)

Screen Shot 1

The screenshot shows the iCare website interface. The top navigation bar includes the iCare logo, a sign-out link, message notifications, and a notifications link. The main header features a greeting "Hello, Michelle Minogue" and a "Create Claim" button. The left sidebar lists navigation options: Home, Eligibility, Claims (which is highlighted in yellow), Authorizations, Member Management, and Additional Links. The main content area is titled "Member Information" and includes a sub-instruction: "Please provide the necessary details below to begin your search. Choose Gender when searching for a member with a same name". It features a "Search by:" section with radio buttons for "Member ID" (selected), "Member Name", and "Subscriber ID". A "Member ID" input field contains "440297" and is marked as "(Required)". A red arrow points to the "Search" button. Below the search area, a "Member:" section displays a blurred profile picture and a table with columns: Group ID, Age, and Status. The table data is: Group ID TZSPONSOR000114, Age 30, Status Eligible. At the bottom left, there is an address: C/O WCS, 3734 W WISCONSIN AVE, MILWAUKEE, WI 53208.

Search Claims [Create Claim](#)

Member Information [Provider Information](#) [Service Details](#) [View Estimate](#)

Member Information
Please provide the necessary details below to begin your search. Choose Gender when searching for a member with a same name

Search by :

Member ID Member Name Subscriber ID

Member ID (Required)

Enter Member ID

⚠ Member ID is required.

Search

Member:

Group ID	Age	Status
TZSPONSOR000114	30	Eligible

C/O WCS, 3734 W WISCONSIN AVE, MILWAUKEE, WI 53208

Search Claims

[Create E-Claim](#)

File/Orm. iQt

Provider Information

!Ser.let IJelals

Submit Claim

Provider Information

Selected File Claim type: (IG-1) Name: Md: File Service Address: \$

Claim Type

(Required)

Professional Claim

Professional Claim

Institutional Inpatient Claim

Institutional Outpatient Claim

Provider Name

(Required)

AU.JS CARE CENTER (ID: O'EM300001771 NPI: 157511671; Address: 2D16&4547; All 1111S; City: 1047; State: WY; ZIP: 82141, WY, UNITED STATES 512141)



Next

Provider Information

Provider Information

Service Details

1.

Submit Claim

Statement summary (Raq111ir)

Statement of Bill

Facility Type

(Required)

Frequency

(Required)

Statement Dates

From Date

(Required)

Statement To Date

(Required)

Select facility type

Select frequency

01/01/2023

11

04/18/2023

Select facility type

11 - Inpatient hospital

12 - Inpatient hospital (Med B only)

21 - Inpatient skilled nursing

22 - Inpatient skilled nursing (MedB only)

Search Claims	Create Claim					
		Provider Info	Item	Statement	View Estimate	Submit Claim
Information						
Statement Summary (Required)			Statement Dates			
Type of Bill	Frequency	Statement Dates	Statement To Date			
Enter Type (Required)	Frequency (Required)	Enter From Date (Required)	Enter To Date (Required)			
St	Select frequency	0411V:01J	0 1111:02J			
<div style="border: 1px solid #ccc; padding: 5px; width: 600px;"> <p>Select frequency</p> <ul style="list-style-type: none"> Selected 00 - Non-Payment/Zero Claim 01 - Admit Through Discharge 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 Poor Claim 08 - Void/Can't File Prior Item </div>						
Admission Details	Enter Admit/SS/100 Date (Required)	Type of Mass, 00 (Frequently Used)				
04/18/2012		Selected type OR B>1m1ssu:in				

Statement summary (Required)		Statement Dates	
Type of Bill		Statement From Date	Statement To Date
Facility Type	(Required)	Frequency	(Required)
21 - Inpatient skilled nursing	ii	04/18/2023	04/18/2023
		ii	ii

Admission Details				
<u>Admission Date</u>	(Required)	Admission Hour	(Required)	Type of Admission
0411812023		17		Select type of admission

Type of Bill

Facility Type (Required)

21 - Inpatient skilled nursing

Admission Details

Admission Date (Required)

04/18/2023

00

01

02

03

04

05

06

07

08

09

10

11

12

13

14

15

16

17

18

Messages | Notifications | &

(Required) Statement To Date

0 | 118/2023

Type of Admission

Select type of admission

⚠ Admission Type is Required

Admission Details	
Admission Date	(Required)
04/18/2023	Admission Hour
AdMISSIONTim	(Required)
<div style="border: 1px solid #ccc; padding: 5px; width: 100%;"> Select type of admission Select type of admission 1- Emergency 2 - unieni 3- El Cobre 4 - N!t,0,11 <input type="checkbox"/> a me.. - 1nrom1,d,or Nol;,N@labb: </div>	

Admission Sources	
<u>Select admission sources</u>	
<input checked="" type="checkbox"/> Select lddrn1@soi.ces	
0 • Trifisrlr liOn'l PS:,dli, Sll\$13'lal AlIIIIH Rtl'lal HOSP lal 1 • Pr,51Cllrl Rerlrlra1 2 • Clfflelll ♦ll!Jral 4 • Transfer 100m s P11:rl)18! 5 • Transradrom SNF B • Tra!!lrlr from another UlchH♦ e ce ... Enrcr r.nl .. • n'Dml111Dn t-ill Ava lable - < o ,a o < b same HHA D aMfo,, rlo,n,npa111t1t in same f t, E • r.ansler from ASC If - Tra!!S1el fillfl 1-DSp.:E SELECT ONE: ,rr.gr.	

Discharge Details

Discharge Date

(Required)

Discharge Hour

04/18/2023

17

17

The screenshot shows the 'Discharge Date' field with the value '04/18/2023' and the 'Discharge Hour' field with the value '17'. A red arrow points to the 'Discharge Hour' field, which is labeled '(Required)'.

The screenshot shows a dropdown menu for 'Select discharge status' with the following options: 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, and 30-Still patient. The '30-Still patient' option is highlighted with a red arrow.

Service Details (Required)

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

(Required)

Primary Diagnosis Code

POA Indicator

ICD-10

Select ICD type

ICD-10

Enter primary diagnosis code

Select POA indicator

17

Service Details (ReQuired)

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

ICDType

(Required)

Pri_a]Y. Diagnosis Code

(Required)

POA Indicat

ICD-10

Z02.9

Select POA Indicat

Service Line 1

Date of Service From

(Required)

Date of Service To

01/01/2023

04/18/2023

Revenue Code

CPT/HCPCS

Modifiers

Enter Revenue Code

Q

Enter CPT / HCPCS

Q

Enter modifiers

Revenue Code

CPT/HCPCS

Modifiers

0120

Q

Enter CPT / HCPCS

Q

Enter modifiers

NOC Code

Units

Regu1red

Unit Type

(Required)

Charge

(Required)

Amt

Enter NDC code

Q

Units

...

\$0.00

Z

NDC Code

(Required)

Unit Type

(Required)

Charge

(Required)

Enter NDC code



0

NOC Code

Units

(Re.quired)

Unit Type

(Required)

Charge

(Required)

Amt

Enter NOC code

1

Units

Claims Service Line

Service Date(s)	Revenue Code	Charged	Allowed	Plan Discount	Copay	Coinsurance	Deductible	Member Responsibility
04118J2023- 04118J2023	0120	51.00	\$0.00	\$1.00	\$0.00	\$0.00	\$0.00	\$0.00

CPT Description

0120-Room & Board - Semi-private [Two Beds]