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Glossary

**CAN** - Coordinated Access Network

**CBT** – Computer Based Training

**CHIP** - Children’s Health Insurance Program

**DME** - Durable Medical Equipment is equipment that can be used over and over again; is ordinarily used for medical purposes; and is generally not useful to a person who is not sick, injured or disabled.

**DOB** – Date of Birth

**DOM** – Division of Medicaid

**Exception Code** – A code providing an explanation of why the claim or line item denied.

**EDI** - Electronic Data Interchange is the electronic transmission of structured data between organizations.

**EFT** – Electronic Funds Transfer is the transfer of money initiated through electronic terminal, automated teller machine, computer, telephone or magnetic tape.

**EPSDT** - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a free health care program for Mississippi’s children ages birth through 21 who are eligible for Medicaid. It provides a way for children to get medical exams, check-ups, follow-up treatment and special care they need to make sure they enjoy the benefits of good health.

**eQHealth Solutions** - eQHealth is the Utilization Review Organization contracted with the Division of Medicaid for the state of Mississippi.

**ERA** – Electronic Remittance Advice

**FAQs** – Frequently Asked Questions (FAQ) are a collection of commonly asked questions regarding a particular subject and the answers to the questions.

**HCBS** – Home and Community Based Services provides individualized assistance with daily living activities to people with disabilities through Medicaid’s optional personal care services program.

**LTC** – Long Term Care (LTC) includes any chronic or disabling condition which requires nursing care or constant supervision.

**MississippiCAN** - MississippiCAN is designed to get a better return on Mississippi’s health care investment by improving the health and well-being of Medicaid beneficiaries. MississippiCAN is a statewide coordinated care program.

**MississippiCHIP** – MississippiCHIP provides health coverage for uninsured children up to age 19 years old.

**NDC** – The National Drug Code (NDC) system was originally established as an essential part of an out-of-hospital drug reimbursement program under Medicare. The NDC serves as a universal product identifier for human drugs.

**ORP** – Ordering, Referring and Prescribing.

**OTC** – Over the Counter

**PA** - Prior Authorization (PA) is certification for drugs and medical services which exceed the benefit limits afforded under the Medicaid program.

**PAS** – Pre-Admission Screening
PCP – A Primary Care Physician or Primary Care Provider (PCP) is a physician who provides primary care. The primary care physician acts as a gatekeeper to the medical system.

Plan of Care – A Plan of Care (POC) is a written plan that directs what type of services and treatment are received.

POS – Point of sale

Quarterly – Every 3 months.

Rebatable – A deduction from an amount to be paid or a return of part of an amount given in payment.

Recertification - The act of having one’s certification renewed.

SSN – Social Security Number

TCN – Transaction Control Numbers (TCNs) are assigned to claims as they are scanned. This 17 digit number uniquely identifies the claim. The TCN assigned to each document allows the document to be tracked throughout the MMIS. The digits and groups of digits in the TCN have special meanings.
This is the homepage of the **Mississippi Envision Web Portal**.

1) **What’s New?**
   - Most recent announcement regarding the Mississippi Medicaid Program

2) **Late Breaking News**
   - An all-inclusive list of notices to providers regarding mass adjustment, policy changes, training, and etc.

3) **The Current Medicaid Provider Bulletin**
   - The Provider Bulletin, a quarterly publication, is a useful resource for providers regarding Medicaid policies and procedures changes and important updates.

4) **Visit**
   - Links to Division of Medicaid, eQHealth Solutions, and Report Fraud and Abuse
Web Portal Registration

The picture above displays the homepage of the Mississippi Envision Web Portal. To register, click Web Registration. It is important for Providers to register to the Web Portal for the following reasons:

- It is mandatory to utilize secure features
- Easily file a claim and know the status instantly, check eligibility, and etc.
- Master Administrator delegates web portal privileges

After you click Web Registration, the Account Registration page will appear.

1. Select Provider using the drop down menu.
2. Click Submit.
After clicking Submit, the **Provider Account Registration** page will appear. All fields with a red asterisk (*) are required to complete registration.

- Log-in is established by the user and should be easy to remember
- Provider ID (8 Digit Mississippi Medicaid Id Number)
- Account Number (Last 5 digit of the Bank Account number associated with your Medicaid Id Number)
- Last Name (when applicable)
- First Name (when applicable)
- SSN (Last Four Digits) (when applicable)
- Organization Name (Name based upon Provider Enrollment when applicable)
- EIN (Employer Identification Number) (when applicable)
- Email address
- Hint Question
Log-in

New Users

1. Enter your User ID
2. Password (Copy temporary password from email. Please do not copy spaces or periods when copying the password. This can create errors when attempting to log in.
3. Prompt to reset password
4. After logging in, the word “Welcome” will display along with your name and Provider number in the upper right-corner.

Current Users

1. Enter your User ID and Password
2. After successful login, your name and provider number will be displayed in the upper right-corner.
If you have any messages, an alert will be displayed under the “Welcome” header. Upon successful login, you can access messages from the Provider tab. Select **Communications Option < Manage Messages**.
Provider tab

Once you are logged into the Secure-Side of the web portal, the Provider tab will have more options available. The Provider tab on the Secure-Side of the web portal consists of the following options:

- Claims Entry
- Communication Options
- EHR Incentive Program
- Fee Schedule
- Forms
- General Billing Tips
- Inquiry Options
- Long Term Care
- MississippiCAN
- MississippiCHIP
- Prior Authorization
- Provider Bulletin
- Provider Enrollment
- Provider Hotlinks
- Provider Rates
- Provider Type Specific Information
- Report Third Party Insurance
- School Based Services
- Search for Provider
- Searching for Ordering/Referring/Prescribing Provider
- Statistics
- Submission Options
- Training Material / CBT
- User Admin Options
- WINASAP 5010 Software
Under the **Claims Entry** tab you are able to submit the following claims or forms via web portal:

- **Enter Medical Claim**
  - ADA Dental Claim
  - Adjustment/Void Form
  - CMS 1500 or CMS 1500 Medicare Crossover
  - UB04 or UB04 Medicare Crossover

- **Pharmacy Claim**
ADA Dental Claim

Once you select the **ADA Dental claim form** from the menu, the **End User License Agreement** will display.

1. Read the **End User License Agreement** and if you agree, click **Accept**. After clicking **Accept**, a screen will appear that allows you to enter the Beneficiary’s ID you will be filing on the claim.
2. Next, enter the **Beneficiary ID**.
3. Once you have entered this information, click **Submit**.
4. After you click **Submit**, The electronic **ADA Dental Claim Form** will display.
Points to Ponder:

- Any required fields will be denoted by a red asterisk (*).

- Any billing requirements for billing dental claims will still be applicable (i.e. the submission of tooth/quadrant numbers. You may refer to the Dental Administrative Code and billing manual if needed).

- Please be sure to enter your Provider Signature date under the “Ancillary Claim Data” section of the claim as this is a required field. (This date cannot be a future date.)

- If attachments will be submitted with the claim, you may attach the document(s) under the “Ancillary Claim Data” section of the claim. (You will have to respond “Yes” to the question, “Does the Claim have Attachments?” in order for the appropriate fields to be displayed).

- Diagnosis codes are also entered under the “Ancillary Claim Data” section of the claim. (Please be sure to use ICD-10 codes for any dates of service on or after 10/01/2015. Also be sure to include the decimal point when entering the diagnosis code).

- If you have multiple lines to bill, you may select “Add Service Line Items” to add additional lines.

- Notice that your submitted charges are calculated automatically in the Summary section of the claim.

- If there is TPL information to be entered, it can be captured in the Summary section of the claim.

- Once data entry has been completed, you will mark the box labeled, “I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for the procedures” and click on Submit.
- The system will process your request.
- Once processed you may scroll to the top right corner of your screen where a TCN and claim status (To be Paid, To be Denied, etc.) will be displayed.
Provider < Claims Entry < Enter Medical Claim < Adjustment/Void Form

Once you select the Adjustment/Void form from the menu, the End User License Agreement will display.

1. Read the End User License Agreement and if you agree, click Accept. After clicking Accept, a screen will appear that allows you to enter the Transaction Control Number (TCN) of the claim you will be Adjusting/Voiding.
2. Next, enter the **Transaction Control Number (TCN)**.
3. After entering the TCN, select the action you will be performing (Adjustment/Void).
4. Once you have entered the correct information, click **Submit**.

**Tips for Adjusting a Claim:**

- The claim information previously billed will display.
- If you are adjusting claim line information, you will select edit on the line item and make the necessary corrections. Once corrections are completed, you will select **Save**.
- You will have to select a “Description of the Request” to make the adjustment. If you have another explanation that is not listed in the drop down menu, you may enter that explanation in the box provided.
- Once data entry has been completed, you will mark the box labeled, “I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for the procedures” and the box labeled, “I acknowledge that any over payments as a result of this adjustment/void will be deducted from future claim payments” click on **Submit**.
- The system will process your request.
- Once processed you may scroll to the top right corner of your screen where the TCN and claim status will be displayed.

**Tips for Voiding a Claim:**

- The claim information previously billed will display.
- If you are voiding the claim, scroll down to the bottom of the page to the section labeled “Info”.
- In the field labeled “Description of the Request” select the void reason.
• Once completed, you will mark the box labeled, “I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for the procedures” and the box labeled, “I acknowledge that any over payments as a result of this adjustment/void will be deducted from future claim payments” click on Submit.

• The system will process your request.

• Once processed you may scroll to the top right corner of your screen where a TCN and claim status will be displayed.
Once you select the **CMS 1500 or CMS 1500 Medicare Crossover** form from the menu, the **End User License Agreement** will display.

1. Read the **End User License Agreement** and if you agree, click **Accept**. After clicking **Accept**, a screen will appear that allows you to enter the Beneficiary’s ID you will be filing on the claim.
2. Next, enter the **Beneficiary ID**, then click **Submit**

3. Afterwards, the **CMS 1500 or CMS 1500 Medicare Crossover form** *(Health Insurance Claim form)* will display. **Note:** Any required fields will be denoted by a red asterisk (*).

4. If the Beneficiary has Medicare primary, select **YES** next to “This is a Medicare Part B claim”. A drop down will generate that allows you to enter the Beneficiary’s Medicare information. If the Beneficiary does not have Medicare primary, select **NO**.

5. **Provider Information** - Provider information will automatically be populated based on the log-in information you entered. If the appropriate NPI is not listed, please contact your Provider Field Representative.
• The Beneficiary’s information will automatically populate based on the Beneficiary’s ID you entered.

6. **Prior Authorization** - If any services that were rendered required a Prior Authorization, you should input the number in the Prior Authorization field.

7. **Timely Filing TCN** - If this claim has a Timely Filing TCN, input the TCN in the Timely Filing TCN field to show proof of timely filing, if the claim is past one year from the Date of Service (DOS).

8. **Provider Signature** - Provider will enter the date that the claim is submitted, not the DOS.
9. **Diagnosis Codes** - In this section, Users will enter any diagnosis codes associated with the claim. Make sure that the letters associated with the diagnosis codes are capitalized. Also, be sure to include the decimal point when entering the diagnosis code.

10. **Does the Claim have Attachments?** – If you select **YES**, a drop down will appear that allows you to select the type of attachment. Once the type of attachment is selected, click browse to upload the attachment. If yes select **NO**, then you may continue to the next step.

![Basic Line Item Information](image.png)

11. **Basic Line Item Information** – The next section allows you to add service line items. Click Add Service Line Item highlighted in blue. A dropdown will then generate that allows you to enter the line item information.

12. **Service Begin/End Date** - Enter the Service Begin Date and the Service End Date.


14. **Provider ID** - Enter the 8-digit Medicaid Provider ID of the servicing Provider. The NPI and the Taxonomy Code will automatically populate.

15. **Submitted Charges** - Enter the Submitted Charges for the line item.

16. **Modifiers** - If you have any Modifiers, enter them in the Modifiers section.

17. **Units** - Enter the number of Units for the line item.

18. **Place of Service** - Select the Place of Service from the menu.

19. Click **Save**

20. To add additional Service Line Items, repeat steps 10 – 17 for each individual line item.
21. **Summary** - Once all of the line items have been entered and saved, the next section will be the claim summary. The total submitted charges will be calculated from the saved line item entries. Click the *(I hereby certify...)* agreeing to the terms, then click **Submit**.

22. Once submitted, the claim form will appear giving the user the claim’s TCN Number, if the claims was submitted successfully, and whether the claim is to be paid or denied. If the Claim Status is To Be Paid, you are done and may stop here. **If the Claim Status is C-To Be Denied, continue to step 23.**
23. If the claim status is **C-To Be Denied**, scroll to the bottom of the claim submission page to see the **Exception Code**. The Exception Code informs you on why the claim is denied.

24. Once you have the Exception Code, to find the meaning of this code, click **Edit Code** to access the MMIS Edit Codes Description.
25. MMIS Edit Codes Description page gives you the description of the Exception Code and what error was made. Once you have the description of the Exception Code, go back to the Claims Submission page.

26. Next, click Edit next to the proper line item to make an adjustment the Exception Code has given you. If you have more than one line item that is denying, you will have to adjust each individual line item.

27. Once you make the proper adjustment(s), click Submit to resubmit the claim. If the claim denies again, repeat steps 23-26.

Points to Ponder:

- Any required fields will be denoted by a red asterisk (*).

- Any billing requirements for billing Professional claims/Part B Crossover claims will still be applicable (You may refer to the Administrative Code and billing manual if needed).

- If you are billing for Part B Crossover services, you will need to select “Yes” to the statement, “This is a Medicare Part B claim”. You will also need to attach the Medicare EOMB.

- Please be sure to enter your Provider Signature date under the “Additional Claim Data” section of the claim as this is a required field. (This date cannot be a future date.)

- If attachments will be submitted with the claim, you may attach the document(s) under the “Additional Claim Data” section of the claim. (You will have to respond “Yes” to the question “Does the Claim have Attachments?” in order for the appropriate fields to be displayed.)

- Diagnosis codes are also entered under the “Additional Claim Data” section of the claim. (Please be sure to use ICD-10 codes for any dates of service on or after 10/01/2015. Also be sure to include the decimal point when entering the diagnosis code).
**UB04 or UB04 Medicare Crossover**

Once you select the **UB04 or UB04 Medicare Crossover** form from the menu, the **End User License Agreement** will display.

1. Read the **End User License Agreement** and if you agree, click **Accept**. After clicking **Accept**, a screen will appear that allows you to enter the Beneficiary’s ID you will be filing on the claim.
2. Next, enter the **Beneficiary ID**, then click **Submit**

3. Afterwards, the **UB04 or UB04 Medicare Crossover** will display.  
   **Note:** Any required fields will be denoted by a red asterisk (*).

4. If the Beneficiary does not have Medicare primary, select **YES** next to "**This is a Medicare Part A claim**". If the Beneficiary has Medicare primary, select **YES** next to "**This is a Medicare Part B claim**". A drop down will generate that allows you to enter the Beneficiary’s Medicare information.

5. Provider information will automatically be populated based on the log-in information you entered. If the appropriate NPI is not listed, please contact your Provider Field Representative.
6. **Prior Authorization** - If any services that were rendered required a Prior Authorization, you should input the number in the Prior Authorization field.

7. **Timely Filing TCN** - If this claim has a Timely Filing TCN, input the TCN in the Timely Filing TCN field to show proof of timely filing if the claim is past one year from the Date of Service (DOS).

8. **Provider Signature** - Provider will enter the date that the claim is submitted, not the DOS.

- The Beneficiary’s information will automatically populate based on the Beneficiary’s ID you entered.
9. **Diagnosis Codes** - In this section, Users will enter any diagnosis codes associated with the claim. Make sure that the letters associated with the diagnosis codes are capitalized. Also, be sure to include the decimal point when entering the diagnosis code.

10. **Does the Claim have Attachments?** – If you select **YES**, a drop down will appear that allows you to select the type of attachment. Once the type of attachment is selected, click **Browse** to upload the attachment. If yes select **NO**, then you may continue to the next step.

11. **Basic Line Item Information** – The next section allows you to add service line items. Click **Add Service Line Item** highlighted in blue. A drop-down will then generate that allows you to enter the line item information.

12. **Service Begin/End Date** - Enter the Service Begin Date and the Service End Date.

13. **Procedure Code** - Enter the Procedure Code

14. **Provider ID** - Enter the 8-digit Medicaid Provider ID of the servicing Provider. The NPI and the Taxonomy Code will automatically populate.

15. **Submitted Charges** - Enter the Submitted Charges for the line item.

16. **Modifiers** - If you have any Modifiers, enter them in the Modifiers section.

17. **Units** - Enter the number of Units for the line item

18. **Place of Service** - Select the Place of Service from the menu.

19. Click **Save**

20. To add additional Service Line Items, repeat steps 10 – 17 for each individual line item.
21. **Summary** - Once all of the line items have been entered and saved, the next section will be the claim summary. The total submitted charges will be calculated from the saved line item entries. Click the *(I hereby certify...)* agreeing to the terms, then click **Submit**.

22. Once submitted, the claim form will appear giving the user the claim’s TCN Number, if the claims were submitted successfully, and whether the claim is to be paid or denied. If the Claim Status is To Be Paid, you are done and may stop here. **If the Claim Status is C-To Be Denied, continue to step 23.**
23. If the claim status is **C-To Be Denied**, scroll to the bottom of the claim submission page to see the **Exception Code**. The Exception Code informs you on why the claim is denied.

24. Once you have the Exception Code, to find the meaning of this code, click **Edit Code** to access the MMIS Edit Codes Description.
25. MMIS Edit Codes Description page gives you the description of the Exception Code and what error was made. Once you have the description of the Exception Code, go back to the Claims Submission page.

26. Next, click **Edit** next to the proper line item to make an adjustment. If you have more than one line item that is denying, you will have to adjust each individual line item.

27. Once you make the proper adjustment(s), click **Submit** to resubmit the claim. If the claim denies again, repeat steps 23-26.

**Points to Ponder:**

- Any required fields will be denoted by a red asterisk (*).
- Any billing requirements for billing Institutional claims/Part A and B Crossover claims will still be applicable (You may refer to the Administrative Code and billing manual if needed).
- If you are billing for Crossover services, you will need to select “Yes” to the statement, “This is a Medicare Part A/B claim.” You will also need to attach the Medicare EOMB.
- If attachments will be submitted with the claim, you may attach the document(s) under the “Claim Information” section of the claim. (You will have to respond “Yes” to the question “Does the Claim have Attachments?” in order for the appropriate fields to be displayed.)
- Diagnosis codes are also entered under the “Claim Information” section of the claim. (Please be sure to use ICD-10 codes for any dates of service on or after 10/01/2015. Also be sure to include the decimal point when entering the diagnosis code).
- If you have multiple lines to bill, you may select “Add Service Line Items” to add additional lines.
- Notice that your submitted charges are calculated automatically in the Summary section of the claim.
- If there is TPL information to be entered, it can be captured in the Summary section of the claim.
- Once data entry has been completed, you will mark the box labeled, “I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple
visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for the procedures” then click “Submit”.

- The system will process your request.

- Once processed, you may scroll to the top right corner of your screen where a TCN and claim status (To be paid, To be Denied, etc.) will be displayed.
Once you select the **Pharmacy Claim** form from the menu, the **End User License Agreement** will display.

1. Read the **End User License Agreement** and if you agree, click **Accept**. After clicking Accept, a screen will appear that allows you to enter the Beneficiary’s ID you will be filing on the claim.
2. Next, enter the **Beneficiary ID**
3. Once you have entered the correct **Beneficiary ID**, click **Submit**.
4. After clicking **Submit**, the **Pharmacy Claim** form will display.
Communication Options

Provider < Communication Options

The **Communication Options** tab allows you to access the following options:

- **Access Seminar**
  Allows you to access information on upcoming seminars

- **Manage Messages**
  Allows you to access your Remittance Advice (RA). Please be advised that these RAs are only available for 60 days.

- **Submit a request to customer service**
  This functionality allows you to submit an inquiry to a customer service representative. Allow a minimum of 2 business days for a response.

**Note:** This is not an email system
The Electronic Health Records (EHR) Incentive Programs were developed to encourage eligible professionals and eligible hospitals to adopt, implement, upgrade (AIU), and demonstrate meaningful use of certified EHR technology. Health care providers receive payments for participating in the Medicare and Medicaid EHR Incentive Programs. Below is an example of the EHR Incentive Program page.

This site will help Eligible Professionals and Eligible Hospitals attest for Electronic Health Records (EHR) Incentive Payments through the MS State Level Registry (MS SLR) and offers information about this program.
Provider < Fee Schedule < Downloadable Fee Schedules

The **Fee Schedule** is a complete listing of fees used by the Division of Medicaid to pay doctors or other providers/suppliers for services. This is where you access the downloadable Fee Schedules (Excel file) after accepting the disclaimer agreement. Below is an example of the Fee Schedule.

![Fee Schedule Example](image)
Interactive Fee Schedule

Once you click **Interactive Fee Schedule**, the page below will display.

1. Enter a specific procedure code and date of service.
2. Click **Interactive Fee Schedule**.
Below is an example of an **Interactive Fee Schedule**:

Once you have accessed the desired Interactive Fee Schedule, you will have the option to **Print** or generate a **New Inquiry**.
Provider < Forms

The **Forms** tab allows you to access the following forms:

- Change of Address Form
- National Provider Identifier (NPI) Submission Form
- NF Ventilator Dependent Care Services Addendum
Provider General Billing Tips

General Billing Tips include the most common concerns regarding billing for providers. Below is an example of the General Billing Tips page.
Inquiry Options

Provider < Inquiry Options

**Inquiry Options** allows you to find the status updates on Claims, Beneficiary eligibility, and Prior Authorization.

1) **Claim Status Inquiry**

**Provider < Inquiry Options < Claim Status Inquiry**

**Claim Status Inquiry** allows you to check the status of a claim by simply entering the claim’s Transaction Control Number (TCN) or Beneficiary ID, with service dates and claim type. Above is an example of the page that will display once you click Claim Status Inquiry.
2) **Eligibility Inquiry**

![Eligibility Inquiry](image)

**Provider < Inquiry Options < Eligibility Inquiry**

**Eligibility Inquiry** allows you to find a Beneficiary’s eligibility status by entering the appropriate Beneficiary ID, first name, last name, SSN, and DOB. To check eligibility for a particular service date provide the beginning and ending service date(s) also.

3) **MS Medicaid Covered OTC NDC List**

![MS Medicaid Covered OTC NDC List](image)

**Provider < Inquiry Options < MS Medicaid Covered DTC NDC List**

**MS Medicaid Covered OTC NDC List** is a weekly updated list that includes all Medicaid covered prescription NDCs along with the generic brand, name brand and manufacturer name.
4) **PA (Prior Authorization) Inquiry**

![PA Inquiry Form]

*Provider < Inquiry Options < PA Inquiry*

**PA inquiry** allows you to see the Prior Authorization (PA) status for medical and pharmacy PAs less than 2 years from the current date.

5) **Payment Status Inquiry**

![Payment Status Inquiry Form]

*Provider < Inquiry Options < Payment Status Inquiry*

**Payment Status Inquiry** displays your latest Remittance Advice payment total. This system is updated weekly. Above is an example of a Payment Status Inquiry results page.

6) **Physician Administered Drug Inquiry**

![Physician Administered Drug Inquiry Form]

*Provider < Inquiry Options < Physician Administered Drug Inquiry*

**Physician Administered Drug Inquiry** allows you to check the name of a drug, drug rebatable status and DESI status by entering the NDC and service date(s).
Long Term Care

The **Long Term Care** tab allows you to access the following:

**HCBS (Home and Community Based Services)**
- HCBS 105
- HCBS Plan of Care
- Recertification

**PAS (Pre Admission Screening)**
- Application for potential beneficiary
- Application for Medicaid beneficiary
- Hard Copy PAS application
- Remote PAS application
HCBS (Home and Community Based Services)

1) **HCBS 105**

All fields marked with a red asterisk (*) are required to submit the **HCBS 105** form.
2) **HCBS Plan of Care**

![HCBS Plan of Care form]

**Provider < Long Term Care < HCBS < HCBS Plan of Care**

All fields mark with a red asterisk (*) are required to submit the **HCBS Plan of Care** form. To add the waiver service line items, enter all applicable information and click **Save**. To add attachments, click **Browse** in the lower left corner of the application. Once completed, click **Submit**.

3) **Recertification**

![Recertification form]

**Provider < Long Term Care < HCBS < Recertification**

Click **Create** to complete the recertification application. If you are recalling an existing Long-Term Care application enter your **Reference Number** then click **Recall**. If you do not have a Reference Number you will have to submit a new application.
PAS (Pre-admission Screening)

Provider < Long Term Care < PAS

1) Application for Potential/Medicaid Beneficiary

Click Create to complete the recertification application. If you are recalling an existing Long-Term Care application, enter your Reference Number then click Recall. If you do not have a reference number you will have to submit a new application.
2) **Hard Copy PAS Application**

![Image of Hard Copy PAS Application]

*Provider < Long Term Care < PAS < Hard Copy PAS Application*

This tab allows you to download the PDF version of the PAS Application, print and complete it, then mail it into the address provided.

3) **Remote PAS Application**

![Image of Remote PAS Application]

*Provider < Long Term Care < PAS < Remote PAS Application*

This tab allows you to download the PDF version of the Remote PAS Application, complete the application and submit it electronically. Please be sure to read all of the instructions before downloading the Remote LTC/PAS PDF located at the bottom of this page.
MississippiCAN Information

The MississippiCAN Information tab will redirect you to the Division of Medicaid website where it provides pertinent information regarding MississippiCAN Beneficiary Workshops, resources and updated schedules.
MississippiCHIP

MississippiCHIP Information

The **MississippiCHIP Information** tab will redirect you the Division of Medicaid website where it provides pertinent information regarding the CHIP program, who is eligible for CHIP, the income limits for the program and the MississippiCHIP State Plan Amendments.
Prior Authorization

Effective December 1, 2013 Prior Authorization requests, excluding Pharmacy PAs, previously submitted to Division of Medicaid (DOM) via the Envision Web Portal shall be submitted to eQHealth Solutions. Providers may submit requests on-line at http://ms.eqhs.org/. Contact eQHealth Solutions at (866) 740-2221 or (601) 360-4961.

1) Pharmacy Prior Authorizations
Provider < Prior Authorizations < Enter PA Request < Pharmacy

This tab allows you to access Prior Authorization Instructions for pharmacy providers and submit a Pharmacy Prior Authorization Request.

2) Pharmacy Prior Authorization Instructions

![Pharmacy Prior Authorization Instructions](image)

Provider < Prior Authorization < Enter PA request < Pharmacy < PA Instructions

The PA Instructions tab directs you to the Division of Medicaid’s website regarding PA instructions.

- Division of Medicaid/Pharmacy PA Unit Website - [http://www.medicaid.ms.gov/PharmacyForms.aspx](http://www.medicaid.ms.gov/PharmacyForms.aspx)
- Web Portal Pharmacy PA Submission Guide - [Pharmacy PA Guide](#)
- Additional PA Submission Instructions from Webinar - [Additional PA Submission Instructions from Webinar](#)

3) Pharmacy Prior Authorization Request

![Pharmacy Prior Authorization Request](image)

Enter the Provider’s NPI, the Beneficiary’s ID and dates of service and click “Submit”.

Secure Web Portal Guide
Provider Bulletin

The **Provider Bulletin** is a useful resource for providers regarding Division of Medicaid policies, procedures changes and updates.

- **Provider Bulletins**
  - Released quarterly (March, June, September and December)
  - Search by Date Range, Keyword or Date and Keyword.
Provider Enrollment

The Provider Enrollment tab allows you to access the following Provider Enrollment options:

- Check Enrollment Status
- Download Enrollment Package
- EFT Enrollment (Direct Deposit)
- Enroll Online
- ERA Enrollment
- Ordering/Referring/Prescribing Enrollment Application
- Primary Care Provider Attestation
- Request an Enrollment Package
- Trading Partner Information (EDI)

1) Check Enrollment Status

Provider < Provider Enrollment < Check Enrollment Status

This option allows you to check the general status of your Provider application. You must enter the tracking number assigned to the application. Once submitted, you will get a status indicating if the Provider Application has been processed and approved or is under review.
2) **Download Enrollment Package**

![Provider Enrollment Required Documentation](image)

**Provider < Provider Enrollment < Download Enrollment Package**

A. The supporting documents that are required with the Provider Enrollment application are listed on this page.

B. Once you have reviewed your application and signatures, mail the completed application and documents to the Provider Enrollment address listed.

C. To download the Provider Enrollment package or supporting documents, Providers can select the PDF links for the forms on this page where it says “Download Provider Enrollment Package”.

3) **EFT Enrollment (Direct Deposit) – Direct Deposit Authorization / Agreement Form**

![EFT Enrollment Form](image)

**Provider < Provider Enrollment < EFT Enrollment (Direct Deposit)**

- This is the online form to update your Electronic Funds Transfer (Direct Deposit).
• A voided check or letter from the bank showing your account type, account number and routing number will need to be uploaded with this form in order to complete your enrollment process and begin depositing your funds electronically.

4) **Enroll Online**

![Enroll Online Form](image)

**Provider < Provider Enrollment < Enroll Online**

1. **Create a New Application** – To submit a provider enrollment application online, the provider must enter a valid email address to start the online application.

2. **Recall Your Existing Application** – Once the provider starts the online application, the application will be given a Reference Number. The Provider can save the application and use the Reference Number to refer back to the saved application.

3. **Forgot Your Reference Number** – The provider can enter valid email to get the Reference Number associated with that email address.

5) **ERA Enrollment**

![ERA Enrollment Form](image)

**Provider < Provider Enrollment < ERA Enrollment**

• Enrolled EDI providers can submit a completed ERA Provider Agreement and Enrollment Form online.
6) **Ordering / Referring / Prescribing Enrollment Application**

1. **Application Instructions** – This page lists the required documents for online and paper submission of application for non-servicing providers. The provider enrollment address is listed for paper applications.

2. **Download Application** – Printable 7 page ORP application to be mailed.

3. **Enroll Online**
   a. **Create a New Application** – To submit a provider enrollment application online, the provider must enter a valid email address to start the online application.
   b. **Recall Your Existing Application** – Once the provider starts the online application, the application will be given a reference number. Provider can save application and use the reference number to refer back to the saved application.
   c. **Forgot Your Reference Number** – The provider can enter valid email to get the reference number associated with that email address.

4. **Frequently Asked Questions**
5. **Status Inquiry**
7) **Primary Care Provider Attestation**

![Primary Care Provider Attestation](image)

**Provider < Provider Enrollment < Primary Care Provider Attestation**

1. The **Primary Care Provider Attestation** tab allows you to access the link to the Primary Care Provider Attestation Form and Instructions on how to complete it.
2. The Provider is able to check the status of their attestation by entering their NPI number.

8) **Request an Enrollment Package**

![Request an Enrollment Package](image)

**Provider < Provider Enrollment < Request an Enrollment Package**

This tab allows Providers to request a Provider Enrollment package to be mailed to them.
9) Trading Partner Information (EDI)

Provider < Provider Enrollment < Trading Partner Information (EDI)

- Providers can download WINASAP 5010 Software
- Access to WINASAP user manual
- Related links access information about transmitting
Provider Hotlinks

Provider Hotlinks provide useful resources to other informative websites. The following links can be found under the Provider Hotlinks tab:

- Centers for Medicare and Medicaid Services
- Department of Health
- Department of Human Services
- Medicare
- Mississippi.gov
- MS Department of Mental Health
- Social Security Administration
Provider Rates

The **Provider Rates** tab gives options on provider rates for multiple facilities. Once the facility type is selected, the current provider rates will be displayed by the facility name. Provider Rates for the following facility types can be found under the Provider Rates tab.

- Dialysis Center
- FQHC
- Home Health
- Hospice
- ICF-MR
- Nursing Facility
- Psychiatric Residential Treatment Facility
- Rural Health Clinics
- State Department of Health
Provider Type Specific Information

Policy information, billing tips, FAQs and forms for the specific provider types can be found under the **Provider Type Specific Information** tab. Each Provider type found under this tab is listed below:

- Ambulance
- Clinics
- Dental
- DME
- Home Health
- Hospitals
- Long Term Care
- Mental Health
- MS Cool Kids (EPSDT)
- Pharmacy
- Physician
- Therapy
- Transportation
- Vision & Hearing
Report Third Party Insurance

The **Report Third Party Insurance** tab allows you to update a Beneficiary’s Third Party Insurance information by providing the following information:

- Beneficiary Policy Information
- Carrier Information
- Employer/Group Information

Below is an example of the **TPL Update** submission page:
Secure Web Portal Guide

School Based Services

Search for Provider

The **Search for Provider** tab allows you to search for a specific provider by the following options:

- Provider Type
- Specialty
- Name
- City, State
- County

Once you have entered the correct information click **Submit**. Below is an example of the Provider Search page:
Searching for Ordering/Referring/Prescribing Provider

This page allows you to lookup Ordering, Referring, and Prescribing Providers with an open Mississippi Medicaid Provider Number:

These providers are only authorized for ordering, referring, or prescribing. Search by NPI or the specialty along with the name and address.
Statistics

Provider < Statistics

Medicaid Statistics by Year

To view .PDF files you will need Adobe Acrobat Reader installed on your machine. For a free download please visit the Acrobat Reader icon.

<table>
<thead>
<tr>
<th>Year</th>
<th>CMS 2002</th>
<th>Dollars Paid by Eligibility Source</th>
<th>Providers Receiving More Than $10,000</th>
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<tr>
<td>2003</td>
<td>View</td>
<td>View</td>
<td>View</td>
</tr>
</tbody>
</table>
Submission Options

Provider < Submission Options

This tab allows you to access the following Submission Options:

1. **Provider Re-verification**

   ![Provider Re-verification](image)

   **Provider < Submission Options < Provider Re-verification**

   - This section of the web portal allows users to complete the re-verification application. To begin, click on the Create button.
   - If you would like to review a re-verification application that you did not complete or to review a returned application, enter the **Reference Number** from the previous entry then click on the **Recall** button.
2. **Provider Update**

![Provider Update Screen](image)

*Provider < Submission Options < Provider Update*

- This section of the web portal allows users to make certain updates to existing provider files (i.e. address, phone numbers, email addresses, etc.).

3. **Upload Document**

![Upload Document Screen](image)

*Provider < Submission Options < Upload Document*

- This section of the web portal allows users to upload various documents via the web portal to the payer.

- There are fields available that allows the user to verify the form and/or document type that will be uploaded, to enter a TCN (when applicable), and a section that allows the user to upload a document when that option is chosen.

4. **Upload/Download Batch Files**
Provider < Submission Options < Upload/Download Batch Files

- This section of the web portal allows users to upload and download X12N electronic files. (In order to use this section of the web portal you would have to be enrolled with MS Medicaid as a trading partner.)

- Once you access the Upload/Download Batch files section of the web portal, the screen shown above will display only if you did not include your EDI Enrollment information when you initially completed your web portal registration. If this information was completed during web portal registration, the screen shown above will not display and you will proceed to the upload/download page shown below.

- On the Upload/Download page, you will be able to browse and enter the file path desired then click on the upload button to upload your file.

- If you wish to download files available under your trading partner id, simply click on the download button next to the file you wish to review. (Please be advised that these files are available for only 60 days after the date it was posted).
Training Material/ Computer Based Training (CBT)

The Training Material (CBT) page embodies useful training material for providers. The Training Materials/Computer-Based Training page consist of the following:

- Adjusting/Voiding Claims
- Top Denials
- Prior Authorization Requirements
- Etc.
User Admin Options

User Admin Options – All users have this option to change their password, but only the Master Administrator has access to modify the users on the account.

- Add Existing User
- Add New User
- Change Password
- Manage Existing Users
WINASAP 5010 Software

WINASAP 5010 Software allows you to submit claim data electronically from your personal computer to Conduent EDI Solutions. Below is an example of the WINASAP 5010 Software download page.
Reach Us Tab

The **Reach Us** tab consists of the following options:

- Adjustment/ Void Requests
- Automated Voice Response System
- EDI Support Unit
- Financial (mail with check/ check returns)
- Form Reorders
- Magnetic Tapes and Diskettes
- Medicaid Regional Offices
- Mississippi Division of Medicaid
- Pharmacy POS
- Provider and Beneficiary Services
- Provider Enrollment
- Report Fraud
- Third Party Liability
The **FAQs** tab allows you to search for answers to the most commonly asked questions. The **FAQs** tab consists of two types of question categories:

- Provider/Beneficiary FAQs
- Provider/Beneficiary Web Portal FAQs
Secure Web Portal Guide

Search Tab

Search all the Web Portal

The **Search all the Web Portal** page allows you to search the entire Web Portal. Below is an example of the screen that will display once you access the Search all the Web Portal page: