



Guide to Online Provider Resources

We work closely with our network providers to ensure that their Peoples Health patients receive the highest quality care. That is why we offer valuable resources online—including clinical resources and patient histories. Our goal in offering these resources is to help providers be more efficient in preparing charts to have more meaningful patient interactions, as well as improve the health outcomes and bolster the risk scores of Peoples Health patients.

We encourage you to explore the online resources described on the following pages. **For more information, contact your provider representative.**

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Provider Portal

The Provider Portal is easy to use and offers quick access to information you may need from time to time to effectively treat your Peoples Health patients. Join the many providers who find that using the portal is more convenient than calling for information.

Provider Portal Features

The Provider Portal allows you to:

- Search and view claims status, amounts paid, paid dates and claims history
- Submit and view authorizations, as well as respond to requests for clinical documentation
- Verify patient eligibility and coverage information, such as effective dates, assigned primary care physician (PCP), benefit utilization, authorizations, and more
- View and download benefit details and documents, such as the *Evidence of Coverage*
- View a patient's annual maximum-out-of-pocket amount
- See important news and updates from Peoples Health on the homepage

If you don't already have an account, visit www.peopleshealth.com/providerportal to create one. Be sure to bookmark the web address for easy access in the future.

Create an Account

You will need to create a local administrator account by accepting the website's License Agreement, creating a username and password, and verifying certain information. To validate your identity and status as a contracted network provider, you need to enter the TIN for the account being set up, as well as enter a paid claim number associated with the TIN. The claim must have been paid within the last 180 days.

To begin, click **Proceed to our sign up process** on the homepage.

PEOPLES HEALTH
Provider Portal

Welcome to the Provider Portal, a unique online tool for accessing benefit, eligibility and claims data.

Log in to:

- View patient eligibility status and benefit information
- Verify patient claims
- Download forms
- Request prior authorization
- And more!

Login

Username

Password

Submit

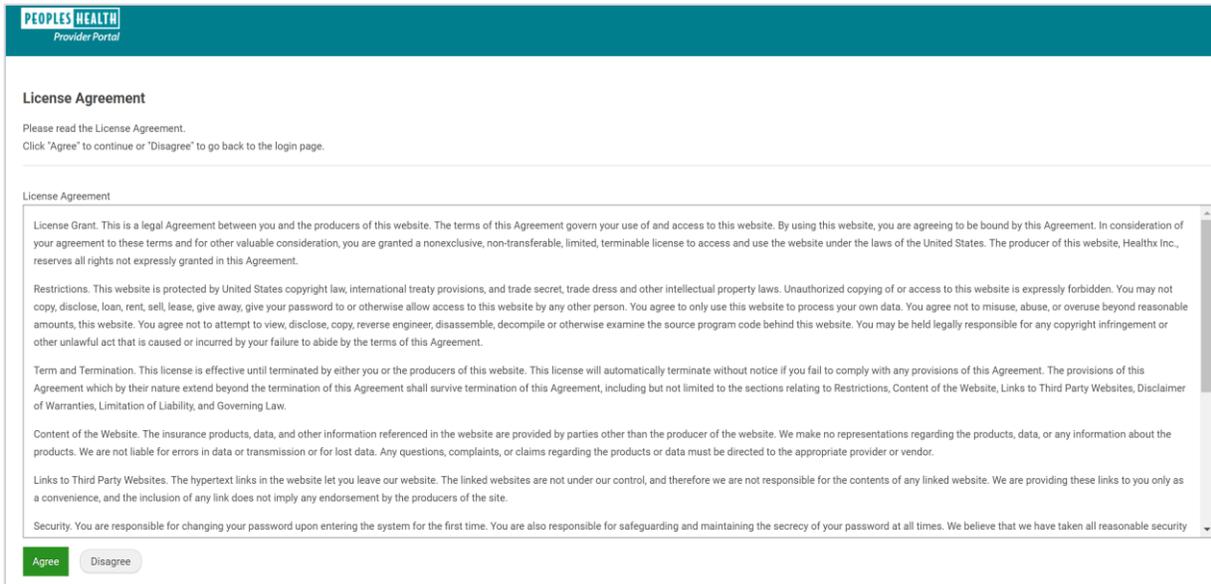
[Forgot your username or password?](#)

Need a username and password?
[Proceed to our sign up process.](#)

Figure 1 - Provider Portal homepage

Step 1: License Agreement

Review the License Agreement. You must agree to create an account.



The screenshot shows the 'License Agreement' page for the 'PEOPLES HEALTH Provider Portal'. The page title is 'License Agreement'. Below the title, there is a brief instruction: 'Please read the License Agreement. Click "Agree" to continue or "Disagree" to go back to the login page.' The main content area contains the full text of the license agreement, including sections on 'License Grant', 'Restrictions', 'Term and Termination', 'Content of the Website', 'Links to Third Party Websites', and 'Security'. At the bottom of the page, there are two buttons: 'Agree' (highlighted in green) and 'Disagree'.

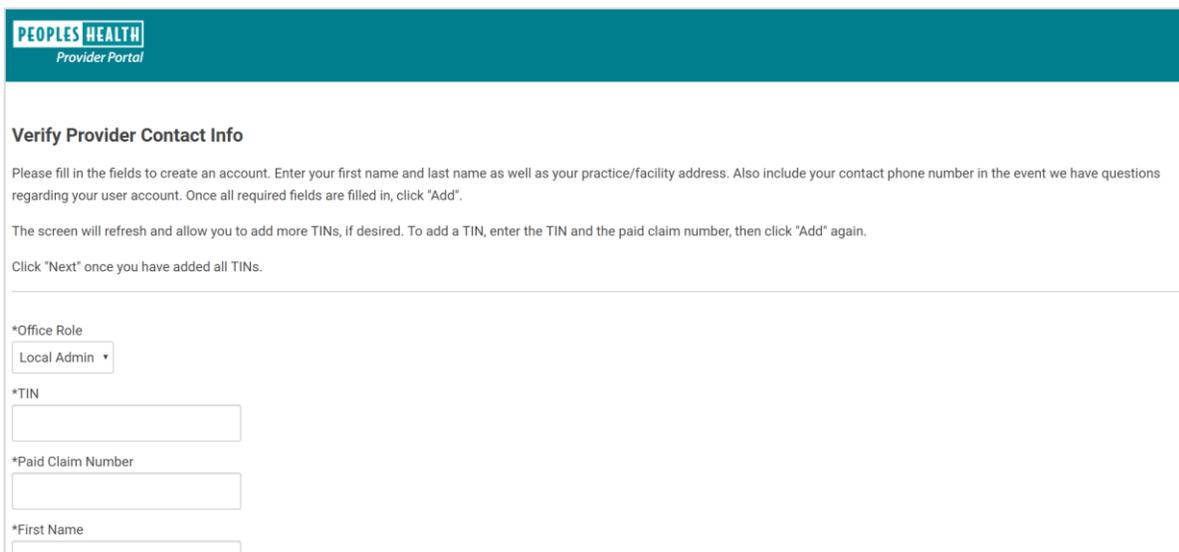
Figure 2 - License Agreement page for setting up an account

Step 2: Verify Provider Contact Information

Complete the fields to verify your provider details and click **Add**. Enter the TIN for the account being set up, and enter a paid claim number associated with the TIN. The claim must have been paid within the last 180 days.

To link an additional TIN to the account, enter the additional TIN, along with an associated paid claim number, then click **Add** again. Once you've entered all TINs, click Next.

You can give access to any of the TINs linked to your account to the user accounts you'll create for authorized personnel in your practice or health care system.



The screenshot shows the 'Verify Provider Contact Info' page for the 'PEOPLES HEALTH Provider Portal'. The page title is 'Verify Provider Contact Info'. Below the title, there is a brief instruction: 'Please fill in the fields to create an account. Enter your first name and last name as well as your practice/facility address. Also include your contact phone number in the event we have questions regarding your user account. Once all required fields are filled in, click "Add".' The page also includes instructions on how to add more TINs and when to click 'Next'. The form fields are: '*Office Role' (a dropdown menu with 'Local Admin' selected), '*TIN' (a text input field), '*Paid Claim Number' (a text input field), and '*First Name' (a text input field).

Figure 3 - Provider details page for setting up an account

Step 3: Create Login Information for the Local Provider Administrator

Input a username and email address for the account. Follow the guidelines on the page for creating a username and password.

You will need to select three security questions and enter a unique answer to each. Make a note of these, as they are required to retrieve a forgotten password.

You will also need to enable two-factor authentication, using either an email address, mobile phone number, or authenticator app such as Google authenticator.

To complete the sign-up process, click Next.

PEOPLES HEALTH
Provider Portal

Create Login Information

You will use this information to log in to your user account.
Keep this information stored safely so your account information remains secure.

Username

Email Address

Confirm Email Address

Password

Confirm Password

Username: Must be a minimum of three characters and must start with a letter

Password: Must be at least eight characters; alpha-numeric and special characters `~!#$%&*@~^\?/+` are accepted

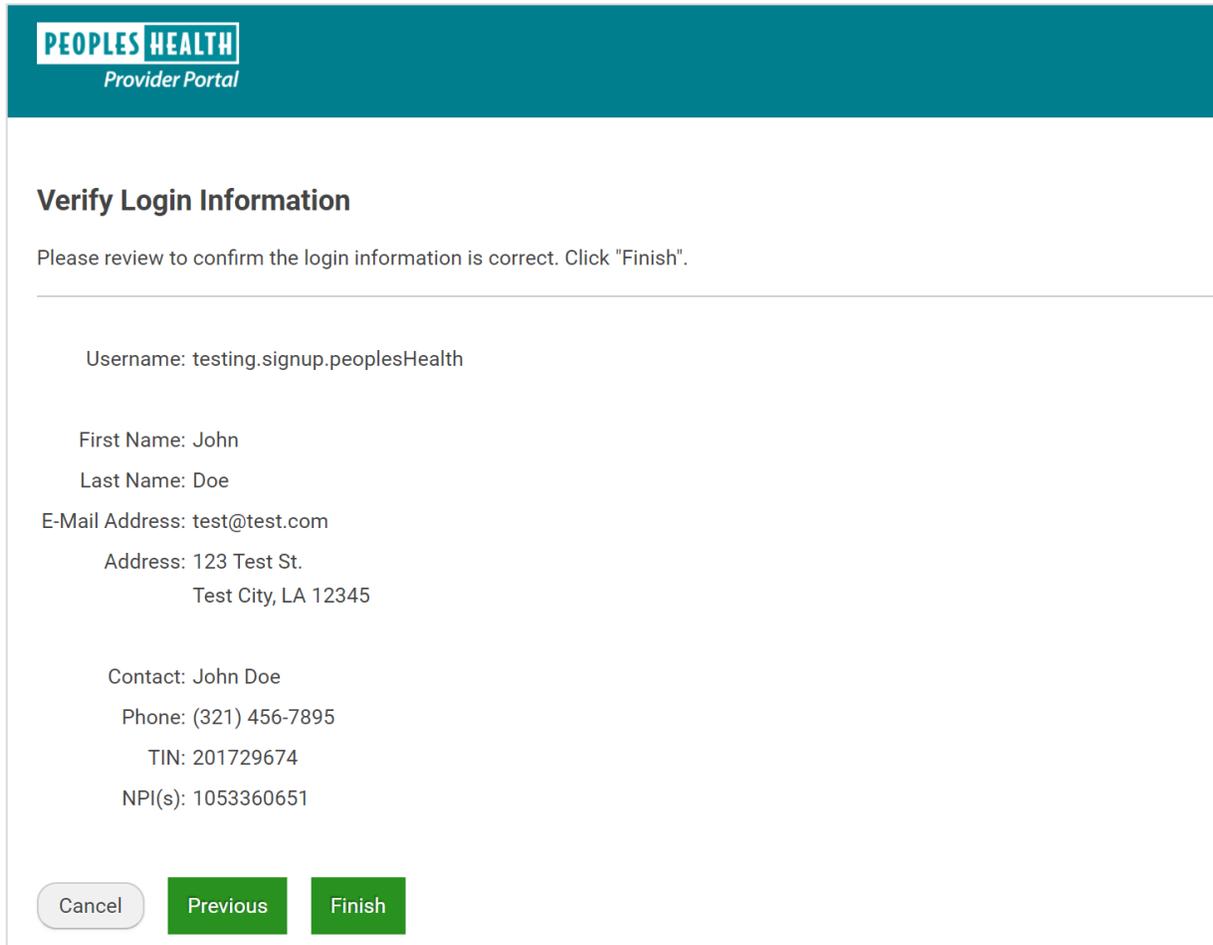
Don't have an email account?
Our Provider Portal requires a valid email address. If you do not have an email address, you may create a free email account with one of these popular providers:

- [Gmail](#)
- [Yahoo!](#)

Figure 4 - Login details page for setting up an account

Step 4: Registration Complete

On the final page, confirm your information, and click Finish. You now have limited access to the Provider Portal. A Peoples Health representative will reach out to you to sign a Data Access and Confidentiality Agreement. This agreement authorizes your account for full access to all information available through the portal, as well as to set up authorized personnel in your practice with access.



PEOPLES HEALTH
Provider Portal

Verify Login Information

Please review to confirm the login information is correct. Click "Finish".

Username: testing.signup.peoplesHealth

First Name: John
Last Name: Doe
E-Mail Address: test@test.com
Address: 123 Test St.
Test City, LA 12345

Contact: John Doe
Phone: (321) 456-7895
TIN: 201729674
NPI(s): 1053360651

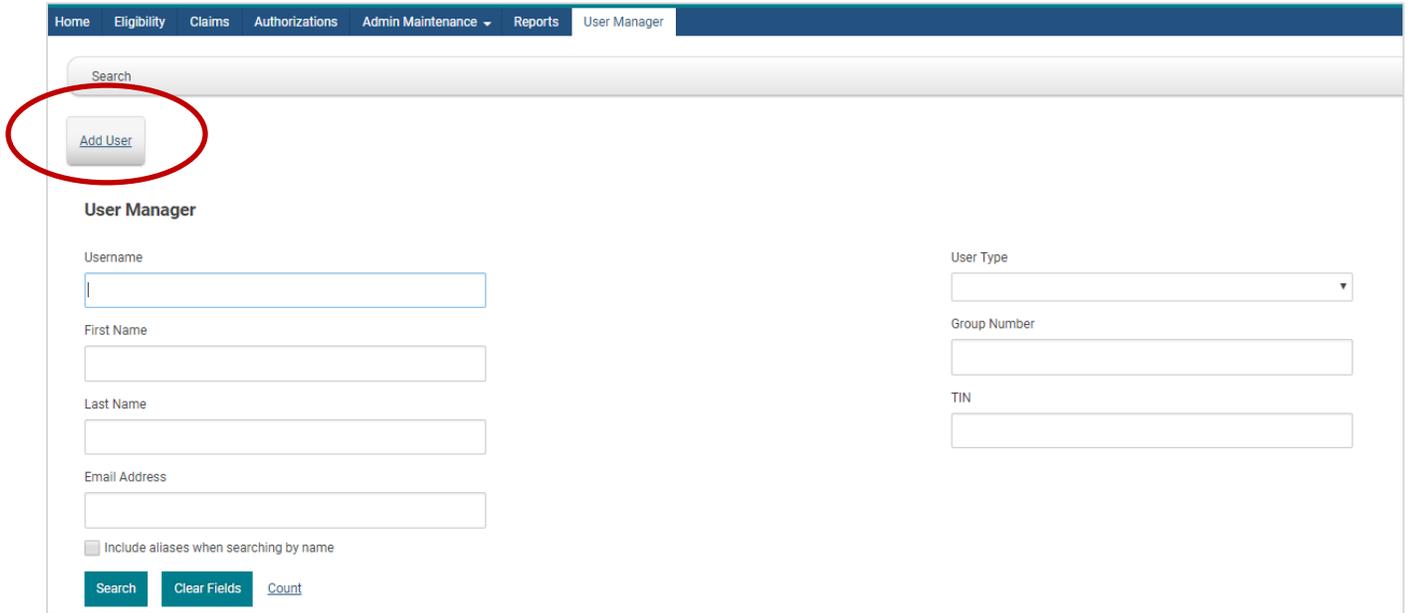
Cancel Previous Finish

Figure 5 - Information verification page for setting up an account

Step 5: Adding Users

Once the account for the local provider administrator is authorized, the administrator for the account can create users (such as other administrators or for billing, front office and back office personnel) who are linked to the account's TIN(s).

Step 1: To add a user, select the User Manager tab, then click the Add User button.



The screenshot shows the 'User Manager' tab in a web application. The navigation bar at the top includes 'Home', 'Eligibility', 'Claims', 'Authorizations', 'Admin Maintenance', 'Reports', and 'User Manager'. Below the navigation bar is a search bar with a search icon and a search input field. A red circle highlights the 'Add User' button. Below the search bar is the 'User Manager' form. The form has the following fields and controls:

- Username:** A text input field.
- First Name:** A text input field.
- Last Name:** A text input field.
- Email Address:** A text input field.
- User Type:** A dropdown menu.
- Group Number:** A text input field.
- TIN:** A text input field.
- Include aliases when searching by name
- Search:** A button.
- Clear Fields:** A button.
- Count:** A button.

Figure 6 - User Manager tab for adding users

Step 2: Create a profile for the user.

The minimum required fields are First Name, Last Name, Email Address, Username, New Password, Confirm Password, Hint Question, Hint Answer, User Type, and Key Code.

You will need the user’s active email address to create an account. We also recommend adding contact information for the profile, including a phone number where the user can be reached.

Key code options—which are Provider Back Office, Provider Front Office, Provider Billing and Provider Local Admin (local administrator)—define the user type.

The key code selected determines the tabs available to the user:

User Type	User Key Code	Provider Portal Access
Provider	Provider Back Office	Home, Claims & Payment, Eligibility & Benefits, Authorizations, Resources, Member Viewer
Provider	Provider Front Office	Home, Eligibility & Benefits, Authorizations, Resources, Member Viewer
Provider	Provider Billing	Home, Claims & Payment, Eligibility & Benefits, Resources
Provider Admin	Provider Local Admin	Home, Claims & Payment, Eligibility & Benefits, Authorizations, User Manager, Resources, Member Viewer, and Reports



IMPORTANT NOTES

- **If creating a profile for Provider Local Admin, you MUST select Provider Admin from the User Type drop-down menu.**
- **If creating a profile for all other key codes, choose Provider from the User Type drop-down menu.**
- **DO NOT select any key codes, except those listed above, or the account will not function as expected.**

Complete the user profile information, select the appropriate User Type, and then select the Key Code for the appropriate level of access for your authorized personnel. To force the user to update account credentials, such as password or hint questions, upon the first login, use the checkboxes in the **Account Actions** section. Click Add User when done.

The screenshot shows a web form for user management. At the top, there is a 'Keycode' section with a dropdown menu. A list of keycodes is visible, including 'Provider Back Office', 'Provider Billing', 'Provider Front Office', and 'Provider Local Admin'. Below this, there are radio buttons for 'Active User' (selected) and 'Inactive User'. The 'Account Actions' section contains several checkboxes: 'Force Password' (checked), 'Force Username' (unchecked), 'Force Hint Q and A' (checked), 'Force Email' (unchecked), 'Force Validate Email' (unchecked), and 'Notify Email Block' (unchecked). At the bottom, there is a 'License Agreement' dropdown menu with 'Hasn't Agreed' selected.

Figure 7 – User Manager tab, page to input user details, select user type and key code, and designate account actions; ONLY use key codes pictured

There is still one more critical step before account setup is complete.

You now need to link the associated provider TIN(s) to the user account.

After clicking Add User, scroll to the top of the screen, and click Provider Details link to add the associated provider TINs. Add TINs at the bottom of the page, by clicking Add TIN button. You must complete this step for each TIN associated with your practice.

If you do not complete this step, your account will not function properly, and you will not be able to complete the step after leaving the profile page.

Step 3: Adding TIN(s)

Click the **Provider Details** link at the top of the page in User Manager. Near the bottom of the screen, click Add TIN under the Associated TINs section.



Figure 8 - User Manager tab, Provider Details screen, Associated TINs section.

Input information in the pop-up box for the TIN, then click **Add TIN**. Note that listing NPIs will limit user access in certain systems; only enter TINs on this screen.

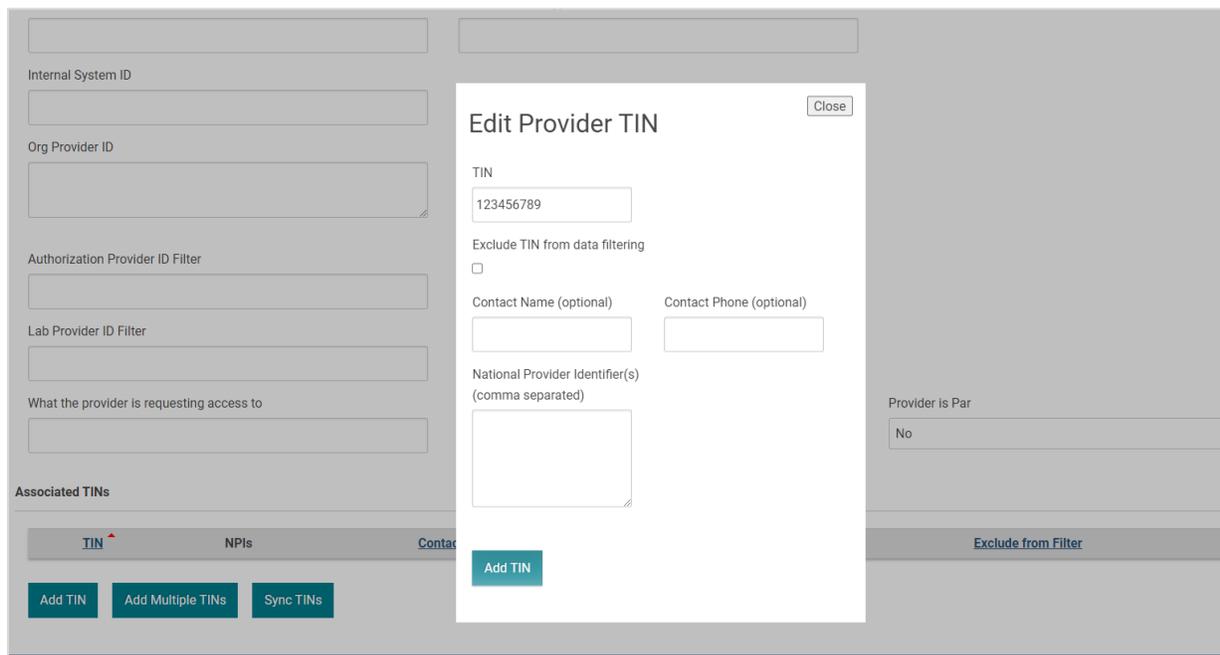


Figure 9 – TIN editing screen.

Note:

- When Provider Local Admin users access User Manager, they are restricted to adding only TIN(s) that they have access to.
- Select the **Imitate** link to test the user's account access. Be sure to notify the user when the account is created, sending the user's account login information. The user will be able to update account security details, including password and hint questions, once logged in to the account.

Search Eligibility and Benefits

To retrieve a patient's plan information and eligibility details, select the **Eligibility & Benefits** tab, then enter the patient's member ID number (G number) or last name *and* date of birth. Click the patient's name in the results list.

Note for multi-provider clinics: Use the Filter by NPI drop-down box to select a specific provider and only view the provider's panel.

The screenshot shows a web application interface with a dark blue navigation bar at the top. The navigation bar contains several tabs: Home, Eligibility & Benefits, Claims & Payment, Authorizations, User Manager, Resources, and Member Viewer. The 'Eligibility & Benefits' tab is highlighted with a red circle. Below the navigation bar, the main content area is titled 'Eligibility & Benefits'. It contains the following elements:

- A heading: **Eligibility & Benefits**
- Text: To search for a patient:
- List of instructions:
 - Enter the member ID *or*
 - Enter the last name *and* date of birth (MM/DD/YYYY)
 - Multiple member IDs can be searched; press "Enter" after each one
- Filter by NPI: All Providers (dropdown menu)
- Form fields:
 - First Name: [input field]
 - Last Name: [input field]
 - Member ID(s): [input field]
 - Date of Birth: [input field]
- Search button: [Search]

Figure 9 - Eligibility & Benefits tab to input search criteria

Verify Eligibility and Benefits

Review the patient's coverage and service accumulators, such as maximum-out-of-pocket costs for the year, or click the plan name link under the Coverages heading for current cost-sharing amounts.

Note: The patient's current plan (active coverage) will have an end date of 12/31/9999. If a plan is listed with an end date other than 12/31/9999, the patient is no longer active in that plan.

Home Eligibility & Benefits Claims & Payment Authorizations User Manager Resources

Current Patient: [JANE DOE](#)

Member

Member:	JANE DOE	Plan Name:	CHOICES 65
Member ID:	G000000123	Status:	Active
PCP:	DR. JOHN	Medicaid Status:	Copay

Coverages

CHOICES 65			
Effective Date:	01/01/2018	End Date:	12/31/9999
Medicaid Status:	N/A		
CHOICES 65			
Effective Date:	01/01/2017	End Date:	12/31/2017
Medicaid Status:	N/A		

Accumulators

In Network	Met	Amount
Out of Pocket Max	\$683.95	\$6,700.00

In Network	Count Met	Count Require
Bone Density Testing	0	1
Myocardial Perfusion Imaging	0	1

Figure 10 - Sample Eligibility & Benefits page, patient results; new accumulators and additional personal demographic details may not be reflected in the above image.

Access Care Plan Documents

Review care plans for dual-eligible SNP members.



Care Plan Documents

<u>Filename</u>	<u>Size</u>	<u>Date Modified</u>
 ZIP		
 CarePlans	750 KB	4/28/2021 2:19 PM

CONFIDENTIAL HEALTH INFORMATION

This report and any accompanying attachments are confidential and privileged. This information is intended solely for the intended recipient; access by anyone else is unauthorized. No confidentiality or privilege is waived or lost by erroneous transmission. If you are not the intended recipient, any forwarding, disclosure, copying, distribution, or other action, is strictly prohibited. If you have received this in error, please delete it and notify the sender at Peoples Health immediately.

Figure 11 - Sample Eligibility & Benefits page, scroll below Accumulators to access Care Plan documents for D-SNP patients.

Review Claims and Payments

From the **Claims & Payment** tab, enter a paid date or enter a claim number, a check number, or a patient's member ID number (G number) *and* a date to view claims status and payments. Use the Select Provider TIN drop-down menu to filter results. Click the **Download Results** link to export an Excel file of the claims report.

Select Provider TIN: All Providers

Claims & Payments

To search for a patient claim:

- Enter the member ID *or*
- Enter a claim number
- Multiple claim numbers can be searched; press "Enter" after each one

Claim Number	Last Name	First Name	Member ID	Service Date	Provider	Total Charge	Member Responsibility	Paid Amount	Claim Status
16070000002				1/22/2016		\$1,152.00	\$25.00	\$275.81	Approved
152110000025				6/12/2015		\$853.00	\$25.00	\$74.29	Approved

2 claims found.

[Download Results](#)

Figure 12 - Claims & Payment tab, sample search results page

Click a link in the **Claim Number** column to view payment or denial details. You can download a printable Explanation of Payment from the claim's details screen. If needed, you can request a claim adjustment request by clicking the button at the top left. The form will auto-populate with details from the claim being viewed. Be sure to include supporting documentation with your claim adjustment request.

[Click here to request an appeal for this claim.](#)

Claim # 12543078910

Member:	JOHN DOE	Date(s) of Service:	01/22/2016	Charges		Allowable		Plan Paid	
Member ID:		Service Provider:							
Plan Name:	CHOICES 65	Total Charges:		Claim Status:	Approved				
Medicaid Status:	N/A								

Payment Details

Claim Received	Pay To	Check Number	Amount	Date Paid
03/02/2016				

Claim Details

Claim Line	Service Date	CPT	Description	Charges	Allowable	Deductible	Copay	Coinsurance	Denied	Paid	Reason Code
100	01/22/2016	72052	RADEX SPINE CERVICAL 6 OR MORE VIEWS			\$0.00	\$25.00	\$0.00	\$0.00		1C - a2 - CP - 2p
200	01/22/2016	72070	RADEX SPINE THORACIC 2 VIEWS			\$0.00	\$0.00	\$0.00	\$0.00		1C - a3 - 2p
300	01/22/2016	72100	RADEX SPINE LUMBOSACRAL 2/3 VIEWS			\$0.00	\$0.00	\$0.00	\$0.00		1C - a3 - 2p
Total						\$0.00	\$25.00	\$0.00	\$0.00		

Reason Code Descriptions

1C - BENEFITS HAVE BEEN COORDINATED WITH PRIMARY CARRIER
a2 - APC - PRICED SERVICE
a3 - APC - PACKAGED SERVICE
2p - BUDGET CONTROL ACT OF 2011 / SEQUESTRATION REDUCTION APPLIED
CP - COPAYMENT AMOUNT

Figure 13 - Claims & Payment tab, sample Claim Number details page with button to request a claim adjustment.

Submit Authorization Requests

Under the **Authorizations** tab, click the **icon for the type of services needed** to access the portal's authorization homepage. For outpatient and inpatient services, follow the steps below, or view the Service Category Tip Sheets for additional instructions. For detailed instructions on how to enter Cancer Treatment requests through Optum's MBMNow, view the CGP Reference Guide.

To request authorization, select the service needed. You must submit an authorization for each service if the patient requires services from multiple categories.

OUTPATIENT SERVICES

INPATIENT SERVICES

CANCER TREATMENT (Part B Services Only)

Tips for Submitting Authorization Requests

Step-by-step instructions for entering authorization requests:

[Authorization Portal Instructions](#)

Service Category Tip Sheets:

Certain services require authorization requests to be entered with specific parameters. Use these tip sheets to ensure you enter the request accurately and reduce processing time.

[DME and Diabetic Supplies](#)

[Home Health and Outpatient Therapies](#)

[Infusions, Injections and Oncology](#)

[Inpatient vs. Outpatient Admissions](#)

[Outpatient Procedures and Testing](#)

Cancer Guidance Program Information:

[CGP Overview Presentation](#)

[CGP Reference Guide](#)

[Click here to search approved and denied authorizations for a certain date of service or range of up to 36 months.](#)

Figure 14 - Authorizations tab, default page

Select the appropriate tab to submit documentation for a pended authorization, resume work on an incomplete request, review submitted authorizations or completed authorizations, or begin a new authorization. See next page for how to begin a request.

Figure 15 - Authorizations tab, Create New & Pending Auths default page

Tab functions:

Action Required - Review pended requests that require additional supporting information before processing. Click on a case, review the notes under the Notes & Attachments tab, then follow the instructions to complete the request. Use the blue **Add Notes and Attachments** button to upload requested clinical documentation.

Completed - Check case status, service details, including date of service, ordering and servicing providers, and request extensions to existing authorizations.

Submitted - Verify requests submitted via the Provider Portal or by fax, and review request status.

Drafts - Resume completion of a draft authorization request that you or your staff previously initiated.

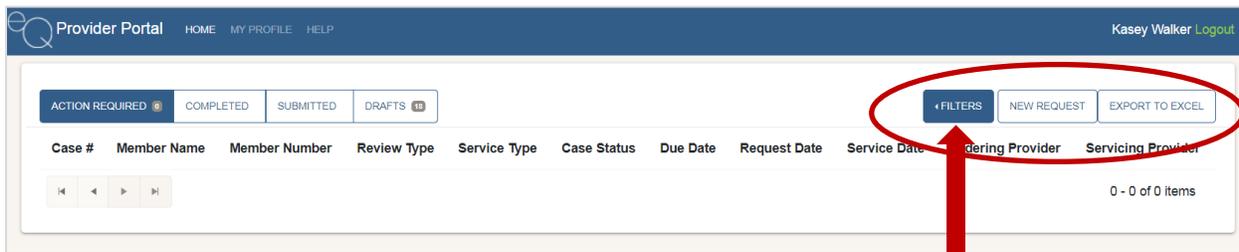


Figure 16 - Authorizations tab, Create New & Pending Auths, apply filters

Filters - Use this option to search for authorization requests by member, service date or servicing provider. You may also search by case number or authorization number if you have it available. To clear a filter, click the green X on the filter.

New Request – Choose to begin a new authorization request.

Export to Excel - Create an Excel report of authorizations submitted through the portal.

- MEMBER
- CASE #
- AUTHORIZATION #
- SERVICING PROVIDER
- SERVICE TYPE
- SERVICE DATE

Begin a New Authorization Request

Click **New Request** then “Find patient...” to begin an authorization request. Enter either the patient’s date of birth and member ID number or the date of birth and patient’s full name. Click the name of the appropriate patient in the search results.

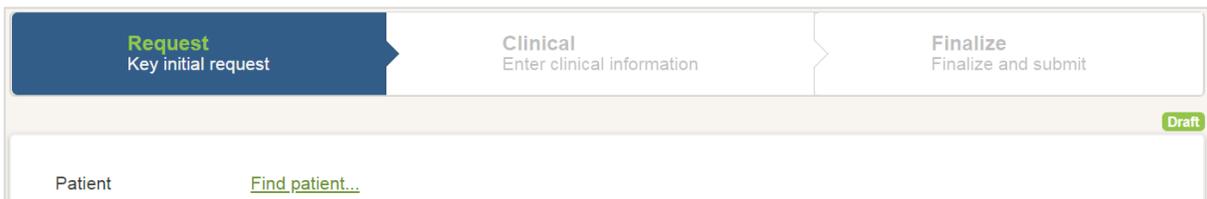


Figure 17 – To begin, click Find patient...

First Name	Last Name	
<input type="text" value="car"/>	<input type="text" value="smith"/>	
Member Id	Birth Date	
<input type="text"/>	<input type="text"/>	
<input type="button" value="SEARCH"/>	<input type="button" value="CANCEL"/>	
Name	BenesysId	Birthday
CAREY SMITH	1	.3
CARL SMITH	1	4

Figure 18 – Find patient search criteria screen

Choose from the **Type of Service** options, and select a **Start Date**. The start date ensures the patient is eligible to receive services on the date of service or on the beginning date of the authorization span. Complete the remaining fields for the service being requested.

Figure 19 - New authorization request, service details

When searching for and selecting a servicing provider, search by name or specialty. Be sure to select a servicing provider located near the patient. Narrow search results by entering a city or ZIP code. If a provider isn't found using the criteria, reduce the criteria entered or remove the criteria and search again. Names may be spelled differently in the system and will not return an exact match, for example, "Ochsner St. Anne Hospital" would not find "Ochsner St Anne" in this system.

When requesting DME, diabetes supplies or a consultation (such as for palliative care), enter "Peoples Health" in the Servicing Provider Name field, and select the first result under Facility Name. NOTE: for **standard wheelchair requests**, please enter your preferred DME in the Servicing Provider field. This will allow our staff to direct your request to the correct provider.

Results

Facility Name	Address	City	Zip	Specialty	Network
PEOPLES HEALTH	3838 N CAUSEWAY BLVD SUITE 2200 METAIRIE, LA 70002	METAIRIE	70002	Single or Multispecialty Clinic or Group Practice	PHN
PEOPLES HEALTH EMPLOYEE	3838 N CAUSEWAY BLVD SUITE 2200 METAIRIE, LA	METAIRIE	70002		PHN

Figure 19 - New authorization request, service provider for DME, diabetes supplies or consultations

When requesting a level-of-care or facility change, select the appropriate option from the Admission Source drop-down menu. For services that are not a level-of-care or facility change, the **Admission Source** field can be left blank, or select “Home” from the menu.

The screenshot shows a form titled "Are you the:" with three radio buttons: "Ordering Provider" (selected), "Servicing Provider", and "Both". Below this are fields for "Ordering Provider" (SMITH, AL) with a "Change ordering provider..." link, "Servicing Provider" (DAVITA MID CITY DIALYSIS) with a "Change servicing provider..." link, "Category" (Dialysis), "Place of Service" (65 Dialysis Center), "Admission Source" (HO Home), and "Request Severity" (Not Selected). A dropdown menu for "Request Severity" is open, showing "HO Home" selected and "LT LTAC" as an option.

Figure 20 - New authorization request, admission source details

Complete all request fields and click Save & Continue to store a draft of the authorization request.

Next, complete the clinical fields of the request form. The system will prompt you to enter the appropriate procedure category for the service you specified. If a pop-up box to select a category does not automatically appear, click the information icon next to **Procedures** to find the correct category.

The screenshot shows a "Request" form with a "Procedure Category Disclaimer" pop-up box. The pop-up box contains the text "Please select the appropriate code below: Dialysis" and a "CLOSE" button. The "Procedures" field in the background is circled in red, and an information icon (i) is visible next to it. The form also includes "Diagnoses", "Attachments", and "Notes" sections, along with "SAVE & CONTINUE" and "RESET" buttons at the bottom.

Figure 21 - New authorization request, procedure selection

Enter a diagnosis code or condition, and select from the options in the drop-down menu.

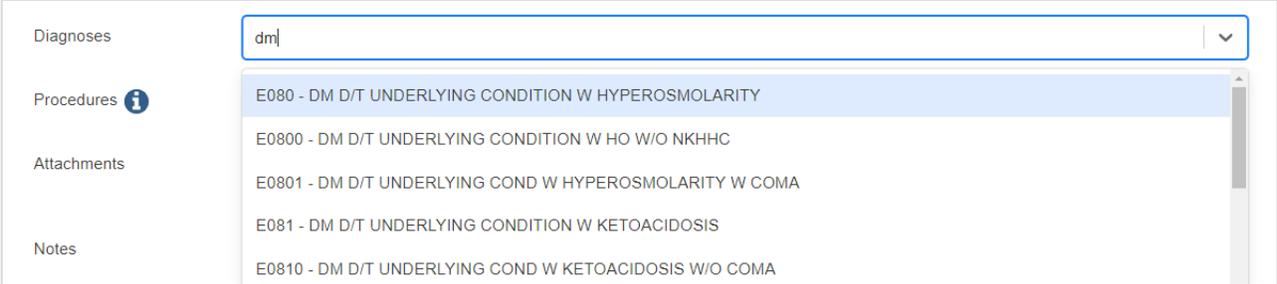


Figure 22 - New authorization request, diagnosis code selection

Enter the procedure code and specify the total units needed, as well as the date span for the procedure frequency. Always select a unit and a total, as well as a date span from the calendar. Download Service Category Tip Sheets from the Authorizations tab of Provider Portal if you need more guidance.

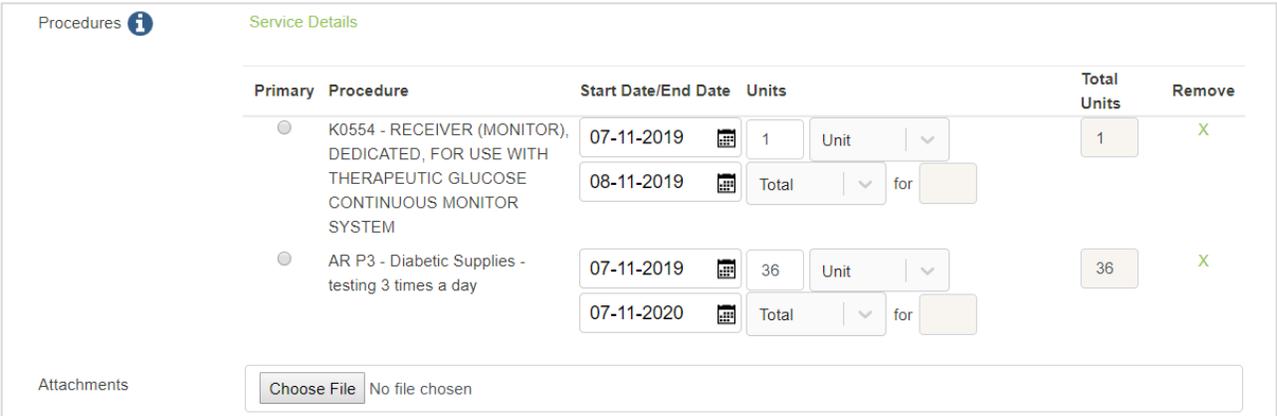


Figure 23- New authorization request, service details

Some procedure categories, such as diabetes testing supplies, will automatically calculate the required units based on the testing frequency you provide. These counts may look different from what you entered. Do not change auto-populated counts.

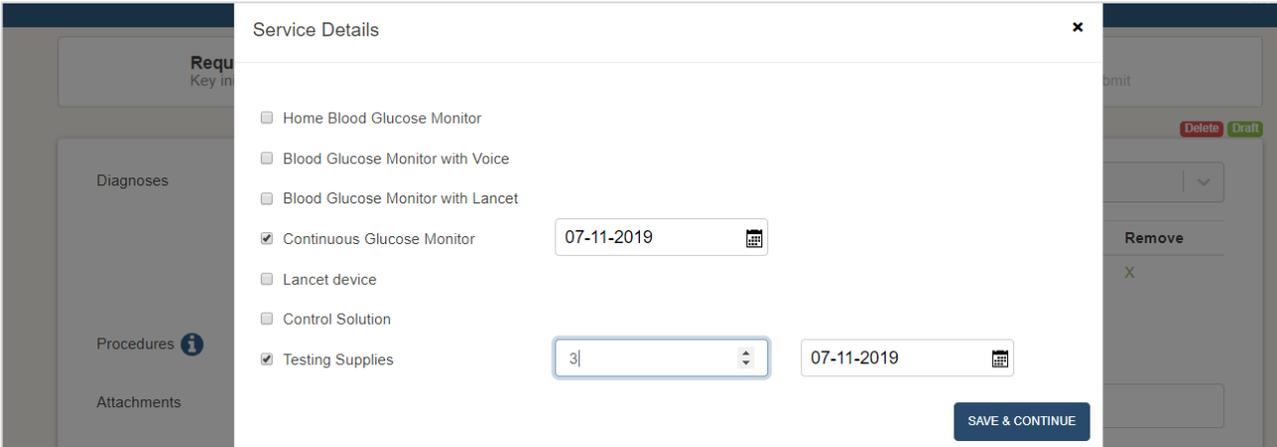


Figure 24 - New authorization request, service details, sample categories with auto-populated units

You must attach a signed physician’s order or provide detailed notes in order to click Save & Continue. To clear the information and enter different details, click the Reset button.

Review the requested procedures for accuracy, including frequency and timespan, then click Submit to finalize the request. Print the detailed summary page if desired. NOTE: Your request will remain in Drafts until you click the Submit button.

Request Key initial request	Clinical Enter clinical information	Finalize Finalize and submit
		Delete Draft
<h2>Finalize</h2>		PRINT
DEMOGRAPHICS		
Member Name	SMITH,	
Member Number		
Date of Birth	01/15/1	
REQUEST		
Requesting Provider		
Servicing Provider	DAVITA MID CITY DIALYSIS	
Place of Service	65 Dialysis Center	
Admission Source	HO Home	
DIAGNOSES		
C790 SECONDARY MAL NEOPLASM KIDNEY & RENAL PELVIS (Primary Diagnosis)		
REQUESTED PROCEDURES		
Dialysis (Primary Procedure)		
3 Visit Per Week For 5 Week(s)		
Total: 15 Visit(s)		
Begin Date: 02/01/2019		
End Date: 03/08/2019		
		SUBMIT

Figure 25 - New authorization request, request details verification screen

Once a request has been submitted, you can create a fax cover sheet to send clinical information in support of the request, or request additional services for the same patient, or return to the main screen.

Finalize PRINT

Case Number: 787415
Case Status: In Progress
Request Date: 01/30/2019

[Create Fax Cover Sheet](#)
[Create New Auth for Current Patient](#)
[Return to Dashboard](#)

DEMOGRAPHICS

Member Name
Member Number
Date of Birth

OUTPATIENT REQUEST

Requesting Provider
Servicing Provider: DAVITA MID CITY DIALYSIS
Place of Service: 65 Dialysis Center

Figure 26 - New authorization request, complete submission screen

Create a Fax Cover Sheet for Supporting Documentation

To fax clinical information to Peoples Health, create a cover sheet. If you have already closed the submission confirmation screen, from the **Actions** button, select **Create Fax Cover Sheet**. The cover sheet contains a code that links to the correct authorization request, speeding up the review process.

Create Fax Cover Sheet

To: Peoples Health
Company: Peoples Health
Phone: 5048494500
Select Fax: 5048496979
From: Dr. Walker
Company: Walker MD
Phone: 5045551234
Fax: 5041111234
Page Count: 3
Use Today's Date?:

CREATE **CANCEL**

Figure 27 - New authorization request, fax cover creation

Follow the steps to complete the form, then click **Create**. Print the cover sheet and send it with your supporting documentation.

FACSIMILE COVER SHEET

To:	Peoples Health
Company:	Peoples Health
Phone:	504-849-4500
Fax:	504-849-6979

From:	Dr. Walker
Company:	Walker MD
Date:	10/7/2019
Phone:	504-555-1234
Fax:	504-111-1234
Pages incl. coversheet:	3

CONFIDENTIAL HEALTH INFORMATION
 This transmission is intended for the person or entity to whom/which it is addressed and contains information that is privileged and confidential, the use and disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of the information associated with this transmission is strictly prohibited. If you have received this transmission in error, please notify the sender at Peoples Health immediately and destroy the related message and documents. No confidentiality or privilege is waived or lost by erroneous transmission.



SABC123SCSP12345675QA 0000001

Figure 28 – New authorization request, sample fax cover

If the patient needs additional services in a different service category, close the fax window to return to the previous screen and click the Create New Auth for Current Patient link to initiate the new request.

Check Authorization Status

Note: This tab contains real-time authorization status for requests submitted through Provider Portal or via fax. Certain services, including home health, outpatient therapies and dialysis, may be automatically authorized once the request and supporting documentation are submitted.

Submitted requests are immediately assigned a case number, and when the authorization is approved, the case status becomes Certified in Total and an authorization number is added to the case. Review case status under the Completed tab.

Action Required Tab

Some cases may be pended for additional information and will appear under the Action Required tab, which is the default view when accessing this page. To review the action needed, click the case and review the information under the **Notes & Attachments** tab.

Case #	Member Name	Member Num...	Review Type	Service Type	Case Status	Due Date	Request Date	Service Date	Ordering Pro...	Servicing Pro...
2280665			Initial	Outpatient	In Progress	7/16/2019	7/3/2019	7/3/2019		

Figure 29 – Action Required tab, sample case link

Respond by clicking the **Add Notes and Attachments** button, and typing a response or uploading the requested documentation.

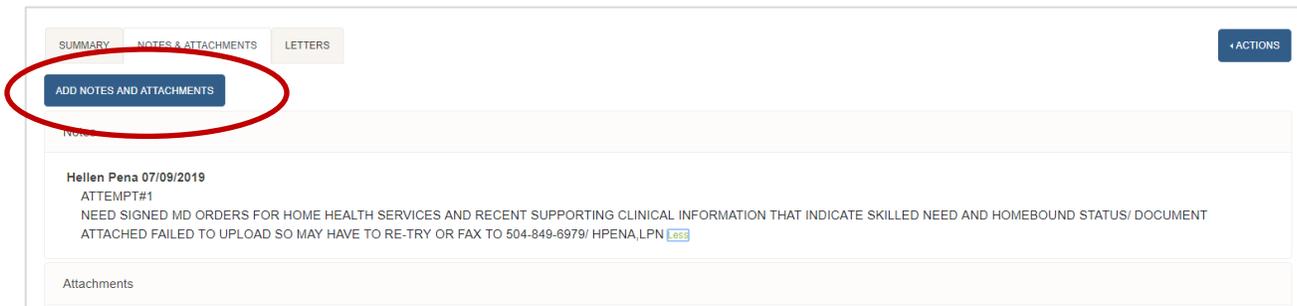


Figure 30 - Action Required tab, sample Notes & Attachments sub-tab to view and provide required actions

Click Save & Continue. Staff from our authorization division will be notified that you've responded to the request and will review the additional information.

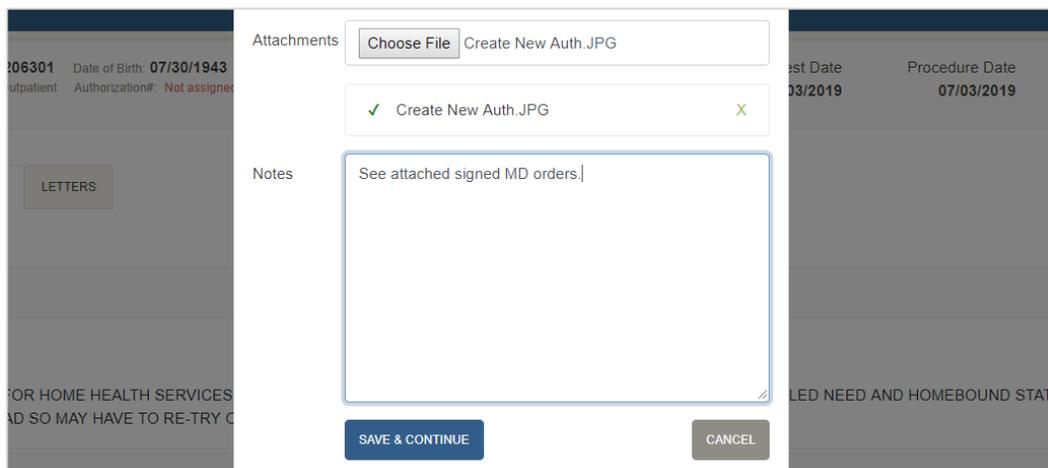


Figure 31 - Add Notes and Attachments sample screen

Completed Tab

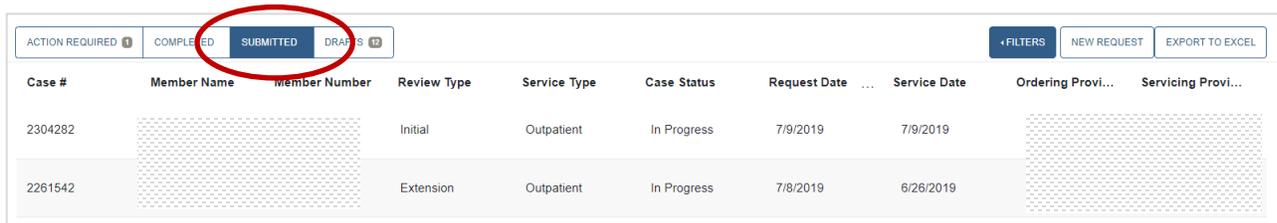
To review the status of an authorization request, click the Completed tab. Authorization requests that have been *approved* will have a Case Status of **Certified in Total**. Denied authorizations show a status of Not Certified and will not have an authorization number. Request an extension of an approved authorization by clicking the Plus Sign to the left of the case number. Submit changes to a case by clicking on the case and typing your requested changes in the Notes and Attachments section. **DO NOT** start a new case when asking for an extension or requesting changes to an existing authorization.

Extension	Case #	Member N...	Member N...	Review Type	Service Ty...	Authorizat...	Complete...	Discharge...	Case Status	Request D...	Service Date
+				Initial	Outpatient	1718685	5/20/2019		Certified in Total	5/7/2019	5/13/2019
+				Initial	Outpatient	1718623	4/29/2019		Certified in Total	4/29/2019	4/29/2019

Figure 32 - Completed Tab sample page

Submitted Tab

See a history of all authorization requests submitted but not yet processed for which you are the ordering or servicing provider. This includes authorizations that are submitted via fax.

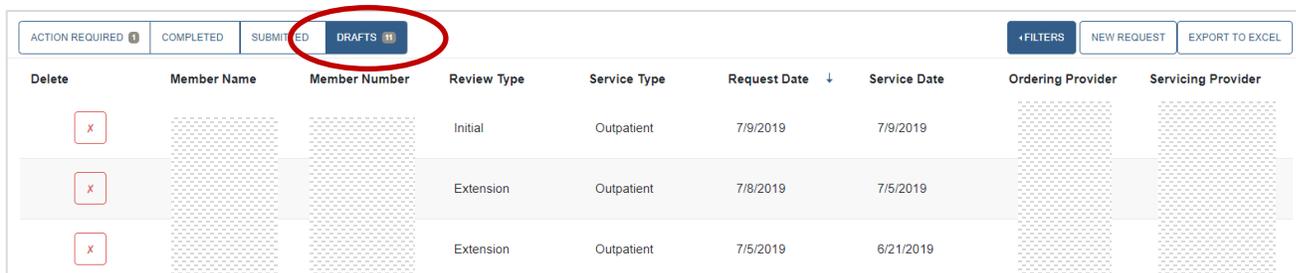


Case #	Member Name	Member Number	Review Type	Service Type	Case Status	Request Date	Service Date	Ordering Provi...	Servicing Provi...
2304282	[REDACTED]	[REDACTED]	Initial	Outpatient	In Progress	7/9/2019	7/9/2019	[REDACTED]	[REDACTED]
2261542	[REDACTED]	[REDACTED]	Extension	Outpatient	In Progress	7/8/2019	6/26/2019	[REDACTED]	[REDACTED]

Figure 33 - Submitted tab sample page

Drafts Tab

Lists all authorization requests that have been started by you or your staff that are not submitted. You can either delete a case, or click a case to resume where you left off and submit the authorization request.



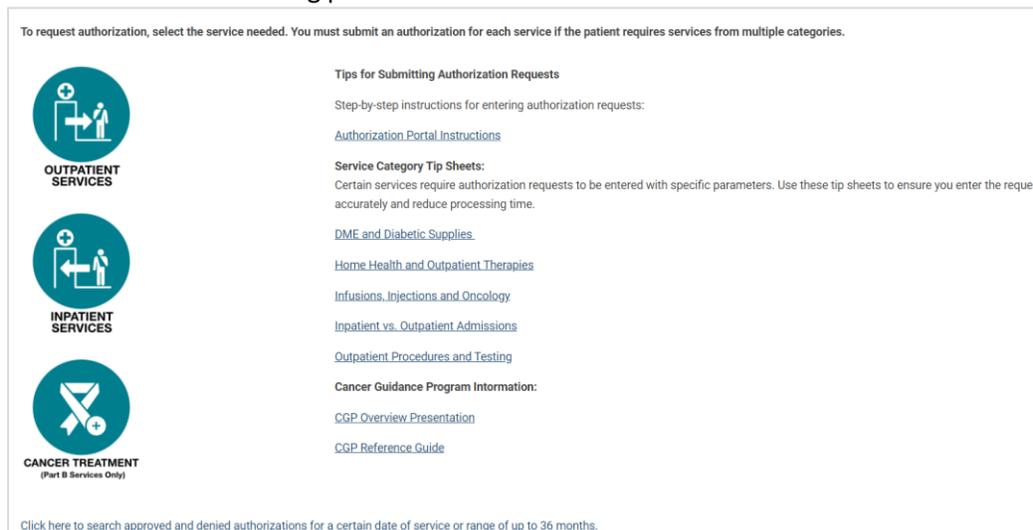
Delete	Member Name	Member Number	Review Type	Service Type	Request Date	Service Date	Ordering Provider	Servicing Provider
X	[REDACTED]	[REDACTED]	Initial	Outpatient	7/9/2019	7/9/2019	[REDACTED]	[REDACTED]
X	[REDACTED]	[REDACTED]	Extension	Outpatient	7/8/2019	7/5/2019	[REDACTED]	[REDACTED]
X	[REDACTED]	[REDACTED]	Extension	Outpatient	7/5/2019	6/21/2019	[REDACTED]	[REDACTED]

Figure 34 - Drafts tab sample page

Search Authorizations

From the Authorizations tab, click the **link at the bottom of the page**. Then enter a date span or a patient's member ID number to search authorizations for up to a three-year date span. You can also search by the authorization ID number.

Note: Authorization information is not real-time and may be delayed for up to three business days. This tool is best for researching past authorizations.



To request authorization, select the service needed. You must submit an authorization for each service if the patient requires services from multiple categories.

Tips for Submitting Authorization Requests

Step-by-step instructions for entering authorization requests:
[Authorization Portal Instructions](#)

Service Category Tip Sheets:
Certain services require authorization requests to be entered with specific parameters. Use these tip sheets to ensure you enter the request accurately and reduce processing time.

- [DME and Diabetic Supplies](#)
- [Home Health and Outpatient Therapies](#)
- [Infusions, Injections and Oncology](#)
- [Inpatient vs. Outpatient Admissions](#)
- [Outpatient Procedures and Testing](#)

Cancer Guidance Program Information:

- [CGP Overview Presentation](#)
- [CGP Reference Guide](#)

[Click here to search approved and denied authorizations for a certain date of service or range of up to 36 months.](#)

Figure 35 – Link: Click here to search approved and denied authorizations (for historical search only)

Click a link in the **Auth Number** column to view details such as the authorizations status, requesting provider, servicing provider, date, service description and more.

Authorizations
Search Authorizations By:

Authorization types
 All authorization types Outpatient Inpatient

Authorization status
 Any authorization status Approved Denied

All Authorization ID Member ID

Authorization date **From*** **To***
 Date of Service 11/13/2017 11/15/2017

Search

Auth Number	Member Name	Provider	Start Date	End Date
\$R0001164678	MILLER, EMILE	WEST JEFFERSON MEDICAL CENTER	11/14/2017	12/13/2017
\$R0000000001	MILLER, SHERYL	WEST JEFFERSON MEDICAL CENTER	11/14/2017	11/14/2017
\$R0000000002		WEST JEFFERSON MEDICAL CENTER	11/14/2017	11/14/2017
\$R0000000003		WEST JEFFERSON MEDICAL CENTER	11/13/2017	11/13/2017
\$R0000000004		WEST JEFFERSON MEDICAL CENTER	11/13/2017	1/12/2018
\$R0000000005		WEST JEFFERSON MEDICAL CENTER	11/13/2017	11/13/2017
* Indic \$R0000000006				

Figure 36 - Authorizations tab, sample results page, view approved and denied authorizations for claims research purposes

Additional Resources

Under the **Resources** tab, find important forms, plan documents, coverage guidelines and more.

Claims & Payment Authorizations User Manager **Resources** Member Viewer Provider Reports

RESOURCES

Provider Reference Guide	Administrative Info	Provider Initiatives	Forms
Referral Guides	Educational Resources	Plan Documents	Policies and Guidelines

Provider Reference Guide.

Search ...

- Introduction – Contact and General Information
- Health Plans and Documents
- Information for Providers

Welcome to the Peoples Health Provider Reference Guide

The Provider Reference Guide delivers vital information to contracted providers on operating within our policies and procedures and meeting high standards of care for our plan members. As a reminder, detailed plan-benefit and cost-sharing information is not part of the guide. This information is delivered to you annually in your Provider Benefit Packet, and is also available to view or download under the Plan Documents tab. If you have questions or prefer a printed copy of the guide, contact your provider representative.

Figure 37 - Resources tab, sample list of items available

Provider Reports

Under the Provider Reports tab, find a list of active users associated with your provider TIN. Providers not using a clearinghouse may request to receive an electronic Explanation of Payment on the Provider Reports tab. Reach out to your provider representative for more information.

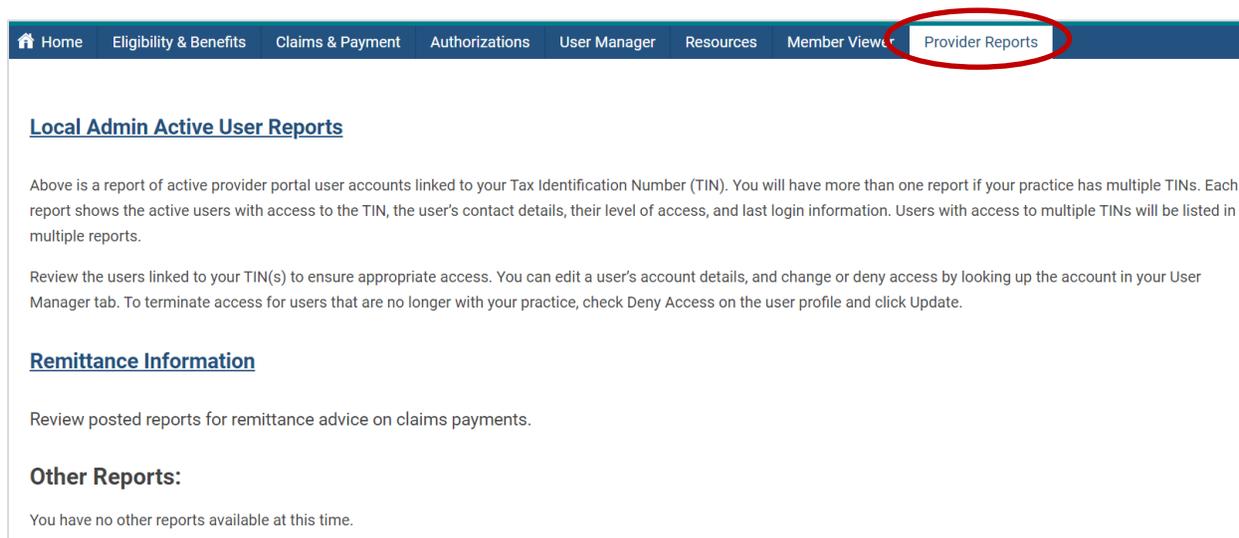


Figure 38 – Provider Reports tab, sample list of items available

Frequently Asked Questions

What are some of the features of the Provider Portal?

Through the Provider Portal, you and your authorized staff and billers can:

- Verify a patient’s eligibility and coverage details, such as plan effective date, primary care physician, etc., without having to call
- View and submit authorization requests
- View and download plan-specific benefit and cost-sharing information
- Search and view claims details and history, including status, amount paid and paid date
- View patient accumulators, including the annual out-of-pocket maximum for Part A and Part B services and benefit utilization counts
- Access provider tools, including important tips and training documents from the resource library, network provider search tools, and an authorization requirements search tool

How can I limit what an authorized user sees through the Provider Portal?

As the local administrator for your account, you must select a role, or a key code, for each authorized user. The key code determines which tabs are available to the user:

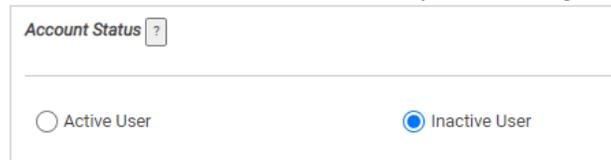
Key code	User has access to these tabs:
Provider Back Office	Home, Claims & Payment, Eligibility & Benefits, Authorizations, Resources, Member Viewer
Provider Front Office	Home, Eligibility & Benefits, Authorizations, Resources, Member Viewer
Provider Billing	Home, Claims & Payment, Eligibility & Benefits, Resources
Local Admin	Home, Claims & Payment, Eligibility & Benefits, Authorizations, Resources, User Manager, Member Viewer, and Reports

You can further restrict user access based on the provider’s NPI if you are in a setting with multiple providers. If staff should be limited to seeing their provider’s patients only, follow these steps:

- 1) Log in to the Local Provider Admin account
- 2) Click the **User Manager** tab
- 3) Search for the user by first and last name, username, or email address
- 4) Select the user's profile
- 5) Click the **Provider Details** link
- 6) Add or remove the TIN or NPI numbers as needed and click Save

How do I delete a user that no longer works for my office?

User accounts cannot be deleted. However, you can *deactivate* accounts, which completely shuts off the user's access. To do this, look up the user in User Manager. Click on the username link for the account you want to deactivate. On the Profile page, click the radio button Inactive User, then click **Update User**. These steps will terminate the user's account access, and they will no longer be able to log in.



The screenshot shows a form titled "Account Status" with a help icon. Below the title, there are two radio button options: "Active User" (which is currently unselected) and "Inactive User" (which is selected, indicated by a blue dot).

What information will I see through my account?

You must link a provider TIN to your account to see claims, authorizations and eligibility information for your office's Peoples Health patients.

Additionally, each time a user is added under the Local Admin account, the TIN for the account must be linked to the user. If the TIN is not added to the user account when the user account is set up, the user will not have full access to all the features in the Provider Portal, and you may not be able to find the user in the system at a later date to update their profile. If you encounter this issue, the Provider Local Admin or the user should contact Peoples Health, so we can assist with completing account set up for the user.

Can I add a new TIN to my account after it's been created?

Yes. Under the **User Manager** tab, search for the account to update. Click the **Provider Details** link and at the bottom of the page, select **Add TIN**. Type the TIN to be linked to the account, and click Add TIN. You can add TINs that are linked to your provider(s) only.

How do I verify patient eligibility?

From the **Eligibility & Benefits** tab, enter the patient's member ID number (G number) **or** the patient's last name and date of birth to retrieve plan information and eligibility details. Review dual-eligible status, including whether the patient is responsible for copays. Click the plan name link to see detailed copay information by benefit category.

How do I request an authorization online?

Click the **Authorizations** tab, then select **the icon for the type of services needed**. Find a patient by entering the member ID number and date of birth, or the patient's full name and date of birth. Complete the required information and attach supporting documentation or clinical notes, and submit the request. Certain services, including therapies, dialysis and home health, are authorized as soon as the request is submitted. Do not begin a new authorization when requesting an extension. For extensions, find the existing authorization on the Completed tab, then click the plus sign to the left to request an extension.

Will I automatically be logged out of the system after a certain period of inactivity?

Yes. The session will timeout after 60 minutes of inactivity, and you will need to log in again to resume working in the portal.

How do I print an EOP (claims remittance advice)?

Click the Claims & Payment. Enter the date range to search and provide a Check Number, Member ID (G number) or Claim Number, then click **Search**. Finally, click on a claim number link to review the claim details screen and click the link to view your EOP in the Remit column.

Claim Details										
Claim Line	Service Date	CPT	Description	Charges	Copay	Coinsurance	Denied	Paid	Reason Code	Remit
100	02/03/2020	99214	OFFICE OUTPATIENT VISIT 25 MINUTES	\$---	\$---	\$---	\$---			U1e0000001

I still have questions. Is there someone who can help me?

Email phn.provider@peopleshealth.com if you need further assistance, or reach out to your provider representative.

Member Viewer

With Member Viewer, you have secure access to your Peoples Health patients' medical profiles, including both current and historical clinical information. Primary care physicians can review their patients' compliance with the CMS stars program.

Having these details readily available and accessible in electronic format can assist you in establishing a clearer picture of your patients' overall health and clinical histories.

Member Viewer Features

Information in Member Viewer is updated regularly, and because of its sensitivity, it is only for physician and authorized staff use.

For each of your Peoples Health patients, you can access medical history, diagnostic information, pharmacy utilization information and more.

Select the **Member Viewer** tab in Provider Portal to access additional clinical tools and information on a separate Peoples Health platform. Access patient-specific information by searching for a member using their G Number or first and last name. You can also find a Daily Census of your patients in the hospital, and other priority lists using the Criteria drop-down search function, without any member information needed.

The screenshot shows the Member Viewer homepage with a navigation bar at the top containing 'HOME', 'MEMBER VIEWER', 'CONTACT', and 'LOGOUT'. Below the navigation bar, there are three search options separated by 'OR' labels. The first option is 'Member Number' with a text input field and a 'Search by Member #' button. Below this is a note: '*You can leave off the "G" in the member number. You must enter the zeros.' followed by a checkbox for 'Fast Search' and a link 'What's this?'. The second option is 'Search by Name' with 'Last Name:' and 'First Name:' text input fields, a 'Search by Name' button, and a checkbox for 'Include members outside my team(s) and practice.'. The third option is 'Search by criteria' with a 'Choose Team:' dropdown menu (set to 'All Teams'), a 'Criteria:' dropdown menu, and a 'Search by criteria' button. Below the search options is a section titled 'What's new:' followed by a disclaimer: 'Information found on this site is confidential and privileged. This information is intended solely for authorized users. Access by anyone else is unauthorized. No confidentiality or privilege is waived or lost by erroneous transmission. If you are not an approved user, any forwarding, downloading or viewing, taking screen captures or photos, disclosure, copying, distribution, or other action, is strictly prohibited.'

Figure 39 – Member Viewer homepage

Note: The Provider Billing user type does not have access to patient clinical information in Member Viewer and, therefore, cannot access this tab.

Member Viewer Profile Summary

The orange Member Viewer Profile Summary button is a helpful tool that offers a printable overview of your patient's health. The profile summary can help improve face-to-face visits with your patient by providing:

- Risk score
- Date of last flu shot (noted in **red** if vaccine is overdue)
- Date of last Medicare annual wellness visit
- Status of Peoples Health annual comprehensive wellness assessment
- Conditions requiring review for risk adjustment purposes (listed under the Disease Management and Clinical Indicators sections)
- Office visits and pharmacy utilization (last 90 days)
- Current and previous hospital admissions (last 12 months)
- Home health and DME utilization (lists open authorizations)
- Lab results (last 90 days)
- Medication adherence rates

Patient Medical History

Details about the following are available:

- Basic demographics, including full name, birth date, gender and contact information
- Plan-specific information, including current plan and member ID number, PCP history, Medicaid level and MOOP status
- Office visit details
- Behavioral health services
- Current and past hospital admissions
- ER visits (within past two years)
- Outpatient services
- Lab history and results
- Needed star and HEDIS measures, including compliance by measure year
- Prescribed medications and prescriptions filled
- Medicare Part B medications administered (medications covered under Medicare Part B—including immunosuppressant drugs, anti-cancer drugs, anti-emetic drugs and dialysis drugs—typically require the intervention of a physician to administer properly)

PCP Quality Reports

PCPs can use a variety of Member Viewer star reports to improve and maintain patient care with regards to specific CMS star measures. For more information, see the guide **Accessing PCP Quality Reports in Member Viewer**.