MEDICAL CARE

HEALTH

PROVIDER PORTAL
Santé Physicians

Table of Contents

INTRODUCTION

The Provider Portal is a robust tool which allows users to both submit and view data, as well as, communicate directly with the organization. Within the portal, the user can perform key tasks including submitting authorization, viewing authorization and claims status. It also gives the user a platform to verify eligibility of patients. In addition, the portal allows the user to upload claims in 837P format and download in 835 format.

This allows the user to print the explanation of benefits (EOBs) on-demand.

Each of these functions and features will assist in making your day-to-day operations more efficient and effective. Here at Santé, we are confident that with our new portal, you will be able to focus on providing the best quality care for your members.

Provider Portal

From the Santé website, users are able to submit a provider portal request.

Submitting a provider portal request

Step 1: Go to www.santephysicians.com, **click** on the **New User.**

Step 2: Enter all the applicable mandatory information.
Note: Please make sure to fill in all **required fields (*)** before you click **submit**.

➡ Request To Login ◁ **Close**

- If you wish for your Organization information to be accessible to third parties(like a billing company), you will be able to create username/passwords for them like described in the tutorial found above. Optionally, you can attach a formal letter below listing the persons you authorize to request this access.

- If you are requesting a username/password for a billing company or similar third party, please request username/passwords from your Organization or make sure they provide us with an authorization letter for you to use their Organization id.

*First Name:	
*Last Name:	
*Title:	
*Organization Tax ID:	
*Name of the Organization:	
*Office Phone:	
Cell No:	
*Fax:	
*Email:	
*Address:	

(Please provide the address of the Primary Organization)

*City:	
*State:	
*Zip:	
Upload optional authorization letter:	Choose File No file chosen

[Max file size 256M]

Notes:

Submit **Reset**

Your request will be sent to Santé for review. If approved, you will receive an email confirmation with your username and password.

Step 3: Login to the QuickCap Provider Portal with your username and temporary password.

2

Step 4: Click Agree on the Terms of Use.

Step 5: Create your new password, confirm your password and create your secret questions for security measures if you need to update or change your password in the future.

Step 6: You are now ready to navigate the new provider portal.

Authorization/Referral

From the **Authorization/Referral** module, users are able to submit new authorizations and referrals and also check the status of an existing authorization.
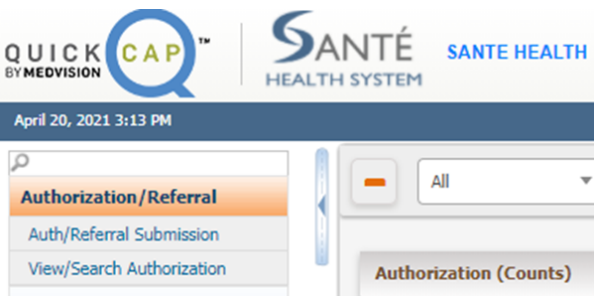

| Authorization/Referral Module

Submitting a new authorization

Step 1: From the drop-down menu of the **Authorization/Referral** module, select **Auth/Referral Submission** submodule.

To submit a new authorization, follow the steps below:

The screen will display as shown below. On this screen, there are three subsections to add an authorization.

Step 2: The first section is the **Member Section**. Users can enter the member's information in one of two ways:

- Enter the **Member ID** for the specific member. The system will begin suggesting members once the user has entered part of an ID. Users can then select the correct ID to add the member's information to the screen.
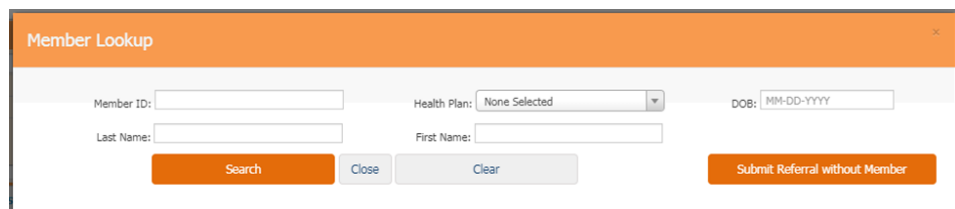
- Or users can click on the **Magnifying Glass** icon to search for the member. The **Member Lookup** screen will open. From this screen, users can search using a combination of **Member ID, Health Plan, Name**, and **DOB** to find the record. Double click the correct record to add it to the authorization request.
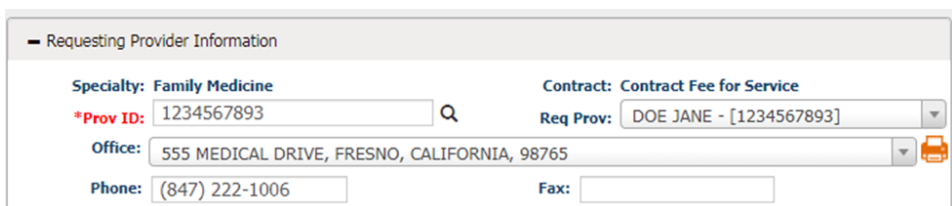

Step 3: The details for the selected member will be populated on the screen. The system will default the **Requesting Provider** information matching the organization and provider logged in.

Step 4: The user can select the **Priority** and the **Place of Service** for the request.

- Within the **Priority** dropdown menu you will have two options which will trigger a popup screen to appear or additional options.
    - **Urgent**: If selected, the **Required Information for Urgent Requests** screen will open. Enter the necessary information and click the **Add** button to complete this step.

    - **Retro**: If the services have already been provided, users should select Retro. A new field, **Retro Date**, will appear and require date entry.

Step 5: The section to the right of the **Member Details** is the **Authorization Date/ Details**. The **Requested Date** is non-editable and will always default to the date of submission.

- The **Service Requested Date**, displayed in the **Service Req. Dt** field should be entered as the date that the service should be performed, scheduled for, or for the authorization to become effective. This date will be reviewed by Santé Physicians internal staff and is subject to their discretion.

Step 6: The **Basic Details** tab displays the **Requesting Provider Information**. This will default to the provider that is logged into the system. This screen includes **the Specialty, Contract Type, Provider ID, Requesting Provider Name**, and the **Contact Information**.

- If the requesting provider needs to be changed, users can search for a new provider by clicking the **Magnifying Glass** icon on the right of the **Provider ID** field. The **Provider Search** screen will open as shown below. Search the provider by entering any of the available information.

- Click the **Provider ID** indicated in orange to populate the details of the requesting provider on the authorization request.

- If the provider has multiple offices, users can select the correct office from the dropdown menu.

Step 7: The next section, **Referring to Provider Information,** allows users to enter the information for the provider that member is being referred to.

- For self-referrals, select the **Same as Requesting Provider** checkbox. This will auto-populate the information from the **Requesting Provider** screen.
- To search for a **Referring To Provider**, click the **Magnifying Glass** icon beside the **Referring To** field. The **Provider Search** screen will populate as shown in the above section. Users can search for the specific provider.

- Click the correct **Provider ID** to enter the details of the referring provider on the authorization request.

- Select the **Referring to Office** from the dropdown menu.

Step 8: This step is optional. Users can **enter Facility Provider Information** for the request, if needed.

Step 9: The next section, **Diagnosis**, is where users will enter all diagnosis details for a request.

- Enter all ICD-10 codes related to the request in the **Diagnosis Code** field.
  - If the user knows the ICD-10 code, they can enter it into the field and press **tab** on their keyboard. The system will populate the description to the right in the **Diag. Description** field. The system will auto suggest codes if they are partially entered.
  - To search for the diagnosis code, click the **Magnifying Glass** icon by the **Diagnosis Code** field. The **Diagnosis Search** screen will populate, as shown below.

- From the **Diagnosis Search** screen:
  - Enter either the diagnosis code or description to search for the code.
  - Users can view the mapping between versions by selecting the **Show Mapping** checkbox.
  - Click the **Search** button.
  - Click the + icon to the left of each code to view the mapping.
  - Select the desired code by clicking on the correct **Diagnosis Code** shown in orange.

Note: Users can add 12 distinct diagnosis codes.

Step 10: The next section is used to enter the CPT/HCPCS codes for the requested services.

- To utilize the **CPT/HCPCS Code** option, users can enter the service code or search for the service code by clicking **F2** on the keyboard.
- After the code is entered, the description will auto populate into the **Service Desc** field.

- Users can enter the **Diagnosis Reference**. The system will default automatically to 1, which indicates that the code is linked to the first ICD code from the **Diagnosis** section. Users can change the digit corresponding to which diagnosis code the service should reference.

Service	Service Desc.	Type	Diag. Ref.	Modifier		Qty.	Unit Type
72148	MRI LUMBAR SPINE W/O DY	P	1	None Selected	∨	1	VISITS ∨

- Users can add any modifiers if needed. **Modifiers** can be selected from the dropdown menu or manually enter the code.

Service	Service Desc.	Type	Diag. Ref.	Modifier		Qty.	Unit Type
72148	MRI LUMBAR SPINE W/O DY	P	1	None Selected	∨	1	VISITS ∨

- Users can enter a quantity for the service and select the unit type. If none is selected, it will default to **None** and for 1 for the **Quantity**.

Service	Service Desc.	Type	Diag. Ref.	Modifier		Qty.	Unit Type
72148	MRI LUMBAR SPINE W/O DY	P	1	None Selected	∨	1	VISITS ∨

- Press **tab** on the keyboard to go to the next CPT (service) line.

Step 11: The next section is **Clinical Indication for Request**. In this section, users can add the member's past medical history, physical findings, service notes being requested, or attach all relevant medical records and test results.

Step 12: The second information tab is Additional Details. Within this tab, three more sections will appear. The first section includes fields to enter Guardian Name, Language preference, Cell/Phone Number, and Medical Record Number (MR#).

Step 13: The first section is **Documents**. Users can upload and attach documents to the referral request. Users are also able to fax documents to the organization. To upload documentation and submit it electronically with the referral request:

- Select the Category and Priority of the document.
- Click **Browse** to find the file from the computer directory.
- Upload documents in the following formats: .doc, .docx, .xls, .xlsx, .pptx, .xps, .psd, .htm, .pdf, .tiff, .rtf, and text.
- Click the **Add Additional Documents** button to add multiple documents.
- Once users click **Save**, the document will send with the referral automatically.

Note: Supporting documentation is required. Failure to submit could delay the completion of your request.

Step 14: After verifying the data entered, users can save the request.

- To submit the referral request, click **Save**.
- To submit the referral request and add another request for the same member, click **Save and Add for Same Member**.

Note: When an authorization or referral request is submitted, users will receive a notification detailing the authorization request number with the status. Then on the **Authorization** screen, the recently submitted authorization number will be displayed automatically on the header portion.

Step 15: Users have the option to Print Auth on the lower section of the screen once it is saved. This feature allows users to print authorization requests. The popup window gives options to print and export the request.

Export Options: There are several options that the reports can be exported to:

- Crystal Reports (RPT)
- PDF
- Excel 97 – 2003
- Excel 97 – 2003 Data Only
- Excel Workbook Data Only
- Word 97 – 2003
- Word 97 – 2003 Editable
- Rich Text Format (RTF)
- Character Separated Values (CSV)
- XML

Checking the status of an authorization

Step 1: From the drop-down menu of the **Authorization/Referral** module, select **View/Search Authorization**.

Step 2: The **Authorization/Referral Status Search** screen will display as shown below:

Step 3: The first section is where users search for authorizations. Enter search criteria in any of the available fields. The search results will display in the results section below.

Step 4: Click the (+) icon on the left column of the result table to view the services requested in the authorization. The service information will be visible.

Step 5: The status of the authorization (requested, approved, denied) is displayed in the **Authorization No. Status** column.

Step 6: To view all of the information for a specific authorization, click on the row for the authorization. This will redirect users to the **Authorization/Referral Status Search** screen with all of the authorization details.

Note: This screen is only for viewing purposes. Only a few sections are enabled.

Step 7: To add additional details to the current authorization request, click the **Additional Details** button. The **Additional Details** screen will populate as shown below.

Claims

From the **Claims** module, users are able to submit a new claim, view and search for previously submitted claims.
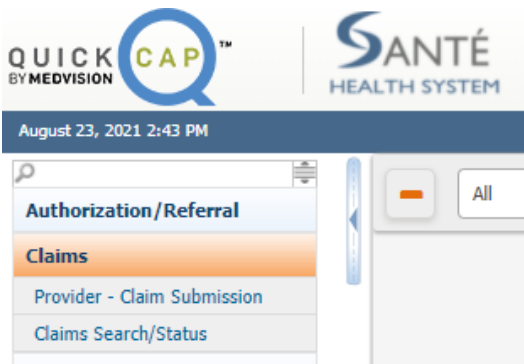
Submitting a new claims

To submit a new claim, follow the below:

Step 1: From the **Claims** list, select Provider – **Provider - Claim Submission** .
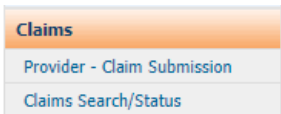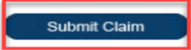
| Provider - Claim Submission Submodule

Step 2: The screen will display as shown below. Look up the member for which you want to add claim for, using Member ID or Last Name, DOB and HealthPlan, by adding details in search and clicking on search icon.

Step 3: Once you have the member record in result field, click on **Submit Claim** button at the left-hand corner of the member record.

Step 4: Once the button is clicked, the system will re-direct to the screen to add claims. Please refer to the image on the next page as to how the screen will look now. There is a total of 10 sections to fill in.

Step 5: Below are the steps to add details to the claim:

- Add **Authorization Number** on the claim. You can click on the magnifying glass to look up an authorization from the system. Click on **Auth#** to select the auth for this claim.

- Basic **Member Information** will automatically populate, based on the member we selected initially before we clicked **Submit Claim**.

- Under **Provider Information** section, you can choose the rendering provider for the claim. Provider can be selected using two options:
  - **Provider ID** search using magnifying glass, to look up provider using filters. Once you have the provider in the result grid, click on the **ID** to select the provider.
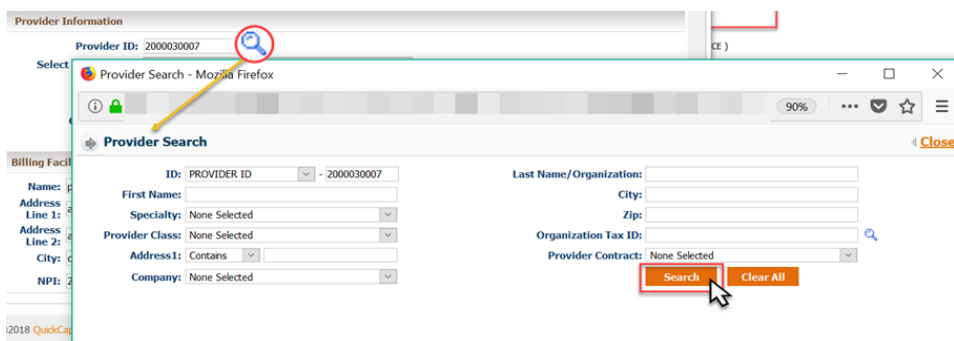
- ○ Select the Provider drop down. This will show you all providers under your organization.

- ○ Once you have selected the provider, all other details will be auto-populated.
- ○ If you wish to change the specialty of the provider (In case the provider is multi-specialty), click on the specialty drop down.
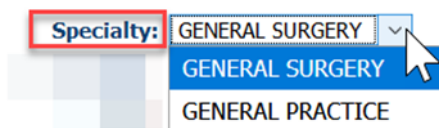
- ○ If you wish to change the organization (Billing entity), you can click on the drop down to choose from different organizations linked to this provider.
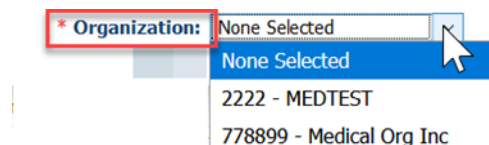
- Addresses – **Billing, Service** and **Pay to**
  - These addresses will auto-populate based on the provider and organization selected. However, if you wish to manually override it, you can.

- **Additional Information** section will let you add additional details on this claim like:
  - **Patient Account #**
  - **Patient paid amount**
  - **Purchase service amount**
- **Claim Details** will let you enter the **POS** of this claim.
  - When the POS added is an inpatient POS, it lets you add the admit and discharge date.

Note: In case of inpatient claim, it is mandatory to add Admit date.

  - When the POS is Ambulance, the ambulance icon gives you a pop-up to add ambulance details. Fill in the details and click OK to save the ambulance details.

- **Diagnosis** field lets you add 12 distinct diagnosis on the claim. You can either type in the diagnosis code (Tab Out) and click add OR you can look up the diagnosis code using the magnifying glass.

- **Services** lets you add all the details for procedures to be billed on this claim.

○ Below are the details you can add on the service line
   ♦ **Service From** and **Service To** *date and time* (Advised to add time for Anesthesia claims).

   ♦ **Service code/Procedure code**. You can type in or look up from the magnifying glass icon. Click on the code to add on claim.

   ♦ **NCD Code – QTY – Unit. (Mandatory to add for all J codes)**
      ◊ You can add NDC code in different formats. Format can be selected from the drop down.

◊ Once you have selected the format, you can add your NDC code or look up using the magnifying glass.

◊ QTY is the space provided to define the number of quantity for the drug specified on NDC code.
◊ Unit, lets you choose the unit for the code.

♦ **Modifier code** lets you add four modifiers on each service line.
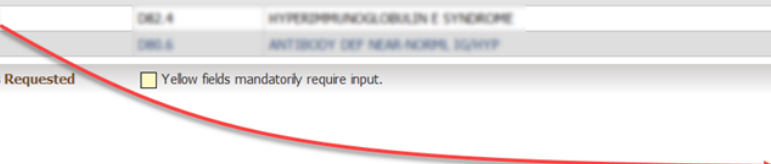
- ◆ **Diagnosis code ref**, lets you add the diagnosis code indicator for each service line. Please add numeric value in this to indicate the diagnosis code place value you would like to add.

- ◆ **QTY** is the quantity for the procedure code you want to bill.
- ◆ **Billed** is the billed amount for this procedure code.
- ◆ **Other Insurance** is the amount received from Primary insurance if this is a secondary claim, etc.
- ◆ **Notes** lets you add s service level notes if needed. Any significant details for this line item can be sent here.
- ◆ **ADD** icon adds these details and makes these fields blank again for the next line item.

○ Once all details are added, you can see the detail lines added and their total below them.

Services Requested	Yellow fields mandatorily require input.						
	Service Date-Time	**Service Code**	**NDC Code - Qty - Unit**	**Modifier**	**Diag. Ref.**	**Qty - Billed**	**Other Insurance**
	From: [ ] 📅 [ ] To: [ ] 📅 [ ]	[ ] 🔍	11-digit 5-4-2 ▼ NDC Code 🔍 Quantity Unit ▼	Modf. 1 Modf. 2 1 Ref. 2 1 Modf. 3 Modf. 4 Ref. 3 Ref. 4 Billed Amount			[ ]
📝	From: 10-01-2017 To: 10-01-2017	99213 - OFFICE/OUTPATIENT VISIT EST	NDC Code: 57520-0547-01 Quantity: 2 Unit Type: ME	25	1	Qty: 1 Billed: $70.00	20
📝	From: 10-02-2017 14:20 To: 10-02-2017 15:05	01440 - ANESTH KNEE ARTERIES SURG	NDC Code: 08021-0000-18 Quantity: 5 Unit Type: ML		1	Qty: 1 Billed: $300.00	50
Totals:						Qty: 2 Billed: $370.00	

*Note: To delete a line item added in error please click on the **Cross** icon at the right end of each service line. To merely update the details, click on the **edit** icon to the left of the service line.*

• **Clinical Indication** is a section where you can add additional details to be submitted on the claim. This can contain patient's history, medical findings or any relevant records.

Clinical indications for request
(include pertinent past medical history, treatment, physical findings, and attach all relevant medical records, test results, etc.)

• **Documents** let you attach any relevant document about the claim being submitted. You can attach files with the type as mentioned on the screen.
  ○ To add document, click on **Browse**, to select a file from your machine.
  ○ To add more than one document, click on the link for **+add more document**.

- To **delete** a document attached before submitting a claim, you can click the cross on the right.

Step 6: Once all the details are added, click on **Save to submit the claim** for processing. You can also use **Save & add for same member** if you wish to add another claim for the same member.

*Note: Once the claim is saved, it will give you a pop up with a claim number as shown below. You can click on **OK** to go back to the screen. If you wish to print the submitted claim as CMS 1500, click on **PRINT CLAIM**.*

Checking the status of a claim

To verify the status of a claim, follow these steps:

Step 1: From the **Claims** list, select **Claims Search/Status**.
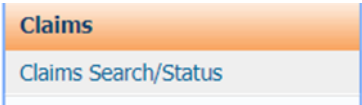
| **The Claims Search/Status submodule**

Step 2: The screen will display as shown below. On this screen, there are three subsections to search claims by.

Step 3: Based on the criteria users have input, the search results will display in Claim Details section, as shown below.

- The **Status** can be found on the right side in the last box. The adjustment code and net amount on the claim is not finalized and is subject to change until the **Status** is **Paid**.

Step 4: To view and print the claim in CMS 1500 format, click the **Print CMS 1500** button.

Step 5: If the claim is in a **Paid** status, there will be an additional button for **Show EOB**.

Communication

From the Communication module, users are able to communicate with any QuickCap user including group/department such as customer service, claims, utilization management, etc.

The Communication Module

Customer Service

From the Customer Service module, users are able to add and view existing customer service requests for their organization.

| **The Customer Service Module**

Adding Customer Service Requests

From this screen, users are able to add customer service requests into the portal. Once an external user submits a request, internal users can review the request.

Step 1: From the **Customer Service** list, select **Customer Service Request**.

Step 2: Click **Add**.
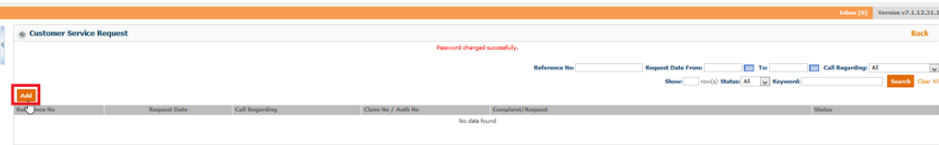
Step 3: The **Customer Service Request – Add** screen will populate. Users can fill in the information below to submit a request.

- **Regarding:** This drop-down menu allows users to select the purpose of the submission.

- **Priority:** This allows users to select the severity between **low, medium,** or **high**.
- **Pref. Comm:** This field represents the best way to contact back in case follow up is needed. The selection includes **Fax, Email,** and **Phone**.
- **Reason:** This field indicates what the user was calling in regards to. Depending on the field selected above from the **Call Regarding** field, the **Reasons** will change.
- **Problem/Description:** Users can add a description to explain further the purpose of this request. This information will assist the representative reviewing the request.
- **Attachment:** Users can attach any documents that would aid the representative in completing the request.

Step 4: Click **Save** to submit the request. A customer service request reference number will be given upon saving the request. This can be used later to check for updates.

Customer service request saved successfully.
Reference Number: 20150831-6892
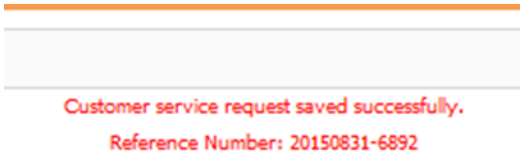
Searching Customer Service Requests

External users can check in the portal to view the status of previously submitted requests.

Step 1: From the **Customer Service** list, select **Customer Service Request**. The **Customer Service Inquiry** screen will open.

Step 2: Enter search criteria.

Step 3: Click **Search** to show the results. Click the **Reference Number** associated to the request to open the entire request. Users can update or add information to an existing request at this time.

Eligibility

From the Eligibility module, users are able to verify a member's eligibility and report any discrepancies.

Authorization/Referral
Claims
Customer Service
Dashboard
Eligibility
Information

The Eligibility Module
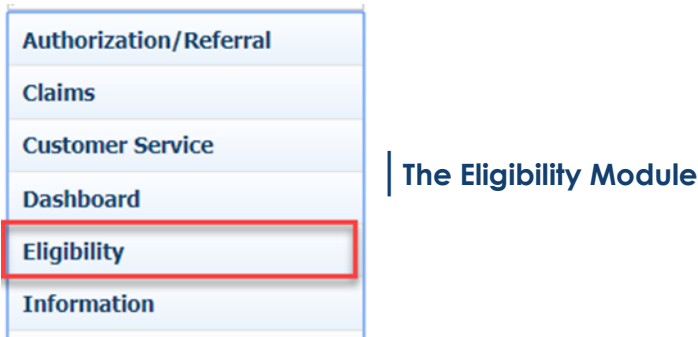
Verifying Eligibility

To verify Eligibility for a member, follow the below:

Step 1: From the **Eligibility** list, select **Member Verification**.

Eligibility
Report Eligibility Discrepancy
Member Verification

The Member Verification submodule

Step 2: The screen will display as shown below by clicking on the search icon.

Eligibility - Member Verification

* Member ID:

(OR)

* Last Name: Health Plan: ▼

First Name: * Date of Birth:

SSN: Service Date: 05-10-2018

* Gender: None Selected ▼

| Verify Eligibility | Report Eligibility Discrepancy | Clear All |

Step 3: Users can search for members in two different ways:

- Search by entering the **Member ID** for the specific person.
- Search by entering the **Last Name, Date of Birth,** and **Gender** of the member; all three fields must be completed.
  - Users can add the **Health Plan, First Name, SSN,** and **Service Date** for a more detailed search.

Step 4: Select **Verify Eligibility**. If the member exists in the system, their details will be displayed as shown below.

Details	Member ID	Name	Gender	Date of Birth	Member SSN	Health Plan	Provider ID	Name	Other Coverage?	Resp. Code	Policy #	HP Status	PCP Status
🔍🖨			F			BC			No	Unknown		Inactive	Inactive

- To view additional details about the member's eligibility, click the **magnifying glass** (first icon) under **Details**.
- To print the member's eligibility, click the **Print** button (second icon) under **Details**.
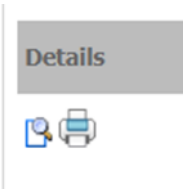
Information

From the Information module, users are able to search and view the code references for ICD codes, CPT codes, and modifiers.
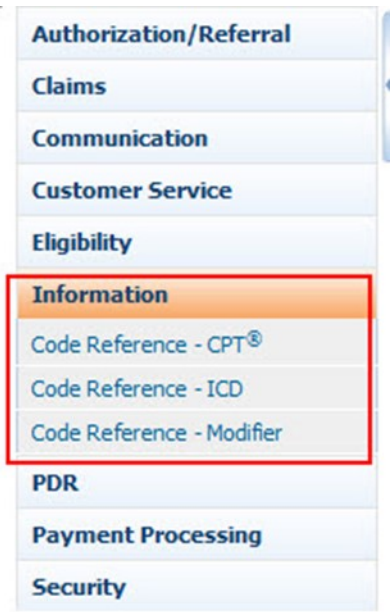
Code Reference—CPT

From this screen, users are able to search and view CPT codes.

Step 1: QuickCap Portal -> Left Panel -> **Information** -> **Code Reference-CPT**

Step 2: The **CPT Search** screen will display as shown below.
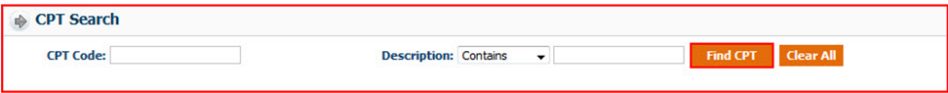
Step 3: Users can search for codes either by entering the CPT Code or by entering the Description.

Note: *It is necessary to enter data in at least one field. It is better to search with less specific descriptions as the search function will find more possible matches.*

Step 4: Click the **Find CPT** button. The search results will display as shown below.

CPT Code	Description	Medium Description	Long Description	GuideLines	NCCI Edits
10100	DRAINAGE OF INFECTED NAIL	DRAINAGE OF INFECTED NAIL	DRAINAGE OF INFECTED NAIL		View
10101	DRAINAGE OF INFECTED NAIL(S)	DRAINAGE OF INFECTED NAIL(S)	DRAINAGE OF INFECTED NAIL(S)		View
1010F	SEVERITY ANGINA BY ACTVTY	SEVERITY OF ANGINA ASSESSED BY LEVEL OF ACTIVITY	Severity of angina assessed by level of activity (CAD)		View
1011F	ANGINA PRESENT	ANGINA PRESENT	Angina present (CAD)		View

1. To view more details regarding the CPT code, click the **CPT Description** Details icon. The CPT Description screen will populate as shown below.

CPT Description   ◄ **Close**

CPT Description:

| Code:	10100
Short Desc:	DRAINAGE OF INFECTED NAIL
Medium Desc:	DRAINAGE OF INFECTED NAIL
Long Desc:	DRAINAGE OF INFECTED NAIL
Hierarchy:	DRAINAGE OF INFECTED NAIL
Code Tip:	

Guideline Documents:

Service Group	Service From	Service To	Specialty	Gender	Notes	Health Plan(s)	File Name
			No Document(s) Found.				

CPT Guidelines:

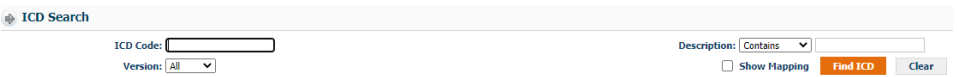| CPT Code	Specialty	Document Name
	No Guideline(s) Found.	

2. To view the NCCI Edits, click the **View** link for the specific row. The NCCI Edits screen will be populated in a separate screen.

Code Reference - ICD

From this screen, users are able to search and view ICD codes.

Step 1: QuickCap Portal -> Left Panel -> **Information** -> **Code Reference-ICD**

Step 2: The **ICD Search** screen will display as shown below.

Step 3: Users can search for codes either by entering the ICD Code (ICD-9 or ICD-10) or by entering the description.
Note: It is necessary to enter data in at least one field. It is better to search with less specific descriptions as the search function will find more possible matches.

Step 4: Users are able to select an ICD-version in the Version field. This allows the system to search by ICD-9, ICD-10, or include both in the search results.

Step 5: User should select the **Show Mapping** button if they would like to have the comparable ICD code map between ICD-9 and ICD-10.

Step 6: Click the **Find ICD** button. The search results will display as shown below.

Step 7: Click the **(+)** icon to view the mapping details.

Step 8: To view more details about the ICD code, click the **ICD Description Details** icon. The **ICD Description** screen will populate as shown below.

Code Reference - Modifier

From this screen, users are able to search and view modifier codes.

Step 1: QuickCap Portal -> Left Panel -> **Information** -> **Modifier**

Step 2: The **Modifier Search** screen will display as shown below.

Modifier Code	Description
20	MICROSURGERY
22	UNUSUAL SERVICES
23	UNUSUAL ANESTHESIA
26	PROF. COMPONENT
30	ANESTHESIA

*Note: Users can search either by entering the Modifier Code or by entering the description. Users can also search by directly clicking the **Find Modifier** button.*

PDR

From the **PDR** module, users are able to submit a provider dispute resolution.

Submit PDR

Step 1: From the **PDR Module**, select **PDR Submission/Search**.

Step 2: Click on the **Add.**

Step 3: The **Submit - PDR** screen will populate. Users can fill in the information below to submit a request.

- **Disputed Claim #** - the user must provider a claim number that is being disputed.

- **PDR Submission Date** - a system generated date based when the day of submission.

- Additional Information need to be filled out including:
  - Member ID
  - Member DOB (Date of Birth)
  - Last Name
  - First Name

- **Submitter Contact Information**
  - Name
  - Preferred Communication (Email or Fax)
  - Phone Number
  - Fax Number
  - Email

- **Additional Files** - submitter will be able to submit additional files

- **Billing Address** - completed provider billing address
- **Detail** - including reason for PDR and PDR Category.

Step 4: Once all the details are added, click on **Save** to submit the PDR for review.

Payment Processing

From the **Payment Processing** module, users are able to generate Explanation of Benefits (EOBs) for members claims that have been submitted and paid for.
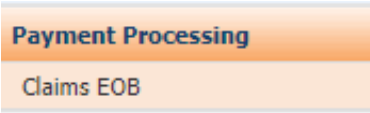
The Payment Processing Module

Claims EOB

To print a claims EOB, follow these steps:

Step 1: From the **Payment Processing** list, select **Claims EOB**.
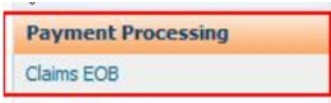
The Claims EOB submodule

The screen will display as shown below.

Step 2: Enter the specific member's name that you want to generate the EOB for.
Note: Users can skip this search criteria if they want to generate EOBs for multiple members from an organization.

Step 3: Enter the correct organization name or search the organization by clicking the magnifying glass icon. The **Organization Search** screen will be displayed as below. Only organizations that users are affiliated with will show in the search screen.

- Search the organization by entering any of the available information.
- Select the organization by clicking the Organization ID.

Step 4: Enter the check number that the EOB was paid with. If the

Organization Search											Close
Organization ID:			**Name:** Medical Organization, Inc				**Tax ID:**				
NPI:			**Category:**				Search	Clear All			
Organization ID	Name	Category	Tax ID	Address1	City	State	Zip	Email	Phone	Fax	NPI
778899	Medical Organization, Inc.	2 - Primary Care	7894561230	123 Main Road	Chicago	IL	60614				7894561230

user does not know the check number, they can search for the check by clicking the **Retrieve Check** button. The **Check No Search** screen will display as shown below.

Check No Search				Close
Check No.:				
From Date: 03-13-2015	**To Date:** 09-13-2015		Search	Clear All
Prefix	Check No	Paid Date		Amount
1	948230	09-13-2015		$24.00
2525	1	09-02-2015		$21.00

- Search the check by entering either the check number or by entering date ranges. To search for all checks ever paid, leave the fields blank and click the **Search** button.
- Select the check by clicking on the **Check No.**

Step 5: By entering the check number, the **Paid Date** field will be populated with the dates automatically. Click the **Display EOB** button and the EOBs will be generated as shown below.

- To print the report, click the **Print** icon.
- To export the report, click the **Export** icon. An **Export** dialogue box will be populated as shown below.

- Select which file format to save the report in.
- Click the **Export** button. The report will be exported in the selected file format.
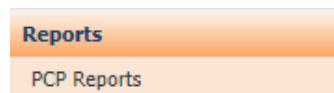
Reports

From the **Reports** module, users are able to generate different type of special reports.
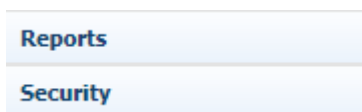
 The Reports Module

PCP Reports

Step 1: From the **Reports** list, select **Claims PCP Reports**.

 The PCP Reports submodule

Step 2: Based on the screen below, a user can run different types of reports that suits their needs.

Members (Export to Excel) - list of all the members assigned to a specific PCP in excel format.

Members - list of all the members assigned to a specific PCP in standard report format.

Members Never Seen by PCP - list of all the members assigned to a specific PCP that hasn't seen the PCP.

Hospital Admission - list of all the members assigned to a specific PCP that has been admitted to the hospital. This report is based on hospital claims in the system.

Urgent Care Visits - list of all the members assigned to a specific PCP that has visited an urgent care provider. This report is based on the urgent care claims received in the system.

Specialty Utilization - list of all the members assigned to a specific PCP that has visited a specialist provider. This report is based on the specialty claims received in the system.

ER Visit Paid, Unpaid & Both- list of all the members assigned to a specific PCP that has been admitted to the emergency room. This report is based on the ER claims received in the system.

Notes

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ABOUT THIS USER GUIDE

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For questions and inquiries, please email Santé Physician Services at PhysicianServices@santehealth.net.

SANTÉ PHYSICIANS

Local (559) 228-5400
Toll Free (800) 652-2900
www.santephysicians.com