

Claim Status – Getting started

Claim Status can be used to instantly obtain the status of your claims from the Hennepin Health's adjudication system. Once Hennepin Health has received your claim, these tools will receive updated status only when Hennepin Health sends a claim status report relating to your claim.

Note, that claim status inquiries will work even if you did not submit your original claim through Change Healthcare. However, if your claim was submitted through ConnectCenter, be sure not to miss the great claim status short-cut available by starting from that claim. Skip to the section at the end of this document titled "[Claims submitted through ConnectCenter](#)" for details.

To begin finding your claim's status, first select **Claim Status** from the **Claims** menu. A minimum set of data elements are required. Required fields are marked with either a red asterisk (*) or a red outline around the field.

Steps to view a claim's status:

[Step 1 - Open the Claim Status request screen](#)

[Step 2 – Select a provider](#)

[Step 3 - Identify the Payer or Plan](#)

[Step 4 - Enter claim information](#)

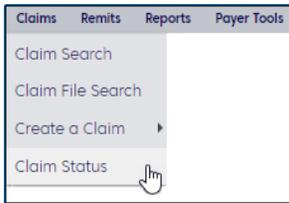
[Step 5 - Claim Status response](#)

Pro tip: Instead of starting from the Claim Status menu as described in steps 1-3 below, start by performing a member eligibility inquiry for the patient for whom you billed this claim. Once you've retrieved the member's benefits, look for the button labeled "Use Member For" and the dropdown list that will say "Select Transaction." Change the transaction to Claim Status and click the button. Steps 1-3 (described below) will be completed automatically allowing you to start on Step 4.

Expert tip: If you or a colleague may have checked the member's eligibility in the past (such as at the time you sent the claim), choose "Search Eligibility History" from the Verification menu. You should be able to easily find the previously submitted member benefit inquiry so that you can initiate your claim status transaction from there, rather than needing to run it again. From the saved eligibility response, set the Use Member For transaction type to Claim Status and click User Member For button. Steps 1-3 (described below) will be completed automatically allowing you to start on Step 4.

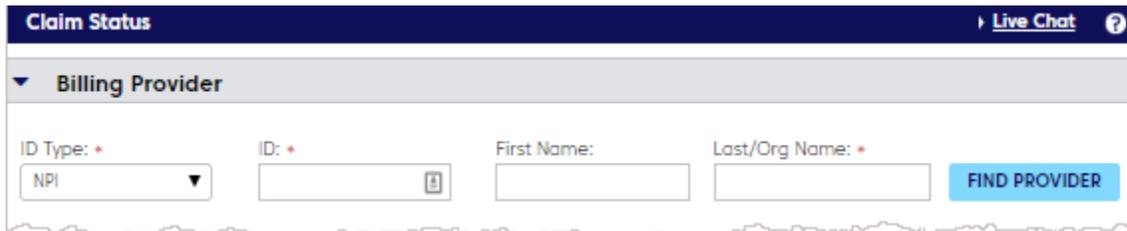
Step 1 – Open the Claim Status request screen

On the Claims menu, select Claim Status.



Step 2 – Select a provider

There are several shortcuts for completing the provider step. If your claim status requests are typically submitted on behalf of just one provider or a relatively small number of providers, use **Admin, Provider Management** to create a list of those frequently used providers. (See **Getting Started with Provider Administration** for additional explanation.) You may also find that provider information you entered in the Sign-Up application when creating your account, is already available in Provider Management.



Once your frequently used providers have been listed in Provider Management, you will be able to use the Find Provider button to open the list of saved providers. Click the radio button in the Select column, on the left, next to the provider you wish to use.

Select	Primary Id	Last/Org Name	First Name	Tax ID	Taxonomy Code	Effective Date	Status	Expiration	Default
<input type="radio"/>	1700031077	'C' CASTING CARE	SPART070			03/23/2017	ACTIVE		<input checked="" type="checkbox"/>

Better yet, Find Provider users can set a default provider by clicking “Find Provider” and then choosing the radio button found next to the desired provider in the Default column, on the right side of the table.

Select	Primary Id	Last/Org Name	First Name	Tax ID	Taxonomy Code	Effective Date	Status	Expiration	Default
<input type="radio"/>	1700031077	'C' CASTING CARE	SPART070			03/23/2017	ACTIVE		<input type="checkbox"/>

A default provider's information will be prefilled whenever a new claim status inquiry is initiated. Note: after opening Find Provider to choose the default provider, you must also select a provider (using the radio button on the other side of the table) in order to close the provider list and return to the Claim Status request.

For those who determine that Find Provider is either unavailable or not suitable, an alternate short-cut involves the provider's NPI. When you set ID Type to NPI and enter the NPI into the ID field, ConnectCenter will attempt to retrieve the matching provider record from NPPES. If found, the remainder of the required provider fields will be completed automatically.

For atypical providers lacking an NPI or any other case where both the NPPES inquiry and the Find Provider options are not helpful, the final solution is to manually key in Provider ID Type, Provider ID and Provider Name.

Following the **Billing Provider** section is the **Rendering Provider** section. This section is not required.

Step 3 – Identify the Payer or Plan

You can only search for Hennepin Health claims. This section defaults to Hennepin Health.

▼ Payer

My Favorites: Payer Name:

Payer Search Options

After selecting a payer, the Payer Search Options field display descriptions of the different types of searches the selected payer supports. Each Payer Search Option will consist of a list of different member attributes (such as name, ID or date of birth). The purpose of these options is to provide guidance about which combinations of member information are sufficient to retrieve claim status. The first option listed will be selected by default

because it contains the preferred combination of member details. However, if you do not have all the information identified in that search option, or if your patient is a dependent, you can review other entries in the Payer Search Option list to evaluate whether there is a combination that better suits your needs. As you select different payer search options from the list, you may notice that the red highlighted fields in the subscriber and dependent sections will change. Because red borders indicate that a field is required, the highlighting will change to match your choice of Payer Search Option.

Step 4 – Enter claim information

In this section red outlines are used to denote required fields. Entries in the claim information fields are expected to exactly match what you included on the claim you are trying to retrieve. Most of these fields are self-explanatory. The most confusing field is probably **Bill Type**. **Bill Type** is used to capture the 3-character code for the place of service as provided on an institutional claim. Use the icon to access a legend of supported codes. If you are searching for a professional claim, you should omit this field. For the Member ID field use the members 8 digit PMI.

Once you've finished entering criteria, use the **Submit** button to send the request.

Step 5 – Claim Status response

Response Information									
▼ Claim Status									
Select Claim Status: <input type="text"/>									
▼ Payer Information									
Payer ID: QA5010					Payer Claim Control Number: 26182501998702				
▼ Claim Status Information									
Patient Last Name: BOSS					Claim Service From Date: 07/02/2018				
Patient First Name: DON					Claim Service To Date:				
Patient Middle Name: F					Claim Charge Amount: \$368.00				
Patient Account Number:					Claim Payment Amount: \$124.00				
Member Number:					Check Effective Date: 11/21/2018				
Type Of Bill: 141					Check Effective Number: 721203801				
Billing Provider NPI: 1808150871									
Billing Provider Number: 1808150871									
Billing Provider Name: Smith, M.D.									
Rendering Provider NPI: 1808150871									
Rendering Provider Tax ID: 1808150871									
Rendering Provider Name: Smith, M.D.									
▼ Payer Messages									
Category					Status				
F1 : Finalized/Payment-The claim/line has been paid.					1 : For more detailed information, see remittance advice.				
Line	Revenue Code	Procedure	Modifier	Units	Service Date	As of	Charge Amt	Payment Amt	Category/Status
		HC-99602		4	07/02/2018	11/16/2018	\$244.00	\$0.00	F2 : Finalized/Denial-The claim/line has been denied. 1 : For more detailed information, see remittance advice.

Claim Status

The Claim Status section of the response is used only in the case where a payer returns multiple matching claims in response to your search. If this happens, a list of the returned claims will be displayed under the “Claim Status” header so that you can choose which claim to review.

Payer Information

The payer information section contains Hennepin Health's payer ID and the Hennepin Health internal control number for the claim returned.

Claim Status Information

This section will display summary claim information such as member demographics, billing provider, rendering provider, claim dates and charges.

If available, **Claim Payment Amount**, **Check Date** and **Check Number** can be found in this section (right column).

Payer Messages

Claim level status messages are presented at the top of the Payer Messages section. Claim status messages will be followed by a service line table. Each line will include procedure code, service dates, charges, and adjudication status. If adjudication is complete, the payment amount appropriate to each service line will also be available.