Insurance and Billing Information

With DLO, you're good to *GO*

DLO has comprehensive insurance partnerships that provide broad coverage for patients. This means dealing with fewer laboratories, gaining access to local clinical lab experts, and achieving consistency of reporting — all of which increase practice efficiency.

About this section

This section will acquaint you with billing and insurance policies and procedures for DLO services in your area.

Billing Overview

eInvoice™

Insurance Payor List

PECOS Enrollment

Medicare Billing

Medicare Limited Coverage Policies (MLCP)

Advance Beneficiary Notice (ABN) Form

Advanced Written Notice (AWN) Form

SoonerCare Prior Authorization Process

Billing Services Overview

We understand that your practice is busy and managing the complexities of insurance coverage and billing can be challenging.

We've simplified our invoicing process and have resources to help you obtain the information you need to streamline your workflow.

Client Billing

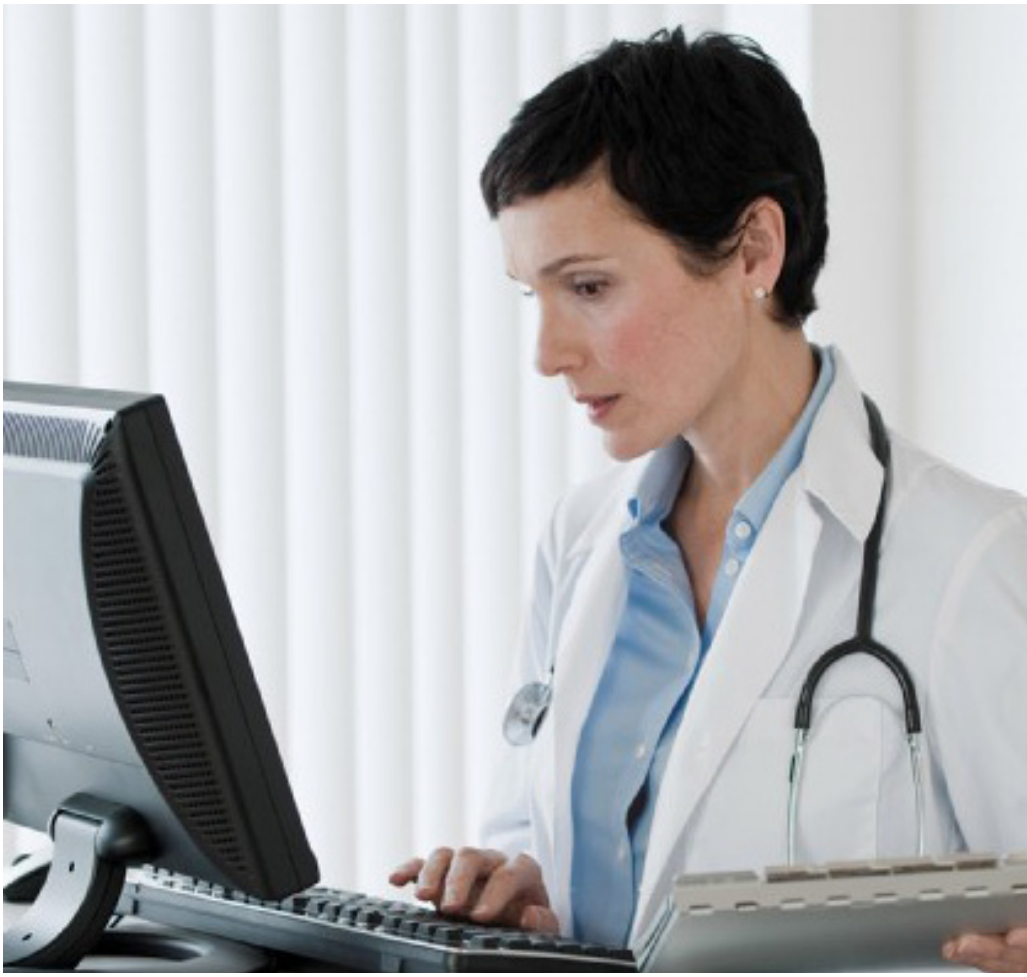
If your account is eligible, you may direct charges to be billed to your client account.

Questions?

For questions regarding your account bill, please call the number listed on your billing statement or our Billing Customer Service Department.

Clients 888.321.0155
Monday through Friday,
8:30 am - 5:00 pm CST

Patients 888.241.7742
Monday through Friday,
8:30 am - 6:00 pm CST



Invoicing

DLO will bill your account upon request (must meet credit check requirements).

Payment is due by the date reflected on your bill. Most payments are net 15 days unless otherwise stated.

- Payments should be made via electronic or manual check.
- The preferred method of payment is through our new simplified electronic invoicing process, eInvoice. Visit dlolab.com/providers/billing-and-payments and enroll today.
- Invoices are considered to be correct unless notification of an error is made within 30 days of receipt.
- Transfers and re-billings can be submitted using a Transfer Request Form or at dlolab.com/providers/billing-and-payments. Transfer requests must be made within 30 days of receipt.
- DLO can bill patients and third party carriers directly, provided that complete billing information is provided.

Note: In some cases, tests performed at DLO may require additional charges. These include processing fees, reflex tests, and multi-component identification. Additional charges may also be made for STAT testing, titers specimen collection at a DLO Patient Service Center, and the transportation of specimens to laboratories outside of DLO. Refer to the digital Directory of Services for additional information.

eInvoice™

More Control, Less Paperwork

We understand that you're busy at your practice and that's why we've simplified our invoicing process with eInvoice. We designed eInvoice to fit into your workflow and help you become more efficient. eInvoice provides easy, secure, and convenient 24/7 access to the account-management tools you need.

The benefits are clear:

Enhanced Account Management

- Access your account 24/7
- One sign on for all accounts
- Electronic payments and payment scheduling
- Store payment information
- Manage discrepancies and disputes without making phone calls
- Enhanced e-mail notifications so you can track important account activity
- Transfer credits between open invoices
- View historical activity, account aging, account balances, open invoices and adjustments

Paperless Invoices

- Reconcile invoices online for increased patient information security
- Receive email notifications when new invoices are generated
- Print, email and download invoices as PDFs
- View or download invoices in Excel CSV format

Seamless Billing

- Bill payers and patients in one convenient application

Experience the ease of eInvoice today:

1. Go to questdiagnostics.com/einvoice and click "Enroll Now"
2. Review and accept the Terms and Conditions
3. Identify your primary account and create your user profile
4. Create your login and customize your security settings
5. Check your e-mail for the "Welcome Notification" and click the activation link included inside it

Multiple Account Access

1. Click "Administration"
2. Click "Link Account"
3. Enter Lab Code, Client Number, Zip Code and Bill Number
4. Click "OK"
5. Repeat as needed

Payer List

DLO will file all insurance claims to the contracted payers shown below. If you have any questions regarding DLO's participation with a specific product or health plan, contact us at (405) 608-6100 or (800) 891-2917, option 5, or contact your health plan provider. Other insurance plans not listed may be considered as out-of-network resulting in a patient bill. Please be aware this list is subject to change. For the most up-to-date list, please visit dlolab.com/insurance.

Preferred Provider for Select Health Plans

Aetna (All plans and products)

Cigna (All plans and products)

Coventry Health Care

Humana (All plans and products)

UnitedHealthcare (All plans and products)

Lab Card® (Exclusive Provider)

- Aliera
- America's Choice Provider Network
- Central States Team Care
- GEHA (Government Employee Health Assoc.)
- HealthPass USA

Key Employer and Health Care Relationships

Costco | Home Depot | MinuteClinic | National Rural Electric Cooperative Association (NRECA) | United Airlines

Health Plans, Health Products and Other Payers

AMSUHC (American Medical Security)

Beech Street (A Multiplan Network)

BlueCross BlueShield of Oklahoma (BCBSOK)

- Blue Advantage PPO℠
- Blue Choice PPO℠
- Blue Cross Medicare Advantage HMO℠
- Blue Cross Medicare Advantage PPO℠
- Blue Plan65 Select℠
- Blue Preferred PPO℠
- Blue Traditional℠
- BlueCard® - BlueCross BlueShield
- BlueLincs HMO
- BlueOptions PPO℠
- Caring Program
- Federal Employee Program (FEP)
- NativeBlue

Bright Health

CapStar PPO (administered by CapRock TPA)

Care Improvement Plus

Centene

- Oklahoma Complete Health
- WellCare of Oklahoma
- WellCare Health Insurance Co. of Okla.

CHAMPVA (Civilian Health and Medical Program of Department of Veteran Affairs)

ChoiceCare (Humana)

Cigna-HealthSpring

CommunityCare HMO (exlcudes St. Francis, ValuMed (St. John) and OMNI Networks)

CommunityCare Life and Health Insurance

Connect Health

CoreCivic

Emblem Health

Evolution

FedMed

First Health Corp Health Systems

Frates Benefit Administrators

Generations Health

GlobalHealth

Healthcare Highways (formerly Oklahoma Health Network)

HealthChoice (aka Oklahoma State and Education Employees Group and Insurance Board)

HealthSmart Preferred Care

Hooray Health

Horizon BCBS

MDVIP

Medica Harmony (via Healthcare Highways)

Medica Quest (administered by First Health)

Medical Mutual of Ohio

MSLA (Medical Support Los Angeles)

MultiPlan (All Groups)

Mutual Assurance Administrators

National Association of Letter Carriers (NALC)

OSMA Health (formerly PLICO)

Preferred CommunityChoice PPO

Private HealthCare System (PHCS)

Providence Health Plan

Pyramid Life Insurance

SAMBA Health Plans

Secure Horizons

Sterling Life Insurance Company (Medicare Supplement)

Stillwater Collaborative Care

Urgent Care Travel

WebTPA

WellNet

State and Federal Government Programs Provider

Medicaid/SoonerCare

Medicare Traditional (Oklahoma)

Medicare Supplement Insurance

- (Medigap) e.g. AARP

Railroad Medicare

TRICARE East

TRICARE West - Patient-Centered Community Care

Veterans Choice Program VA/VHA

Please be aware that this is not an exhaustive list of all of the health plans with which we participate and is subject to change without notice over time. There may be exceptions in certain areas or for certain members or plans. If your insurance plan is not listed, please check with your provider. Other insurance plans not listed may generate a patient bill that the insured individual may be able to use to submit for reimbursement. If you have any questions regarding DLO's participation with a specific product or health plan, please contact us at (800) 891-2917, option 5.

DLOInsList 09/21

Enroll in PECOS in 5 easy steps

Provider enrollment in PECOS is a CMS mandate

The Patient Protection and Affordable Care Act *requires* that physicians and eligible professionals enroll in Medicare to order and refer services, including clinical laboratory tests, for Medicare beneficiaries.

Medicare will not pay for clinical laboratory services unless the physician or non-physician practitioner that ordered the testing is enrolled in Medicare's Provider Enrollment, Chain and Ownership System (PECOS).

All providers with a National Provider Identifier (NPI) number must enroll.

Ensure quality testing from DLO without disruption for Medicare patients

Quality lab testing is a vital part of your patient care. DLO will now only accept lab orders through Quanum for Medicare patients from providers enrolled in PECOS.

-- If the provider is not registered, they will need to cancel their order and enroll in PECOS before they can proceed with testing.

Lab testing is vital to patient care. Enroll in PECOS today so you can continue to provide your Medicare patients with quality services from DLO.

The good news is it's easy to enroll in PECOS—you can choose to enroll online or by mail.

Enrollment is quick and easy

1. **Prepare for enrollment** see the "Plan ahead" checklist
2. **Visit https://pecos.cms.hhs.gov**
3. **Complete and submit the enrollment application**
4. After enrollment, **print, date and sign the Certification Statement**
5. **Mail the signed Certification Statement** within 7 days of submission to your designated Medicare contractor

Need help?

Watch a step-by-step video on how to enroll in PECOS at https://pecos.cms.hhs.gov

Contact the CMS External User Services Help Desk at 1.866.484.8049 or at eussupport@cgi.com

For questions regarding these important lab ordering changes, please contact your DLO Account Executive or call 800.891.2917, Option 5.

Plan ahead.

Information you will need to complete your PECOS application

- NPI number
- NPPES ID and password
- Personal Information (name, date of birth, Social Security number)
- Educational Information (school name, year of graduation)
- Professional License Information
  - -- Medical license number
  - -- Original effective date
  - -- Renewal date
  - -- State where issued
- Certification Information
  - -- Certification number
  - -- Original effective date
  - -- Renewal date
  - -- State where issued
- Specialty/Secondary Specialty Information
- Drug Enforcement Agency (DEA) Number
- Information About Final Adverse Actions (if applicable)
- Practice Location Information
  - -- Medical practice location
  - -- Special payment information
  - -- Medical record storage information
  - -- Billing agency information (if applicable)
  - -- Any federal, state, and/or local professional licenses, certification and/or registrations required for practice
- Electronic Funds Transfer documentation

Tips for Billing Medicare

Using the Support Center

Laboratory testing plays a vital role in the care of patients.

When lab orders are submitted with missing or inaccurate information it can lead to unnecessary costs for your patients, as well as disruption to your practice and delays in testing.

DLO is committed to providing the test results needed to help you do the best for your patients.

When you ensure your lab orders are submitted with complete and accurate information you can avoid:

- Disruption to your practice caused by follow-up calls to obtain missing or accurate information
- Higher out-of-pocket expenses for your patients when they receive bills for non-covered services
- Missing information necessary to care for your patients because of delayed laboratory testing
- Important reminders to ensure laboratory orders are submitted correctly

Managing the complexities of insurance coverage is challenging. DLO is here to help with timely access to the information you need that can help you better care for your patients.

Diagnosis Codes

All claims for laboratory services must include diagnosis codes. Remember to always include a diagnosis code when submitting an order for laboratory testing. Ensure the code(s) submitted are consistent with the patient's medical condition. ICD-10 diagnosis codes will be required for all lab orders.

Medicare Limited Coverage Policy (MLCP)

Medicare publishes limited coverage policies for certain laboratory tests. Tests subject to a limited coverage policy are only considered medically necessary and reimbursable by Medicare if ordered for patients with specific conditions. Ensure you provide all relevant diagnosis information documented on the patient's chart when submitting laboratory orders for tests included in the MLCP.

CMS provides a diagnosis code reference guide as an aid to providers for determining when an ABN (Advance Beneficiary Notice) is necessary. Diagnosis codes must be applicable to the patient's symptoms or conditions and must be consistent with documentation in the patient's medical record. DLO does not recommend any diagnosis codes and will only submit diagnosis information provided by the ordering provider.

If the diagnosis provided does not meet the reimbursement rules, or if the frequency limit on test procedures has been exceeded, payment may be denied. In that case, DLO can seek reimbursement from the patient only when the patient has been notified in advance of the testing that Medicare is likely to deny payment for these services. If the patient chooses to have the test performed, they must complete an Advance Beneficiary Notice (ABN), confirming their understanding that they will be responsible for payment.

The CPT codes provided are based on AMA guidelines and are for informational purposes only. CPT coding is the sole responsibility of the ordering provider. Please direct any questions regarding coding to the payor being billed.

Your cooperation in complying with the Medicare Regulations and related test ordering procedures will eliminate the need for time-consuming follow-up calls to your office.

Refer to the next page for details on accessing helpful information about MLCPs.

Advance Beneficiary Notice (ABN)

Medicare patients must sign an ABN when laboratory tests are ordered for a condition that is not listed in the applicable MLCP. Submit a complete ABN form when required to avoid delays in testing. In the future, DLO may no longer perform testing when laboratory orders are submitted without the required valid ABN form.

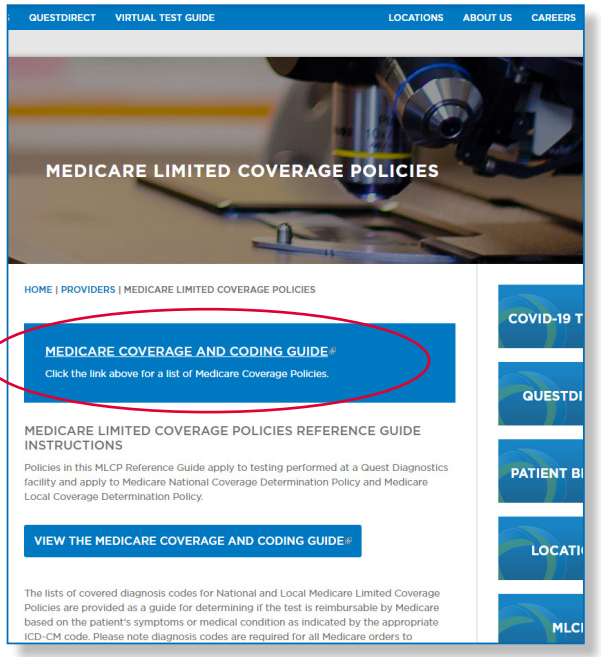
Uncovering MLCP Diagnosis Codes

Get Guidance on Medicare Limited Coverage Policies

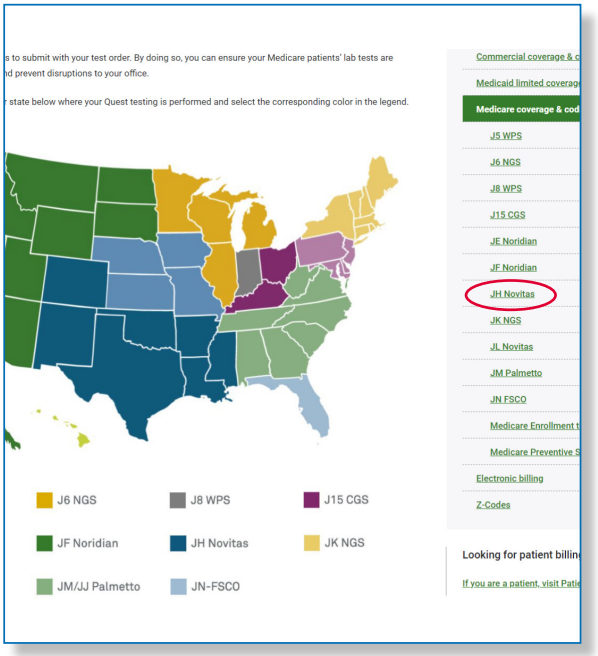
Managing the complexities of insurance coverage is challenging. DLO is here to help with timely access to the information you need that can help you better care for your patients.

DLO provides resources to help you understand if a laboratory test is reimbursable by Medicare based on a patient's condition as indicated by the relevant diagnosis code. They also aid you in determining when an ABN must be submitted with a laboratory order. To access these resources, follow the instructions below.

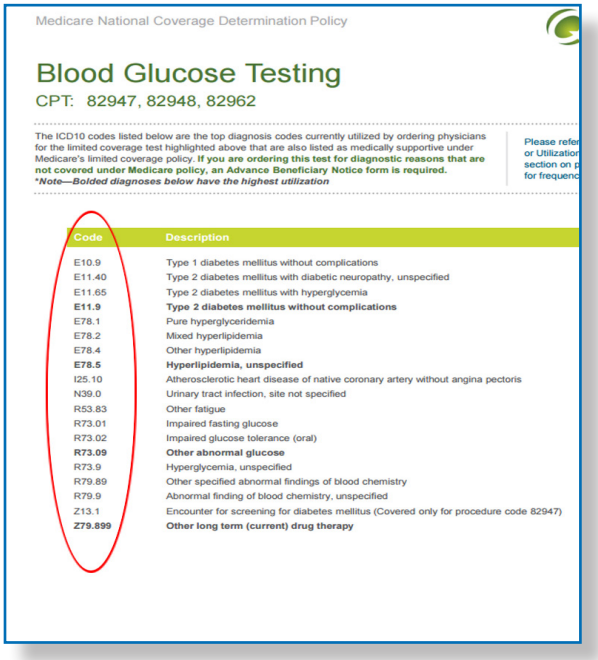
1) From the dlolab.com home page, hover over "Providers". Click "MLCP" from the drop-down menu.



2) Click "Medicare Coverage and Coding Guide" in the blue box. This will take you to the Quest Diagnostics website.



3) Click "JH Novitas" in the right hand column.

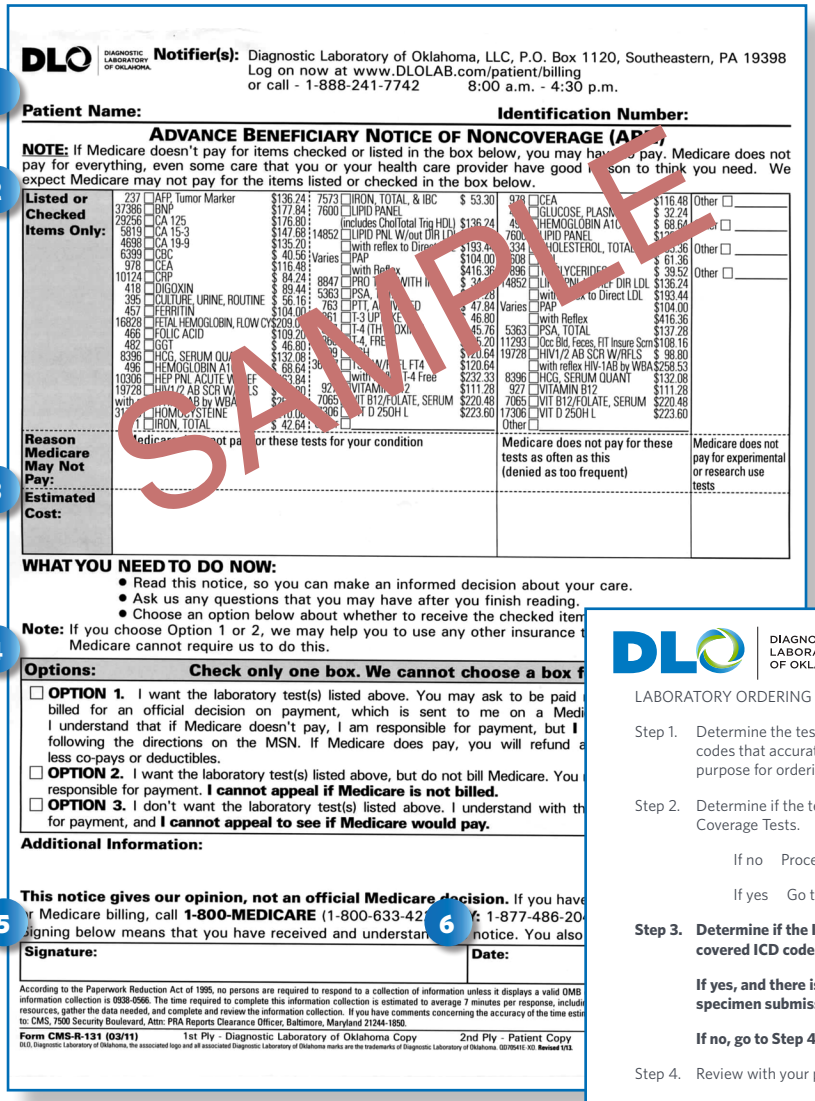


4) Select the type of testing and scroll down until you see the list of acceptable codes for that test. The list of codes may span several pages.

Advance Beneficiary Notice (ABN) Form

Instructions for Completing the Form

The DLO ABN form is straightforward and easy to complete. Patients must understand their non-coverage options prior to providing services and that the patient selects an option, signs and dates the form. **Quanum will auto generate an ABN form** when used for test ordering. If it does not, the manual form must be completed prior to testing.



DLO DIAGNOSTIC LABORATORY OF OKLAHOMA **Notifier(s):** Diagnostic Laboratory of Oklahoma, LLC, P.O. Box 1120, Southeastern, PA 19398
Log on now at www.DLOLAB.com/patient/billing
or call - 1-888-241-7742 8:00 a.m. - 4:30 p.m.

Patient Name: **Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items listed or checked in the box below.

Listed or Checked Items Only:			Other ☐
Reason Medicare May Not Pay:	Medicare does not pay for these tests for your condition	Medicare does not pay for these tests as often as this (denied as too frequent)	Medicare does not pay for experimental or research use tests
Estimated Cost:			

SAMPLE

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the checked item

Note: If you choose Option 1 or 2, we may help you to use any other insurance t
Medicare cannot require us to do this.

Options: **Check only one box. We cannot choose a box f**

☐ **OPTION 1.** I want the laboratory test(s) listed above. You may ask to be paid billed for an official decision on payment, which is sent to me on a Medi I understand that if Medicare doesn't pay, I am responsible for payment, but I following the directions on the MSN. If Medicare does pay, you will refund less co-pays or deductibles.

☐ **OPTION 2.** I want the laboratory test(s) listed above, but do not bill Medicare. You responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the laboratory test(s) listed above. I understand with th for payment, and **I cannot appeal to see if Medicare would pay.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have Medicare billing, call **1-800-MEDICARE** (1-800-633-42 ; 1-877-486-20 Signing below means that you have received and understan notice. You also

Signature: **Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, includi resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estir to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11) 1st Ply - Diagnostic Laboratory of Oklahoma Copy 2nd Ply - Patient Copy

OLD, Diagnostic Laboratory of Oklahoma, the associated logo and all associated Diagnostic Laboratory of Oklahoma marks are the trademarks of Diagnostic Laboratory of Oklahoma. OD70541E-XO. Revised 1/13.

1. Print patient's name
2. Check box or handwrite test name and number
3. Provide the estimated cost of the test(s) that the patient may be responsible to pay
4. Patient MUST choose an option
5. Patient MUST sign
6. Patient MUST write the date

The back page of your ABN form outlines laboratory procedures for Medicare patients. Submit the completed form with your requisitions and specimens.

DLO DIAGNOSTIC LABORATORY OF OKLAHOMA.

LABORATORY ORDERING PROCEDURE FOR MEDICARE PATIENTS

Step 1. Determine the tests to be ordered and indicate on the requisitions all medically appropriate ICD codes that accurately reflect the patient's condition or symptoms, and therefore, the diagnostic purpose for ordering the test(s).

Step 2. Determine if the tests or any test in a panel/profile ordered appear on the list of Medicare Limited Coverage Tests.

If no Proceed with lab submission procedures.

If yes Go to Step 3.

Step 3. Determine if the ICD codes you have specified are included on the Medicare carrier's list of covered ICD codes for that test.

If yes, and there is no frequency symbol (F) next to the test on the requisition, proceed with lab specimen submission procedures.

If no, go to Step 4.

Step 4. Review with your patient the Advanced Beneficiary Notice (ABN) Form

Insert your patient's name

Write in or check off the test(s) that Medicare may not cover in the appropriate column.

Refer to the current Diagnostic Laboratory of Oklahoma Patient Price List for the estimated costs of the test(s) that the patient may be responsible to pay.

INSERT THE PRICE IN THE SPACE MARKED "ESTIMATED COST" ON THE ABN.

Present the entire ABN form to your patient and explain that Medicare may deny the services listed on the ABN and the patent may be responsible for payment of the tests(s)listed on the ABN. Make sure that the patient reads the ABN in its entirety and understands it.

Explain why you think the test(s) is medically appropriate.

Have your patient personally select Option 1, Option 2 or Option 3 on the ABN. **(Choose only one option box)**

After the option is selected, the "**patient must sign and date the form**".

Provide your patient with a copy of the signed ABN

Note: All spaces must be filled out completely.

Step 5. Submit the completed Advanced Beneficiary Notice form with the completed requisition for those test(s) that the patient has agreed to receive.

Advance Written Notice (AWN) Form

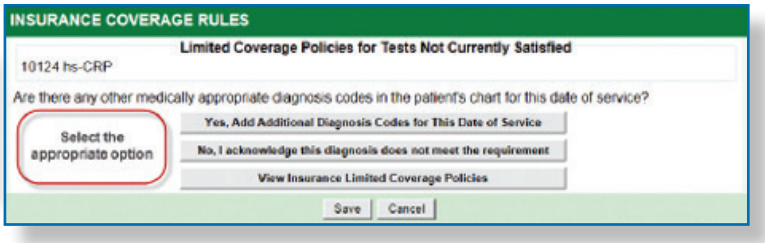
Instructions for Completing the Form

An AWN is a written notification used to inform a patient that their insurance may not pay for the laboratory testing ordered. It is similar to the ABNs. These forms are generated based on published coverage policies of an insurance carrier.

AWN's will increase patient awareness regarding potential charges for lab tests. Obtaining signed AWNs will potentially reduce billing trailers from DLO and billing questions from patients. This process covers select private third party insurance carriers.

Quanum will determine if an AWN is necessary.

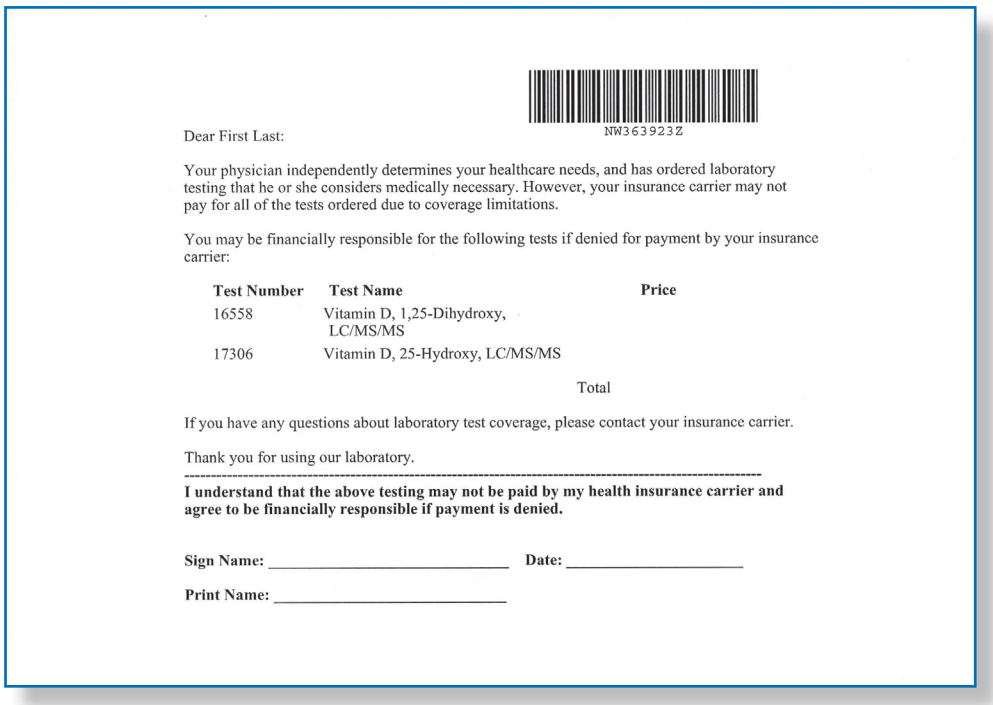
Quanum users will need to acknowledge the Insurance Coverage Rules (IRC).



If there are additional diagnosis codes in the patient's chart for the date of service, the ordering physician may add them to the order. If the ordering physician has already provided all applicable diagnosis information for the patient on the date of service, two copies of the AWN will print with the requisition. The Quanum user will provide the AWN to the patient. After reading the AWN, if the patient has questions regarding their coverage they should be referred to their insurance company.

The AWN will be presented to the patient for their signature. This indicates the patient has been informed that their insurance carrier may not pay for the testing, and if it does not, the patient has agreed to be personally responsible to pay for the testing. Once the AWN is completed, the signed copy should be packaged with the requisition to be sent to the lab. The patient will retain the other copy of the AWN.

Sample AWN Letter



NW363923Z

Dear First Last:

Your physician independently determines your healthcare needs, and has ordered laboratory testing that he or she considers medically necessary. However, your insurance carrier may not pay for all of the tests ordered due to coverage limitations.

You may be financially responsible for the following tests if denied for payment by your insurance carrier:

Test Number	Test Name	Price
16558	Vitamin D, 1,25-Dihydroxy, LC/MS/MS	
17306	Vitamin D, 25-Hydroxy, LC/MS/MS	
	Total	

If you have any questions about laboratory test coverage, please contact your insurance carrier.

Thank you for using our laboratory.

I understand that the above testing may not be paid by my health insurance carrier and agree to be financially responsible if payment is denied.

Sign Name: _____ **Date:** _____

Print Name: _____

SoonerCare Prior Authorization

Required for payment of specific types of testing

Information is an excerpt of the Oklahoma Health Care Authority website, pertaining to medical prior authorization. *https://okhca.org/providers.aspx?id=14665*

This information is designed to assist the providers with submitting prior authorization requests (PAR) correctly the first time. The goal of the Medical Authorization Unit (MAU) is to streamline the PAR process while maintaining compliance with OHCA, state and federal policy and rules. Please sign on to WEB ALERTS to receive email notifications when changes are made to this web page.

- Some OHCA covered services require a prior authorization (PA)
- Failure to obtain a PA for an item requiring a PA will result in denial of a claim
- The provider assumes full financial risk in providing services without an approved PA
- Providers are not allowed to bill a member for a covered service if a PA is not obtained/approved

NOTICE: Effective 11/1/2016, all initial (new) PARs must be initiated using the Sooner Care Provider Portal – all PA's sent by providers via fax or mail will be returned – see Provider Letter 2016-29 and PA Processing document for reference.

Laboratory Testing Requiring Prior Authorization

Allergy Testing/Immunotherapy *Effective July 30, 2014 according to OHCA guidelines*

Genetic Testing *Please visit OHCA's Genetic Testing for the most up-to-date guidelines*

High Risk OB (HROB) *Updated guidelines effective March 24, 2016 according to OHCA guidelines*

Urine Drug Screens *Updated guidelines effective January 6, 2016 according to OHCA guidelines*

Prior Authorization Process

Please complete the following steps for ***patients with Medicaid/SoonerCare before ordering tests*** which require a prior authorization. Prior Authorization requests are made using the OHA Provider Portal.

Documentation Matters - ALL prior authorization (PA) requests require the submitting provider to send in supporting medical documentation and necessary forms. This allows OHCA to perform a comprehensive review to determine the medical necessity of the requested service.

Why Create a PA on the Portal?

- Easier tracking
- No risk of returned mail
- No lost attachments
- OHCA receives uploaded documents in a timely manner
- Documents are more legible if electronically uploaded
- Photos are clear when electronically uploaded
- Eventually, OHCA will transition to completely paperless ("go green")

Creating a OHA Prior Authorization

Log-in your OHA Provider Portal Account.

Hover over Prior Authorizations, then click on Create Authorization.

Complete the required information on the PA Application, example on page 41.

SoonerCare Prior Authorization

Medicaid/SoonerCare PA Request Form

Application Submission Requirements

Log-in your OHA Provider Portal Account

Hover over Prior Authorizations, then click on Create Authorization

Create a Medical Prior Authorization. Disclaimer notice advises that the PA may be subject to a post-payment review.

Requesting Provider Information. This section will automatically populate the provider logged in.

Member ID Enter the SoonerCare member ID.

Service Provider Information This field may be required depending on the Assignment Code selected.

Assignment Code Select the appropriate assignment code.

Managed Care, Fund, Letter Leave blank.

ICD Version Select the ICD version of the diagnosis code.

Diagnosis Code Enter the diagnosis code without the decimal, then click Add.

From and To Date Enter the date range. The 30-day retro rule applies.

Code Type Select Procedure Code or Revenue.

Code Enter the procedure code.

Modifiers Use appropriate modifiers, if applicable. Up to four modifiers can be entered.

Units Enter the number of units.

Dollars Leave blank.

Payment Method Leave blank.

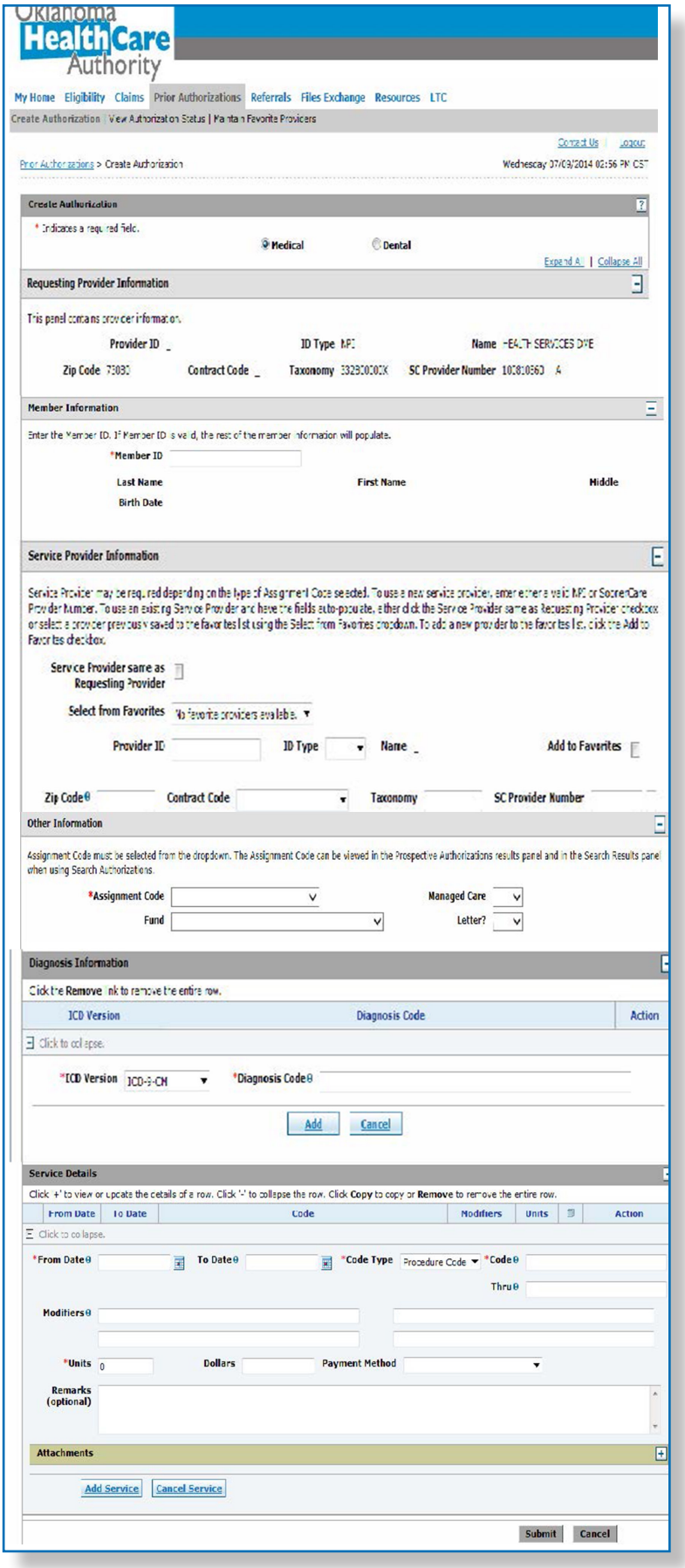
Remarks (optional) For items listed as miscellaneous, enter the line item and description in the remark field.

If uploading electronic documentation through the Provider Portal, enter a contact name and phone number.

Attachments Click on the "+" sign to designate how the documentation will be submitted. Note: The attachment must be added before the first service line can be added.

Transmission Method Select from the following:

ET –Electronic Only
Acceptable file type: JPG, PDF, TIFF (up to 10 MB)



Additional information on the following page.

Adding Documentation

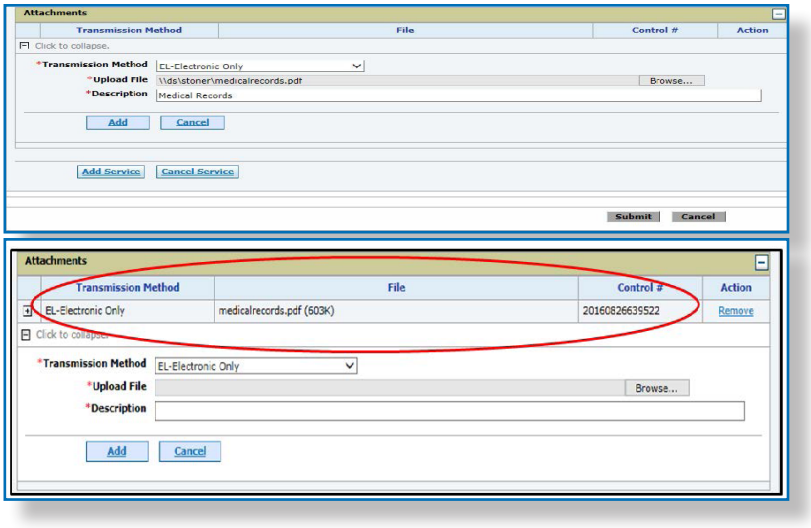
Upload File –This field only appears when the attachments are uploaded electronically. Select Browse to search for the attachments.

The portal will give an error message if the file exceeds the capacity limit.

Description Enter a brief description of the documentation.

Once the required fields are completed, click Add to attach the documentation. *If you do not add the attachment prior to adding the service details, the attachments will not be included.*

If the electronic file upload has successfully attached to the PA request, it will reflect the transmission method, file and control number.

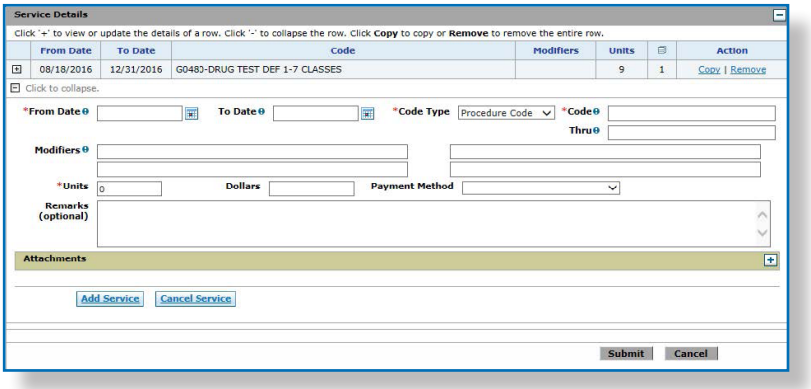


Add Service

If documentation is attached, click Add Service.

Notice: The system will show the attachment file included on the first service line. The page will then refresh and populate another section if other service details need to be added.

If no other service details will be added, click Submit.



Application Submission

Review the information entered and **click the Confirm** button.

If the electronic file upload is not successfully attached to the request prior to the addition of the first service line, the system returns an error message when the request is submitted.

Authorization Receipt The Portal will generate a PA number and confirm that the request is successfully submitted. This does not mean the PA is approved.

Attachment Coversheet button will only show if the transmission method selected is by mail -BM or by fax -FX .Click the Attachment Coversheet button if you selected the BM (by mail) or FX (by fax) transmission method. *An auto-populated HCA-13A cover sheet will appear.*

Place the HCA-13A cover sheet on top of the documents that you mail or fax. The HCA-13A cover sheet is the only accepted cover sheet. **DO NOT** place other documents on top of the HCA-13A.