



XPressClaim (XPC) guide

East Region

XPressClaim

- XPressClaim (XPC) is an option for claim submission available to our East Region providers.
- You can submit claims by logging in to provider self-service, opening the **Provider Access Claims Center** and then by choosing **Submit an XPressClaim**.
- XPC allows for professional (CMS-1500) and institutional (UB-04) submissions.
- The Send Documents feature is also available to submit supporting documents for any claim.
- This guide will show you how to submit both professional and institutional as well as how to send supporting documents.

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Registration

XPressClaim registration

- Upon initial navigation to XPressClaim from provider self-service access claims center, the **Sign up** page is displayed

XPressClaim agreement

- Next, the **TRICARE XPressClaim agreement** collects the provider's electronic signature and title

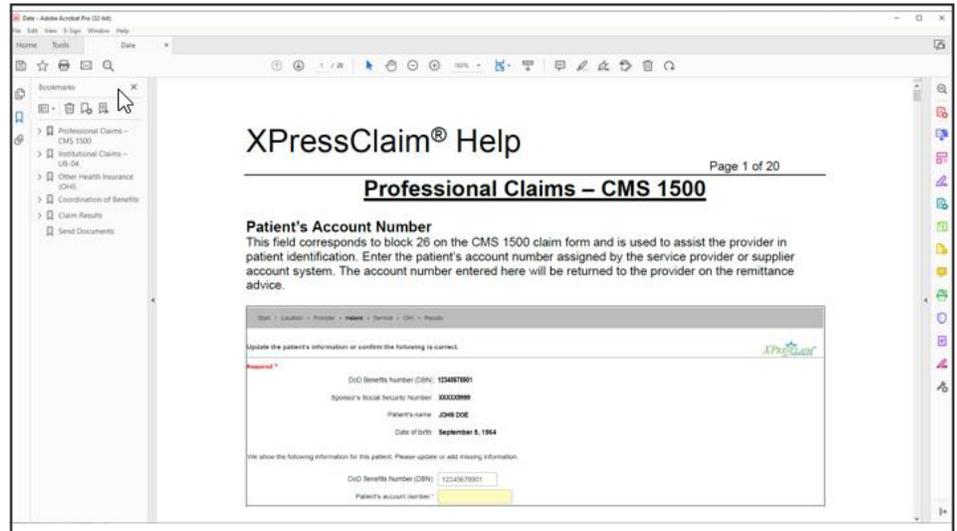
XPressClaim

- After confirming acceptance of the agreement, the provider can begin using XPC immediately
- On future visits from the same web account, the provider is navigated directly to this XPC start page

Registration continued

XPressClaim Help

- The XPressClaim Help guide is a valuable resource to download prior to claim submission

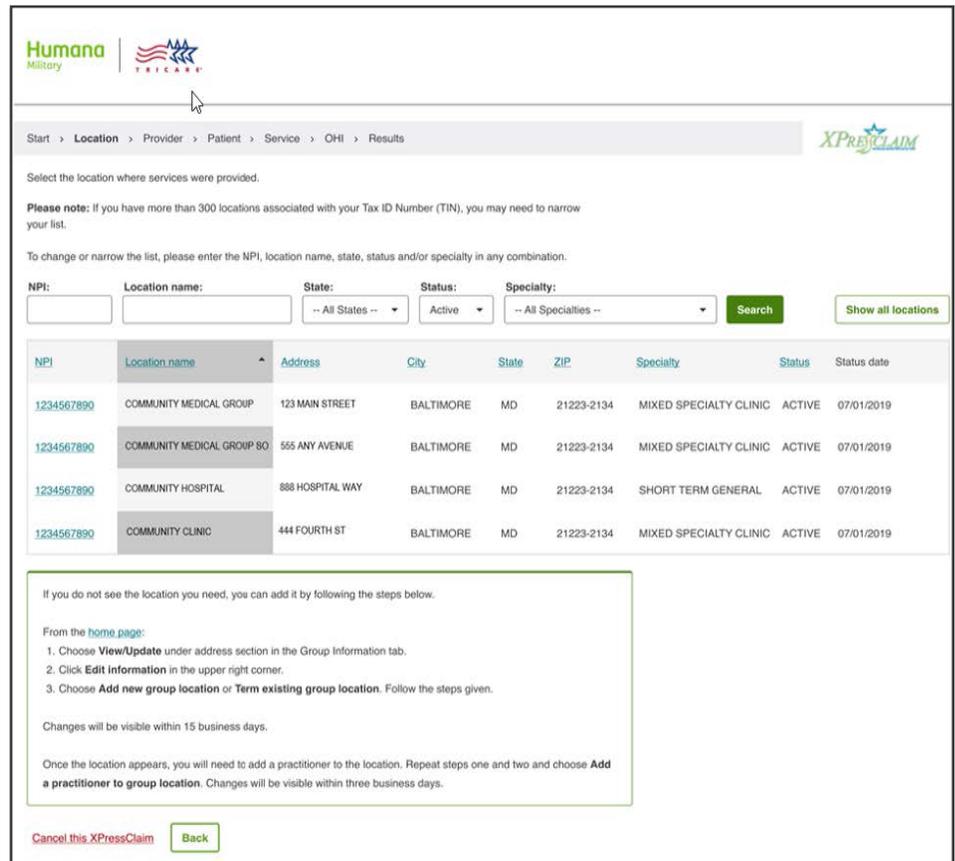


Professional claim

XPressClaim

The first step is to select the **location where services were provided:**

- Locations that were active within the last 365 days are displayed from PGBA's Provider Information Management System (PIMS)
- Narrow the list by NPI, location name, state, status and/or specialty
- The specialty of the location selected determines the claim path –professional (CMS1500) or institutional (UB04)
- Some specialties (based on TRICARE policy) can submit both institutional and professional claims
- If the location cannot be found, follow the steps provided to request a location to be added to our system



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Start > Location > Provider > Patient > Service > OHI > Results

Select the location where services were provided.

Please note: If you have more than 300 locations associated with your Tax ID Number (TIN), you may need to narrow your list.

To change or narrow the list, please enter the NPI, location name, state, status and/or specialty in any combination.

NPI: Location name: State: -- All States -- Status: Active Specialty: -- All Specialties -- Search Show all locations

NPI	Location name	Address	City	State	ZIP	Specialty	Status	Status date
1234567890	COMMUNITY MEDICAL GROUP	123 MAIN STREET	BALTIMORE	MD	21223-2134	MIXED SPECIALTY CLINIC	ACTIVE	07/01/2019
1234567890	COMMUNITY MEDICAL GROUP SO	565 ANY AVENUE	BALTIMORE	MD	21223-2134	MIXED SPECIALTY CLINIC	ACTIVE	07/01/2019
1234567890	COMMUNITY HOSPITAL	888 HOSPITAL WAY	BALTIMORE	MD	21223-2134	SHORT TERM GENERAL	ACTIVE	07/01/2019
1234567890	COMMUNITY CLINIC	444 FOURTH ST	BALTIMORE	MD	21223-2134	MIXED SPECIALTY CLINIC	ACTIVE	07/01/2019

If you do not see the location you need, you can add it by following the steps below.

From the [home page](#):

1. Choose **View/Update** under address section in the Group Information tab.
2. Click **Edit information** in the upper right corner.
3. Choose **Add new group location** or **Term existing group location**. Follow the steps given.

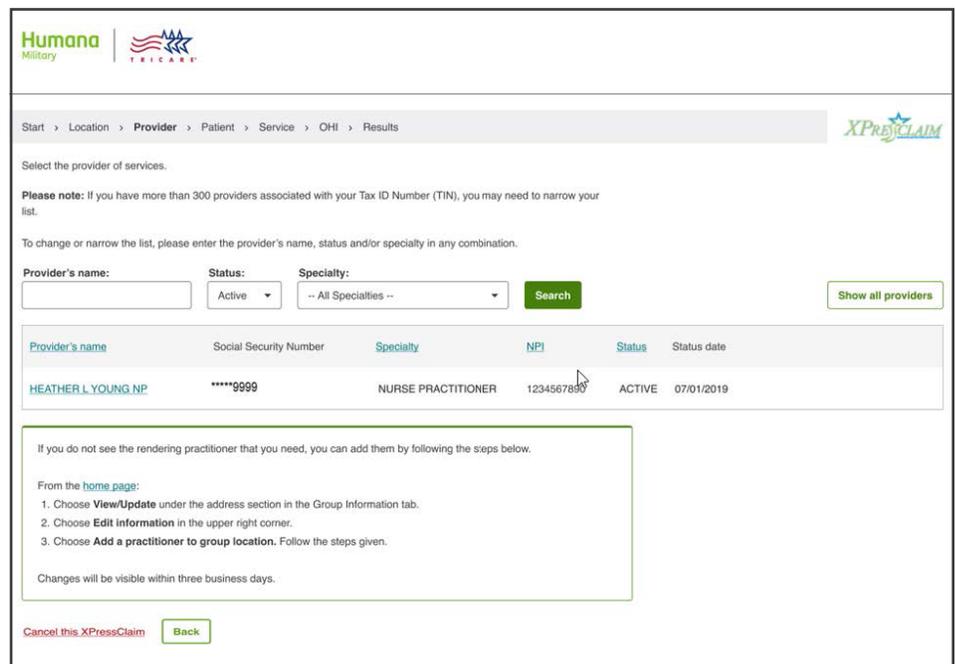
Changes will be visible within 15 business days.

Once the location appears, you will need to add a practitioner to the location. Repeat steps one and two and choose **Add a practitioner to group location**. Changes will be visible within three business days.

Cancel this XPressClaim Back

Select the **rendering provider:**

- This page is only displayed if the selected location requires a rendering provider
- All rendering providers that were active within the last 365 days and affiliated with the location selected are displayed from PGBA's Provider Information Management System (PIMS)
- Narrow the list by provider's name, status and/or specialty
- If the rendering provider is not found, follow the steps provided to request a practitioner to be added to our system



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Start > Location > Provider > Patient > Service > OHI > Results

Select the provider of services.

Please note: If you have more than 300 providers associated with your Tax ID Number (TIN), you may need to narrow your list.

To change or narrow the list, please enter the provider's name, status and/or specialty in any combination.

Provider's name: Status: Active Specialty: -- All Specialties -- Search Show all providers

Provider's name	Social Security Number	Specialty	NPI	Status	Status date
HEATHER L YOUNG NP	****9999	NURSE PRACTITIONER	1234567890	ACTIVE	07/01/2019

If you do not see the rendering practitioner that you need, you can add them by following the steps below.

From the [home page](#):

1. Choose **View/Update** under the address section in the Group Information tab.
2. Choose **Edit information** in the upper right corner.
3. Choose **Add a practitioner to group location**. Follow the steps given.

Changes will be visible within three business days.

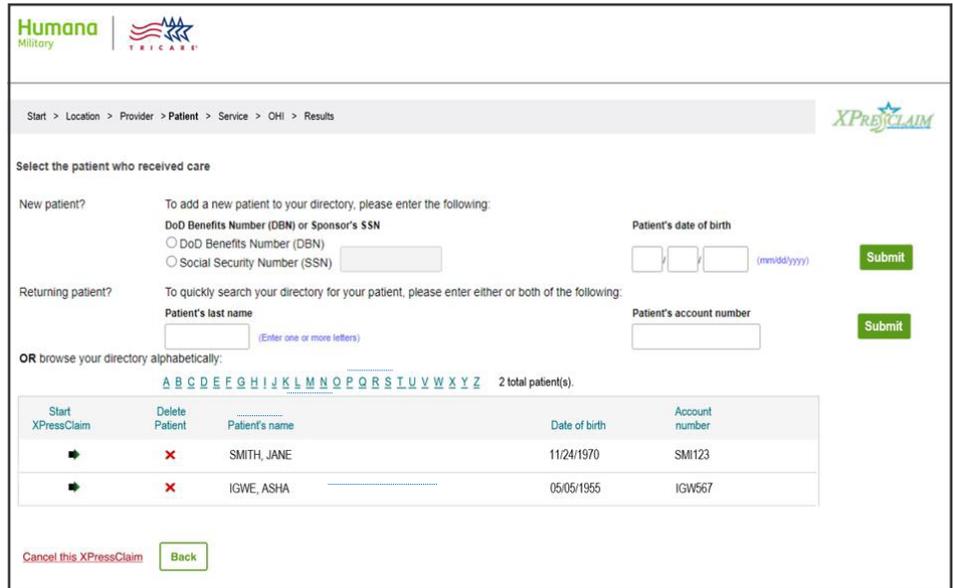
Cancel this XPressClaim Back

Professional claim continued

Select the **patient** who received care:

- Add a new patient by DoD Benefits Number (DBN) or Social Security Number (SSN) and patient's date of birth
- Search for a returning patient by last name or account number
- Browse the directory alphabetically

Please note: Patients are required to be listed on the Defense Eligibility and Enrollment System (DEERS) with the exception of newborns less than 365 days old.



Start > Location > Provider > Patient > Service > OHI > Results

Select the patient who received care

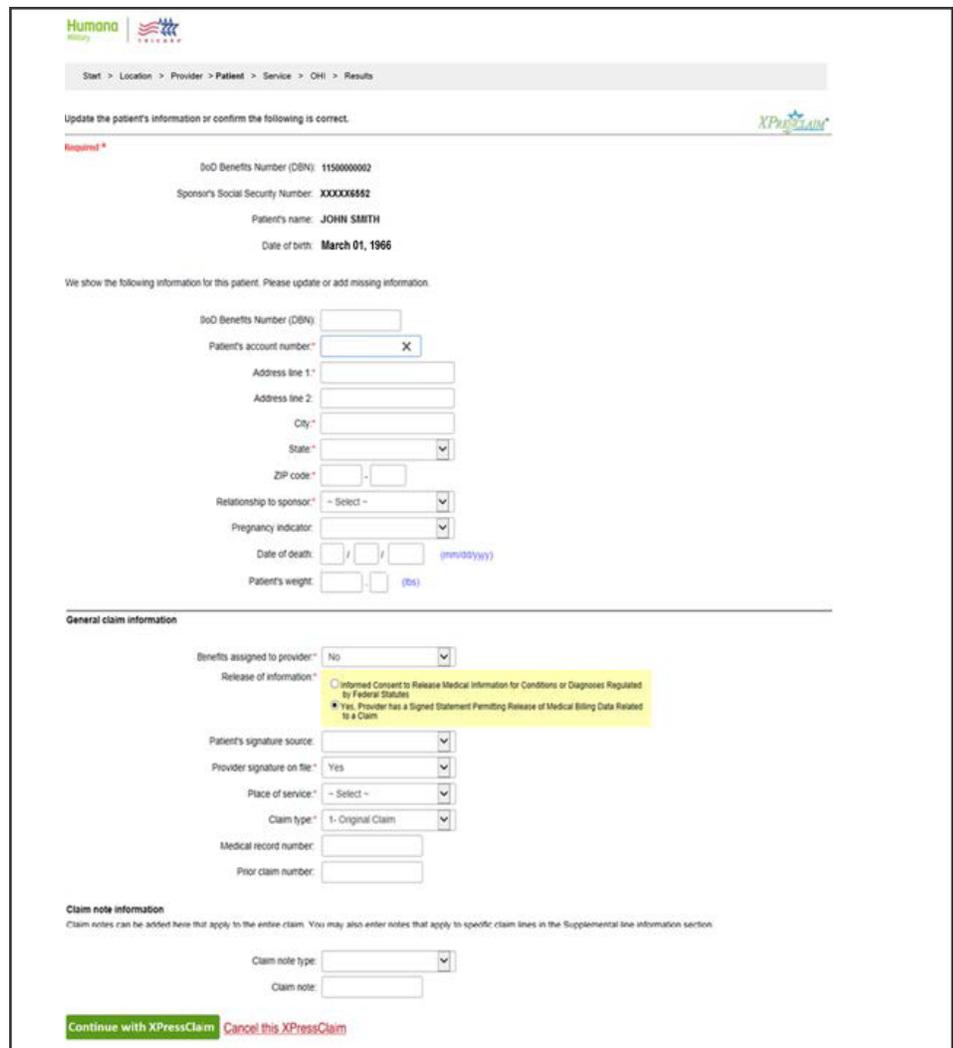
New patient? To add a new patient to your directory, please enter the following:
 DoD Benefits Number (DBN) or Sponsor's SSN
 DoD Benefits Number (DBN)
 Social Security Number (SSN)
 Patient's date of birth (mm/dd/yyyy)

Returning patient? To quickly search your directory for your patient, please enter either or both of the following:
 Patient's last name (Enter one or more letters)
 Patient's account number

OR browse your directory alphabetically:
 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 2 total patient(s).

Start XPressClaim	Delete Patient	Patient's name	Date of birth	Account number
<input type="checkbox"/>	<input checked="" type="checkbox"/>	SMITH, JANE	11/24/1970	SMI123
<input type="checkbox"/>	<input checked="" type="checkbox"/>	IGWE, ASHA	05/05/1955	IGW567

- Enter the **patient's information**, the **general claim information** and **claim note information**
- Some HIPAA required fields are prepopulated with the most common values
- Select **Continue with XPressClaim**
- **Helpful hint - The patient's account number:**
 - Corresponds to block 26 on the CMS1500 claim form
 - Assists the provider in patient identification
 - Is assigned by the provider or supplier account system
 - Is returned to the provider on the remittance advice



Start > Location > Provider > Patient > Service > OHI > Results

Update the patient's information or confirm the following is correct.

Required *

DoD Benefits Number (DBN): 115000002
 Sponsor's Social Security Number: XXXXX652
 Patient's name: JOHN SMITH
 Date of birth: March 01, 1966

We show the following information for this patient. Please update or add missing information.

DoD Benefits Number (DBN):
 Patient's account number: X
 Address line 1:
 Address line 2:
 City:
 State:
 ZIP code: -
 Relationship to sponsor: -- Select --
 Pregnancy indicator:
 Date of death: / / (mm/dd/yyyy)
 Patient's weight: (lbs)

General claim information

Benefits assigned to provider: No
 Release of information: Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes
 Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim
 Patient's signature source:
 Provider signature on file: Yes
 Place of service: -- Select --
 Claim type: 1- Original Claim
 Medical record number:
 Prior claim number:

Claim note information

Claim notes can be added here that apply to the entire claim. You may also enter notes that apply to specific claim lines in the Supplemental line information section.

Claim note type:
 Claim note:

Home Professional claim continued

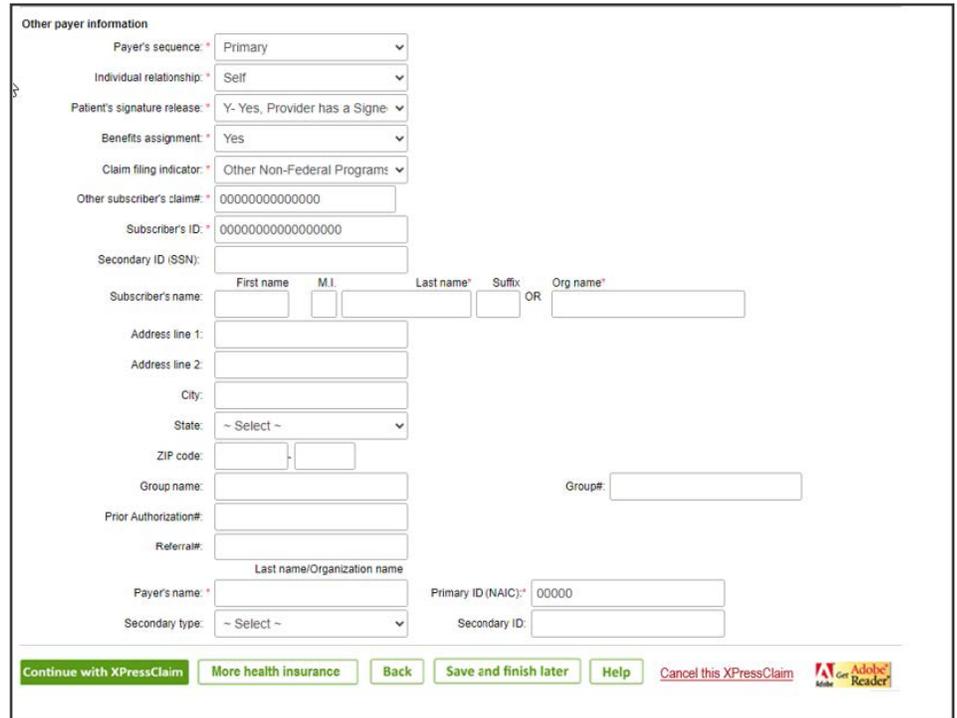
- Enter the **details for each claim line**
- Do not enter zeroes in the OHI Paid field if the patient does not have other health insurance
- Leave it blank
- Select **Continue with XPressClaim**

If an OHI Paid amount is entered on the line details page, additional OHI information is required:

- **Prior adjudication date:** This is the date that the other payer processed the claim
- **Claim adjustment group code:** “Patient responsibility” is pre-populated as this is the most common reason for adjustments
- **Reason code, Amount and Quantity** must be entered if there is an outstanding balance owed by the patient. Reason codes can be found at <http://www.x12.org/codes/claim-adjustment-reason-codes/>

Professional claim continued

- Enter and/or verify the **OHI information** such as the Payer's name
- Select **Continue with XPressClaim**



Other payer information

Payer's sequence: * Primary

Individual relationship: * Self

Patient's signature release: * Y- Yes, Provider has a Signe

Benefits assignment: * Yes

Claim filing indicator: * Other Non-Federal Programs

Other subscriber's claim#: * 00000000000000

Subscriber's ID: * 0000000000000000

Secondary ID (SSN):

Subscriber's name: First name M.I. Last name* Suffix OR Org name*

Address line 1:

Address line 2:

City:

State: ~ Select ~

ZIP code:

Group name: Group#:

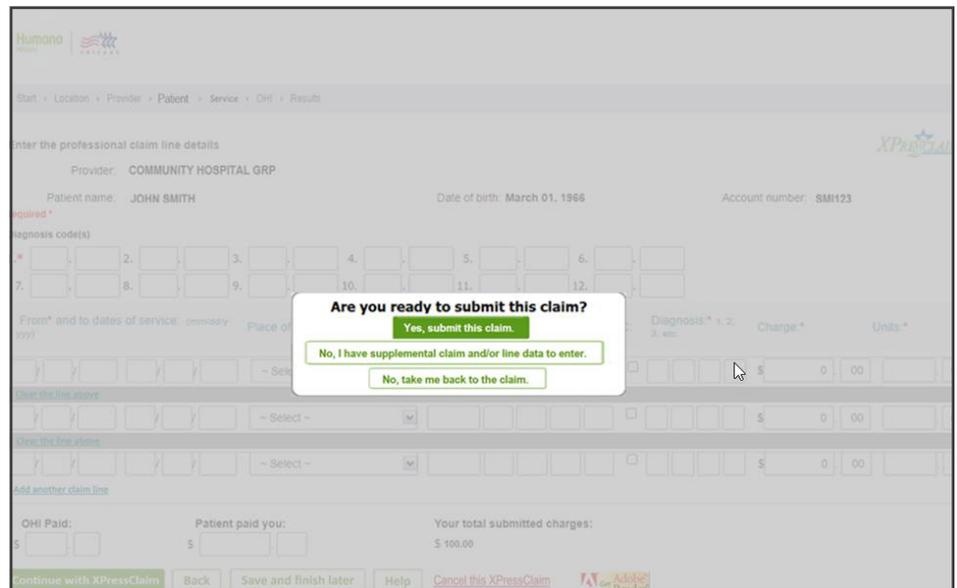
Prior Authorization#: Referral#: Last name/Organization name

Payer's name: * Primary ID (NAIC):* 00000

Secondary type: ~ Select ~ Secondary ID:

Continue with XPressClaim More health insurance Back Save and finish later Help Cancel this XPressClaim Adobe Reader

- If there is **no supplemental information** to add, select **Yes, submit this claim**
- To enter **supplemental information** such as a referring provider, select **No, I have supplemental claim and/or line data to enter**



Humana
Start Location Provider Patient Service OHI Results

Enter the professional claim line details

Provider: COMMUNITY HOSPITAL GRP

Patient name: JOHN SMITH Date of birth: March 01, 1966 Account number: SM1123

Required *

Diagnosis code(s)

From* and to dates of service: (mm/yy) Place of service

Diagnosis: * 1, 2, 3, etc. Charge * Units *

OHI Paid: Patient paid you: Your total submitted charges: \$ 100.00

Are you ready to submit this claim?

Yes, submit this claim.

No, I have supplemental claim and/or line data to enter.

No, take me back to the claim.

Continue with XPressClaim Back Save and finish later Help Cancel this XPressClaim Adobe Reader

Home Professional claim continued

- Select a checkbox from the **Supplemental claim information** page to add claim level data
- The page will re-display with the fields related to the checkbox selected
- Once all applicable information has been entered, select **Continue with XPressClaim**

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Start > Location > Provider > Patient > Service > OHI > Results

Supplemental claim information

Provider: COMMUNITY HOSPITAL GROUP

Patient name: JOHN SMITH Date of birth: March 01, 1966 Account number: SM1123

Please check the box for the information you wish to add to this claim. Uncheck the box to delete the information.

Required*

<input checked="" type="checkbox"/> Accident information	<input type="checkbox"/> Hearing and vision prescription date	<input type="checkbox"/> Patient condition information - vision
<input type="checkbox"/> Ambulance information	<input type="checkbox"/> Hospitalization date(s)	<input type="checkbox"/> Prior authorization or referral number
<input type="checkbox"/> Anesthesia related surgical procedure code	<input type="checkbox"/> Initial treatment date	<input type="checkbox"/> Referring provider information
<input type="checkbox"/> Assumed or relinquished care date	<input type="checkbox"/> Investigational device exemption number	<input type="checkbox"/> Rendering provider information
<input type="checkbox"/> CLIA information	<input type="checkbox"/> Last menstrual period date	<input type="checkbox"/> Service authorization exception code
<input type="checkbox"/> Delay reason code	<input type="checkbox"/> Last x-ray date	<input type="checkbox"/> Service facility information
<input type="checkbox"/> Demonstration project identifier	<input type="checkbox"/> Mammography certification number	<input type="checkbox"/> Spinal manipulation service information
<input type="checkbox"/> Disability related dates	<input type="checkbox"/> Onset of current illness/symptom date	<input type="checkbox"/> Supervising provider information
<input type="checkbox"/> EPSDT information	<input type="checkbox"/> Patient condition codes	<input type="checkbox"/> Supplemental paperwork information

Accident information

Related cause 1*: ~ Select -

Accident state: ~ Select -

Accident date: / / (mm/dd/yyyy)

Continue with XPressClaim Back Save and finish later Help Cancel this XPressClaim

- Next, the option to enter line level supplemental data is displayed
- Select a line using the [Add](#) link

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Start > Location > Provider > Patient > Service > OHI > Results

Supplemental claim information

Provider: COMMUNITY HOSPITAL GROUP

Patient name: JOHN SMITH Date of birth: March 01, 1966 Account number: SM1123

Please select a line to which the supplemental information will be added.

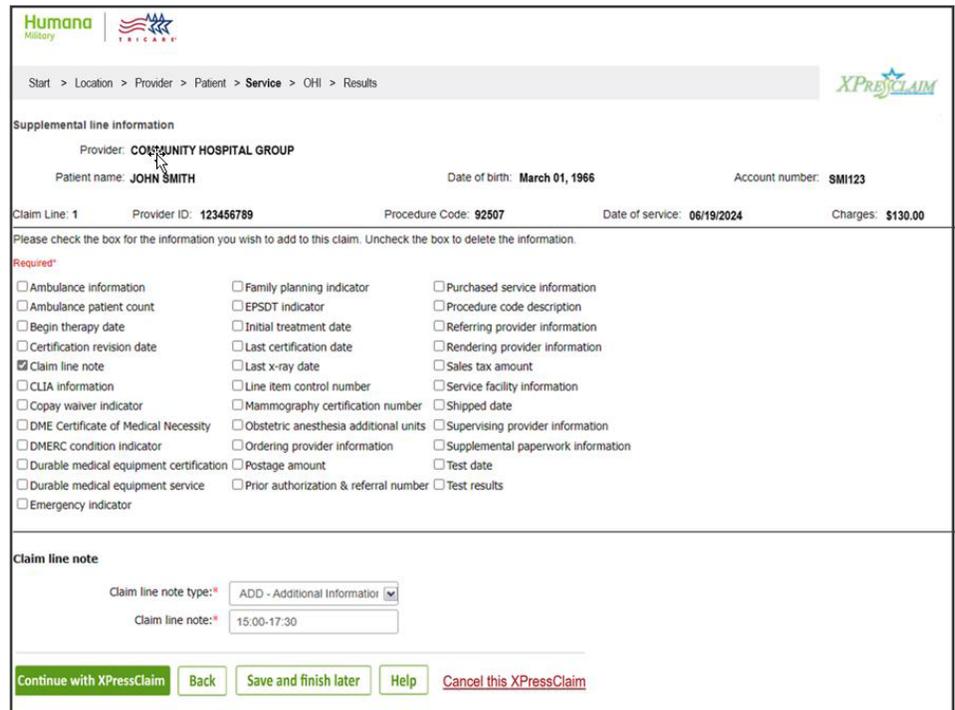
Line selection

Line	Procedure code	From date of service	Charges	Supplemental information
1	92507	06/19/2024	\$130.00	Add
2	92507	06/19/2024	\$130.00	Add

Continue with XPressClaim Back Save and finish later Help Cancel this XPressClaim

Professional claim continued

- The **Supplemental line information** page displays for the chosen line
- Select the desired checkboxes and enter the corresponding information
- Once all applicable information has been entered, select **Continue with XPressClaim**
- To enter start and stop times for Applied Behavior Analysis (ABA)/Autism Care Demonstration (ACD) services, navigate to each line and enter the start and stop times in military format as a claim line note
- Example: 15:00 – 17:30



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Start > Location > Provider > Patient > Service > OHI > Results

Supplemental line information

Provider: **COMMUNITY HOSPITAL GROUP**
 Patient name: **JOHN SMITH** Date of birth: **March 01, 1966** Account number: **SMI123**

Claim Line: 1 Provider ID: **123456789** Procedure Code: **92507** Date of service: **06/19/2024** Charges: **\$130.00**

Please check the box for the information you wish to add to this claim. Uncheck the box to delete the information.

Required:

<input type="checkbox"/> Ambulance information	<input type="checkbox"/> Family planning indicator	<input type="checkbox"/> Purchased service information
<input type="checkbox"/> Ambulance patient count	<input type="checkbox"/> EPSDT indicator	<input type="checkbox"/> Procedure code description
<input type="checkbox"/> Begin therapy date	<input type="checkbox"/> Initial treatment date	<input type="checkbox"/> Referring provider information
<input type="checkbox"/> Certification revision date	<input type="checkbox"/> Last certification date	<input type="checkbox"/> Rendering provider information
<input checked="" type="checkbox"/> Claim line note	<input type="checkbox"/> Last x-ray date	<input type="checkbox"/> Sales tax amount
<input type="checkbox"/> CLIA information	<input type="checkbox"/> Line item control number	<input type="checkbox"/> Service facility information
<input type="checkbox"/> Copay waiver indicator	<input type="checkbox"/> Mammography certification number	<input type="checkbox"/> Shipped date
<input type="checkbox"/> DME Certificate of Medical Necessity	<input type="checkbox"/> Obstetric anesthesia additional units	<input type="checkbox"/> Supervising provider information
<input type="checkbox"/> DMERC condition indicator	<input type="checkbox"/> Ordering provider information	<input type="checkbox"/> Supplemental paperwork information
<input type="checkbox"/> Durable medical equipment certification	<input type="checkbox"/> Postage amount	<input type="checkbox"/> Test date
<input type="checkbox"/> Durable medical equipment service	<input type="checkbox"/> Prior authorization & referral number	<input type="checkbox"/> Test results
<input type="checkbox"/> Emergency indicator		

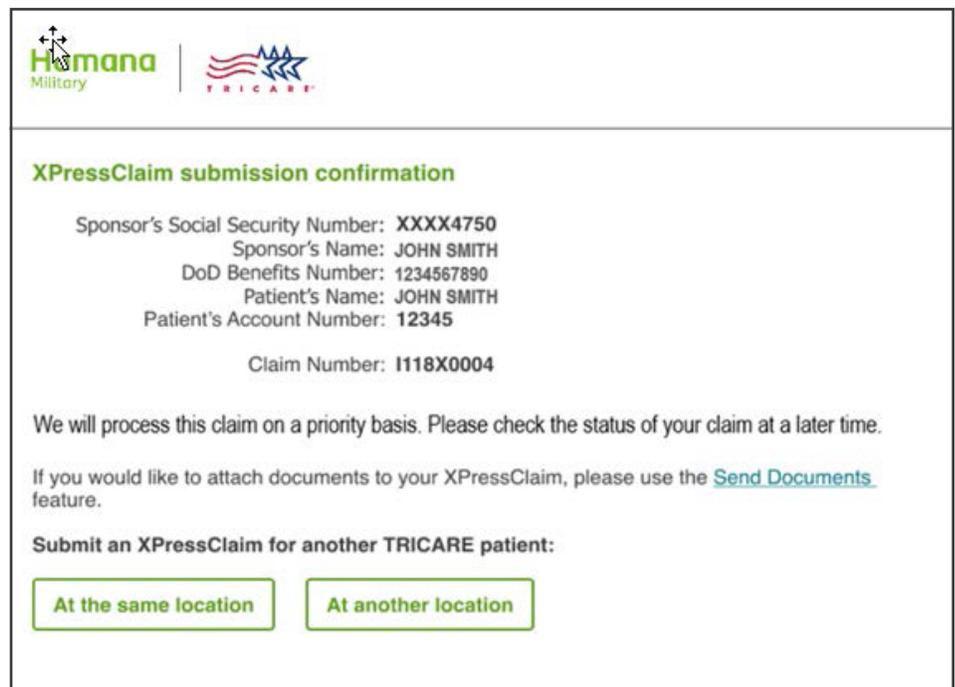
Claim line note

Claim line note type:*

Claim line note:*

[Continue with XPressClaim](#) [Back](#) [Save and finish later](#) [Help](#) [Cancel this XPressClaim](#)

- **Submission confirmation** - This claim was accepted and is in process



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XPressClaim submission confirmation

Sponsor's Social Security Number: **XXXX4750**
 Sponsor's Name: **JOHN SMITH**
 DoD Benefits Number: **1234567890**
 Patient's Name: **JOHN SMITH**
 Patient's Account Number: **12345**

Claim Number: **I118X0004**

We will process this claim on a priority basis. Please check the status of your claim at a later time.

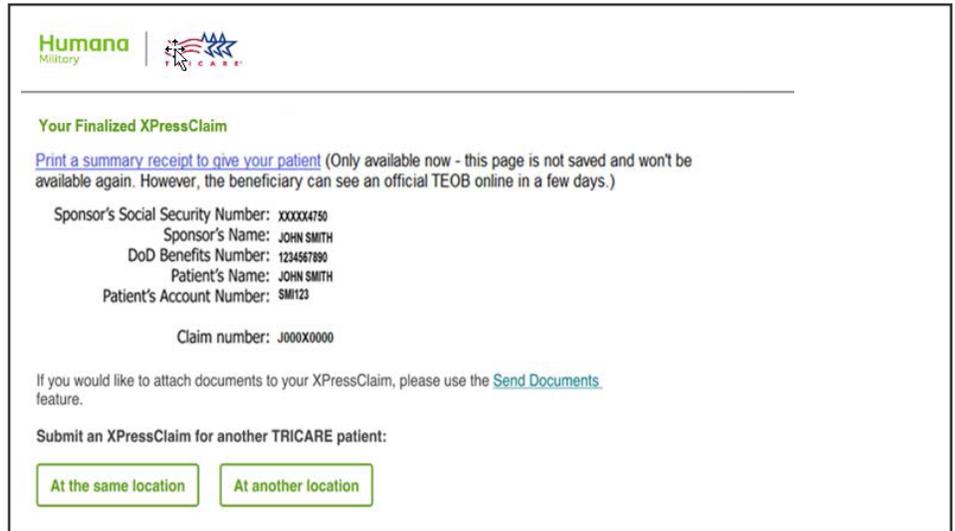
If you would like to attach documents to your XPressClaim, please use the [Send Documents](#) feature.

Submit an XPressClaim for another TRICARE patient:

[At the same location](#) [At another location](#)

Professional claim continued

- **Finalized claim** – This claim was accepted and processed
- Payment may or may not be made on finalized claim
- Some lines on a claim may be denied/rejected while other lines are accepted and paid
- [Send Documents](#) →



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Your Finalized XPressClaim

[Print a summary receipt to give your patient](#) (Only available now - this page is not saved and won't be available again. However, the beneficiary can see an official TEOB online in a few days.)

Sponsor's Social Security Number: XXXXX4750
 Sponsor's Name: JOHN SMITH
 DoD Benefits Number: 1234567890
 Patient's Name: JOHN SMITH
 Patient's Account Number: SM123

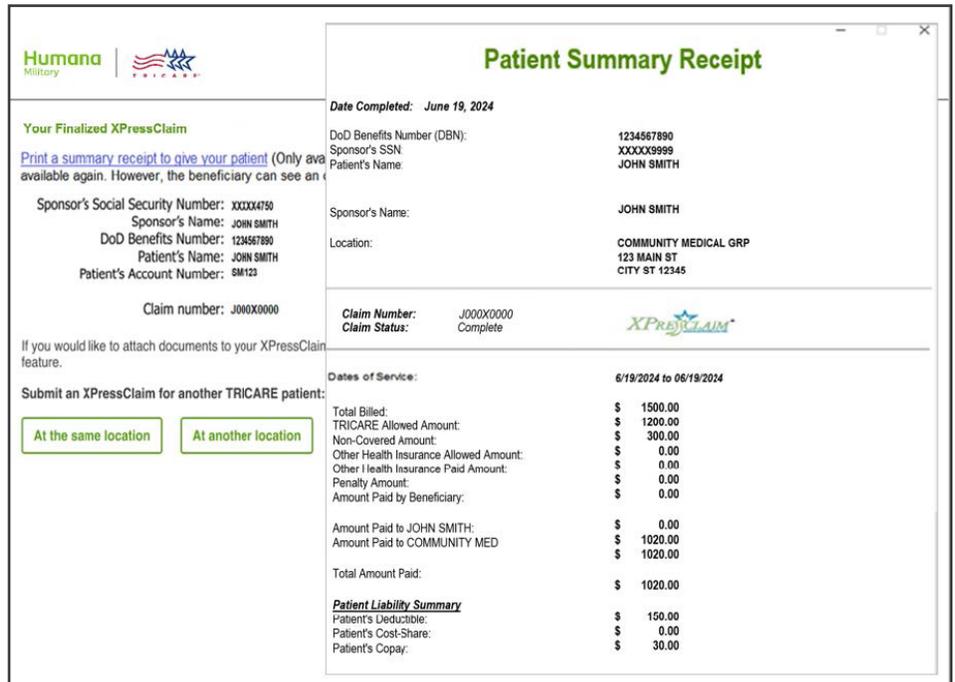
Claim number: J000X0000

If you would like to attach documents to your XPressClaim, please use the [Send Documents](#) feature.

Submit an XPressClaim for another TRICARE patient:

[At the same location](#) [At another location](#)

- Providers can print a **summary receipt** to give to the patient



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Patient Summary Receipt

Date Completed: June 19, 2024

DoD Benefits Number (DBN): 1234567890
 Sponsor's SSN: XXXXX9999
 Patient's Name: JOHN SMITH
 Sponsor's Name: JOHN SMITH
 Location: COMMUNITY MEDICAL GRP
 123 MAIN ST
 CITY ST 12345

Claim Number: J000X0000
 Claim Status: Complete

XPressCLAIM

Dates of Service: 6/19/2024 to 06/19/2024

Total Billed:	\$ 1500.00
TRICARE Allowed Amount:	\$ 1200.00
Non-Covered Amount:	\$ 300.00
Other Health Insurance Allowed Amount:	\$ 0.00
Other Health Insurance Paid Amount:	\$ 0.00
Penalty Amount:	\$ 0.00
Amount Paid by Beneficiary:	\$ 0.00
Amount Paid to JOHN SMITH:	\$ 0.00
Amount Paid to COMMUNITY MED:	\$ 1020.00
Total Amount Paid:	\$ 1020.00

Patient Liability Summary

Patient's Deductible:	\$ 150.00
Patient's Cost-Share:	\$ 0.00
Patient's Copay:	\$ 30.00

If you would like to attach documents to your XPressClaim feature.

Submit an XPressClaim for another TRICARE patient:

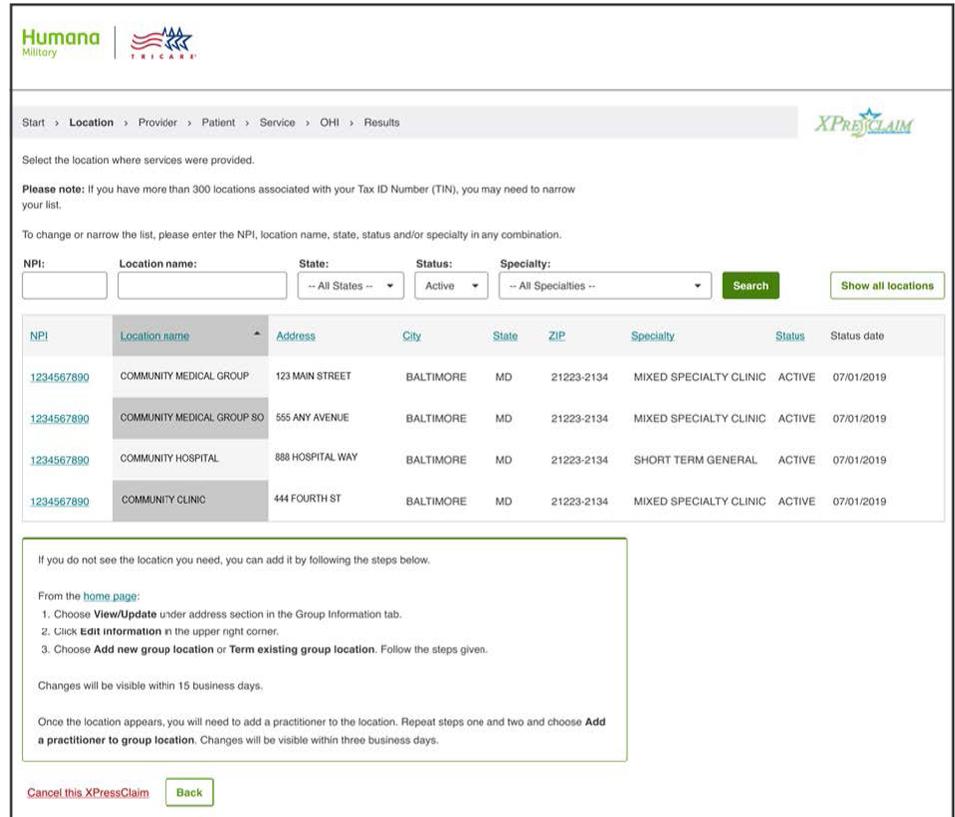
[At the same location](#) [At another location](#)

Institutional claim

XPC Institutional

The first step is to select the **location where services were provided:**

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- Narrow the list by NPI, location name, state, status and/or specialty
- The specialty of the location selected determines the claim path –professional (CMS1500) or institutional (UB04)
- Some specialties (based on TRICARE policy) can submit both institutional and professional claims
- If the location cannot be found, follow the steps provided to request a location to be added to our system



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Start > Location > Provider > Patient > Service > OHI > Results

Select the location where services were provided.

Please note: If you have more than 300 locations associated with your Tax ID Number (TIN), you may need to narrow your list.

To change or narrow the list, please enter the NPI, location name, state, status and/or specialty in any combination.

NPI: Location name: State: Status: Specialty:

NPI	Location name	Address	City	State	ZIP	Specialty	Status	Status date
1234567890	COMMUNITY MEDICAL GROUP	123 MAIN STREET	BALTIMORE	MD	21223-2134	MIXED SPECIALTY CLINIC	ACTIVE	07/01/2019
1234567890	COMMUNITY MEDICAL GROUP SO	555 ANY AVENUE	BALTIMORE	MD	21223-2134	MIXED SPECIALTY CLINIC	ACTIVE	07/01/2019
1234567890	COMMUNITY HOSPITAL	888 HOSPITAL WAY	BALTIMORE	MD	21223-2134	SHORT TERM GENERAL	ACTIVE	07/01/2019
1234567890	COMMUNITY CLINIC	444 FOURTH ST	BALTIMORE	MD	21223-2134	MIXED SPECIALTY CLINIC	ACTIVE	07/01/2019

If you do not see the location you need, you can add it by following the steps below.

From the [home page](#):

1. Choose **View/Update** under address section in the Group Information tab.
2. Click **Edit information** in the upper right corner.
3. Choose **Add new group location** or **Term existing group location**. Follow the steps given.

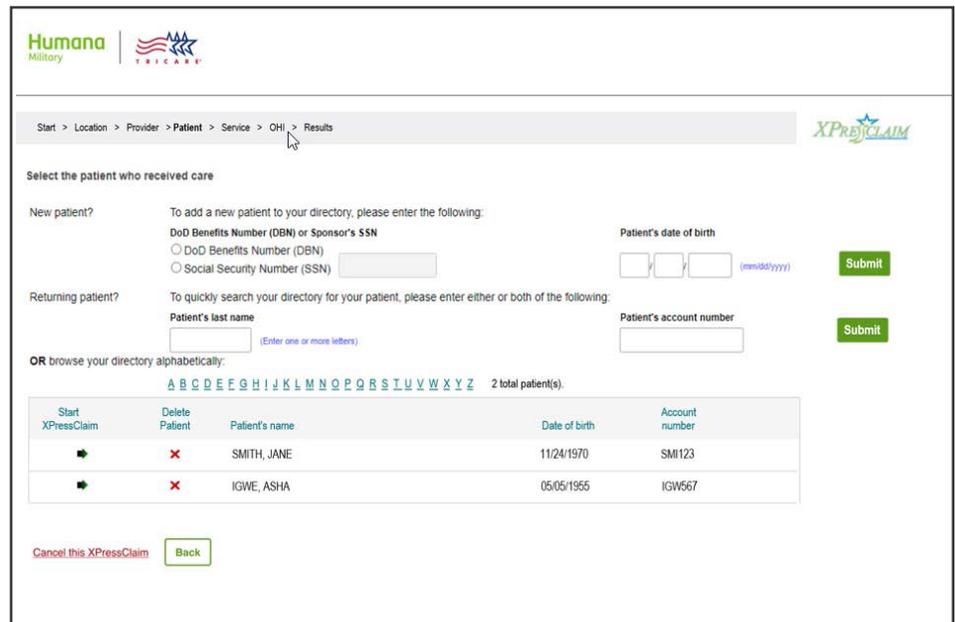
Changes will be visible within 15 business days.

Once the location appears, you will need to add a practitioner to the location. Repeat steps one and two and choose **Add a practitioner to group location**. Changes will be visible within three business days.

Select the **patient** who received care:

- Add a new patient by DoD Benefits Number (DBN) or Social Security Number (SSN) and patient's date of birth
- Search for a returning patient by last name or account number
- Browse the directory alphabetically

Please note: Patients are required to be listed on the Defense Eligibility and Enrollment System (DEERS) with the exception of newborns less than 365 days old.



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Start > Location > Provider > Patient > Service > OHI > Results

Select the patient who received care

New patient? To add a new patient to your directory, please enter the following:

DoD Benefits Number (DBN) or Sponsor's SSN

DoD Benefits Number (DBN)

Social Security Number (SSN)

Patient's date of birth

Returning patient? To quickly search your directory for your patient, please enter either or both of the following:

Patient's last name (Enter one or more letters)

Patient's account number

OR browse your directory alphabetically: [A](#) [B](#) [C](#) [D](#) [E](#) [F](#) [G](#) [H](#) [I](#) [J](#) [K](#) [L](#) [M](#) [N](#) [O](#) [P](#) [Q](#) [R](#) [S](#) [T](#) [U](#) [V](#) [W](#) [X](#) [Y](#) [Z](#) 2 total patient(s).

Start XPressClaim	Delete Patient	Patient's name	Date of birth	Account number
<input type="button" value="Start"/>	<input checked="" type="checkbox"/>	SMITH, JANE	11/24/1970	SMI123
<input type="button" value="Start"/>	<input checked="" type="checkbox"/>	IGWE, ASHA	05/05/1955	IGW567

Institutional claim continued

- Enter the **patient's information**, the **general claim information** and **claim note information**
- Some HIPAA required fields are prepopulated with the most common values
- Select Continue with **XPressClaim**
- **Helpful hint**
 - The **patient's account number**:
 - Corresponds to block 3a on the UB04 claim form
 - Assists the provider in patient identification
 - Is assigned by the provider or supplier account system
 - Is returned to the provider on the remittance advice

- Fill in the applicable **institutional claim entry** fields
- Select **Continue with XPressClaim**

Institutional claim continued

- Enter the **diagnosis codes, Present On Admission (POA) codes, attending physician information and ICD procedure codes**
- Then, select **Continue with XPressClaim**

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Start > Location > Provider > Patient > Service > OHI > Results

Enter the diagnosis codes and procedure codes for this claim

Provider: **COMMUNITY MEDICAL**

Patient name: **JANE SMITH** Date of birth: **November 24, 1970** Account number: **SMI123**

Required *

Diagnosis codes

Principal diagnosis and Present on Admission (POA) code: *

1.

Other diagnosis and Present on Admission (POA) codes:

2. 3. 4. 5.

6. 7. 8. 9.

[Show more Other diagnosis codes](#)

Admitting diagnosis code: Diagnosis related group (DRG):

Patient's reason for visit codes:

1. 2. 3.

Attending physician information

Please note: Last name and either the Primary or Secondary ID (not both) are required when submitting attending physician information.

First name:

M.I.:

Last name:

Suffix:

Primary ID: (NPI)

Secondary ID: (Provider Commercial Number)

External cause of injury codes and present on admission (POA) codes: [*]

ICD procedure codes

Principal procedure code and date: (mm/dd/yyyy)

1.

Other procedure codes and dates: (mm/dd/yyyy)

2. 3. 4. 5.

6. 7. 8. 9.

[Show more Other procedure codes](#)

Continue with XPressClaim Back Save and finish later Help Cancel this XPressClaim Adobe Reader

- Enter **Condition codes and Occurrence codes/dates**
- Select **Continue with XPressClaim**

Helpful hint: These fields correspond to blocks 35 – 36 on the UB04 claim form and are only used for Home Health Agency/Prospective Payment System (HHA/PPS) and Skilled Nursing Facility/Prospective Payment System (SNF/PPS) claims.

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Start > Location > Provider > Patient > Service > OHI > Results

Provider self-service: Secure Messages

Provider: **COMMUNITY MEDICAL**

Patient's Name: **JANE SMITH** Date of birth: **November 24, 1970** Account number: **SMI123**

Condition codes

1. 2. 3. 4. 5. 6. 7. 8.

[Show more Condition codes](#)

Occurrence codes and dates (mm/dd/yyyy)

1. 2. 3.

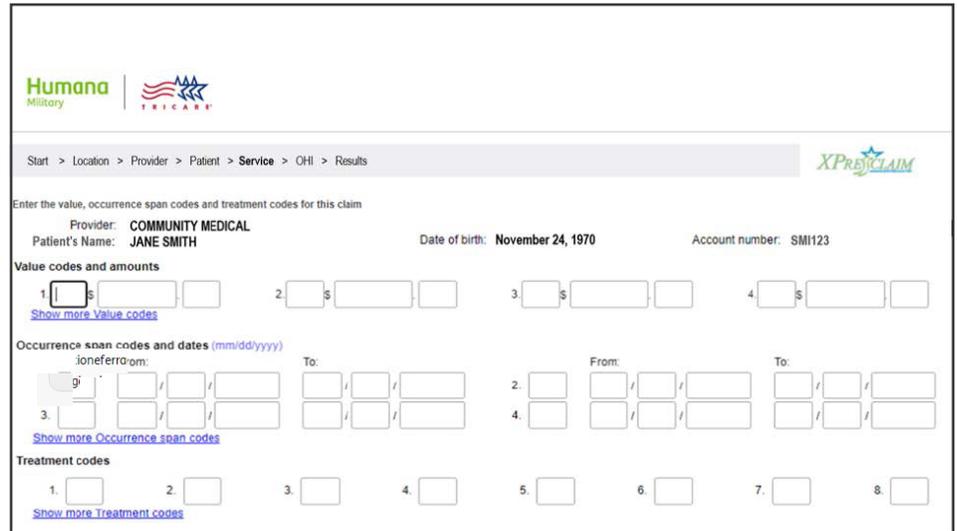
4. 5. 6.

[Show more Occurrence codes](#)

Continue with XPressClaim Back Save and finish later Help Cancel this XPressClaim Adobe Reader

Institutional claim continued

- Enter **value codes and amounts, occurrence span codes and dates and treatment codes**
- Select **Continue with XPressClaim**



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Start > Location > Provider > Patient > Service > OHI > Results XPressCLAIM

Enter the value, occurrence span codes and treatment codes for this claim

Provider: **COMMUNITY MEDICAL** Date of birth: **November 24, 1970** Account number: **SMI123**
 Patient's Name: **JANE SMITH**

Value codes and amounts

1. \$ 2. \$ 3. \$ 4. \$

[Show more Value codes](#)

Occurrence span codes and dates (mm/dd/yyyy)

1. From: / / To: / / 2. From: / / To: / /

3. From: / / To: / / 4. From: / / To: / /

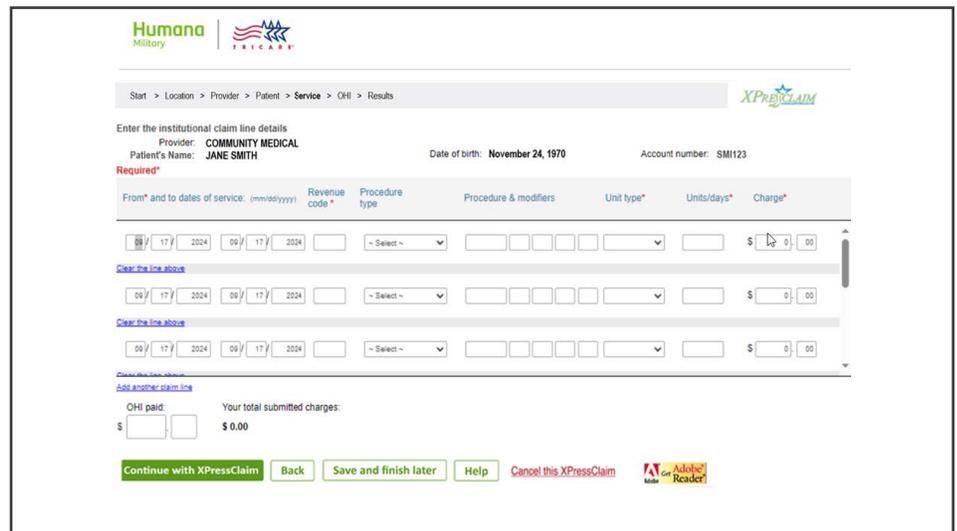
[Show more Occurrence span codes](#)

Treatment codes

1. 2. 3. 4. 5. 6. 7. 8.

[Show more Treatment codes](#)

- Enter the **details for each claim line**
- Do not enter zeroes in the OHI Paid field if the patient does not have OHI, leave it blank
- Select **Continue with XPressClaim**



Humana Military | TRICARE

Start > Location > Provider > Patient > Service > OHI > Results XPressCLAIM

Enter the institutional claim line details

Provider: **COMMUNITY MEDICAL** Date of birth: **November 24, 1970** Account number: **SMI123**
 Patient's Name: **JANE SMITH**

Required*

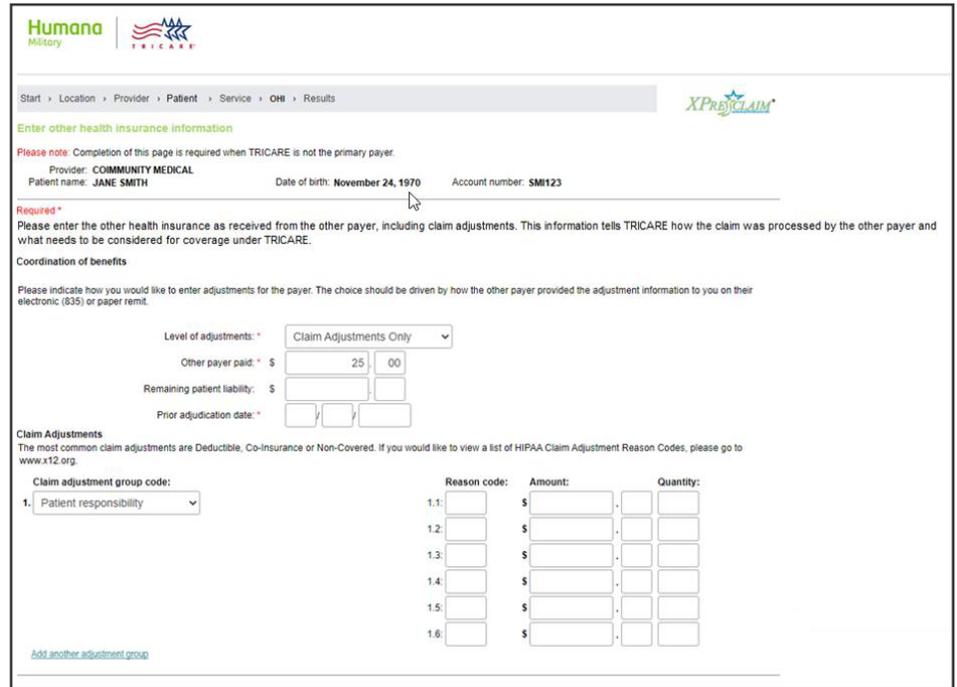
From* and to dates of service: (mm/dd/yyyy)	Revenue code*	Procedure type	Procedure & modifiers	Unit type*	Units/days*	Charge*
09/17/2024 - 09/17/2024	<input type="text"/>	- Select -	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Clear this line above						
09/17/2024 - 09/17/2024	<input type="text"/>	- Select -	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Clear this line above						
09/17/2024 - 09/17/2024	<input type="text"/>	- Select -	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Clear this line above						
Add another claim line						

OHI paid: Your total submitted charges: **\$ 0.00**



Institutional claim continued

- If an OHI Paid amount is entered on the line details page, additional OHI information is required:
 - **Prior adjudication date:** This is the date that the other payer processed the claim
 - **Claim adjustment group code:** “Patient responsibility” is pre-populated as this is the most common reason for adjustments
 - **Reason code, Amount and Quantity** must be entered if there is an outstanding balance owed by the patient. Reason codes can be found at <http://www.x12.org/codes/claim-adjustment-reason-codes/>



Humana Military | TRICARE

Start > Location > Provider > Patient > Service > OHI > Results

Enter other health insurance information

Please note: Completion of this page is required when TRICARE is not the primary payer.

Provider: COMMUNITY MEDICAL
 Patient name: JANE SMITH
 Date of birth: November 24, 1970
 Account number: SM123

Required *

Please enter the other health insurance as received from the other payer, including claim adjustments. This information tells TRICARE how the claim was processed by the other payer and what needs to be considered for coverage under TRICARE.

Coordination of benefits

Please indicate how you would like to enter adjustments for the payer. The choice should be driven by how the other payer provided the adjustment information to you on their electronic (835) or paper remit.

Level of adjustments: * Claim Adjustments Only

Other payer paid: \$ 25 00

Remaining patient liability: \$

Prior adjudication date: *

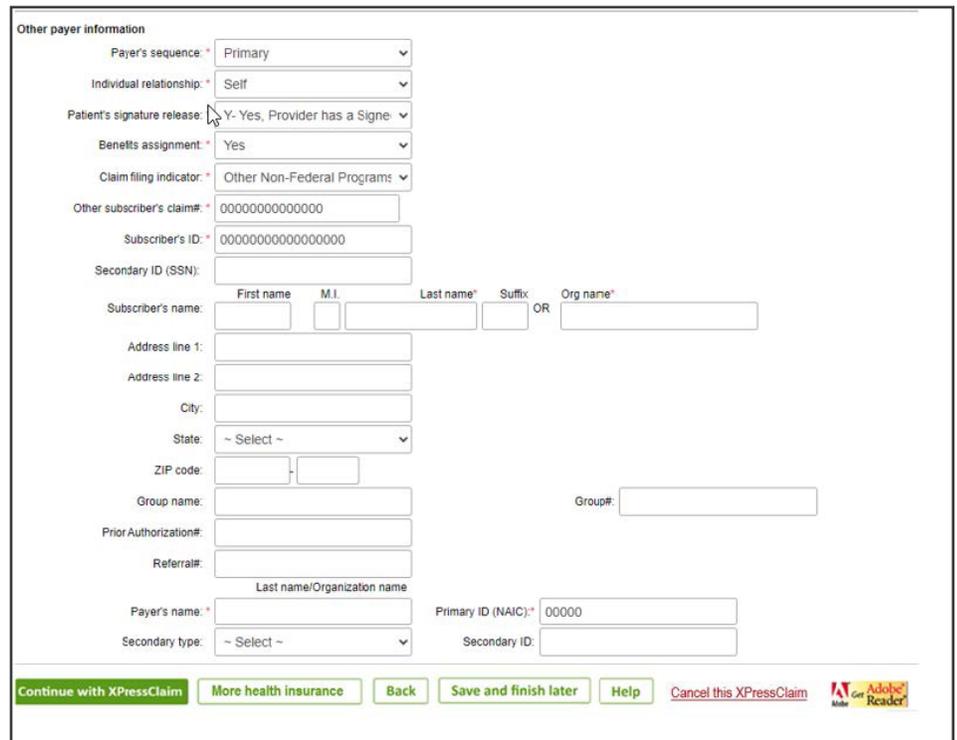
Claim Adjustments

The most common claim adjustments are Deductible, Co-Insurance or Non-Covered. If you would like to view a list of HIPAA Claim Adjustment Reason Codes, please go to www.x12.org.

Claim adjustment group code:	Reason code:	Amount:	Quantity:
1. Patient responsibility	1.1	\$	
	1.2	\$	
	1.3	\$	
	1.4	\$	
	1.5	\$	
	1.6	\$	

[Add another adjustment group](#)

- Enter and/or verify the **OHI information** such as the Payer’s name
- Select **Continue with XPressClaim**



Other payer information

Payer's sequence: * Primary

Individual relationship: * Self

Patient's signature release: * Y- Yes, Provider has a Signe

Benefits assignment: * Yes

Claim filing indicator: * Other Non-Federal Programs

Other subscriber's claim#: * 00000000000000

Subscriber's ID: * 0000000000000000

Secondary ID (SSN):

Subscriber's name: First name M.I. Last name* Suffix OR Org name*

Address line 1:

Address line 2:

City:

State: ~ Select ~

ZIP code:

Group name: Group#:

Prior Authorization#:

Referral#:

Last name/Organization name

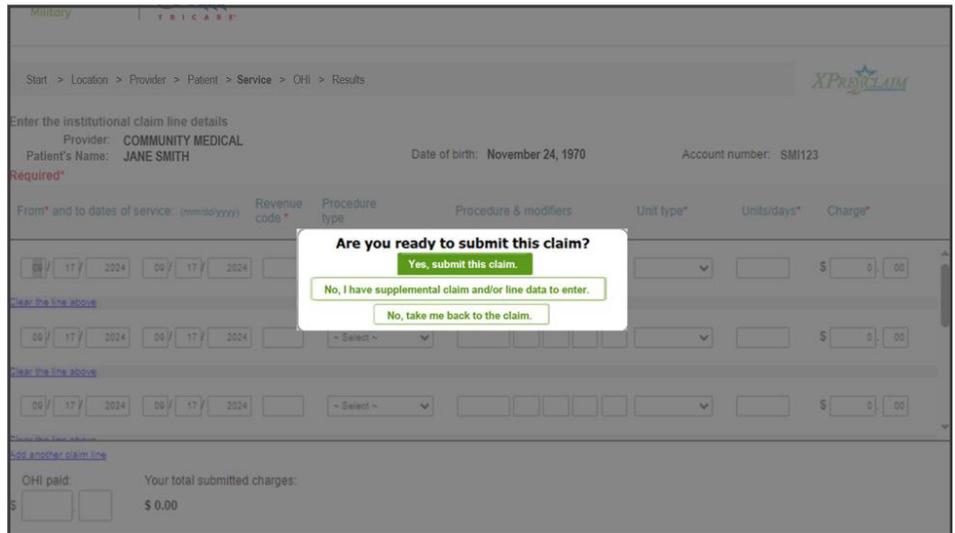
Payer's name: * Primary ID (NAIC):* 00000

Secondary type: ~ Select ~ Secondary ID:

[Continue with XPressClaim](#) [More health insurance](#) [Back](#) [Save and finish later](#) [Help](#) [Cancel this XPressClaim](#) 

Institutional claim continued

- If there is **no supplemental information** to add, select **Yes, submit this claim**
- To enter **supplemental information** such as a referring provider, select **No, I have supplemental claim and/or line data to enter**



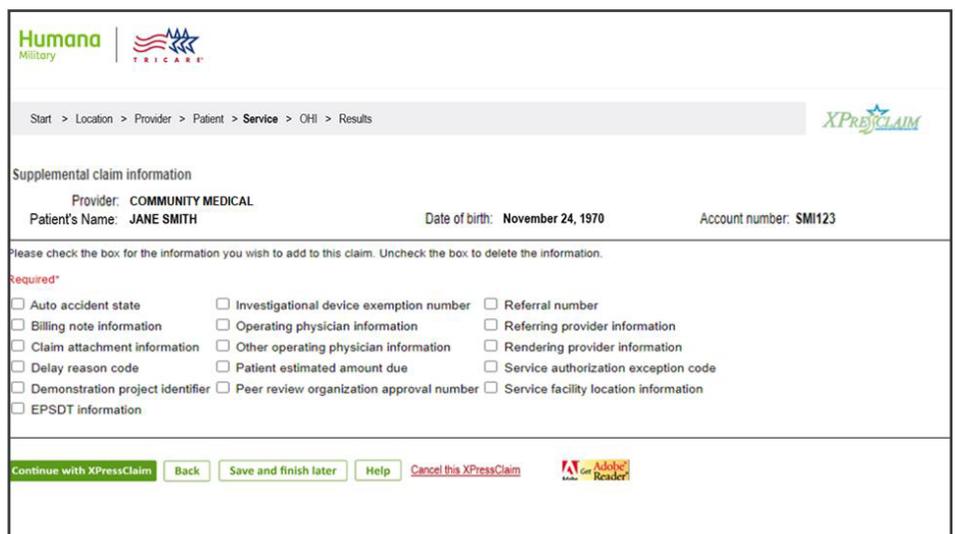
Are you ready to submit this claim?

Yes, submit this claim.

No, I have supplemental claim and/or line data to enter.

No, take me back to the claim.

- Select a checkbox from the **Supplemental claim information page** to add **claim level data**
- The page will re-display with the fields related to the checkbox selected
- Once all applicable information has been entered, select **Continue with XPressClaim**



Supplemental claim information

Provider: COMMUNITY MEDICAL
Patient's Name: JANE SMITH
Date of birth: November 24, 1970
Account number: SMI123

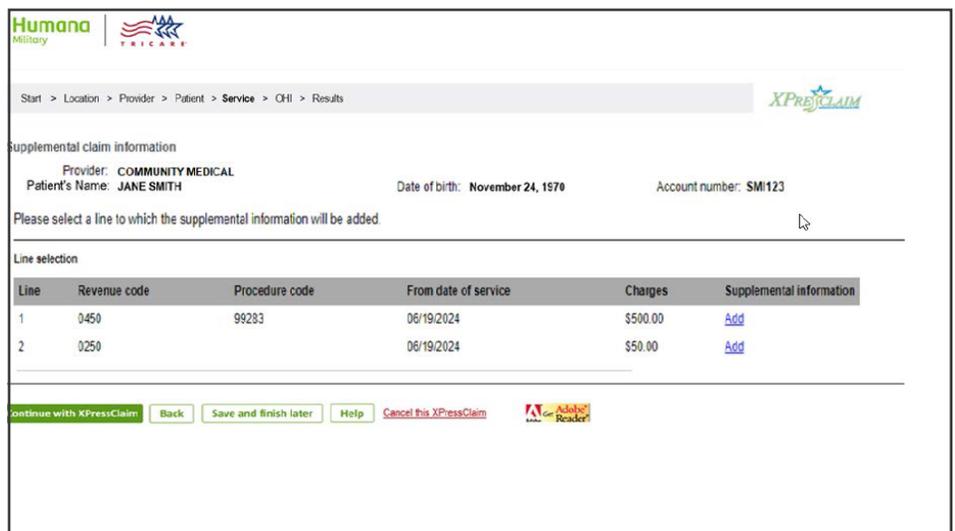
Please check the box for the information you wish to add to this claim. Uncheck the box to delete the information.

Required*

Auto accident state Investigational device exemption number Referral number
 Billing note information Operating physician information Referring provider information
 Claim attachment information Other operating physician information Rendering provider information
 Delay reason code Patient estimated amount due Service authorization exception code
 Demonstration project identifier Peer review organization approval number Service facility location information
 EPSDT information

Continue with XPressClaim Back Save and finish later Help Cancel this XPressClaim

- Next, the option to enter **line level supplemental data** is displayed
- Select a line using the [Add link](#)



Supplemental claim information

Provider: COMMUNITY MEDICAL
Patient's Name: JANE SMITH
Date of birth: November 24, 1970
Account number: SMI123

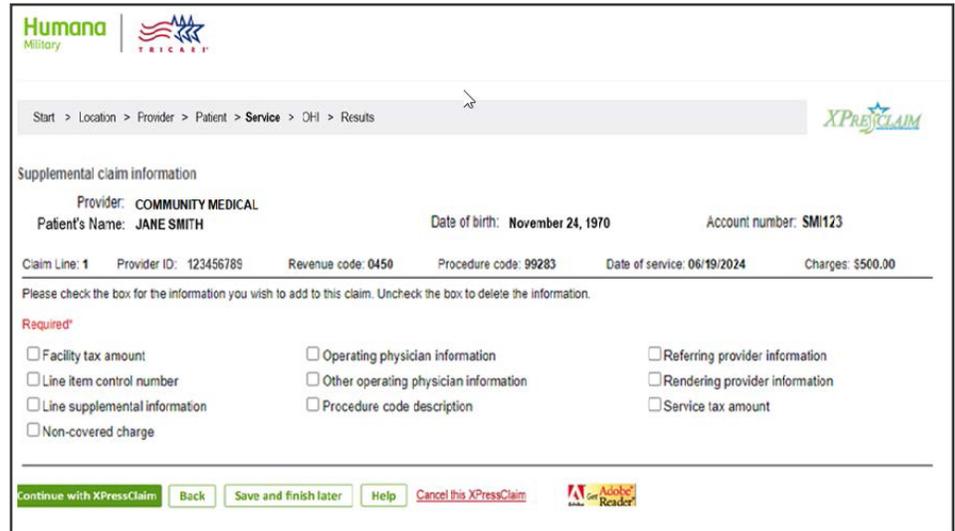
Please select a line to which the supplemental information will be added.

Line	Revenue code	Procedure code	From date of service	Charges	Supplemental information
1	0450	99283	06/19/2024	\$500.00	Add
2	0250		06/19/2024	\$50.00	Add

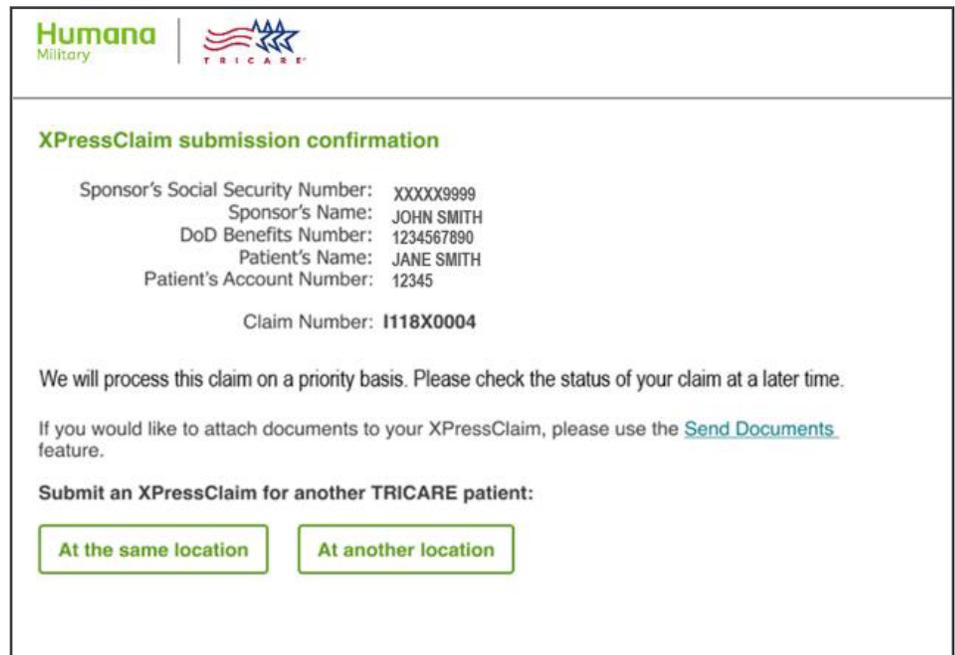
Continue with XPressClaim Back Save and finish later Help Cancel this XPressClaim

Institutional claim continued

- The **Supplemental line information** page displays for the chosen line
- Select the desired checkboxes and enter the corresponding information
- Once all applicable information has been entered, select **Continue with XPressClaim**



- **Submission confirmation** - This claim was accepted and is in process



🏠 Institutional claim continued

- **Finalized claim** – This claim was accepted and processed
- Payment may or may not be made on finalized claim
- Some lines on a claim may be denied/rejected while other lines are accepted and paid
- [Send Documents](#) →

Humana Military | **TRICARE**

Your Finalized XPressClaim

[Print a summary receipt to give your patient](#) (Only available now - this page is not saved and won't be available again. However, the beneficiary can see an official TEOB online in a few days.)

Sponsor's Social Security Number: XXXXX4750
 Sponsor's Name: JOHN SMITH
 DoD Benefits Number: 1234567890
 Patient's Name: JOHN SMITH
 Patient's Account Number: SM123

Claim number: J000X0000

If you would like to attach documents to your XPressClaim, please use the [Send Documents](#) feature.

Submit an XPressClaim for another TRICARE patient:

[At the same location](#) [At another location](#)

- Providers can print a summary receipt to give to the patient

Humana Military | **TRICARE**

Patient Summary Receipt

Date Completed: June 19, 2024

Your Finalized XPressClaim

[Print a summary receipt to give your patient](#) (Only available now - this page is not saved and won't be available again. However, the beneficiary can see an official TEOB online in a few days.)

Sponsor's Social Security Number: XXXXX4750
 Sponsor's Name: JOHN SMITH
 DoD Benefits Number: 1234567890
 Patient's Name: JOHN SMITH
 Patient's Account Number: SM123

Claim number: J000X0000

If you would like to attach documents to your XPressClaim, please use the [Send Documents](#) feature.

Submit an XPressClaim for another TRICARE patient:

[At the same location](#) [At another location](#)

DoD Benefits Number (DBN):	1234567890
Sponsor's SSN:	XXXXX9999
Patient's Name:	JOHN SMITH
Sponsor's Name:	JOHN SMITH
Location:	COMMUNITY MEDICAL GRP 123 MAIN ST CITY ST 12345
Claim Number:	J000X0000
Claim Status:	Complete

XPRESSCLAIM

Dates of Service:	6/19/2024 to 06/19/2024
Total Billed:	\$ 1500.00
TRICARE Allowed Amount:	\$ 300.00
Non-Covered Amount:	\$ 0.00
Other Health Insurance Allowed Amount:	\$ 0.00
Other Health Insurance Paid Amount:	\$ 0.00
Penalty Amount:	\$ 0.00
Amount Paid by Beneficiary:	\$ 0.00
Amount Paid to JOHN SMITH:	\$ 1020.00
Amount Paid to COMMUNITY MED:	\$ 1020.00
Total Amount Paid:	\$ 1020.00

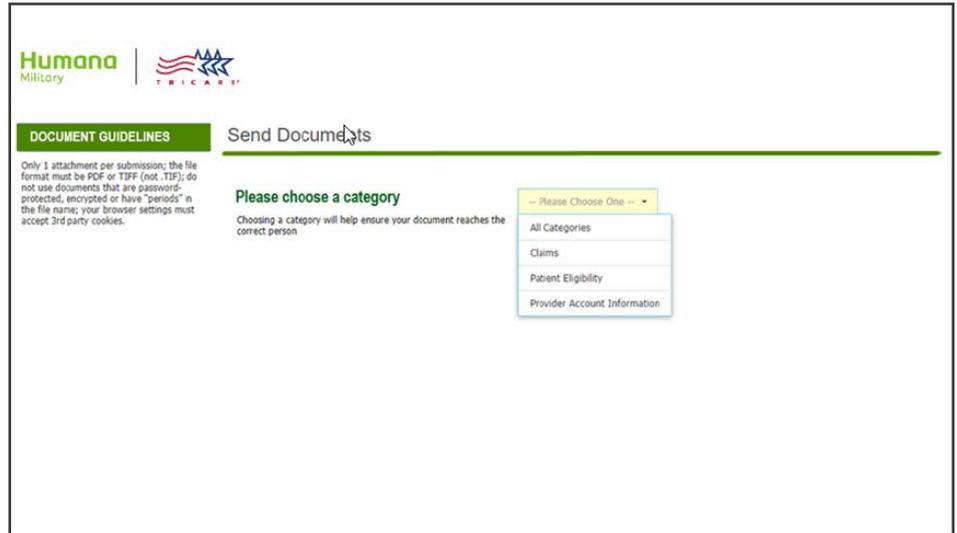
Patient Liability Summary

Patient's Deductible:	\$ 150.00
Patient's Cost-Share:	\$ 0.00
Patient's Copay:	\$ 30.00

Send Documents

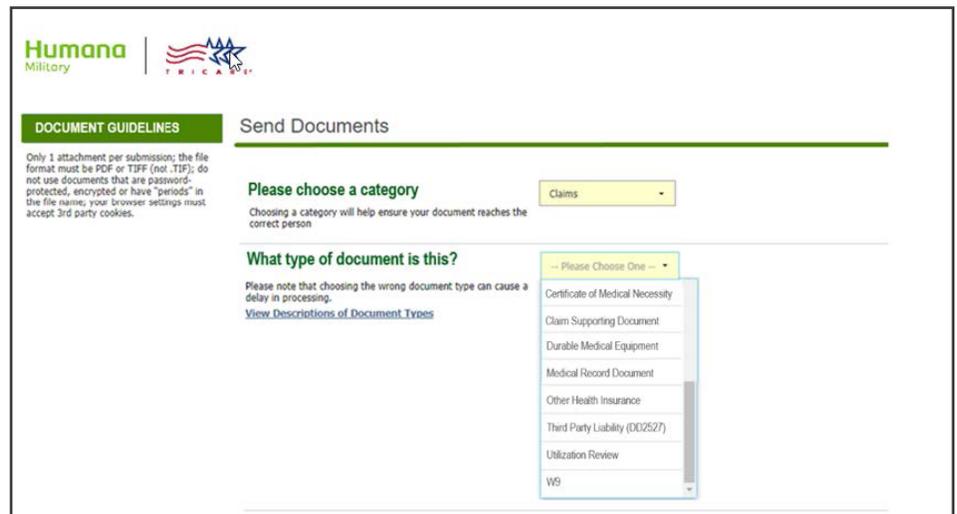
Send Documents

- Upon selection of the **Send Documents** link from the **XPressClaim submission confirmation page**, the **Send Documents** feature opens in a new window
- This allows the provider to close it to return to the XPC window at any time
- The first step is to choose a **category**



The screenshot shows the 'Send Documents' interface. At the top left, there are logos for 'Humana Military' and 'TRICARE'. Below the logos is a 'DOCUMENT GUIDELINES' section with text: 'Only 1 attachment per submission; the file format must be PDF or TIFF (not .TIF); do not use documents that are password-protected, encrypted or have "periods" in the file name; your browser settings must accept 3rd party cookies.' To the right of the guidelines is the 'Send Documents' title. Below the title is a 'Please choose a category' section with a dropdown menu. The dropdown menu is open, showing options: 'All Categories', 'Claims', 'Patient Eligibility', and 'Provider Account Information'. The 'Claims' option is highlighted.

- Next, choose a **document type**



The screenshot shows the 'Send Documents' interface. At the top left, there are logos for 'Humana Military' and 'TRICARE'. Below the logos is a 'DOCUMENT GUIDELINES' section with text: 'Only 1 attachment per submission; the file format must be PDF or TIFF (not .TIF); do not use documents that are password-protected, encrypted or have "periods" in the file name; your browser settings must accept 3rd party cookies.' To the right of the guidelines is the 'Send Documents' title. Below the title is a 'Please choose a category' section with a dropdown menu. The dropdown menu is open, showing options: 'All Categories', 'Claims', 'Patient Eligibility', and 'Provider Account Information'. The 'Claims' option is highlighted. Below the category selection is a 'What type of document is this?' section with a dropdown menu. The dropdown menu is open, showing options: 'Certificate of Medical Necessity', 'Claim Supporting Document', 'Durable Medical Equipment', 'Medical Record Document', 'Other Health Insurance', 'Third Party Liability (DD2527)', 'Utilization Review', and 'W9'. The 'Certificate of Medical Necessity' option is highlighted.

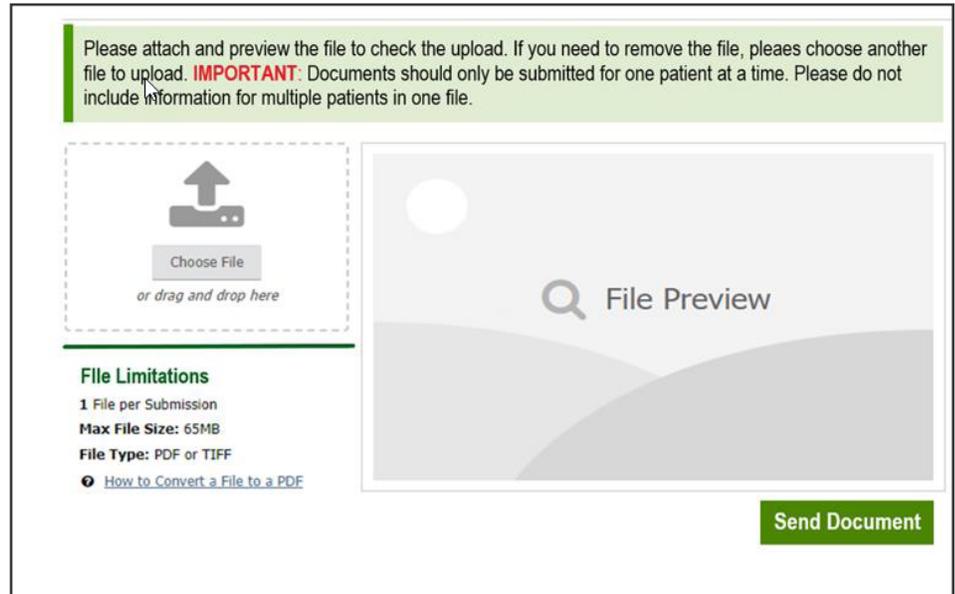
Send Documents

- In the **additional information** section, the patient's name, sponsor's SSN, patient's date of birth and claim number are pre-populated from **XPressClaim**
- The provider should let us know a request for this information was received

- There is an option for the provider to submit **notes**
- The notes are written to a cover page and stored with the document

Send Documents

- Next, the provider should **choose a file** or drag and drop the file for submission



Please attach and preview the file to check the upload. If you need to remove the file, please choose another file to upload. **IMPORTANT:** Documents should only be submitted for one patient at a time. Please do not include information for multiple patients in one file.

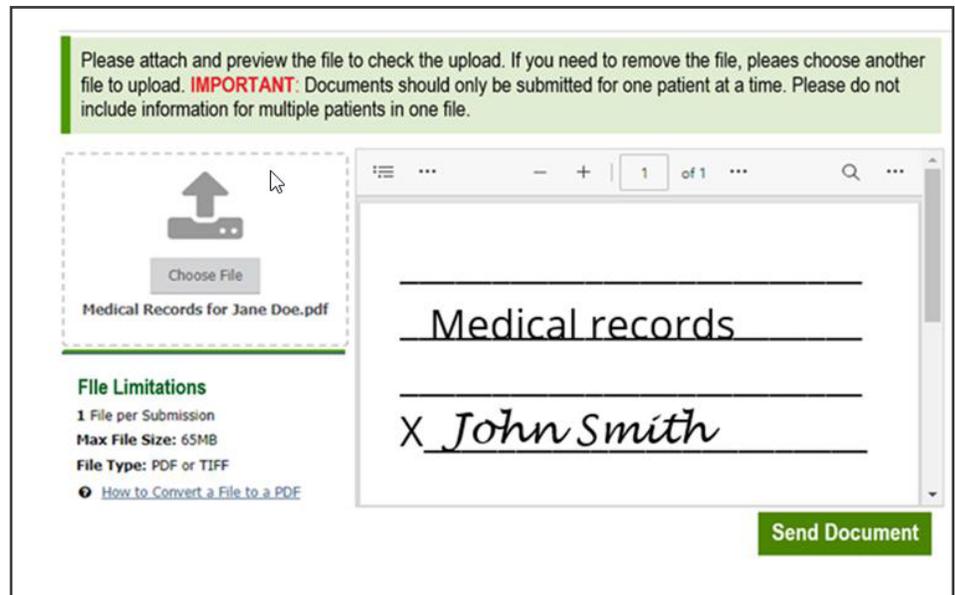

Choose File
or drag and drop here

File Limitations
1 File per Submission
Max File Size: 65MB
File Type: PDF or TIFF
[How to Convert a File to a PDF](#)

File Preview

Send Document

- The chosen document displays in the file **preview** window for verification
- Select **Send Document** to submit



Please attach and preview the file to check the upload. If you need to remove the file, please choose another file to upload. **IMPORTANT:** Documents should only be submitted for one patient at a time. Please do not include information for multiple patients in one file.

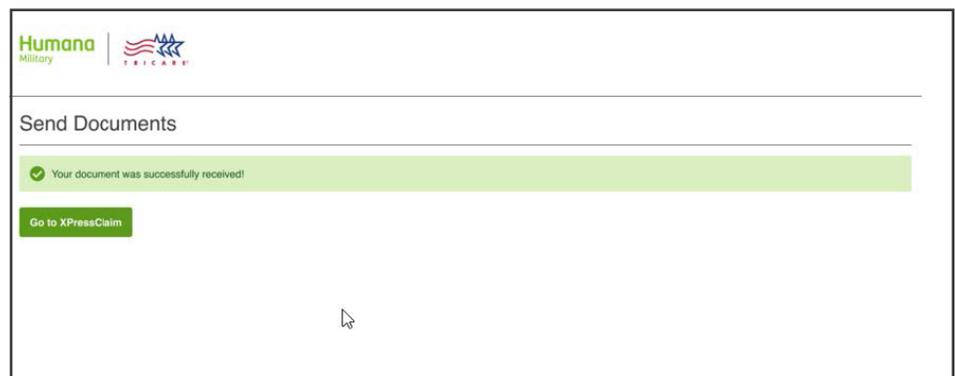

Choose File
Medical Records for Jane Doe.pdf

File Limitations
1 File per Submission
Max File Size: 65MB
File Type: PDF or TIFF
[How to Convert a File to a PDF](#)

Medical records
X *John Smith*

Send Document

- A **confirmation message** displays to let the provider know that the documentation was successfully submitted
- **Go to XPressClaim** closes the Send Documents window



Send Documents

 Your document was successfully received!

Go to XPressClaim

XPressClaim (XPC) guide

