

eClaims
enabled
Claim & receive.



eClaims User Guide

January 2020



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Every effort will be made to inform users of these changes as soon as possible, provided the changes affect the performance and operation of the software.

Preface

Welcome to the Provider Portal System

Welcome to the TELUS Health Provider Portal, a tool that allows you to create and submit extended healthcare claims securely online on behalf of your patients. It also allows you to view and manage the results of your claim submissions.

About this Guide

Information provided in this manual will guide you through starting and using the system. Using your PC, the Internet and a click of the mouse, you can perform tasks such as submitting, viewing and voiding extended healthcare payment or predetermination requests. Illustrations of the menus and dialog boxes are provided to facilitate your tasks.

This guide is organized into the following chapters:

Chapter 1	Overview
Chapter 2	Getting started
Chapter 3	Submitting electronic claims
Chapter 4	How to interpret the Insurance Company's response
Chapter 5	Viewing transaction history
Chapter 6	Cancelling a request after a response was obtained
Chapter 7	Authorization forms
Chapter 8	Managing passwords
Chapter 9	Email and banking information
Chapter 10	Application error
Chapter 11	Glossary of terms
Chapters 12	Coordination of Benefits – determining order of coverage

Working with the System

To get you started with the system, this guide provides step-by-step instructions with menus and descriptions of commands appearing in the drop-down menus. Once you become familiar with the system, you may only need to refer to this guide for more help or specific details about a task you may not have performed for some time. Your routine tasks such as starting the application and performing basic functions are described in the *Getting Started* chapter.

Intended Audiences for this User Guide

TELUS Health registered providers of the eClaims service and their staff are the primary audience for this user document.

This guide assumes that you have a basic familiarity with Windows operation and terminology. The most commonly used features of Windows that you will be using are described in the *Getting Started* chapter of this guide. If you need more details on working with Windows, refer to your Microsoft Windows documentation.

Using this Guide Effectively

Your user guide is an effective and helpful tool, which has answers to many of your questions, and pertinent information that will help you get the most out of the system.

Document Conventions

The following text conventions will be used throughout this guide.

Convention	Description
Page	Items in bold dark purple denote a page
[Tab]	Items in bold dark purple with square brackets denote an application tab resembling this: 
Field	Items in bold black denote the label representing a field such as this: 
Field value	Items in bold dark blue denote a possible field value for fields that allow the user to select a value.
Button	Items highlighted in light grey with black writing denote a button and its label.

The following pictorial conventions will be used in this guide.



A caution gives advice to you about potential problems and helps you avoid disaster.



A note presents interesting pieces of information related to the surrounding discussion.

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1 Overview

The TELUS Health Provider Portal is designed to give providers the ability to submit extended healthcare claims electronically to their patient's Insurance Company who will respond in real time. Providers will also have the ability to display, print and/or save the Insurer's response any time during the day of submission. A limited view of a transaction in the month of submission and for an additional month will also be available.

Who Should Read this Chapter?

All users who have access to the eClaims section of the TELUS Health Provider Portal should read this chapter to familiarize themselves with the Extended Healthcare functions they can perform using this application.

1.1 eClaims Application Functionality

The TELUS Health Provider Portal allows users the ability to do the following when they have access to use the eClaims application of the Portal. These are the basic eClaims related business processes:

- Submission of a payment request
- Submission of a predetermination (or treatment plan) request
- Print or save an electronic copy of the Insurance Company's response
- View the current day's transactions
- View transactions from the current month and an additional month
- Void a payment request
- Print blank consent forms

1.2 Users

The users of the TELUS Health Provider Portal's eClaims application are providers registered for eClaims and their designated delegates. Delegates may be administrative staff, receptionist or other authorized person employed by the provider.

2 Getting started

Welcome to the TELUS Health Provider Portal eClaims application. This web-based interface allows you to quickly navigate from tab to tab with the click of the mouse, easily accessing the tabs available to submit requests, print or save the Insurance Company's responses, view current and past transactions as well as print consent forms.

In this chapter, you will learn how to quickly get started with the system. The information provided includes instructions for logging-on to the system, descriptions of the navigation bars, and how to use them. Information regarding the minimum hardware and software requirements is also presented.

Who Should Read this Chapter?

All users of the TELUS Health Provider Portal eClaims application should read this chapter in order to familiarize themselves with the basic information for using or navigating around the application.

2.1 Accessing the eClaims application

The eClaims application is accessible by logging on to the Provider Portal. The login functionality should be used whenever you wish to access the Provider Portal.

To login:

1. From the desktop, open the Internet browser (e.g. Internet Explorer).
2. In the address box, type <https://providereservices.telushealth.com> and press <Enter>.

The system displays the Login window.

TELUS | HEALTH®

Log in

Username *

Username assigned by TELUS Health

Password *

Log in

Register for our services

Make life easier for your patients by directly billing — on their behalf — the participating insurers who cover 85% of privately-insured Canadians.
[Register for eClaims >](#)

Enhance service for people with workplace injuries in Ontario by streamlining communications with WSIB.
[Register for WSIB >](#)

Submit paper claims and receive direct deposit payments from participating insurers.
[Register for direct deposit >](#)

No cheques. No forms. No stamps. Paying taxes can be a lot easier.
[Learn more about paying your taxes online >](#)

Trouble logging in?

[Forgot my username >](#)

[Forgot/reset my password >](#)

[Forgot both?](#)

If you need help to log in, please contact TELUS Health at 1-866-240-7492, Monday to Friday, from 8:00 a.m. to 8:00 p.m. ET.

You may also encounter problems logging in if:

- You entered an invalid username or password
- The Caps Lock key is turned on
- Your account was locked after 5 consecutive invalid login attempts

My security profile

[Update my security profile information >](#)

[Use this link to review and/or update your security profile information.](#)

3. Type your **Username**. This field is not case-sensitive.
4. Type your **Password**. This field is case-sensitive.
5. Click **Log in** or press <Enter>.

The Legal Notice displays.

Legal

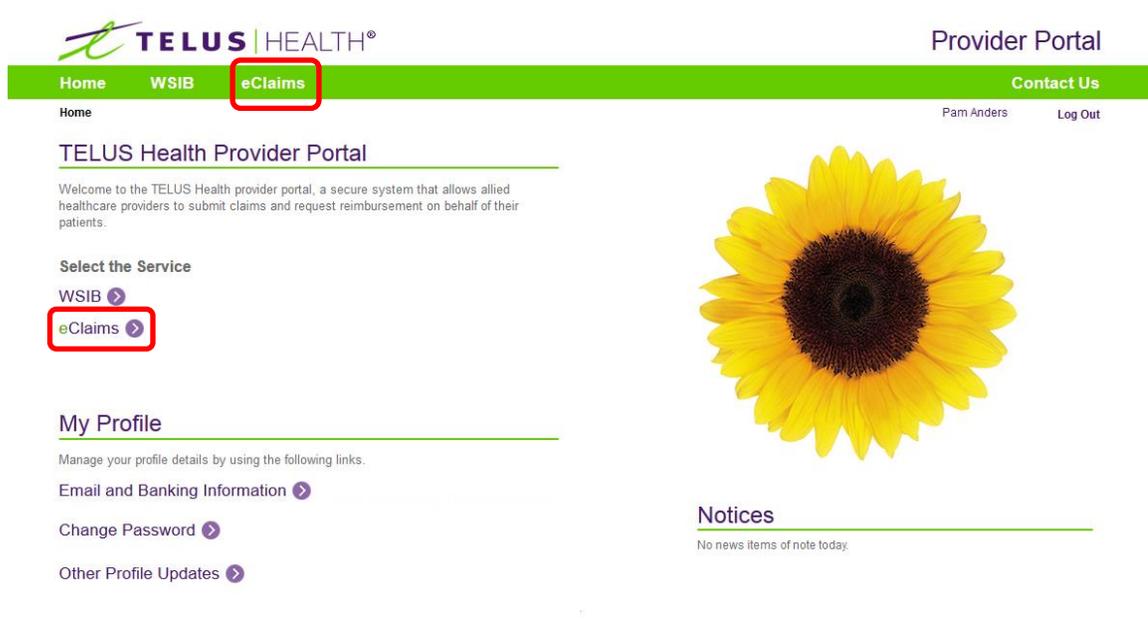
All information contained herein is protected by privacy laws including the Personal Information Protection and Electronic Documents Act (PIPEDA) and all the corresponding provincial legislation. All users agree to protect the personal health information contained herein from unauthorized use, disclosure, loss, theft, or compromise in accordance with the above noted laws and with at least the same care employed to protect their own confidential information. Any unauthorized access, disclosure or use of this information is illegal.

Print

I Accept

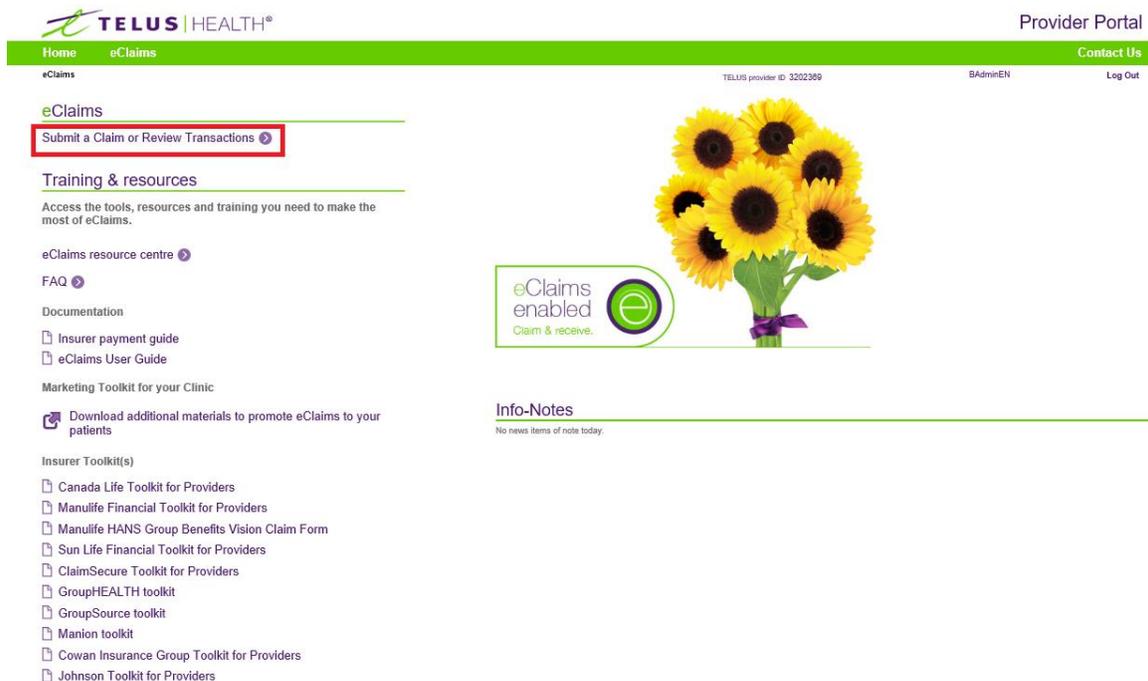
6. Click **I Accept**.

The TELUS Health Provider Portal home page displays:



Depending on your account access, you may be able to access submission applications through the Portal.

- To access the eClaims application, click on either of the two “eClaims” links circled above. The eClaims home page will be displayed:



- To submit a claim or review transactions, click on “Submit a Claim or Review Transactions” circled above. The **[Claim Entry]** tab will appear by default:



TELUS HEALTH

Provider Portal

Home eClaims Contact Us

eClaims > Submit a Claim or Review Transactions Lena Bones Log Out

Submit a Claim or Review Transactions

Claim Entry Today's Transactions Past Transactions Authorization Forms

Frequently Asked Questions User Manual

If you do not have access, you will get the User Access Alert message.

User Access Alert:

You are currently not registered in the eClaims program. If you are interested in submitting electronic health claims to other Payers, please register with TELUS Health - Provider Registration Team by using the following [hyperlink](#).

2.2 Getting help logging in

There are a few ways to get help if you cannot remember your user name or password, or are unable to log in for another reason.

2.2.1 Obtaining your user name

If you have forgotten your user name, you can request that it be sent to the email account associated with your user name.

To obtain your user name:

1. From the desktop, open the Internet browser (e.g. Internet Explorer).
2. In the address box, type <https://providereservices.telushealth.com> and press <Enter>.

The system displays the Login window.

3. Click the Forgot my username link that is circled below.



Log in

Username *

Username assigned by TELUS Health

Password *

[Log in](#)

Register for our services

Make life easier for your patients by directly billing — on their behalf — the participating insurers who cover 85% of privately-insured Canadians.
[Register for eClaims >](#)

Enhance service for people with workplace injuries in Ontario by streamlining communications with WSIB.
[Register for WSIB >](#)

Submit paper claims and receive direct deposit payments from participating insurers.
[Register for direct deposit >](#)

No cheques. No forms. No stamps. Paying taxes can be a lot easier.
[Learn more about paying your taxes online >](#)



Trouble logging in?

[Forgot my username >](#)

[Forgot/reset my password >](#)

[Forgot both?](#)

If you need help to log in, please contact TELUS Health at 1-866-240-7492, Monday to Friday, from 8:00 a.m. to 8:00 p.m. ET.

You may also encounter problems logging in if:

- You entered an invalid username or password
- The Caps Lock key is turned on
- Your account was locked after 5 consecutive invalid login attempts

My security profile

[Update my security profile information >](#)

Use this link to review and/or update your security profile information.

The system displays the Forgot username window.



Forgot username

Email *

Enter the email address associated with your username and password.
 Your username will be sent to this address.

If you don't know which email address to enter, please contact TELUS Health at 1-866-240-7492, Monday to Friday, from 8:00 a.m. to 8:00 p.m. ET.

[Cancel](#) [Submit](#)

4. Type your email address in the **Email** field, and click **Submit**.
5. Go to your email inbox, and retrieve the email that you were sent.
6. Log in using the user name that was provided in the email.

2.2.2 Resetting your password

If you have forgotten your user name, you can reset it from the Login window.

To reset your password:

1. From the desktop, open the Internet browser (e.g. Internet Explorer).
2. In the address box, type <https://providereservices.telushealth.com> and press <Enter>. The system displays the Login window.
3. Click the Forgot/reset my password link that is circled below.

TELUS | HEALTH®

Log in

Username *

Username assigned by TELUS Health

Password *

Log in

Register for our services

Make life easier for your patients by directly billing — on their behalf — the participating insurers who cover 85% of privately-insured Canadians.
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Enhance service for people with workplace injuries in Ontario by streamlining communications with WSIB.
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You may also encounter problems logging in if:

- You entered an invalid username or password
- The Caps Lock key is turned on
- Your account was locked after 5 consecutive invalid login attempts

My security profile

[Update my security profile information >](#)

Use this link to review and/or update your security profile information.

The system displays the Forgot/reset my password window.

TELUS | HEALTH®

Forgot/reset my password

Username *

Enter the username of the account for which you forgot the password, then click the 'Next' button to retrieve your security questions.

Username assigned by TELUS Health

Cancel **Next**

4. Type your user name in the **Username** field, and click **Next**. The system displays the Forgot/reset my password window.



Forgot/reset my password

Username

Username assigned by TELUS Health

Security question 1 <input type="text" value="In what city or town was your first job?"/>	Answer 1 * <input type="text"/>
Security question 2 <input type="text" value="Who was your childhood hero?"/>	Answer 2 * <input type="text"/>
Security question 3 <input type="text" value="Which country did you go to on your first flight?"/>	Answer 3 * <input type="text"/>

New password *

Confirm new password *

Must start with an alphabetic character
 Must be a minimum of 8 characters long, including at least:

- 2 alphabetic characters
- 1 uppercase letter
- 1 lowercase letter
- 1 numeric character

Must not match or contain:

- First name
- Last name
- Username

Must not contain spaces

5. Type in your answers to the three security questions.
6. Type your new password in both the **New password** and **Confirm** new password fields.
7. Click **Submit**.

You can now log in with the new password you set in step 6.

2.3 Moving around in the Provider Portal System

The information provided in this section will guide you through the basics of moving around in the Provider Portal System. A brief description of menus/instructions is included.

2.3.1 About the Navigation Bars

The Provider Portal System has a main navigation bar that is visible on every page of the Provider Portal application. A detailed description of each option follows.



2.3.2 Provider Portal navigation bar commands

Before going any further, you should learn about the commands available on the navigation bar and the tasks you can perform using them.

- **Home:** this link takes you to the Provider Portal's home page. Depending on your access, you may see submission applications.
- **WSIB:** this link, when applicable, takes you to the home page of the Workplace Safety and Insurance Board of Ontario services.
- **eClaims:** this link takes you to the home page of the eClaims application, from which you can submit claims, review transactions and access supporting information related to eClaims.
- **Contact Us:** this link takes you where you can contact TELUS Health by filling out and submitting an online form and where you will find the TELUS Health Service Desk contact information.
- **Logout:** enables you to logout. Using the Portal Logout functionality will end your session, and log you out of the Portal and the application(s) within the Portal.

2.4 Moving around in the Extended Healthcare application

The information provided in this chapter will guide you through the basics of moving around in Extended Healthcare application of the TELUS Health Provider Portal. A brief description of the tabs as well as instructions for submitting and viewing transactions is included.

2.4.1 About the navigation tabs

The TELUS Health Provider Portal always has a main navigation bar displayed and additional navigation tabs when in the Extended Healthcare application. A description of each tab follows.



Provider Portal navigation bar



eClaims navigation tabs

2.4.2 eClaims navigation tabs

The following tabs are available in the Extended Healthcare navigation bar.

Claim Entry: this tab takes you to the first screen from which you can enter and submit a payment or predetermination (treatment plan) request to your patient's Insurance Company.

Today's Transactions: this tab takes you to where you can search for and view a transaction done during the day. From this tab, you will be able to view the original details submitted, the response generated or print or save an electronic copy of the response.

Also use this tab when you wish to cancel a payment request that the Insurance Company responded to with an Explanation of Benefits or an Acknowledgement.

Past Transactions: this tab takes you to where you can search for and view a summary of a transaction done in the current month or in the previous month. This view excludes the transactions done during the day.

Authorization Forms: this tab takes you to the page where you can access consent forms for your patient or patient's parent/guardian to sign when submitting a request electronically or when the patient assigns payment over to the provider or the provider's organization.

2.5 General Tips

2.5.1 Working with the Mouse

Moving the mouse moves the mouse pointer around the window. Nothing else happens unless you press the left mouse button.

You can do the following with the mouse button:

- **Click** – Press down on the mouse’s left button and quickly release it anywhere on the window. This moves the mouse cursor to a new position.
- **Press** – Hold the mouse’s left button down, keeping the mouse stationary. This performs the select function only if you click on an object.
- **Hover** – Moving the mouse pointer over certain fields for a few seconds, without clicking a mouse button, will invoke a pop up description or helpful hint.
- **Drag and Drop** – Hold the mouse’s left button down, move the mouse, and then release the mouse button. If you click on an object or text (or select it) while holding the mouse button down, then move the mouse to another location on the window and release it, the object or text will be dragged with the mouse to a new location on the window.
- **Double-click** – Press down on the mouse’s left button twice in a row. This is usually a quick way to perform two steps in one – select and execute a command. Commands in this application only require a single click.

2.5.2 Paging

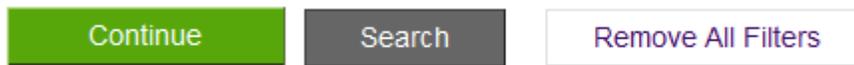
The Extended Healthcare application enables you to use the left or right arrows, as available, in your searches to display the information that you are specifically looking for.

In the Search Results section, click [Next »](#) to view the records of the next page. Click [« Previous](#) to view the records of the previous page.

You can also click on the tab name of the page you wish to view.

2.5.3 Command buttons

Buttons are green or grey with a white label, or white with a purple label.



Clicking on a button will activate the function associated to it. Each button will execute a certain function based on where the button is available. A button’s functionality is described as part of the section it is available in.

2.5.4 Entering and Deleting Data

The areas in a window where data or information is entered or selected are known as fields. Fields exist in a number of different formats with various methods for entering or selecting data.



Some fields are mandatory whereas others are optional. Fields displayed with a red asterisk () are mandatory. Some fields are only mandatory depending on the value entered in a different field.*

For example:

- A field may be a text box that you type directly into.

- A small box that is checked ✓ when clicked.

- An option button that is filled in black ● when selected.

- A box filled by choosing an option from a drop-down list displayed when clicking the down arrow of the box.

To Enter Data:

1. To enter data in a window, click once in the appropriate box with your left mouse button.
2. Enter the data.

To Delete Data:

- Highlight the data with the mouse (click and drag), and then press **Delete**, OR
- Highlight the data and type over with the correct data, OR
- Backspace to erase the entry one character at a time.

2.5.5 Sorting lists

A user can sort data displayed in a table in ascending or descending order by clicking on a column header that is underlined.

<u>Web Claim ID</u>	<u>Provider</u>	<u>Submit Date</u>	<u>Request Type</u>	<u>Insurance Company</u>	<u>Submit Status</u>	<u>Insurance Co. Claim ID</u>	<u>Response Status</u>	<u>Patient Name</u>	Total Submitted	Total Paid
<input checked="" type="checkbox"/> 166557	Lena Bones	2014-05-07	Payment Request	MBCM	Submitted	3817581	Explanation of Benefits	Rudd, Ami	\$9.71	\$8.27
<input type="checkbox"/> 166548	Lena Bones	2014-05-07	Payment Request	MBCM	Submitted	3817574	Explanation of Benefits	rudd, elizabeth	\$8.50	\$0.00
<input type="checkbox"/> 166544	Lena Bones	2014-05-07	Payment Request	MBCM	Submitted	3817564	Explanation of Benefits	rudd, elizabeth	\$8.50	\$0.00

Place the mouse pointer over the column header and left click. The system will sort the data in ascending order or if already sorted by that column, it will sort the column in the opposite order than currently sorted. It is possible to sort in ascending or descending order.

- If the column has a triangle that points up (▲), the records are sorted in ascending order based on the values in that column.
- If the column has a triangle that points down (▼), the records are sorted in descending order based on the values in that column.



It is possible to sort on multiple columns. The last column header selected will be the primary column used by the application to sort the search results.

If a column is a secondary sort, it will have a [2] next to the triangle; if the column is a tertiary sort, it will have a [3] next to the triangle, and so on.

2.5.6 Hyperlinks

When text is presented underlined, it allows the user to open another window corresponding to the text:

Electronic transmission consent

Obtain consent to submit claims electronically on behalf of your patient

Benefit assignment

Obtain consent to receive payment from the patient's insurer

 [English](#)

|  [French](#)

Place the mouse pointer over the underlined text and left click. The system will open a new window corresponding to the selection.

2.5.7 Using the Date Calendar tool

Some date fields in the system have a pop-up window that allows you to view a calendar to assist in entering a date. This functionality is accessed by clicking on the  icon beside the date box that will display the calendar or by mouse clicking into the date type-in box.

May, 2013						
<<	<	Today			>	>>
Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	
Select date						

The tool allows selection of date in the following ways:

- Use the  and  buttons to move back and forth one month at a time. Hold mouse button on any of the above buttons to display a drop-down list of the months allowing a faster selection of the month.
- Use the  and  buttons to move back and forth one year at a time. Hold mouse button on any of the above buttons to display a drop-down list of 24 years allowing a faster selection of the year.
- Click on the specific day and the date will fill the date box of the previous window.
- Click on "Today" to select today's date
- The 'Drag to move' message will appear at the bottom of the Calendar tool when your mouse is at the top of the bottom of the Calendar tool. When this happens, keep the mouse button pressed to move the calendar.
- If you wish to make Sunday the First day of the week, click on "**Mon**"
- If you wish to make Monday the First day of the week, click on "**Sun**"
- If you do not wish to select a date, click the  in the top right corner to close the calendar tool.



If you access the date field using the Tab key from the previous field, the calendar will NOT popup.

If you click the calendar tool with the left button on the mouse, the calendar will open.

2.5.8 Help icons

Certain important fields in the application have an image or a PDF document with pertinent information in relation to the field or the section accessible to the user

- Click on the  help icon of the field or the section to display an image or a pdf document with pertinent information for the user.

2.5.9 Minimizing, Resizing or Closing an Application Window

Any window that can be closed has a control bar  on the top-right corner of the window with Minimize, Resize and Close buttons.

To Minimize, Resize or Close a window:

- Click  to minimize the window.
- Click  to resize the window.
- Click  to close the window. You may be prompted to save the work you have done.

If you are prompted to save your work, click **Yes** to save it, **No** to exit without saving it or **Cancel** to cancel your last action.

2.5.10 Capturing a Screenshot

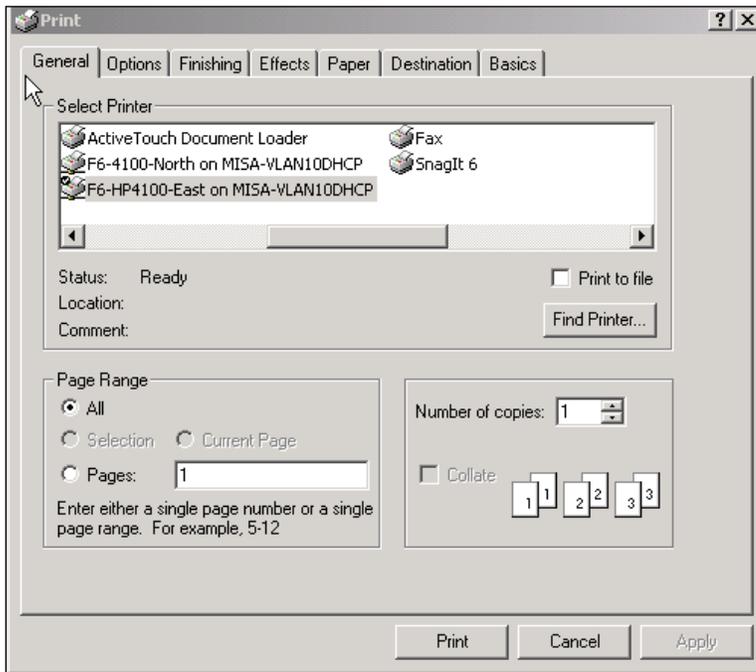
If you wish to capture a screenshot, follow the steps below:

1. Using your keyboard, press <Alt> + <Print Scrn>. This copies the window to the clipboard.
2. Go to **Start, Programs, Accessories** and select **Paint** from the pop-up menu. The Paint Program displays.

Important: If you are capturing a large number of screens, it is **highly** recommended that you invest in screen capturing software such as Snag it or other similar ones. Using Paint to capture multiple screens will **increase your file size significantly** and may present some file management challenges.

3. Choose **Paste** from the Edit menu. The window displays the captured window.
4. From the File menu, select **Print**.
5. Click **Print**.

You are prompted to select the appropriate printer from the print dialog box.



6. Select the printer, and click **Print**.

2.6 PC Configuration Requirements to use the Provider Portal

To ensure expected operation of the Provider Portal application, the following guidelines for configuration and set-up of the PC apply:

Hardware

- Personal Computer
 - a. Computer with at least a Pentium III processor or better
 - b. Minimum 128 Meg memory
 - c. Graphics adapter with 8 Meg memory
 - d. A minimum Windows resolution of 1024x768 is **HIGHLY** recommended for best performance to display screens as per their original design. The 800x600 Windows resolution is supported, but is **not** recommended because column contents and headers in tables will appear misaligned or appear on more than one line (which can make reading the table at a glance a bit confusing).
- Router – in the case of home or office internet access through a network
 - a. Port 443 must allow connections for all functions on the router

Software

- Operating System
 - a. One of:
 - i. Windows Vista
 - ii. Windows 7
 - b. Port 443 must allow connections for all functions on the operating system
 - c. Port 443 must allow connections for all functions on any firewall software on the PC
- Browser – capable of 128 bit encryption with JavaScript turned on
 - a. Internet Explorer: the latest version and the two previous versions are supported.
 - i. One of the following setting options is also recommended:
 - IE→Tools→Internet Options→General→Temporary Internet files
→Settings→check for newer versions of stored pages:
Recommended Options:
 - Every visit to the page (strongly recommended)
 - Automatically
 - ii. The following additional setting is recommended if internet is accessed through a proxy server:
 - IE → Tools → Internet Options → Advanced
Recommended Option:
 - Check “Use HTTP 1.1 through proxy connections”

- b. Firefox: the latest version is supported.

Note: unlike the behaviour of IE, opening a second instance of the browser is not considered a new session.



Enter key can only be used when a button is in focus.

The following setting is recommended for Firefox browser:

Firefox→Tools → Options→Privacy→Clear Your Recent History:

Recommended Option:

- Clear All History – Time range to clear ‘Everything’

- c. Chrome: the latest version is supported.

- d. Safari and other browsers are not supported.

- A valid user ID and password issued by TELUS Health

Internet Access

- Dial-up internet access from an Internet Service Provider (ISP)
- High speed internet access from an ISP
- Each Operating System and router brand has its own instructions on how to make changes to port settings, as does its firewall software. Please refer to your appropriate user manuals for the required steps.

2.7 Security Features of Provider Portal

TELUS Health places great importance on the security and privacy of its customers' health data.

To use or view information available through the Web interface, a provider and his staff must first be assigned a unique User ID and Password linked to the provider. This User ID and Password authenticates you to the system. The login also ensures that only requests associated with the Provider can be viewed by that user.

The system allows three attempts for you to correctly enter a User Name and Password before your account is locked. If your account becomes locked, you can wait for thirty minutes and the account will automatically be unlocked, or you can contact the TELUS Health Service Desk prior the thirty-minute timeframe.

If you close your browser without logging-out, your connection will close after 30 minutes. If the application sits idle for thirty minutes, you will also be logged-out. You can log back in immediately in this situation.

A User Name and Password are associated with a role in the system and this role determines the functions that you are able to perform. If you are not able to perform certain functions that you believe you should have access to, please contact the TELUS Health Service Desk.

You are required to change your password at the initial login and when your password has been reset by an Administrator.

The Home page will display a warning message below the "My Profile" section starting 10 days before your password's expiry date. The warning message will count down daily (10 to 0 days) until your password expires.

If it does expire, the only option you will have is to contact the TELUS Health Service Desk to have it reset. Please refer to the Managing Passwords section of this document for help in changing your password before it expires.

Your password is case-sensitive, should be a minimum of eight alphanumeric characters and a maximum of ten characters. It must have no spaces and be different from your user name. To ensure security, the previous six passwords that you have entered may not be reused.

Information that is transmitted between your PC and TELUS Health is encrypted.

2.8 Logging out of the eClaims application

Using the Portal Logout functionality will end your session, and log you out of the Portal and the application(s) within the Portal.

To log out:

1. From the Provider Portal Navigation bar, click **Log Out**.



Within a few seconds, the Login window displays.

TELUS HEALTH

Log in

Username*

Username assigned by TELUS Health

Password*

Log in

Register for our services

Make life easier for your patients by directly billing — on their behalf — the participating insurers who cover 85% of privately-insured Canadians.
[Register for eClaims >](#)

Enhance service for people with workplace injuries in Ontario by streamlining communications with WSIB.
[Register for WSIB >](#)

Submit paper claims and receive direct deposit payments from participating insurers.
[Register for direct deposit >](#)

No cheques. No forms. No stamps. Paying taxes can be a lot easier.
[Learn more about paying your taxes online >](#)

Trouble logging in?

[Forgot my username >](#)

[Forgot/reset my password >](#)

[Forgot both?](#)

If you need help to log in, please contact TELUS Health at 1-866-240-7492, Monday to Friday, from 8:00 a.m. to 8:00 p.m. ET.

You may also encounter problems logging in if:

- You entered an invalid username or password
- The Caps Lock key is turned on
- Your account was locked after 5 consecutive invalid login attempts

My security profile

[Update my security profile information >](#)

Use this link to review and/or update your security profile information.

2. If you wish to login again, please refer to the [Accessing the eClaims application](#) section or you can close your browser by clicking on the  button at the top-right of the browser window.

3 Submitting electronic claims

The eClaims application of the Provider Portal gives providers the ability to submit extended healthcare requests on behalf of their patients at the time the patient pays for the healthcare service with a real time result generated by the patient's Insurance Company.

Who Should Read this Chapter?

A user who will submit eClaims payment or predetermination requests to Insurance Companies.

3.1 Submitting a payment request

A payment request is submitted once the patient has actually received a healthcare service and the patient is covered by an Insurance Company that accepts electronic healthcare payment requests.



It is important to submit the payment request before the patient leaves in order to provide the patient with his Insurance Company's response. Delaying submission could result in the Insurance Company rejecting the request as many Insurers limit the number of days you have to submit a payment request.

“NOTE – at no time should a surcharge or an administration fee be levied to a plan member/patient for submitting their claim through the Provider Portal. The provider cannot charge a fee in any form, including increasing the dollar amount of the claim being submitted, nor a separate fee, over and above the claim amount for services rendered.”

Submitting a payment request is a 3-step process:

1. [Step 1 – Start Claim](#)
2. [Step 2 – Complete Patient Coverage and Claim Details](#)
3. [Step 3 – Review and Submit](#)

3.2 Step 1 - Start Claim

The **Start Claim** page is the first page displayed of the **[Claim Entry]** tab.

The screenshot shows the TELUS Health Provider Portal interface. At the top right, it says "Provider Portal". Below that is a navigation bar with "Home", "WSIB", "eClaims", and "Contact Us". The "eClaims" tab is active. Below the navigation bar, the breadcrumb "eClaims > Submit a Claim or Review Transactions" is visible, along with the user name "Pamela Anderson" and a "Log Out" link. The main heading is "Submit a Claim or Review Transactions". Below this is a progress indicator with three steps: "1 Start Claim", "2 Today's Transactions", and "3 Past Transactions". There are also links for "Frequently Asked Questions" and "User Manual". The "Start Claim" section contains the following fields:

- Insurance Company***: A dropdown menu with "Select" as the current value.
- Servicing Location***: A dropdown menu with "56 Bloomfield ~ Hills, Mississauga, ON K1B 2C3" as the current value and a help icon.
- Servicing Provider***: A dropdown menu with "DR. Pam Anders, Chiropractor" as the current value and a help icon.
- Request Type**: Two radio button options: "Payment Request" (which is selected) and "Predetermination Request".

At the bottom of the form is a green "Continue" button.

To submit a payment request:

1. Log into the Provider Portal. Ensure that the user name and password used to log into the Portal correspond to a user that can submit extended healthcare claims for the provider who performed the service(s) at the location where the services were rendered.
2. Ensure that **[Claim Entry]** is the tab currently displayed (will have a white background). The **Start Claim** page is the default view displayed when first selecting Submit a Claim or Review Transactions on the eClaims Home page. If this window is not displayed, click the **[Claim Entry]** tab.
3. Select the **Insurance Company** on behalf of whom you are submitting the request.
4. Select the **Servicing Location** corresponding to where the patient received the service(s). When the user is associated to a single servicing location, this servicing location will automatically be selected.



If you notice an incorrect address, you must contact the TELUS Health – Provider Registration Team at 1-866-240-7492 to inform them of the correct address.

The address selected is the address that will be used to send payments when the payment recipient is the provider or the provider's organization.

5. Select the **Servicing Provider**. The provider selected must correspond to the provider from whom the patient has received the service(s).



When the organization represents an optical supplier, the provider selected must correspond to the provider who is considered responsible for the services or products received by the patient.

If a provider or a servicing location is not listed, it can be because the wrong user name was used to log into the Portal. Simply logout and login with the correct user name.

The provider or location may also not be listed for one of the following reasons:

- *The provider or location is NOT registered for the eClaims service, OR*
- *The user was NOT identified as being able to use the eClaims application on behalf of the provider, OR*
- *The user was NOT identified as working at the servicing location.*

In the above cases, the provider must contact the TELUS Health – Provider Registration Team at 1-866-240-7492, to register or to have the user added as a delegate for the provider/location.



6. Select **Request Type** value **Payment Request**.
7. Click **Continue**.

Note: If the selected Insurance Company has restrictions on the type of eClaims services they can support, you may be presented with a [Problem Encountered](#) message requesting that a manual submission be made.

3.3 Step 2 - Complete Patient Coverage and Claim Details

The second page of the [Claim Entry] tab displays the fields where you can continue to enter the payment request information.

TELUS HEALTH Provider Portal

Home eClaims Contact Us

eClaims > Submit a Claim or Review Transactions Lena Bones Log Out

Submit a Claim or Review Transactions

Claim Entry (2) Today's Transactions Past Transactions Authorization Forms Frequently Asked Questions User Manual

Complete Patient Coverage and Claim Details

Provider Name: **Lena Bones** Servicing Provider: **Lena Bones, Chiropractor, 340 Lovely Road, Brampton** Request Type: **Payment**

Patient Information

First Name * Middle Name Last Name * Date of Birth * Search for a recent patient
yyyymmdd ?

Birth Order: Not applicable/Unkno Gender: Select

Primary Coverage Information

Relationship * Member First Name * Middle Name Member Last Name * Date of Birth *
yyyymmdd

Insurance Company * Policy * Member ID * Benefit Type *
 Simulated Adjudicator ? ? Extended Health Care ?

Secondary coverage available? *
 Yes
 No

Additional Claim Information

Payable To * Predetermination#
 Select

Is this an injury caused by an accident? *
 Yes
 No

Was this service prescribed or a referral? *
 Yes
 No

Claim Lines ?

Line	Date of Service *	Service Code *	Quantity *	Duration(min)	Cost per Unit *	Service Cost	
1	<input type="text"/>	<input type="text"/> ?	<input type="text"/>	<input type="text"/>	<input type="text"/>		
2	<input type="text"/>	<input type="text"/> ?	<input type="text"/>	<input type="text"/>	<input type="text"/>		
3	<input type="text"/>	<input type="text"/> ?	<input type="text"/>	<input type="text"/>	<input type="text"/>		

yyyymmdd

This page contains the following sections and will be described in detail:

- Provider Information
- Patient Information
- Primary Coverage Information
- Secondary Coverage Information
- Additional Claim Information
- Claim Lines
- Command buttons

3.3.1 Provider Information

The top section of the page displays information based on the selections made on the **Start Claim** page. The **Provider Name** displayed on the left of the section corresponds to the provider profile associated to the user. The selected **Servicing Provider and Address** displayed corresponds to the selections made on the previous page. The Request Type previously selected displays on the right. None of the information displayed in this section can be modified on this page.

To modify the **Request Type** and/or the **Selected Insurance Company, Provider and Address**, you must return to the **Start Claim** page using the **Cancel and Exit** button. If the address on file is incorrect, you must contact the TELUS Health – Provider Registration Team at 1-866-240-7492.

3.3.2 Patient Information

This section supports a search for a patient with a transaction in the past 16 months.

Typing two characters in either the First Name or Last Name field will enable the **Search** button. First Name or Last Name is mandatory. A minimum two characters is required in these fields:

- First Name: implicit wildcard search
- Last Name: implicit wildcard search

The following search criteria are also supported in combination with the above:

- Middle Name: explicit match
- Date of Birth: full date, explicit match
- Gender: explicit match
- Birth order: explicit match

When you click the **Search** button, a search will be executed based on your defined criteria and the results will be provided to you in the **Patient Search Results** pop-up window:

Patient Search Results

The following patients have successfully submitted a claim through eClaims within the past sixteen months.

A patient's personal information (such as last name or policy number) may change. The topmost row of the search results will display the patient's latest information. Ensure that you select the correct row for the claim to be processed.

	Patient	Member	Policy/Member ID
<input type="radio"/>	Brian Simpson, 1948-10-04, Male ,Insured Member	Brian Simpson	845785362/ A785492
<input type="radio"/>	Sally Simpson, 1952-10-17, Female ,Insured Member	Sally Simpson	54821586/ A451158

If the search results provided you with the correct patient, you can choose a patient and then click **Select**. The **Patient Search Results** pop-up window will close and your selection will be used to populate most of the entry page.

If the search results were not favourable, you can click **Cancel**. You will be returned to the entry page where you can enter in the new patient information.



eClaims retains a maximum of 16 months of data, and is refreshed at the beginning of each month. If your patient does not appear in the search results, the patient's name may have already been purged from the database.

If you do not wish to use the Patient Search functionality or have a new patient to enter, you can complete the Patient Information section by filling out every field.

All mandatory fields prefixed with a red asterisk (*) must be filled.

For the patient's **Date of Birth**, you can type a date in the following formats: yyyy-mm-dd, yyyymmdd or yyyy-m-d. The date will display as yyyy-mm-dd. You can also select a date using the Calendar tool.

To complete this section:

1. Fill out the Patient Information section.

The following table provides a description of the fields in this section.

Field	Description
First Name	The first name of the patient.
Middle Name	The middle name of the patient.
Last Name	The last name of the patient.
Date of Birth	The date of birth of the patient. You can type a date in the format yyyymmdd, yyyy-m-d, or yyyy-mm-dd. The date will display as yyyy-mm-dd. You can also select a date using the Calendar tool. The date of birth can be no earlier than January 1 st , 1900.
Birth Order	The order of birth of the patient when more than one dependent has the same date of birth; for example, where the patient is part of a multiple birth. The available values are: <ul style="list-style-type: none"> ■ Not applicable/Unknown ■ Numbers 1 thru 9
Gender	The gender of the patient. The following values are available: <ul style="list-style-type: none"> ■ Female ■ Male ■ Unknown (use this value when the patient's gender is unknown or other)

3.3.3 Primary Coverage Information

This section enables you to enter information about the primary coverage holder, including the basics of their coverage details. All mandatory fields prefixed with a red asterisk (*) must be filled.



Refer to the [Coordination of benefits - determining order of coverage](#) section for information about determining the order of coverage that the request should be submitted against.

To complete this section:

1. Fill out the Primary Coverage Information section by obtaining from your patient or his/her parent/guardian the coverage information to which the payment request must be submitted to **first**.

Primary Coverage Information

Relationship * Member First Name * Middle Name Member Last Name * Date of Birth

Insurance Company * Policy * Member ID * Benefit Type *

Secondary coverage available? *
 Yes
 No



If the Relationship value **Insured Member** is selected, the member name and date of birth will automatically be populated with the same values entered for the patient.

The following table provides a description of the fields in this section.

Field	Description
Relationship	<p>This field is used to indicate the relationship between the patient and the person who holds coverage. The following values are available:</p> <ul style="list-style-type: none"> ■ Insured Member: use this value when the patient and the person who holds coverage are the same person. When this value is chosen, the member name and date of birth will automatically be populated with the same values entered for the patient. ■ Spouse: use this value when the patient is the spouse of the person who holds coverage ■ Child: use this value when the patient is the child of the person who holds coverage ■ Handicapped Dependent: use this value when the patient is a handicapped child of the person who holds coverage ■ Part Time Student: use this value when the patient is the child of the person who holds coverage and is a part time student at a post-secondary institution ■ Full Time Student: use this value when the patient is the child of the person who holds coverage and is a full time student at a post-secondary institution ■ Domestic Partner: use this value when the patient cohabits with the person who holds coverage but is not considered the person's spouse

Field	Description
Member First Name	The first name of the person who holds primary coverage.
Middle Name	The middle name of the person who holds primary coverage.
Member Last Name	The last name of the person who holds primary coverage.
Date of Birth	The date of birth of the person who holds primary coverage. You can type a date in the format yyyyymmdd, yyyy-m-d, or yyyy-mm-dd. The date will display as yyyy-mm-dd. You can also select a date using the Calendar tool. The date of birth can be no earlier than January 1 st , 1900.
Insurance Company	The Insurance Company you selected on the Start Claim page.
Policy	The policy number provided by the patient or the patient's parent/guardian.
Member ID	The member identification number provided by the patient or the patient's parent/guardian.
Benefit Type	The type of policy the request is being submitted against. Extended Health Care is the only value available at this time.

- If the patient has additional healthcare coverage, you must indicate **Yes** by clicking the yes option button to the question **Secondary coverage available?** This will make the Secondary Coverage section display. By default, the option **No** is selected.
- If the patient does not have additional healthcare coverage, you can go directly to the [Additional Claim Information](#) section.
- If the patient has additional healthcare coverage, also complete the [Secondary Coverage Information](#) section.



Click the Help icon  found on either side of the Policy and Member ID fields to display an image of the card of the insurance company selected. This image will help the user identify the information needed in the fields.

3.3.4 Secondary Coverage Information

This section is where you enter information about the member who holds secondary coverage and the corresponding coverage information. The section displays only when the value **Yes** is selected for the question **Secondary coverage available?**. Fields prefixed with a red asterisk (*) must be filled when there is secondary coverage.

Secondary Coverage Information

Relationship: * Select	Member First Name * [Text Field]	Middle Name: [Text Field]	Member Last Name * [Text Field]	Date of Birth [Calendar Icon] yyyyymmdd
Insurance Company * Select	Policy [Text Field] ?	Member ID [Text Field] ?	Benefit Type * Extended Health Care [Dropdown] ?	

To complete this section:

1. Fill out the Secondary Coverage Information section by obtaining from your patient or his/her parent/guardian the coverage information to which the payment request must be submitted to next.



If the insurance Company is not listed, select the value "Other Health Care Insurance Company".

2. The field definitions in this section are the same as in the Primary Coverage Information section. At this time, it is only possible to enter two instances of extended healthcare coverage.
3. Once the section is completed, continue to the [Additional Claim Information](#) section.



Click the Help icon ? found next to the Policy and Member ID fields to display an image of the card of the insurance company selected. This image will help the user identify the information needed in the fields.

3.3.5 Additional Claim Information

This section is where you enter information that is relevant to the claim in general. Fields prefixed with a red asterisk (*) must be filled.

The Additional Claim Information displayed is based on the servicing provider selected on the **Start Claim** page.

The following provides what the Additional Claim Information section looks like for a payment request based on the type of service(s) being submitted:

- Additional Claim Information section if submitting physiotherapy service(s):

Additional Claim Information

Payable To * Predetermination#

Provincial insurance exhausted?

Is this an injury caused by an accident? *

Yes

No

Was this service prescribed or a referral? *

Yes

No

- Additional Claim Information section if submitting other specialized service(s):

Additional Claim Information

Payable To * Predetermination#

Is this an injury caused by an accident? *

Yes

No

Was this service prescribed or a referral? *

Yes

No

- Additional Claim Information section if submitting vision care service(s):

Additional Claim Information

Payable To * Predetermination#

Is this an injury caused by an accident? *

Yes

No

Was this service prescribed or a referral? *

Yes

No

To complete this section:

1. Determine who will receive the payment. The available values depend on who registered for the Extended Healthcare service, the provider or the organization the provider works for.

The following provides the definition of each **Payable to** values:

- **Insured Member:** use this value when you want the amount paid by the Insurance Company to go to the person who holds the coverage.
- **Servicing Provider:** use this value when you want the amount paid by the Insurance Company to go to the provider who rendered the services and is associated to the claim.
- **Clinic/Organization:** use this value when you want the amount paid by the Insurance Company to go to the clinic or organization that the provider works for.



*The values **Servicing Provider** and **Clinic/Organization** will never be available at the same time. The values available depend on the provider the user is associated to.*

2. If the payment request is related to a predetermination (or treatment plan) accepted by the Insurance Company, enter the Insurance Company identifier assigned to the predetermination.
3. If the treatment was given to the patient as a result of an accident, answer **Yes** to the question **Is this an injury caused by an accident?** to make the **Accident Type** and **Accident Date** fields appear. By answering **Yes**, the fields related to the accident become mandatory.

<p>Is this an injury caused by an accident? *</p> <p><input checked="" type="radio"/> Yes</p> <p><input type="radio"/> No</p>	<p>Accident Type</p> <p>Select ▼</p>	<p>Accident Date</p> <p><input type="text" value=""/>📅</p> <p>yyymmdd</p>
---	--	--

- 3.1. Obtain from the patient the type of accident that occurred.

The following provides the definition of each **Accident Type** value:

- **Workplace:** use this value when the type of accident was work related.
- **Motor vehicle:** use this value when the type of accident was related to a motor vehicle accident.
- **Other:** use this value if the type of accident is not listed.

- 3.2. Obtain from the patient when the accident occurred. Enter the accident date in a numeric format of yyyy-mm-dd, yyymmdd or yyyy-m-d. The date field format will display in yyyy-mm-dd, or select a date using the Calendar tool.

4. If the treatment that was given to the patient was not as a result of an accident, answer **No** to the question **Is this an injury caused by an accident?**. You must always answer the question, as there is no default value pre-selected for you.

5. If the treatment was given as a result of a prescription or a referral, answer **Yes** to the **Was this service prescribed or a referral?** question to make the **Prescriber Type**, **Prescriber Last Name** and **Prescriber First Name** fields appear. By answering **Yes**, the fields related to the healthcare professional that prescribed or made the referral become mandatory.

Was this service prescribed or a referral? *

Yes

No

Prescriber Type: Select

Prescriber First Name: [Text Field]

Prescriber Last Name: [Text Field]

- 5.1. Obtain from the patient the relevant prescription or referral information. Select the type of healthcare professional that prescribed the service(s) or made the referral (**Prescriber Type**).

The **Prescriber Type** corresponds to the type of healthcare professional that provided the prescription or referral.



The list of healthcare professional types is based on the type of servicing provider selected as servicing provider. For example, for vision care claims, the vision healthcare specialists will be available for selection.

The following provides the definition of each **Prescriber Type** values possible based on the type of healthcare claim being submitted.

- **Physician:** use this value when the healthcare professional that provided the prescription or referral is a medical doctor or physician.
- **Optometrist:** use this value when the healthcare professional that provided the prescription or referral is an optometrist.
- **Ophthalmologist:** use this value when the healthcare professional that provided the prescription or referral is an ophthalmologist.

- 5.2. Enter the name of the healthcare professional who prescribed the service(s) or made the referral.
6. If the treatment given to the patient was not the result of a prescription or a referral, answer **No** to the question **Was this service prescribed or a referral?**. You must always answer the question; there is no default value pre-selected for you.

7. When the healthcare claim is for physiotherapy services, the question **Provincial insurance exhausted?** will be displayed. Depending on the provincial government health care plan of the province where the patient is covered, it may be necessary for you to indicate if the coverage by the provincial healthcare plan has been fully exhausted. If this is the case, check the box. The box can be unchecked if clicked by mistake.

Provincial insurance exhausted?



In certain provinces, it is not permitted to submit healthcare expenses covered by the provincial plan to a private healthcare Insurance Company until the provincial coverage has been fully exhausted.

3.3.6 Claim Lines

This section is where you enter information corresponding to the services that the patient has actually received. Fields prefixed with a red asterisk (*) must be filled. You must enter a minimum of one line item in order to submit the request.

The fields available are described in the tables at the end of the Claim Lines section.



Click on the Help icon  found next to the Claim Lines to display if applicable, relevant information about service codes given by the insurance company.

The following provides what the Additional Claim Information section looks like for a payment request based on the type of service(s) being submitted:

- Physiotherapy service(s) and other specialized service(s):

Claim Lines 

Line	Date of Service *	Service Code *	Quantity *	Duration(min)	Cost per Unit *	Service Cost	
1	<input type="text" value=""/>		 				
2	<input type="text" value=""/>		 				
3	<input type="text" value=""/>		 				

yyyyymmdd

- Vision care service(s):

Claim Lines 

Line	Date of Service *	Service Code *	Quantity *	Cost per Unit *	Service Cost	Purpose	Eye	
1	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>		Select	<input type="checkbox"/> Left <input type="checkbox"/> Right	 
2	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>		Select	<input type="checkbox"/> Left <input type="checkbox"/> Right	 
3	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>	<input type="text" value=""/>		Select	<input type="checkbox"/> Left <input type="checkbox"/> Right	 

yyyyymmdd

To complete this section:

1. First, enter the **Date of Service**. Only a single date can be specified for a given line.
2. Enter a **Service Code** (or product code). You can also use the service code search tool to find and select a service code. Refer to the [Using the Service Code search functionality](#) section for more information on using the search tool.



The application will disable the service code search tool  if there is no Date of Service entered or an invalid Date of Service.



The Help icon  found next to the Service Code field will be deactivated if there is no Service Code entered or selected using the Service Code search functionality.

- Enter the **Quantity** for the claim line. The quantity should reflect the number of times the service code is being claimed on that date. For example, if the service represents a treatment, enter the number of treatments received on the date specified; if the service code represents X-rays, enter the number of films (or views) being claimed; if lenses are claimed, enter the number of lenses being claimed. For Vision claims, quantity should also reflect the number of times the service code is being claimed on that date.
The Quantity value must be set to '1', if the services performed are time based and the user will be entering in the number of minutes of the visit in the **Duration** field (when available).

Quantity*

- Enter the **Duration** for the claim line, if the services performed are time-based. The value will represent the number of minutes the services were rendered.
- Enter the **Cost per Unit** for the claim line. The entered value must represent the cost of one **Quantity** instance of the service code being claimed or the entire cost of the **Duration**.

The application will automatically calculate the **Service Cost** when both fields have a value.

Quantity *	Duration(min)	Cost per Unit *	Service Cost
<input type="text" value="1"/>	<input type="text" value="30"/>	<input type="text" value="60"/>	\$60.00
<input type="text" value="5"/>	<input type="text"/>	<input type="text" value="10"/>	\$50.00

- Enter the relevant information in the other available fields.

The following are display fields for each claim line submitted for all types of healthcare payment requests:

Field	Description
Line	This field represents the line number of the claim line. There is a maximum of 31 lines possible.
Service Cost	This field represents the amount claimed for the line. It is automatically calculated by multiplying fields Quantity and Cost per Unit .

The following fields are mandatory for each claim line submitted for all types of healthcare payment requests:

Field	Description
Date of Service	Use this field to enter the date that the patient received the service being submitted. You can type a date in the numeric format of yyyy-mm-dd, yyyymmdd or yyyy-m-d. The date field format will display in yyyy-mm-dd. Or select a date using the Calendar tool
Service Code	Use this field to specify the service or product associated to the claim line. You can choose to type a service code or select one using the search tool. Go to the Using the Service Code search functionality section for more information on how to use the search tool. You must enter or select a Service Code that is allowed to be rendered by the servicing provider selected on the Start Claim page.
Quantity	Use this field to specify the number of times this service code is being claimed on the date of service specified. For claims where Duration is available and entered, a value of '1' is required.
Cost per Unit	This field represents the cost of the service if the quantity value was 1.

The following fields are only available for **Vision Care** claims and are optional:

Field	Description
Eye	For vision care claims, you are able to identify if the service is related to a specific eye (Left or Right). Use the check box corresponding to the eye only when the service applies to one of the eyes. Click on the box again to deselect the eye. You cannot select both Left and Right at the same time. If the service code applies to both eyes, do not specify which eye. If you have clicked left or right by mistake, you may need to delete the incorrect line and add a new line.
Purpose	For vision care claims, you are able to identify the reason, need or purpose for the optical supply being claimed. This information is sometimes used by Insurance Companies to determine coverage of the service. Simply select one of the following values: <ul style="list-style-type: none"> ■ Initial prescription: use this value when the service is due to an initial vision care prescription. ■ Changed prescription: use this value when the service is due to a change in prescription. ■ Lost or broken: use this value if the service was the result of a lost or broken item such as glasses. ■ Refill prescription: use this value if the service was the result of refilling a prescription. ■ Other: use this value if the purpose or reason for the service is not listed. <p>Note: Use only for optical supplies, not services such as eye exams.</p>



*You cannot select both **Left** and **Right** eye at the same time. If the service code applies to both eyes, do not use these checkboxes.*

3.3.7 Using the Service Code search functionality

If you do not know what **Service Code** corresponds to the service rendered, you can use the search functionality to select a valid service code from the available service codes that can be submitted.

Claim Entry | Today's Transactions | Past Transactions | Authorization Forms | Frequently Asked Questions > | User Manual

Select Service Code

Select a service code from the list below. To search for a service code, select a category from the drop-down list, or input part of the code in the Service Code field.

Back to Claim | Category: Select | Service Code: | Search | Clear Results

Search Results
20 records were found.

Service Code	Category	Description
2.ZZ.02	Diagnostic	Assessment (examination or consultation), total body
7.SE.02.AW	Diagnostic	Environment assessment of workplace
3.xx.10	Imaging	Xray
6.VA.50	Instruction/Training	Motor and living skills training [includes occupational therapy/training for activities of daily living (ADL), training for use of assistive/adaptive devices]
7.SC.59.QH	Instruction/Training	Instruction for self-directed exercises
7.SP.10	Instruction/Training	Counseling [includes against (existing) health risk, health and safety practices, lifestyle]
7.SP.60	Instruction/Training	Education, promoting health and preventing disease [includes education for condition, disease, injury management, counseling for health and wellness]
7.SF.12.ZZ	Miscellaneous	Planning for other reason not elsewhere classified
7.SF.15	Miscellaneous	Brokerage Service [includes telephone advice, health advisory, clinical support, case management, monitoring, referral]
7.SJ.30	Miscellaneous	Documentation activity undertaken on behalf of the patient for external recipients
7.SJ.32.TD	Prescription Support Activity	Prescription for using assistive/adaptive device
1.ZX.10.HA	Treatment/Intervention	Acupuncture, multiple body sites using percutaneous (needle) approach
1.xx.02	Treatment/Intervention	Exercise (including brief assessment), assisting/supervising client in performing exercise [includes structured rehabilitation, work hardening/conditioning]
1.xx.04.HI	Treatment/Intervention	Mobilization/myofascial therapy (including brief assessment), using external approach with manual technique
1.xx.05.HI	Treatment/Intervention	Manipulation (including brief assessment), using external approach with manual technique
1.xx.06.IA	Treatment/Intervention	Hypothermy (including brief assessment), using external approach
1.xx.07.IA	Treatment/Intervention	Hyperthermy (including brief assessment), using external approach
1.xx.09	Treatment/Intervention	Stimulation (including brief assessment) [includes ultrasound, TENS, EMS, laser, IFC, etc.]
1.xx.xx	Treatment/Intervention	Brief assessment with multiple treatment interventions
1.xx.xx.HV	Treatment/Intervention	Brief assessment with multiple treatment interventions, at client's home



*The list of Service Codes available is based on the **Servicing Provider** selected on the **Start Claim** page.*

To use the search functionality:

1. Click on the  icon next to the **Service Code** box for the line you wish to find a service code. If there is no **Date of Service** or an invalid date entered for the line, the tool will be visible but disabled.
2. The **Select Service Code** page will be presented with a list of all the available service codes sorted by **Category**.
3. You may use **Category**, **Service Code** or a combination of the **Category** and **Service Code** fields to filter the results.

3.3.7.1 Searching using the category alone

To search for a service code using the category:

1. To search using the **Category** field, simply select a category from the list of available categories then click **Search**

The service codes in the selected category will display. For each code listed in the search results, the **Service Code**, the **Category** chosen and a long **Description** will display:

Back to Claim

Category
Treatment/Intervention

Service Code

Search

Clear Results

Search Results
9 records were found.

Service Code	Category	Description
1.ZX.10.HA	Treatment/Intervention	Acupuncture, multiple body sites using percutaneous (needle) approach
1.xx.02	Treatment/Intervention	Exercise (including brief assessment), assisting/supervising client in performing exercise [includes structured rehabilitation, work hardening/conditioning]
1.xx.04.JH	Treatment/Intervention	Mobilization/myofascial therapy (including brief assessment), using external approach with manual technique
1.xx.05.JH	Treatment/Intervention	Manipulation (including brief assessment), using external approach with manual technique
1.xx.06.JA	Treatment/Intervention	Hypothermy (including brief assessment), using external approach
1.xx.07.JA	Treatment/Intervention	Hyperthermy (including brief assessment), using external approach
1.xx.09	Treatment/Intervention	Stimulation (including brief assessment) [includes ultrasound, TENS, EMS, laser, IFC, etc.]
1.xx.xx	Treatment/Intervention	Brief assessment with multiple treatment interventions
1.xx.xx.HV	Treatment/Intervention	Brief assessment with multiple treatment interventions, at client's home



A category will be available for selection only if there is at least one Service Code in that category.

2. If no service code corresponds to the desired code, try a new search. If the service or product is not available, select a code that most corresponds to the desired service or product.
3. Click on the underlined code in the **Service Code** column that corresponds to the desired service or product. The system will return you to the **Claim Entry** page where the **Service Code** will be populated with the chosen service or product code.

Service Code *

1.xx.xx

4. To clear the search results and start a new search, click **Clear Results**.
5. To return to the previous page without selecting a service code, click **Back to Claim**.

3.3.7.2 Searching using the service code field alone

To search using the **Service Code** field:

1. Type in the full or partial service code desired, then click **Search**. The system will search for all service codes matching the text typed in the field.

Service Code

The service codes matching the entered text will display. For each code listed in the search results, the **Service Code**, the **Category** the code belongs to and a long **Description** will display:

Service Code	Category	Description
1.xx.02	Treatment/Intervention	Exercise (including brief assessment), assisting/supervising client in performing exercise [includes structured rehabilitation, work hardening/conditioning]
1.xx.04.H	Treatment/Intervention	Mobilization/myofascial therapy (including brief assessment), using external approach with manual technique
1.xx.05.H	Treatment/Intervention	Manipulation (including brief assessment), using external approach with manual technique
1.xx.06.A	Treatment/Intervention	Hypothermy (including brief assessment), using external approach
1.xx.07.A	Treatment/Intervention	Hyperthermy (including brief assessment), using external approach
1.xx.09	Treatment/Intervention	Stimulation (including brief assessment) [includes ultrasound, TENS, EMS, laser, IFC, etc.]
1.xx.xx	Treatment/Intervention	Brief assessment with multiple treatment interventions
1.xx.xx/HV	Treatment/Intervention	Brief assessment with multiple treatment interventions, at client's home

If no records match the entered text, the system will indicate that no records were found:

Search Results

0 records were found.

3.3.7.3 Searching using the category and service code combined

To search using the **Category** and **Service Code** field combined:

1. Select a **Category** from the available values.
2. Type in the full or partial service code desired, then click **Search**.

Category Service Code

The service code(s) matching the entered text available in the selected category will display. For each code listed in the search results, the **Service Code**, the **Category** the code belongs to and a **Long Description** will display:

Service Code	Category	Description
7.SE.02.AW	Diagnostic	Environment assessment of workplace

If no records match the entered text, the system will indicate that no records were found:

Search Results

0 records were found.

3.3.8 Adding Claim Lines

By default, three (3) lines are available in which to enter services. At the end of each line, you have the ability to add additional empty claim lines.

The recommended maximum number of claim lines is 10. However, it is possible for you to enter up to 31 lines if this is necessary. Reminder: a service code should be submitted on the day it took place so the majority of your payment requests will normally require less than 10 lines and most often 3 or less.



If the services make up more than 31 lines, you will have to submit two healthcare payment requests.

Claim Lines ?

Line	Date of Service *	Service Code *	Quantity *	Duration(min)	Cost per Unit *	Service Cost	
1	2014-05-16	3.xx.10	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
2	2014-05-14	<input type="text"/>					
3	2014-05-12	<input type="text"/>					
yyyyymmdd							



There will always be a minimum of 3 lines displayed.

If you require additional lines:

1. Click the button of the claim line under which you wish to add a new line.

For example, to add a line between lines 2 and 3, click on the button of line 2. A new empty claim line will be added between lines 2 and 3:

Claim Lines ?

Line	Date of Service *	Service Code *	Quantity *	Duration(min)	Cost per Unit *	Service Cost	
1	2014-05-16	3.xx.10	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
2	2014-05-14	<input type="text"/>					
3	<input type="text"/>						
4	2014-05-12	<input type="text"/>					
yyyyymmdd							



It is not possible to add a claim line above the first line.

- To add more than 10 lines, click **Add** when the following message displays:

The maximum recommended number of claim lines is 10. If you have additional lines to enter, click on the "Add" button. Click on Close otherwise.

Close
Add

- Click **Close** if you do not need to add more lines to your request.

3.3.9 Deleting Claim Lines

At the end of each line, you have the ability to remove a specific claim line.

Claim Lines ?

Line	Date of Service *	Service Code *	Quantity *	Duration(min)	Cost per Unit *	Service Cost	
1	2014-05-16	3.xx.10	<input type="text"/>	<input type="text"/>	<input type="text"/>		
2	2014-05-14	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
3	2014-05-12	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		

yyymmdd

If you need to remove a line:

- Click the **X** button of the claim line you wish to remove.
- To confirm deletion of the line, answer **Yes** to the question **Are you sure you wish to remove claim line #?**. Click **No** to cancel the delete request.

For example, to remove line 1, click on the **X** button of line 1. Answer **Yes** when the following message displays:

Are you sure you wish to remove this claim line?

No
Yes

Line 2 will become line 1; line 3 will become line 2; and so on:

Claim Lines ?

Line	Date of Service *	Service Code *	Quantity *	Duration(min)	Cost per Unit *	Service Cost	
1	2014-05-16	3.xx.10	<input type="text"/>	<input type="text"/>	<input type="text"/>		
2	2014-05-14	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
3	<input type="text"/>						

yyymmdd



There will always be 3 lines displayed.

Deleting the last line when there are 3 lines displayed will simply empty the line.

3.4 Step 3 – Review and Submit

Once the payment request has been completed, you can review and confirm the information before submitting the payment request to the Insurance Company.

The Insurance Company has a choice on whether or not they wish to invoke their own User's Terms and Conditions statement. If the Insurance Company chooses to invoke this feature, the statement will appear at the bottom of the page. You must 'Accept' the terms and conditions in order to continue with the submission of the request.

I ACCEPT the terms and conditions:

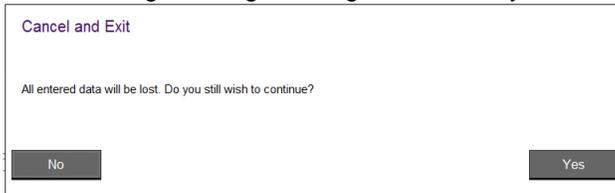
I confirm that all the information I have provided on the claim form is accurate and complete.

I confirm that I have the patient's permission to submit his request for payment of health care by electronic transmission.

If you want to cancel the information that was entered and return to the **Start Claim** page:



1. Click **Cancel and Exit**.
2. The following warning message will advise you that the entered information will be lost:

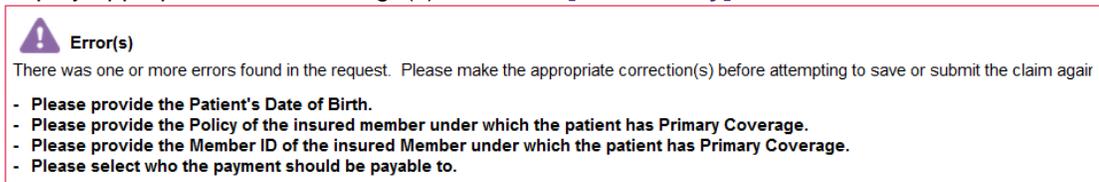


3. Click **Yes** if you wish to continue to an empty **Start Claim** page. The application will return you to a blank **Start Claim** page where you can start a new request.
4. Click **No** if you wish to return to the request and continue entering information.

If you want to continue and confirm the details of the payment request:



1. Click **Continue**. Note: If this button is not available, you must 'Accept' the Insurance Company's User Terms and Conditions statement. Once you 'Accept', the **Continue** button will be enabled.
2. If there were problems with the entered information, the **Claim Entry** page will remain and display appropriate error message(s) above the **[Claim Entry]** tab.



3. Once all errors are fixed, you can attempt to submit the payment request again by clicking **Continue**.

- If there are no errors with the request, the payment **Review and Submit** page will display:

TELUS HEALTH Provider Portal

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eClaims > Submit a Claim or Review Transactions Lena Bones Log Out

Submit a Claim or Review Transactions

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Review and Submit

Provider Name: **Lena Bones** Servicing Provider: **Lena Bones, Chiropractor, 340 Lovely Road, Brampton** Request Type: **Payment**

Patient Information

First Name: **First Name** Date of Birth: **1977-03-19**
 Middle Name: Birth Order: **Not applicable/Unknown**
 Last Name: **Last Name** Gender: **Unknown**

Primary Coverage Information

Relationship: **Insured Member** Insurance Company: **Simulated Adjudicator**
 Member First Name: **First Name** Policy: **55555**
 Middle Name: Member ID: **555555555**
 Member Last Name: **Last Name** Benefit Type: **Extended Health Care**
 Date of Birth: **1977-03-19**

Additional Claim Information

Payable To: **Insured Member** Service Prescribed/Referral: **No**
 Predetermination #: Prescriber First Name:
 Injury Caused by an Accident: **No** Prescriber Last Name:
 Accident Type: Prescriber Type:
 Accident Date:

Claim Lines

Line	Date of Service	Service Code	Quantity	Duration(min)	Cost per Unit	Service Cost
1	2014-05-22	3.xx.10	1		\$100.00	\$100.00

ACCEPT the terms and conditions:
 I, the stated provider, certify that all details being entered for this claim are accurate. I realize that submitting false, inaccurate or medically unnecessary claims may result in one or more of the following actions being taken by Great-West Life against me:
 - I may lose my access to submit claims electronically

If the information above is correct, click on "Confirm Submit" to submit the claim. To make a correction, click on "Cancel Submit" to return to the claim and you will be able to change the entered information.

[Back to Claim](#) [Submit](#)

- Carefully review the entered information.
- To make corrections, click **Back to Claim** to return to the **Start Claim** page where you can make changes to the entered information.
- If appropriate, Accept the Insurance Company's Terms and Conditions statement.
- If the information is correct, click **Submit** and the payment request will be submitted to the Insurance Company identified in the Primary Coverage section. A wait page will advise you that the payment request is being processed:

Processing

Web Claim ID: **166719** has been submitted.

Please wait while your claim is being processed.



Do not close the processing window; the Insurance Company's response will normally appear within two to thirty seconds.

- Once processing is complete, the Insurance Company's response will display in the window.

Successful submission of a payment request will lead to one of the following responses from the Insurance Company based on the title of the page that is generated:

Explanation of Benefits:

This type of response is generated when the Insurance Company has fully adjudicated (or processed) the payment request. This statement provides the actual results of the adjudication, including what amounts, if any, will be paid by the Insurance Company.

Based on the amounts that will be paid and who the payment recipient is, you will know what amount outstanding, if any, is owed by the patient.

Acknowledgement:

This type of response is generated when the Insurance Company has successfully received the payment request but is unable to complete its adjudication process. This statement simply serves to confirm reception of the payment request.

Actual adjudication results will be provided at a later time through a paper means.



When Acknowledgement response is generated, you will NOT receive an electronic notification when the Insurance Company has completed its adjudication process for the payment request.

Go to the [Printing and saving the Insurance Company's Response](#) section for information on how to print and save the statement. Go to section [How to interpret the Insurance Company's response](#) for more information about all possible responses and examples.

3.5 Printing and saving the Insurance Company's Response

Once the payment request has been processed by the Insurance Company, the ability to print a copy for your patient will be available depending on the type of response that was generated.

You can also save an electronic copy of the Statement or print a copy for your records.

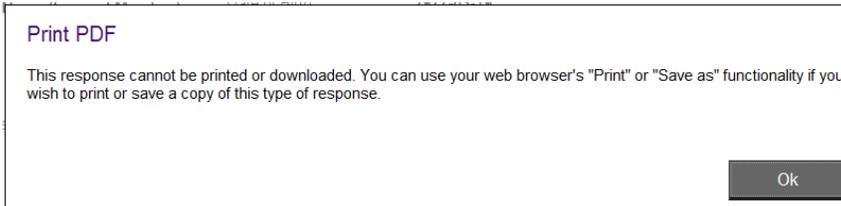


A PDF version of the response will be generated for you to print or save.

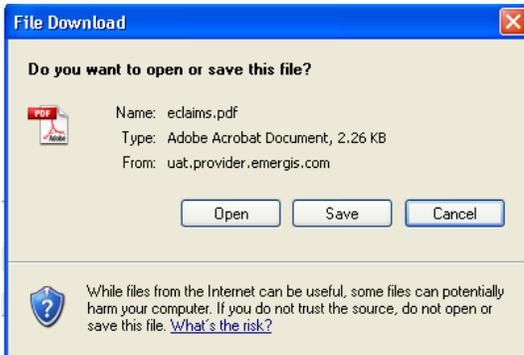
If you want to print either of the above responses:

1. Click **Print PDF**.

- If a response cannot be printed or saved, the following message will generate:



If the response can be printed or saved, the File Download pop up window displays:



- Click **Open**.

The response will open as a PDF document:

The document is titled "Simulated Adjudicator" and "Explanation of Benefits". It is powered by TELUS HEALTH. The document contains the following information:

Expected Payment Date: Unavailable
Total Payable To: Insured Member
Payee Name: Clarissa Baron
Insurance Company Claim ID: 3251
Policy: 5209 (Extended Health Care)
Insured/Member: Clarissa Baron
Member ID: 8191384
Date of Birth: -

Servicing Provider: Clara Turner
Servicing Location ID: 75160
Licence ID: 717
Patient: Evan Baron
Relationship to Insured/Member: Spouse
Dependent ID: -
Date of Birth: 1940-11-25

Claim accepted
 Claim has been accepted and payment will be made to Insured Member.
 Please see Insurer notes for a detailed explanation of benefits.

Provider Claim Reference ID: 97527
Date Submitted: 2016-10-17

Date of Service	Service Description	Submitted	Eligible	Deductible	Payable at	Paid amount	Note(s)
2016-10-03	Initial visit assessment	66.00	59.40		100%	59.40	
Totals:		66.00				59.40	

Insurer's note(s)
 IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE INSURER AT [REDACTED]
 The information contained on this form has been used to process your claim electronically. Please verify the accuracy of this data and report any discrepancies. Do not mail this form to the Insurer/Plan administrator.

4. You can either click the print icon button  or select **File->Print...** from the menu to print the response.
5. To close the PDF document, simply select **File->Exit** from the menu or click the  button of the window.

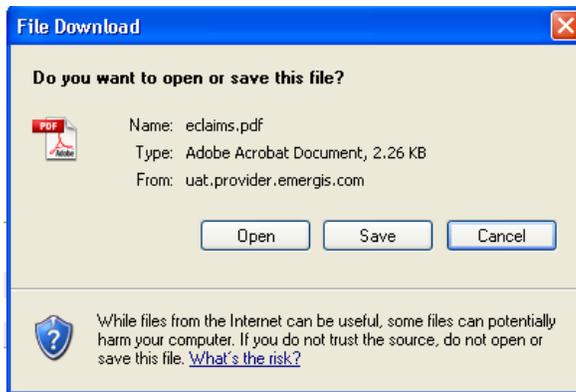


Ensure you give a printed copy of the Insurance Company's response to your patient and keep one for your records.

If you want to save either of the above responses:

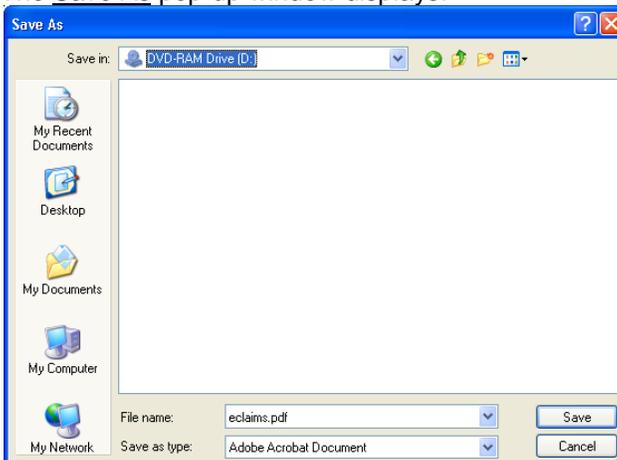
1. Click **Print PDF**.

The File Download pop up window displays:



2. Click **Save**.

The Save As pop-up window displays:



3. Browse to the desired location where you wish to save the PDF response.
4. Enter the desired file name for the PDF response.
5. Select the type of document you want to save the response as.
6. Click the **Save** button of the Save As window.

The PDF response will be saved at your chosen location.

3.6 Saving an incomplete payment request

If you are unable to complete the request when first created, or you wish to prepare a request ahead of time and are not ready to submit the request, it is possible to save the payment request for completion later that same day.

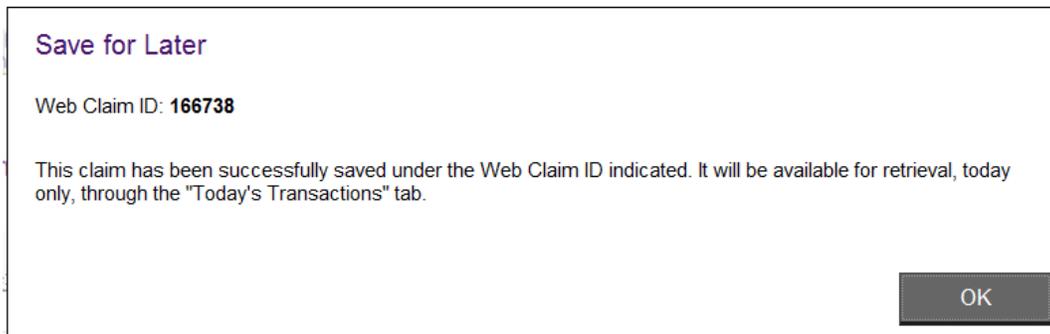


A saved request is only available the day it was saved.



To save a payment request:

1. Click on **Save for Later**.
2. The following message will advise you that your claim was successfully saved and provide the Web Claim ID assigned by the Portal to the claim:

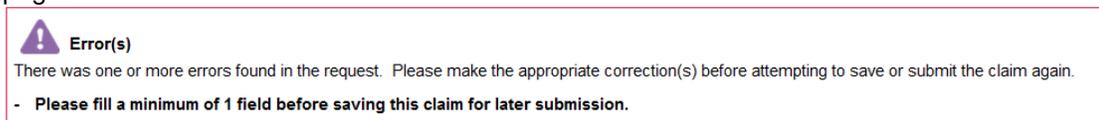


3. Click **OK**.
4. To retrieve the request for completion, you must use the **[Today's Transactions]** tab. Go to the [Today's Transactions](#) section for more information on how to retrieve the transaction.



At least one field must be populated in the request in order to be able to save the request.

If you attempt to save an empty request, the following error will generate at the top of the page:



3.7 Creating a payment request for another member of the same family

Once the Insurance Company’s response has been printed and saved, you are able to create a claim for a different member of the same family. The system will pre-populate for you certain fields to save you time.



*You can only use the **New Claim from the Same Family** option if the provider was the same for both members of the same family.*

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Submit a Claim or Review Transactions

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Explanation of Benefits

Claim accepted
 Claim has been accepted and payment will be made to **Insured Member**.
 Please see Insurer notes for a detailed explanation of benefits.
 It is recommended to create a PDF for your files using the button below.
Insurer notes:
 IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE INSURER AT [REDACTED]
[Show more](#)

Total payable to: **Insured Member**
 Payee Name: **Clarissa Baron**
 Expected Payment Date: **Unavailable**

Statement Date: **2016-10-17**
 Insurance Co. Claim ID: **3251**
 Servicing Provider: **Tina Turner**
 Address: **232 Mountain ST
 Calgary, AB T5G 3A3**

Insurance Company: **Simulated Adjudicator**
 Policy: **5209**
 Benefit Type: **Extended Health Care**

Insured Member: **Clarissa Baron**
 Member ID: **8191384**
 Date of Birth: [REDACTED]

Patient Name: **Evan Baron (Spouse)**
 Date of Birth: **1940-11-25**

Details of your claim

Line	Date of Service	Service Description	Submitted Amount	Eligible Amount	COB	Deductible	% Payable	Paid by Plan	Note(s)
1	2016-10-03	Initial visit assessment	\$66.00	\$59.40			100%	\$59.40	
Totals:			\$66.00	\$59.40			Total Paid:	\$59.40	

Print PDF New Claim New Claim from the Same Family Done

To submit a claim based on the claim just processed:

1. Click **New Claim from the Same Family** when available.

The **Start Claim** page displays with the following sections pre-populated with the information from the previous request:

- Provider Information
- Primary Coverage Information
- Secondary Coverage Information

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Complete Patient Coverage and Claim Details

Provider Name: **Lena Bones** Servicing Provider: **Lena Bones, Chiropractor, 340 Lovely Road, Brampton** Request Type: **Payment**

Patient Information

First Name * Middle Name Last Name * Date of Birth *
 Birth Order Gender *
 Not applicable/Unknown Select

Primary Coverage Information

Relationship * Member First Name * Middle Name Member Last Name * Date of Birth *
 Insured Member New Patient New Patient Last Name 1988-05-10
 Insurance Company * Policy * Member ID * Benefit Type *
 Simulated Adjudicator 12345 9876543219 Extended Health Care
 Secondary coverage available? *
 Yes
 No

2. Validate that all the pre-populated information applies to the new claim and make corrections as required.
3. Proceed with completing the Patient Information, Additional Claim Information and Claim Lines sections as you would any other request.



If a different provider performed the services, you will need to create an entirely new claim by clicking the **New Claim** button in order to return to the Start Claim page to select a different provider.

3.8 Submitting a predetermination request

You can submit a predetermination request when your patient wants to know how much his Insurance Company would pay if the planned service(s) or treatment(s) were to occur on the day the request is submitted.

Submitting a predetermination follows the same process as submitting a payment request with slight differences in the data entry fields and the generated responses explained in this section.

To submit a predetermination request:

1. Log into the Provider Portal. Ensure that the user name and password used to log into the Portal corresponds to a user that can submit health claims for the provider that will eventually perform the service(s).
2. Ensure that **[Claim Entry]** is the tab currently displayed (will have a white background). The **Start Claim** page is the default view displayed when first selecting Extended Healthcare on the Home Page. If this window is not displayed, click the **[Claim Entry]** tab.
3. The provider or organization that the user is linked to is displayed at the top of the **Start Claim** page.

The screenshot shows the 'Start Claim' form in the eClaims system. The form is under the 'Claim Entry' tab. It includes the following fields and options:

- Insurance Company ***: A dropdown menu with 'Simulated Adjudicator' selected.
- Servicing Location ***: A dropdown menu with '340 Lovely Road, Brampton, ON L5X 1C0' selected. A question mark icon is visible to the right.
- Servicing Provider ***: A dropdown menu with 'Lena Bones, Chiropractor' selected. A question mark icon is visible to the right.
- Request Type**: Radio buttons for 'Payment Request' (unselected) and 'Predetermination Request' (selected).
- Continue**: A green button at the bottom of the form.

4. Select the **Insurance Company** on behalf of whom you are submitting the Request.
5. Select the **Servicing Location** corresponding to where the patient will receive the planned service(s). When the user is associated to a single servicing location, this servicing location will automatically be selected.
6. Select the **Servicing Provider**. The provider selected must correspond to the provider who will provide the planned service(s).
7. Select **Request Type** value **Predetermination Request**.
8. Click on **Continue**.

The second page of the **[Claim Entry]** tab displays the fields where you can continue to enter the predetermination request information.

Submit a Claim or Review Transactions

The screenshot shows a web form titled "Complete Patient Coverage and Claim Details" for a "Predetermination" request. The provider is "Lena Bones, Chiropractor, 340 Lovely Road, Brampton". The form is divided into several sections:

- Patient Information:** Fields for First Name, Middle Name, Last Name, Date of Birth (yyyyymmdd), Birth Order (Not applicable/Unknown), and Gender (Select).
- Primary Coverage Information:** Fields for Relationship (Select), Member First Name, Middle Name, Member Last Name, Date of Birth (yyyyymmdd), Insurance Company (Simulated Adjudicator), Policy, Member ID, and Benefit Type (Extended Health Care).
- Secondary coverage available?** Radio buttons for Yes and No (No is selected).
- Additional Claim Information:** Radio buttons for "Is this an injury caused by an accident?" and "Was this service prescribed or a referral?" (both Yes and No options are present).
- Claim Lines:** A table with columns: Line, Service Code, Quantity, Duration(min), Cost per Unit, and Service Cost. It contains three rows (1, 2, 3) with search icons and expand/collapse controls.

At the bottom of the form are three buttons: "Cancel and Exit", "Save for Later", and "Continue".

The following sections of the predetermination are different from a payment request and will be explained in the next two sections:

- Additional Claim Information
- Claim Lines

Refer to the [Step 2 - Complete Patient Coverage and Claim Details](#) section for additional information on each of the following sections:

- Provider Information
- Patient Information
- Primary Coverage Information
- Secondary Coverage Information
- Claim Lines

3.8.1 Predetermination - Additional Claim Information

This section provides an explanation of the differences between a payment and predetermination request for this specific section of the request. Go to the [Additional Claim Information](#) section of the [Step 2 - Complete Patient Coverage and Claim Details](#) section for more information on the other fields available for a predetermination in this section.

The following provides what the Additional Claim Information section looks like for a predetermination based on the type of service(s) being submitted:

■ Physiotherapy service(s):

Additional Claim Information

Provincial insurance exhausted?

Is this an injury caused by an accident? *

Yes

No

Was this service prescribed or a referral? *

Yes

No

■ Other specialized service(s):

Additional Claim Information

Is this an injury caused by an accident? *

Yes

No

Was this service prescribed or a referral? *

Yes

No

■ Vision care service(s):

Additional Claim Information

Is this an injury caused by an accident? *

Yes

No

Was this service prescribed or a referral? *

Yes

No

The following table explains the differences between a payment request and a predetermination:

Field	Payment Request	Predetermination
Payable to	Available	Unavailable. A predetermination is not a request for payment so this field is not applicable.
Predetermination #	Available	Unavailable. This is what the predetermination is requesting from the Insurance Company to eventually use on an actual payment request when the services are actually rendered.

To complete this section for a predetermination:

1. If the treatment will be given to the patient as a result of an accident, answer **Yes** to the **Is this an injury caused by an accident?** question to make the **Accident Type** and **Accident Date** fields appear. By answering **Yes**, the fields related to the accident become mandatory.

- 1.1. Obtain from the patient the type of accident that occurred.

-
- 1.2. Obtain from the patient when the accident occurred. Enter the accident date in a numeric yyyy-mm-dd, yyyymmdd or yyyy-m-d. The date field format will display in yyyy-mm-dd. Alternatively, select a date using the Calendar tool.
 2. If the treatment that will be given to the patient was not the result of an accident, answer **No** to the question **Is this an injury caused by an accident?**. You must always answer the question: there is no default value pre-selected for you.
 3. If the treatment will be given as a result of a prescription or a referral, answer **Yes** to the **Was this service prescribed or a referral?** Question to make the **Prescriber Type**, **Prescriber Last Name** and **Prescriber First Name** fields appear. By answering **Yes**, the fields related to the healthcare professional that prescribed or made the referral become mandatory.
 - 3.1. Obtain from the patient the relevant prescription or referral information. Select the type of healthcare professional that prescribed the service(s) or made the referral (**Prescriber Type**).

The **Prescriber Type** corresponds to the type of healthcare professional that provided the prescription or referral.
 - 3.2. Enter the name of the healthcare professional that prescribed the service(s) or made the referral.
 4. If the treatment that will be given to the patient was not the result of prescription or a referral, answer **No** to the question **Was this service prescribed or a referral?**. You must always answer the question: there is no default value pre-selected for you.
 5. When the healthcare predetermination will be for physiotherapy services, the question **Provincial insurance exhausted?** will be displayed. Depending on the provincial government health care plan of the province where the patient is covered, it may be necessary for you to indicate if the coverage by the provincial healthcare plan will have been fully exhausted. If this is the case, check the box. The box can be unchecked if clicked by mistake.

3.8.2 Predetermination - Claim Lines

This section provides an explanation of the differences between a payment and predetermination request for this specific section of the request. Refer to the [Claim Lines](#) section of the [Step 2 - Complete Patient Coverage and Claim Details](#) section for more information on the fields available for a predetermination in this section.

The following provides what the Claim Lines section looks like for a predetermination based on the type of service(s) being submitted:

- Physiotherapy service(s):

Claim Lines ?

Line	Service Code *	Quantity *	Duration(min)	Cost per Unit *	Service Cost	
1	<input type="text"/>  	<input type="text"/>	<input type="text"/>	<input type="text"/>		 
2	<input type="text"/>  	<input type="text"/>	<input type="text"/>	<input type="text"/>		 
3	<input type="text"/>  	<input type="text"/>	<input type="text"/>	<input type="text"/>		 

- Other specialized service(s):

Claim Lines ?

Line	Service Code *	Quantity *	Duration(min)	Cost per Unit *	Service Cost	
1	<input type="text"/>  	<input type="text"/>	<input type="text"/>	<input type="text"/>		 
2	<input type="text"/>  	<input type="text"/>	<input type="text"/>	<input type="text"/>		 
3	<input type="text"/>  	<input type="text"/>	<input type="text"/>	<input type="text"/>		 

- Vision care service(s):

Claim Lines ?

Line	Service Code *	Quantity *	Cost per Unit *	Service Cost	Purpose	Eye	
1	<input type="text"/>  	<input type="text"/>	<input type="text"/>		Select	<input type="checkbox"/> Left <input type="checkbox"/> Right	 
2	<input type="text"/>  	<input type="text"/>	<input type="text"/>		Select	<input type="checkbox"/> Left <input type="checkbox"/> Right	 
3	<input type="text"/>  	<input type="text"/>	<input type="text"/>		Select	<input type="checkbox"/> Left <input type="checkbox"/> Right	 

The only difference between a payment request and a predetermination is the **Date of Service** field. There is no **Date of Service** required for a predetermination so the Date of Service field is not available for a predetermination. The Insurance Company uses today's date as basis for processing.

4 How to interpret the Insurance Company's response

This chapter provides you with information on each type of responses that can be generated from the request sent to the Insurance Company. The response will follow the message that the request is being processed. The type of response generated by the Insurance Company is provided as the title of the page that will display.

Who Should Read this Chapter?

A user who will submit healthcare payment or predetermination requests to Insurance Companies.

4.1 The Explanation of Benefits response

This type of response is generated when the Insurance Company has fully adjudicated (or processed) the payment request. The Explanation of Benefits response provides the actual results of the adjudication, including what amounts, if any, will be paid by the Insurance Company.

The two main responses are variants of "Claim accepted."



Claim accepted



Claim accepted - Payable to modified

To determine if there is an amount outstanding that the patient owes, examine both the amounts that will be paid and the setting for "Total payable to". When the payable-to field has been modified, this change is now highlighted in the heading of the response summary.

Displayed

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Submit a Claim or Review Transactions

Claim Entry Today's Transactions Past Transactions Authorization Forms Frequently Asked Questions User Manual

Claim accepted

Claim has been accepted and payment will be made to **Insured Member**.

Please see Insurer notes for a detailed explanation of benefits. It is recommended to create a PDF for your files using the button below.

Insurer notes:
IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE INSURER AT [REDACTED]

[Show more](#)

Total payable to: **Insured Member**
 Payee Name: **Clarissa Baron**
 Expected Payment Date: **Unavailable**

Statement Date: **2016-10-17**
 Insurance Co. Claim ID: **3251**
 Servicing Provider: **Clara Turner**
 Address: **232 Mountain ST
 Calgary, AB T5G 3A3**

Insurance Company: **Simulated Adjudicator**
 Policy: **5209**
 Benefit Type: **Extended Health Care**

Insured Member: **Clarissa Baron**
 Member ID: **8191384**
 Date of Birth: [REDACTED]

Patient Name: **Evan Baron (Spouse)**
 Date of Birth: **1940-11-25**

Details of your claim

Line	Date of Service	Service Description	Submitted Amount	Eligible Amount	COB	Deductible	% Payable	Paid by Plan	Note(s)
1	2016-10-03	Initial visit assessment	\$66.00	\$59.40			100%	\$59.40	
Totals:			\$66.00	\$59.40			Total Paid:	\$59.40	

Print PDF New Claim New Claim from the Same Family Done

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Submit a Claim or Review Transactions

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Claim accepted - Payable to modified

Further action required

Claim has been accepted but payable to has been changed from **Client/Organization** to **Insured member**. This has occurred because of the insured member's benefit plan rules. **Insured member must pay full claim amount.**

Please see Insurer notes for a detailed explanation of benefits. It is recommended to create a PDF for your files using the button below.

Insurer notes:
IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE INSURER AT [REDACTED]

[Show more](#)

Total payable to: **Other Third Party**
 Payee Name: **Sam Kris**
 Expected Payment Date: **Unavailable**

Statement Date: **2011-05-16**
 Insurance Co. Claim ID: **3434**
 Servicing Provider: **Clara Turner**
 Address: **232 Mountain ST
 Calgary, AB T5G 3A3**

Insurance Company: **Simulated Adjudicator**
 Policy: **5463**
 Benefit Type: **Extended Health Care**

Insured Member: **Lochana Pad**
 Member ID: **765765**
 Date of Birth: **1990-01-01**

Patient Name: **Lochana Pad (Insured Member)**
 Date of Birth: **1990-01-01**

Details of your claim

Line	Date of Service	Service Description	Submitted Amount	Eligible Amount	COB	Deductible	% Payable	Paid by Plan	Note(s)
1	2016-10-10	X-ray	\$267.00	\$240.30			100%	\$240.30	
2		Assessment, standard	\$132.00	\$132.00			80%	\$105.60	
Totals:			\$399.00	\$372.30			Total Paid:	\$345.90	

Print PDF New Claim New Claim from the Same Family Done

Printed



eClaims
enabled
Claim & receive.

powered by 

Simulated Adjudicator

Explanation of Benefits

Expected Payment Date: Unavailable	Servicing Provider: Clara Turner
Total Payable To: Insured Member	Servicing Location ID: 75160
Payee Name: Clarissa Baron	Licence ID: 717
Insurance Company Claim ID: 3251	Patient: Evan Baron
Policy: 5209 (Extended Health Care)	Relationship to Insured/Member: Spouse
Insured/Member: Clarissa Baron	Dependent ID: -
Member ID: 8191384	Date of Birth: 1940-11-25
Date of Birth: -	

✔ **Claim accepted**

Claim has been accepted and payment will be made to **Insured Member**.

Please see Insurer notes for a detailed explanation of benefits.

Provider Claim Reference ID: 97527
Date Submitted: 2016-10-17

Date of Service	Service Description	Submitted	Eligible	Deductible	Payable at	Paid amount	Note(s)
2016-10-03	Initial visit assessment	66.00	59.40		100%	59.40	
Totals:		\$66.00				\$59.40	

Insurer's note(s)

IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE INSURER AT [REDACTED]

The information contained on this form has been used to process your claim electronically. Please verify the accuracy of this data and report any discrepancies. Do not mail this form to the Insurer/Plan administrator.

4.1.1 Top section of a Displayed Explanation of Benefits response

This section of the page represents a summarized explanation of the generated response including the Insurance Company's notes relevant to the claim lines or to the claim in general, and the patient and coverage information that the Insurance Company used to adjudicate (or process) the request. The information in this section cannot be modified.

Explanation of Benefits

 **Claim accepted**

Claim has been accepted and payment will be made to **Insured Member**.

Please see Insurer notes for a detailed explanation of benefits.
It is recommended to create a PDF for your files using the button below.

Insurer notes:

IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE INSURER AT

[Show more](#)

<p>Total payable to: Insured Member Payee Name: Clarissa Baron Expected Payment Date: Unavailable</p> <p>Statement Date: 2016-10-17 Insurance Co. Claim ID: 3251 Servicing Provider: Clara Turner Address: 232 Mountain ST Calgary, AB T5G 3A3</p> <p>Insured Member: Clarissa Baron Member ID: 8191384 Date of Birth:</p>	<p>Insurance Company: Simulated Adjudicator Policy: 5209 Benefit Type: Extended Health Care</p> <p>Patient Name: Evan Baron (Spouse) Date of Birth: 1940-11-25</p>
---	--

It is possible that the Insurance Company has changed information that was specified on the request based on information they have on file. It should be reviewed with your patient or your patient's parent/guardian.



The information in this section will generally correspond to the information submitted but may be different as it is based on the insurance company's records.

The following data is provided in this section. None of the information can be modified. The fields on the left are described first followed by the fields on the right:

Field	Description
Response Summary	A heading and explanatory text that provide a summary and details of the response from the Insurance Company.
Total payable to	This field represents to whom the payment will be made out, sometimes identified as a payee class (Insurer Member, Patient, Clinic/Organization, Servicing Provider, Other Third Party). In some cases, this may be different from what was on the request. A note will normally be present in the bottom note section when this situation occurs.
Payee Name	This is the name of the person or organization to whom the Insurance Company will issue the payment.
Expected Payment Date	When provided by the Insurance Company, this corresponds to the date that payment can be expected.
Statement Date	This is the date when the response was generated. It should correspond to the date the request was submitted when a response is generated in real time.
Insurance Co. Claim ID	This is the insurance company's claim identifier assigned by the Insurance Company. Use this identifier when communicating with the insurance company.
Servicing Provider; Address	This is the provider name and address that the request was associated with based on the selection made at the time of the request.

Field	Description
Insured Member; Member ID; Date of Birth	This is the full name of the insured member, the member ID that the response was adjudicated against, and date of birth according to the Insurance Company's records.
Insurance Company	This is the name of the Insurance Company that generated the response.
Policy	This is the policy identifier that the response was adjudicated or processed against.
Benefit Type	This is the type of policy that the response was adjudicated against.
Patient Name (Relationship); Date of Birth	This is the patient's full name and date of birth according to the Insurance Company's records. The relationship of the patient to the member is indicated in parentheses next to the patient's name.



If your patient or your patient's parent/guardian indicates that there is an error about information on the response (such as an incorrect date of birth), your patient must contact his insurance company directly to have the error(s) corrected.

4.1.2 Top section of a Printed Explanation of Benefits response

This section of the page represents the patient and coverage information that the Insurance Company used to adjudicate (or process) the request as well additional information about the generated response. The information in this section cannot be modified and provides some information that is different from what is displayed.

Simulated Adjudicator

Explanation of Benefits

Expected Payment Date: Unavailable	Servicing Provider: Clara Turner
Total Payable To: Insured Member	Servicing Location ID: 75160
Payee Name: Clarissa Baron	Licence ID: 717
Insurance Company Claim ID: 3251	Patient: Evan Baron
Policy: 5209 (Extended Health Care)	Relationship to Insured/Member: Spouse
Insured/Member: Clarissa Baron	Dependent ID: -
Member ID: 8191384	Date of Birth: 1940-11-25
Date of Birth: -	

✔ **Claim accepted**

Claim has been accepted and payment will be made to **Insured Member**.
Please see Insurer notes for a detailed explanation of benefits.

Provider Claim Reference ID: **97527**
Date Submitted: **2016-10-17**

The following data is provided for printed responses:

Field	Description
<Simulated Adjudicator>	This is the name of the Insurance Company that generated the response and is shown at the top of the response.
Expected Payment Date	When provided by the Insurance Company, this corresponds to the date that payment can be expected.
Total Payable To	This field represents to whom the payment will be made out, sometimes identified as a payee class (Insured Member, Patient, Clinic/Organization, Servicing Provider, Other Third Party). In some cases, this may be different from what was on the request. A note will normally be present in the bottom note section when this situation occurs.
Payee Name	This is the name of the person or organization to whom the Insurance Company will issue the payment.
Insurance Company Claim ID	This is the insurance company's claim identifier assigned by the Insurance Company. Use this identifier when communicating with the insurance company.
Policy	This is the policy identifier that the response was adjudicated or processed against.
Insured/Member Member ID Date of Birth	This is the member's full name, member ID that the response was adjudicated against, and date of birth according to the Insurance Company's records.

Field	Description
Response Summary	A heading and explanatory text that provide a summary and details of the response from the Insurance Company.
Provider Claim Reference ID	This is the request identifier assigned by the submission application.
Date Submitted	This is the date corresponding to when the request was submitted.
Servicing Provider	This is the provider name and address that the request was associated with based on the selection made at the time of the request unless the provider selected was an optician, in which case it is the Optical Supplier name that will be displayed.
Servicing Location ID	This indicates the location identifier against which the request has been submitted.
Licence ID	This will show the servicing provider's licence if he is a licensed professional.
Patient	This is the patient's full name according to the Insurance Company's records.
Relationship to Insured/Member	This is the relationship of the patient to the member.
Dependent ID	When provided, this is the identifier assigned to the patient.
Date of Birth	This is the patient's date of birth according to the Insurance Company's records.

4.1.3 Displayed Details of your claim

The remaining part of the page represents how the patient's Insurance Company adjudicated or processed the claim lines submitted. The information in this section cannot be modified.

[Details of your claim](#)

Line	Date of Service	Service Description	Submitted Amount	Eligible Amount	COB	Deductible	% Payable	Paid by Plan	Note(s)
1	2016-10-03	Initial visit assessment	\$66.00	\$59.40			100%	\$59.40	
Totals:			\$66.00	\$59.40			Total Paid:	\$59.40	

The following information is provided in this section. The columns are described first followed by the summary line and the remaining fields:

Field	Description
Line	This column represents the line number of the claim line.
Date of Service	This column represents the submitted date of service for the claim line.

Field	Description
Service Description	This column represents a short description of the code for the claim line based on the Insurance Company's response.
Submitted Amount	This column represents the total amount originally submitted for the claim line. If this amount is blank, the claim line was added by the Insurance Company. There should be a note explaining why a line was added.
Eligible Amount	This column represents the amount that the Insurance Company deemed eligible when calculating the amount paid for the claim line.
COB	When there is coordination of benefits, this column represents the amount paid by coverage that took precedence over the coverage that the response refers to.
Deductible	When applicable, this column represents the amount of deductible retained for the claim line.
% Payable	When applicable, this column represents the percentage that is covered by the patient's policy for the claim line.
Paid by Plan	This column represents the amount that the Insurance Company has determined will be paid for the claim line under the coverage indicated in the top section.
Note(s)	When applicable, this column represents one or more notes giving further explanation on how the claim line was adjudicated (or processed). The column will indicate a note identifier for a note listed in the Note(s) section below the Payment Intent Date .
Totals	The Submitted Amount , Eligible Amount and Deductible columns have a total indicated.
Total Paid	This amount represents the total amount that the Insurance Company will pay for all claim lines combined. The difference between the Total Paid and the Submitted Amount corresponds to the unpaid portion and is owed by the patient or patient's parent/guardian.



Ensure you verify to whom the Insurance Company will make the payment, as it may be different from what was indicated on the payment request.

4.1.4 Printed claim details

The remaining part of the page represents how the patient's Insurance Company adjudicated or processed the claim lines submitted. The information in this section cannot be modified and provides some information that is different from what is displayed.

Date of Service	Service Description	Submitted	Eligible	Deductible	Payable at	Paid amount	Note(s)
2016-10-03	Initial visit assessment	66.00	59.40		100%	59.40	
Totals:		\$66.00				\$59.40	

Insurer's note(s)

IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE INSURER AT [REDACTED]

The information contained on this form has been used to process your claim electronically. Please verify the accuracy of this data and report any discrepancies. Do not mail this form to the Insurer/Plan administrator.

The following data is provided for printed responses:

Field	Description
Date of Service	This column represents the submitted date of service for the claim line.
Service Description	This column represents a short description of the code for the claim line based on the Insurance Company's response.
Submitted	This column represents the total amount originally submitted for the claim line. If this amount is empty, the claim line was added by the Insurance Company. There should be a note explaining why a line was added.
Eligible	This column represents the amount that the Insurance Company deemed eligible when calculating the amount paid for the claim line.
Deductible	When applicable, this column represents the amount of deductible retained for the claim line.
Payable At	When applicable, this column represents the percentage that is covered by the patient's policy for the claim line.
Paid Amount	This column represents the amount that the Insurance Company has determined will be paid for the claim line under the coverage indicated in the top section.
Note(s)	When applicable, this column represents one or more notes giving further explanation on how the claim line was adjudicated (or processed). The column will indicate a note identifier for a note listed in the Note(s) section below the second horizontal line.
Totals	The Submitted Amount , Eligible Amount and Deductible columns have a total indicated.
Insurer's Note(s)	This section provides all the Insurance Company's notes relevant to the claim lines or to the claim in general. There will generally be a note providing how to contact the Insurance Company.

4.2 The Claim Acknowledgement response

This type of response is generated when the Insurance Company has successfully received the payment request but is unable to complete its adjudication process. The Acknowledgement response simply serves to confirm reception of the payment request.

Actual adjudication results will be provided at a later time by the Insurance Company based on who was identified to receive the payment. In some cases, this may be different from what was on the request. A note will normally be present in the bottom note section when this situation occurs.

4.2.1 Displayed Claim Acknowledgement

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Submit a Claim or Review Transactions

Claim Entry Today's Transactions Past Transactions Authorization Forms Frequently Asked Questions User Manual

Claim Acknowledgement

Claim pending

The insurer is reviewing your claim request and will get back to you when a decision has been made. No further actions are needed.

Please see Insurer notes for additional details. It is recommended to create a PDF for your files using the button below.

Insurer notes:
724-CLAIM HAS BEEN ACCEPTED FOR FURTHER PROCESSING.
[Show more](#)

Total payable to: **Insured Member**
Payee Name: **Clarissa Baron**
Expected Payment Date: **Unavailable**

Statement Date: **2016-10-17**
Insurance Co. Claim ID: **4521**
Servicing Provider: **Clara Turner**
Address: **232 Mountain ST
Calgary, AB T5G 3A3**

Insurance Company: **Simulated Adjudicator**
Policy: **5209**
Benefit Type: **Extended Health Care**

Insured Member: **Clarissa Baron**
Member ID: **8191384**
Date of Birth: [blank]

Patient Name: **Evan Baron (Spouse)**
Date of Birth: **1940-11-25**

Details of your claim

Line	Date of Service	Service Description	Submitted Amount	Eligible Amount	COB	Deductible	% Payable	Paid by Plan	Note(s)
1	2016-10-06	Workplace assessment	\$89.00						
Totals:			\$89.00					Total Paid:	

Print PDF New Claim New Claim from the Same Family Done

For Claim Acknowledgement responses, the top of the page will be nearly identical to a displayed Explanation of Benefits response except for the Response Summary and the Details of your claim section will only provide the information about what has been submitted and no details about how the Insurance Company has adjudicated the submitted services.

The Details of your claim has the same format as an Explanation of Benefits but the information supplied by the Insurance Company is left blank since none is provided for a Claim Acknowledgement response.



If it is indicated on the request to make the payment to the provider/organization, to change the recipient of the payment you must first void the Acknowledgement (see [Voiding the transaction](#)) then resubmit a new request with the insured member identified as the recipient of payment (field Total payable to).

 **Claim pending**

The insurer is reviewing your claim request and will get back to you when a decision has been made. However, **payment could be sent to the Insured Member** because of their benefit plan rules. Therefore, we recommend that you:

- 1) Void this claim.
- 2) Submit a new claim payable to the Insured Member.
- 3) Ask the Insured Member to pay the full claim amount.

Please see Insurer notes for additional details.
It is recommended to create a PDF for your files using the button below.

Insurer notes:

724.CLAIM HAS BEEN ACCEPTED FOR FURTHER PROCESSING.

[Show more](#)

The following explains the differences field by field between an Explanation of Benefits and a Claim Acknowledgement:

Field	Explanation of Benefits	Claim Acknowledgement
Total payable to	Available, provided by the Insurance Company.	May be available, depending on the Insurance Company.
Payee Name	Available, provided by the Insurance Company.	May be available, depending on the Insurance Company.
Expected Payment Date	May be available depending on the Insurance Company.	May be available depending on the Insurance Company.
Date of Service	Available, provided by the Insurance Company.	Available, based on what was submitted.
Service Description	Available, provided by the Insurance Company.	Available, based on what was submitted.
Submitted Amount	Available, provided by the Insurance Company.	Available, based on what was submitted.
Eligible Amount	Available, provided by the Insurance Company.	Unavailable and is left blank.
COB	Available but not used at this time.	Unavailable and is left blank.
Deductible	Available, provided by the Insurance Company.	Unavailable and is left blank.
% Payable	Available, provided by the Insurance Company.	Unavailable and is left blank.
Paid by Plan	Available, provided by the Insurance Company.	Unavailable and is left blank.

Field	Explanation of Benefits	Claim Acknowledgement
Note(s)	Available, provided by the Insurance Company.	Unavailable at the claim line level.

4.2.2 Printed Claim Acknowledgement

Simulated Adjudicator

Claim Acknowledgement

Expected Payment Date: Unavailable
 Total Payable To: Insured Member
 Payee Name: Clarissa Baron

Service Provider: Clara Turner
 Servicing Location ID: 75160
 Licence ID: 717

Insurance Company Claim ID: 4521
 Policy: 5209 (Extended Health Care)
 Insured/Member: Clarissa Baron
 Member ID: 8191384
 Date of Birth: -

Patient: Evan Baron
 Relationship to Insured/Member: Spouse
 Dependent ID: -
 Date of Birth: 1940-11-25

Claim pending

The insurer is reviewing your claim request and will get back to you when a decision has been made. No further actions are needed. Please see Insurer notes for additional details.

Provider Claim Reference ID: 97532
 Date Submitted: 2016-10-17

Date of Service	Service Description	Submitted
2016-10-06	Workplace assessment	89.00
Totals:		\$89.00

Insurer's note(s)

724.CLAIM HAS BEEN ACCEPTED FOR FURTHER PROCESSING.
 IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE INSURER AT [REDACTED]
 This claim has been submitted electronically-This is a receipt only.

Same as displayed responses, the top of the page will be nearly identical to a printed Explanation of Benefits response except for the Response Summary and line details will only provide the information about what has been submitted and no details about how the Insurance Company has adjudicated the submitted services.

The following explains the differences field by field between an Explanation of Benefits and an Acknowledgement (note that the sample above does is one where no payment information was provided):

Field	Explanation of Benefits	Acknowledgement
Date of Service	Available, provided by the Insurance Company.	Available, based on what was submitted.

Field	Explanation of Benefits	Acknowledgement
Service Description	Available, provided by the Insurance Company.	Available, based on what was submitted.
Submitted	Available, provided by the Insurance Company.	Available, based on what was submitted.
Expected Payment Date	May be available depending on the Insurance Company.	May be available depending on the Insurance Company.
Total Payable To	Available, provided by the Insurance Company.	May be available, depending on the Insurance Company.
Payee Name	Available, provided by the Insurance Company.	May be available, depending on the Insurance Company.
Payee Address	May be available, provided by the Insurance Company.	May be available, depending on the Insurance Company.
Note(s)	Available, provided by the Insurance Company.	Unavailable at the claim line level.

4.3 The Predetermination Explanation of Benefits response

This type of response is generated when the Insurance Company has successfully processed the predetermination request. The Predetermination response provides what the Insurance Company would have paid if the services had taken place on that date.

4.3.1 Displayed Predetermination Explanation of Benefits


Provider Portal

Home WSIB eClaims
Contact Us

eClaims > Submit a Claim or Review Transactions John Deer Log Out

Submit a Claim or Review Transactions

Claim Entry
Today's Transactions
Past Transactions
Authorization Forms

[Frequently Asked Questions](#)
[User Manual](#)

Predetermination Explanation of Benefits

✔

Predetermination request accepted

Predetermination request has been accepted.

Please see Insurer notes for additional details. It is recommended to create a PDF for your files using the button below.

Insurer notes:

THE ESTIMATED BENEFIT PAYMENT FOR THIS TREATMENT WAS CALCULATED BASED ON THE INFORMATION PROVIDED. HOWEVER ANY OF THE FOLLOWING CONDITIONS MAY RESULT IN A DIFFERENT PAYMENT AMOUNT.

1. THIS AMOUNT MAY BE LOWER IF THE PLAN HAS AN ANNUAL BENEFIT MAXIMUM AND ADDITIONAL CLAIMS ARE PROCESSED FOR THIS PATIENT BEFORE THE CLAIM FOR THIS TREATMENT IS SUBMITTED. WE RECOMMEND THAT CLAIMANTS REVIEW THEIR CLAIM RECORDS, CONTACT THEIR PLAN ADMINISTRATOR OR CHECK WITH OUR CONTACT CENTRE BEFORE PROCEEDING WITH TREATMENT TO ENSURE BENEFITS WILL NOT BE AFFECTED BY THE PLAN MAXIMUM.
2. THIS AMOUNT MAY BE HIGHER OR LOWER IF THE PLAN HAS A DEDUCTIBLE THAT WILL BE AFFECTED BY THE DATE OF TREATMENT OR SUBMISSION OF OTHER CLAIMS.
3. THIS AMOUNT MAY NOT BE PAID IF COVERAGE TERMINATES BEFORE THE TREATMENT IF THE DEPENDENT IS NO LONGER ELIGIBLE ON THE DATE OF TREATMENT OR IF THE CLAIM IS SUBMITTED AFTER THE CLAIM SUBMISSION PERIOD SPECIFIED BY THE PLAN.
4. THIS AMOUNT MAY CHANGE IF THERE ARE ANY UPDATES TO THE BENEFIT PLAN.
5. THIS AMOUNT MAY BE LOWER IF THE PATIENT IS ENTITLED TO PAYMENT FOR THESE SERVICES UNDER ANY OTHER PLAN.

[Show more](#)

Statement Date: **2016-10-17**

Predetermination #: **6405**

Servicing Provider: **John Deer**

Address: **11 King St.
Montreal, QC G4C 5N7**

Insured Member: **Laura Gilly**

Member ID: **1209**

Date of Birth: **1969-10-17**

Insurance Company: **Simulated Adjudicator**

Policy: **719312**

Benefit Type: **Extended Health Care**

Patient Name: **Laura Gilly (Insured Member)**

Date of Birth: **1969-10-17**

Details of your predetermination

Line	Service Description	Submitted Amount	Eligible Amount	COB	Deductible	% Payable	Estimated Paid Amount	Note(s)
1	Initial visit assessment	\$75.00	\$67.50			100%	\$67.50	
Totals:		\$75.00	\$67.50			Total Paid:	\$67.50	

Print PDF
New Claim
New Claim from the Same Family

Done

The following table explains the differences between a displayed Explanation of Benefits response and a displayed Predetermination Explanation of Benefits response:

Field	Explanation of Benefits	Predetermination Explanation of Benefits
Total payable to	Available	Not applicable – is not visible.
Payee Name	Available	Not applicable – is not visible.
Expected Payment Date	Available	Not applicable – is not visible.
Insurance Co. Claim ID	Available	Not applicable. This is replaced by Predetermination #.
Predetermination #	Not applicable	Available and corresponds to the identifier generated by the Insurance Company. Use this identifier when communicating with the Insurance Company.
Date of Service	Not applicable	Unavailable. The Insurance Company uses the day of submission as date of service. It is not displayed.
Paid by Plan	Available	Unavailable. This is replaced by Estimated Paid Amount.
Estimated Paid Amount	Unavailable	Available.
Total Paid	Corresponds to the total amount that the Insurance Company is paying for all claim lines	Corresponds to the total amount that the Insurance Company would have paid for all claim lines if the services had taken place that day.

4.3.2 Printed Predetermination Explanation of Benefits



**eClaims
enabled**
Claim & receive.

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Simulated Adjudicator

Predetermination Explanation of Benefits

Expected Payment Date: Unavailable
Total Payable To: -
Payee Name: -

Insurance Company: 6405
Predetermination ID:
Policy: 719312 (Extended Health Care)
Insured/Member: Laura Gilly
Member ID: 1209
Date of Birth: 1969-10-17

Servicing Provider: John Deer
Servicing Location ID: 73941
Licence ID: 112

Patient: Laura Gilly
Relationship to Insured/Member: Insured Member
Dependent ID: -
Date of Birth: 1969-10-17

✔ Predetermination request accepted

Predetermination request has been accepted.
Please see Insurer notes for additional details.

Provider Claim Reference ID: 97582
Date Submitted: 2016-10-17

Service Description	Submitted	Eligible	Deductible	Payable at	Estimated amount	Note(s)
Initial visit assessment	75.00	67.50		100%	67.50	
Totals:	\$75.00				\$67.50	

Insurer's note(s)

THE ESTIMATED BENEFIT PAYMENT FOR THIS TREATMENT WAS CALCULATED BASED ON THE INFORMATION PROVIDED. HOWEVER ANY OF THE FOLLOWING CONDITIONS MAY RESULT IN A DIFFERENT PAYMENT AMOUNT.

1. THIS AMOUNT MAY BE LOWER IF THE PLAN HAS AN ANNUAL BENEFIT MAXIMUM AND ADDITIONAL CLAIMS ARE PROCESSED FOR THIS PATIENT BEFORE THE CLAIM FOR THIS TREATMENT IS SUBMITTED. WE RECOMMEND THAT CLAIMANTS REVIEW THEIR CLAIM RECORDS, CONTACT THEIR PLAN ADMINISTRATOR OR CHECK WITH OUR CONTACT CENTRE BEFORE PROCEEDING WITH TREATMENT TO ENSURE BENEFITS WILL NOT BE AFFECTED BY THE PLAN MAXIMUM.
2. THIS AMOUNT MAY BE HIGHER OR LOWER IF THE PLAN HAS A DEDUCTIBLE THAT WILL BE AFFECTED BY THE DATE OF TREATMENT OR SUBMISSION OF OTHER CLAIMS.
3. THIS AMOUNT MAY NOT BE PAID IF COVERAGE TERMINATES BEFORE THE TREATMENT IF THE DEPENDENT IS NO LONGER ELIGIBLE ON THE DATE OF TREATMENT OR IF THE CLAIM IS SUBMITTED AFTER THE CLAIM SUBMISSION PERIOD SPECIFIED BY THE PLAN.
4. THIS AMOUNT MAY CHANGE IF THERE ARE ANY UPDATES TO THE BENEFIT PLAN.
5. THIS AMOUNT MAY BE LOWER IF THE PATIENT IS ENTITLED TO PAYMENT FOR THESE SERVICES UNDER ANY OTHER PLAN.

IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE INSURER AT [REDACTED]

The information contained on this form has been used to process your claim electronically. Please verify the accuracy of this data and report any discrepancies. Do not mail this form to the Insurer/Plan administrator.

The following table explains the differences between a printed Explanation of Benefits response and a printed Predetermination Explanation of Benefits response:

Field	Explanation of Benefits	Predetermination Explanation of Benefits
Expected Payment Date	Available	Not applicable – is not visible.
Total Payable to	Available	Not applicable – is not visible.
Payee Name	Available	Not applicable – is not visible.
Insurance Company Claim ID	Available	Not applicable. This is replaced by Insurance Company Predetermination ID.
Insurance Company Predetermination ID	Not applicable	Available and corresponds to the identifier generated by the Insurance Company. Use this identifier when communicating with the Insurance Company.
Date of Service	Not applicable	Unavailable. The Insurance Company uses the day of submission as date of service. It is not displayed.
Paid by Plan	Available	Unavailable. This is replaced by Estimated Amount.
Estimated Amount	Unavailable	Available and corresponds to the amount that the Insurance Company would have paid for the claim line if the service had taken place that day.

4.4 Other possible responses

This section describes other responses that can be received.

4.4.1 Problem Encountered

In some cases, the Insurance Company may have encountered a problem while processing the request. When this occurs, the Insurance Company will provide the details of the problem (or problems) with the request.

A Problem Encountered response will have a box in the top of the response labelled “Problem Encountered”. Below is an example:

The screenshot shows the TELUS Health Provider Portal interface. At the top, there is a navigation bar with 'Home', 'eClaims', and 'Contact Us'. The main header includes 'Submit a Claim or Review Transactions' and 'Log Out'. Below this, there are tabs for 'Claim Entry', 'Today's Transactions', 'Past Transactions', and 'Authorization Forms'. A 'Problem Encountered' message is displayed in a box, indicating that there was missing, invalid, or unaccepted information submitted. The message includes a 'Problem type' (KEY204 - unknown key identifier) and 'Insurer notes' (NO PATIENT RECORD FOUND. ENSURE POLICYID ARE CORRECT AND RETRY OR MAIL IN.). Below the message, there is a section for 'Details of your claim' with a table showing the claim line, date of service, service description, submitted amount, eligible amount, COB, deductible, % payable, paid by plan, and note(s). The table shows one line item for 'Motor and living skills training' with a submitted amount of \$150.00. At the bottom of the page, there are buttons for 'Print PDF', 'Correct', 'New Claim', 'New Claim from the Same Family', and 'Done'.

Problem encountered

There was missing, invalid or unaccepted information submitted.
Please see Insurer notes and make appropriate correction(s) before resubmitting.

Problem type:
KEY204 - unknown key identifier

Insurer notes:
NO PATIENT RECORD FOUND. ENSURE POLICYID ARE CORRECT AND RETRY OR MAIL IN.

Statement Date: 2016-10-17
Insurance Co. Claim ID: 7213
Servicing Provider: Clara Turner
Address: 232 Mountain ST
Calgary, AB T5G 3A3
Insured Member: Clarissa Baron
Member ID: 8191384
Date of Birth:

Insurance Company: Simulated Adjudicator
Policy: 5209
Benefit Type: Extended Health Care
Patient Name: Evan Baron (Spouse)
Date of Birth: 1940-11-25

Line	Date of Service	Service Description	Submitted Amount	Eligible Amount	COB	Deductible	% Payable	Paid by Plan	Note(s)
1	2016-10-10	Motor and living skills training	\$150.00						
Totals:			\$150.00					Total Paid:	

Print PDF Correct New Claim New Claim from the Same Family Done

To make a correction:

1. Review the error(s) in the Note(s) section.
2. If the error(s) can be corrected, click **Correct** and you will be returned to the claim entry page where you can make the appropriate corrections.
3. Once all corrections have been made, you can resubmit the request.

If you cannot fix the error(s), you have the option to:

1. Create an entirely new request by clicking **New Claim**, OR
2. Submit another request for a member of the same family by clicking **New Claim from the Same Family**.

4.4.2 Connection error

In some cases, the time to process your request may take too long (timeout) if there is a connection problem somewhere between the Portal and the Insurance Company. When this occurs, a set time after the request was submitted, you will receive a page with a connection (or timeout) error.

 **Connection Error**

The connection has timed out or an error while connecting to the server was encountered. You can make another attempt by clicking on "Try Again".

Should this error persist, please contact the TELUS Health Service Desk at 1-866-240-7492 option 3 and provide the error that occurred (error code: 262782).

To try again later: This claim has been saved under the following claim identifier: **956492**. It is available for re-submission, **today only**, from the "Today's Transactions" tab where you will be able to select this claim, return to the Claim Entry page and re-submit.

Try Again
New Claim
New Claim from the Same Family

You can also get a connection error on a Void request:

 **Connection Error**

The connection has timed out or an error while connecting to the server was encountered. **The claim was not voided.** You can make another attempt by clicking on "Try Again".

Should this error persist, please contact the TELUS Health Service Desk at 1-866-240-7492 option 3 and provide the error that occurred (error code:).

To try again later: Reselect the claim from "Today's Transactions" and click on "Void".

Try Again
Exit
New Claim

Depending on the request submitted, you have the option to:

1. Try again by clicking **Try Again**. The Portal will resubmit the same request to the Insurance Company.
2. Try again at a later time. If the transaction led to a connection error, it is automatically saved and can be accessed through the **[Today's Transactions]** tab, that day only. Simply find and select the claim, **View Submitted Claim**. Once in the claim, click **Try Again**.



Transactions that have led to a connection error are only available during the day they were originally submitted. A new request will need to be created if you want to resubmit the request the next day or later.

3. Starting a new claim. Simply click **New Claim** to create a completely new request or **New Claim - Same Family** to create a request for another member of the same family.
4. Go back to **[Today's Transactions]** tab if you were attempting to void a request. Simply click **Exit** and you will be brought back to **[Today's Transactions]** tab.

4.4.3 Outage error message

The following error message is displayed if a claim, predetermination, or void claim request is sent to an insurer experiencing a system outage.

 **Insurer System Outage**

There is currently a system outage for this insurer.
For this reason, we were unable to send your request. Please try again later today.
Should this error persist, please contact the TELUS Health Service Desk at 1-866-240-7492, option 3.

To try again later: This claim has been saved under the following claim identifier: 956492. It is available for re-submission, today only, from the "Today's Transactions" tab where you will be able to select this claim, return to the Claim Entry page and re-submit.

4.4.4 Predetermination Acknowledgement response

Depending on the Insurance Company, this type of response may be generated if the Insurance Company has successfully received the predetermination request but is unable to complete its adjudication process.

The Predetermination Acknowledgement response simply serves to confirm reception of the predetermination request.

Actual processing results will be provided at a later time by the Insurance Company through a paper means to the provider and/or the patient based on the Insurance Company's practices.

Similarly to the Acknowledgement response for a payment request, the details of the claim will only provide what was submitted.

4.4.5 Code substitution

In some cases, one or more lines could be replaced by one or more additional lines. When this occurs, you can expect an explanation in the form of notes at the line(s) that were replaced and for the additional line(s).

Claim accepted
 Claim has been accepted and payment will be made to **Insured Member**.
 Please see Insurer notes for a detailed explanation of benefits.
 It is recommended to create a PDF for your files using the button below.
Insurer notes:
 IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE INSURER AT [REDACTED]
[Show more](#)

Total payable to: **Insured Member**
 Payee Name: **Clarissa Baron**
 Expected Payment Date: **Unavailable**

Statement Date: **2016-10-17**
 Insurance Co. Claim ID: **6546**
 Servicing Provider: **Clara Turner**
 Address: **232 Mountain ST
 Calgary, AB T5G 3A3**

Insurance Company: **Simulated Adjudicator**
 Policy: **5209**
 Benefit Type: **Extended Health Care**

Insured Member: **Clarissa Baron**
 Member ID: **8191384**
 Date of Birth: [REDACTED]

Patient Name: **Evan Baron (Spouse)**
 Date of Birth: **1940-11-25**

Details of your claim

Line	Date of Service	Service Description	Submitted Amount	Eligible Amount	COB	Deductible	% Payable	Paid by Plan	Note(s)
1	2016-10-10	X-ray	\$125.00	\$0.00				\$0.00	1
2	2016-10-11	Service Planning	\$35.00	\$0.00				\$0.00	1
3	2016-10-11	Service Planning		\$160.00			100%	\$160.00	2
Totals:			\$160.00	\$160.00			Total Paid:	\$160.00	

Buttons: Print PDF, New Claim, New Claim from the Same Family, Done

4.4.6 The Claim Rejection Notice

Depending on the Insurance Company, this type of response may be generated if the Insurance Company is unable to respond electronically to your payment or predetermination request.

A note requesting to submit a paper claim (or to submit manually) for the request will normally be present in the bottom note section when this situation occurs.

Some Insurance Companies may also give you the option to call.

Displayed

Claim rejected
 Claim has been rejected.
 Please see Insurer notes for additional details.
Insurer notes:
 CLAIMS FOR THIS PLAN MUST BE SUBMITTED MANUALLY.
[Show more](#)

Total payable to: **Insured Member**
 Payee Name: **Clarissa Baron**
 Expected Payment Date: **Unavailable**

Statement Date: **2016-10-17**
 Insurance Co. Claim ID: **4880**
 Servicing Provider: **Clara Turner**
 Address: **232 Mountain ST
 Calgary, AB T5G 3A3**

Insurance Company: **Simulated Adjudicator**
 Policy: **5209**
 Benefit Type: **Extended Health Care**

Insured Member: **Clarissa Baron**
 Member ID: **8191384**
 Date of Birth: [REDACTED]

Patient Name: **Evan Baron (Spouse)**
 Date of Birth: **1940-11-25**

Details of your claim

Line	Date of Service	Service Description	Submitted Amount	Eligible Amount	COB	Deductible	% Payable	Paid by Plan	Note(s)
1	2016-10-05	Workplace assessment	\$89.00	\$0.00				\$0.00	
Totals:			\$89.00				Total Paid:	\$0.00	

Buttons: Print PDF, New Claim, New Claim from the Same Family, Done

Printed



eClaims
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TELUS HEALTH

Simulated Adjudicator

Claim Rejection Notice

Expected Payment Date: Unavailable	Servicing Provider: Clara Turner
Total Payable To: Insured Member	Servicing Location ID: 75160
Payee Name: Clarissa Baron	Licence ID: 717
Insurance Company Claim ID: 4880	Patient: Evan Baron
Policy: 5209 (Extended Health Care)	Relationship to Insured/Member: Spouse
Insured/Member: Clarissa Baron	Dependent ID: -
Member ID: 8191384	Date of Birth: 1940-11-25
Date of Birth: -	

✘ **Claim rejected**

Claim has been rejected.
Please see Insurer notes for additional details.

Provider Claim Reference ID: **97531**
Date Submitted: **2016-10-17**

Date of Service	Service Description	Submitted
2016-10-05	Workplace assessment	89.00
	Total:	\$89.00

Insurer's note(s)

CLAIMS FOR THIS PLAN MUST BE SUBMITTED MANUALLY.
IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE INSURER AT [REDACTED]
The information contained on this form has been used to process your claim electronically. Please verify the accuracy of this data and report any discrepancies. Do not mail this form to the Insurer/Plan administrator.

5 Viewing transaction history

This chapter provides information on how to view transaction history and what information about a transaction can be viewed.

The eClaims application provides two views to browse a provider’s transaction history. There is a view for all transactions done during the day and a view for transactions submitted in the current month and for an additional month. The full details of a transaction are only available during the day on which it was created. Starting the following day, only a summarized view of the transaction is available.



Ensure you print or save the Insurance Company’s response the day it is generated. Starting the day following submission, only a summarized view of the request and response is available.

Who Should Read this Chapter?

Users who will submit healthcare payment or predetermination requests to Insurance Companies or users who will need to reconcile Insurance Company payments should read this chapter.

5.1 Today’s Transactions

You can access the transactions done during the day by clicking the **[Today’s Transactions]** tab. By default, all transactions for the day associated to the provider/organization the user is linked to are listed.

At the top of the Today’s Transactions page, the provider’s name associated to the user is indicated along with today’s date.



The options available for a transaction is based on the type of transaction selected. The application will only display the options available after a transaction is actually selected.

5.1.1 Searching for transactions

The **[Today's Transaction]** tab allows you to specify one or more criteria to search for a particular transaction.

The following table explains each search criterion available.

Search Field	Description
Provider	This search field provides a drop-down list of the provider(s) available for selection, including providers for whom there may be no transaction. The list is built based on the providers to whom the user can submit requests.
Request Type	This search field provides a drop-down list of the types of transactions available to search. The only possible types of transactions are: <ul style="list-style-type: none"> ■ Payment Request ■ Predetermination Request
Insurance Company	This search field provides a drop-down list of the insurance companies that accept electronic extended healthcare claims.
Submit Status	This search field provides a drop-down list of the transaction submit statuses. The only possible submit statuses are: <ul style="list-style-type: none"> ■ Saved: for transactions that were saved by the user ■ Submitted: for transactions that were actually submitted to the Insurance Company ■ Unsuccessful: for transactions that were submitted but for which there was not a successful response. Some of these transactions can be tried again
Insurance Co. Claim ID	This search field allows you to search directly for a transaction by entering the claim identifier assigned by the Insurance Company. Leave this field blank if you want the application to ignore this search criterion. Note: Transactions that were saved or were unsuccessfully submitted will not have an Insurance Company claim identifier.
Web Claim ID	This search field allows you to search directly for a claim by entering the identifier assigned by the Portal. Leave this field blank if you want the application to ignore this search criterion.
Patient Last Name	This search field allows you to search directly for a patient by entering the patient's last name. Leave this field blank if you want the application to ignore this search criterion.



Because the application allows you to save a transaction whether a single field or all fields are populated, the transaction may have no value corresponding to some of the search fields. Consequently, the saved transaction might not be selected during a search.

To search for one or more transactions:

1. Click on the **[Today's Transactions]** tab. You can use this tab at the same time as other tabs without losing the information you may have entered in those tabs.
2. Use the search fields to indicate the criteria of the transaction(s) you wish to find.
3. Click **Search**.

The results of the search are provided in the Search Results section with a summary line representing each transaction that matched the search criteria.

Claim Entry
Today's Transactions
Past Transactions
Authorization Forms

[Frequently Asked Questions](#)
[User Manual](#)

Today's Transactions

Today's transactions are listed below. You can filter the results using the search fields. To void a transaction, select the transaction and click "Void".

Provider Name: **Lena Bones** Today's Date: **2014-06-22**

Provider:

Request Type:

Web Claim ID:

Insurance Company:

Submit Status:

Patient Last Name:

Insurance Co. Claim ID:

Search Results
1 records were found.

Web Claim ID	Provider	Request Type	Insurance Company	Submit Status	Insurance Co. Claim ID	Response Status	Patient Name	Total Submitted	Total Paid
C 170250	Lena Bones	Payment Request	Simulated Adjudicator	Submitted	5193	Problem Encountered	Last Name, First Name	\$100.00	
End									

The application displays up to 25 records at one time (to a maximum of 250 records retrieved), and at the bottom of the search results, you can see which records out of how many are currently being displayed:

Record(s) 1 to 25 of 26

The following will display if only one record is returned to the Search Results:

End

If no records matched the search criteria, the application will return the following:

Search Results

0 records were found.

4. To view the next 25 records, click [Next »](#) located at the bottom right of the search results section.
5. To return to the previous 25 records, click [« Previous](#) located at the bottom left of the search results section.

The following explains what each column header represents for the columns that cannot be searched on:

Search Field	Description
Response Status	<p>The request’s status is provided in this column when the request was submitted at least once. The following provides the possible values:</p> <ul style="list-style-type: none"> ■ Explanation of Benefits: this status is used to indicate that the request generated an Explanation of Benefits; that is, the request was fully adjudicated. This type of response can be cancelled. ■ Acknowledgement: this status is used to indicate that the request generated an Acknowledgement; that is, the request was received but did not complete adjudication. This type of response can be cancelled. ■ Predetermination: this status is used to indicate that the request generated a successful Predetermination response. ■ Predetermination Acknowledgement: this status is used to indicate that the request generated a Predetermination Acknowledgement; that is, the request was received but did not complete adjudication. ■ Problem Encountered: this status is used to indicate that the request generated a Problem Encountered response. It may be possible to select this request, make a correction and resubmit. ■ Timeout: this status is used to indicate that the request did not reach the Insurance Company or was not processed in the expected delay. It is possible to select this request and attempt to submit it again on the same day. ■ Voided: this status is used to indicate that the originally submitted request was cancelled. Only Explanation of Benefits and Acknowledgement responses can be voided. ■ Void Request Declined: this status is used to indicate that the request to void the originally submitted request was rejected. A reason was provided at the time the request was rejected. The original response (Explanation of Benefits or Acknowledgement) is still valid. ■ Void Timeout: this status is used to indicate that the cancel request did not reach the Insurance Company or was not processed in the expected delay. It is possible to select this request and try to submit it again the same day. The original response (Explanation of Benefits or Acknowledgement) is still valid. ■ Error(s): this status is used to indicate that the request triggered one or more errors. A request will have this response status only if the application was able to save the request. <p>If the transaction was saved, and consequently never submitted, the Response Status will be blank.</p>
Patient Name	The patient name associated to the request, if there is any, is provided on the summary line in the format last name, first name.
Total Submitted	The total submitted amount associated to the request, if there is any, is provided on the summary line.

Search Field	Description
Total Paid	The Insurance Company's total amount paid for an Explanation of Benefits or the estimated amount that would be paid for a Predetermination associated to the request, if there is any, is provided on the summary line.

- Select the desired transaction by clicking the option button () to the left of the summary line.

The transaction line will be bolded.

Search Results
1 records were found.

<u>Web Claim ID</u>	<u>Provider</u>	<u>Request Type</u>	<u>Insurance Company</u>	<u>Submit Status</u>	<u>Insurance Co. Claim ID</u>	<u>Response Status</u>	<u>Patient Name</u>	Total Submitted	Total Pa
<input checked="" type="radio"/> 170250	Lena Bones	Payment Request	Simulated Adjudicator	Submitted	5193	Problem Encountered	Last Name, First Name	\$100.00	

Record(s) 1 to 1 of 1

Based on the transaction selected, you will be presented with different options.

To return to the default list in the Search Results, click **Remove All Filters**. All transactions done during the day will be available in the Search Results.

5.1.2 Sorting the search results

The application allows you to sort the results in ascending or descending order on certain columns.

To sort the results:

- Select the column by which you wish the results to be sorted.

The results can be sorted based on the following columns (the column header is underlined):

- Web Claim ID
- Provider
- Request Type
- Insurance Company
- Submit Status
- Response Status
- Patient Name

- When a column is sorted, an up () or down () triangle will appear to the right of the column header.
 - If the triangle points up (), the records will be sorted in ascending order based on the values in that column.
 - If the triangle points down (), the records will be sorted in descending order based on the values in that column.

- To reverse the order of the sort on a column, simply click on the column header again.



It is possible to sort on multiple columns. The last column header selected will be the primary column used by the application to sort the search results.

If a column is a secondary sort, it will have a  next to the triangle; if the column is a tertiary sort, it will have a  next to the triangle, and so on.

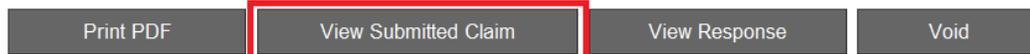
5.1.3 Viewing the submitted information

The option to view the details of the submitted information is available for transactions with a **Submit Status** of **Submitted** or **Unsuccessful**.

To view the submitted information:

- Click on the **[Today's Transactions]** tab.
- Select the transaction from the list (all are displayed by default) or search for the transaction for which you wish to view the submitted details.
- In the Search Results, click the option button () to the left of the summary line corresponding to the desired request.

The appropriate action buttons become available. Note: These buttons will vary depending upon whether you selected a payment request or predetermination request.



- To view the details of what was originally submitted click **View Submitted Claim**.

The submitted information will display as it was displayed in the **Review and Submit** page at the time of submission.

Refer to the [Step 3 - Review and Submit](#) section for more information about the information found on this page.

- To return to the **Today's Transactions** page, click **Exit**.

The **Today's Transactions** page will display with the same Search Results and same transaction selected.

5.1.4 Viewing the generated response

The option to view the response generated by the Insurance Company is available for transactions with a **Submit Status** of **Submitted**.

To view a transaction's response:

- Click on the **[Today's Transactions]** tab.
- Select the transaction from the list (all are displayed by default) or search for the transaction for which you wish to view the response.
- In the Search Results, click the option button () to the left of the summary line corresponding to the desired request.

Note: These buttons will vary depending upon whether you selected a payment request or predetermination request.



4. Click **View Response**.

The last response generated for the request will display. The information is the same as was originally presented at the time the response was received from the Insurance Company.

Refer to the [How to interpret the Insurance Company's response](#) section for more information about the information found on the response page.



Once the response is displayed, you will be able to:

- Print or save an electronic copy of the response by clicking **Print PDF**. Refer to [Printing and saving the Insurance Company's Response](#) section for more information on printing or saving a response.
- Submit a new claim by clicking **New Claim**.
- Submit a claim for another member of the same family by clicking **New Claim from the Same Family**.
- Return to the **Today's Transactions** main page by clicking **Done**.

5.1.5 Creating a payment request based on a predetermination

You can base a payment request on a predetermination that was submitted earlier on the current day, rather than re-entering the information from a predetermination into a new payment request. This is achieved by selecting a predetermination, and then copying it into a new payment request.

After the payment request is created, you can work with it as you would work with payment requests that were not copied from predeterminations, with the exception of the following fields, which are copied as read-only:

- **Insurance Company**
- **Provider Name**
- **Servicing Provider**



You cannot change the name of the provider to another provider who works out of the same clinic.

When creating payment requests based on predeterminations, you can only use predeterminations that were submitted earlier on the current day.

The option to copy a predetermination request as a payment request is available for transactions with a **Response Status** of **Predetermination** and a **Submit Status** of **Submitted**. You can use a predetermination as a basis for multiple claims; source predeterminations are not removed when they are copied.

To create a payment request based on a predetermination:

1. Click on the **[Today's Transactions]** tab.
2. Select the predetermination transaction from the list (all are displayed by default) or search for the transaction you wish to copy.

- In the Search Results, click the option button () to the left of the summary line corresponding to the desired request.

At the bottom of the page, the **Copy to Payment Request** button becomes visible:

Copy to Payment Request

- Click **Copy to Payment Request**.

A payment request is created. It contains the values from the selected predetermination. The following message appears at the top of the page:

 **Warning**

All the content of the predetermination has been copied. Please verify that these fields are filled accurately:

- Payable To
- Date of Service
- Service Codes

- Verify the information copied from the predetermination. Update it as needed, and ensure that all mandatory fields are completed.
- Complete the claim as described in Step 2 - Complete Patient Coverage and Claim Details and Step 2 - Complete Patient Coverage and Claim Details

5.1.6 Resubmitting a timeout transaction

The option to resubmit a transaction that received a connection error or timeout is only available for transactions with a **Response Status** of **Timeout** or **Void Timeout**.

To resubmit a transaction that received a connection error (or timeout):

- Click on the **[Today's Transactions]** tab.
- Select the transaction from the list (all are displayed by default) or search for the transaction you wish to resubmit.
- In the Search Results, click the option button () to the left of the summary line corresponding to the desired request.

At the bottom of the page, the **View Submitted Claim** button becomes visible:

View Submitted Claim

- Click **View Submitted Claim**.

The originally submitted information will display as was displayed in the **Review and Submit** or the **Void Confirmation** page at the time of submission with the following options:

Exit

Try Again

- To attempt the submission again, click **Try Again**.
- To return to the **Today's Transactions** page, click **Exit**.

The **Today's Transactions** page will display with the same Search Results and same transaction selected.

5.1.7 Completing a saved request

The application allows you to return to a previously saved request in order to complete it and submit it to the Insurance Company. The option to resubmit a saved transaction is only available for transactions with a **Submit Status** of **Saved**.

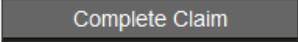


*A saved transaction is only available for completion on the day it was saved.
The option to complete a request is only available for requests that have been saved.*

To return to a saved transaction:

1. Click on the **[Today's Transactions]** tab.
2. Select the transaction from the list (all are displayed by default) or search for the transaction for you to complete.
3. In the Search Results, click the option button  to the left of the summary line corresponding to the saved request.

At the bottom of the page, the **Complete Claim** button becomes visible:



Complete Claim

4. Click **Complete Claim**. You will be taken to the **Claim Entry** page where you can complete the request.

Once in the request, you have the option to:

1. Complete the claim by entering the remaining request information (if necessary) and clicking **Continue**. For more information on how to complete and submit a request, refer to the [Submitting electronic claims](#) section. To return to the **[Today's Transactions]** tab, click on the **[Today's Transactions]** tab.
2. Return to the **[Today's Transactions]** tab by clicking **Cancel and Exit**. If you have updated the request, all changes to the request will be lost.
3. Update the request and click **Save for Later** again to return to the **Today's Transactions** page. You will get a message confirming that the claim was saved and providing the Web Claim ID for the request. Clicking **OK** brings you back to the **[Today's Transactions]** tab.



If you select to complete a previously saved claim, information previously entered in the Claim Entry tab, if any, will be replaced by the information in the saved claim.

5.1.8 Resubmitting a Problem Encountered response

The option to resubmit a transaction that led to a Problem Encountered response is only available for transactions with a **Response Status** of **Problem Encountered**.

To resubmit a transaction that has a Problem Encountered status:

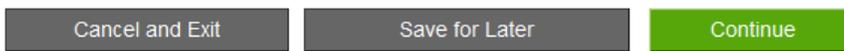
1. Click on the **[Today's Transactions]** tab.
2. Select the transaction from the list (all are displayed by default) or search for the transaction that has a Problem Encountered response status.
3. In the Search Results, click the option button () to the left of the summary line corresponding to the desired request.

At the bottom of the page, the action buttons become visible:



4. Click **Complete Claim**.

You will be brought to the **Complete Patient Coverage and Claim Details** page where you can update the request and resubmit. The same options that are available for a new request will be available:



5. Update the request as necessary.
6. Click **Continue** to resubmit the request.

The **Review and Submit** page will display. Refer to the [Submitting electronic claims](#) section for more information on how to complete the submission of the request.

7. To save changes done to the transaction, click **Save for Later** then **OK** when the message that confirms that the transaction was saved generates. The **Today's Transactions** page will display with the same Search Results and same transaction selected.
8. To return to the **Today's Transactions** page, click **Cancel and Exit**. The system will warn you that you will lose any updated information. The transaction will still be available in its original state. The **Today's Transactions** page will display with the same Search Results and same transaction selected.

5.1.9 Void option

For Explanation of Benefits and Acknowledgement responses, the application allows you to cancel or void the transaction. Refer to the [Cancelling a request after a response was obtained](#) section for more information on how to void a claim.

5.2 Past Transactions

You can access a summarized view of most transactions submitted in the current month (excluding the current day) and for an additional month in the past by clicking the **[Past Transactions]** tab. By default, the transactions for the past 10 days are listed.



Transactions that were saved will not be available in the Past Transactions view.

At the top of the **Past Transactions** page, the provider's name is indicated.



Starting the day after the transaction was generated, only a summary of the transaction is available. There are no details about the submitted claim lines; only the total amount submitted and paid (or estimated) is available.

5.2.1 Searching for and downloading transactions

The application allows you to specify one or more criteria to search for a particular transaction.

Submit a Claim or Review Transactions

Claim Entry
Today's Transactions
Past Transactions
Authorization Forms
Frequently Asked Questions >
User Manual

Past Transactions

Transactions for the past 10 days are listed by default. Only transactions of current month and the previous month are available. A maximum of 250 transactions will be displayed. You can narrow the search results by using the filters below.

To sort the results, click on an underlined column header.

You can also use the wildcard character "%" in Patient Last Name field if you are not sure of exact spelling (ex: "Sm%" will find "Smith" and "Smythe").

To download transactions in a delimited text file (csv), select them and click the "Download" button.

New! Now you can download a claim response by clicking the PDF icon in the "PDF Response" column. If the claim doesn't get processed successfully, a PDF is not created.

Provider Name: **ONUAT Facility Rehab**

Provider <input type="text" value="Select"/>	Request Type <input type="text" value="Select"/>	Insurance Company <input type="text" value="Select"/>	Insurance Co. Claim ID <input type="text"/>
Web Claim ID <input type="text"/>	Patient Last Name <input type="text"/>	Patient First Name <input type="text"/>	From * <input type="text" value="2019-08-11"/> <small>yyyymmdd</small>
			To * <input type="text" value="2019-08-20"/> <small>yyyymmdd</small>

Search
Remove All Filters



By default, the period (the From and To dates) is set to a 10 day period.

The following table explains each search criteria available. If the value is **Select** when multiple values are available for the search field, the application will ignore this search criterion:

Search Field	Description
Provider	This search field provides a drop-down list of the provider(s) available for selection, including providers for whom there may be no transactions. The list is built based on the providers the user can submit requests for.
Request Type	This search field provides a drop-down list of the type of transactions available to search. The only possible type of transactions are: <ul style="list-style-type: none"> ■ Payment Request ■ Predetermination Request
Insurance Company	This search field provides a drop-down list of the Insurance Company that accepts electronic extended healthcare claims.
Insurance Co. Claim ID	This search field allows you to search directly for a transaction by entering the claim identifier assigned by the Insurance Company. Leave this field blank if you want the application to ignore this search criterion.
Web Claim ID	This search field allows you to search directly for a claim by entering the identifier assigned by the Portal. Leave this field blank if you want the application to ignore this search criterion.
Patient Last Name	This search field allows you to search directly for a patient by entering the patient's last name Leave this field blank if you want the application to ignore this search criterion.
From/To	These search fields allow you to search directly for transactions within a given period. Simply specify the start and end dates of the period you wish to find transactions for in the From and To fields. You can enter a date in the format yyyy-mm-dd, yyyyymmdd or yyyy-m-d. The date field format will display in yyyy-mm-dd. Alternatively, select a date using the calendar tool.



The only option available once one or more transactions have been selected is to save or open the summarized information as a text file.

To search for one or more transactions:

1. Click on the **[Past Transactions]** tab. You can use this tab at the same time as other tabs without losing the information you may have entered in those tabs.
2. Use the search field(s) to indicate the criteria of the transaction(s) you wish to find.
3. Click **Search**.

The results of the search are provided in the Search Results section with a summary line representing each transaction that matched the search criteria:

Past Transactions

Transactions for the past 10 days are listed by default. Only transactions of current month and the previous month are available. A maximum of 250 transactions will be displayed. You can narrow the search results by using the filters below.

To sort the results, click on an underlined column header.
 You can also use the wildcard character “%” in Patient Last Name field if you are not sure of exact spelling (ex. “Sm%” will find “Smith” and “Smythe”).
 To download transactions in a delimited text file (.csv), select them and click the “Download” button.
New! Now you can download a claim response by clicking the PDF icon in the “PDF Response” column. If the claim doesn’t get processed successfully, a PDF is not created.

Provider Name: **ONUAT Facility Rehab**

Provider: Request Type: Insurance Company: Insurance Co. Claim ID:
 Web Claim ID: Patient Last Name: Patient First Name:
 From: To:
 yyyyymmdd yyyyymmdd

Search Results

13 records were found.

Web Claim ID	Provider	Submit Date	Request Type	Insurance Company	Insurance Co. Claim ID	Response Status	PDF Response	Patient Name	Payable To	Total Submitted	Total Paid
<input type="checkbox"/> 1332292	Paul Chiro-ONUAT	2019-09-03	Payment Request	MBCM	4547531	Acknowledgement		Smith, Julie		\$250.00	
<input type="checkbox"/> 1332281	Paul Chiro-ONUAT	2019-09-03	Payment Request	MBCM	4547495	Acknowledgement		Smith, Julie		\$250.00	
<input type="checkbox"/> 1332268	Paul Chiro-ONUAT	2019-09-03	Payment Request	MBCM	4547474	Acknowledgement		Smith, Julie		\$250.00	

The application displays up to 25 records at one time (to a maximum of 250 records retrieved), and at the bottom of the search results, you can see which records out of how many are currently being displayed:

Record(s) 1 to 25 of 26

The following will display if only one record is returned to the Search Results:

End

- To view the next 25 records, click [Next »](#) located at the bottom right of the search results section.
- To return to the previous 25 records, click [« Previous](#) located at the bottom left of the search results section.
- To display the EOB or Acknowledgement response associated with a specific transaction, click the PDF icon within the PDF Response column.

The following explains what each column header represents for the columns that cannot be searched on:

Search Field	Description
Submit Date	The submit date represents the date when the transaction was submitted to the Insurance Company.
Response Status	<p>The request's status is provided in this column when the request was submitted at least once. The following provides the possible values in this view and their meaning:</p> <ul style="list-style-type: none"> ■ Explanation of Benefits: this status is used to indicate that the request generated an Explanation of Benefits, that is, the request was fully adjudicated. This type of response can be cancelled. ■ Acknowledgement: this status is used to indicate that the request generated an Acknowledgement; that is, the request was received but did not complete adjudication. This type of response can be cancelled. ■ Predetermination: this status is used to indicate that the request generated a successful Predetermination response. ■ Predetermination Acknowledgement: this status is used to indicate that the request generated a Predetermination Acknowledgement, that is, the request was received but did not complete adjudication. ■ Problem Encountered: this status is used to indicate that the request generated a Problem Encountered response. It may be possible to select this request, make a correction and resubmit. ■ Voided: this status is used to indicate that the originally submitted request was cancelled. Only Explanation of Benefits and Acknowledgement responses can be voided. ■ Void Request Declined: this status is used to indicate that the request to void the originally submitted request was rejected. A reason was provided at the time the request was rejected. The original response (Explanation of Benefits or Acknowledgement) is still valid. ■ Timeout: this status is used to indicate that the request did not reach the Insurance Company or was not processed in the expected delay. It is possible to select this request and attempt to submit it again on the same day. ■ Void Timeout: this status is used to indicate that the cancel request did not reach the Insurance Company or was not processed in the expected delay. It is possible to select this request and try to submit it again the same day. The original response (Explanation of Benefits or Acknowledgement) is still valid.
PDF Response	If the PDF  icon is present, you can click it to display the EOB or Acknowledgement response.
Patient Name	The patient name associated to the request, if there is any, is provided on the summary line in the format Last Name, First Name.
Total Submitted	The total submitted amount associated to the request, if there is any, is provided on the summary line.
Total Paid	The Insurance Company's total amount paid for an Explanation of Benefits or the estimated amount that would be paid for a Predetermination associated to the request, if there is any, is provided on the summary line.

If no records matched the search criteria, the application will return the following:

Search Results

0 records were found.

To select and download one or more transactions into a csv file:

1. Select the desired transactions by clicking the check box to the left of each desired transaction.
2. You can select all transactions by clicking the check box option () at the top of the check box column. Click  to deselect all transactions.



The option to deselect is only available if the option to select all transactions was used.

3. Click **Download**. The file generated is an Excel Comma (or semicolon) Separated Values (csv) file depending on your regional settings.



You have the option to:

4. If you have Excel, click **Open**. Depending on your browser settings, Excel may or may not become the active window. Simply switch to Excel and you should see the delimited file.



If Excel is minimized, it should become the active window. If you remain on the Past Transactions screen, simply switch to the file opened in Excel.

The file will open directly into Excel (depending on your version):

A	B	C	D	E	F	G	H	I	J	K
Web Claim Provider	Submit Date	Request Type	Insurance Company	Insurance Co. Claim ID	Response Status	Patient Name	Payable To	Total Submitted	Total Paid	
110318 Sam Dev	20/08/2019	Payment Request	Simulated Adjudicator	'6951'	Explanation of Benefits	Ball, Bill	Insured Member	\$15.00	\$0.00	
110279 Sam Dev	19/08/2019	Payment Request	Simulated LIUNA Local 183	'7821'	Acknowledgement	test, Bill	Insured Member	\$320.00		
110130 Sam Dev	13/08/2019	Predetermination Request	Simulated Adjudicator	'1047'	Predetermination	Testing, Bill		\$15.00	\$13.50	



Depending on your Regional and Language settings, and the language in which you use the Portal, the file may open in Excel with the fields separated into columns or badly separated.



When all fields appear in a single column, select the column and use the Text to Columns option in Excel's Data section (or tab).

You will be asked to specify the structure of the data. Based on the separator, simply select that the file is a delimited file then specify the separator (which will be a comma or a semi colon depending on the language you use the Portal).

If the fields are badly separated into columns, save the file locally first then follow the following steps:



1. From Excel, open a new workbook.
2. Access the From Text functionality from the Data tab or menu.
3. Browse to the file saved locally select it and then click Import.
4. Using the assistant, identify the file as being a delimited file then click Next.
5. Select the correct separator (comma when the Portal is in English and semi colon when the Portal is in French). Ensure no other separator is checked then click Finish.

5. Click **Save**.
6. Browse through your folders to specify the location where you want to save the file.
7. Provide the name of the file you want to save the transaction(s) as. By default, the file name given to the file is "eClaims_Activity_yyyy-mm-dd" where yyyy-mm-dd is the current date.
8. Select your application of choice to open the comma or semicolon delimited file.
9. To return to the **Past Transactions** page, click **Cancel** at any time.

5.2.2 Available information for download

The following fields are available in the delimited file:

Data Field	Description
Web Claim ID	This represents the request identifier assigned by the Portal. Use this identifier when communicating with the TELUS Health service desk.
Provider	This represents the name of the provider associated to the transaction. The name is in the format First name first followed by Last Name separated by a space.
Submit Date	This represents the day the request was submitted to the Insurance Company.
Request Type	This represents the type of request submitted to the Insurance Company.
Insurance Company	This represents the Insurance Company the transaction was submitted to.
Insurance Co. Claim ID	This represents the request identifier assigned by the Insurance Company. Use this identifier when communicating with the Insurance Company.
Response Status	<p>This represents the status of the response generated. The following response status types are possible:</p> <ul style="list-style-type: none"> ■ Explanation of Benefits ■ Acknowledgement ■ Predetermination ■ Predetermination Acknowledgement ■ Voided ■ Void Request Declined ■ Detected Issue ■ Timeout ■ Void Timeout <p>Each status is described in the previous section.</p>
Patient Name	This represents the name of the patient associated to the request.
Payable To	This represents the recipient to whom the claim payment will be made out.
Total Submitted	This represents the total submitted amount associated to the request.
Total Paid	This represents the total paid amount or total estimated amount associated to the request. This is the amount that will be paid to the recipient identified in the Payable to data field.

5.2.3 Sorting the search results

The application allows you to sort the results in ascending or descending order on certain columns.

To sort the results:

1. Select the column you wish the results to be sorted by. By default, the transactions are sorted in descending order by submit date.

The results can be sorted based on the following columns and also have the column header underlined:

- Web Claim ID
- Provider
- Submit Date
- Request Type
- Insurance Company
- Response Status
- Patient Name

2. When a column is sorted, a triangle an up (▲) or down (▼) triangle will appear to the right of the column header.
 - If the triangle points up (▲), the records will be sorted in ascending order based on the values in that column.
 - If the triangle points down (▼), the records will be sorted in descending order based on the values in that column.
3. To reverse the order of the sort on a column, simply click on the column header again.



It is possible to sort on multiple columns. The last column header selected will be the primary column used by the application to sort the search results.

If a column is a secondary sort, it will have a [2] next to the triangle; if the column is a tertiary sort, it will have a [3] next to the triangle, and so on.

6 Cancelling a request after a response was obtained

This chapter provides information on how to cancel (or void) a payment request after it has been successfully submitted.



It is only possible to cancel a payment request the day it was submitted.

Cancelling (or voiding) a transaction is done by going through the **[Today's Transactions]** tab where you can select the transaction then void it. Because it is only possible to cancel a transaction the day it was submitted, the option to cancel is only available through the **[Today's Transactions]** tab.



It is only possible to cancel a payment request that received an Explanation of Benefits or an Acknowledgement response. In the future, this could be based on the Insurance Company that generated the response.

Who Should Read this Chapter?

All users who will submit healthcare payment or predetermination requests to Insurance Companies and who need to cancel a previously submitted request should read this chapter.



If you notice an error (such as wrong patient or wrong provider) after the Insurance Company has generated a response, you must first void the first request then generate a new request with the information corrected.

It is not possible to simply update a previously submitted request even if the Insurance Company has not yet completed their adjudication process.

6.1.1 Voiding the transaction

To cancel a transaction you must first go to the **[Today's Transactions]** tab to find the request to cancel. Refer to the [Today's Transactions](#) section for more information on how to use the **[Today's Transactions]** tab.

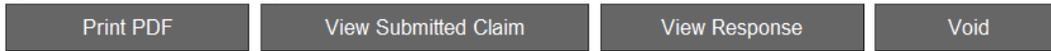


There will be no buttons available until a transaction is selected.

To search for a transaction:

1. Click on the **[Today's Transactions]** tab. You can use this tab at the same time as other tabs without losing the information you may have entered in those tabs.
2. Use the search fields to indicate the criteria of the transaction(s) you wish to find. You can use the Insurance Company's claim identifier to find the request directly. The identifier is located in the top left section of the Explanation of Benefits or Acknowledgement responses.
3. Click **Search**.
4. Select the transaction in the Search Results by clicking the option button () to the left of the request you wish to cancel.

Based on the transaction selected, you will be presented with different options. The following options are available if you have selected a transaction that can be voided:



5. Click **Void**.

The **Void Confirmation** page displays.

Claim Entry
Today's Transactions
Past Transactions
Authorization Forms
Frequently Asked Questions >
Help Manual

Void Confirmation

Total payable to: **Insured Member**
 Payee Name: **Brian Simpson**
 Expected Payment: **Unavailable**
 Date:

Statement Date: **2016-10-19** Insurance Company: **Simulated Adjudicator**
 Insurance Co. Claim: **8992** Policy: **845785362**
 ID: Benefit Type: **Extended Health Care**

Servicing Provider: **Ann Anderson**
 Address: **56 Bloomfield ~ Hills**
Mississauga, ON K1B 2C3

Insured Member: **Brian Simpson** Patient Name: **Brian Simpson (Insured Member)**
 Member ID: **A785492** Date of Birth: **1948-10-04**
 Date of Birth: **1948-10-04**

Details of your claim									
Line	Date of Service	Service Description	Submitted Amount	Eligible Amount	COB	Deductible	% Payable	Paid by Plan	Note(s)
1	2016-10-11	Exercise	\$50.00	\$45.00			100%	\$45.00	
2	2016-10-11	Prescription	\$10.00	\$10.00			80%	\$8.00	
Totals:			\$60.00	\$55.00			Total Paid:	\$53.00	

Please indicate the reason you are voiding:

Reason: * Entered in Error
 Altered Decision

Cancel
Confirm Void

6. Review the information on the page to confirm this is the transaction you wish to void.
7. Select the reason you are cancelling by clicking the option button that corresponds to your situation.

Reason: * Entered in Error
 Altered Decision

The following explains what each reason represents:

- **Entered in Error:** use this reason when the information in the submitted request was recorded incorrectly or was recorded in the wrong record. For example, the claim was submitted against the wrong provider or wrong patient.
- **Altered Decision:** use this reason if there was no error made and you no longer wish to accept the Insurance Company's response.



If a Claim Acknowledgement response is generated and it was indicated to make the payment to the provider/organization, to change the recipient of the payment you must first void the first request then resubmit a new request with the insured member identified as the recipient of payment (Payable to). Use the reason "Altered Decision" in this case.

8. Click **Confirm Void** to confirm that you wish to submit the request to void the transaction.

The processing page will display, followed by the confirmation that the claim was voided.

Processing ⌄

Web Claim ID: **97679** Void Request has been submitted.

Please wait while your claim is being processed.

When the void request is successful, a **Claim voided** message appears at the top of page.

Claim Entry
Today's Transactions
Past Transactions
Authorization Forms
Frequently Asked Questions ▶

Explanation of Benefits

Claim voided

Claim has been voided.
Please see Insurer notes for additional details.

Insurer notes:
IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE INSURER AT

[Show more](#)

Statement Date: **2016-10-19**

Insurance Co. Claim ID: **8992**

Servicing Provider: **Ann Anderson**

Address: **56 Bloomfield ~ Hills
Mississauga, ON K1B 2C3**

Insured Member: **Brian Simpson**

Member ID: **A785492**

Date of Birth: **1948-10-04**

Insurance Company: **Simulated Adjudicator**

Policy: **845785362**

Benefit Type: **Extended Health Care**

Patient Name: **Brian Simpson (Insured Member)**

Date of Birth: **1948-10-04**

Details of your claim

Line	Date of Service	Service Description	Submitted Amount	Eligible Amount	COB	Deductible	% Payable	Paid by Plan	Note(s)
1	2016-10-11	Exercise	\$50.00	\$45.00			100%	\$45.00	
2	2016-10-11	Prescription	\$10.00	\$10.00			80%	\$8.00	
Totals:			\$60.00	\$55.00			Total Paid:	\$53.00	Voided

Print PDF
Done

If the void request is not successful, you can also get one of the following responses:

- **Problem Encountered:** this response will be generated if there was some problem with the void request. This will also set the response status of the original request to **Void Request Declined**.
- **Connection Error:** when this occurs, a box will generate with this title if the void request did not reach the Insurance Company or did not process in the expected delay.

Refer to the [How to interpret the Insurance Company's response](#) section for more information on the responses indicated.

6.1.2 What if the transaction I want to cancel was not done today?

You may only become aware that a mistake was made one or more days after the request was submitted and the Insurance Company generated a response. At this time, when this occurs, you must contact the Insurance Company directly to cancel the request.

Contact information is normally provided in the response as well as all the identifiers that the Insurance Company will require to trace the request. You can also check your reference guide for the Insurance Company contact information.



It is important to keep a printed or electronic copy of the response in case you need to contact the Insurance Company as it contains all the information the Insurance Company requires to properly answer your inquiries.

7 Authorization forms

This chapter provides information on the consent forms available for your use. They are not pre-filled. They are meant to be filled by your patient or your patient's parent/guardian.

Who Should Read this Chapter?

A user who will submit healthcare payment or predetermination requests to Insurance Companies.



You must ask your patient or your patient's parent/guardian for permission to submit their healthcare payment request or predetermination electronically.

You must also ask their permission every time they wish to assign the payment over to the provider (or the provider's organization).

7.1 The Consent Forms

Use this form anytime you are submitting an electronic payment request or predetermination on behalf of your patient.

1. To access the forms, click on the [\[Authorization Forms\]](#) tab.

The available forms are provided.

Electronic transmission consent

Obtain consent to submit claims electronically on behalf of your patient

Benefit assignment

Obtain consent to receive payment from the patient's insurer



|



2. Click the Form link.

A PDF of the form will open in a new window.



Electronic transmission authorization and consent form

Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Provider		
First name	Last name	
Address		
City	Province	Postal code
Patient		
First name	Last name	
Primary coverage insurer/payer	Primary coverage plan member name	
Primary coverage policy number (also referred to as group or contract number)		
Primary coverage certificate (also referred to as member/identification number)		
(Canada Life only) secondary coverage plan member name		

Consent to collect and exchange personal information

Purpose

Personal information that we collect and disclose about you, and if applicable, is used by the insurer, and/or plan administrator of your group benefits plan, its affiliates and their service provider(s) for the purposes of assessing eligibility for your claims, underwriting, investigating, auditing and otherwise administering the group benefits plan, including the investigation of fraud and / or plan abuse and for internal data management and data analytical purposes.

Authorization and consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize such insurer and / or plan administrator and their service provider(s) to:

- use my personal information for the above purposes.
- exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits, or other benefits programs, other organizations, or service providers working with such insurer and/or plan administrator or any of the foregoing, when relevant for the above purposes.
- where applicable exchange personal information concerning any claims with any assignee of benefits payable and exchange personal information for the above purpose electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning any claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my employer or benefit plan sponsor, for the purposes of investigation and prevention of fraud and/or benefit plan abuse. I understand that the submission of fraudulent claims is a criminal offence.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my benefit plan sponsor, for that purpose.

If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information for the healthcare provider and the insurer and/or plan administrator and their service provider(s) to use and disclose their personal information as set out above.

I accept the terms and conditions

Benefit assignment form

I hereby assign benefits payable for the eligible claims to the healthcare provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to such provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the healthcare provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this benefit assignment form, that any benefit payment made in accordance with this benefit assignment form will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this assignment will apply to all eligible claims submitted electronically by my healthcare provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the healthcare provider.

I accept the terms and conditions

Date

Signature of plan member

All information contained herein is protected by privacy laws including the Personal Information Protection and Electronic Documents Act (PIPEDA) and all the corresponding provincial legislation. All users agree to protect the personal health information contained herein from unauthorized use, disclosure, loss, theft, or compromise in accordance with the above noted laws and with at least the same care employed to protect their own confidential information. Any unauthorized access, disclosure or use of this information is illegal.

3. Print and fill out the blank form. Ensure your patient or your patient's parent/guardian sign the form.

1.

8 Managing Passwords

The “My Profile” section on the Provider Portal’s home page enables you to access the change password page.

To change your password:

1. Go to the Provider Portal’s Home page, section “My Profile”, in the bottom right corner of the page:

My Profile

Manage your profile details by using the following links.

Email and Banking Information >

Change Password >

Other Profile Updates >

2. Click **Change Password**.

The **Change Password** page displays:

3. Type the password currently being used in the **Current Password** field.
4. Type the new desired password in the **New Password** field.

Your password must respect the following conditions:



- *Contain at least one alphabetic and one non-alphabetic character*
- *Must be 8-10 characters in length*
- *Must not contain any spaces*
- *Must not be the same as your user name*
- *Must not be a previously used password*

5. Type the new desired password again in the **Confirm New Password** field
6. Click **Change Password**.

The message “Password changed successfully.” will display.



For a successful password change, you must correctly enter your current password. Your new password and confirmed password must also be the same.

9 Email and banking information

The Email and banking information tool allows registered providers to create or modify their Banking information and contact email address that is provided to TELUS Health.

Banking information and contact email address is supported as a reimbursement method by participating insurance companies. We invite registered users to view their current registration and update if desired with the banking details information and contact email address to be able to experience the convenience of receiving reimbursements directly into their bank accounts.

After logging into the Provider Portal, go to the “My Profile” section, at the bottom right corner of the Provider Portal home page, and click on the “Email and banking information” link to open the **Email and Banking Information** page:

My Profile

Manage your profile details by using the following links.

[Email and Banking Information >](#)

[Change Password >](#)

[Other Profile Updates >](#)

For further details regarding the Online Registration Process, please reference the Direct Deposit user guide available on the **Email and Banking Information** page.

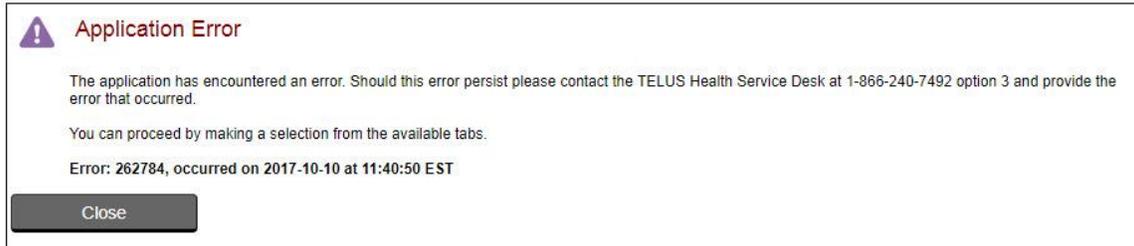
A User Name and Password are associated with a role in the system and this role determines the provider profile and service(s) you have on file. If your profile indicating no bank account details and no contact email address has been provided to TELUS Health, a reminder message will display.

You are required to provide TELUS Health with your bank account details and contact email address.

The Home page will display a notification message below the “My Profile” section for providers who have no banking details and no contact email address with TELUS Health. The notification message will remain until your banking details and contact email address are provided.

10 Application Error

In rare instances, the application may encounter an application problem from which it cannot recover. An Application Error will be presented to you whenever an unavoidable or unexpected error occurs within the application:



The problem may be temporary but if this error occurs frequently, simply contact the TELUS Health Service Desk by calling 1-866-240-7492, and providing the error that occurred.

To continue working with the application when such an error is encountered, simply click on one of the tabs.

11 Glossary of Terms

This section includes a description/definition of term used in this application.

Term	Description
Acknowledgement	See Claim Acknowledgement .
Adjudication	This refers to the process where the Insurance Company's claim processing system reviews then generates a response to a healthcare claim payment or predetermination request.
Benefit Assignment	This corresponds to the patient or patient's parent/guardian requesting that the amount paid by the Insurance Company be paid out directly to the provider or the provider's organization.
Claim Acknowledgement	This is a type of response generated when the Insurance Company has successfully received the payment request but is unable to complete its adjudication process. This statement simply serves to confirm reception of the payment request. Actual adjudication results will be provided at a later time through a paper means.
COB / Coordination of Benefits	Coordination of benefits. This applies when a patient has coverage under more than one plan that may or may not be from the same Insurance Company.
Deductible	When applicable, this represents the line amount of deductible retained by the Insurance Company for the claim line. This is the amount required to be paid before the Insurance Company can pay for a claim line.
eClaims	This corresponds to electronic extended healthcare claims submitted to health coverage held with Insurance Companies.
Eligible/Eligible Amount	This represents the line amount that the Insurance Company deemed eligible when calculating the amount paid for the claim line.
Explanation of Benefits (EOB)	This is a type of response generated when the Insurance Company has fully adjudicated (or processed) the payment request. This statement provides the actual results of the adjudication, including what amounts, if any, will be paid by the Insurance Company.
Insurance Company	This corresponds to an organization that provides extended health care coverage to plan members and their dependents when applicable.
Optical Supplier	This is an organization where optical supplies and/or optometrist services can be dispensed. There must be at least one registered optician or optometrist for the optical supplier to be registered. Note: At time of claim submission, when an optician is selected, it simply represents the person responsible for the request.
Payable to	This corresponds to whom the payment will be made out to.
Payment Request	Claim to an Insurance Company requesting payment for healthcare service(s) that a patient covered by the Insurance Company received.

Term	Description
Predetermination Request	Request to an Insurance Company requesting information about how the Insurance Company would pay for healthcare service(s) that a patient covered by the Insurance Company could or will receive.
Prescriber role	This corresponds to the type of healthcare professional that provides a prescription or a referral.
Provincial Insurance	This corresponds to the healthcare plan of the province where the patient resides. In some cases, it is necessary to fully exhaust all coverage with the provincial healthcare plan before coordinating payment with the Insurance Company.
Relationship	This corresponds to the relationship between the patient and the person who holds primary or secondary coverage. For example, a patient may be the insured member for primary coverage but the spouse of the person holding secondary coverage.
Service Code	This corresponds to the code representing a healthcare service or product. The list of service codes available to be claimed is based on the provider who performed the service.
Servicing Location	This corresponds to where the patient received or will receive the service(s).
Servicing Provider	This corresponds to the provider who has provided the patient one or more services or will provide the services. When an optician is selected, this corresponds to the provider responsible for the claim.
Submitted Amount	This represents the total line amount originally submitted for the claim line.
Timeout or Connection Error	When there is a connection problem with the Insurance Company or the Insurance Company's response takes too long to reach the Portal, a Timeout or Connection Error occurs.
Void	This corresponds to cancelling or asking for a reversal of the response of a payment request. Only Explanation of Benefits and Acknowledgements can be voided.

12 Coordination of benefits - determining order of coverage

Rules regarding order of coverage can be found in the document issued by the Canadian Life and Health Insurance Association Inc.

To access this document, click the following link:

[http://www.clhia.ca/domino/html/clhia/CLHIA_LP4W_LND_Webstation.nsf/resources/Consumer+Brochures/\\$file/Brochure_Guide_To_CoOrdinationBenefits_ENG.pdf](http://www.clhia.ca/domino/html/clhia/CLHIA_LP4W_LND_Webstation.nsf/resources/Consumer+Brochures/$file/Brochure_Guide_To_CoOrdinationBenefits_ENG.pdf)

