



PALMETTO GBA[®]
eServices

User Manual

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Revision History

Date	Description
1/01/2022	2022 Version
3/15/2022	Updated section 3.5 with new preventative information
4/08/2022	Clarified verbiage in section 3.9, updated 1.11, 8.5, and 8.6
7/27/2022	Updated the Eligibility Note section with the new date range limitations. Updated the Hospice/HomeHealth tab information with NOA Indicator message. Added a new section for ADR Status Widget and Dashboard.
3/3/2023	Update with update login information and new form availability.

Glossary and Acronyms

Acronym	Description
CMS	Centers for Medicare & Medicaid Services
CWF	Medicare Common Working File
EDI	Electronic Data Interchange
EDI Enrollment Agreement	This agreement must be completed by each provider prior to submitting electronic media claims (EMC) or other EDI transactions to Medicare. It is also required to participate in eServices.
eServices	The eServices application. This application is available through the Palmetto GBA website.
ESRD	End-stage Renal Disease
DOEBA	Date of Earliest Billing Activity
DOLBA	Date of Latest Billing Activity
FAQ	Frequently Asked Question
HETS	HIPAA Eligibility Transaction System
HHEH	Home Health Episode Period
HIPAA	The Health Insurance Portability and Accountability Act of 1996
IVR	Interactive Voice Response
MAC	Medicare Administrative Contractor
MBI	Medicare Beneficiary Identifier
MFA	Multi-Factor Authentication
NPI	National Provider Identifier. The NPI is a unique identification number for covered health care providers.
PHI	Protected Health Information
Provider administrator	The provider representative who registered and who has the authority to add users.
Provider user	A person who has been granted permission by the provider administrator to access information for that provider.
PTAN	Provider Transaction Access Number. Also called a legacy number or Medicare PIN.
QMB	Qualified Medicare Beneficiary. Beneficiaries who are enrolled in the Qualified Medicare Beneficiary (QMB) program are dually eligible for both Medicare and Medicaid.
SNF	Skilled Nursing Facility
Tax ID	Tax Identification Number. Also called a TIN.

1.0 General Information

1.1 What is eServices?

There is no cost to the provider for registering and using eServices.

Palmetto GBA's eServices is an Internet-based, provider self-service secure application. Palmetto GBA's goal is to give the provider secure and fast access to their Medicare information seamlessly via our website through the eServices application.

The eServices application provides information access over the Web for the following online services:

- Eligibility
- Claims Status
- eClaim Submissions - available for Part B and Railroad Medicare providers
- Clerical Error Claim Reopening Requests - available for Part B
- Remittances Online
- Financial Information - payment floor and last three checks paid
- Financial Forms - eOffset requests, eCheck payments and CMS-838 Credit Balance form (Part A and HHH only)
- Secure Forms - Appeals, Medical Review ADR Response Form, Prior Authorization Form (JM Part B only), Documentation Submission Form (Part A only), Benefit Integrity Form (RRM only), and General Inquiry Form
- eDelivery
- eReview (JM, JJ, and RRB only)
- Additional Documentation Form – available for JJ Part B and JM Part B
- MBI (Medicare Beneficiary Identifier) Lookup
- Billing Dispute Request Form (JJ Part A and JM Part A)

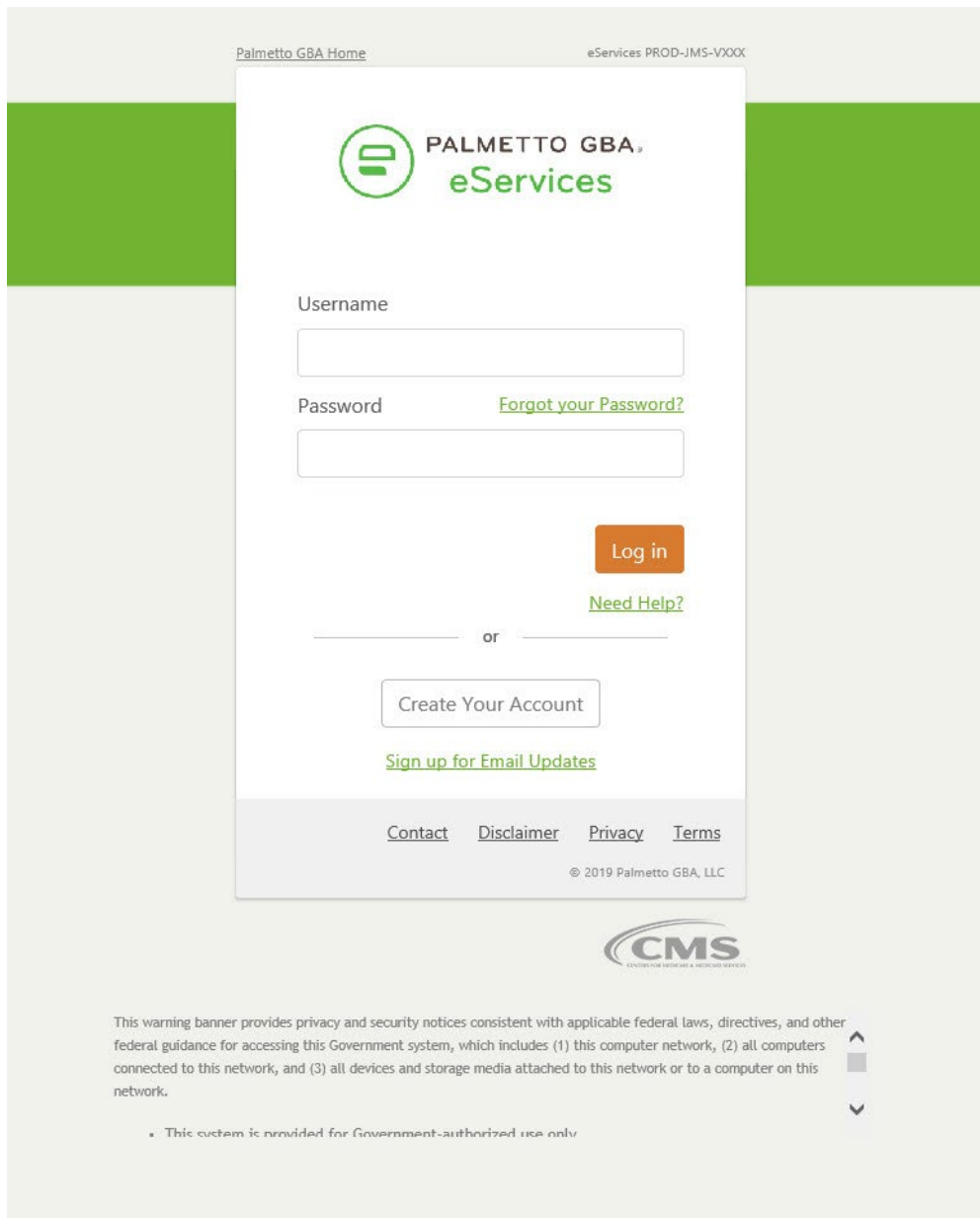
You can participate in eServices if you have a signed Electronic Data Interchange (EDI) Enrollment Agreement on file with Palmetto GBA and have payment amounts on file. To find instructions on how to get one, go to the EDI section for your line of business on PalmettoGBA.com.

NOTE

Users must have an EDI enrollment agreement on file with Palmetto GBA to participate.

The eServices home page is: www.palmettogba.com/eServices

Figure 1: Login Page



1.2 How much does eServices cost?

There is no cost to the provider for registering and using eServices.

1.3 Who can participate in eServices?

You can participate in eServices if you have a signed Electronic Data Interchange (EDI) Enrollment Agreement on file with Palmetto GBA. The EDI Enrollment Agreement is a form that is included in the EDI Enrollment Packet, which can be located under the EDI areas of PalmettoGBA.com. If you do not have an EDI Enrollment agreement on file with us, please go to PalmettoGBA.com and select your line of business. Then, select EDI from the Topics drop-down menu. Select Enrollment for online articles about EDI enrollment.



NOTE

Only **one** provider administrator per EDI Enrollment Agreement related to a PTAN/NPI combination performs the registration process. The provider administrator grants permissions to additional users related to that PTAN/NPI combination.

1.4 How to report misuse or suspicious use of eServices?

If you suspect misuse or suspicious use of the system, contact your Medicare Contractor immediately.

Palmetto GBA reserves the right to terminate any user's access if suspicious or improper activity is determined. Access can be terminated without notice.

1.5 How do I contact technical support?

Please use this manual to answer your questions and troubleshoot problems. If you need additional support with registering, logging in, administration or viewing information on our application, contact your Medicare Contractor. Be prepared to provide the following information when you call:

- Provider name
- Your name, email address and telephone number
- PTAN
- NPI
- Tax ID
- Line of Business (Medicare Parts A, B, Railroad, etc.)
- eServices user ID (if one has been assigned)
- Browser type/version
- Tab and/or function you are calling about
- If calling about an error message, include the specific error message text received

You can view contact numbers via the Contact Us link on your line of business's home page on palmettogba.com or the Home tab in eServices.

1.6 How do I report a privacy incident that occurred in eServices?

If you are able to view protected health information (PHI) for an organization other than the one associated with your user ID, please contact your Medicare Contractor immediately.

Please provide the date and time the error occurred in addition to all other details of the privacy incident during your call. If the PHI has been printed or saved, please make sure these copies are properly destroyed and/or deleted.

1.7 Why can't I view or print information in eServices?

Please make sure that your system meets our minimum system requirements as outlined in Section 1.11. You will also want to make sure your JavaScript is enabled. In Internet Explorer, go to the Tools menu, click on Internet Options, go to the Security tab and click 'Reset all zones to default.'

Some Web browser add-ons or your security software may be blocking Web page scripts. Check your Web browser settings and help sections to troubleshoot display problems.



1.8 When is eServices available and what are the maintenance times?

eServices will generally be available 24 hours a day, seven days a week. However, access to eServices does not guarantee that all functions will be available.

Occasionally a function will temporarily be unavailable as updates are made either by the eServices team or by other systems from which eServices pulls information.

eServices scheduled maintenance will typically occur:

- Monday – Friday 6:00 am to 8:00 am ET
- Sunday afternoon through evening

Other systems with which eServices interacts typically undergo maintenance:

- Monday – Friday late evening
- Occasionally Saturdays or Sundays

Our goal is to avoid any service interruptions during normal operating hours. However, unscheduled maintenance may be necessary in order to immediately address systems security threats or performance issues. When you access the eServices website and it is not available, you should see a page that indicates maintenance is in progress.

1.9 Can I use the back button in my browser to view the previous screen in eServices?

No. When signed into eServices, users should not use the browser’s back button. Using the back button will cause the user to be logged out of eServices. This security requirement ensures the safety of previously viewed/submitted data. If a user is logged out of eServices due to using the back button, the user will just need to log back in.

1.10 eServices Lockout and Logout Scenarios

The table below discusses some of the most common reasons users get locked out/logged out of eServices.

Action	Lockout/Logout Details
User attempted to log into eServices using an incorrect password or MFA code three times in a row	The user will be locked out of eServices. This is a CMS security requirement. To unlock the account, please contact your provider administrator for assistance.
User is locked out three times in a row	The user ID will remain locked until the user calls to verify their identity and have their ID unlocked. Please contact your Medicare Contractor for assistance.

Action	Lockout/Logout Details
<p>The user has not logged into their account within the past 30 days or clicked the link in the prevent account suspension email.</p> <p>or</p> <p>No provider administrators on the account have logged into their account within the past 30 days</p>	<p>If a provider user does not log into eServices at least once every 30 days or click the link in the prevent account suspension email, then their account is disabled. To regain access, the user must have an active provider administrator reinstate their access.</p> <p>If a user does not log in after being disabled, their user ID will be permanently deactivated after 120 days of inactivity. If no provider administrators on the account log into eServices within 120 days, the entire account, including all users, are terminated. To regain access to eServices, the provider must re-register.</p> <p>If a provider administrator has not logged into their account in the past 120 days, but there is another active provider administrator on the account, then only their access is terminated. To regain access the user must have an active provider administrator assign them a new user ID and temporary password.</p>
<p>User enters registration information incorrectly eight times</p>	<p>If an error is encountered during the registration process, e.g., incorrect payment amount entered, the account will be locked for 60 minutes. This is a CMS security requirement. The provider may attempt to re-register after the 60 minute time period has expired. We are unable to unlock accounts that are in the 60 minute lockout period.</p>
<p>User tries to register eight times before the 60 minute registration lockout has expired</p> <p>or</p> <p>User tries to incorrectly register and goes through the 60 minute registration lockout two times</p>	<p>The provider's registration record is locked indefinitely. The user will receive a message that they need to call in and verify their identity. Please contact your Medicare Contractor for assistance.</p>
<p>A registered user who already has a user ID is locked out of their account because of improper log out</p>	<p>The user must wait for the 30 minute lockout period to expire before attempting to log in again. We are unable to unlock IDs that are in the 30 minute lockout period.</p>
<p>Provider administrator has not completed recertification in the past 360 days</p>	<p>All users are locked out of their account and must contact one of the active provider administrators on the account to complete recertification and restore access. Provider administrators are directed to the recertification screen and will be locked out of other functions of eServices until recertification is complete.</p>
<p>Provider user or administrator has not completed profile verification in the past 250 days</p>	<p>The user will be directed to their My Account tab and will be locked out of other functions of eServices until profile verification is complete.</p>
<p>Provider administrator failed to complete recertification within 360 days</p>	<p>If no provider administrators on the account complete the recertification within 360 days, the entire account, including all users, are terminated. To regain access to eServices, the provider must re-register.</p>
<p>Provider user or administrator has not completed profile verification in the past 260 days</p>	<p>If a provider user does not complete profile verification at least once every 260 days, their account is terminated. To regain access, the user must have an active provider administrator assign them a new user ID and temporary password.</p> <p>If no provider administrators on the account complete profile verification at least once in the past 260 days, the entire account, including all users, are terminated. To regain access to eServices, the provider must re-register.</p>

Action	Lockout/Logout Details
User selects the browser's 'back' button	The user will be logged out of the application and redirected to the eServices login page.
User is inactive in eServices for 30 minutes	<p>If a user becomes inactive for 30 minutes while logged into eServices, their session will timeout.</p> <p>If they become active again during that time, the session will remain open until activity stops again, in which case the 30 minute inactivity clock starts again.</p> <p>After 25 minutes of inactivity the user is prompted with a pop-up reminding them of the timeout limit and gives them 5 minutes to become active again before they are logged off.</p>

1.11 eServices Minimum System Requirements

To optimize usability of eServices, we recommend that users verify their system adheres to the following requirements.

Operating System:

- Windows 10
- Mac OS X 11.x

Supported Internet Browsers*:

- Microsoft Edge: Version 88.x
- Google Chrome: Version 98.x

(IE 11 browser will no longer be supported as of June 2022)

Recommended Screen Resolution: 1024 x 768

Additional Requirements:

- Adobe Acrobat Reader Version DC or Adobe Acrobat Pro Version DC
- JavaScript enabled
- Compatibility view disabled
- Pop-up blocker disabled
- Use TLS 1.2 selected in browser settings. This option is typically located on the Advanced tab under Internet Options in your browser

Please note: Although eServices may still be accessible without meeting these requirements, only the options above are supported. Failure to meet these requirements may adversely affect the functionality and layout of eServices.

*We recommend always using the most current browser version that is available.

1.12 How do I navigate the eServices calendar options using the keyboard?

To navigate the calendar options in eServices, users may utilize the following keyboard shortcuts.

- Page Up – Move to the previous month
- Page Down – Move to the next month
- Ctrl + Home – Move to the current month; Open the date selector (if closed)



- Ctrl + Page Up – Move to the previous year
- Ctrl + Page Down – Move to the next year
- Ctrl + Left – Move to the previous day
- Ctrl + Right – Move to the next day
- Ctrl + Up – Move to the previous week
- Ctrl + Down – Move to the next week
- Enter – Select the focused date
- Ctrl + End – Close the date selector and erase the date
- Esc – Close the date selector without selection

2.0 Registration

2.1 How do providers register for eServices?

You can participate in eServices if you have a signed Electronic Data Interchange (EDI) Enrollment Agreement on file with Palmetto GBA. Only **one** provider administrator per EDI Enrollment Agreement may register for eServices. The provider administrator may then grant access to the different features of the application to their associates, who are provider users. The provider administrator also has the ability to assign additional provider administrators by selecting the Admin permission for the user. If you are a provider user, you must contact the provider administrator for your provider to request access to the system.

It's easy to register. Just go to the eServices link from PalmettoGBA.com. You'll see the eServices introduction screen.

You must enter the information listed below to register:

- Provider name
- Contact name (The person assigned to this user ID)
- Email address
- Phone number
- Extension
- Provider, billing service or clearinghouse indicator
- PTAN
- NPI
- Tax ID
- Most recent Medicare payment amount received or access code. If you have several payments received in one day, use the amount related to the highest check number.
- Line of business: choose from drop-down selections
- Billing service/clearinghouse information, if required

You must also agree to the Terms of Use to register. If you have entered registration information in an incorrect format, the eServices application will display an error message in red at the top of the screen. Carefully read that error message and enter the information again. If the information you enter matches the information on file with Palmetto GBA, you will be able to choose a password and security questions and answers.

Once this is completed, you will receive an email at the email address you registered. You must access the email and click on the validation link. If you do not click on the validation link and you try to log in, you will see the profile screen where you can update or correct your email address and submit. If your email address is correct, you may click on the link to request a new email. Please make sure your email address is correct on your profile before calling Palmetto GBA for assistance.

If you are sure your email address is correct, but you do not receive your email, your company's email security settings may need to be updated to allow incoming emails from Palmetto GBA. The email



address you will be receiving the validation email from is:

ops.no.reply@palmettogba.com

Generic user names are **not** permitted. Each user of eServices must have a unique user ID and password. This means that we expect each user to have a legitimate first and last name. Generic first and last names are not permitted. Examples of generic user names are: Front Desk, Account Coordinator, Billing Department, User A, or the name of your provider office. No sharing of user IDs and passwords is permitted. Palmetto GBA will delete, without notice, any user names we find that are generic.

NOTE

You must register each PTAN/NPI combination separately. If you have multiple NPIs associated with a PTAN, you must register each PTAN/NPI combination. Each combination will have a unique user ID.

Figure 2: eServices Registration Screen

The screenshot shows the 'eServices Registration' page. At the top, there are navigation links for 'Palmetto GBA Corporate' and 'Palmetto GBA Medicare'. The main header includes the 'PALMETTO GBA eServices' logo and the 'CMS' logo. Below the header is a navigation bar with 'PALMETTO GBA HOME', 'CONTACT US', and 'E-MAIL UPDATES'. The registration form includes the following fields:

- Provider Name: [Text Input]
- Contact Name: [Text Input] Last [Text Input] First [Text Input]
- E-mail Address: [Text Input]
- Re-enter Email Address: [Text Input]
- Phone Number: [Text Input]
- Extension: [Text Input]
- I am/work for: [Dropdown Menu: Choose One]
- PTAN: [Text Input] [\(Click here to learn more.\)](#)
- NPI: [Text Input] [\(Click here to learn more.\)](#)
- Tax ID: [Text Input]
- Line of Business: [Dropdown Menu]
- Most Recent Medicare Payment Amount Received or Access Code: [Text Input] [\(Click here to learn more.\)](#)
- Billing Service/ClearingHouse Name: [Text Input]
- Company Address 1: [Text Input]
- Company Address 2: [Text Input]
- Company City: [Text Input]
- Company State: [Text Input]
- Company Zip Code: [Text Input]

At the bottom of the form, there is a checkbox for 'I agree to the Terms of Use.', a 'Submit' button, and a 'Clear' button. A 'Return to Login' link is located in the top right corner of the form area. The footer contains the text: '© 2020 PALMETTO GBA, LLC | DISCLAIMER | PRIVACY POLICY | GET ADOBE READER'.



2.2 How do I choose my password?

You will automatically be assigned a user ID in a format defined by CMS. You will be allowed to choose your own password. Your password is case sensitive and must meet certain format criteria which will be displayed when creating your password.

More secure passwords are those which are based on pass phrases and/or non-dictionary words (including 'nonsense' words), combined with obscure character substitutions.

Use the following guidelines to protect your password and your information:

- Must be at least 8 characters long (at least 15 characters for Super Admin users)
- Must start with a letter
- Must contain an uppercase letter
- Must contain a lowercase letter
- Must contain at least one number
- Must have at least one of the following special characters @#\$!%&)(*~.,:][+;<=>?^_`~}{|/\`"
- Must contain a minimum number of 75% changed characters from the previous password. Examples:
 - If current and new passwords are 8 characters long then 6 characters must be different
 - If current and new passwords are 12 characters long then 9 characters must be different
 - If current password is 15 characters and the new password is 20 characters, at least 11 characters must be different
 - If current password is 20 characters and the new password is 23 characters, at least 15 characters must be different
- Must be changed every 60 days
- May contain spaces in the middle of a password. Spaces are not allowed in the first or last character space
- Cannot contain leading portion of the first or last name
- Cannot use the same password as the previous 13 passwords

2.3 How do I choose my security questions?

You have several questions from which to choose. Answers to your security questions are case sensitive and include spaces. Enter your answers carefully. You must answer these questions exactly as they were entered to change your password or reset your password if you cannot remember it. You can verify or change your security questions and answers through your My Account tab once you are logged in.



Figure 3: Password and Validation Questions Choice Screen

The screenshot shows the 'eServices Login' page. At the top right is a 'Return to Login' link. The form includes a 'User ID' field with 'XXXXXXXX' entered. Below are six validation questions, each with a dropdown menu and a text input field for the answer. The questions are: 'In what city was your father born?', 'What was the make of your first car?', 'What was the mascot at your last high school?', 'What was the name of your first boyfriend?', 'Who is your favorite singer?', and 'What is your favorite movie?'. All answer fields contain 'TEST'. Below the questions are fields for 'Enter New Password', 'Re-enter New Password', and 'Suggested Password' (containing 'so/R7Kiu'). A red notice states: 'Due to a CMS mandate you are now required to use Multi-Factor Authentication (MFA). You will be presented with a verification page each time you log into eServices. If you would like to use your mobile phone to receive a code for authentication, please enter your mobile phone and carrier in the fields below. You will also have the option to use your registered email address on file for authentication.' Below this are fields for 'Mobile Phone' (123-456-7890) and 'Carrier'. A final red notice at the bottom states: 'Standard text messaging rates may apply based on your plan with your mobile phone carrier. If you do not want to enter a mobile phone number, you can still use the MFA feature with your registered email address on file.'

2.4 Someone from my office has already registered. How do I get access?

You must contact your provider administrator to request access to the system. If you do not know who your provider administrator is, you will want to contact your provider's staff to find out if they have registered to the system and who is the provider administrator.

If you are a provider administrator, you can see who else is designated as provider administrators on the Admin tab.

2.5 I am having trouble with my registration. What should I do?

Only one provider administrator per provider can register for eServices. If an administrator from your office has already registered, please contact that person for access to eServices.

If you are the provider administrator and your registration information is entered in an incorrect format, the eServices application will display an error message in red at the top of your screen. Carefully read that error message and enter the information again.

Providers who have a Do Not Forward (DNF) on file with Palmetto GBA will not be able to register until the DNF is lifted.

If you are sure you entered all information correctly and cannot register, make sure you have an EDI enrollment agreement on file with CMS. If you do not, please access the [EDI section](#) of PalmettoGBA.com for helpful articles about how to complete the EDI agreement. If you are sure you have an EDI agreement on file, but still cannot register, please contact your Medicare Contractor.



2.6 I have multiple NPIs and PTANs. Do I need to register each one?

You must register for each PTAN/NPI combination. If you have multiple NPIs associated with a PTAN, you must register each PTAN/NPI combination separately. Each combination will have a unique user ID.

2.7 How do I find out my PTAN?

You must have a Provider Transaction Account Number (PTAN) to register for eServices. Palmetto GBA cannot release patient or provider specific information if you do not identify yourself with your PTAN. You may access the National Plan & Provider Enumeration System (NPPES) [NPI Registry](#) to search for the PTANs listed for your office.

For Railroad Medicare: If you do not know your Railroad Medicare PTAN, you can visit our [PTAN Lookup & Request Tool](#). This tool allows you to lookup an existing PTAN, as well as to request a new PTAN for new providers who have seen a Railroad Medicare patient and are ready to submit a claim. If you need assistance using the tool, you may call our Provider Contact Center at 888-355-9165 and select Option 3. Customer Service Representatives are available Monday – Friday, from 8:30 a.m. to 4:00 p.m. in all time zones, with the exception of Pacific Time, which receives service from 8:00 a.m. to 4:30 p.m.

2.8 How do I find out my NPI?

You must have a National Provider Identifier (NPI) to register for eServices. Palmetto GBA cannot release patient or provider specific information if you do not identify yourself with your NPI. You may access the National Plan & Provider Enumeration System (NPPES) [NPI Registry](#) to search for the NPIs listed for your office.

2.9 How do I find out my tax identification number (TIN)?

You must have a tax identification number (TIN) to register for eServices. Palmetto GBA cannot release patient or provider specific information if you do not identify yourself with your TIN. It is referred to as the tax ID on the registration page of eServices. If you do not know your tax ID, check with your administrative office or refer to your tax records.

2.10 How do I find out my last payment received?

Call the IVR to verify your last payment received. You must call the IVR related to your line of business. IVR telephone numbers are listed in the [Contact Us](#) pages of [PalmettoGBA.com/Medicare](#).

Providers who have a Do Not Forward (DNF) on file with Palmetto GBA will not be able to register until the DNF is lifted.

2.11 How do I obtain my access code?

Brand new providers who submit a current EDI enrollment agreement will receive an email with the access code upon processing the EDI agreement. The access code may be used to complete the registration in the eServices portal. On the Registration page, providers can either register with the last Medicare check amount received or access code. Once the access code is validated along with the provider information, users may continue the registration process.



2.12 I am getting an error message that I do not have an EDI Enrollment Agreement on file. What do I do?

You can participate in eServices if you have a signed electronic data interchange (EDI) Enrollment Agreement on file with Palmetto GBA. If you receive an error that you do not have an EDI enrollment agreement on file with Palmetto GBA, please double check your records and make sure you are choosing the line of business that relates to your EDI Enrollment Agreement.

The EDI Enrollment Agreement is a form that is included in the EDI Enrollment Packet which can be located under the [EDI areas](#) of [PalmettoGBA.com/Medicare](#).

2.13 I am a new Medicare provider. When can I register?

New providers must have an Electronic Data Interchange (EDI) Enrollment Agreement on file with Palmetto GBA and wait until they receive a payment from Medicare to register for eServices. If you are new to Medicare and you call technical support for registration assistance, you will be asked to wait until your first Medicare payment is issued to enroll.

2.14 What do I do if I did not receive my validation email?

Once you register or update your profile, you will receive an email with a link to validate your access. Make sure that you log out of your profile update before clicking on the link in your email. Once this is completed, you will be able to log in to eServices. If you do not click on the validation link and you try to log in, you will see your profile screen where you can update or correct your email address and submit. If your email address is correct, you may click on the link to request a new email. Please make sure your email address is correct on your profile before calling Palmetto GBA for assistance.

If you are sure your email address is correct, but you do not receive your email, your company's email security settings may need to be updated to allow incoming emails from Palmetto GBA. The email address you will be receiving the validation email from is:

ops.no.reply@palmettogba.com

If you experience password errors during the above process, please use the 'Forgot or Change Your Password?' link on the login page to reset your password.

3.0 Login

3.1 How do I log in to eServices?

You must have either registered for eServices or been given access to eServices by a provider administrator for your provider. If you have completed these steps, you will have a user ID.

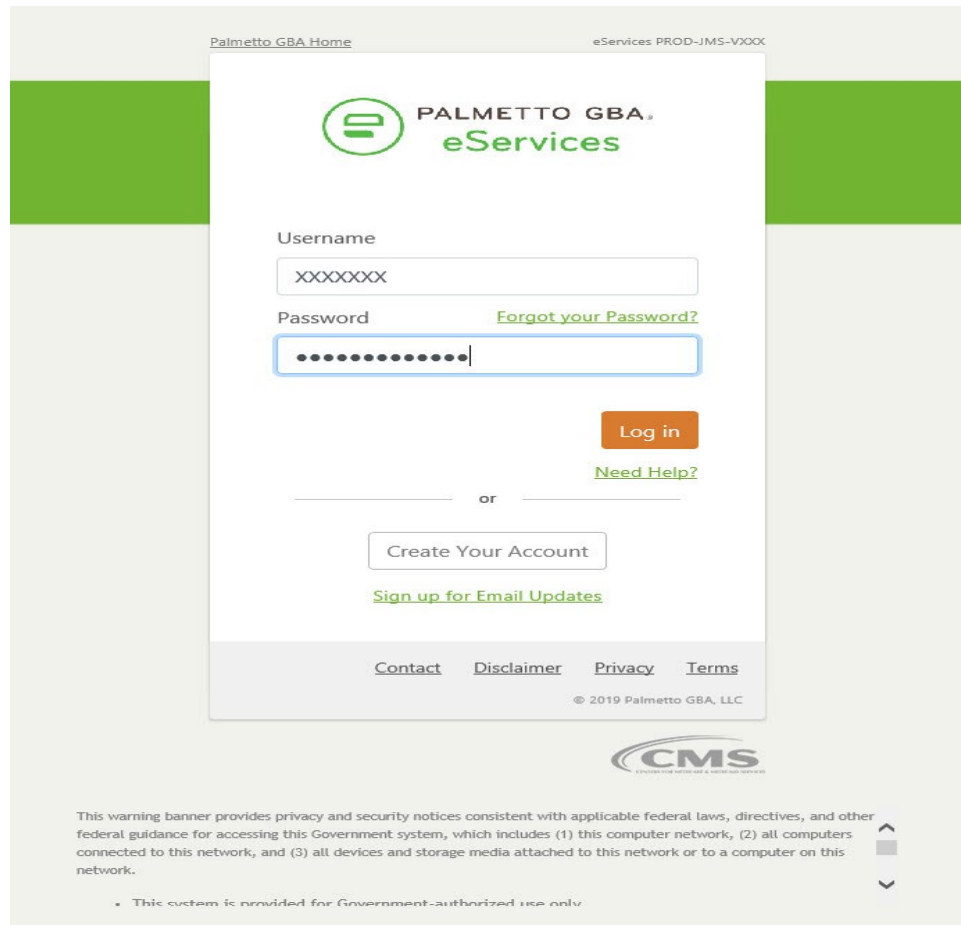
Access our eServices introduction screen and enter your user ID and password. Enter your user ID manually, please do not copy and paste.

If you were assigned a password by your provider administrator and this is the first time you have logged in, you will be prompted to agree to the terms of use, change your password and choose your security questions and answers. Once you have successfully completed these steps, you will be given access to eServices.

NOTE

A log out link is located in the upper right of each screen, once you have logged in. You must log out to end your session. If you do not log out, your user ID will be locked for one hour.

Figure 4: eServices Registration and Log in Screen



3.2 Once I log in, some of my tabs are grayed out or cannot be accessed. What should I do?

If you have been granted access by the provider administrator for your office, your provider administrator has chosen the tabs you can access. Please contact your provider administrator.

If you are the provider administrator for your office, you automatically have access to all the functions. If you are the provider administrator and are having problems accessing the tabs, please contact your Medicare Contractor.

3.3 How do I receive a user ID?

If you are a provider administrator, your user ID is assigned when you register.



If you are a provider user, meaning you have been granted access by your provider administrator, your provider administrator will give you a user ID.

3.4 What if I do not know my user ID?

If you are a provider user, meaning you have been granted access by your provider administrator, contact your provider administrator if you do not know your user ID.

If you are a provider administrator and you cannot find your user ID, please contact your Medicare Contractor.

3.5 What happens if I cannot log into eServices?

You must enter your password exactly as it was entered when you chose it. If you do not remember your password, you can click on the 'Forgot or Change Your Password?' link from the returning user box of the eServices introduction screen. You will receive an email with a secure link to then answer two security questions. You must answer both security questions correctly to reset your password.

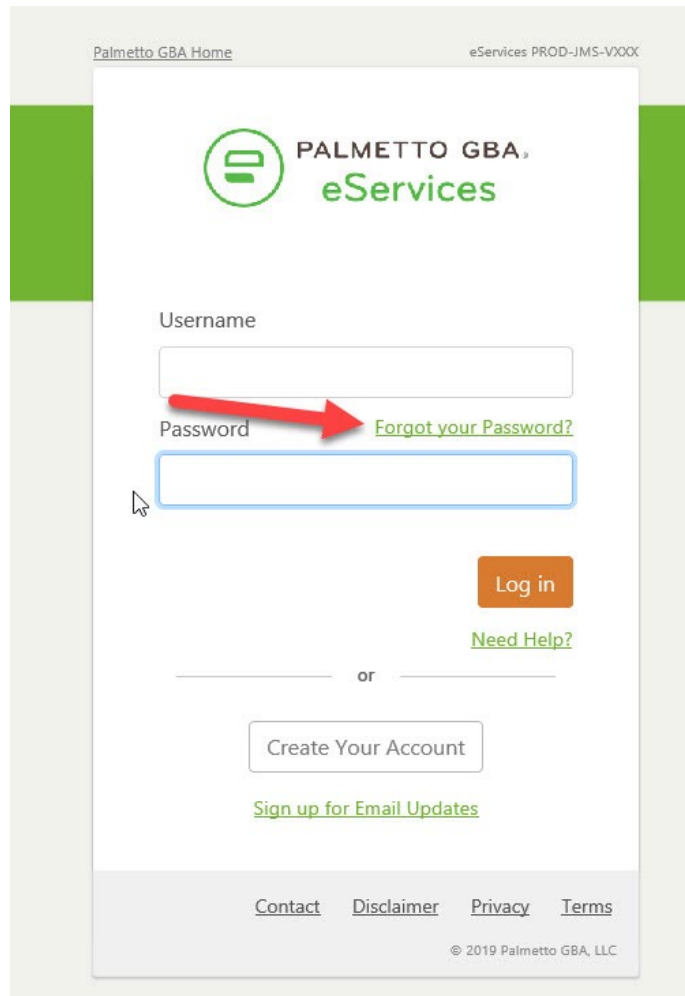
If you attempt to log in incorrectly three times in a 120 minute period, you will be locked out of eServices. To unlock your account, you must contact your Medicare contractor to verify your identity and regain access.

You can verify or change your security questions and answers through your My Account tab once you are logged in.


NOTE

You cannot change your password more than one time for every 24-hour period. Keep in mind that if you are logged into eServices and you want to exit, click on the log out link in the upper right of every page. If you do not do this, you will be locked out for one hour. We do not unlock accounts that are in the one hour lockout period.

Figure 5: Request to Reset Password



Palmetto GBA Home eServices PROD-JMS-VXXX



Username

Password [Forgot your Password?](#)

[Need Help?](#)

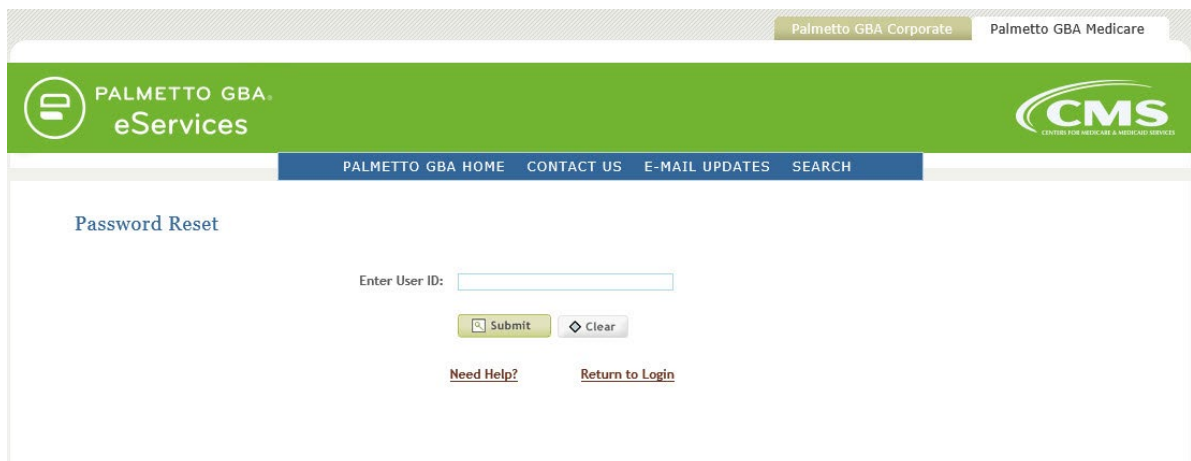
or

[Sign up for Email Updates](#)



[Contact](#) [Disclaimer](#) [Privacy](#) [Terms](#)

© 2019 Palmetto GBA, LLC

Figure 6: Password Reset, Enter User ID



Palmetto GBA Corporate Palmetto GBA Medicare

 **PALMETTO GBA®
eServices** 

PALMETTO GBA HOME CONTACT US E-MAIL UPDATES SEARCH

Password Reset

Enter User ID:

[Need Help?](#) [Return to Login](#)



Figure 7: Password Reset Validate, Answering Validation Questions

3.6 I cannot answer my security questions. What should I do?

When you opt to reset your password, you will be randomly presented with two of your security questions. You must answer both questions correctly to reset your password.

If you cannot reset your password and you are a provider user, meaning you have been granted access by the provider administrator for your provider, contact your provider administrator to verify your identity and regain access.

If you are a provider administrator and you cannot answer your security questions, please contact your Medicare Contractor. Keep in mind that you can update your security questions through your My Account tab.

3.7 How do I change my password?

Click on the 'Forgot or Change Your Password?' link from the returning user box of the eServices introduction screen. You will receive an email with a secure link to answer two security questions. You must answer both questions correctly to reset your password. If you want to change or verify your security questions and answers, you can update it through your My Account tab once you are logged in.

Keep in mind that if you attempt to login incorrectly three times in a 120 minute period, you will be locked out of eServices. To unlock your account, you must contact your Medicare Contractor to verify your identity and regain access.



NOTE

If your organization requires you to confirm or acknowledge the link in the Forgot Password email is a valid and secure link, you may need to copy and paste the link from the email into a browser.

3.8 I left the system without logging out, and now I cannot get back in. What should I do?

A log out link is located in the upper right of each screen, once you have logged in. You must log out to end your session. If you do not log out, your user ID will be locked for one hour. If you continue to be locked out and you are a provider user, meaning you have been granted access by the provider administrator for your provider, contact your provider administrator to verify your identity and regain access.

If you are a provider administrator, you must contact your Medicare Contractor to verify your identity and regain access.

3.9 Can my eServices access expire?

Palmetto GBA and CMS are dedicated to keeping your information safe. Palmetto GBA will disable any user that has not logged in the past 30 days or click the link in the prevent account suspension email per CMS security requirements. Likewise, your user ID will be disabled if your provider administrator has not logged in within the last 30 days. If you are a provider administrator and you have not logged in within the last 30 days or clicked the link in the prevent account suspension email, your user ID **and** the user IDs of your account will be disabled.

To keep your eServices access current, please log in to eServices with your user ID and password. If you have forgotten your password, please use the 'Forgot or Change Your Password?' link on the returning user screen.

If you are a provider administrator, please log in to make sure the access for your provider users is not disabled.

When the user has not successfully logged in for 120 days, the user ID will be deactivated indefinitely. If you have been deactivated, you will receive the following error message:

“Your eServices access has expired and your user ID is now invalid. If you are a provider administrator, please register again. If you are a provider user, please contact your provider administrator for access.”

If you receive this error message and you are a provider user, your provider administrator must add you again as a new user. You will receive a new user ID from your provider administrator.



If you receive this error message, and you are the only provider administrator on the account, you must register again. You will receive a new eServices user ID. You must also add any provider users to eServices as new users.

If you are a provider administrator, but there are other active provider administrators on your account, you must contact one of the active provider administrators. The active provider administrator must add you again as a new user. You will receive a new user ID for the active provider administrator.

It is recommended that all users and provider administrators log into their account at least once every 30 days to keep their access current.

3.10 Disabled User Status

This functionality will disable users instead of deactivating them if they have not logged in within the 30 day window. The users will be placed in the disabled status for an additional 90 days after the 30 day period of login inactivity. After 120 days, the user ID will be deactivated indefinitely. This means that a user can reactivate their account within the 90 day window and essentially has 120 (30+90) full days before being terminated.

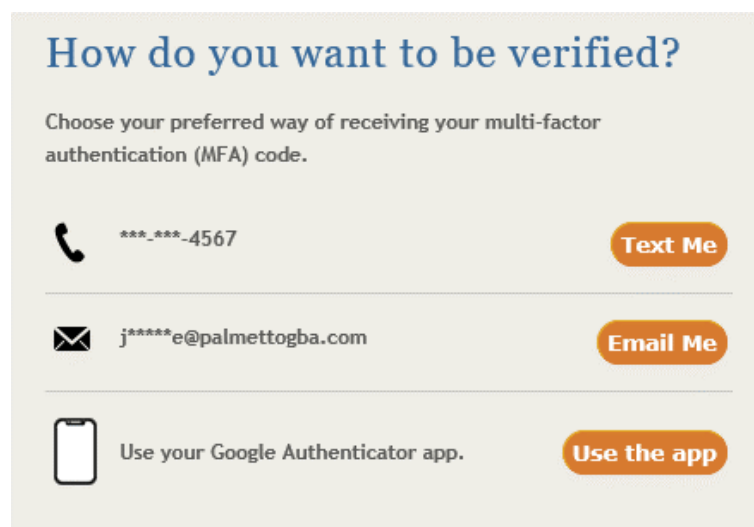
3.11 Will my eServices session timeout?

Yes. To be in compliance with CMS security requirements, your eServices session will timeout after 30 minutes of inactivity. A notification box will display when you are approaching your inactivity limit. Users should not use the portal in multiple tabs as this could cause you to get locked out.

3.12 Multi-Factor Authentication (MFA)

To enhance the security of Medicare data, CMS requires the use of multi-factor authentication (MFA) in eServices. After successfully entering your user name and password, you will be directed to the MFA verification screen where you will need to enter an MFA verification code to complete the login process. Once on this screen you will be prompted to select a method to receive your MFA code. You may elect to either receive a text (if the mobile phone number was entered on the My Account tab), an email message, or utilize a code via Google Authenticator. All users will have the option to receive their code via email by default.

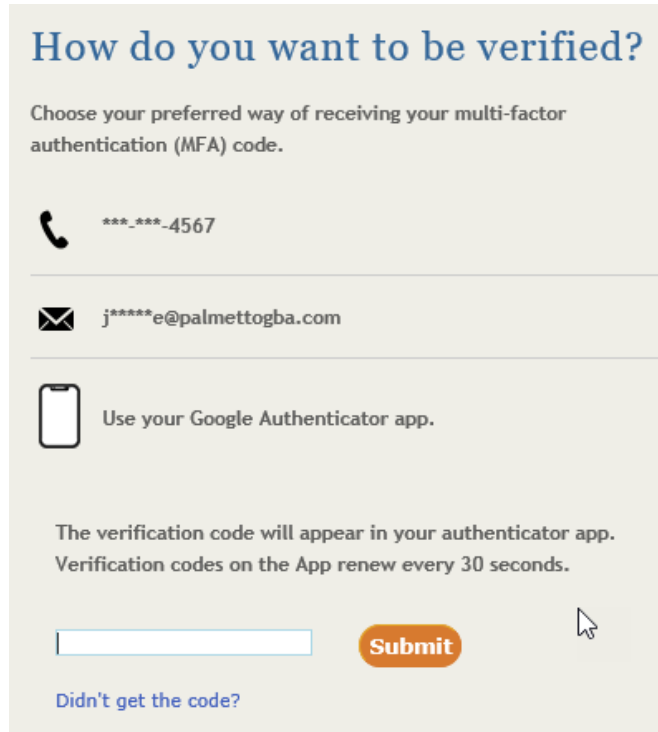
Figure 8: MFA Verification Screen, Method Selection



After you have made your selection you will be sent either a text or email message with an eight digit verification code or you can utilize the current six digit code in your Google Authenticator app. Enter


the code in the field provided on the verification page. Upon successful validation of the verification code, you will be able to access the portal.


Figure 9: MFA Verification Screen, Verification Code Entry




How do you want to be verified?

Choose your preferred way of receiving your multi-factor authentication (MFA) code.

 ***-***-4567

 j*****@palmettogba.com

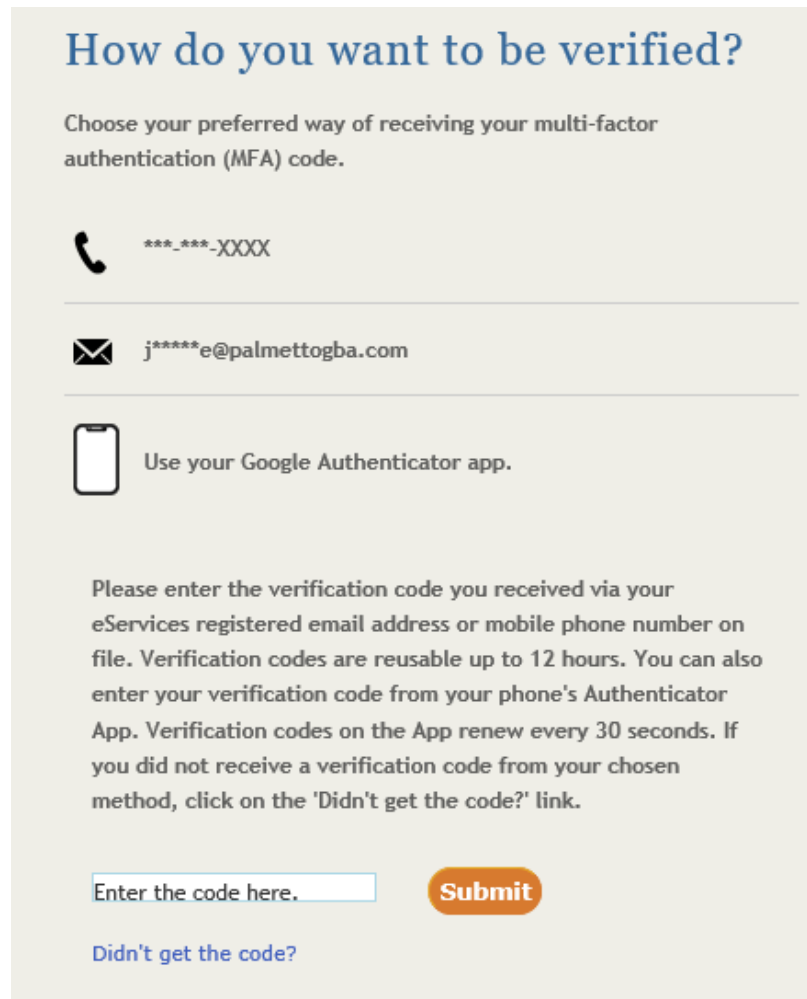
 Use your Google Authenticator app.

The verification code will appear in your authenticator app.
Verification codes on the App renew every 30 seconds.

[Didn't get the code?](#)


Your text or email verification code can be reused repeatedly for up to 12 hours from the time the code was requested. If you are reusing your verification code, enter the code in the box on the 'How do you want to be verified' screen. You may still request a new MFA code at any time. Simply use the 'Didn't get the code' link to begin the request. Once a new MFA code is generated, the previously generated MFA code cannot be used. Google Authenticator codes change automatically every 30 seconds. If logging in with a Google Authenticator code, you must always use the current code to log in.


Figure 10: MFA Verification Screen, Reuse Verification Code




How do you want to be verified?

Choose your preferred way of receiving your multi-factor authentication (MFA) code.

 ***-***-XXXX

 j*****e@palmettogba.com

 Use your Google Authenticator app.

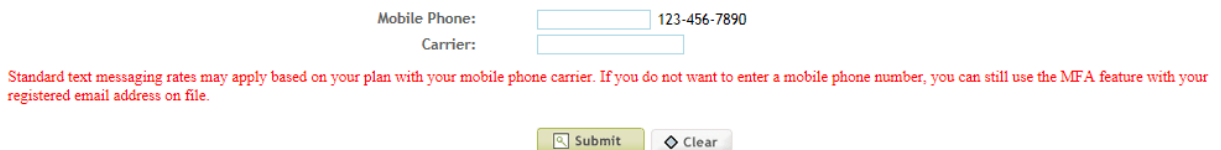
Please enter the verification code you received via your eServices registered email address or mobile phone number on file. Verification codes are reusable up to 12 hours. You can also enter your verification code from your phone's Authenticator App. Verification codes on the App renew every 30 seconds. If you did not receive a verification code from your chosen method, click on the 'Didn't get the code?' link.

Enter the code here. **Submit**

[Didn't get the code?](#)

Once logged into eServices, you may access the My Account tab to add mobile number information for the additional option to receive your MFA verification code via text message (standard messaging rates may apply). You may also add the additional option to utilize a Google Authenticator code from this tab.

Figure 11: My Account Tab, MFA Mobile Opt In



Mobile Phone: 123-456-7890
Carrier:

Standard text messaging rates may apply based on your plan with your mobile phone carrier. If you do not want to enter a mobile phone number, you can still use the MFA feature with your registered email address on file.

To set up the Google Authenticator option, begin by clicking the 'Authenticator Setup' button under the MFA Setup section of your My Account tab.

Figure 12: My Account Tab, MFA Google Authenticator Opt In

MFA Setup

For your security, Palmetto GBA eServices requires Multi-factor Authentication (MFA) to log in. You will be prompted after logging in to enter an MFA code.

Get an email

Email Address
Your email address will always be used by default

Receive a Text

Mobile Phone


Carrier
Standard text messaging rates may apply

Using an App

Then, follow the instructions for your mobile device type (iPhone or Android). Once you have completed this setup, you will be able to access the MFA code for the associated user ID from the Google Authenticator app on your device going forward. You will not be required to perform the setup steps at each log in.

Figure 13: MFA, Google Authenticator Setup

Using an App iPhone Android



Install Google Authenticator

- Using your phone, go to iTunes
- Search for Google Authenticator ([Download](#))
- Download and Install the app

Scan the Barcode

- In Google Authenticator, tap the red button icon on the bottom right.
- Click 'Scan a barcode'
- Use your phone's camera to scan the barcode to the right. [Can't see the barcode? Click here.](#)

Check and confirm code

- In the field to the right type the 6 digit code that appears in the app and click check code.





Figure 14: MFA, Google Authenticator Setup Confirmation

Using an App

iPhone **Android**

Your device is linked. Click the submit button below to save these changes.



Install Google Authenticator


1. Using your phone, go to the Android Play Store
2. Search for Google Authenticator ([Download](#))
3. Download and Install the app

Scan the Barcode

4. In Google Authenticator, tap the red button icon on the bottom right.
5. Click 'Scan a barcode'
6. Use your phone's camera to scan the barcode to the right. [Can't see the barcode? Click here.](#)

Check and confirm code

7. In the field to the right type the 6 digit code that appears in the app and click check code.

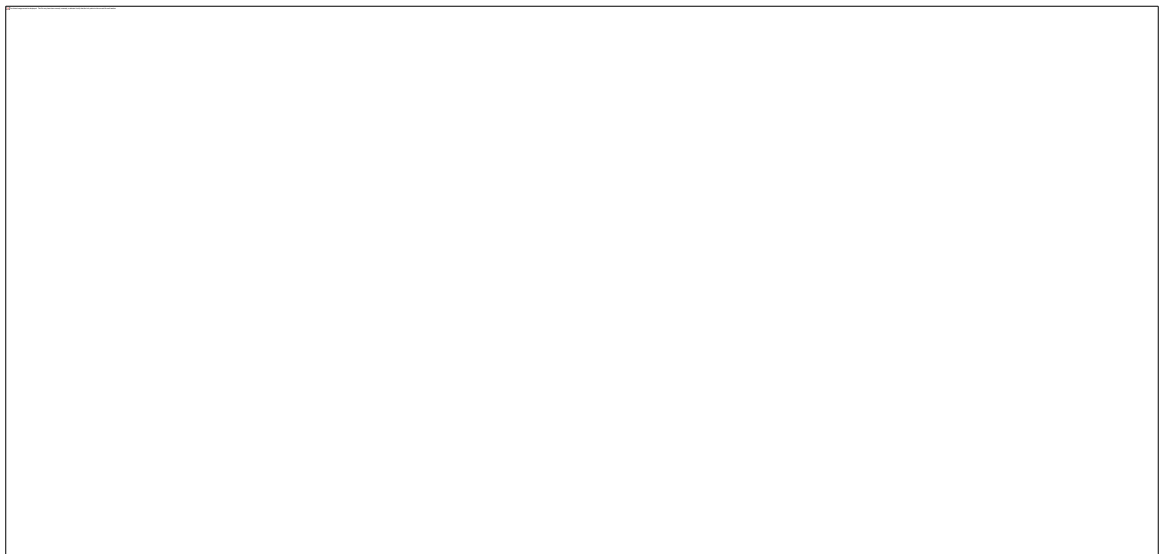


Check Code

Verify My Profile

Submit

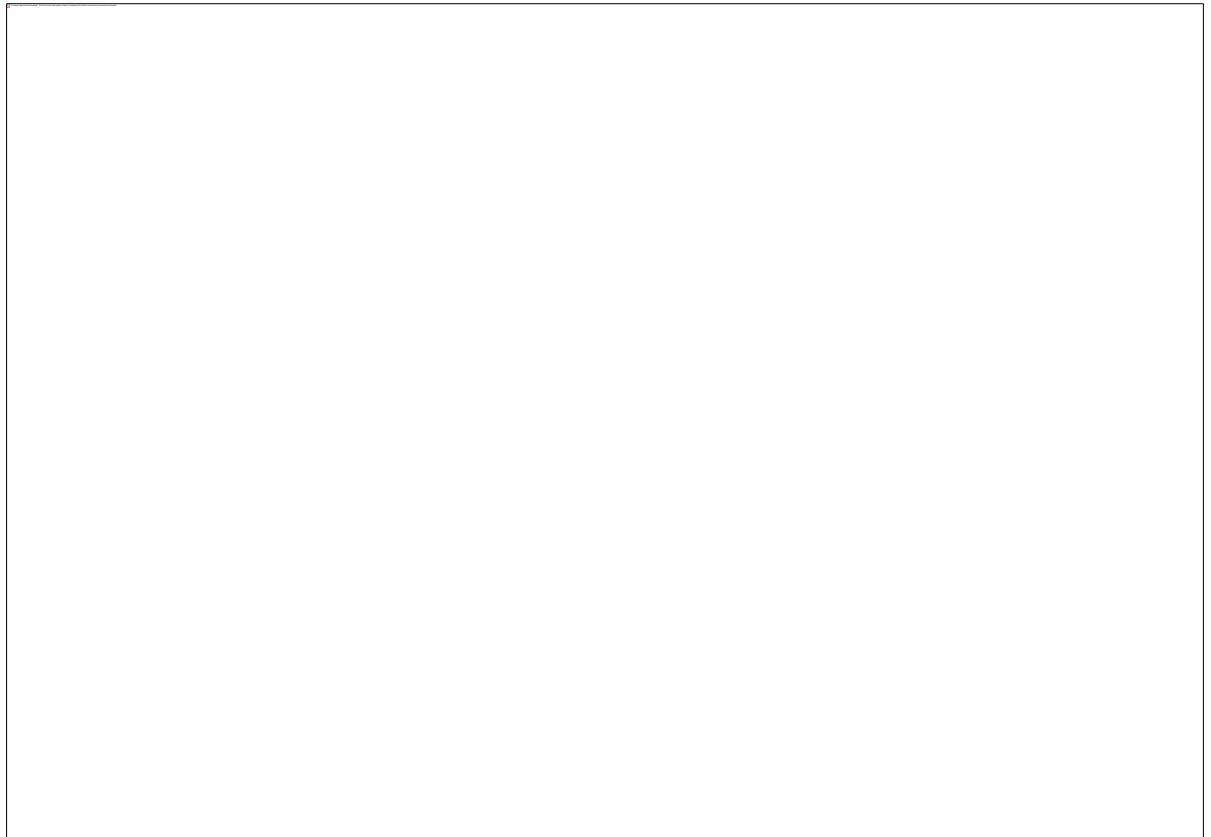
Figure 15: Google Authenticator Duplicate Setup Confirmation





If the user has setup google authenticator for the user ID, they will receive a pop-up message indicating the feature has already been setup. If the user clicks ok, a new QR code will be generated. Users will need to scan code before clicking on verify my profile or submit buttons. The user will receive a pop-up message indicating they need to scan code before using either button when trying to reset the google authenticator feature.

Figure 16: Scan Code, Google Authenticator



4.0 Claims Status/Claims Submission

4.1 How do I use the claims status feature?

If you have access to claims status and are successfully logged in, click on the Claims tab. The claims status screen will appear. The few required fields are marked as required. Other fields are optional.

If your search is for a specific claim number, the details on that claim will appear. If you search using other criteria a list of claims matching your search criteria will display. You may click a link to view the details of any claims in the list.

Searches for long periods of time may take longer to return results. In addition, offline claims will not be displayed. Many claims are offline after three years, sometimes earlier.

Part B providers can view claim line messages by viewing “View” on the Claim Status Information

screen. Please note that additional messages will be found on remittances. Please download a copy of your remittance to see all messages.

Figure 17: Part B Claims Search

Home **Claims (MCS)** Remittance Eligibility MBI Lookup Financial Tools Messages Forms ADR eReview Support Admin My Account eDelivery

Claims Additional Documentation Form

Claim Status Inquiry

To view claim data for a patient, please enter the Medicare ID or Claim Number.

Select Type of Search:

Medicare ID: *

Optional. When no dates are entered, all claims for the past 3 years will be returned up to 2,000 claims

Date of Service From:

Date of Service To:

Submit

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Figure 18: Part B List of Claims Status Information

List of Claim Status Information: (Medicare ID:)

Claim Status Information

Claim Number	Date of Service From	Date of Service To	Status	Remit Number	Bill Amount	Paid Amount	Remit Date	Details	Submit an Appeal
<input type="text"/>	06/13/2016	06/13/2016	Approved	<input type="text"/>	263.00	0.0	06/24/2016	View / Remit	Submit an Appeal

[Back to Claim Search](#)

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Figure 19: Part B Claim Status Information

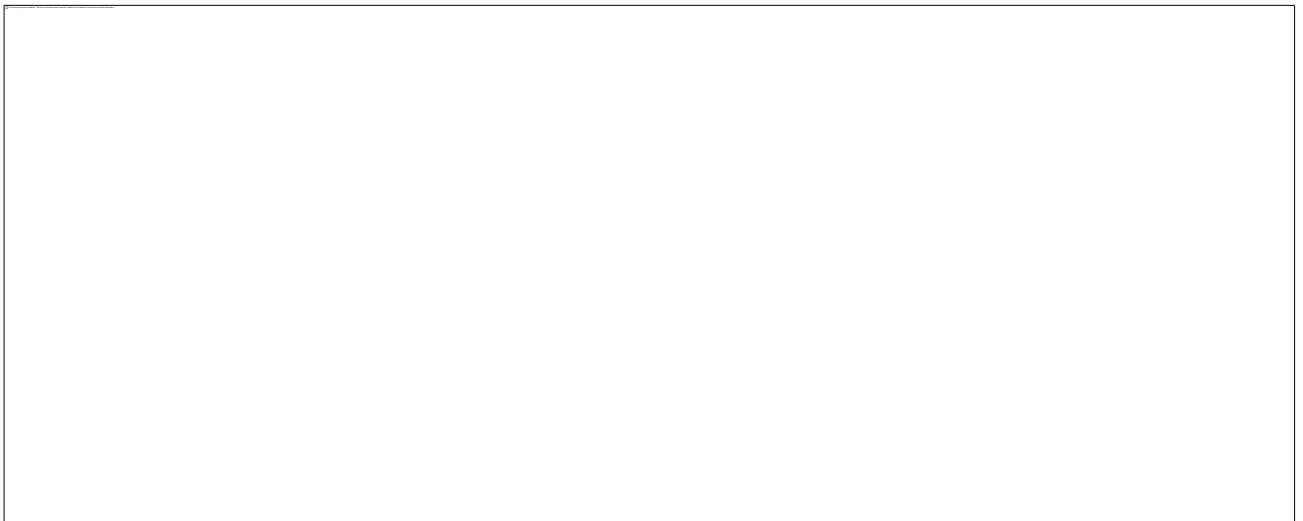


Figure 20: Part B Claim Line Messages Pop-up



Figure 21: Part A Claims Search

Home Claims Claims (New) Remittance Eligibility MBI Lookup Financial Tools Messages Forms eReview ACO Support Admin My Account eDelivery

Results are limited to a maximum of 500 claims.

Claim Search

Search for a specific claim number or retrieve a list of claims from the Medicare Beneficiary ID.

Search Claim Information

Search by

Medicare ID and Service Dates

Select your search criteria

Medicare ID

XXXXXXXXXX

You can find the Medicare ID using the [MBI](#) Tool

Date Range Predefines Dates Custom Dates

Select Service Dates

Last 30 Days

Search

Need Help?

 [Access our User Manual](#)

Get in touch with our Provider Contact Center (PCC) at:

JM users: 855-696-0705

JJ users: 877-567-7271

[Provider Contact Center](#) →

Figure 22: Part A Claims Search Results

[← Back to Claim Search](#)

Select New Dates ▾

Search Results

Service Date(s)
01/01/2024 - 09/18/2024

Search: All Statuses ▾

Download As: PDF / Excel

Claim Number	MBI	Beneficiary Patient Acct	Service Dates	Receipt Date	Billed Amt	Paid Amt	Bill Type	Status	Check # Date Paid	Remit	Claim Details
			04/15/2024 - 04/17/2024	04/26/2024	\$38338.22	\$445.70	111	Suspended		-	View Claim Details & Appeals
			04/04/2024 - 04/18/2024	04/26/2024	\$171502.36	\$2045.93	111	Suspended		-	View Claim Details & Appeals

Showing 1 to 2 of 2 entries

Figure 23: Part A Claim Details

[← Back to Claim Results](#)

Claim Details

Claim Number	Medicare Beneficiary ID	Beneficiary Name	Service Date(s) 04/15/2024 - 04/17/2024	Billed Amount \$38338.22
--------------	-------------------------	------------------	--	-----------------------------

[Claim Details](#) [Diagnosis Codes](#) [Appeals](#) [Line Items](#)

Claim Details					
Check Number	Co Insurance \$0.00	Deductible \$0.00	Type of Bill 111	Claim Level Reason Code U5234	Reject Code

Diagnosis Codes
E6601Y, E1140Y, E1169Y, Z6838, I10Y, G4730Y, G4733Y, E785Y

Appeals
No appeals for this claim Submit an Appeal

Line Items					
Show	10	entries	Search:	<input type="text"/>	
Line Item	Revenue Code	HCPCS Code	Service Dates	Allowed Amount	Not Covered
1	0110			\$4,332.00	\$0.00

[More](#)

4.2 I am getting a message that there is no information to display for the date period chosen. What should I do?

If no claims are displayed for the date period you have chosen, you may want to choose a different date range or double-check your records to make sure you have entered the correct Medicare ID. If



you have multiple linked accounts, please confirm that you are searching under the correct PTAN and NPI. Claims that are paid, in process, returned or denied are displayed. Information is retrieved from CMS standard systems and is as current as the standard systems. Claims that are offline or returned without processing will not appear.

Retrieving claims information older than six months may take additional time. In addition, offline claims will not be displayed. Many claims are offline after three years, sometimes earlier.

4.3 I think my claim information is incorrect. What should I do?

If you believe the information is incorrect, you must contact your Medicare Contractor. Telephone numbers are listed in the [Contact Us](#) pages of PalmettoGBA.com/Medicare.

4.4 How far back can I look for claims status information?

Retrieving claims information older than six months may take additional time. In addition, offline claims will not be displayed. Many claims are offline after three years, sometimes earlier.

4.5 I am being told I have entered an invalid Medicare ID. What do I do?

You must double-check the Medicare ID. It should be entered without spaces, dashes or any other special characters.

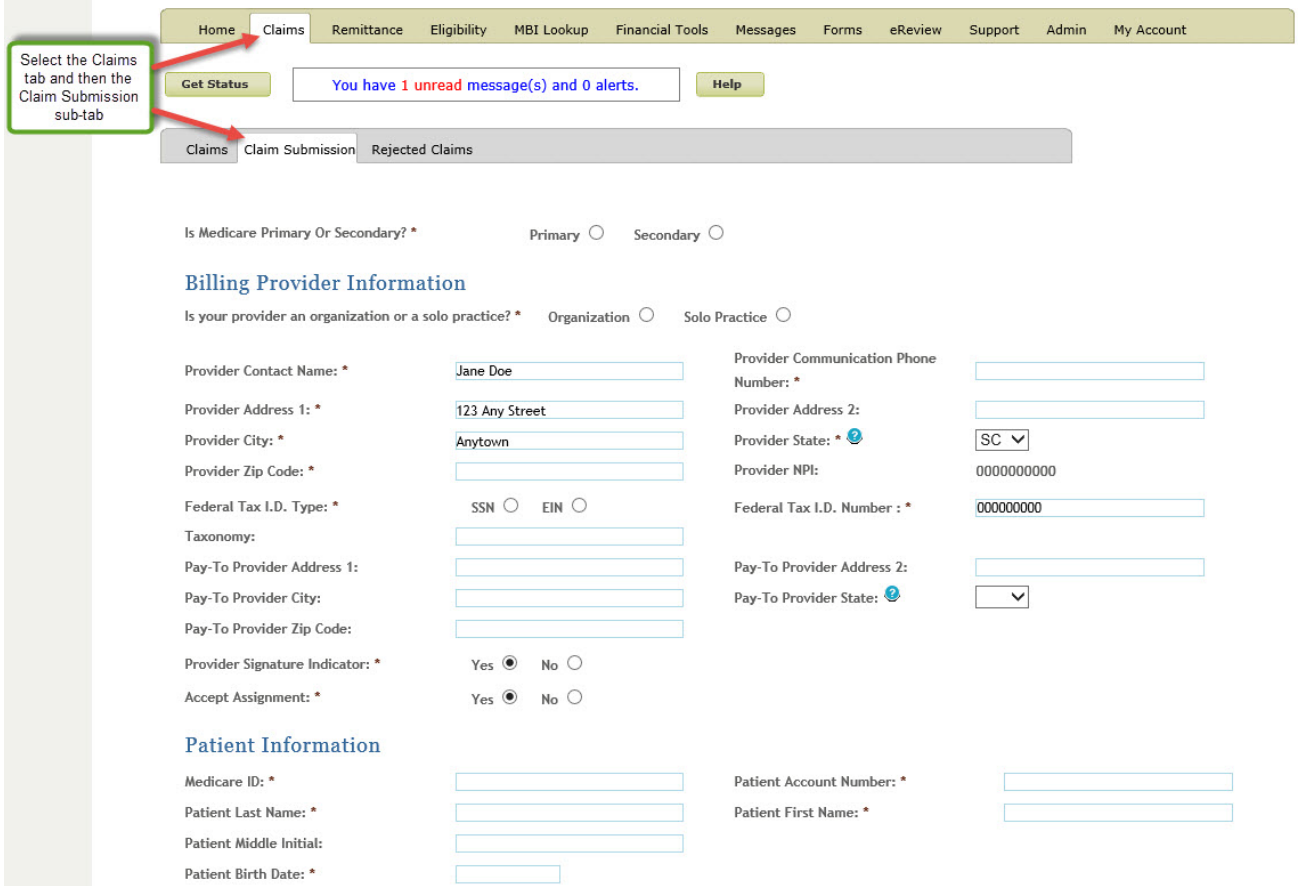
4.6 Claims Submission

Part B users can access the electronic claim submission (eClaim) feature by accessing the Claim Submission sub-tab located under the Claims tab. If the Claim Submission sub-tab is not displaying, the user may not have access to this feature yet. Part A/HHH claims cannot be submitted via the portal.

NOTE

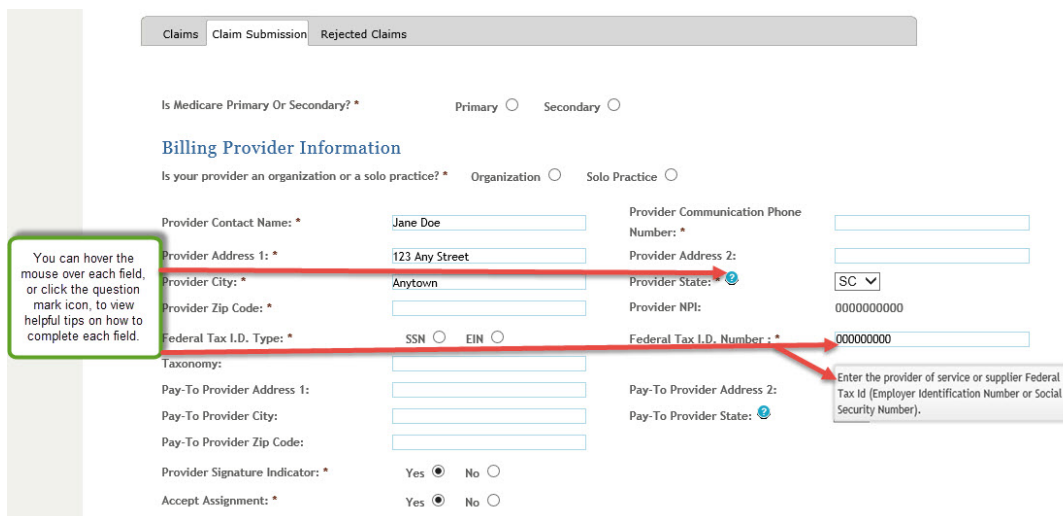
While eServices provider administrators will have access to the feature by default, provider users must be granted permission by an active provider administrator on their account. Additionally, new registrants must wait 48–72 hours (not including weekends and holidays) before the Claim Submission feature is available. If the provider administrator still cannot access the Claim Submission sub-tab after the 72 hours they will need to contact their Medicare Contractor for assistance.

Figure 24: Claim Submission Sub-tab



The eClaim form is dynamic so the fields that display will vary based on the data that is entered on the form. Required fields are marked with an asterisk. Throughout the form you will see tool tips that will provide helpful hints. Note, the total charge field will automatically calculate the amount based on the line information entered. You do not need to enter it.

Figure 25: Claim Submission Tool Tips



Users may attach PDF files; up to 40 MB in size each, to their claim. While there is no longer a limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB. The attachments must be in PDF format and created using appropriate PDF creation software. Failure to create the PDF correctly can result in a corrupt file that could prevent the user from successfully submitting their eClaim.

Once the user successfully submits their eClaim form, they will be directed to a Claim Submission Summary page that will provide them with the eServices Transaction ID for this eClaim submission. The eServices transaction ID will serve as a confirmation number for the eClaim submission until the submission is accepted. Rejected claims will not receive an ICN.

Figure 26: Claim Submission Summary

Claim Submission Summary

eServices Transaction ID: 00001
 Medicare ID : XXXXXXXXXXXX
 Patient's Name: John Smith
 Provider NPI: 0000000000

DATE OF SERVICE (DOS):

Primary Date From	Primary Date To	Secondary Date From	Secondary Date To
03/01/2018	03/01/2018		

Create New Claim

Create Duplicate Claim

Users will receive messages and updates regarding their eClaim submission in their eServices Notification Center. This can be accessed by selecting the Messages tab. The message details will contain history of the eClaim submission. Detailed History will include the Submission Confirmation and when the eClaim submission was accepted or rejected. This may take 24–48 hours (not including weekends or holidays) to receive. If the submission is accepted, an ICN and DCN (if attachments are submitted) will be provided in the message.

NOTE

Receiving an accepted message does not mean that the claim was approved to be paid. Once the claim is processed, the approval or denial information will be on the remittance.

A rejected status will include the corresponding error messages, informing the user what to correct. If the user needs to contact their Medicare Contractor regarding questions about a rejected claim, they must provide the file name listed in the rejected inbox message.

4.7 Claims Reopenings

Claims Reopenings Part B users can request some clerical error reopenings directly from the MCS Claims tab in eServices. Search for the claim using the claim status feature on the Claims tab. Click the word 'link' under the Details column for the claim you wish to view. This will redirect you to a detailed list of the claim's line items.

When performing a Reopening Request, select Reopen on the Claim Status Detail Screen beside the claim line that you want to reopen.

Figure 27: Reopening Request

Get Status
You have 0 unread message(s) and 0 alerts.
Help

List of Claim Status Information: 6000000000 010010000000

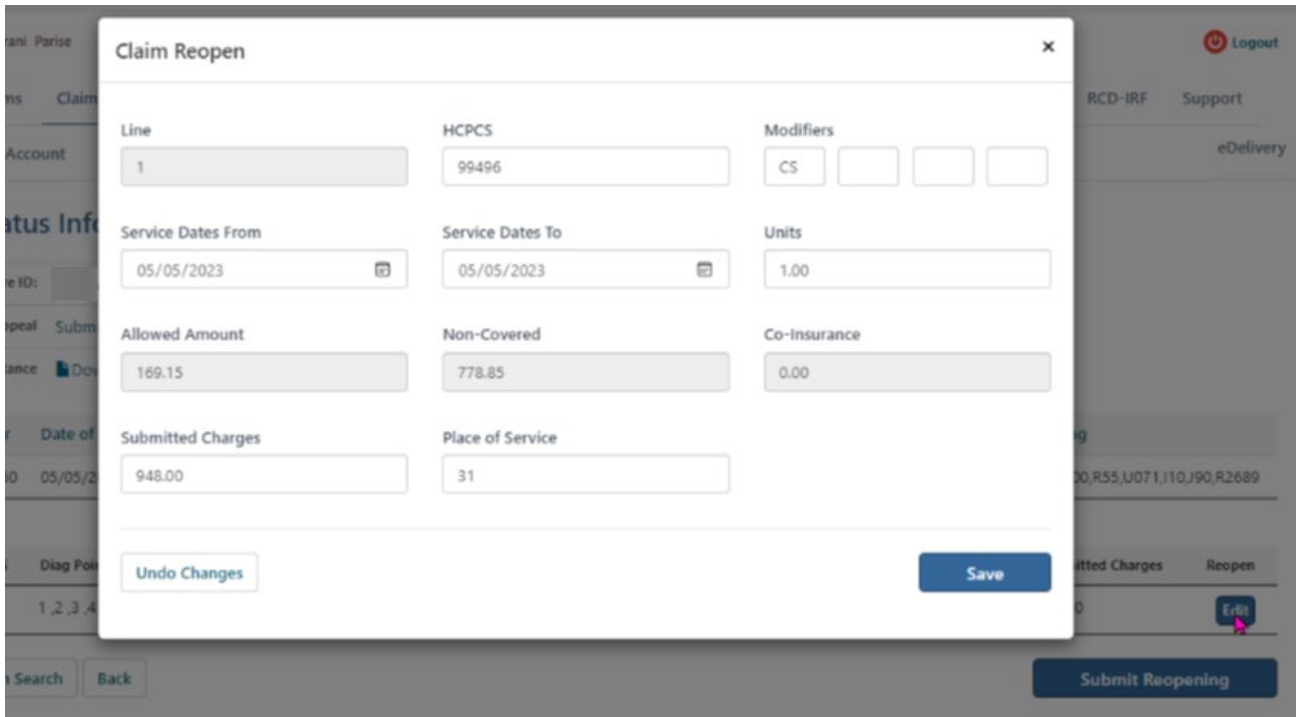
Provider Number: H000000000
 Medicare ID: 600000000
 Claim Number 010010000000

Claim Status Information								
Claim Number	Date of Service	Bill Amt	Claim Status	Co-Ins	Ded	Blood Ded	Paid	Diag
012000000000	01/23/2020 - 03/13/2020	3500.00	Approved	464.5	0.00	0.00	1685.50	R1110
Line	HCPCS	Modifiers	Service Dates	Units	Allowed Amount	Non-Covered	Submitted Charges	
1	99212		01/23/2020 - 01/23/2020	1.00	43.00	27.00	70.00	Reopen
2	99212		01/24/2020 - 01/24/2020	1.00	43.00	27.00	70.00	Reopen
3	99212		01/25/2020 - 01/25/2020	1.00	43.00	27.00	70.00	Reopen

Claim line detail displays. Updates can be made to the following fields:

- HCPCS Code field
- 4 Modifier fields
- Number of units
- Place of service
- Dates of service
- Submitted charges

Figure 28: Claim Status Information



Line	HCPCS	Modifiers
1	99496	CS
Service Dates From	Service Dates To	Units
05/05/2023	05/05/2023	1.00
Allowed Amount	Non-Covered	Co-Insurance
169.15	778.85	0.00
Submitted Charges	Place of Service	
948.00	31	

Buttons: Undo Changes, Save

Closing the window before saving will cancel out any changes on the screen and take you back to the Claim Status Detail Information Screen.

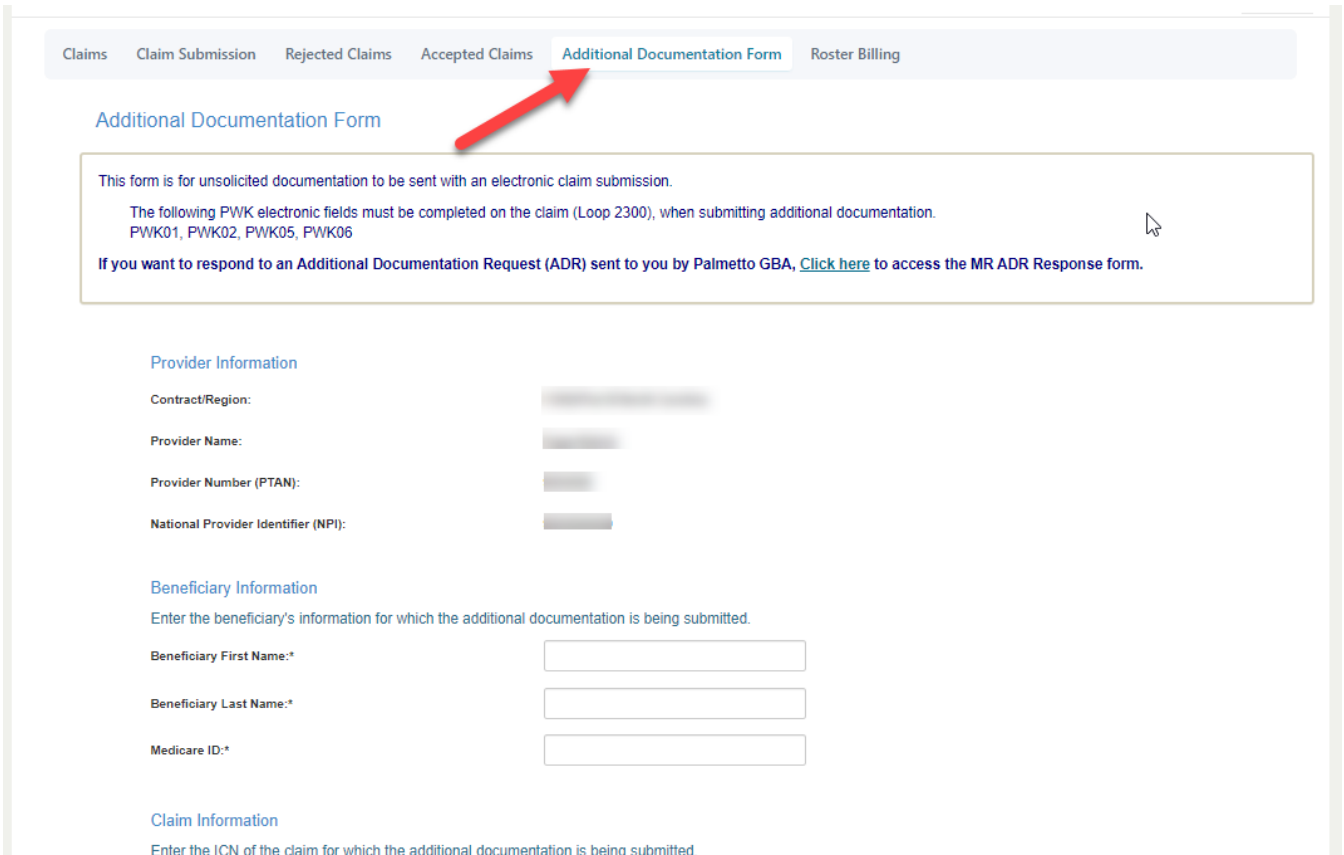
The Save button saves any changes and takes you back to the Claim Status Detail Information Screen.

Undo Changes will undo any changes and takes you back to the Claim Status Detail Information Screen.

4.8 Submitting an Additional Documentation form

JJ Part B and JM Part B users can access the additional documentation form from the Additional Documentation Form sub-tab located under the Claims tab. This form is used to attach documents when submitting a claim. If the sub-tab is not displaying, you may not have access to this feature.

Figure 29: Additional Documentation Form Navigation



Claims Claim Submission Rejected Claims Accepted Claims **Additional Documentation Form** Roster Billing

Additional Documentation Form

This form is for unsolicited documentation to be sent with an electronic claim submission.

The following PWK electronic fields must be completed on the claim (Loop 2300), when submitting additional documentation.
PWK01, PWK02, PWK05, PWK06

If you want to respond to an Additional Documentation Request (ADR) sent to you by Palmetto GBA, [Click here](#) to access the MR ADR Response form.

Provider Information

Contract/Region:

Provider Name:

Provider Number (PTAN):

National Provider Identifier (NPI):

Beneficiary Information

Enter the beneficiary's information for which the additional documentation is being submitted.

Beneficiary First Name:*

Beneficiary Last Name:*

Medicare ID:*

Claim Information

Enter the ICN of the claim for which the additional documentation is being submitted.

The form is prepopulated with the information we know from your registration record. This will save you several steps. Complete all of the required information. In the Line Item Information section, you must select a procedure code, modifier code, and/or other from the list provided. After completing this section, use the Add Line Information button to add the information to the form. You may then choose to add additional line items following the same process. Each Additional Documentation form may contain up to five line items total.

Figure 30: Additional Documentation Form - Line Item Information

You can click on the drop down arrow to select one procedure code, modifier code, and/or other from the list provided.

Line Item Information
Select at least one line item from the list provided.

Line Item - Procedure Code:*

Line Item - Modifier:*

Line Item - Other:*

Select the date of service on the claim that is applicable for additional documentation.

Date of Service (MM/DD/YYYY):*

Enter a comment **ONLY** if needed.

Comments:

Add Line Information

Show entries Search:

Line #	Procedure/Modifier Code/Other Code	Date of Service	Comments	Edit	Delete
No data available in table					

Users may submit attachments up to 40 megabytes (MB) in size. While there is not a limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB in size. Files must be either PDF or Word format. Special characters, such as commas, will be removed from uploaded file names; and duplicate file names will not be accepted.

Figure 31: Additional Documentation Form - Attachments

Attach Documents here:

NOTE: Attachment files can be one of the following types: PDF, Word (*.doc, *.docx). Each attachment can be up to 40 MB in size. The total size of all attachments cannot exceed 150 MB. Special characters such as commas will be removed from uploaded file names, and duplicate file names will not be accepted.

Attachment:

Attached Files

File Name	File Size (in bytes)	File Type
No data available in table		
Total File Size:		

Showing 0 to 0 of 0 entries

Email ID:*

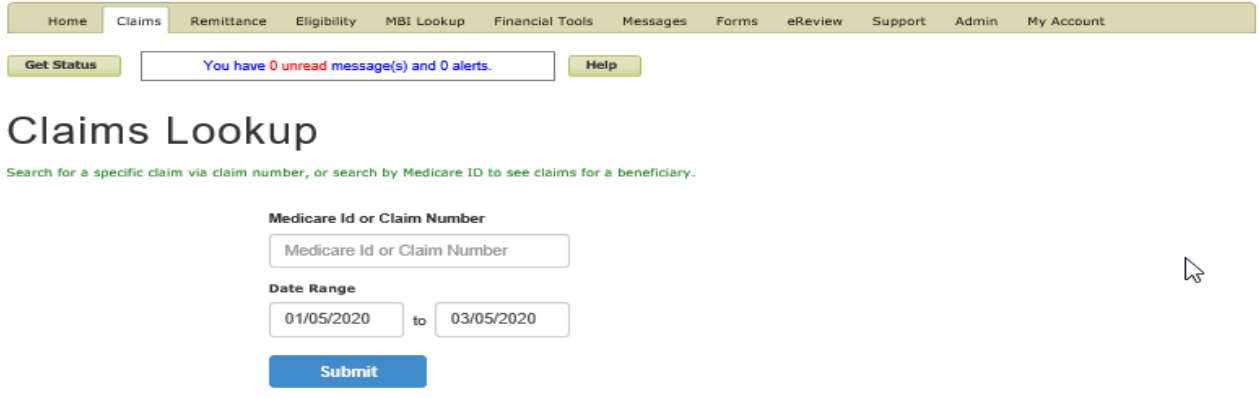
Name:* Date : 02/23/2018

*Required Field

4.9 Submitting a Level 2 Appeal Form

JJ Part A, JM Part A and HHH users can access appeals data from the Claims Lookup feature located under the Claims tab.

Figure 32: Claims Lookup Inquiry



Home | **Claims** | Remittance | Eligibility | MBI Lookup | Financial Tools | Messages | Forms | eReview | Support | Admin | My Account

Get Status | You have 0 unread message(s) and 0 alerts. | Help

Claims Lookup

Search for a specific claim via claim number, or search by Medicare ID to see claims for a beneficiary.

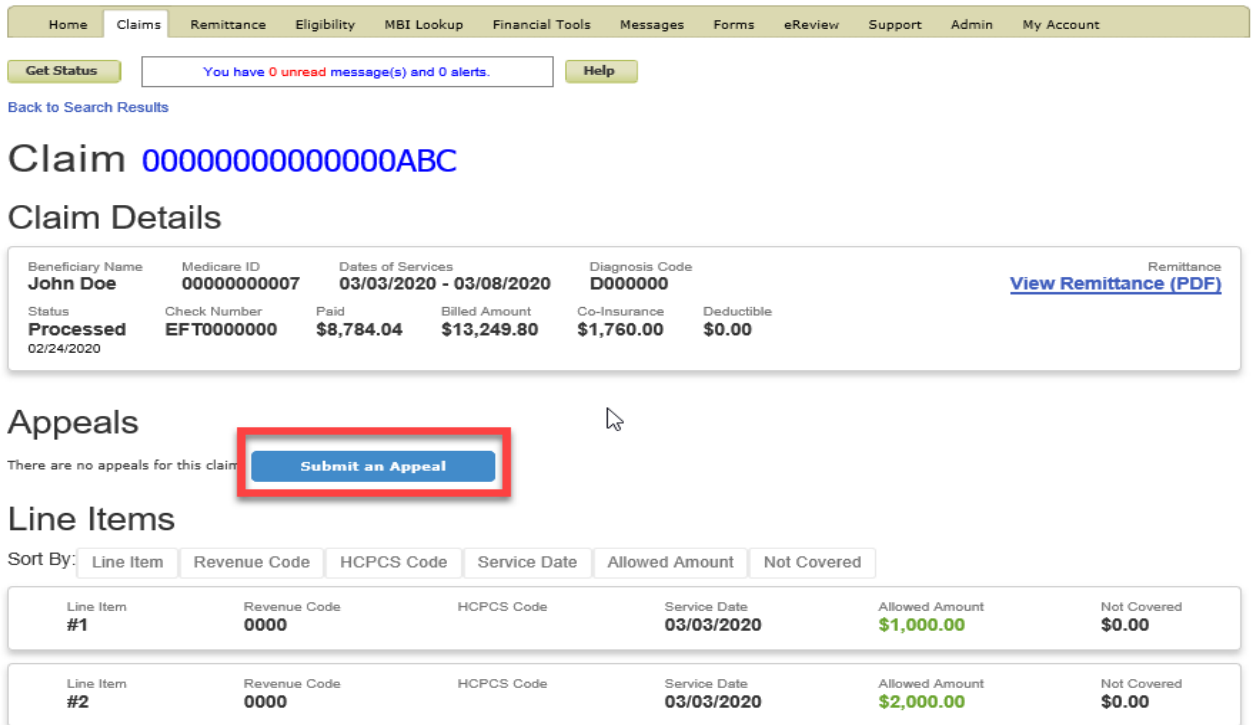
Medicare Id or Claim Number

Date Range
 to

Submit

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Figure 33: Submitting An Appeal



Home | **Claims** | Remittance | Eligibility | MBI Lookup | Financial Tools | Messages | Forms | eReview | Support | Admin | My Account

Get Status | You have 0 unread message(s) and 0 alerts. | Help

Back to Search Results

Claim 00000000000000ABC

Claim Details

Beneficiary Name John Doe	Medicare ID 00000000007	Dates of Services 03/03/2020 - 03/08/2020	Diagnosis Code D000000	View Remittance (PDF)	
Status Processed 02/24/2020	Check Number EFT0000000	Paid \$8,784.04	Billed Amount \$13,249.80	Co-Insurance \$1,760.00	Deductible \$0.00

Appeals

There are no appeals for this claim.

Submit an Appeal

Line Items

Sort By:

Line Item	Revenue Code	HCPCS Code	Service Date	Allowed Amount	Not Covered
#1	0000		03/03/2020	\$1,000.00	\$0.00
#2	0000		03/03/2020	\$2,000.00	\$0.00

If no appeals are found, "Submit an Appeal" button will be displayed. Users will be redirected to the Redetermination form after confirming whether the appeal is late (over 120 days).

Figure 34: Level 1 Appeal - View Decision Letter

Home Claims Remittance Eligibility MBI Lookup Financial Tools Messages Forms eReview Support Admin My Account

Get Status You have 0 unread message(s) and 0 alerts. Help

[Back to Claim Search](#)

Claim 00000000000000ABC

Claim Details

Beneficiary Name John Doe	Medicare ID 00000000007	Dates of Services 01/26/2020 - 01/31/2020	Diagnosis Code D000000	Remittance View Remittance (PDF)
Status Processed <small>01/29/2020</small>	Check Number EFT00000000	Paid \$8,000.00	Billed Amount \$8,000.00	Co-Insurance \$1,000.00
		Deductible \$0.00		

Appeals

Appeal Level L1 Redetermination	Status Final-Affirmation <small>Closed 02/25/2020</small>	Appeal # 1-0000000000 <small>Received 02/21/2020</small>	Decision Letter View Decision Letter <small>Mailed 02/25/2020</small>
--	--	---	---

[Submit a 2nd Level Appeal](#)

Line Items

Sort By: Line Item Revenue Code HCPCS Code Service Date Allowed Amount Not Covered

Line Item	Revenue Code	HCPCS Code	Service Date	Allowed Amount	Not Covered
#1	0000		01/01/2000	\$1,000.00	\$0.00

If a Level 1 appeal is found, the status of the appeal will be provided. Multiple links are available for Level 1 Appeals. The links are made available based on the status of the appeal. View Decision Letter link will allow users to download and view the decision letter of the appeal.

Figure 35: Submitting 2nd Level Appeal

Home
Claims
Remittance
Eligibility
MBI Lookup
Financial Tools
Messages
Forms
eReview
Support
Admin
My Account

Get Status
You have 0 unread message(s) and 0 alerts.
Help

[Back to Claim Search](#)

Claim 00000000000000ABC

Claim Details

Beneficiary Name John Doe	Medicare ID 00000000007	Dates of Services 01/26/2020 - 01/31/2020	Diagnosis Code D000000	Remittance View Remittance (PDF)
Status Processed <small>01/29/2020</small>	Check Number EFT00000000	Paid \$8,000.00	Billed Amount \$8,000.00	Co-Insurance \$1,000.00
Deductible \$0.00				

Appeals

Appeal Level L1 Redetermination	Status Final-Affirmation Closed 02/25/2020	Appeal # 1-0000000000 Received 02/21/2020	Decision Letter View Decision Letter <small>Mailed 02/25/2020</small>
			Submit a 2nd Level Appeal

If a Level 1 appeal is found, the status of the appeal will be provided. Multiple links are available for Level 1 Appeals. The links are made available based on the status of the appeal. Submit a 2nd level Appeal link redirects the user to complete and submit the Level 2 appeal form. The form can only be submitted if the date of submission is less than 186 days from the date the decision letter was mailed.

Figure 36: Level 1 Appeal – Submitting Additional Documentation

Home
Claims
Remittance
Eligibility
MBI Lookup
Financial Tools
Messages
Forms
eReview
Support
Admin
My Account

Get Status
You have 0 unread message(s) and 0 alerts.
Help

[Back to Claim Search](#)

Claim 000000000000ABC

Claim Details

Beneficiary Name	Medicare ID	Dates of Services	Diagnosis Code		
John Doe	000000007	04/06/2019 - 04/06/2019	D000000		
Status	Check Number	Paid	Billed Amount	Co-Insurance	Deductible
Processed 03/08/2019		\$8,000.00	\$3,000.00	\$0.00	\$1,000.00

Appeals

Appeal Level	Status	Appeal #	Decision Letter
L1	Reopened	1-0000000006	View Decision Letter
Redetermination	Closed 01/21/2020	Received 01/13/2020	Mailed 01/21/2020

Appeal Level	Status	Appeal #	
L1	Pending	1-00000000001	
Redetermination		Received 01/21/2020	

Submit Additional Documentation

If a Level 1 appeal is found, the status of the appeal will be provided. Multiple links are available for Level 1 Appeals. The links are made available based on the status of the appeal. Submit Additional Documentation link will redirect users to complete and submit additional documents that can be reviewed as part of the appeal.

Note: Submission of additional documentation for an appeal does not guarantee the inclusion of the documents for review. Normal business practices for reviewing additional documentation are not changed with this new function.

Figure 37: Level 2 Appeal

Home Claims Remittance Eligibility MBI Lookup Financial Tools Messages Forms eReview Support Admin My Account

Get Status You have 0 unread message(s) and 0 alerts. Help

[Back to Claim Search](#)

Claim 00000000000000ABC

Claim Details

Beneficiary Name John Doe	Medicare ID 00000000007	Dates of Services 06/03/2019 - 06/08/2019	Diagnosis Code D000000	Remittance View Remittance (PDF)
Status Processed 05/24/2019	Check Number EFT0000000	Paid \$9,000.00	Billed Amount \$13,000.00	Co-Insurance \$0.00
Deductible \$0.00				

Appeals

Appeal Level L1 Redetermination	Status Final-Affirmation Closed 02/21/2020	Appeal # 1-00000000000 Received 07/10/2019	Decision Letter View Decision Letter Mailed 08/24/2019
Appeal Level L1 Redetermination	Status Reopened Closed 02/13/2020	Appeal # 1-00000000000 Received 01/14/2020	Decision Letter View Decision Letter Mailed 02/13/2020
Appeal Level L2 Reconsideration	Status Pending	Appeal # 1-00000000000 Received 02/13/2020	Submit Additional Documentation

Line Items

Sort By: Line Item Revenue Code HCPCS Code Service Date Allowed Amount Not Covered

Line Item	Revenue Code	HCPCS Code	Service Date	Allowed Amount	Not Covered
#1	0000		01/01/2000	\$1,000.00	\$0.00

If a Level 2 appeal is found, the status of the appeal will be provided. Submit Additional Documentation link will redirect users to complete and submit additional documents that can be reviewed as part of the appeal.

Note: Submission of additional documentation for an appeal does not guarantee the inclusion of the documents for review. Normal business practices for reviewing additional documentation are not changed with this new function.



4.10 Submitting a Roster Bill

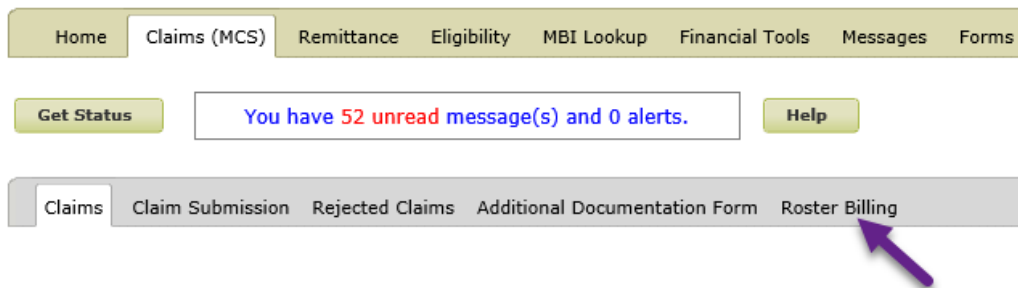
Part B providers, particularly mass immunizers, can create electronic claims for immunization services for up to fifty patients using the roster billing feature. If you need to submit an invoice for pricing with the claim, please use the single eClaim submission feature and not Roster Bill.

Note: If you just registered your eServices account please allow 72 hours before trying to submit your first roster bill.

Users must have the claim submission permission to submit a Roster Bill.

Navigate to the Claims tab and look for the Roster Billing sub-tab.

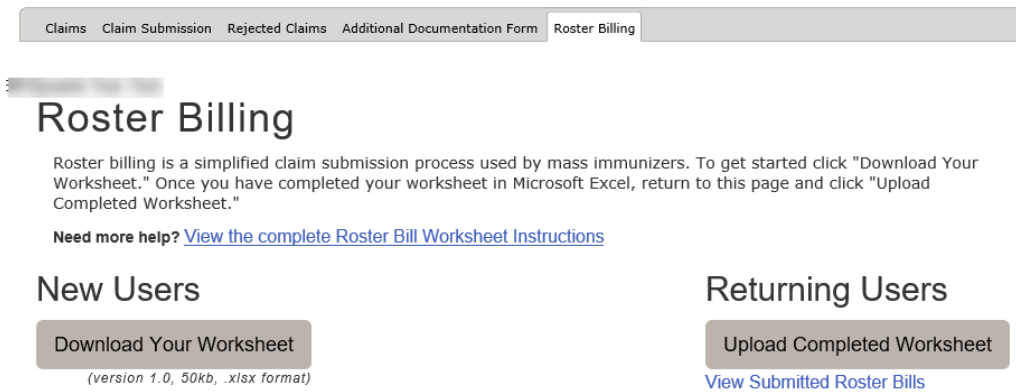
Figure 38: Roster Billing Subtab



Claim Status Inquiry

Click on Roster Billing. The Roster Billing home page will display.

Figure 39: Submitting a Roster Bill



Complete Worksheet:

If you are new to Roster Billing or want a new blank worksheet:

Download a worksheet to enter the claim data and the patients' information. The worksheet will be a blank Excel document.

Figure 40: Roster Bill Worksheet

Need more help? [View the complete Roster Bill Worksheet Instructions](#)

New Users

Download Your Worksheet

(version 1.0, 50kb, .xlsx format)



If you are not new to Roster Billing, complete a worksheet previously downloaded.

The worksheet will be an Excel document with two sections to complete. The first step is the claim information and the next step is the roster information.

Required fields will have an asterisk.

Default or unavailable fields will be grayed out.

For guidance in completing the worksheet see the Roster Bill Worksheet Instructions on the Roster Bill home page and see the links to jurisdiction websites at the top of the worksheet.

You can currently submit claims for influenza, pneumococcal and COVID-19 (vaccine and monoclonal antibody infusion).

***Note:** If you are mass immunizer such as a pharmacy with one NPI, please select the organization type of Solo.*



Figure 41: Roster Billing Worksheet Example

eServices Roster Billing Worksheet

Please complete your eServices Roster Bill using the inputs below under both steps.
Once you have finished, save your work and return to eServices to upload your completed worksheet.
Visit [JM Part B](#), [JJ Part B](#), or [Railroad/Medicare](#) Roster Billing websites for detailed information.

Step 1: Claim Information

Please complete the tables below with the required information. Rendering NPI is required if this is a group practice.

Claim Information		Billing Provider Information	
Vaccine Type *		Organization Type	
Admin HCPCS *		First Name ¹	
Admin Charge *		Name *	¹ First name is needed when Billing Provider is a solo practice
Vaccine HCPCS ²		Address Line 1 *	² Do not enter a Vaccine HCPCS or Vaccine Charge for COVID-19 claims at this
Vaccine Charge ²		Address Line 2	
Place of Service *	60	Address City *	
Diagnosis Code *	Z23	Address State *	
Service Date *		Address Zip *	(ex. 12345-5678) (Date ex. 1/1/2021)
		Phone *	(ex. 123-456-7890)
		NPI *	
		Tax Type *	
		Tax ID *	
Service Facility Location Information		Rendering Provider Information ³	
Name *		NPI ³	
Address Line 1 *		First Name ³	
Address Line 2		Last Name ³	
Address City *			³ Rendering Provider information is needed when Billing Provider is organization
Address State *			
9 digit Zip Code *			
NPI *			

Step 2: Roster Information

Please complete with required information in columns B-N. There is a maximum of 50 patients per Roster.

	Medicare ID *	Last Name *	First Name *	MI	Sex *	Date of Birth *	Address Line 1 *	City *	State *	Zip Code *	Signature on File *
1											
2											
3											

Once you fill out the worksheet, you will want to save a copy for your records.

Upload/ Drag Completed Worksheet:

Click the Upload Completed Worksheet button.

Figure 42: Roster Billing Existing Users

Roster Billing

Roster billing is a simplified claim submission process used by mass immunizers. To get started click "Download Your Worksheet." Once you have completed your worksheet in Microsoft Excel, return to this page and click "Upload Completed Worksheet."

Need more help? [View the complete Roster Bill Worksheet Instructions](#)

New Users

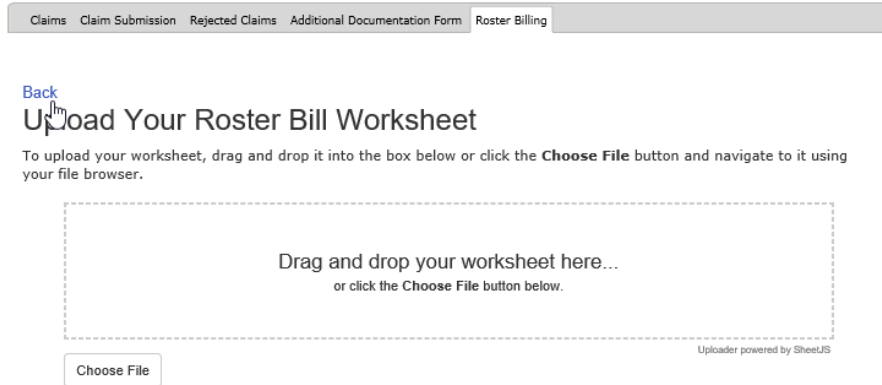
[Download Your Worksheet](#)
(version 1.0, 50kb, .xlsx format)

Returning Users

[Upload Completed Worksheet](#) 
[View Submitted Roster Bills](#)

The following page will appear.

Figure 43: Worksheet Upload



Choose a file or drag and drop your worksheet.

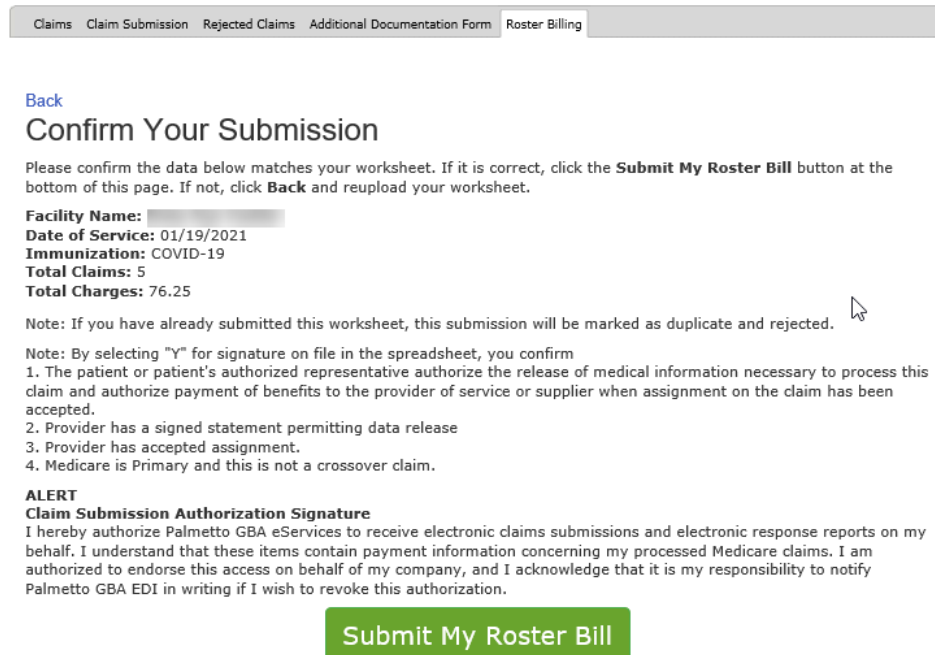
Submit Worksheet:

Once the worksheet is added the following page will appear.

Read over the worksheet summary and if everything is correct.

Click the confirm/ submit button.

Figure 44: Roster Bill Confirmation



The following confirmation page will display.

Figure 45: Roster Bill Completion

[Return Home](#)

Roster Bill Complete!

Thank you for using eServices to submit your Roster Bill. Your Transaction ID is 114155.

[View Roster Bill Detail](#)

If submitting during business hours, you should receive Status from EDI within 24 hours.

Note: If there are any validation errors with the data entered in the worksheet an error will appear.

4.11 Checking the Status of Roster Bills

Inbox Message

Within an hour you will receive a message in your inbox.

Figure 46: Inbox Message

Form Name	Details	Submitted on	Status	Submitted By
<input type="checkbox"/> Roster Bill	Details	11/02/2021		

Showing 1 to 1 of 1 entries

Within two to three days your Detail History will be updated with additional information.

Figure 47: Detail History Information

Roster Bill-EDI APPROVED		
Details		
Transaction ID	Submitted By	Accepted
		2
Rejected		
0		
History		
11/02/2021	Submitted The portal has received the submission	
11/02/2021	Decision Received EDI APPROVED	

Close

View list of submissions

Click on View Submitted Roster Bills link.

Figure 48: View Submitted Roster Bills

Roster Billing

Roster billing is a simplified claim submission process used by mass immunizers. To get started click "Download Your Worksheet." Once you have completed your worksheet in Microsoft Excel, return to this page and click "Upload Completed Worksheet."

Need more help? [View the complete Roster Bill Worksheet Instructions](#)

New Users

Download Your Worksheet

(version 1.0, 50kb, .xlsx format)

Returning Users

Upload Completed Worksheet

[View Submitted Roster Bills](#)



A list of all the roster bills submitted will display. You can sort the rows by the data column of your choice. The default sort is by Submission Date with the most current submission being at the top.

Figure 49: Submitted Roster Bills

[Return Home](#)

Submitted Roster Bills

View the list of all roster bills submitted in eServices with this account.

Show entries

Transaction ID	Submission Date	Service Date	Immunization	# of Claims	Total Charges	Claims Accepted	Claims Rejected
90	1/14/2021	01/10/2021	Influenza	5	100.0	3	2
86	1/14/2021	01/10/2021	Pneumococcal	5	100.0	3	2
73	1/14/2021	01/01/2021	COVID-19	10	5000.0	10	0
36	1/14/2021	01/01/2021	COVID-19	10	140.0	0	10
95	1/14/2021	01/01/2021	COVID-19	10	5000.0	0	10
93	1/14/2021	09/09/2020	Pneumococcal	10	10000.0	10	0
91	1/14/2021	06/30/2020	Influenza	10	10000.0	10	0
75	1/13/2021	01/10/2021	COVID-19	1	10.0	0	1
45	1/13/2021	01/10/2021	COVID-19	1	10.0	0	1

View details of specific submission

Click on the transaction ID to view the details of the specific Roster Bill.

Figure 50: Specific Roster Bill
[Return Home](#)

Submitted Roster Bills

View the list of all roster bills submitted in eServices with this account.

 Show entries

Transaction ID	Submission Date	Service Date	Immunization	# of Claims	Total Charges	Claims Accepted	Claims Rejected
90	1/14/2021	01/10/2021	Influenza	5	100.0	3	2
86	1/14/2021	01/10/2021	Pneumococcal	5	100.0	3	2
73	1/14/2021	01/01/2021	COVID-19	10	5000.0	10	0

After the bill submission summary section, each line in the worksheet will display.

Bill submissions will show in a pending status for the first day or two until the individual claims reach the processing system.

The ICN will display where claims were accepted into the claim system. If a claim is rejected there will be no ICN.

Figure 51: Roster Bill Detail
[Return to Roster Bills](#)

Roster Bill Detail

 Thursday, January 14, 2021
4:22 PM

TRANSACTION ID 86

SUBMISSION DATE
TOTAL CLAIMS 5
CLAIMS ACCEPTED 3
CLAIMS REJECTED 2

Billing Provider

Date of Service
01/10/2021

Admin HCPCS
G0009

Vaccine HCPCS
90732

Thank you for your recent submission, please allow 3-4 business days before checking claim status

File Name: S00003.SS00003.Jan14.T162602646.001112.tran.1.flat

Claim Summary

 Show entries

 Search:

ICN	MEDICARE ID	PATIENT LAST NAME	STATUS	CSCC	CSC	EIC
			REJECTED	A7	501	IL
			REJECTED	A7	501	IL
300			ACCEPTED	A2	20	PR
310			ACCEPTED	A2	20	PR

Allow three to four days for the ICNs to be available for viewing from the claim inquiry feature.

5.0 Remittances

5.1 How do I access remittances online?

If you have access to remittances online and are successfully logged in, click on the Remittance tab. The remittance screen will appear.

To access remittances, you can choose to view remittances for the last 30 days or for a specific date range. The remittance selection screen defaults to the last 30 days.

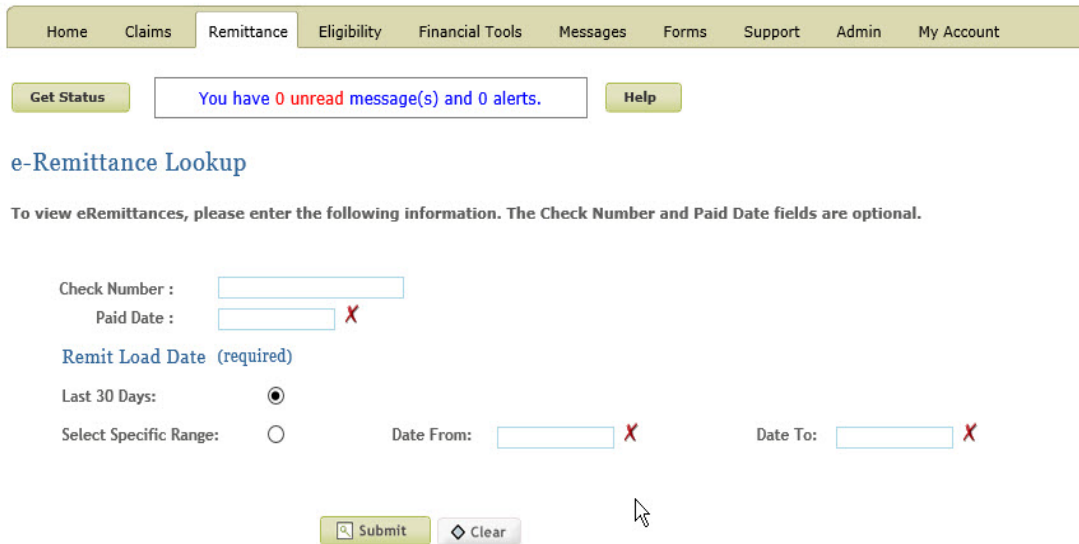
Additional search parameters, such as Check Number and Paid Date, can also be entered to narrow down your query results.

These values will also be displayed in your results screen to help you identify specific remittances.

Once a remittance has been viewed, the line will be grayed out. Users have the option to select remittances that have been viewed by you or by anyone.

You may also download and print the Remittance Search Results to excel.

Figure 52: Remittance Tab



The screenshot shows the 'Remittance' tab selected in a navigation bar. Below the navigation bar is a 'Get Status' button and a notification box stating 'You have 0 unread message(s) and 0 alerts.' with a 'Help' button. The main section is titled 'e-Remittance Lookup' and contains the following fields:

- Check Number :
- Paid Date : X
- Remit Load Date (required)
 - Last 30 Days:
 - Select Specific Range:
 - Date From: X
 - Date To: X

At the bottom of the form are 'Submit' and 'Clear' buttons.

Remits are also accessible directly from the Claim Summary Screen. Perform your claim status inquiry on the Claims tab to return the list of claims that match your search criteria. Then click the Remittance link on the claim line you wish to view.

Figure 53: Claim Summary Screen

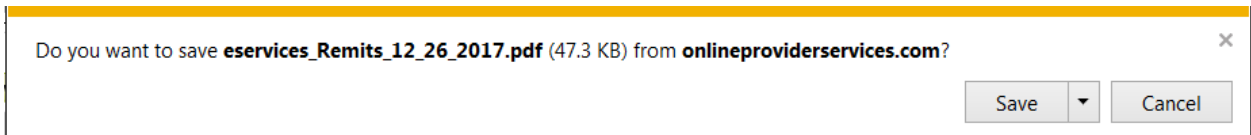
List of Claim Status Information: XXXXXXXXXXX

Provider Number: 0000000000
Medicare ID: XXXXXXXXXXX

Claim Status Information							
Claim Number	Date of Service	Bill Amt	Process Date	Check Number	Claim Status	Details	Remittance
0000000000003	10/13/2018 - 10/13/2018	5440.03	01/30/19	000000003	Completed	link	link
0000000000002	10/13/2018 - 10/13/2018	3040.03	12/26/18	000000002	Completed	link	link
0000000000001	10/13/2018 - 10/13/2018	5440.03	11/13/18	000000001	Completed	link	link

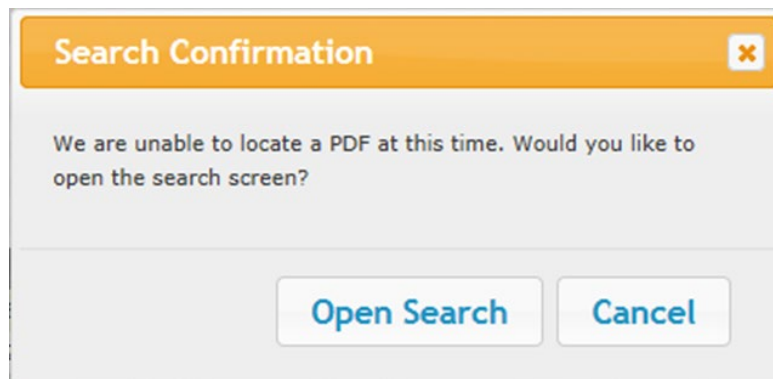
If a single match is found, the option to save as a PDF file will display at the bottom of the screen.

Figure 54: Save Message Pop-up



If a match is not immediately found or multiple remittances are found, a pop-up window will display providing the option to search.

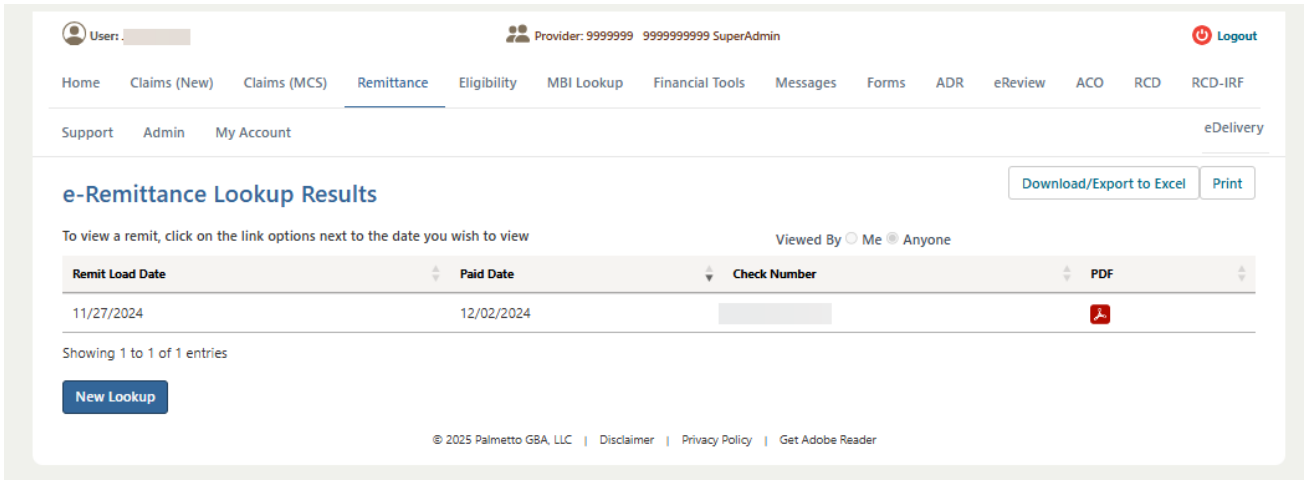
Figure 55: Search Confirmation Pop-up



Click Open Search to display the e-Remittance Lookup Screen. Click Cancel to remain on the Claim Inquiry Summary Screen.

For claims that do not have a check number, a list of possible remittances based on NPI will be displayed.

Figure 56: Remittance Results



You can use the buttons above the results table on the right side of the page to download the results to Excel. You can use the print button to print to a PDF.

5.2 How far back can I view remittances?

Remittances are readily available for approximately one year. If you need to retrieve remittances over one year old, eServices may experience a delay. Palmetto GBA does not guarantee that older remittances are available.

5.3 I do not see remittances online for the date range I have chosen. What should I do?

If you have chosen to view remittances for the last 30 days, you will only see those remittances. If no remittances are displayed, you may want to select a specific date range.

Remittances are readily available online as described in section 5.2.

NOTE

You will only be able to view remits for the one PTAN/NPI combination associated with your user ID. If you have additional NPIs, they will need to be registered separately.

5.4 I do not see a remittance for the deposit date I am searching for. What should I do?

Remittances are listed in eServices by the remittance upload date and not the deposit date, so you may need to search a few days earlier or later in the remit list to find the specific remittance you are looking for.

NOTE

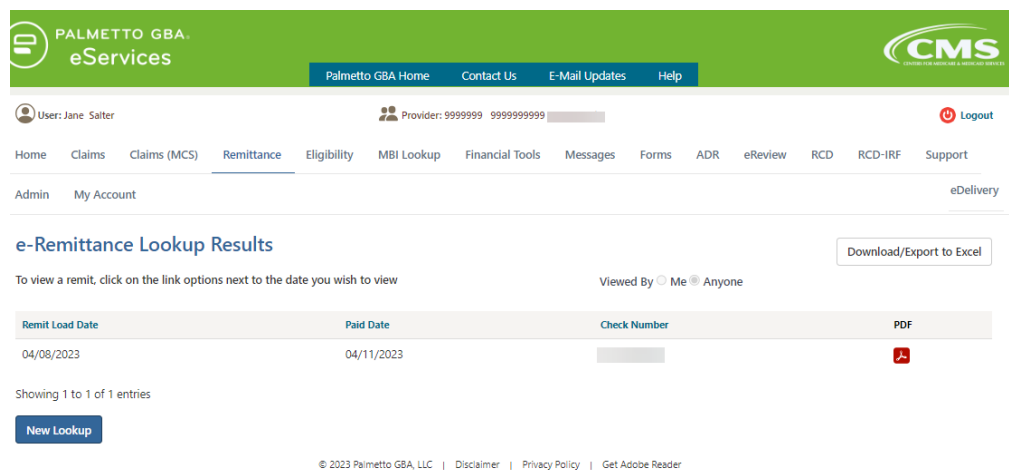
You will only be able to view remits for the one PTAN/NPI combination associated with your user ID. If you have additional NPIs, they will need to be registered separately.

5.5 How do I print a remittance?

View your remittance by clicking on the Portable Document Format (PDF) link in the remittance list. You may sort the list of remittances by clicking on the date column header. The option to save as a PDF file will display at the bottom of the screen. You may then select the option to open the saved file. Once your remittance is displayed, click on the print icon in the menu of your Acrobat Reader to print the remittance. If you do not have Acrobat Reader software, you can [download](#) it at no cost. You must use Acrobat Reader X or Acrobat Pro X to successfully print remittances in eServices.

Please see [Section 5.1](#) for information about how to access the remittance list.

Figure 57: Remittance Look-up Results



6.0 Eligibility

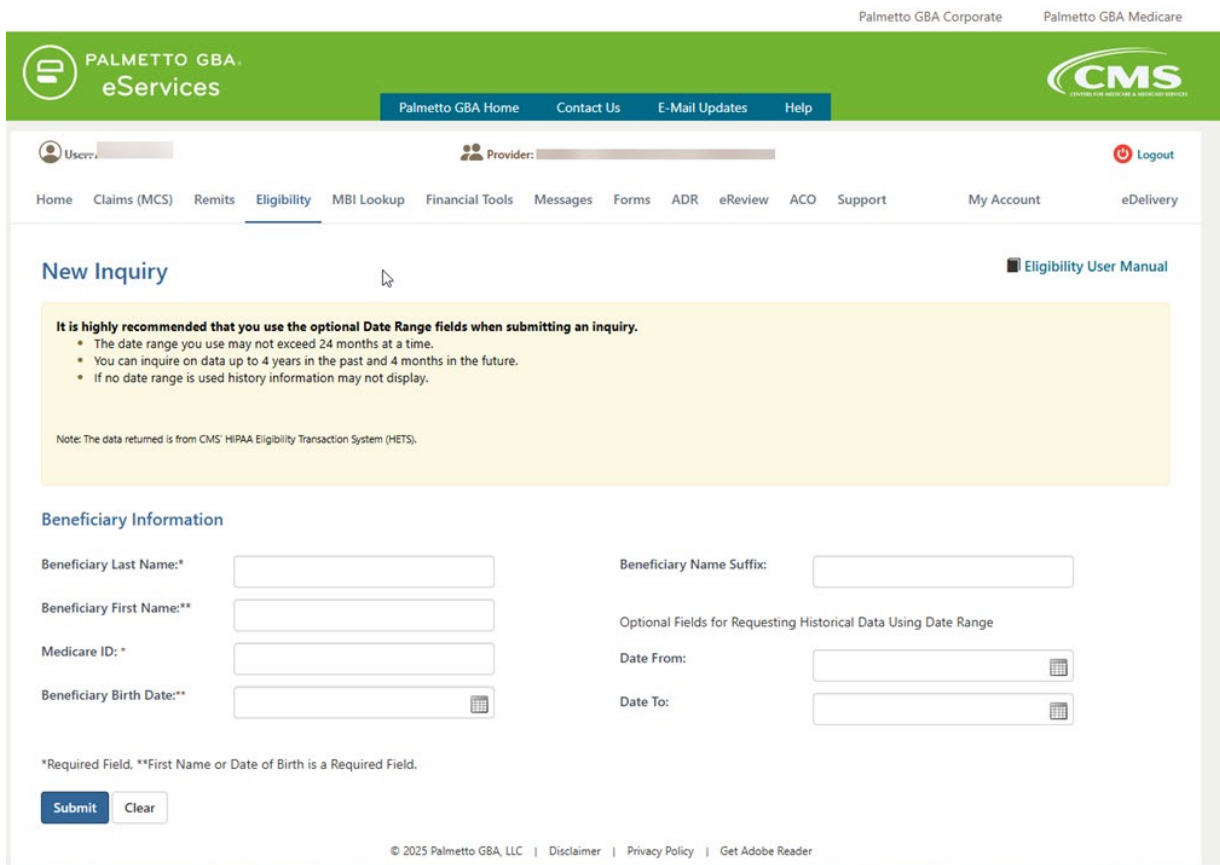
The eServices eligibility functions are based on CMS' HIPAA Eligibility Transaction System (HETS). When you choose the Eligibility tab, you will see a new set of tabs to display information related to your inquiry. Information is presented on the following tabs:

- Inquiry
- Eligibility
- Deductibles/Caps
- Preventive
- Plan Coverage
- MSP
- Hospice/Home Health
- Inpatient
- QMB

NOTE

eServices uses CMS's HETS 270/271 system, as required by CMS, for all eligibility inquiries. Although eServices pulls data from HETS in real time, the data available in the HETS 270/271 system is only updated once daily in the mornings (Eastern Time). The HETS response is not updated further during the day. Providers should not resubmit the same transaction multiple times thought out the day expecting to receive different results. As soon as updated data is available in the HETS 270/271 system, providers will be able to view it in eServices. For more information on HETS, visit [HIPAA Eligibility Transaction System \(HETS\) | CMS](#).

Figure 58: Eligibility Tab



The screenshot shows the Palmetto GBA eServices interface. At the top, there is a green header with the Palmetto GBA logo and 'eServices' text. To the right of the header are links for 'Palmetto GBA Corporate' and 'Palmetto GBA Medicare'. Below the header is a navigation bar with 'Palmetto GBA Home', 'Contact Us', 'E-Mail Updates', and 'Help'. The main content area has a user profile section with 'User:' and 'Provider:' fields, and a 'Logout' button. A menu bar includes 'Home', 'Claims (MCS)', 'Remits', 'Eligibility' (which is highlighted), 'MBI Lookup', 'Financial Tools', 'Messages', 'Forms', 'ADR', 'eReview', 'ACO', 'Support', 'My Account', and 'eDelivery'. The 'Eligibility User Manual' link is also visible. The main form area is titled 'New Inquiry' and contains a yellow warning box with the following text: 'It is highly recommended that you use the optional Date Range fields when submitting an inquiry.' followed by three bullet points: 'The date range you use may not exceed 24 months at a time.', 'You can inquire on data up to 4 years in the past and 4 months in the future.', and 'If no date range is used history information may not display.' Below this is a note: 'Note: The data returned is from CMS' HIPAA Eligibility Transaction System (HETS)'. The form fields are organized under 'Beneficiary Information' and include: 'Beneficiary Last Name:*', 'Beneficiary First Name:**', 'Medicare ID:*', 'Beneficiary Birth Date:**', 'Beneficiary Name Suffix:', and 'Optional Fields for Requesting Historical Data Using Date Range' which includes 'Date From:' and 'Date To:' with calendar icons. At the bottom of the form are 'Submit' and 'Clear' buttons, and a footer with '© 2025 Palmetto GBA, LLC | Disclaimer | Privacy Policy | Get Adobe Reader'.

6.1 How do I successfully perform an eligibility inquiry?

Navigate to the Eligibility Inquiry Page using the Eligibility tab in the menu bar. Enter the required data and any optional data you wish and then press submit. To receive results, all information entered must match the beneficiary's data maintained in the CMS' HIPAA Eligibility Transaction System (HETS).

Required fields:

- Beneficiary's Last Name
- Medicare ID
- Beneficiary's First Name or Date of Birth

Optional fields:

- Beneficiary's Name Suffix (include it if it is on the beneficiary's card)
- Date From and Date To (recommended to see full benefit usage/ coverage history)

If the data entered in an optional field does not match the beneficiary's data maintained in HETS system, no results will be returned.

Once you have successfully retrieved the beneficiary's information, multiple subtabs will display benefit and coverage information for the beneficiary.

NOTE

To retrieve all information available, you must enter a valid date range. The HETS 270/271 system we are required to access for eligibility allows date requests up to four (4) years prior to, and four (4) months in the future of, the current date. Date ranges may not exceed 24 months at a time.

Figure 59: Eligibility, Inquiry Tab

Inquiry
Eligibility
Deductibles/Caps
Preventive
Plan Coverage
MSP
Hospice/HomeHealth
Inpatient
QMB
All screens

Beneficiary:
Medicare ID:
Sex: Female
DOB:
DOD:

New Inquiry

Beneficiary Information

<p>Beneficiary Last Name:* <input type="text"/></p> <p>Beneficiary First Name:** <input type="text"/></p> <p>Medicare ID:* <input type="text"/></p> <p>Beneficiary Birth Date:** <input type="text"/></p>	<p>Beneficiary Name Suffix: <input type="text"/></p> <p>Optional Fields for Requesting Historical Data Using Date Range</p> <p>Date From: <input type="text" value="02/01/2023"/></p> <p>Date To: <input type="text" value="02/01/2025"/></p>
---	---

*Required Field, **First Name or Date of Birth is a Required Field.

Submit
Clear

6.2 How do I use the date range optional fields in the eligibility Inquiry tab?

The 'Date From' and 'Date To' fields are optional fields you can input to request beneficiary eligibility data for a specific time period. If no 'Date From' or 'Date To' is entered, the system will automatically use the current calendar date for the inquiry.

You will receive an invalid format error message when an invalid character or an invalid date is entered on the Medicare Eligibility Benefit Inquiry screen. You are prompted to correct the date and submit a new inquiry.

NOTE

To retrieve all information available, you must enter a valid date range. The HETS 270/271 system we are required to access for eligibility allows date requests up to four (4) years prior to, and four (4) months in the future of, the current date. Date ranges may not exceed 24 months at a time.

Based on the 'Date From' and 'Date To' the system will determine the beneficiary data to display. The application will display an error message if you enter a date and/or date range within one of the following scenarios:

- A 'Date From' that is before the date of eligibility and no 'Date To' is entered
- A 'Date From' that is after the date of termination or date of death
- A specified date range(s) that is outside of the date(s) of eligibility

If you receive the error message because of one of the above scenarios, retry the inquiry leaving the date range fields blank. If the beneficiary is currently eligible for Medicare benefits and the user leaves the date range fields blank, the user will see the effective and termination (if applicable) dates of eligibility based on the current calendar date.

All information provided in the Eligibility tab is based on what is or is not entered in the date range fields. If you are looking for prior year information, adjust your date ranges accordingly. Information is available up to four (4) years prior to, and four (4) months in the future of, the current date. Data ranges may not exceed 12 months at a time. The eServices Eligibility functions are based on the data available in CMS' HETS system.

6.3 How do I use the Eligibility sub-tab?

The Eligibility sub-tab provides information regarding the beneficiary's Part A and Part B eligibility, inactive periods (e.g., unlawful, deported, and incarcerated), beneficiary address and end-stage renal disease (ESRD). If this tab is available, it indicates that the beneficiary has some type of Medicare eligibility. If the beneficiary is eligible for Medicare benefits, the screen will display the beneficiary's Part A and/or Part B Eligibility period(s) as appropriate. The ESRD section provides information regarding a beneficiary's eligibility to receive Medicare benefits based on permanent kidney failure requiring dialysis or a kidney transplant.

Figure 60: Eligibility, Eligibility Tab

Inquiry **Eligibility** Deductibles/Caps Preventive Plan Coverage MSP Hospice/HomeHealth Inpatient QMB All screens

Beneficiary: [Redacted] Medicare ID: [Redacted] Sex: [Redacted] DOB: [Redacted] DOD: [Redacted] [Print](#)

Eligibility

Part A Eligibility

Effective Date: 06/01/2012 Termination Date:

Part B Eligibility

Beneficiary insured due to age OASI (Old-Age and Survivors Insurance)

Effective Date: 06/01/2012 Termination Date:

Part B Immunosuppressive Drug Eligibility

Effective Date: Termination Date:

Inactive Periods

Effective Date: Termination Date:

Beneficiary Address

Address Line 1: [Redacted] Address Line 2: [Redacted]
City: [Redacted] State: [Redacted]
Zip: [Redacted]

End Stage Renal Disease (ESRD)

Coverage Period Effective Date: Coverage Period End Date:
Dialysis Start Date: Dialysis End Date:
Transplant Effective Date:

Additional Information

[Redacted]

MBI End Date

End Date:

Audiology Screening

HCPCS Code	Next Professional Date	Next Technical Date	Remaining Deductible	Co-insurance
92550	07/01/2023		257	20%
92552	07/01/2023		257	20%
92553	07/01/2023		257	20%
92652	07/01/2023		257	20%

MDPP Coverage

Period	Start Date	End Date	Co-insurance
Period 1	02/01/2023		01/31/2024
Period 2	05/01/2024		12/31/2024

MDPP Inactive Periods

Start Date: End Date:

MDPP Deductible

Period	Start Date	End Date	Deductible Amount	Co-insurance
Period 1	02/01/2023		0	01/31/2024
Period 2	05/01/2024		0	12/31/2024

MDPP Co-Insurance

Period	Start Date	End Date	Co-Insurance Amount	Co-insurance
Period 1	02/01/2023		0	01/31/2024
Period 2	05/01/2024		0	12/31/2024

MDPP Usage Information

[Redacted]

NOTE

If the 'Part A Eligibility' benefit information, 'Part B Eligibility' or "Part B Immunosuppressive Drug Eligibility" does not contain data; it means the beneficiary is not eligible to receive Medicare benefits for the requested period on the inquiry screen. The ESRD section only displays active ESRD data and will not be available if notification has not been received by CMS indicating an ESRD period is active and in effect per the date(s) requested.

The following tables provide information for the Eligibility Benefit tab

Part A Eligibility Benefit Information

Field Name	Descrip
Effective Date	A date that indicates the start of eligibility for Medicare Part A benefits
Termination Date	A date that indicates the termination of eligibility for Medicare Part A benefits. No date in this field means Medicare Part A eligibility has not terminated

Part B Eligibility Benefit Information

Field Name	Description
Effective Date	A date that indicates the start of eligibility for Medicare Part B benefits
Termination Date	A date that indicates the termination of eligibility for Medicare Part B benefits. No date in this field means Medicare Part B eligibility has not terminated

Part B Immunosuppressive Drug Eligibility Benefit Information

Field Name	Description
Effective Date	A date that indicates the start of eligibility for Medicare Part B – ID benefits
Termination Date	A date that indicates the termination of eligibility for Medicare Part B – ID benefits. No date in this field means Medicare Part B – ID benefits has not terminated

Inactive Periods

Field Name	Description
Effective Date	A date that indicates the start of an inactive period due to unlawful, deported, or incarcerated reasons
Termination Date	A date that indicates the end of an inactive period due to unlawful, deported, or incarcerated reasons

Beneficiary Address

Field Name	Description
Address Line 1	The address line 1 of the beneficiary, if available
Address Line 2	The address line 2 of the beneficiary, if available
City	The city of the beneficiary, if available
State	The state of the beneficiary, if available
ZIP	The ZIP code of the beneficiary, if available

End Stage Renal Disease (ESRD) Information

Field Name	Description
Effective Date	The date that indicates the start of eligibility for ESRD services
Benefit Description Service Type Code	The Type of Dialysis (14 or 15) services that are being rendered
Transplant Discharge Date	The date the transplant services were discharged

6.4 How do I use the Deductibles Tab?

The Deductibles sub-tab provides information regarding the beneficiary's Part B deductibles; coinsurance; blood deductibles; occupational therapy; physical and speech therapy; pulmonary, cardiac and intensive cardiac rehabilitation sessions; Part B free services and mental health co-insurance amounts.

Figure 61: Eligibility, Deductibles Tab

Inquiry Eligibility **Deductibles/Caps** Preventive Plan Coverage MSP Hospice/HomeHealth Inpatient QMB All screens

Beneficiary: [Redacted] Medicare ID: [Redacted] Sex: [Redacted] DOB: [Redacted] DOD: [Redacted] [Print](#)

Deductibles/Caps

Acupuncture			
Eligibility begins:	01/21/2020	Eligibility begins:	01/21/2020
Technical Sessions Remaining	20	Professional Sessions Remaining	20

Part B Deductible			
Start Date:	01/01/2023	End Date:	12/31/2023
Deductible Amount:	\$226		

Part B Remaining Deductible			
Start Date:	01/01/2023	End Date:	12/31/2023
Deductible Amount:	\$0		

Co-insurance Details			
Start Date:	01/01/2023	End Date:	12/31/2023
Co-insurance Amount:	20%		

Blood Deductible			
Calendar Year:	2025	Number Of Units Remaining:	3

Occupational Therapy Cap			
Calendar Year:	2025	Amount Used:	\$0

Physical And Speech Therapy Cap			
Calendar Year:	2025	Amount Used:	\$0

Pulmonary Rehabilitation Services			
Calendar Year:	2025	Professional Sessions Remaining:	72
Technical Sessions Remaining:	72		

Cardiac Rehabilitation Services			
Calendar Year:	2025	Professional Sessions Used:	0
Technical Sessions Used:	0		

Intensive Cardiac Rehabilitation Services			
Calendar Year:	2025	Professional Sessions Used:	0
Technical Sessions Used:	0		

Part B Free Services List of STC Codes			
STC Codes:	42.5,67.80,AJ.CO	Value:	0%
Start Date:	01/01/2025	End Date:	12/31/2025

Mental Health Co-insurance (if different from the plan level Co-insurance) List of STC Codes			
STC Codes:		Value:	
Start Date:		End Date:	

The following tables provide information for the Deductible Tab.

Part B Deductible Information

Field Name	Description
Calendar Year	The calendar year associated with the deductible amounts
Deductible Amount	The Medicare Part B deductible amount associated with the calendar year
Remaining Deductible Amount	The Medicare Part B remaining deductible amount associated with the calendar year indicated

Co-insurance Amount

Field Name	Description
Co-insurance Amount	The patient's portion of responsibility for a benefit, represented as a percentage
Start Date	The start date of the benefit period, typically the first day of the calendar year indicated
End Date	The end date of the benefit period, typically the last day of the calendar year

Blood Deductible Information

Field Name	Description
Calendar Year	The calendar year associated with the remaining deductible amount
Number of Units Remaining	The blood deductible units remaining associated with the calendar year indicated

Occupational Therapy Information

Field Name	Description
Calendar Year	The calendar year associated with the used dollar amount applied to the capitation limit
Amount Used	Occupational Therapy services used dollar amount applied to the capitation limit associated with the calendar year indicated

Physical and Speech Therapy Information

Field Name	Description
Calendar Year	The calendar year associated with the used dollar amount applied to the capitation limit
Amount Used	Physical and Speech Therapy services used dollar amount applied to the capitation limit associated with the calendar year indicated

Pulmonary Rehabilitation Services Information

Field Name	Description
Calendar Year	The calendar year associated with the remaining sessions for pulmonary rehabilitation services

Field Name	Description
Professional Sessions Remaining	The number of pulmonary rehabilitation sessions remaining for the professional component
Technical Sessions Remaining	The number of pulmonary rehabilitation sessions remaining for the technical component

Cardiac Rehabilitation Services Information

Field Name	Description
Calendar Year	The calendar year associated with the remaining sessions for cardiac rehabilitation services
Professional Sessions Remaining	The number of cardiac rehabilitation sessions used for the professional component
Technical Sessions Remaining	The number of cardiac rehabilitation sessions used for the technical component

Intensive Cardiac Rehabilitation Information

Field Name	Description
Calendar Year	The calendar year associated with the remaining sessions for intensive cardiac rehabilitation
Professional Sessions Used	The number of intensive cardiac rehabilitation sessions used for the professional component
Technical Sessions Used	The number of intensive cardiac rehabilitation sessions used for the technical component

Part B Free Services

Field Name	Description
STC Codes	The STC codes associated with Part B services that have a 0% co-insurance amount
Value	The patient's portion of responsibility for a benefit, represented as a percentage
Start Date	The start date of the benefit period, typically the first day of the calendar year indicated
End Date	The end date of the benefit period, typically the last day of the calendar year

Mental Health Co-insurance

Field Name	Description
STC Codes	The mental health STC codes that are listed as having a co-insurance amount that is different than the plan level co-insurance
Value	The patient's portion of responsibility for a benefit, represented as a percentage

Field Name	Description
Start Date	The start date of the benefit period, typically the first day of the calendar year indicated
End Date	The end date of the benefit period, typically the last day of the calendar year

6.5 How do I use the Preventive tab?

The Preventive tab provides information regarding the beneficiary's smoking cessation and preventive services. The information on the screen is organized into the Healthcare Common Procedure Coding System (HCPCS) categories (e.g. Cardiovascular, Colorectal and Diabetes).

NOTE

Only HCPCS codes for which a particular beneficiary is eligible will be displayed and grouped together under their appropriate categories. If a service has been rendered, it is removed from the list until closer to the time the beneficiary is eligible to receive the service again. Pneumococcal Vaccine (PPV) information is displayed for the last 10 dates of service.

Figure 62: Eligibility, Preventive Tab

Inquiry Eligibility Deductibles/Caps **Preventive** Plan Coverage MSP Hospice/HomeHealth Inpatient QMB All screens

Beneficiary: [REDACTED] Medicare ID: [REDACTED] Sex: [REDACTED] DOB: [REDACTED] DOD: [REDACTED] [Print](#)

Preventive

COVID

COVID-19 Immunization

Immunization Date	HCPC Code	Rendering Medicare NPI
No data available		

Pneumococcal Vaccine (PPV)

Pneumococcal Vaccine

Date of Service	HCPC Code	Rendering Medicare NPI
05/15/2015	90670	[REDACTED]

Flu

Flu Vaccination

Vaccination Date	HCPC Code	Rendering Medicare NPI
No data available		

Cognitive Assessment and Care Plan Services

Cognitive Assessment and Care Plan Services

Date of Service	HCPC Code	Rendering Medicare NPI
No data available		

Smoking Cessation

Number of Sessions in Benefit Period:	8	Initial Session Date:
Benefit Period Sessions Remaining:	8	

Preventive

HCPCS Code	Next Professional Date	Next Technical Date	Remaining Deductible	Co-insurance
G0402	[REDACTED]	[REDACTED]	[REDACTED]	
G0404	[REDACTED]	[REDACTED]	[REDACTED]	
G0403	[REDACTED]	[REDACTED]	[REDACTED]	
G0405	[REDACTED]	[REDACTED]	[REDACTED]	
76706	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Q0091	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Hepatitis Screening

Date Of Service	HCPCS Code	Provider or Rendering NPI	Deductible	Co-insurance
12/04/2017	G0472	[REDACTED]	[REDACTED]	[REDACTED]

The following tables provide information for the Preventive Tab.

COVID-19 Immunization

Field Name	Description
Immunization Date	Immunization date for the HCPC code
HCPC Code	A Healthcare Common Procedure Coding System (HCPCS) code
Rendering Medicare NPI	NPI of the provider that administered the services for the applicable code.

Pneumococcal Vaccine

Field Name	Description
Date of Service	Date the HCPC was administered.
HCPC Code	A Healthcare Common Procedure Coding System (HCPCS) code
Rendering Medicare NPI	NPI of the provider that administered the services for the applicable code.

Flu Vaccination

Field Name	Description
Date of Service	Date the HCPC was administered.
HCPC Code	A Healthcare Common Procedure Coding System (HCPCS) code
Rendering Medicare NPI	NPI of the provider that administered the services for the applicable code.

Cognitive Assessment and Care Plan Services

Field Name	Description
Date of Service	Date the HCPC was administered.
HCPC Code	A Healthcare Common Procedure Coding System (HCPCS) code
Rendering Medicare NPI	NPI of the provider that administered the services for the applicable code.

Pneumococcal Vaccine (PPV) Information

Field Name	Description
Date of Service	Last date of service for the applicable code. The last 10 dates of service will be provided.
HCPC Code	A Healthcare Common Procedure Coding System (HCPCS) code
Rendering NPI	NPI of the provider that administered the services for the applicable code.

Smoking Cessation Information

Field Name	Description
Number of Sessions in Benefit Period	Number of smoking cessation counseling sessions available for a beneficiary during the benefit period
Benefit Period Sessions Remaining	Number of smoking cessation counseling sessions remaining for a beneficiary

Field Name	Description
Next Session Date	The next available begin date for smoking cessation counseling session program if there are no sessions remaining in their current period

Preventive Information

Field Name	Description
HCPCS Code	A Healthcare Common Procedure Coding System (HCPCS) code
Next Professional Date	The date a beneficiary is next eligible for professional services associated with the indicated HCPCS code
Next Technical Date	The date a beneficiary is next eligible for technical services associated with the indicated HCPCS code
Remaining Deductible	The remaining deductible amount associated with the indicated HCPCS code
Co-insurance	The patient's portion of responsibility for the indicated HCPCS code, represented as a percentage

6.6 How do I use the Plan Coverage Tab?

The Plan Coverage tab provides information regarding the beneficiary's enrollment under MA and Part D contracts and/or MA Managed Care Plans (Part C contracts) that provide Part A and B benefits for beneficiaries enrolled under a contract.

NOTE

Whenever eServices indicates that a beneficiary has coverage through a non-Medicare entity (MA or Medicare Drug Benefit plans) the inquiring provider should always contact the non-Medicare entity for complete beneficiary entitlement information. All information provided in the Plan Coverage tab is based on what is or is not entered in the date range fields in the Inquiry tab. Information is available up to four (4) years prior to, and four (4) months in the future of, the current date. Data ranges may not exceed 24 months at a time.

Figure 63: Eligibility, Plan Coverage Tab

[Inquiry](#) [Eligibility](#) [Deductibles/Caps](#) [Preventive](#) **[Plan Coverage](#)** [MSP](#) [Hospice/HomeHealth](#) [Inpatient](#) [QMB](#) [All screens](#)

Beneficiary: Medicare ID: Sex: DOB: DOD: [Print](#)

Plan Coverage

Medicare Advantage

Plan Type:

Enrollment Date: **Disenrollment Date:**
Contract Number: **Contract Name:**
Plan Number: **Plan Name:**
Address Line 1: **Phone Number:**
Address Line 2: **City:**
State: **Zip Code:**
Website: **Bill Code :**

VBID Model Hospice Benefit Component Links
[Hospice Benefit Component participating plans](#)
[Directions for submitting claims for plans supporting the Hospice Benefit Component of the Model](#)

Plan Type:

Enrollment Date: **Disenrollment Date:**
Contract Number: **Contract Name:**
Plan Number: **Plan Name:**
Address Line 1: **Phone Number:**
Address Line 2: **City:**
State: **Zip Code:**
Website: **Bill Code :**

VBID Model Hospice Benefit Component Links
[Hospice Benefit Component participating plans](#)
[Directions for submitting claims for plans supporting the Hospice Benefit Component of the Model](#)

Medicare Part D

Enrollment Date: **Disenrollment Date:**
Contract Number: **Contract Name:**
Plan Number: **Plan Name:**
Address Line 1: **Phone Number:**
Address Line 2: **City:**
State: **Zip Code:**
Website: **Drug Plan :**

Enrollment

Enrollment Date: **Disenrollment Date:**
Contract Number: **Contract Name:**
Plan Number: **Plan Name:**
Address Line 1: **Phone Number:**
Address Line 2: **City:**
State: **Zip Code:**
Website: **Drug Plan :**

Enrollment



Part D contracts provide prescription drug coverage

Part C contracts will return whether the MA is a Health Maintenance Organization Medicare Non Risk (HM), a Health Maintenance Organization Medicare Risk (HN), an Indemnity (IN), a Point of Service (PS), a Preferred Provider Organization (PR), or a Pharmacy (Part D). The response will display only the most current plan description (HM, HN, IN, PS, PR, or Part D) and Plan Type Code for a contract. This may happen if a contract's plan description and Plan Type Code has changed since the beneficiary originally enrolled. Providers are advised to contact the plan provider if there is any question about the plan's terms and conditions.

The table below describes the Plan Coverage fields.

Plan Coverage Information

Field	Description
Plan Type	A full plan description followed by Plan Type Code: <ul style="list-style-type: none"> • Health Maintenance Organization Medicare Non Risk – HM • Health Maintenance Organization Medicare Risk – HN • Indemnity – IN • Preferred Provider Organization – PR • Point of Service – PS • Pharmacy – Part D
Enrollment Date	The date that indicates the start of enrollment to the coverage plan
Disenrollment Date	The date that indicates the termination of enrollment to the coverage. No date in this field means the plan enrollment has not terminated.
Contract Number/Plan Benefit Package ID	The contract number followed by the plan number (if on file)
Plan Name	A descriptive name of the beneficiary's insurance coverage organization
Address Line 1	The coverage plan's address line 1
Phone Number	The coverage plan's contract telephone number (if on file) displayed as XXX-XXX-XXXX
Address Line 2	The coverage plan's address line 2
City	The coverage plan's city address
State	The coverage plan's state address
ZIP Code	The coverage plan's ZIP code
Bill Code	The bill code of the plan type. This field only applies to plan types HM, HN, IN, PR and PS. <u>Medicare Beneficiary "locked in" to MCO</u> <ul style="list-style-type: none"> A - Fiscal Intermediary should process all claims B - MCO should process only in-plan Part A claims and in-area Part B claims C - MCO should process all claims <u>Medicare Beneficiary NOT "locked in" to MCO</u> <ul style="list-style-type: none"> 1 - Fiscal Intermediary should process all claims 2 - MCO should process only in-plan Part A claims and in-area Part B claims
Website	The coverage plan's website address that will provide information on the beneficiary's insurance

6.7 How do I use the MSP Tab?

When a beneficiary has a primary payer other than Medicare, the Medicare Secondary Payer (MSP) tab provides the beneficiary's primary insurance information.

Figure 64: Eligibility, MSP Tab

Inquiry Eligibility Deductibles/Caps Preventive Plan Coverage **MSP** Hospice/HomeHealth Inpatient QMB All screens

Beneficiary: Medicare ID: Sex: DOB: DOD: [Print](#)

Medicare Secondary Payer

Medicare Secondary Payer	
Effective Date:	Termination Date:
Insurer Name:	Policy Number:
Patient Relationship:	Group Number:
Type of Primary Insurance:	Diagnosis Codes:
Address Line 1:	Address Line 2:
City:	State:
Zip Code:	Source Code:
Maintenance Date:	Ongoing Responsibility For Medicals:

NOTE The MSP tab only displays MSP data per the dates requested. When inquiring on MSP information, always enter a date range on the search page. You can search for up to 24 months at a time, going back for up to 4 years prior.

The following table describes the MSP fields.

MSP Information

F	Description
Effective Date	The date that indicates the start of the primary insurer's coverage
Termination Date	The date that indicates the termination of the primary insurer's coverage. No date in this field means primary insurance coverage has not terminated
Insurer Name	The name of the insurance company
Policy Number	The primary insuring organization's policy number for the Medicare beneficiary
Patient Relationship	The relationship to the other policy 01 = Self 02 = Spouse 03 = Child 04 = Other 20 = Life or Domestic Partner
Group Number	The other insurance group policy number

F	Description
Type of Primary Insurance	12 = Medicare Secondary - Working aged beneficiary or spouse with employer group health plan 13 = Medicare Secondary – End-stage Renal Disease Beneficiary in the 12 month coordination period with an employer group health plan 14 = Medicare Secondary – No-Fault insurance including auto is primary 15 = Medicare Secondary – Workers’ Compensation 16 = Medicare Secondary - Public Health Service (PHS) or other Federal Agency 41 = Medicare Secondary - Black Lung 42 = Medicare Secondary - Veteran’s Administration 43 = Medicare Secondary - Disabled beneficiary under age 65 with large group health plan 47 = Medicare Secondary – Other liability insurance is primary WC = Workers’ Compensation Medicare Set-aside Arrangement
Address Line 1	The address line 1 of the insurance company
Address Line 2	The address Line 2 of the insurance company
City	The city of the insurance company
State	The state of the insurance company
ZIP Code	The ZIP code of the insurance company
Source Code	Describes the origin of the patient’s admission to the hospital
Maintenance Date	The last date an update was made to the beneficiary’s MSP information
Ongoing Responsibility for Medicals(ORM)	“Yes” will be displayed when bene is marked available and “blank” when bene is marked not

6.8 How do I use the Hospice/Home Health Tab?

The Hospice/Home Health tab includes two sections:

- Home Health Care
- Hospice

NOTE

The Hospice/Home Health tab only displays active Hospice and/or Home Health data and will not be accessible when there have been no claims received by CMS indicating Hospice or Home Health coverage is active and is in effect per the date(s) requested. To make sure you see all of the information, enter a date range in the inquiry screen. The HIPAA Eligibility System (HETS) 270/271 system we are required to access for eligibility allows date requests up to four (4) years prior to, and four (4) months in the future of, the current date. Data ranges may not exceed 24 months at a time.

The Home Health Care section provides information for each episode start and end date and the corresponding billing activity dates.

Figure 65: Eligibility, Hospice/Home Health Tab

Inquiry Eligibility Deductibles/Caps Preventive Plan Coverage MSP **Hospice/HomeHealth** Inpatient QMB All screens

Beneficiary: [] Medicare ID: [] Sex: [] DOB: [] DOD: [] [Print](#)

Hospice/HomeHealth

Home Health Care

Patient Status:
NOA Indicator:
HHEH Start Date: HHEH End Date:
HHEH DOEBA Date: HHEH DOLBA Date:
Provider Number: Provider Number Type:
Contractor Number: Contractor Name:
HH Certification Start Date(s): HH Recertification Start Date(s):

Hospice

Hospice Episodes:

Effective Date	Termination Date	Start Date (DOEBA)	End Date (DOLBA)	Hospice Days Used	Provider Number	Provider Number Type

Notices of Election (NOE):

Date	Election Receipt Date	Provider Number	Provider Number Type	Revocation Code	Election Revocation Date

The Hospice section provides eligibility information when the hospice benefit is effective and when it terminates in addition to the total hospice occurrence count for the listed beneficiary.

If the patient has any gap in their episode of care or changes providers at any time, or if their hospice provider has sent the final claim revoking hospice care, you will see more than just a single effective date being returned. Once the final claim has been submitted, the hospice termination (or revocation) date is returned along with the revocation code. If the patient is still in hospice care, but has changed providers, the start and termination date with each provider will be returned. Therefore, if no termination date is returned it is to be assumed that the patient is still under hospice care as no claim has yet been processed that revokes that period of care.

The tables below describe the Home Health and Hospice Information fields.

Home Health Information

Field	Description
Patient Status	A display of the beneficiary status code along with its description.
NOA Indicator	This field will indicate if the NOA was received with or without condition code 47.
HHEH Start Date	The date the 60-day home health episode period started
HHEH End Date	The date that the home health episode terminated
HHEH DOEBA Start Date	The date of earliest billing activity for spell of illness
HHEH DOLBA End Date	The date of latest billing activity for spell of illness
Provider Number	The NPI or Legacy Provider Number of the home health facility
Provider Number Type	A display of 'Legacy' or 'NPI' depending on the source of the provider number
Contractor Number	A display of the contractor number
Cert Date	The date the beneficiary was certified to receive home health care services
Recert Date	The date the beneficiary was recertified to receive home health care services

Hospice Information

Field	Description
Total Occurrence Count	Total number of hospice occurrences on file for the beneficiary, including those listed for the date range requested
Effective Date	The start date of a beneficiary's elected period of hospice coverage
Termination Date	The termination date of a beneficiary's elected hospice coverage. No date in this field means the beneficiary's elected period of hospice coverage has not terminated
Provider Number	The NPI or Legacy provider number of the Hospice Facility. If you click the hyperlink you will be taken to the National NPI Registry to look up the Provider name and address.
Provider Number Type	A display of 'Legacy' or 'NPI' depending on the source of the provider number

Field	Description
Revocation Code	<p>The code indicating the revocation status for the spell listed</p> <p><u>Medicare Beneficiary in Hospice Care</u> 0 - Not revoked, open spell</p> <p><u>Medicare Beneficiary with Hospice Care Revoked</u> 1 - Revoked by notice of revocation 2 - Revoked by notice of revocation with a non-payment code of 'N' and an occurrence code of '42' 3 - Revoked by a hospice claim with an occurrence code of '23'</p>

6.9 How do I use the Inpatient Tab?

The Inpatient sub-tab includes Inpatient, Skilled Nursing Facility (SNF), and Psychiatric Benefit Data sections. The inpatient section provides hospital inpatient benefit and billing information. The SNF section provides SNF benefit and billing information.

NOTE

While the Psychiatric Benefit Data section now displays in eServices, the data is not yet available in CMS' HIPAA Eligibility Transaction System (HETS) 270/271 system we are required to access for eligibility.

Figure 66: Eligibility, Inpatient Tab

[Inquiry](#) [Eligibility](#) [Deductibles/Caps](#) [Preventive](#) [Plan Coverage](#) [MSP](#) [Hospice/HomeHealth](#) **Inpatient** [QMB](#) [All screens](#)

Beneficiary: [REDACTED] Medicare ID: [REDACTED] Sex: [REDACTED] DOB: [REDACTED] DOD: [REDACTED] [Print](#)

Inpatient

Part A Deductible			
Start Date:	01/01/2025	End Date:	12/31/2025
Deductible Amount:	\$1676		

Part A Base Deductible Remaining			
Start Date:	01/01/2025	End Date:	12/31/2025
Remaining Deductible:	\$1676		

Deductible Remaining By Spell		
DOEBA Date	DOLBA Date	Deductible Amt
No data to display		

Inpatient Spell Dates
Includes Hospital and Skilled Nursing Facility (SNF) Dates
No data to display

Inpatient Base Summary				
Start Date	End Date	Full Days Allowed	Full Copayment Days Allowed	Copay Amount
01/01/2025	12/31/2025	60	30	\$419

Inpatient Days Remaining (May Also Include Spells)				
DOEBA Date	DOLBA Date	Full Inpatient Days	Full Inpatient Copay Days	Copay Amount
01/01/2025	12/31/2025	60	30	\$419

SNF Base Summary				
Start Date	End Date	SNF Full Days Allowed	SNF Full Copayment Days Allowed	SNF Copay Amount
01/01/2025	12/31/2025	20	80	\$209.5

SNF Days Remaining (May Also Include Spells)				
DOEBA Date	DOLBA Date	Full SNF Days	Full SNF Copay Days	SNF Copay Amount
01/01/2025	12/31/2025	20	80	209.5

Lifetime Reserve Days			
Lifetime Days Allowed:	60	Lifetime Days Remaining :	60
Start Date:	01/01/2025	End Date:	12/31/2025
Copayment Amount Per Day:	\$838		

Lifetime Psychiatric Benefit Data			
Lifetime Psychiatric Base Days:	190	Lifetime Psychiatric Remaining:	190

Part A Free Services List of STC Codes			
STC Codes:	42.45	Value:	0%
Start Date:	01/01/2025	End Date:	12/31/2025

The system will return hospital inpatient default deductibles based on the requested start year when the following occurs:

- No inpatient spell data returned from the database overlaps or falls within 60 days of the requested date (range)
- Entitlement period and request date period overlap
- Part A Entitlement start year is less than the requested start year

In addition, the system will continue to return the hospital inpatient default deductible remaining amounts, inpatient copayment days and SNF copayment days based on the beneficiary's Part A entitlement start year when the following occurs:

- No inpatient spell data returned from the database overlaps or falls within 60 days of the requested date (range)
- Entitlement period and request date period overlap
- Part A Entitlement start year is less than or equal to the requested start year

NOTE

Depending on the date(s) range requested, multiple inpatient and SNF spells might be displayed. The data returned on this screen is directly impacted by timely submission of claims by the provider. The data returned is compiled from claims that have been processed by the Common Working File (CWF). To make sure you see all of the information, enter a date range in the inquiry screen. The HETS 270/271 system we are required to access for eligibility allows date requests up to four (4) years prior to, and four (4) months in the future of, the current date. Data ranges may not exceed 24 months at a time.

If a single hospital inpatient/SNF spell spans more than one calendar year, eServices will return the daily copayment amounts associated with the beginning year of the spell.

If there is no hospital inpatient/SNF spell within 60 days of the requested date(s) of service, eServices will return default values for Part A spell data.

The tables below describe the Inpatient Tab fields.

Deductible Remaining By Spell

Field Name	Description
DOEBA Date	The date of earliest billing activity for the spell of illness
DOLBA Date	The date of latest billing activity for spell of illness

Field Name	Description
Deductible Amount	The amount of the deductible remaining to be met for the spell of illness

Inpatient Days Remaining By Spell

Field	Description
DOEBA Date	The date of earliest billing activity for the spell of illness
DOLBA Date	The date of latest billing activity for the spell of illness
Full Inpatient Days	The full inpatient days remaining in the spell
Full Inpatient Co-Pay Days	The full inpatient co-payment days remaining in the spell

SNF Days Remaining By Spell

Field	Description
DOEBA Date	The date of earliest billing activity for the spell of illness
DOLBA Date	The date of latest billing activity for the spell of illness
Full SNF Days	The full SNF days remaining in the spell
Full SNF Co-Pay Days	The full SNF co-payment days remaining in the spell

Inpatient Base Summary

Field	Description
Calendar Year	The calendar year requested
Full Days Allowed	The number of inpatient full days allowed for the calendar year requested
Full Co-payment Days Allowed	The number of inpatient full co-payment days allowed for the calendar year requested
Co-pay Amount	The amount of the inpatient co-payment for the calendar year requested
Deductible	The amount of the inpatient deductible for the calendar year requested

Inpatient Spell Dates

Field	Description
Start Date	The start date of the benefit period, typically the first day of the calendar year indicated
End Date	The end date of the benefit period, typically the last day of the calendar year
Billing NPI	NPI of the provider that administered the services for the applicable code
Type	Type of facility

Field	Description
Inpatient Details	Get Details will take them to NPPES for address, contact no and more details.

SNF Base Summary

Field	Description
Calendar Year	The calendar year requested
SNF Full Days Allowed	The number of SNF full days allowed for the calendar year requested
SNF Full Co-payment Days Allowed	The number of SNF full co-payment days allowed for the calendar year requested
SNF Co-pay Amount	The amount of the SNF co-payment for the calendar year requested

Lifetime Reserve Days

Field	Description
Lifetime Days Allowed	The number of lifetime reserve days allowed
Lifetime Days Remaining	The number of lifetime reserve days remaining
Calendar Year	The calendar year requested
SNF Co-pay Amount	The co-payment amount per lifetime reserve day

Psychiatric Benefit Data

Field	Description
Lifetime Psychiatric Base Days	The number of lifetime psychiatric days allowed
Lifetime Psychiatric Remaining	The number of lifetime psychiatric days remaining

6.10 How do I use the QMB tab?

Beneficiaries who are enrolled in the Qualified Medicare Beneficiary (QMB) program are dually eligible for both Medicare and Medicaid. Beneficiaries who are enrolled in the QMB program are not liable for Medicare co-insurance or deductible payments. Note that QMB status may fluctuate for a minority of Beneficiaries. If eligibility results indicate the Beneficiary QMB enrollment has terminated, please verify the patient's QMB status through state online Medicaid eligibility systems or other documentation, including Medicaid Identification cards and documents issued by the state proving the patient qualifies for the QMB program.

The QMB sub-tab includes Medicaid Enrollment, Part A Deductible, Inpatient, Skilled Nursing Facility (SNF), Part B Deductible, and Part B Co-Insurance sections.

Figure 67: Eligibility, QMB Tab



[Inquiry](#) [Eligibility](#) [Deductibles/Caps](#) [Preventive](#) [Plan Coverage](#) [MSP](#) [Hospice/HomeHealth](#) [Inpatient](#) **QMB** [All screens](#)

Beneficiary: [] Medicare ID: [] Sex: [] DOB: [] DOD: []

Print

Qualified Medicare Beneficiary (QMB) Program Eligibility

Beneficiaries who are enrolled in the Qualified Medicare Beneficiary (QMB) program are dually eligible for both Medicare and Medicaid. Beneficiaries who are enrolled in the QMB program are not liable for Medicare co-insurance or deductible payments. Note that QMB status may fluctuate for a minority of Beneficiaries. If eligibility results indicate the Beneficiary QMB enrollment has terminated, please verify the patient's QMB status through State online Medicaid eligibility systems or other documentation, including Medicaid Identification cards and documents issued by the State proving the patient qualifies for the QMB program.

Medicaid Enrollment			
State:			
Enrollment Date:		Termination Date:	
Part A Deductible			
Start Date:		End Date:	
Deductible Amount:			
Inpatient Base Summary			
Start Date:		End Date:	
Full Days Allowed:		Full Copay Days Allowed:	
Copay Amount:			
Inpatient Days Remaining (May Also Include Spells)			
DOEBA Date:		DOLBA Date:	
Full Inpatient Days:		Full Inpatient Copay Days:	
Copay Amount:			
SNF Base Summary			
Start Date:		End Date:	
SNF Full Days Allowed:		SNF Full Copay Days:	
Copay Amount:			
SNF Days Remaining (May Also Include Spells)			
DOEBA Date:		DOLBA Date:	
Full SNF Days:		Full SNF Copay Days:	
Copay Amount:			
Lifetime Reserve			
Lifetime Days Allowed:		Lifetime Days Remaining :	
60		60	
Start Date:		End Date:	
Copayment Amount:			
Part B Deductible			
Start Date:		End Date:	
Deductible Amount:			
Part B Co-Insurance			
Start Date:		End Date:	
Co-Insurance Amount:			

6.11 What error messages might I see?

- a. HETS validates if the submitted NPI is valid and active with Medicare and found in HETS. If it the NPI does not meet the criteria, an error is displayed.

Figure 68: NPI Error

! Please review data entered
NPI is not currently Medicare eligible.

Beneficiary: Medicare ID: Sex: DOB: DOD: [Eligibility User Manual](#)

New Inquiry

It is highly recommended that you use the optional Date Range fields when submitting an inquiry.

- The date range you use may not exceed 24 months at a time.
- You can inquire on data up to 4 years in the past and 4 months in the future.
- If no date range is used history information may not display.

Note: The data returned is from CMS' HIPAA Eligibility Transaction System (HETS).

Test

Beneficiary Information

Beneficiary Last Name:* <input type="text"/>	Beneficiary Name Suffix: <input type="text"/>
Beneficiary First Name:** <input type="text"/>	Optional Fields for Requesting Historical Data Using Date Range
Medicare ID: * <input type="text"/>	Date From: <input type="text" value="02/01/2023"/>
Beneficiary Birth Date:** <input type="text"/>	Date To: <input type="text" value="02/01/2023"/>

*Required Field. **First Name or Date of Birth is a Required Field.

7.0 Financial Tools

7.1 How do I use the Financial Tools tab?

Open the Financial Tools tab to inquire about your payment floor status and last three checks paid. When you first access the screen there will be no information. Click the Submit button and information will be retrieved.



Figure 69: Financial Tools Tab

Cash Flow Snapshot

Payment Floor Status

Total Claims:	1
Total to be Paid:	117.6

Last 3 Checks

Date Paid	Amount
01/14/2019	0.00
11/09/2018	0.00
11/02/2018	0.00

Payment History (The last 30 days of payments are displayed below. Please use the Date From and Date To fields to view a different date range.)

Date From: Date To:

Show entries Search:

Issue Date	Check No	Amount	Status	Status Date
02/27/2023	<input type="text"/>	0.0	NO-PAY ISSUE.	02/27/2023
03/09/2023	<input type="text"/>	0.0	NO-PAY ISSUE.	03/09/2023
03/17/2023	<input type="text"/>	0.0	NO-PAY ISSUE.	03/17/2023

Showing 1 to 3 of 3 entries Previous Next

7.2 What is the payment floor amount?

Medicare contractors are required to hold payments for a minimum predetermined number of days. The payment floor for electronic claims is 14 days, and the payment floor for paper claims is 29 days. This tab refers to all claims in process and awaiting the payment floor as of the date of the look-up. These are payments that have been approved but have not yet been released for payment.

The payment history for the last 30 days will be listed. Users also have the option to search for other payments using the Date From and the Date To fields. The date range cannot exceed 30 days.

The Payment History section will provide the payment history for the last 30 days. Users can change the date range using the Date From and Date to fields. The date range can be no more than 30 days.

7.3 What is eCheck?

The eCheck function allows payments to be sent electronically via ACH to Palmetto GBA. Only direct debits from your designated bank account are accepted through this form. Submitting the form through eServices automatically enters your information into Palmetto GBA's workflow management system, iFlow, for processing according to current Medicare guidelines. There is no transaction fee for submitting a check payment.

The eCheck function can be accessed from the Financial Forms sub-tab located under the Financial Tools tab. Once on the financial forms landing page, select the option for 'eCheck' from the 'Payment Type' drop-down menu. Then select the eCheck form link.

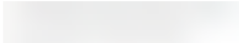

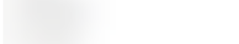


The form will prepopulate the Contract/Region, Provider Number (PTAN) and National Provider Identifier (NPI) fields with the data associated with the user ID that is logged in.

Figure 70: eCheck Form

Home Claims Claims (New) Remittance Eligibility MBI Lookup Financial Tools Messages Forms eReview ACO RCD Support Admin My Account

eDelivery


Refund Overpayment - Electronic Check (e-Check) Form

Contract/Region: 
 Provider Name: 
 Provider Number (PTAN): 
 National Provider Identifier (NPI): 
 Tax ID: 

Provider Information



Provider Contact Name: * Provider Address 1: *
 Provider Phone Number: * Provider Address 2:
 Provider City: *
 Provider State: *
 Provider Zip Code: *

Are you submitting this request for an Affiliated Provider Number? * Yes No
 Yes, we have a Corporate Integrity Agreement with OIG
 Is this payment for a new ERS request or existing ERS request?: * Yes No
 Do you have an overpayment demand?: * Yes No
 Did you receive an over payment letter?: * Yes No

Letter Number: 
 Account Receivable Number(s): * [Add AR](#)

Please attach your demand letter or other documentation if you do not have a demand letter.

Transaction Information

Amount Payable: * Name on Account: *
 Confirm Amount Payable: * Bank Account Number: * 
 Transaction Fee: * Bank Routing Number: * 
 Total Amount to be Paid: * Account Type: *

The form is dynamic meaning the answers to the questions on the top of the form will determine the additional information needed to submit the form. Users may submit multiple PDF attachments up to 40 megabytes (MB) each. The combined size of all attachments cannot exceed 150 MB in size. Once the form is submitted, users will be prompted with a payment confirmation summary pop-up where they confirm the payment information for processing. The check box labeled " I authorize this payment" has been added to allow a user to signify their approval of submission. This is a required field and the user will need to check the box to proceed.

Figure 71: eCheck Payment Confirmation

Payment Summary
✕

By submission of this payment request, you authorize Palmetto GBA to debit your account for the amount indicated below. This is authorization for a single transaction only and does not provide authorization for any additional unrelated debits or credits to your account. You also authorize that you have added the appropriate company ID to the ACH debit filter for the bank account being debited to prevent unauthorized ACH returns.

Contract	Company ID
JMA	2571062326
JMB	3571062326
JJA	4571062326
JJB	5571062326
RRB	6571062326

Payment Amount :
Routing #:
Account #:

I authorize this payment.

Submit Payment
Cancel

You will receive a message when the form is submitted and another message with the Document Control Number (DCN) when the form has started processing.

7.4 What is eOffset?

The eOffset function allows offset information to be sent electronically to Palmetto GBA. Users have the option to request an immediate offset when they receive a demanded overpayment or make a permanent request for all future demanded overpayments. More information regarding this is located on the form page.

The eOffset function can be accessed from the Financial Forms sub-tab located under the Financial Tools tab. Once on the financial forms landing page, select the option for 'eOffset' from the 'Payment Type' drop-down menu. Then select the eOffset form link.

The form will prepopulate the Contract/Region, Provider Number (PTAN) and National Provider Identifier (NPI) fields with the data associated with the user ID that is logged in.



Figure 72: eOffset Form

Home
Claims
Remittance
Eligibility
Financial Tools
Messages
Forms
Support
Admin
My Account

Get Status
You have 0 unread message(s) and 1 alerts.
Help

Immediate Offset Request

Beginning July 1, 2012, a new, standard immediate offset process is implemented for all Part A providers and all Part B physician and other suppliers. This new process allows you to request an immediate offset each time you receive a demanded overpayment or you can make a permanent request for all future demanded overpayments.

You can elect the immediate offset process to avoid making a payment by check and for avoid the assessment of interest if the immediate offset satisfies the overpayment in full before aging 31 days from the initial demand.

Please Note: An immediate offset request will be processed as soon as possible; however, this request does not guarantee that interest will not accrue on the overpayment. To eliminate the risk of interest accruing, your request should be submitted as soon as possible after being notified of the debt as interest automatically accrues 31 days from the date of the initial demand letter.

REQUESTING AN IMMEDIATE OFFSET

To request an immediate offset for an already established account receivable:

- Option 1: Attach copy of the first page of the overpayment demand letter and enter the letter number or all associated Invoice Number(s).
- Option 2: To request immediate offset for all existing and future accounts receivable: choose Yes under the Permanent Immediate Offset heading of this form.

Contract/Region:

Provider Number (PTAN): National Provider Identifier (NPI):

Requestor Name: * Requestor Phone Number: *

Are you submitting this request for an Affiliated Provider Number? * Yes No

Permanent Immediate Offset: * Yes No

Offset Using: *

Letter Number

Invoice Number(s) X Add Invoice

NOTE: Each attachment must be a PDF and can be up to 40 MB in size. The total size of all attachments cannot exceed 150 MB.

Attachment Choose File No file chosen

Id	File Name	File Size (In Bytes)	File Type	Delete File

Signature: * Date:

*Required Field

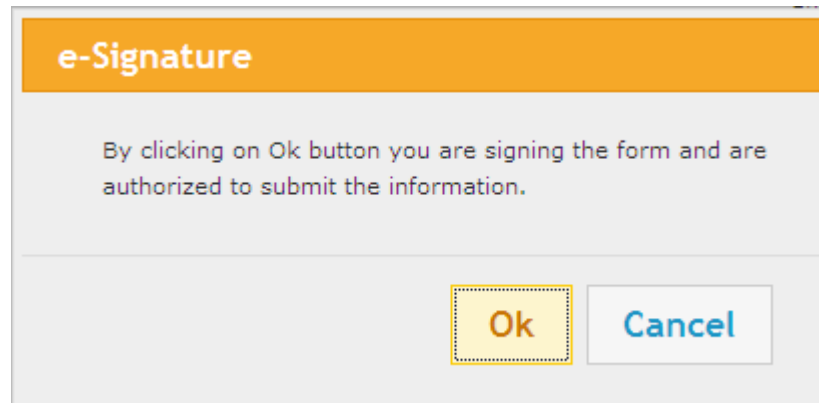
Submit
Clear

EO-122012

The form is dynamic and contains edits to ensure that the information needed to process the overpayment is entered. Users may submit PDF attachments up to 40 megabytes (MB) in size. While there is no longer a limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB in size. Once the form is submitted, users will be prompted with a signature confirmation pop-up where they confirm their authorization to submit the request for processing.

NOTE Users are only able to submit an eOffset form for the PTAN/NPI combination that matches the user ID they are logged in with.

Figure 73: eOffset Signature Confirmation



You will receive a message when the form is submitted and another message with the Document Control Number (DCN) when the form has started processing.

7.5 How to submit a CMS-838 Credit Balance Report

The form is prepopulated with the information we know from your registration record. This will save you several steps. Complete all of the required information. Then, add any attachments. Users may submit attachments up to 40 megabytes (MB) in size. While there is no longer a limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB in size. Files must be either PDF or Excel format.

The CMS-838 Credit Balance Report Form must be an attachment to this submission and be completed in full. This will include the provider name, six digit provider number, calendar quarter end, signature of officer or administrator, date signed, and name and phone number of contact person. Also, indicate if the provider is low utilization, if a detail page is attached, or if there are no credit balances to report for the given quarter. If a fully completed, correct CMS-838 form is not attached, Medicare payments may be withheld until a correct report is received.

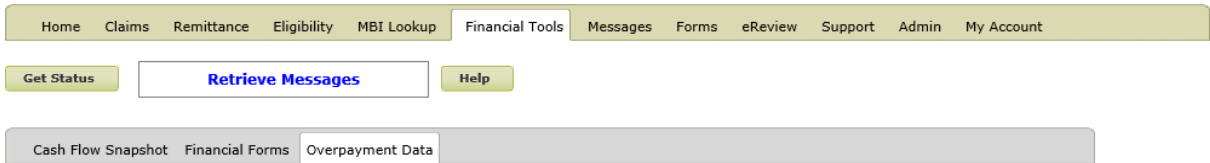
7.6 What is Overpayment Data?

Overpayment data is available for all lines of business including JJ Part A/B, JM Part A/B, and RRB. To access this data, you will enter either an Accounts Receivable (AR) Transaction number or a Demand Letter number.

Accessing your overpayment balance is achieved in four easy steps. After logging into the eServices portal:

1. Click on Financial Tools Tab
2. Select Overpayment Data sub tab
3. Input AR Transaction Number or Demand Letter Number
4. Click Submit

Figure 74: Overpayment Data



Home Claims Remittance Eligibility MBI Lookup **Financial Tools** Messages Forms eReview Support Admin My Account

Get Status **Retrieve Messages** Help

Cash Flow Snapshot Financial Forms **Overpayment Data**

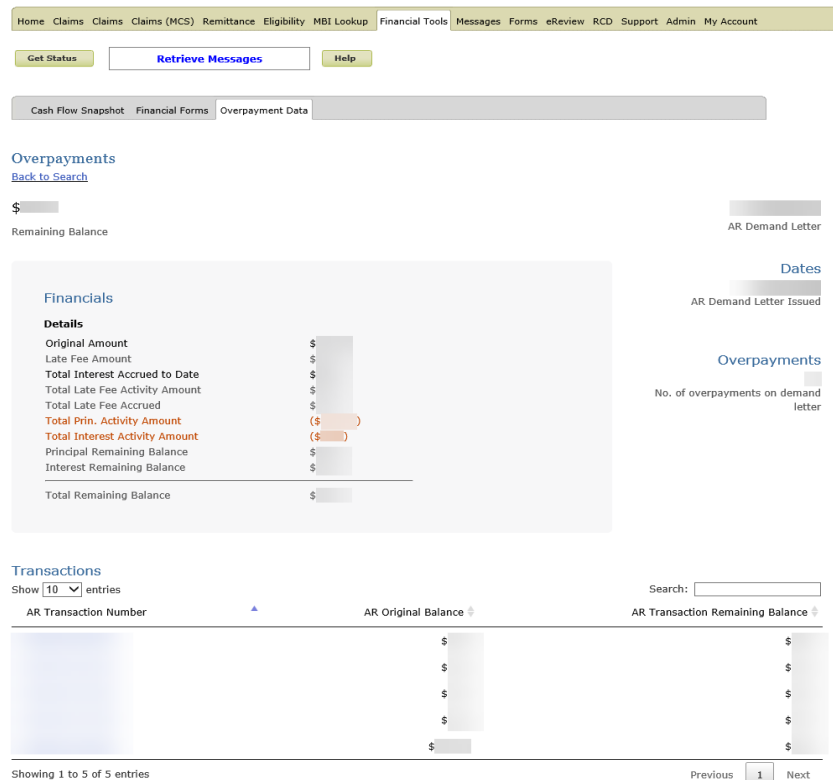
Search for Overpayments

Enter an AR Transaction Number or Letter Number to continue.

AR TRANSACTION NUMBER OR LETTER NUMBER **Submit**

When the Demand Letter number is searched, all information related to the searched number will be displayed. Any AR Transaction number associated the Demand Letter will also be listed. You can access the information for each AR Transaction by selecting the AR Transaction Number link.

Figure 75: Demand Letter Details



Home Claims Claims Claims (MCS) Remittance Eligibility MBI Lookup **Financial Tools** Messages Forms eReview RCD Support Admin My Account

Get Status **Retrieve Messages** Help

Cash Flow Snapshot Financial Forms **Overpayment Data**

Overpayments
[Back to Search](#)

\$ [] Remaining Balance

AR Demand Letter []

Financials

Details

Original Amount	\$ []
Late Fee Amount	\$ []
Total Interest Accrued to Date	\$ []
Total Late Fee Activity Amount	\$ []
Total Late Fee Accrued	\$ []
Total Prin. Activity Amount	(\$ [])
Total Interest Activity Amount	(\$ [])
Principal Remaining Balance	\$ []
Interest Remaining Balance	\$ []
Total Remaining Balance	\$ []

Dates

AR Demand Letter Issued []

Overpayments

No. of overpayments on demand letter []

Transactions

Show [10] entries Search: []

AR Transaction Number	AR Original Balance	AR Transaction Remaining Balance
[]	\$ []	\$ []
[]	\$ []	\$ []
[]	\$ []	\$ []
[]	\$ []	\$ []
[]	\$ []	\$ []
[]	\$ []	\$ []

Showing 1 to 5 of 5 entries Previous **1** Next



7.7 What is Extended Repayment Schedule Request?

A provider is expected to repay any overpayment promptly. If repaying an overpayment within 30 days would constitute a “hardship” on the provider, the provider can request an Extended Repayment Schedule (ERS) which is an option to pay the overpayment amount back in monthly installments. On the ERS form, supply the necessary information such as the number of months requested, the monthly payment amount and the supporting documentation. You can send the payments using the eCheck function in eServices. Once the form is officially received, you will receive a Document Control Number (DCN). The DCN will be available in the Messages tab. ERS requests are reviewed on a case-by-case basis by the Finance team to determine if you are eligible for an ERS.

Figure 76: Extended Repayment Schedule Request

Request for Extended Repayment Schedule

Contract/Region:
 Provider Name:
 Provider Number (PTAN):
 National Provider Identifier (NPI):
 Tax ID:

Provider Information

Address:

Address Line 1

Address Line 2

City:

City

State:

Zip:

Zip

Contact Information

Contact Name:

Contact Title:

Contact Phone Number:

Ext (Optional):

Contact E-mail:

Overpayment Detail Information

Overpayment Amount:

Invoice Number (Optional):

Demand Letter Date:

Number of Months Requested for ERS (6-60 months):

I authorize Palmetto GBA to automatically apply underpayments and/or manual refunds to this overpayment.

Certification

Please ensure that all balance sheets and income statements include the following statements:
 MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THE BALANCE SHEETS OR INCOME STATEMENTS MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

Certify Name: I HEREBY CERTIFY THAT I HAVE EXAMINED THE BALANCE SHEETS AND INCOME STATEMENTS PREPARED BY AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT FROM THE BOOKS AND RECORDS OF THE DEBTOR.

Signed: Date: Officer or Owner of debtors:

Required Documentation to Support ERS Request

NOTE: Attachments files can be one of the following types: PDF (*.pdf), Word (*.doc, *.docx), Excel (*.xls, *.xlsx). Each attachment can be up to 40 MB in size. The total size of all attachments cannot exceed 150 MB. Special characters such as commas will be removed from uploaded file names, and duplicate file names will not be accepted.

Attachment: No file chosen

File Name	File Size (in bytes)	File type	Action
No data available in table			

Total File Size:
Max Allowed: 150MB

Displaying 0 to 0 of 0 = First = Prev Next = Last =

Signature:
 Date: 03/08/2024

FN-JM-B-2004

8.0 Forms

8.1 What are Forms

eServices offers many widely used forms that you can complete and submit in eServices. It is a fast and secure method for submitting forms and attachments to the forms to Palmetto GBA. What forms are available to you will depend on your line of business (Part A, Part B, or RRB). The Forms tab will automatically display in the menu bar to provider administrator. Individual user must be granted the permission to these forms by the provider administrator.

Some of the Forms available in the Forms tab:

- Redetermination Appeals
- Medical Review Additional Documentation Response
- General Inquiry
- Prior Authorization for Outpatient Facility Services
- Prior Authorization for Ambulance (RSNAT)
- Billing Dispute Resolution Request
- Benefit Integrity Record Request

The forms include edits and validations to help ensure that the necessary information is included when the form is submitted.

Most forms allow you to attach supporting or requested documentation. On most forms the attachments must be PDFs. See 8.4 on how to attach documents.

Once the form is submitted you will receive a message that the submission has been received. You can get further information such as the Document Control Number (DCN) using the Messages tab in the menu bar.

Some other specialized forms are available under other menu tabs. For example, the eCheck and Extended Repayment Schedule Request forms are under the Financial Tools tab, the Pre-Claim Review form is found under the RCD tab and the Claim Additional Documentation form is under the Claims tab.

8.2 How do I access Forms?

If the Forms function is available for you, you will see a Forms tab as part of the menu once you successfully log in. If you do not have permission to this tab, it will appear 'grayed out'. Reach out to your account administrator to request the permission.

Once you access the Forms page, use the 'Select a Topic and Select a type' drop down boxes to access forms available to you. The forms available will appear as links under the Select a Type box. Select the link to access the secure form.

Figure 77: Secure Forms Screen

Home Claims (MCS) Remittance Eligibility MBI Lookup Financial Tools Messages **Forms** ADR eReview ACO Support Admin My Account eDelivery

Contract Id : 10212

Secure Forms

Welcome to the Palmetto GBA eServices secure form submission page. You may submit forms, along with associated attachments, for submission directly into our workflow management system. You will receive confirmation of your form submission in your Message Inbox under the Messages tab. Thank you for making form processing more efficient and cost effective.

To begin, please select an answer to the questions from the drop-down selections below. Based upon the answer given for each of the questions, the available form(s) will appear at the bottom of this box.

Claims Documents
 Appeals – First Level Appeal on a Medicare Claim
 Billing Resolution – Billing Dispute Resolution Request Form
 Medical Review – ADR (Additional Documentation Request) Response
 Prior Authorization – Outpatient Prior Authorization

Medicare Cost Report Documents
 Audit and Reimbursement – Documentation Submission Related to Medicare Cost Reports

Customer Service
 Provider Contact Center – General Written Inquiry Request Form

Select a Topic:

Select a Type:*

Redetermination: First Level Appeal: AP-JJ-B-1000

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8.3 How do I submit a form?

The form is prepopulated with the information we know from your registration record. This will save you several steps. Complete all the required fields. Then, add any attachments. Users may submit attachments up to 40 megabytes (MB) in size. The combined size of all attachments cannot exceed 150 MB in size. Generally, attachments must be in PDF format.

At the bottom of the form there will be a submit button. Once you click submit format and edit validations will be performed. If any missing information or invalid information is found, red error messages will display at the top of the form. If all validations pass the form will complete submission. Once the form is submitted you will receive a message with a Transaction ID.

Figure 78: Appeals Form Example

Home Claims (MCS) Remittance Eligibility MBI Lookup Financial Tools Messages **Forms** ADR eReview ACO Support Admin My Account eDelivery

Redetermination: First Level Appeal - JJ Part B

Provider Information

Contract/Region: [Redacted]
 Provider Name: [Redacted]
 National Provider Identifier (NPI): [Redacted]
 Provider Address 2: [Text Field]
 Provider State: * [Dropdown]
 Provider Phone Number: * [Text Field]

Provider Number (PTAN): [Redacted]
 Provider Address 1: * [Text Field]
 Provider City: * [Text Field]
 Provider Zip Code: * [Text Field]

Requestor Information

Requestor Name: * [Text Field]
 Requestor Phone Number: * Same as Provider Phone Number [Text Field]
 Requestor Address: * Same as Provider Address [Text Field]
 Requestor Address 1: * [Text Field]
 Requestor City: * [Text Field]
 Requestor Zip Code: * [Text Field]

Requestor Address 2: [Text Field]
 Requestor State: * [Dropdown]

Appeal Type

Did you receive PRIMARY payments from both - Medicare and another insurance - * [Dropdown]

Non-Overpayment (OP) Appeal * Overpayment (OP) Appeal *

Remittance Advice Date: * [Text Field] X

Patient & Claims Information

Patient Name: * [Text Field] Medicare ID: * [Text Field]
 Date From: * [Text Field] X Date To: * [Text Field] X

Claim Numbers (ICN): * [Text Field] X

CPT Code(s): * [Text Field] X

ICD-9/ICD-10 Code(s): * [Text Field] X

Reason for Appeal: * [Text Area]

Characters Left

NOTE: Each attachment must be a PDF and can be up to 40 MB in size. The total size of all attachments cannot exceed 150 MB. Special characters such as commas will be removed from uploaded file names, and duplicate file names will not be accepted.

Attachment: No file chosen

File Name	File Size (in bytes)	File Type	Action
No data available in table			
Total File Size:			
Max Allowed: 150MB			
Displaying 0 to 0 of 0			
« First « Prev Next » Last »			

E-mail Id: * [Text Field]
 Name: * [Text Field] Date: 06/06/2024

*Required Field



Redetermination: First Level Appeal - JM Part B

Provider Information

Contract/Region: 11302/Part B Virginia
 Provider Name: Provider Number (PTAN):
 National Provider Identifier (NPI): Provider Address 1: *
 Provider Address 2: Provider City: *
 Provider State: * Provider Zip Code: *
 Provider Phone Number: * Tax ID:

Requestor Information

Requestor Name: *
 Requestor Phone Number: * Same as Provider Phone Number
 Requestor Address: * Same as Provider Address
 Requestor Address 1: * Requestor Address 2:
 Requestor City: * Requestor State: *
 Requestor Zip Code: *

Patient & Claims Information

Patient Name: * Medicare ID: *
 Date From: * X Date To: * X

Claim Numbers (ICN): * X

CPT Code(s): * X

ICD-9/ICD-10 Code(s): * X

Reason for Appeal: *

Characters Left

NOTE: Each attachment must be a PDF and can be up to 40 MB in size. The total size of all attachments cannot exceed 150 MB. Special characters such as commas will be removed from uploaded file names, and duplicate file names will not be accepted.

Attachment:

File Name	File Size (in bytes)	File Type
No data available in table		
Total File Size:		
Displaying 0 to 0 of 0		
<input type="button" value="First"/> <input type="button" value="Prev"/> <input type="button" value="Next"/> <input type="button" value="Last"/>		

E-mail Id: * Date:
 Name: *

*Required Field

8.4 How do I upload attachments in secure forms?

You may add attachments up to 40 megabytes (MB) each to a form. The combined size of all attachments cannot exceed 150 MB. Generally, all attachments must be PDF documents unless

otherwise noted. If you receive an error when uploading the file, your form will refresh with the error listed at the top of the page.

8.5 How will I know my form has been received in eServices?

An initial message will display with a Transaction ID when a form is successfully. You can further track the receipt of your form by accessing the Messages Tab. Once the form has been accepted into our processing system, the official date of receipt by Palmetto GBA and the Document Control Number (DCN) for this form submission will display in the Messages tab.

Figure 79: Secure Messaging Inbox

Form Name	Details	Submitted on	Status	DCN	UTN	Decision	Last Name	Medicare ID	DOB	Start Date	Submitted By
<input type="checkbox"/> Redeterminations Form	Details	12/08/2021	Confirmed & (DOR)								
<input type="checkbox"/> Redeterminations Form	Details	11/10/2021	Confirmed & (DOR)								
<input type="checkbox"/> Redeterminations Form	Details	11/10/2021	Confirmed & (DOR)								

8.6 How do I check the status of a submitted form?

Access the Messages Notification Center using the Message tab in the menu bar. This page has lots of useful information about forms submitted. You can search, filter and sort the information available. The Document Control Number (DCN) is the official tracking number of the form submission. During regular business hours, the DCN will become available a couple of hours after the form is submitted and will display in the Messages tab. If a form is submitted in the evening, it will display the next day. Forms submitted on the weekend will have the DCN available on Mondays.

8.7 Submitting an Outpatient Prior Authorization (OPA) form?

Outpatient Prior Authorization (OPA) is prior authorization that will determine if a requested procedure is medically necessary instead of cosmetic. This form is applicable to JJ Part A, JM Part A and HHH users.

Users can access the OPA Form via the Forms tab in eServices. Once on the Forms tab, choose Prior Authorization from the 'Select a Topic' drop-down menu and Outpatient Prior Authorization from the 'Select a Type' drop-down menu. The link to the form should appear in blue, just below the second drop-down menu. Once you click the link, you will be directed to the Outpatient Prior Authorization Form.



Figure 80: Outpatient Prior Authorization Form

Home Claims Remittance Eligibility MBI Lookup Financial Tools Messages Forms eReview

Get Status You have 1 unread message(s) and 0 alerts. Help

Contract Id : 00000

Secure Forms

Welcome to the Palmetto GBA eServices secure form submission page. You may submit forms, along with associated workflow management system. You will receive confirmation of your form submission in your Message Inbox upon processing more efficient and cost effective.

To begin, please select an answer to the questions from the drop-down selections below. Based upon the answer you will appear at the bottom of this box.

Select a Topic:

Select a Type*:

[Outpatient Prior Authorization: OPA-JM-A-6002](#)

The Provider Information section will be pre-filled with the information related to the PTAN/NPI combination associated with the eServices user ID that you are logged in under, or the PTAN/NPI combination selected if you have multiple accounts linked to your user ID. You may then complete the Outpatient Prior Authorization Data section and upload attachments.

Note: For Outpatient Prior Authorization forms, eServices users may submit attachments only in PDF format. Each attachment may be up to 40 MB in size. While there is no limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB.

9.0 Profile Verification and Recertification

9.1 Why am I being asked to complete eServices profile verification?

Palmetto GBA and CMS are dedicated to ensuring that access to Medicare data is secure. To do this, CMS requires that all users regularly verify and/or update the information on their eServices profile. This includes validating the user's email address listed on their profile. This must occur for Palmetto GBA to continue to offer eServices. Users must verify their profile for each user ID at least once every 250 days to avoid an interruption in access and/or deactivation. We appreciate your effort to help us keep Medicare data secure.

9.2 Why am I being asked to complete eServices recertification?

Palmetto GBA and CMS are dedicated to ensuring that access to Medicare data is secure. To do this, CMS requires that all provider administrators verify access for all of the users on the account at least once every 360 days for security purposes. This must occur for Palmetto GBA to continue to offer eServices. Provider administrators must complete recertification at least once every 360 days to avoid an interruption in access and/or deactivation. We appreciate your effort to help us keep Medicare data secure.



9.3 Do I have to complete profile verification for each of my eServices user IDs?

Yes. eServices profile verification is completed on the user ID level. Users will only be able to verify and/or update the profile for the eServices user ID they are currently logged in under.

9.4 Do I have to complete recertification for all of my eServices accounts?

Yes. Each PTAN/NPI combination must be registered separately in eServices. Therefore, recertification of user access is completed on the eServices account level. Provider administrators will only be able to recertify access for the active users listed for the PTAN/NPI combination associated with their eServices user ID.

9.5 How often will profile verification occur?

CMS requires that all users regularly verify and/or update the information on their eServices profile. This includes validating the user's email address listed on their profile. This must occur for Palmetto GBA to continue to offer eServices. Users must verify their profile for each user ID at least once every 250 days to avoid an interruption in access and/or deactivation. We appreciate your effort to help us keep Medicare data secure.

9.6 How often will recertification occur?

CMS requires that all provider administrators verify access for all of the users on the account at least once every 360 days for security purposes. This must occur for Palmetto GBA to continue to offer eServices. Provider administrators must complete recertification at least once every 360 days to avoid an interruption in access and/or deactivation. We appreciate your effort to help us keep Medicare data secure.

9.7 What happens if I do not verify my eServices profile?

If your profile has not been verified and/or updated within 10 days of entering the profile verification period, your access will be restricted to your My Account tab until this process is completed. If your profile has still not been verified within 10 days after your access has been restricted, your user ID will become permanently deactivated and you must contact your active provider administrator for access. If the only provider administrator on the account fails to complete their profile verification, the entire eServices account will be terminated. Once terminated, the provider administrator would need to re-register and create new user IDs for any additional users to regain access. Users must verify their profile for each user ID at least once every 250 days to avoid an interruption in access and/or deactivation.

9.8 What happens if a provider administrator does not recertify user access?

If user access has not been recertified for the account within 10 days of entering the recertification period, your access will be suspended until this process is completed. If your access has still not been recertified within 10 days after your access has been suspended, the entire eServices account will be terminated. Once terminated, the provider administrator would need to re-register and create new user IDs for any additional users to regain access. Provider administrators must complete recertification at least once every 360 days to avoid an interruption in access and/or deactivation.

9.9 What do I do if I did not receive my validation email?

Once you register or update your profile, you will receive an email with a link to validate your access. Make sure that you are logged out of your account before clicking on the link in your email. Once this is completed, you will be able to log in to eServices. If you do not click on the validation link and you try to log in, you will see your profile screen where you can update or correct your email address and submit. If your email address is correct, you may use the request new email button to have another



email sent. Please make sure your email address is correct on your profile before calling Palmetto GBA for assistance.

If you are sure your email address is correct, but you do not receive your email, your company's email security settings may need to be updated to allow incoming emails from Palmetto GBA. The email address you will be receiving the validation email from is:

ops.no.reply@palmettogba.com

If you experience password errors during the above process, please use the 'Forgot or Change Your Password?' link on the login page to reset your password.

9.10 I have requested a new validation email several times, but I never receive it. What do I need to do to complete eServices profile verification?

You must click the link in the validation email to complete your profile verification. Please verify that the email address listed on your eServices profile is entered correctly. If the email address is correct, please add our email address to your safe senders list. Then log into your eServices account and use the request new email button to receive a new email to complete your profile verification. You may need to get the email address added so you will be allowed to receive the email. Your company's email security settings may need to be updated to allow incoming emails from Palmetto GBA. The email address you will be receiving the validation email from is:

ops.no.reply@palmettogba.com

The process of receiving the email may take a while and is based on your email client configuration and the security configuration of your network. You may have to refresh your inbox to make sure all emails have been received.

If you still do not receive your validation email, please contact your Medicare Contractor for further assistance.

9.11 I have completed eServices profile verification, but when I log in I get the message that my account has not been verified. What do I need to do?

Once you have updated the information on your profile, you must log out and click the link in your email to validate your email address and finalize the profile verification process. The profile verification process is not complete until you have successfully used the profile verification link and logged in.

9.12 I have clicked on the link in my validation email and I got the error message 'This user is already logged in or failed to logout properly.' How can I log back into my account?

If you do not properly log out of eServices, you must wait 15 minutes to log in again. Please keep in mind that if you are logged in to eServices and you want to exit eServices, you will need to click on the logout link in the upper right of every page. If you do not do this, you will be locked out for 15 minutes. We do not unlock accounts that are in the lock-out period.

9.13 I am a provider administrator, how do I recertify the provider users on my account?

Provider administrators can recertify access for all users, including additional provider administrators, from their Admin tab. If it has been less than 360 days since the last recertification, you may use the Recertify Users button to begin the process. Active accounts that have not recertified in the past 360



days will automatically be directed to the recertify users screen upon login. Please check the boxes next to all users who need their access recertified. Any IDs left unchecked will be permanently deactivated. Failure to recertify access for at least one provider administrator will result in termination of the entire account.

9.14 Who should I recertify?

Provider administrators should only recertify access for users who should still have access to eServices. Users must have also participated in basic security awareness training within the past year as outlined in the eServices Terms of Use.

Any user IDs left unchecked will be permanently deactivated. Failure to recertify access for at least one provider administrator will result in termination of the entire account.

9.15 How do I recertify access for users who are not displaying on my recertification screen?

Provider administrators can only recertify access for users who have an active user ID for the PTAN/NPI combination that corresponds to the user ID they are logged in with. They must recertify access for each PTAN/NPI combination separately. Provider administrators can grant access for any additional users who are not currently listed by using the 'Add New User' button on their Admin tab.

9.16 I am a provider administrator and I mistakenly left off one of my users when I was trying to recertify their access. How can I restore their access?

You must create a new user ID for this user. Once you log in to your eServices account, go to the Admin tab and use the 'Add New User' button to create a new account for this user.

9.17 Once I recertify users, I am taken to a Terms and Conditions screen. How do I get back to my account??

After reading the document, please check the 'I agree' box at the bottom and click 'Submit'. If you close the browser window without logging out first, you will be locked out of your eServices account for 15 minutes. We do not unlock accounts that are in the lock-out period.

9.18 I am receiving a message that my provider administrator must recertify my access. How do I find out who is listed as the provider administrator for my account?

If you do not know who the eServices provider administrator is for your account, contact the provider's staff to find out if they have registered to the system and who is designated as the provider administrator.

If you are an eServices provider administrator, you can see who else is designated as a provider administrator for this account on the Admin tab.



9.19 I am an eServices user and I completed profile verification. Why am I now receiving a notification that my provider administrator must complete recertification?

eServices recertification and profile verification are two separate processes, but users may be due for both during the same time frame. Please follow the directions in the notification to have your provider administrator complete eServices recertification and prevent termination of access.

9.20 I am a provider administrator and completed profile verification. Why am I now receiving a notification that I must complete recertification?

eServices recertification and profile verification are two separate processes, but users may be due for both during the same time frame. Please follow the directions in the notification to complete eServices recertification and prevent termination of access.

9.21 My provider administrator completed recertification. Why am I now receiving a notification that I must complete profile verification?

eServices recertification and profile verification are two separate processes, but users may be due for both during the same time frame. Please follow the directions in the notification to complete eServices profile verification and prevent termination of access.

9.22 I am a provider administrator and completed recertification. Why am I now receiving a notification that I must complete profile verification?

eServices recertification and profile verification are two separate processes, but users may be due for both during the same time frame. Please follow the directions in the notification to complete eServices profile verification and prevent termination of access.

9.23 I have completed my profile verification, but when I log in I get an error stating that my access to eServices has been suspended until my provider administrator completes the recertification process. How can I get my access restored?

You must contact your provider administrator on this account and have them recertify your access.

10.0 Administration

10.1 How do I administer users?

The person who registers is the provider administrator. Only **one** provider administrator can register per PTAN/NPI combination. Provider administrators have access to the Admin tab. Through this function, they can administer users. The provider administrator grants access for additional users to access, view and print from eServices the information related to registered provider.

Provider administrator responsibilities include the following:

- Creating the provider user
- Assigning a temporary password to the provider user
- Assigning application permissions to the provider user



- Creating additional provider administrators
- Modifying the provider user profile
- Terminating provider users or additional provider administrators
- Select letters to receive as Greenmail

Any access granted and maintained by the provider administrator is the sole responsibility of that provider administrator. Palmetto GBA has no responsibility for maintaining provider user access and permission to the data assigned to them by the provider administrator.

Figure 81: Administration Tab, List of Provider Users

The screenshot displays the 'Administration Tab' interface. At the top, there are buttons for 'Get Status' and 'Help', and a notification box stating 'You have 0 unread message(s) and 0 alerts.' Below this is a navigation bar with 'User Listing' selected, and other options: 'Add New User', 'eDelivery Preferences', and 'Provider Profile'. The main heading is 'Provider User Listing', followed by a sub-heading: 'A listing of all registered users associated with your provider account.'

The 'Registered Users' section features a table with the following columns: First Name, Last Name, User ID, Last Profile Verification Date, Last Recert Date, Type, User Status, and Actions. The table contains four entries, all with a status of 'Active'. Below the table, there is a pagination control showing 'Showing 1 to 4 of 4 entries' and a page indicator '1'.

First Name	Last Name	User ID	Last Profile Verification Date	Last Recert Date	Type	User Status	Actions
[Redacted]	[Redacted]	[Redacted]	12/17/2015			Active	Edit Delete
[Redacted]	[Redacted]	[Redacted]	11/13/2015		Admin	Active	Edit Delete
[Redacted]	[Redacted]	[Redacted]	12/11/2015		Admin	Active	Edit Delete
[Redacted]	[Redacted]	[Redacted]	12/14/2015		Admin	Active	Edit Delete

At the bottom of the interface, there is an 'Add New User' button.

Figure 82: Administration Tab, Creating a New User

Home Claims Remittance Eligibility MBI Lookup Financial Tools Messages Forms eReview Support **Admin** My Account eDelivery

User Listing **Add New User** eDelivery Preferences Provider Profile

Create New User

Name (First)

Name (Last)

Temporary Password:

Confirm Password

Suggested Password J9rjYWe

Permissions:

- Admin (This will auto-select all functions)
- Claims
- Remits
- Eligibility
- Financial Tools
- Secure Messaging
- Secure Forms (This will auto-select Secure Messaging function)
- e-Check/e-Offset Forms (This will auto-select Secure Messaging and Financial Tools functions)
- eCBR
- Pre-Claim Review
- eUtilization
- eAudit

User's Business Type

Figure 83: Administration Tab, Modifying a User

Home Claims Remittance Eligibility MBI Lookup Financial Tools Messages Forms eReview Support **Admin** My Account

Modify User

User ID 0

Name (First) First Name

Name (Last) Last Name

Temporary Password:

Confirm Password

Suggested Password VK1hbG(N)

User's Business Type Provider

Permissions:

- Admin (This will auto-select all functions)
- Claims
- Remits
- Eligibility
- Financial Tools
- Secure Messaging
- Secure Forms (This will auto-select Secure Messaging function)
- e-Check/e-Offset Forms (This will auto-select Secure Messaging and Financial Tools functions)
- eCBR
- Pre-Claim Review
- eUtilization
- eAudit

Return to List Submit Clear

A provider user may be granted administrative access by the provider administrator. Keep in mind that provider administrators have access to all functions of eServices. Granting administrative access to a provider user also gives them access to all functions, including the ability to modify or delete the original provider administrator. Provider administrators can create and delete additional provider administrators. The provider administrator will receive the provider user's user ID and create a temporary password for the provider user. The provider administrator is responsible for giving the provider user their user ID and password.

If a user does not know who their provider administrator is, they need to contact the provider's staff to find out if they have registered to the system and who is designated as the provider administrator. Provider administrators can see who is designated as provider administrators on the Admin tab.

If you are a provider administrator and are leaving the office, or are no longer functioning as the provider administrator, you must assign an additional provider administrator before leaving the role. Once a new provider administrator is assigned, he or she can log in and delete the old provider administrator or change the provider administrator to a provider user by deselecting the Admin box in the role selections of the user's profile. Do not delete the provider administrator before assigning an additional provider administrator. If you do this, your record must be removed and you must register again. To request that your record be removed, please contact your Medicare Contractor.

Palmetto GBA has the right to terminate any user's access if suspicious or improper activity is determined. Access may be terminated without notice.

10.2 Who is my provider administrator?

If you do not know who the provider administrator is, contact the provider's staff to find out if they have registered to the system and who is designated as the provider administrator.

If you are a provider administrator, you can see who is designated as provider administrators on the Admin tab.



10.3 How do I change the provider administrator?

If you are a provider administrator and are leaving the office, or are no longer functioning as the provider administrator, you must assign an additional provider administrator before leaving the role. Once a new provider administrator is assigned, he or she can log in and delete the old provider administrator or change the provider administrator to a provider user by deselecting the Admin box in the role selections of the user's profile.

Do not delete the provider administrator before assigning an additional provider administrator. If you do this, your record must be removed and you must register again

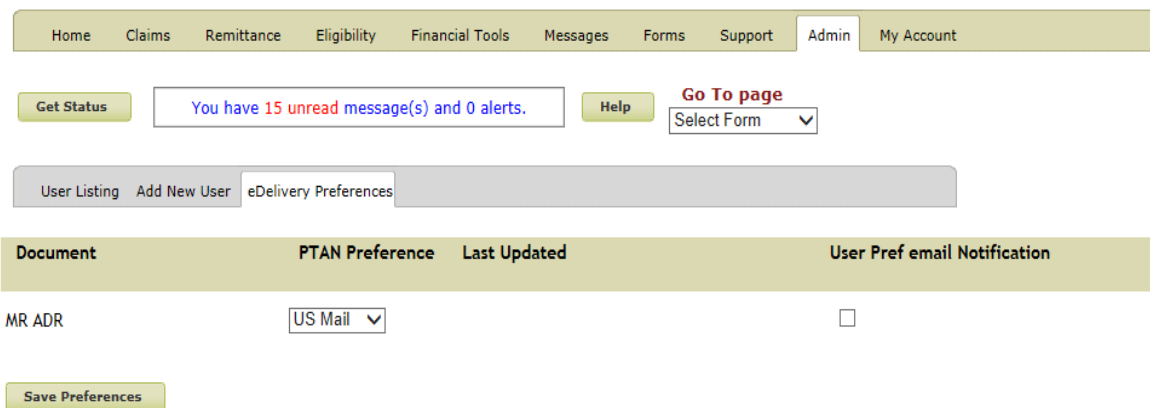
10.4 Can I use generic contact (user) names for provider administrators or provider users?

Generic contact (user) names are not permitted. Each user of eServices must have a unique user ID and password. This means that we expect each user to have a legitimate first and last name associated with each user ID. Examples of generic user names are: Front Desk, Account Coordinator, Billing Department, User A, or the name of the provider office. No sharing of user IDs and passwords is permitted. Palmetto GBA will delete, without notice, any user IDs that are associated with a generic user name.

10.5 eDelivery

Provider Administrators may select to receive letters electronically through eServices. After navigating to the admin tab, the user will have the option to select the eDelivery Preferences sub-tab.

Figure 84: Administration Tab, Selecting eDelivery Preferences



From this sub-tab, providers can opt to receive their letters by US mail or through eServices via eDelivery. For providers enrolled in eDelivery, an eDelivery message will be sent with a link to the letter. There is also a User Pref email Notification option that allows the user to receive an email when new eLetters are available in eServices.

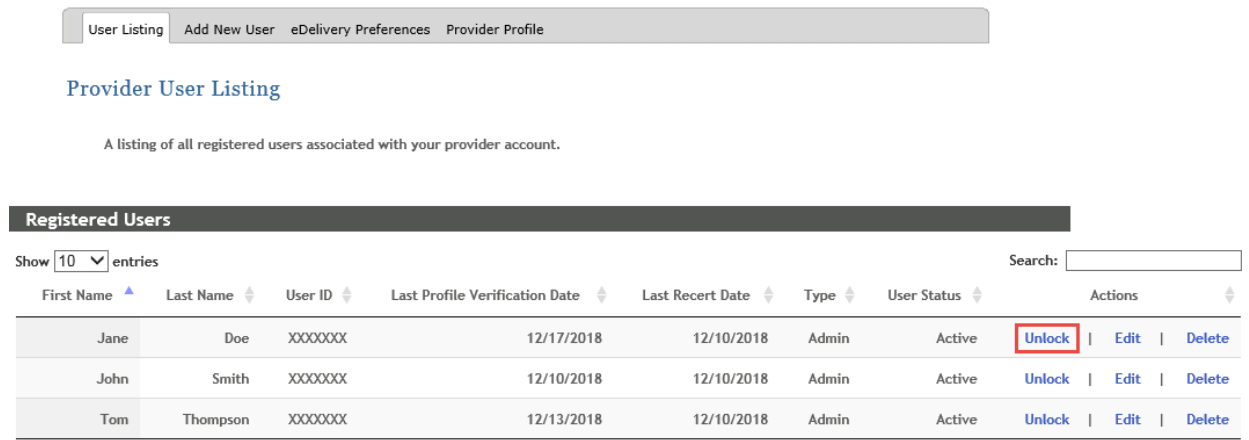
Note: If you have a registered account with esMD, you must select “B” as your delivery option. This will allow letters to be delivered in both the eServices portal and esMD.

10.6 User Unlocks

In the event that a user is locked out of their eServices account due to entering their password incorrectly three times, a provider administrator may unlock the user from their Admin tab. On the User Listing sub-tab, select the Unlock option listed in the Actions section for the user you wish to unlock.

Note: If there are multiple active provider administrators on the account, any provider administrator may unlock another provider administrator.

Figure 85: User Unlock



User Listing | Add New User | eDelivery Preferences | Provider Profile

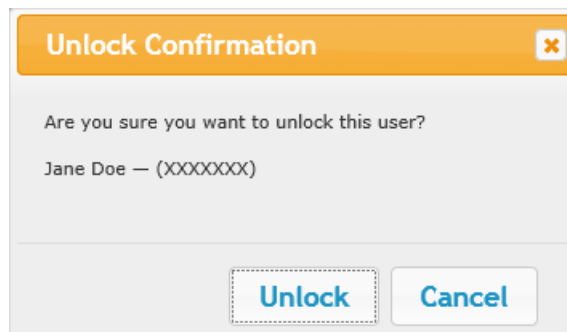
Provider User Listing

A listing of all registered users associated with your provider account.

Registered Users								Search:
First Name	Last Name	User ID	Last Profile Verification Date	Last Recert Date	Type	User Status	Actions	
Jane	Doe	XXXXXXX	12/17/2018	12/10/2018	Admin	Active	Unlock Edit Delete	
John	Smith	XXXXXXX	12/10/2018	12/10/2018	Admin	Active	Unlock Edit Delete	
Tom	Thompson	XXXXXXX	12/13/2018	12/10/2018	Admin	Active	Unlock Edit Delete	

You will be prompted to confirm that you want to unlock this user. Click the Unlock button to proceed.

Figure 86: User Unlock Confirmation Request



Unlock Confirmation ✕

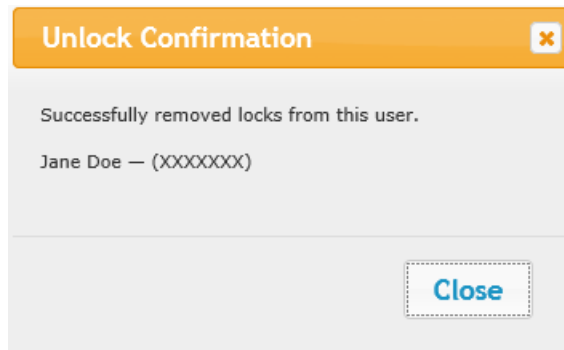
Are you sure you want to unlock this user?

Jane Doe — (XXXXXXX)

Unlock
Cancel

A confirmation message will display advising that the selected user was successfully unlocked.

Figure 87: User Unlock Success Confirmation



11.0 eReview

11.1 How do I use the eCBR function?

Palmetto GBA uses Comparative Billing Reports (CBRs) as an educational tool for providers to use in order to provide insight into your billing patterns and utilization of services in comparison to your peers. Providers can use this information to conduct a self-audit to ensure they are in compliance with the Medicare regulations and prevent improper claims submission in order to avoid possible pre or post-pay medical review.

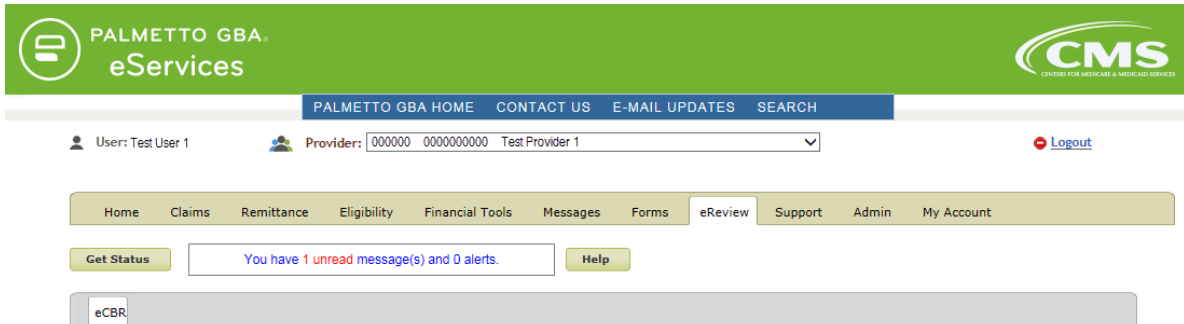
The portal's eCBR function allows you to view and download your individual CBR online. You may also select the link for more topic-specific education.

To use the function,

- Enter Rendering NPI
- Select 'Get Topics' (This will dynamically populate the Topics and Time Frames based on your available data)
- Choose the Topic
- Choose the Timeframe
- Select "How do I compare?"
- View your data & download PDF if desired

A sample screenshot is shown below for your reference.

Figure 88: eCBR Report



The screenshot shows the Palmetto GBA eServices interface. At the top, there is a green header with the Palmetto GBA logo and 'eServices' text, and the CMS logo on the right. Below the header is a navigation bar with links: PALMETTO GBA HOME, CONTACT US, E-MAIL UPDATES, and SEARCH. Below that, user information is displayed: User: Test User 1 and Provider: 000000 0000000000 Test Provider 1. A 'Logout' link is also present. A secondary navigation bar includes links for Home, Claims, Remittance, Eligibility, Financial Tools, Messages, Forms, eReview, Support, Admin, and My Account. A status bar indicates 'You have 1 unread message(s) and 0 alerts.' and a 'Help' button. At the bottom of this section, there is a search bar with the text 'eCBR' entered.

eCBR Lookup

Rendering NPI

[Get Topics](#)

Distribution of E&M Code

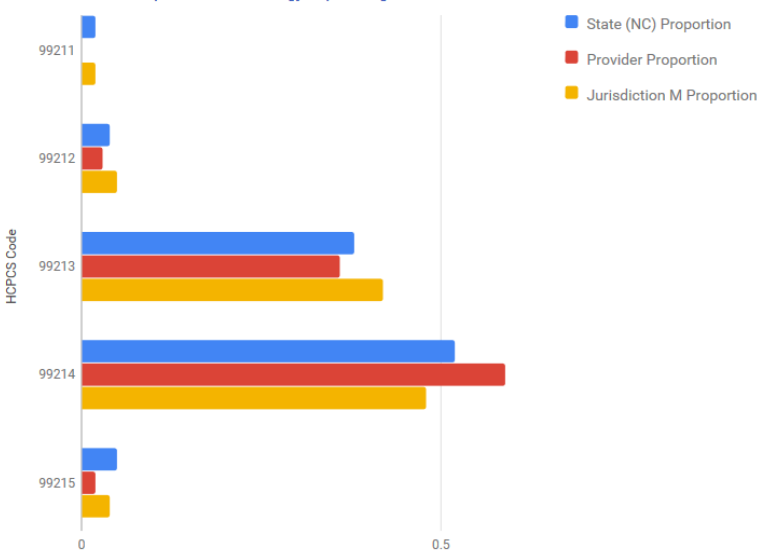
Last 3 Months

[How do I compare?](#)

Want a different eCBR? Just select a different topic and/or timeframe and click "How do I compare?" again.

Distribution of E&M Codes 99211 to 99215 - between 02/01/2016 and 04/30/2016

[Learn more about this topic and its methodology on palmettogba.com](#)



HCPCS Code	State (NC) Proportion	Provider Proportion	Jurisdiction M Proportion
99211	0.02	0	0.02
99212	0.04	0.03	0.05
99213	0.38	0.36	0.42
99214	0.52	0.59	0.48
99215	0.05	0.02	0.04

[Download full PDF of my results](#)



11.2 How do I use the eUtilization function?

Electronic Utilization (eUtilization) reports offer rendering providers and ordering and referring providers access to their personal data. This data can be reviewed to ensure you are aware of when and by whom your NPI is being used for billing Medicare services and when you are notated on a Medicare claim as the ordering referring physician. This will provide you with the ability to identify possible misuse of your NPI.

Ordering and Referring

This function enables an individual physician to see all claims billed where their NPI was indicated as the ordering and referring provider for the beneficiary. The report will also allow you to click and see a summary by the type of code for the services billed.

Rendering

This will allow an individual provider who is part of a group practice or multiple groups to pull a data report for their NPI, which will enable them to view their utilization for each associated provider ID for a specified time period. Refer to the appropriate section on Palmettogba.com for more education.

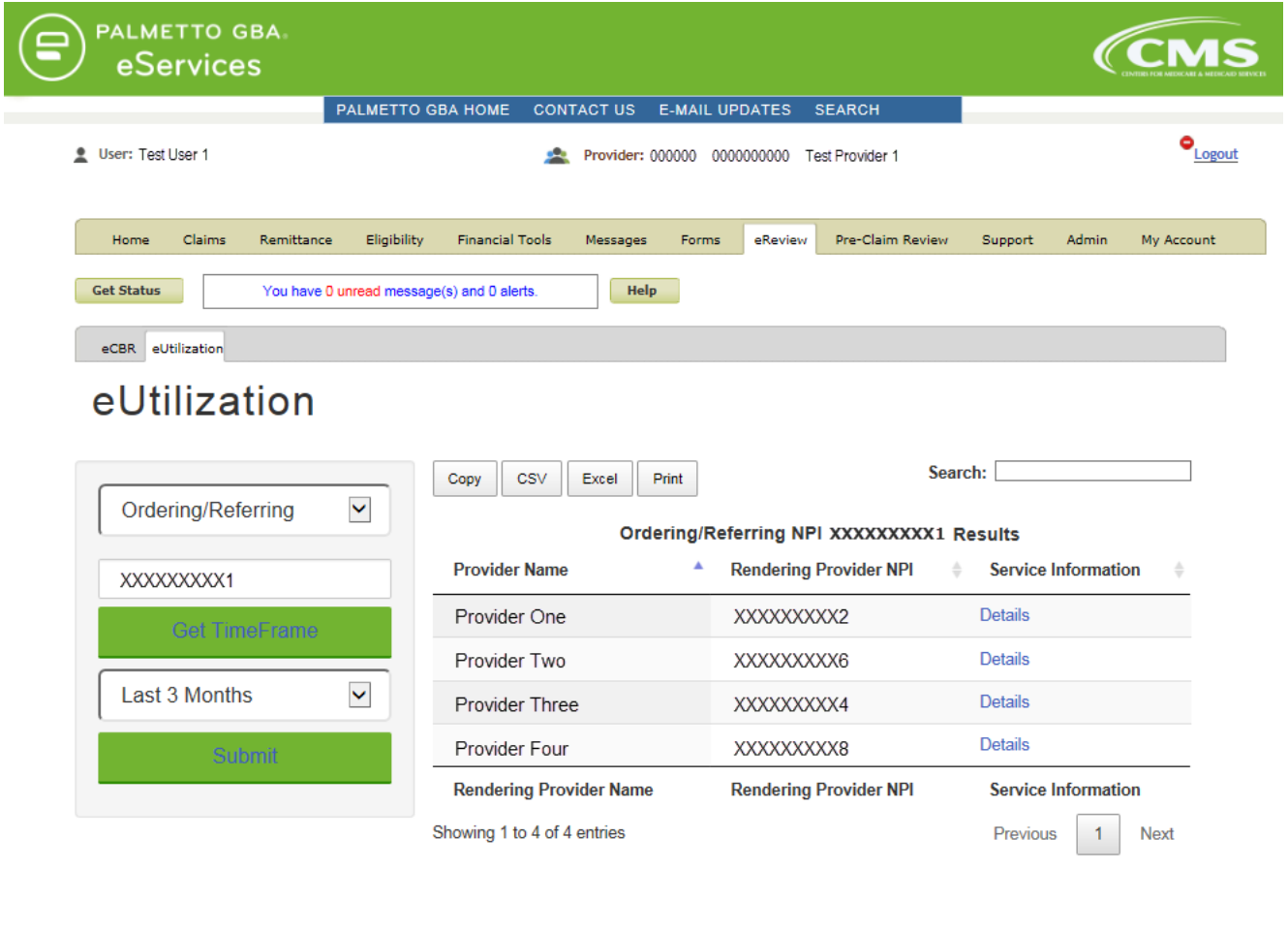
To use the function,

- Select the Type (Ordering/Referring or Rendering)
- Enter Rendering NPI
- Select 'Get Time Frame' (This will dynamically populate the Time Frames based on your available data)
- Pick a Time Frame to view
- Select "Submit"

To view more information, select the 'Details' link for the desired provider and you will be shown the HCPCS codes, descriptions, and number of occurrences.

Sample screenshots are shown below for your reference.

Figure 89: eUtilization Summary Screen



The screenshot shows the Palmetto GBA eServices interface. At the top, there is a green header with the Palmetto GBA logo and 'eServices' text, and the CMS logo on the right. Below the header is a navigation bar with links: PALMETTO GBA HOME, CONTACT US, E-MAIL UPDATES, and SEARCH. The user is logged in as 'User: Test User 1' and 'Provider: 00000 0000000000 Test Provider 1'. A 'Logout' link is visible in the top right.

The main navigation menu includes: Home, Claims, Remittance, Eligibility, Financial Tools, Messages, Forms, eReview, Pre-Claim Review, Support, Admin, and My Account. A 'Get Status' button shows 'You have 0 unread message(s) and 0 alerts.' and a 'Help' button.

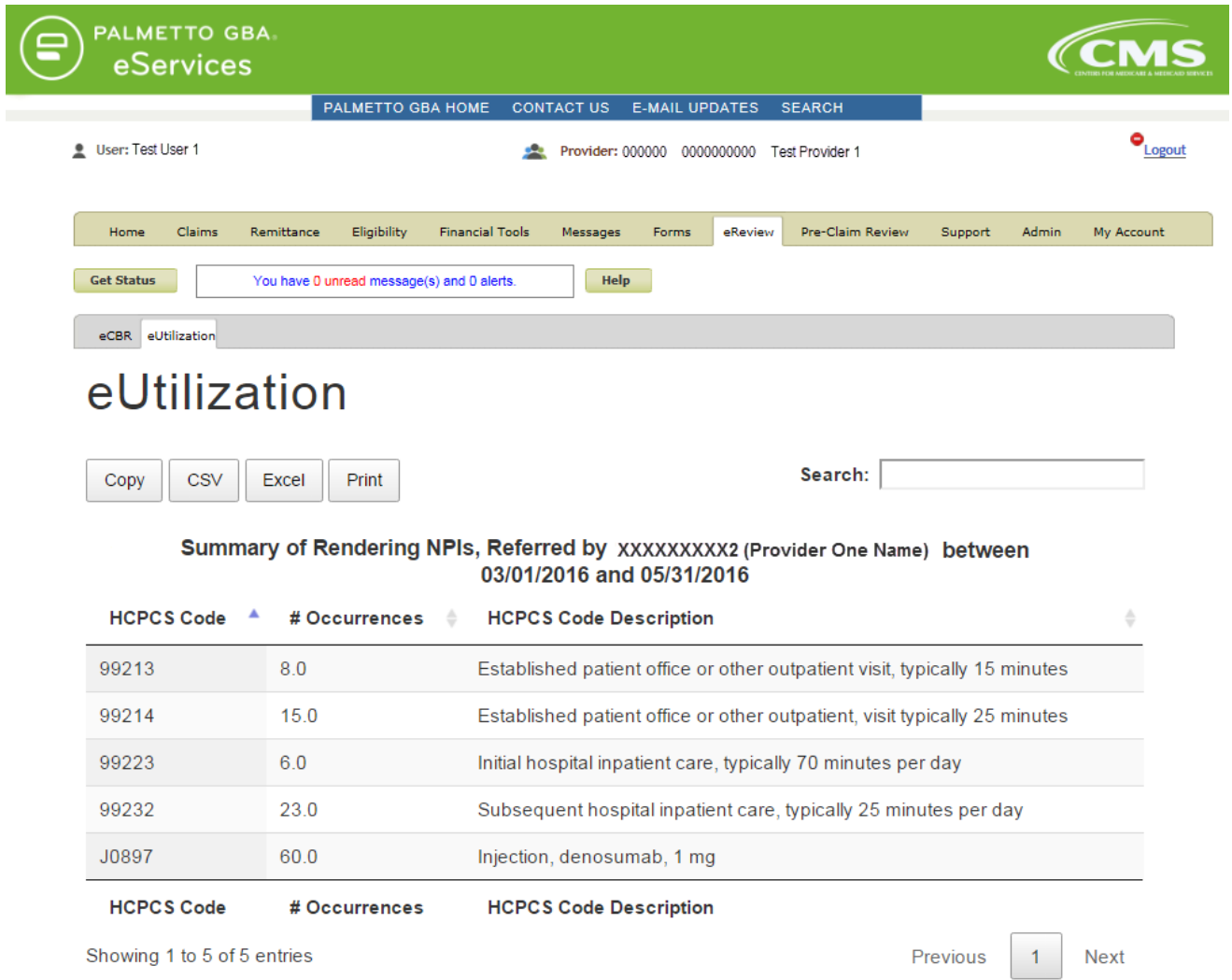
The 'eUtilization' section is active. It features a search box and buttons for 'Copy', 'CSV', 'Excel', and 'Print'. The search results are for 'Ordering/Referring NPI XXXXXXXXX1'. The results table is as follows:

Provider Name	Rendering Provider NPI	Service Information
Provider One	XXXXXXXXX2	Details
Provider Two	XXXXXXXXX6	Details
Provider Three	XXXXXXXXX4	Details
Provider Four	XXXXXXXXX8	Details

Below the table, it says 'Showing 1 to 4 of 4 entries'. There are 'Previous' and 'Next' buttons, with '1' selected in the pagination.

At the bottom of the page, there is a footer with the text: © 2016 PALMETTO GBA, LLC | SITE TUTORIAL | DISCLAIMER | PRIVACY POLICY | SITE HELP | SITE MAP | GET ADOBE READER

Figure 90: eUtilization Detail Screen



The screenshot displays the eUtilization detail screen. At the top, there is a green header with the Palmetto GBA eServices logo and the CMS logo. Below the header is a navigation bar with links for Home, Claims, Remittance, Eligibility, Financial Tools, Messages, Forms, eReview, Pre-Claim Review, Support, Admin, and My Account. A user status bar shows 'User: Test User 1' and 'Provider: 000000 0000000000 Test Provider 1'. A message notification indicates 'You have 0 unread message(s) and 0 alerts.' The main content area is titled 'eUtilization' and includes buttons for Copy, CSV, Excel, and Print, along with a search field. The primary data is a table titled 'Summary of Rendering NPIs, Referred by XXXXXXXXX2 (Provider One Name) between 03/01/2016 and 05/31/2016'. The table lists five entries with columns for HCPCS Code, # Occurrences, and HCPCS Code Description. A secondary table below shows the same columns for the first five entries. Navigation controls at the bottom indicate 'Showing 1 to 5 of 5 entries' and include 'Previous', '1', and 'Next' buttons.

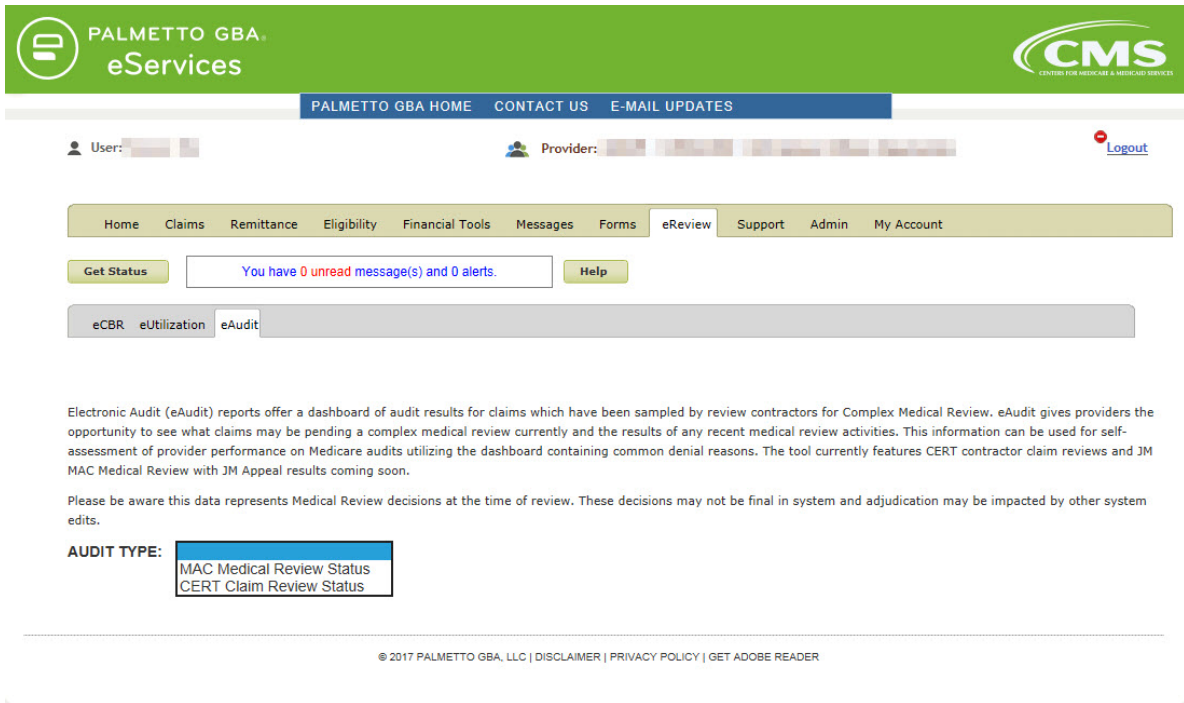
HCPCS Code	# Occurrences	HCPCS Code Description
99213	8.0	Established patient office or other outpatient visit, typically 15 minutes
99214	15.0	Established patient office or other outpatient, visit typically 25 minutes
99223	6.0	Initial hospital inpatient care, typically 70 minutes per day
99232	23.0	Subsequent hospital inpatient care, typically 25 minutes per day
J0897	60.0	Injection, denosumab, 1 mg

11.3 How do I use the eAudit function?

Electronic Audit (eAudit) reports offer a dashboard of audit results for claims which have been sampled by review contractors for Complex Medical Review. eAudit gives providers the opportunity to see what claims may be pending a complex medical review currently and the results of any recent medical review activities. This information can be used for self-assessment of provider performance on Medicare audits utilizing the dashboard containing common denial reasons.

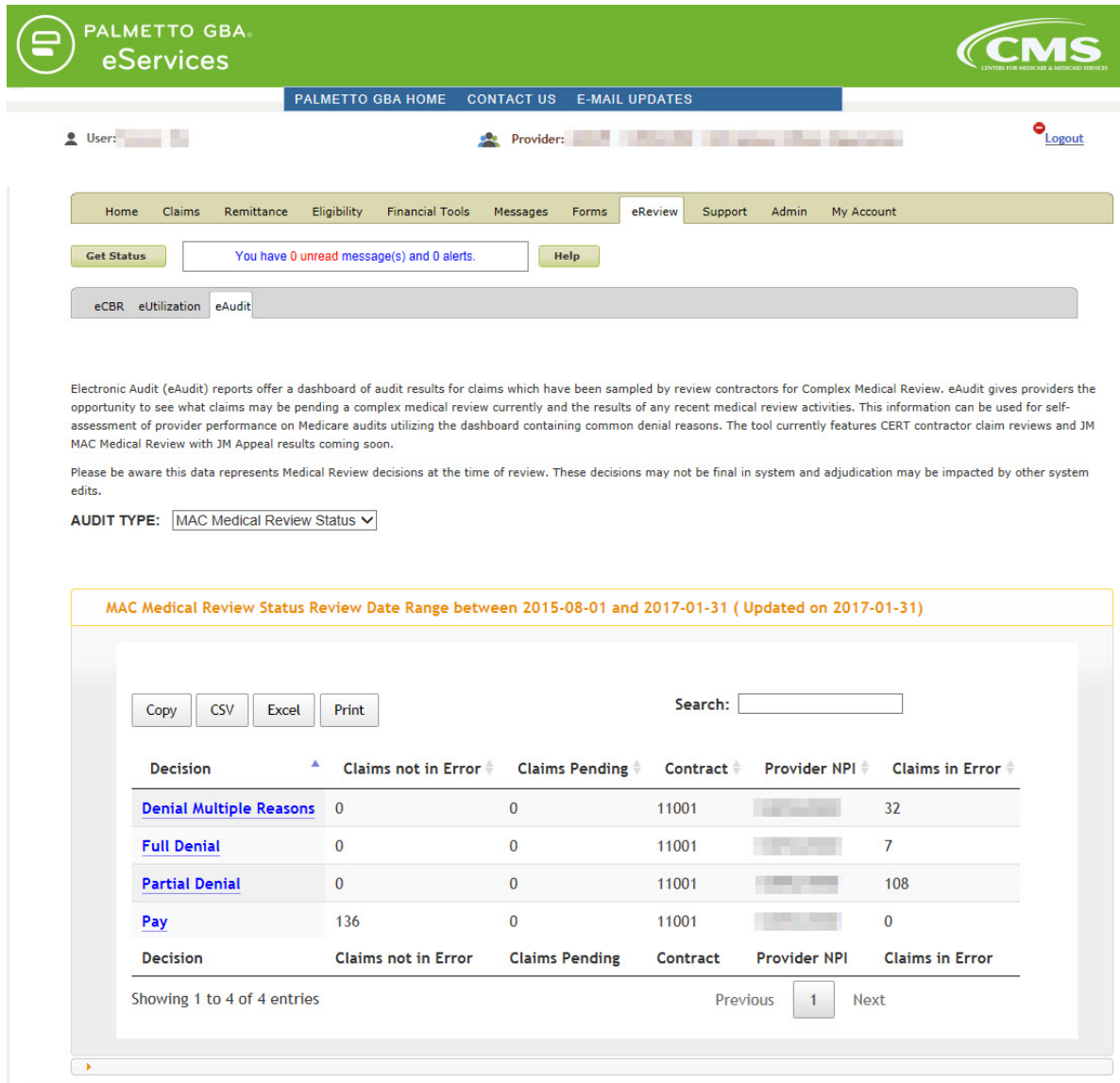
To get started, select the eAudit tab, under the eReview tab. Once there, select the Audit Type and the screen will populate with a summary table of audit data.

Figure 91: Audit Type Landing Page



The screenshot shows the Palmetto GBA eServices interface. At the top, there is a green header with the Palmetto GBA logo and 'eServices' text, and the CMS logo on the right. Below the header is a blue navigation bar with links for 'PALMETTO GBA HOME', 'CONTACT US', and 'E-MAIL UPDATES'. The main content area includes a user and provider selection section, a navigation menu with 'eReview' selected, and a message notification stating 'You have 0 unread message(s) and 0 alerts.' Below this is a breadcrumb trail: 'eCBR > eUtilization > eAudit'. The main text describes the Electronic Audit (eAudit) reports, which provide a dashboard of audit results for claims sampled by review contractors for Complex Medical Review. It mentions that eAudit gives providers the opportunity to see what claims may be pending a complex medical review and the results of any recent medical review activities. The tool currently features CERT contractor claim reviews and JM MAC Medical Review with JM Appeal results coming soon. A disclaimer states that the data represents Medical Review decisions at the time of review and may be impacted by other system edits. At the bottom, there is a section for 'AUDIT TYPE:' with a dropdown menu showing 'MAC Medical Review Status' and 'CERT Claim Review Status'. The footer contains the copyright notice: '© 2017 PALMETTO GBA, LLC | DISCLAIMER | PRIVACY POLICY | GET ADOBE READER'.

Figure 92: eAudit Claim Data Table – MAC Med Review Status



The screenshot shows the Palmetto GBA eServices interface. At the top, there is a green header with the Palmetto GBA logo and 'eServices' text, and the CMS logo on the right. Below the header is a navigation bar with links for 'PALMETTO GBA HOME', 'CONTACT US', and 'E-MAIL UPDATES'. A user and provider selection area is visible, along with a 'Logout' link. A secondary navigation bar contains links for 'Home', 'Claims', 'Remittance', 'Eligibility', 'Financial Tools', 'Messages', 'Forms', 'eReview', 'Support', 'Admin', and 'My Account'. A 'Get Status' button and a message box stating 'You have 0 unread message(s) and 0 alerts.' are present. Below this is a tabbed interface with 'eCBR', 'eUtilization', and 'eAudit' tabs. A paragraph of text explains the eAudit reports and their purpose. Below the text is an 'AUDIT TYPE:' dropdown menu set to 'MAC Medical Review Status'. The main content area is titled 'MAC Medical Review Status Review Date Range between 2015-08-01 and 2017-01-31 (Updated on 2017-01-31)'. It features a table with columns for 'Decision', 'Claims not in Error', 'Claims Pending', 'Contract', 'Provider NPI', and 'Claims in Error'. The table contains four rows of data: 'Denial Multiple Reasons' (0, 0, 11001, 32), 'Full Denial' (0, 0, 11001, 7), 'Partial Denial' (0, 0, 11001, 108), and 'Pay' (136, 0, 11001, 0). Below the table are 'Copy', 'CSV', 'Excel', and 'Print' buttons, a search box, and pagination controls showing 'Showing 1 to 4 of 4 entries' and 'Previous 1 Next'.

Users can select the category to be taken to a Claim Data Details Table to see the claim line details for that audit error code category. Each of the items in the Claim Data Details Table can be expanded for extra details as shown below.



Figure 93: eAudit Claim Data Details Table – MAC Med Review Status

[PALMETTO GBA HOME](#) | [CONTACT US](#) | [E-MAIL UPDATES](#)

User: [redacted] Provider: [redacted] [Logout](#)

[Home](#) | [Claims](#) | [Remittance](#) | [Eligibility](#) | [Financial Tools](#) | [Messages](#) | [Forms](#) | **eReview** | [Support](#) | [Admin](#) | [My Account](#)

[Get Status](#) | You have 0 unread message(s) and 0 alerts. | [Help](#)

[eCBR](#) | [eUtilization](#) | **eAudit**

Electronic Audit (eAudit) reports offer a dashboard of audit results for claims which have been sampled by review contractors for Complex Medical Review. eAudit gives providers the opportunity to see what claims may be pending a complex medical review currently and the results of any recent medical review activities. This information can be used for self-assessment of provider performance on Medicare audits utilizing the dashboard containing common denial reasons. The tool currently features CERT contractor claim reviews and JM MAC Medical Review with JM Appeal results coming soon.

Please be aware this data represents Medical Review decisions at the time of review. These decisions may not be final in system and adjudication may be impacted by other system edits.

AUDIT TYPE: MAC Medical Review Status

MAC Medical Review Status Review Date Range between 2015-08-01 and 2017-01-31 (Updated on 2017-01-31)

MAC Medical Review Status Review Date Range between 2015-08-01 and 2017-01-31 (Updated on 2017-01-31)

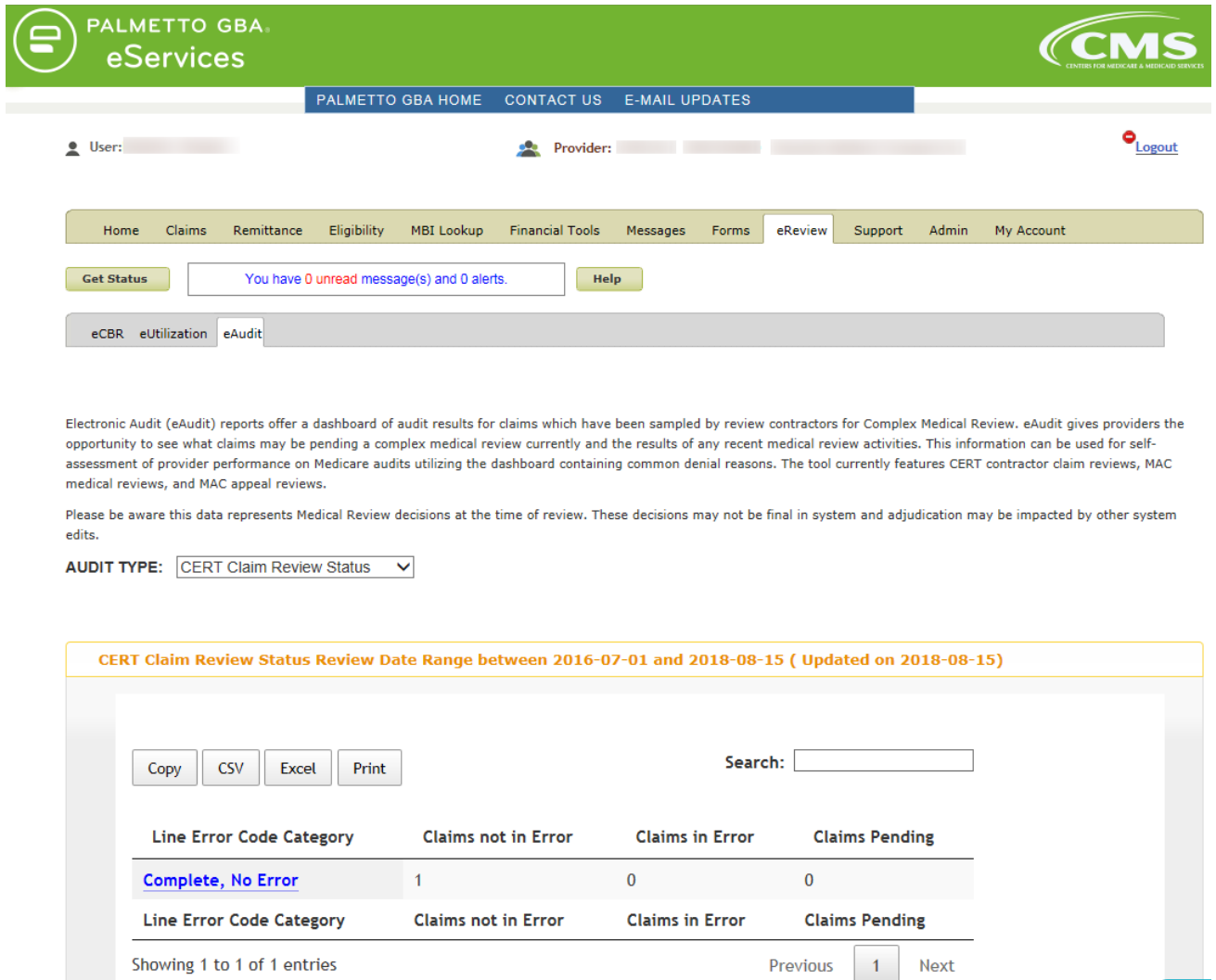
[Copy](#) | [CSV](#) | [Excel](#)

Search:

	Claim Control Number	Line Number	Service Date	Original Allow Amt	Final Allow Amt
▼	[redacted]	0	09/29/2015	\$24111.14	\$0.00
Decision		Full Denial			
Provider ID		[redacted]			
Bill Type		110			
DRG Code		460			
CPT Code					
Granular Error Description		THERE WAS NO DOCUMENTATION OF PAIN IMPACTING THE FUNCTIONAL ABILITY OF BENEFICIARY DESPITE CONSERVATIVE TREATMENT.			
▼	[redacted]	0	08/31/2016	\$24230.30	\$0.00
Decision		Full Denial			
Provider ID		[redacted]			
Bill Type		110			
DRG Code		460			
CPT Code					
Granular Error Description		THERE WERE NO X-RAY, CT OR MRI RESULTS SUBMITTED THAT SUPPORT ADVANCED DEGENERATIVE CHANGES, MECHANICAL INSTABILITY, AND DEFORMITY OF THE LUMBAR SPINE OR NEURAL COMPRESSION THAT WOULD REQUIRE THIS TYPE OF PROCEDURE.			
▶	[redacted]	0	09/02/2016	\$24230.30	\$0.00
▶	[redacted]	0	08/22/2016	\$24230.30	\$0.00
▶	[redacted]	0	10/13/2016	\$312.30	\$0.00
▶	[redacted]	0	10/14/2016	\$312.30	\$0.00
▶	[redacted]	0	09/07/2016	\$5621.40	\$0.00

Showing 1 to 7 of 7 entries
Previous 1 Next

Figure 94: eAudit Claim Data Details Table – CERT Claim Review Status



The screenshot shows the Palmetto GBA eServices interface. At the top, there is a green header with the Palmetto GBA logo and 'eServices' text, and the CMS logo on the right. Below the header is a navigation bar with links for 'PALMETTO GBA HOME', 'CONTACT US', and 'E-MAIL UPDATES'. A user profile section shows 'User:' and 'Provider:' fields. A main navigation menu includes 'Home', 'Claims', 'Remittance', 'Eligibility', 'MBI Lookup', 'Financial Tools', 'Messages', 'Forms', 'eReview', 'Support', 'Admin', and 'My Account'. A 'Get Status' button is followed by a message: 'You have 0 unread message(s) and 0 alerts.' and a 'Help' button. Below this is a sub-menu with 'eCBR', 'eUtilization', and 'eAudit' options. The 'eAudit' section contains a paragraph explaining that electronic audit reports offer a dashboard of audit results for claims sampled by review contractors for Complex Medical Review. It also includes a note that the data represents Medical Review decisions at the time of review. Below the text is an 'AUDIT TYPE:' dropdown menu set to 'CERT Claim Review Status'. The main content area is titled 'CERT Claim Review Status Review Date Range between 2016-07-01 and 2018-08-15 (Updated on 2018-08-15)'. It features a search bar and buttons for 'Copy', 'CSV', 'Excel', and 'Print'. A table displays the following data:

Line Error Code Category	Claims not in Error	Claims in Error	Claims Pending
Complete, No Error	1	0	0
Line Error Code Category	Claims not in Error	Claims in Error	Claims Pending

Showing 1 to 1 of 1 entries

Previous 1 Next

Figure 95: eAudit Claim Data Details Table – CERT Claim Review Status

eCBR eUtilization **eAudit**

Electronic Audit (eAudit) reports offer a dashboard of audit results for claims which have been sampled by review contractors for Complex Medical Review. eAudit gives providers the opportunity to see what claims may be pending a complex medical review currently and the results of any recent medical review activities. This information can be used for self-assessment of provider performance on Medicare audits utilizing the dashboard containing common denial reasons. The tool currently features CERT contractor claim reviews, MAC medical reviews, and MAC appeal reviews.

Please be aware this data represents Medical Review decisions at the time of review. These decisions may not be final in system and adjudication may be impacted by other system edits.

AUDIT TYPE:

CERT Claim Review Status Review Date Range between 2016-07-01 and 2018-08-15 (Updated on 2018-08-15)

CERT Claim Review Status Review Date Range between 2016-07-01 and 2018-08-15 (Updated on 2018-08-15)

Copy CSV Excel Search:

	CID	Claim Control Number	Paid Correctly	Paid Incorrectly	Line Error Code Category
<input checked="" type="checkbox"/>			\$352.32		Complete, No Error
Line Nbr		1			
Review Status		COMPLETE			
Line HCPCS Code					
Line Error Code Long Description		Review has been completed for this claim, no error was identified for this claim line.			
<input type="checkbox"/>					Complete, No Error

Showing 1 to 2 of 2 entries Previous Next

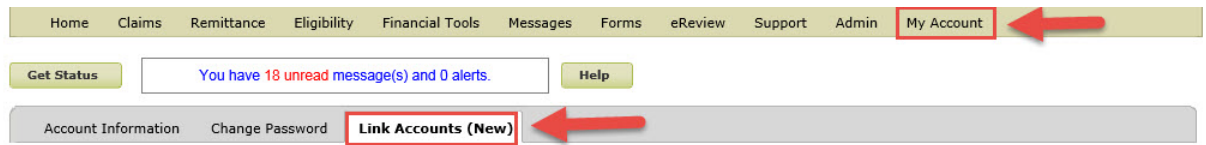
12.0 Account Linking

12.1 How to link existing eServices user IDs

Palmetto GBA gives users the ability to link their previously assigned eServices user IDs under one default ID through the Account Linking sub-tab. Users should log into eServices with the user ID that they wish to use as their default. This is the user ID that will be used to access any linked accounts. Once the user has successfully logged into eServices, they may access the Account Linking sub-tab by first selecting the My Account Tab.



Figure 96: Account Linking Sub-Tab



Account Linking

Be sure you are logged in to the account with the User ID you want as your default User ID.

For each account you want to link, enter the User ID and password for that account below.

You will be notified of the status of your link request via inbox messages to your selected default User ID. Link requests may take up to 24 hours to be processed.

User ID:

Password:

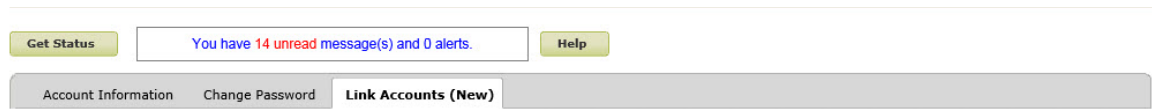
Notes:

- You cannot link accounts that are already linked to a default User Id.
- You cannot link accounts that are inactive/have been terminated for any reason. Examples include, but are not limited to:
 - Terminated by provider administrator
 - Terminated by Palmetto GBA support team
 - Terminated for inactivity (no log in for 60 days)
 - Terminated for not completing recertification or profile verification timely

Simply enter the user ID and password of the eServices account that you wish to link in the corresponding fields and click the Link Account button. Please note that only active IDs that are not already linked to a default user ID are eligible for account linking. In the event that there is an issue preventing successful linkage of the requested account, an error message will display. Please read the message and proceed accordingly.



Figure 97: Account Linking Error Message Example



Account Linking

Be sure you are logged in to the account with the User ID you want as your default User ID.

For each account you want to link, enter the User ID and password for that account below.

You will be notified of the status of your link request via inbox messages to your selected default User ID. Link requests may take up to 24 hours to be processed.

The User ID entered is inactive. You cannot link an inactive User ID.

User ID:

Password:

Link Account

Notes:

- You cannot link accounts that are already linked to a default User ID.
- You cannot link accounts that are inactive/have been terminated for any reason. Examples include, but are not limited to:
 - Terminated by provider administrator
 - Terminated by Palmetto GBA support team
 - Terminated for inactivity (no log in for 60 days)
 - Terminated for not completing recertification or profile verification timely

If the account link request is submitted successfully, a submission confirmation message will display. Additionally, users will receive an eServices inbox message related to their account link request. Users may continue the account linking process for all desired user IDs.

12.2 Accessing linked accounts in eServices

Once your eServices user IDs have been linked, you will need to log in with your default ID. All other user IDs will be deactivated. You will still use the password that you previously created for this user ID to access eServices. Attempts to access eServices with a user ID that was linked to a default ID will result in an error message.

12.3 Switching between accounts in eServices

eServices users can easily switch between their linked accounts by using the Provider dropdown box located near the top of each tab. Simply click on the dropdown box to display the list of all linked accounts available and select the desired provider account. The dropdown box will be updated to show the selected provider. Upon login you will only be able to view tabs that match the access for your default account. As you choose a different account from the Provider dropdown menu at the top of the screen, you will see the tab availability change based upon your permissions. In the event that you do not have permission to view the current tab for the selected provider, you will receive an error message in red at the top of the page. The screen will display the tab for the previously selected provider account.

Figure 98: Account Linking Provider Dropdown

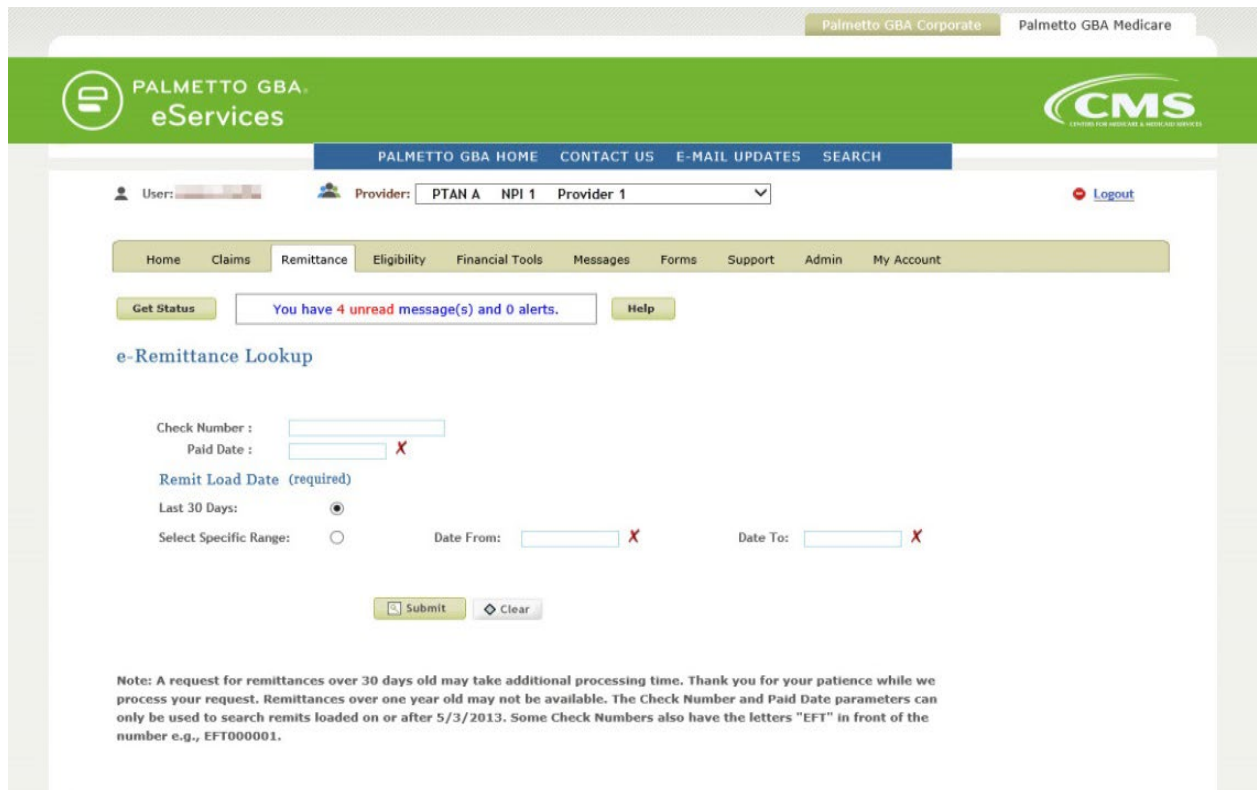


Figure 99: Account Linking Expanded Provider Dropdown

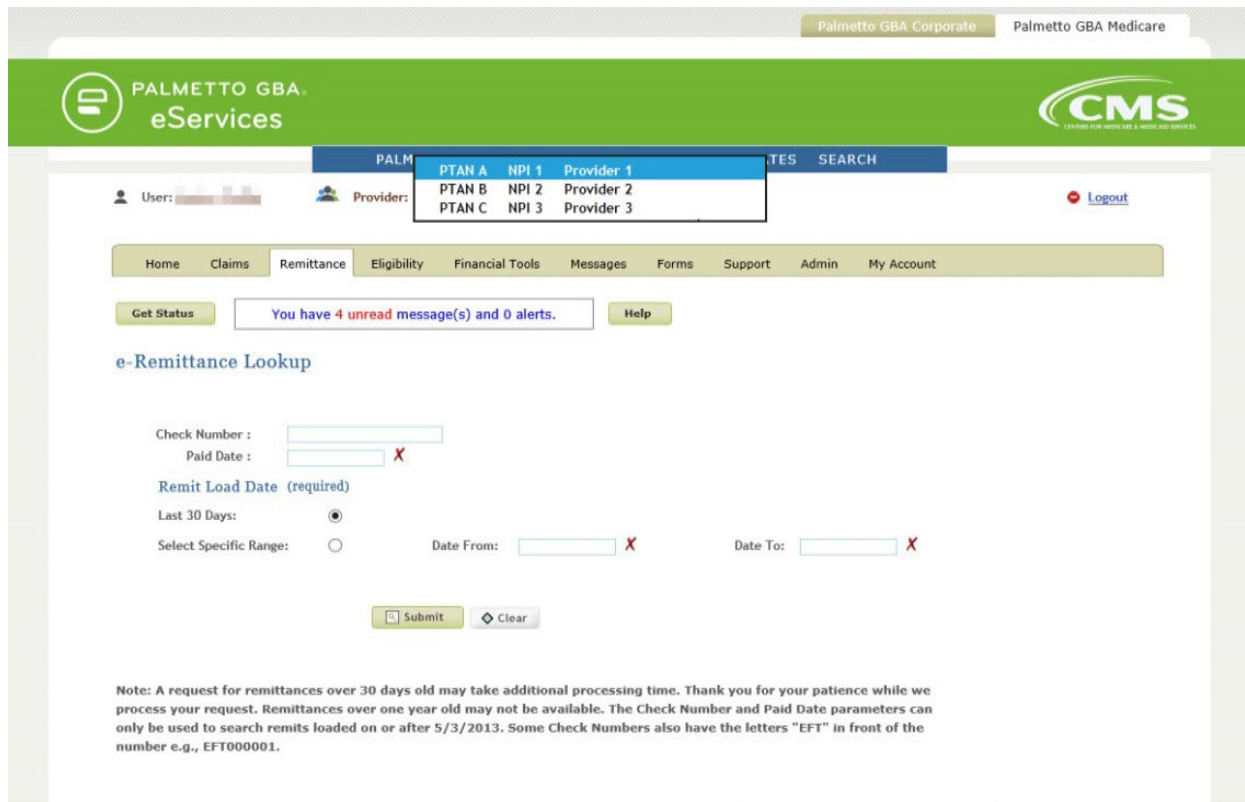


Figure 100: Account Linking Successful Provider Change

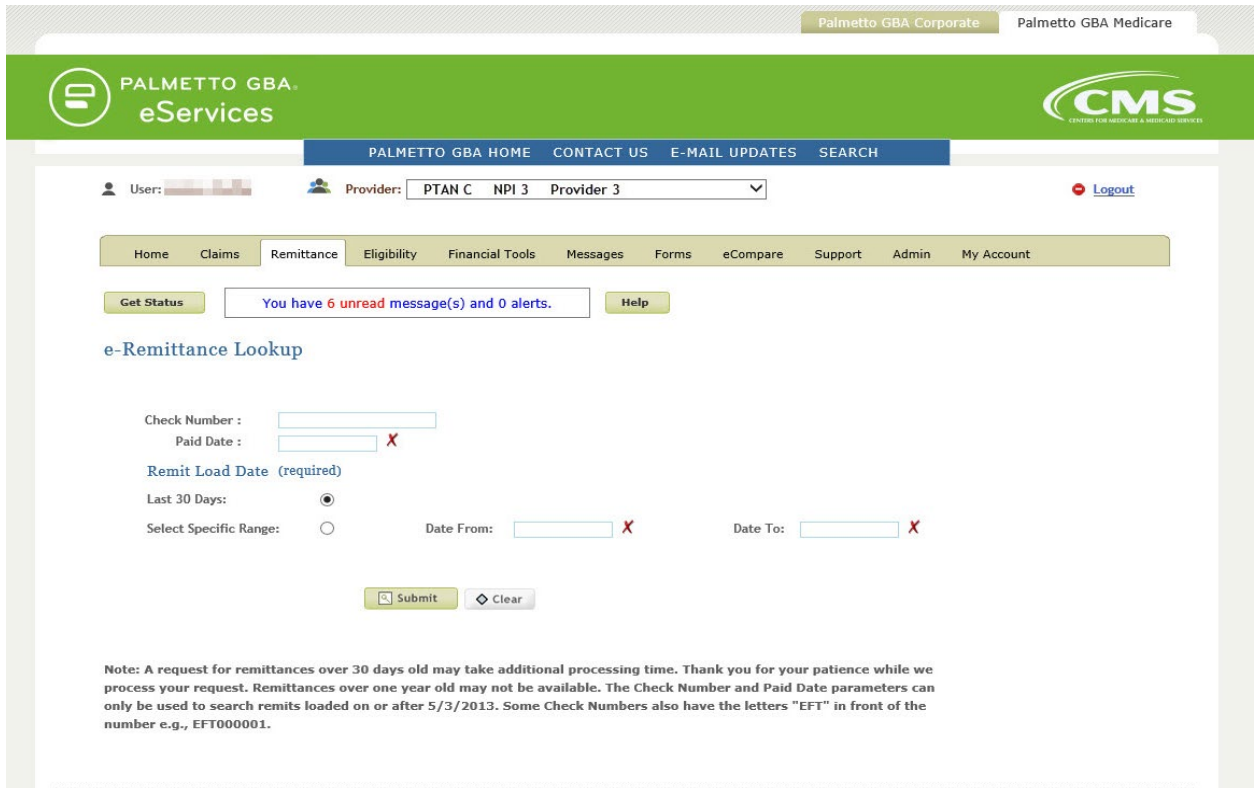
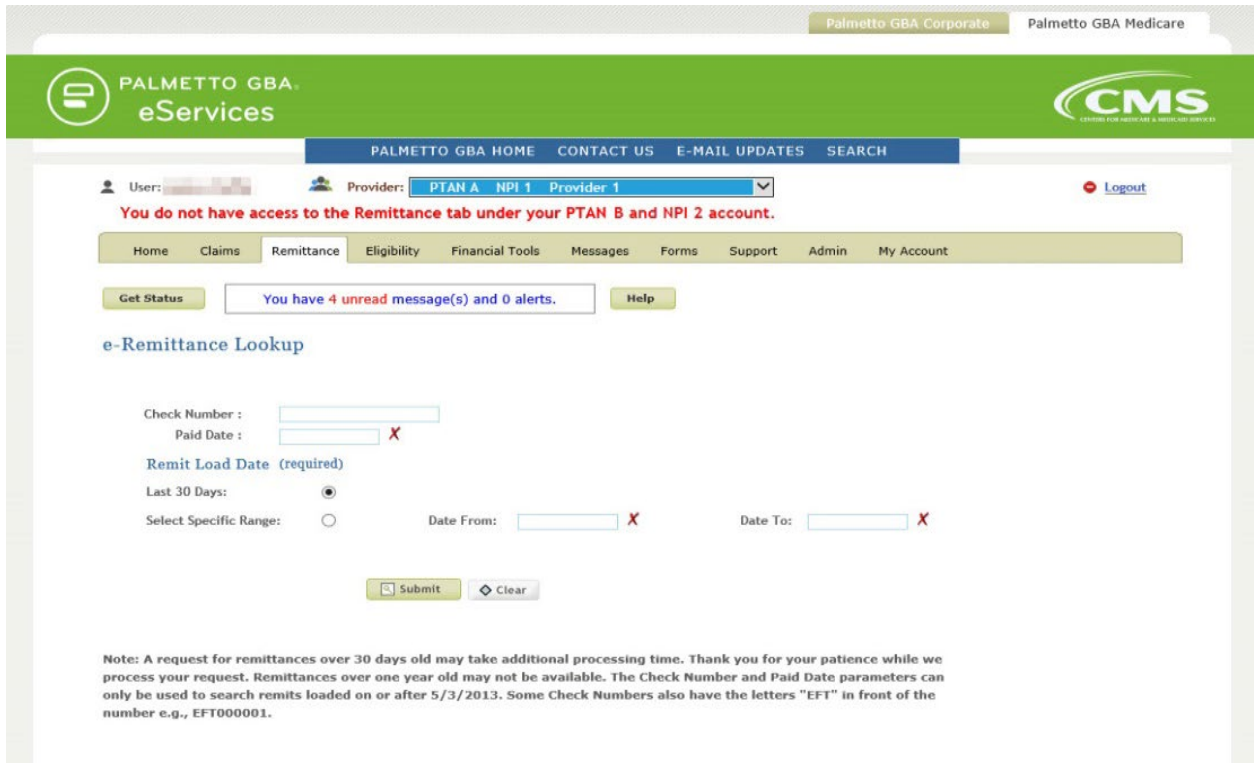


Figure 101: Account Linking Provider Change Error

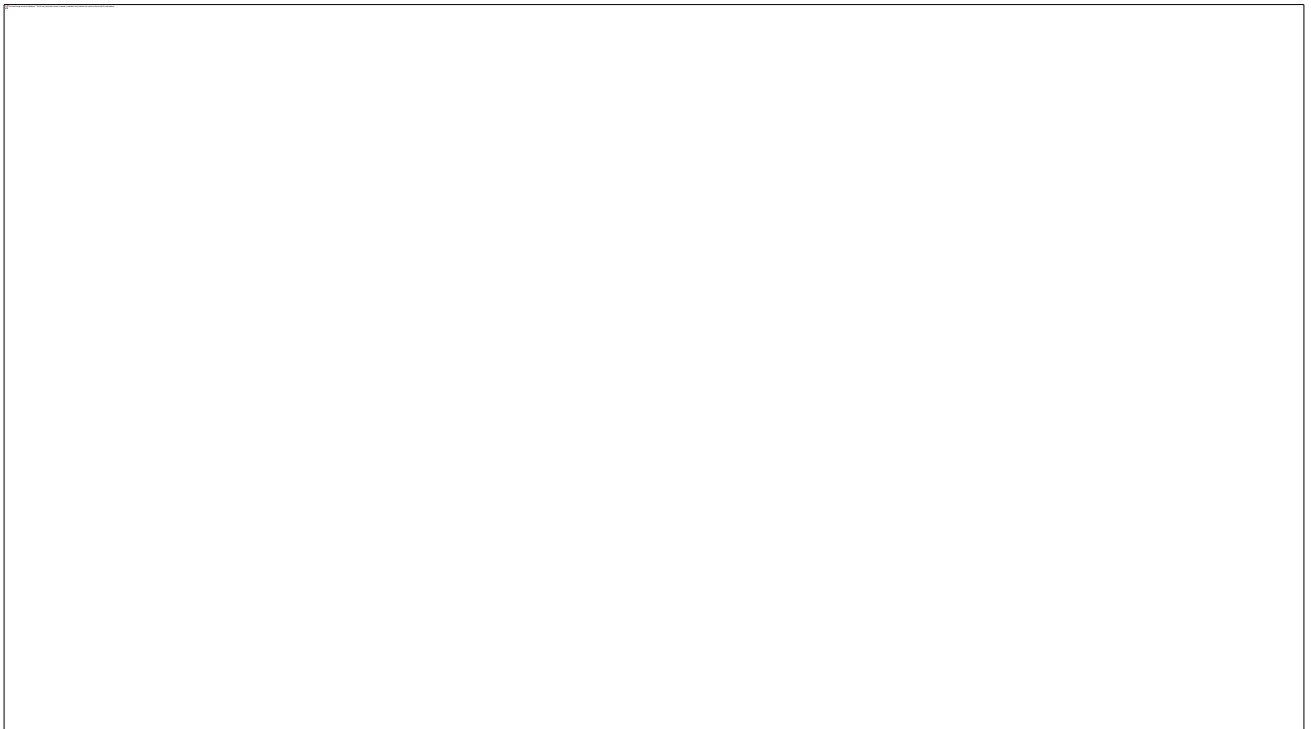


13.0 MBI Lookup

13.1 How to successfully perform an MBI lookup

When you click on the MBI Lookup tab, you will be presented with the MBI Lookup screen. You can use this MBI Lookup tool to find MBIs on behalf of Medicare patients when they don't have them or are unable to provide them. The user should enter a beneficiary's information into the fields below and use the Submit Inquiry button. To protect the privacy of beneficiary data, all fields entered, including optional fields, must match the beneficiary's data; otherwise, MBI data will not be returned. The beneficiary's Social Security Number will be masked. To view the entire Social Security Number, click show/hide link.

Figure 102: MBI Lookup Tab



The following fields are required:

- Beneficiary Last Name
- Beneficiary First Name
- Beneficiary Date of Birth
- Beneficiary Social Security Number

The optional fields are as follows:

- Beneficiary Name Suffix – The beneficiary's suffix may be entered in this field if the beneficiary has it printed on their Medicare health insurance card.

If the inquiry successfully returns an MBI, the screen will refresh with the data at the bottom.

Figure 103: MBI Lookup Successful Response

Beneficiary Information

Beneficiary Last Name:*	<input type="text" value="Doe"/>	Beneficiary First Name:*	<input type="text" value="Jane"/>
Beneficiary Name Suffix:	<input type="text"/>	Beneficiary Date Of Birth:*	<input type="text" value="00/00/0000"/>
Beneficiary Social Security Number:*	<input type="text" value="000-00-0000"/>		

*Lookup Status: **MBI: 0X00XX0XX00**

13.2 MBI Lookup error messages

In the event that your MBI lookup request does not result in a successful response, eServices will display error messages to assist you. If any required fields are left blank or are not in a proper format, a message will appear advising you which fields to correct.

Figure 104: MBI Lookup Unsuccessful Response

MBI Lookup

Medicare Administrative Contractor (MAC) Provider Medicare Beneficiary Identifier (MBI) Lookup Tool

Starting in April 2018, to make it easier for health care providers and those working on their behalf to get Medicare patients' MBIs when they don't or can't give them, providers can use a MAC's secure portal to look up MBIs. To find MBIs through the portal, providers must key the Medicare patient's first name, last name, date of birth and SSN.

Beneficiary Information

Beneficiary Last Name:*	<input type="text" value="Doe"/>	Beneficiary First Name:*	<input type="text" value="Jane"/>
Beneficiary Name Suffix:	<input type="text"/>	Beneficiary Date Of Birth:*	<input type="text" value="00/00/0000"/>
Beneficiary Social Security Number:*	<input type="text" value="000-00-0000"/>		

*Lookup Status: **MBI not found**

Figure 105: MBI Lookup Data Entry Errors

MBI Lookup

! Please review the data entered

- Beneficiary Date Of Birth is required.**
- Please enter Beneficiary Social Security Number in XXX-XX-XXXX format.**

Medicare Administrative Contractor (MAC) Provider Medicare Beneficiary Identifier (MBI) Lookup Tool

Starting in April 2018, to make it easier for health care providers and those working on their behalf to get Medicare patients' MBIs when they don't or can't give them, providers can use a MAC's secure portal to look up MBIs. To find MBIs through the portal, providers must key the Medicare patient's first name, last name, date of birth and SSN.

Beneficiary Information

<p>Beneficiary Last Name:* <input type="text" value="Doe"/></p> <p>Beneficiary Name Suffix: <input type="text"/></p> <p>Beneficiary Social Security Number:* <input type="text" value="abc-12-3ab0"/></p>	<p>Beneficiary First Name:* <input type="text" value="Jane"/></p> <p>Beneficiary Date Of Birth:* <input type="text"/></p>
--	---

I'm not a robot

*Required Field

14.0 ADR Status Dashboard

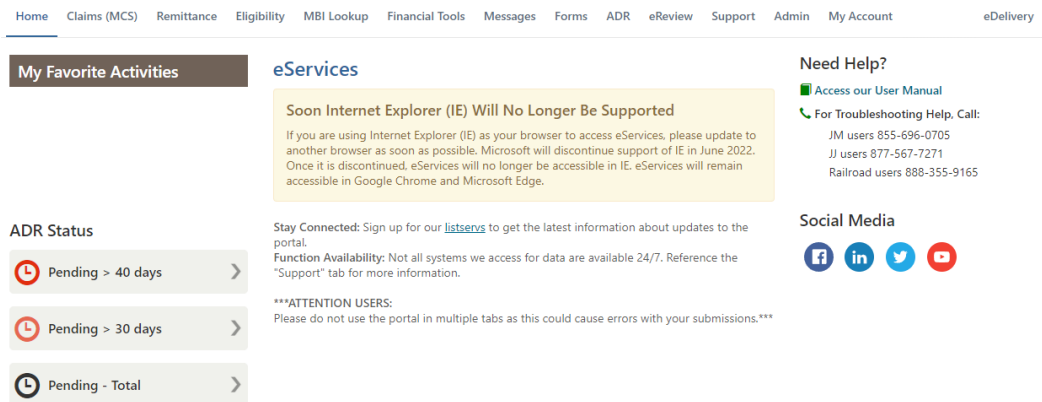
14.1 Using the ADR Status Home Page Widgets

Part B users will see a Pending ADR widget on the Home page. This new widget will provide an alert to users when there are ADRs that are older than 30 and 40 days. To see more details about the pending ADRs, a user can select the widget option to navigate to the new Pending ADR Dashboard.

When the provider does not have pending ADRs, the home page will be gray with zeros. The user will also not be able to click on the widget to get to the ADR tab.

Note: Users must have access to Secure Forms in order to view the details on the Pending ADR Dashboard.

Figure 106: ADR Status Widget on Home Page



The screenshot shows the eServices Home Page navigation bar with links: Home, Claims (MCS), Remittance, Eligibility, MBI Lookup, Financial Tools, Messages, Forms, ADR, eReview, Support, Admin, My Account, and eDelivery. Below the navigation bar, there are three main sections:

- My Favorite Activities:** A dark brown button.
- eServices:** A yellow box with the heading "Soon Internet Explorer (IE) Will No Longer Be Supported" and a warning message about browser updates.
- Need Help?:** A green box with links to the User Manual and Troubleshooting Help, along with contact numbers for JM, JJ, and Railroad users.

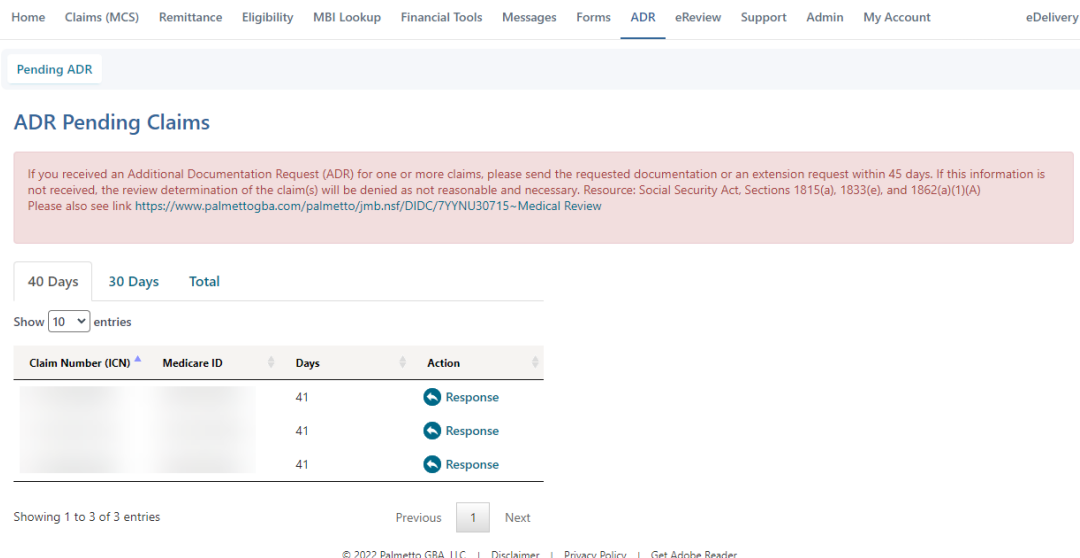
Below these sections, there is a "Social Media" area with icons for Facebook, LinkedIn, Twitter, and YouTube. The "ADR Status" section is highlighted, showing three widgets: "Pending > 40 days", "Pending > 30 days", and "Pending - Total", each with a clock icon and a right-pointing arrow.

14.2 Pending ADR Dashboard

Users can access the Pending ADR Dashboard by selecting either the ADR Status Widget or the ADR tab. The dashboard will have the ADRs organized in tabs by the number of days the ADRs have been pending. Users can click the claim number listed to navigate to the claim detail page.

Once an ADR Response is submitted, the Response action will be removed as an option.

Figure 107: Pending ADR Widget on Home Page



The screenshot shows the "Pending ADR" dashboard. At the top, there is a navigation bar with the "ADR" tab selected. Below the navigation bar, there is a "Pending ADR" header and a "ADR Pending Claims" section. A pink warning box contains information about the 45-day deadline for submitting documentation. Below the warning box, there are tabs for "40 Days", "30 Days", and "Total", with "40 Days" selected. A "Show 10 entries" dropdown is visible. The main content is a table with the following columns: Claim Number (ICN), Medicare ID, Days, and Action. The table contains three rows, each with a claim number of 41 and a "Response" action button. At the bottom, there is a pagination bar showing "Showing 1 to 3 of 3 entries" and "Previous 1 Next".

14.3 Submitting MR ADR Form from the Dashboard

Users can use the Response option to complete the submission for the MR ADR form. When Response is selected, the user will be navigated to the MR ADR form. The MBI and ICN fields on the form will be prepopulated with the information from the Pending ADR dashboard.

15.0 Messages Inbox

15.1 Using the Secure Message Inbox

When you click on the Messages tab, you will be presented with your Notification Center inbox. It contains important notifications regarding eServices submissions and eServices alert messages.

Note: Only messages for to the account associated with the user ID you are logged in with, or the account selected if you have multiple accounts linked to your user ID, will display.

15.2 Inbox Filtering

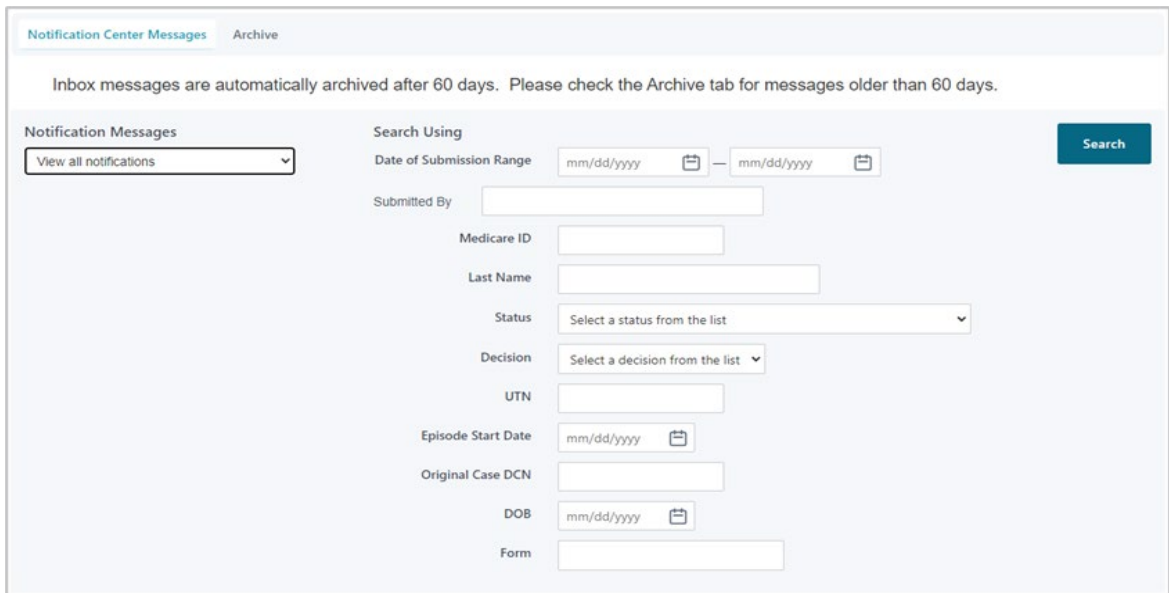
The list of messages displayed will appear in chronological order. You may use the inbox filtering options to only view a certain message type and/or view messages related to a specific DCN. If you receive a message that there is no data available in the table, please adjust your filter criteria and try again. Items must match all entered criteria to display.

When using the filter feature, you must select the Search button to display the results found.

Users will be able to Export (Excel) or Download (PDF) the table information for the provider's inbox.

Note: Only messages for to the account associated with the user ID you are logged in with, or the account selected if you have multiple accounts linked to your user ID, will display.

Figure 108: Inbox Filtering



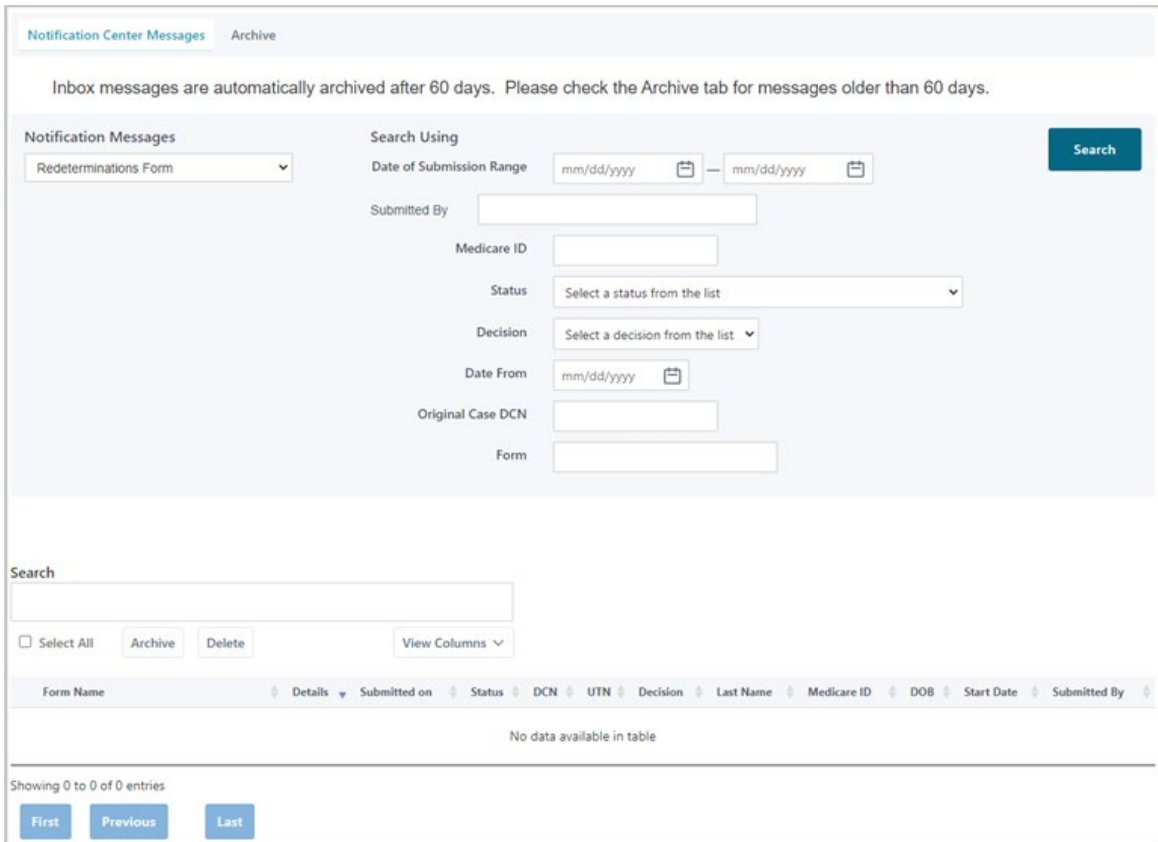
The screenshot shows the 'Notification Center Messages' interface. At the top, there are tabs for 'Notification Center Messages' and 'Archive'. Below the tabs, a message states: 'Inbox messages are automatically archived after 60 days. Please check the Archive tab for messages older than 60 days.'

The main section is titled 'Notification Messages' and contains a dropdown menu currently set to 'View all notifications'. To the right, under 'Search Using', there are several input fields for filtering:

- Date of Submission Range:** Two date pickers with the format 'mm/dd/yyyy' and a range separator.
- Submitted By:** A text input field.
- Medicare ID:** A text input field.
- Last Name:** A text input field.
- Status:** A dropdown menu with the text 'Select a status from the list'.
- Decision:** A dropdown menu with the text 'Select a decision from the list'.
- UTN:** A text input field.
- Episode Start Date:** A date picker with the format 'mm/dd/yyyy'.
- Original Case DCN:** A text input field.
- DOB:** A date picker with the format 'mm/dd/yyyy'.
- Form:** A text input field.

A blue 'Search' button is located to the right of the search criteria fields.

Figure 109: Inbox Filtering - No Data Available



The screenshot shows the 'Notification Center Messages' interface. At the top, there are tabs for 'Notification Center Messages' and 'Archive'. A message states: 'Inbox messages are automatically archived after 60 days. Please check the Archive tab for messages older than 60 days.' Below this is a search filter section with a dropdown menu set to 'Redeterminations Form'. The 'Search Using' section includes fields for 'Date of Submission Range' (mm/dd/yyyy), 'Submitted By', 'Medicare ID', 'Status' (a dropdown menu), 'Decision' (a dropdown menu), 'Date From' (mm/dd/yyyy), 'Original Case DCN', and 'Form'. A 'Search' button is located to the right of these fields. Below the search filters is a search input field, a 'Select All' checkbox, and buttons for 'Archive', 'Delete', and 'View Columns'. A table header is visible with columns: Form Name, Details, Submitted on, Status, DCN, UTN, Decision, Last Name, Medicare ID, DOB, Start Date, Submitted By. The table content area displays 'No data available in table'. At the bottom, it shows 'Showing 0 to 0 of 0 entries' and buttons for 'First', 'Previous', and 'Last'.

15.3 Using the eDelivery Inbox

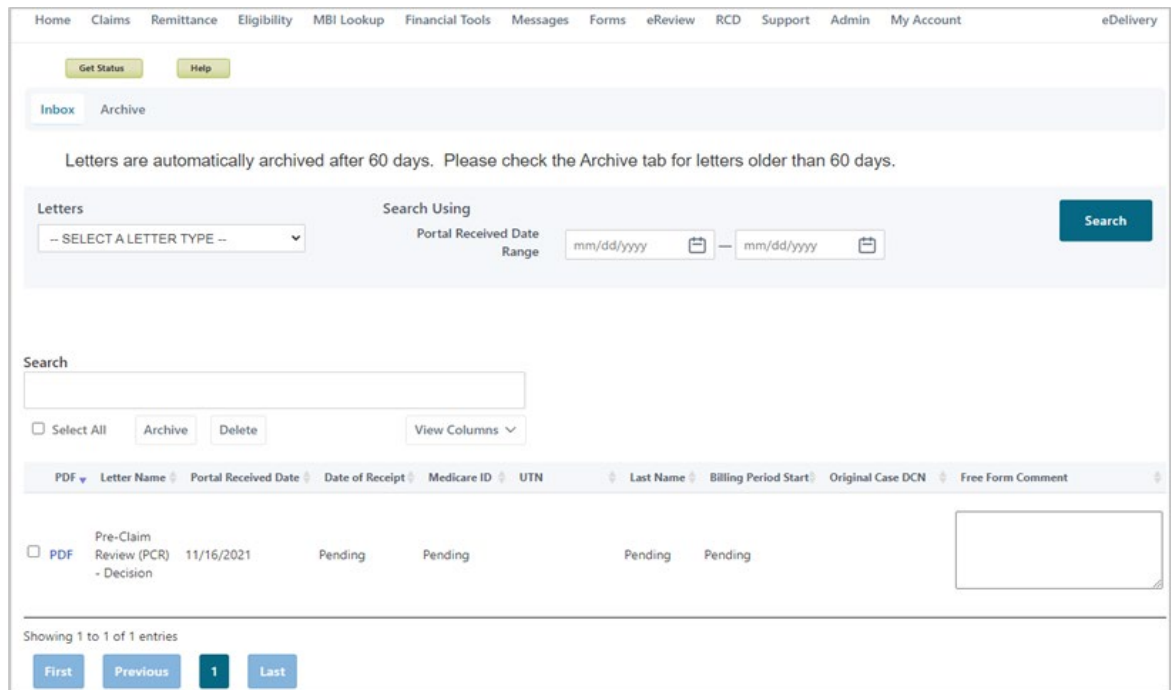
When you click on the eDelivery tab, you will be presented with your eDelivery inbox. It contains eServices Letters. Users can also leave comments for each eDelivery message. Comments left on eDelivery messages are for provider use only. These messages are not transmitted back to Palmetto GBA to respond.

When there is an unread eDelivery message the eDelivery tab will be green.

Note: Only messages for to the account associated with the user ID you are logged in with, or the account selected if you have multiple accounts linked to your user ID, will display.

For certain eLetters, a “Take Action” column will display in the results grid. The column will contain links to other functions in eServices that are related to the letter topic. For example, if you received a MR ADR letter you will see the link to the ADR Response form. It will navigate you directly to the form. Users will need the permission to access the linked function.

Figure 110: eDelivery Inbox



The screenshot shows the eDelivery Inbox interface. At the top, there is a navigation menu with links: Home, Claims, Remittance, Eligibility, MBI Lookup, Financial Tools, Messages, Forms, eReview, RCD, Support, Admin, My Account, and eDelivery. Below the menu are 'Get Status' and 'Help' buttons. The main area has 'Inbox' and 'Archive' tabs. A message states: 'Letters are automatically archived after 60 days. Please check the Archive tab for letters older than 60 days.' Below this is a search section with a 'Letters' dropdown menu (currently showing '-- SELECT A LETTER TYPE --'), a 'Search Using' section with 'Portal Received Date Range' filters (mm/dd/yyyy), and a 'Search' button. A 'Search' input field is also present. Below the search section are 'Select All', 'Archive', 'Delete', and 'View Columns' buttons. A table of messages is displayed with columns: PDF, Letter Name, Portal Received Date, Date of Receipt, Medicare ID, UTN, Last Name, Billing Period Start, Original Case DCN, and Free Form Comment. One message is visible: 'Pre-Claim Review (PCR) - Decision' with a date of 11/16/2021 and a status of 'Pending'. At the bottom, it says 'Showing 1 to 1 of 1 entries' and includes 'First', 'Previous', '1', and 'Last' navigation buttons.

15.4 Archived Messages

At any time, you may opt to archive an inbox message. Simply click the icon in the Archive column for the item you wish to archive. Once an item is archived, it cannot be moved back to your inbox. You may view archived messages at any time by selecting the Archive sub-tab under the Messages tab.

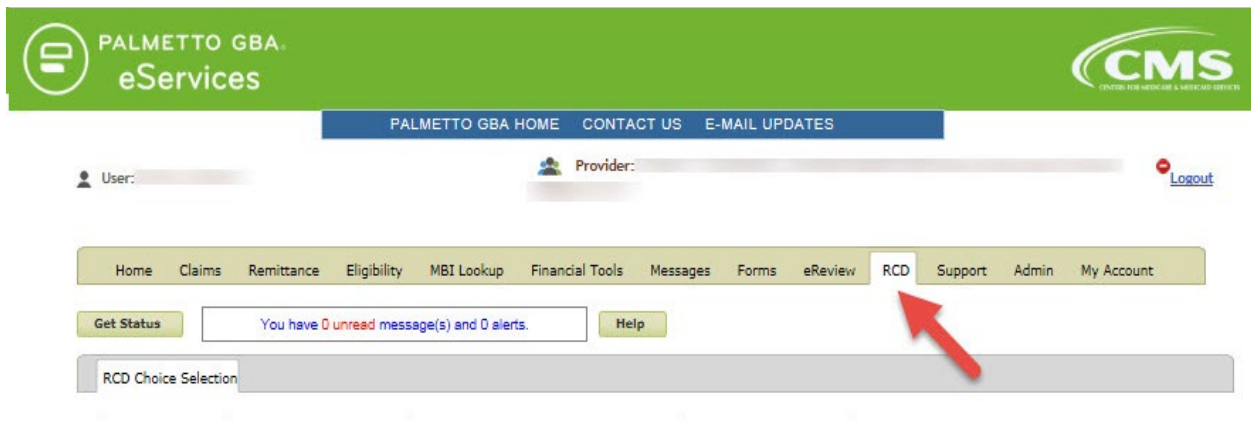
Any messages or eLetters older than sixty days will automatically be archived.

16.0 Review Choice Demonstration (RCD) Home Health (HH)

The Review Choice Demonstration -- Home Health program initiated by CMS for review claims/services for home health services. The demonstration will help ensure that payments for home health services are appropriate through either pre-claim, prepayment or post payment review.

Multiple sub-tabs will display under the RCD tab depending on the provider's review choice selection and the user's permissions.

Figure 111: RCD Tab



16.1 RCD Choice Selection Sub-tab

The RCD Choice Selection sub-tab is located under the RCD tab at the top of the page. Providers will use this tab to make their review choice selection.

Important information about RCD selection:

- Providers should read each option thoroughly prior to making a selection as some review choice selections require the provider to remain in that choice for the duration of the demonstration.
- Only eServices provider administrators are able to make the review choice selection.
- Multiple selections can be made in one day. Only the last one of the day will be processed.
- The page will indicate the selection is In Processing until the selection updates overnight.
- Under History, the last five selections can be viewed.
- The selection period will last for multiple weeks and the page will inform providers when the selection period ends.
- Providers can change their selection multiple times during the selection period.
- Once the selection period ends, providers will not be able to make any changes to the selection.
- If no selection choice is made before the selection period ends, the default choice will be the provider's selection.

Please Remember: The last review choice selected when the selection period ends will be the one in place for the duration of the cycle, or for the duration of the demonstration depending on the choice selected.

Once the review choice selection period ends, the Review Choice Selection page will not allow users to change their review choice selection until the next selection period begins. The date the next selection period begins will display.

16.2 Pre-Claim Review (PCR) Submission Sub-tab

Home Health providers that have chosen Pre-Claim Review during the Review Choice Demo (RCD) will have access to send PCR requests via the eServices portal. The Pre-Claim Review Submission sub-tab is located under the RCD tab at the top of the page. If the provider selected PCR as their review choice selection, this sub-tab will display and you will be able to enter the review request in eServices. To access the form, you will need the Pre-Claim Review permission. Provider administrators will have this permission by default. Provider users needing this feature will need to have their provider administrator update their permissions to include access to this submittal request

When completing the form:

- Pay close attention to the asterisks. These symbols indicate that a field is required and your PCR submission cannot be submitted if it is left blank.
- Check the beneficiary data entered by clicking the 'Validate Beneficiary Information' button. This will perform an eligibility check against CMS's HETS 270/271 system that we are required to use for eligibility inquiries. The review cannot be successfully processed with invalid beneficiary data.
- You have the option to save, submit, or clear the form. In order to save, the user must have completed through the Beneficiary Information section. Attachments will not be saved.
- You will be presented with a dynamic question and answer section. This decision tree will lead you through a series of questions based on previously entered data.
- You may submit PDF attachments up to 40 megabytes (MB) each to a form. While there is no limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB.

Figure 112: Pre-Claim Review Submission Sub-tab

RCD Choice Selection	Pre-Claim Review Submission	Incomplete PCR Requests
----------------------	-----------------------------	-------------------------

Pre-Claim Review JM HH

Provider Information

Contract/Region 11001/Part A South Carolina / HHH	Provider Number (PTAN) XXXXXX
Provider/Facility Name ABC Provider	National Provider Identifier (NPI) XXXXXXXXXX
Requestor Name* Jane Doe	Requestor Phone Number* XXX-XXX-XXXX
Requestor E-mail * janedoe@domain.com	Ext
Date 05/21/2019	
Is this a Resubmission?* Yes <input type="radio"/> No <input type="radio"/>	

A decision letter will be sent to your eServices Inbox in the Messages tab.

Beneficiary Information

Beneficiary First Name* John	Beneficiary Last Name* Smith
Beneficiary DOB* 00/00/0000	Medicare ID* XXXXXXXXXXXX

Validate Beneficiary Information

After clicking the Validate Beneficiary Information button, a message will display advising if the beneficiary was verified. While you will be able to submit the PCR form if the beneficiary is not successfully verified, please keep in mind that the review cannot be successfully processed with invalid beneficiary data.

Figure 113: PCR – Beneficiary Verified

Beneficiary Information

Beneficiary Information verified

Beneficiary First Name* John	Beneficiary Last Name* Smith
Beneficiary DOB* MM/DD/YYYY	Medicare ID* XXXXXXXXXXXX

Validate Beneficiary Information

Figure 114: PCR – Beneficiary Not Verified

Beneficiary Information

The beneficiary you requested cannot be verified at this time. Please proceed with your submission.

Beneficiary First Name*	Beneficiary Last Name*
<input type="text" value="John"/>	<input type="text" value="Smith"/>
Beneficiary DOB*	Medicare ID*
<input type="text" value="MM/DD/YYYY"/>	<input type="text" value="XXXXXXXXXX"/>

Validate Beneficiary Information

If you need to save your progress and return to complete the PCR form at a later time, you may use the Save button at the bottom of the form. You can then pick up with the form under the Incomplete PCR Requests sub-tab.

Note: Any attachments uploaded will not be saved. You will need to reattach them before submitting your PCR.

Figure 115: PCR – Incomplete PCR Requests Sub-tab

RCD Choice Selection Pre-Claim Review Submission **Incomplete PCR Requests**

Incomplete PCR List

Show entries Search:

Date	User Id	Medicare ID	Action
2019-05-29 15:16:55.456	XXXXXXX	XXXXXXXXXXXX	Edit Delete

Showing 1 to 1 of 1 entries Previous Next

Figure 116: Pre-Claim Review Submission Sub-tab - Continued

Ordering / Referring Physician Information

NPI*	<input type="text"/>		
Name*	<input type="text"/>	Address Line 1*	<input type="text"/>
Address Line 2	<input type="text"/>	City*	<input type="text"/>
State*	<input type="text" value="▼"/>	Zip*	<input type="text"/>

Attending / Certifying Physician Information

NPI*	<input type="text"/>		
Name*	<input type="text"/>	Address Line 1*	<input type="text"/>
Address Line 2	<input type="text"/>	City*	<input type="text"/>
State*	<input type="text" value="▼"/>	Zip*	<input type="text"/>

Episode 1 Information



Pre-Claim Review Episode Start Date*	<input type="text"/>	Pre-Claim Review Episode End Date*	<input type="text"/>
Type of Bill (TOB)*	<input type="text" value="▼"/>	HCPCS Code(s)* 	<input type="text" value="Select HCPCS Codes by holding down the ctrl key while making selections."/>

Dynamic Tree

Q1: Was the beneficiary admitted to your home health agency directly from an acute or post-acute facility?* Yes No

The Dynamic Tree section will dynamically expand and present questions based on information entered. In this section you will be prompted to attach corresponding documentation. You may submit PDF attachments up to 40 megabytes (MB) each to a form. While there is no limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB. Once an attachment is uploaded, it can be referenced for subsequent answers. In the 'Refer to another Task for Task# Attachment' field, select the task number that contains the uploaded attachment from the drop-down menu. A list of all attachments will be displayed in the Attached Files section at the bottom of the page.

Figure 117: PCR – Attached Files

Attached Files							
File Name	Episode Start Date	Episode End Date	Episode Number	File Size (in bytes)	File Type	File Description	Action
File1	07/01/2019	08/01/2019	1	8216891	application/pdf	Task 1: The actual F2F clinical encounter note used by the certifying physician to justify the referral for Medicare home health services	
File2	07/01/2019	08/01/2019	1	8450611	application/pdf	Task 2: The HHA generated records that have been signed, dated, and incorporated into the certifying physician's medical records	

Total File Size: 16 MB
Max Allowed: 150MB

Showing 1 to 2 of 2 entries « First « Prev 1 Next » Last »

*Required Field

Save Submit Clear

Once the initial episode information is entered on the form, including all dynamic tree questions, the system will prompt the user to enter Episode 2 information by asking “Is there a subsequent episode?” If Yes, Episode 2 fields will populate for user entry. Once all episodes are entered, the form can be submitted.

Figure 118: PCR – Multiple Episodes

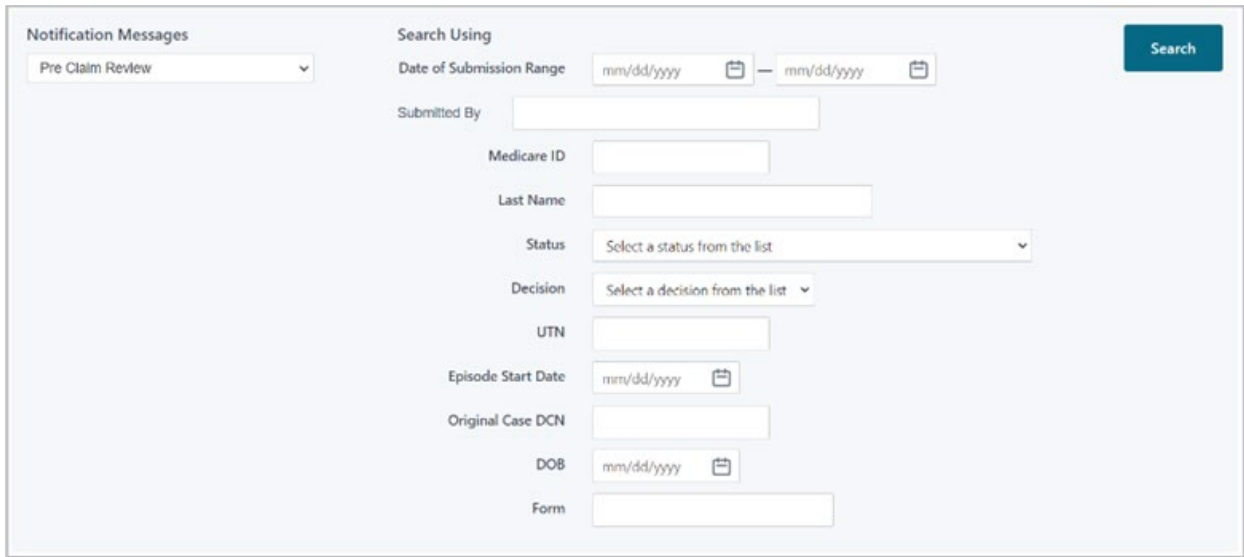
Episode 2 Information

Is there a subsequent episode?* Yes No

Once you submit the form:

- You will receive a Notification Center inbox message.
- Additional details and the status will be included as it becomes available. For example, the document control number (DCN) for your submission will be added. This may take 24–48 hours (not including weekends or holidays) to receive.
- Subsequent details for the UTN, decision, and decision letter will generally come to follow as the request processes. Find your related PCR inbox messages easily using the secure inbox filtering feature.
- Select Pre-Claim Review from the Notification Type drop-down menu.
- Enter a sub-filter (Medicare ID, Episode Start Date, and/or UTN).
- Select the Search button.
- Refer to section 15.0 for additional information on inbox filtering.

Figure 119: PCR – Inbox Filtering



If you receive a decision of partially affirmed or non-affirmed you may enter the updated request from the Pre-Claim Review Submission tab. Note that this request is a resubmission by selecting the 'yes' option for the 'Is this a resubmission' question in the Provider Information section. Enter the UTN for the request you are resubmitting and select 'Get Previous Submission Information'. Editable fields can be changed as applicable. Once updated, the form can be resubmitted. The resubmission will be assigned a new DCN and UTN.

Figure 120: PCR – Resubmission

Is this a Resubmission?* Yes No

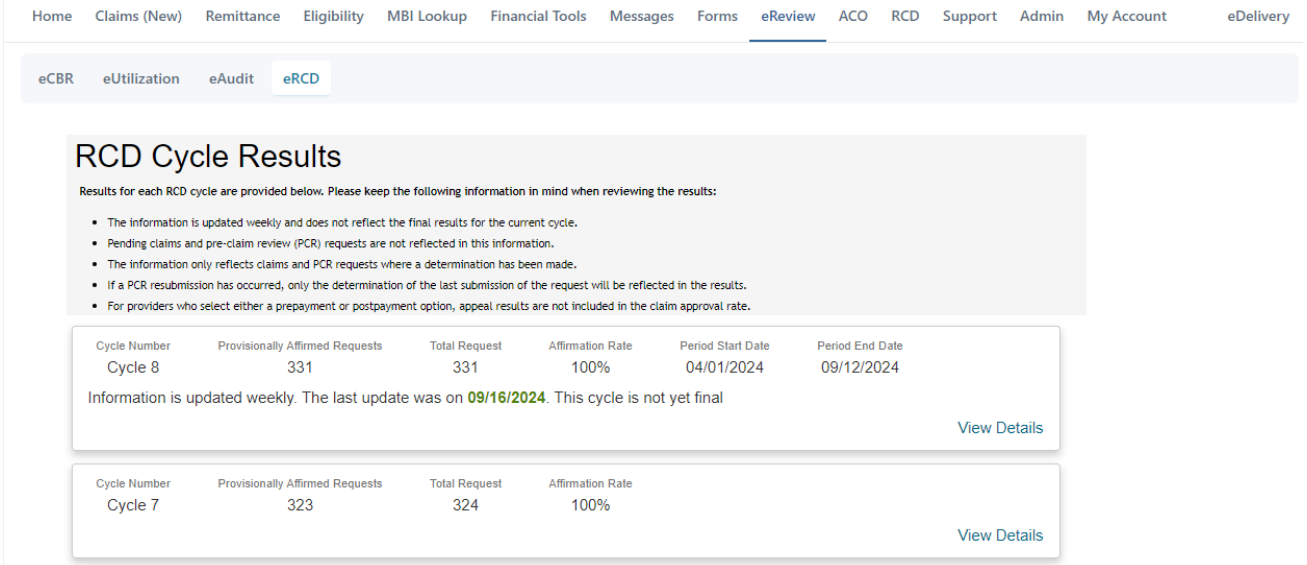
UTN*

Get Previous Submission Information

16.3 RCD Cycle Results (eRCD)

The RCD Cycle Results eRCD sub-tab is located under the eReview tab at the top of the page. Medicare providers who need to make review option choices for the Review Choice Demonstration will have access to the RCD Cycle Results eRCD sub-tab.

Figure 121: RCD Cycle Results (eRCD) Sub-Tab



Home Claims (New) Remittance Eligibility MBI Lookup Financial Tools Messages Forms **eReview** ACO RCD Support Admin My Account eDelivery

eCBR eUtilization eAudit **eRCD**

RCD Cycle Results

Results for each RCD cycle are provided below. Please keep the following information in mind when reviewing the results:

- The information is updated weekly and does not reflect the final results for the current cycle.
- Pending claims and pre-claim review (PCR) requests are not reflected in this information.
- The information only reflects claims and PCR requests where a determination has been made.
- If a PCR resubmission has occurred, only the determination of the last submission of the request will be reflected in the results.
- For providers who select either a prepayment or postpayment option, appeal results are not included in the claim approval rate.

Cycle Number	Provisionally Affirmed Requests	Total Request	Affirmation Rate	Period Start Date	Period End Date
Cycle 8	331	331	100%	04/01/2024	09/12/2024

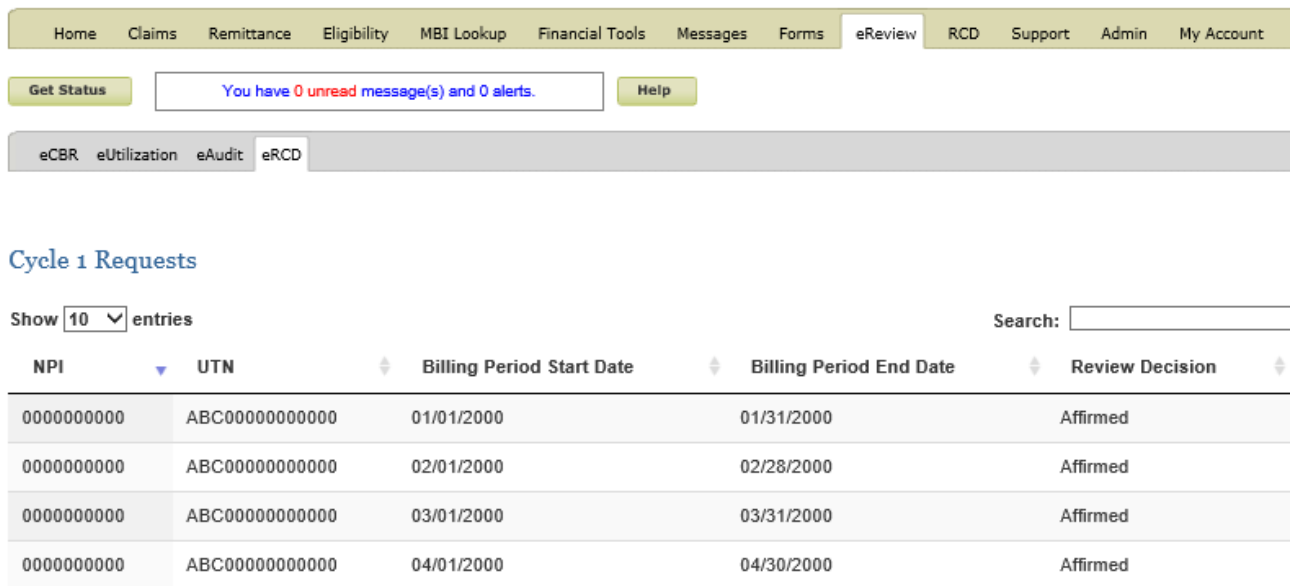
Information is updated weekly. The last update was on **09/16/2024**. This cycle is not yet final

[View Details](#)

Cycle Number	Provisionally Affirmed Requests	Total Request	Affirmation Rate
Cycle 7	323	324	100%

[View Details](#)

Figure 122: RCD Cycle Result Details



Home Claims Remittance Eligibility MBI Lookup Financial Tools Messages Forms **eReview** RCD Support Admin My Account

Get Status You have 0 unread message(s) and 0 alerts. **Help**

eCBR eUtilization eAudit **eRCD**

Cycle 1 Requests

Show entries Search:

NPI	UTN	Billing Period Start Date	Billing Period End Date	Review Decision
0000000000	ABC00000000000	01/01/2000	01/31/2000	Affirmed
0000000000	ABC00000000000	02/01/2000	02/28/2000	Affirmed
0000000000	ABC00000000000	03/01/2000	03/31/2000	Affirmed
0000000000	ABC00000000000	04/01/2000	04/30/2000	Affirmed



Note: Please keep the following in mind when reviewing the results:

- The information is updated weekly and does not reflect the final results for the current cycle.
- Pending claims and pre-claim review (PCR) requests are not reflected in the information.
- The information only reflects claims and PCR requests where a determination has been made.
- If a PCR resubmission has occurred, only the determination of the last submission of the request will be reflected in the results.
- For providers who select either a prepayment or post payment option, appeal results are not included in the claim approval rate.

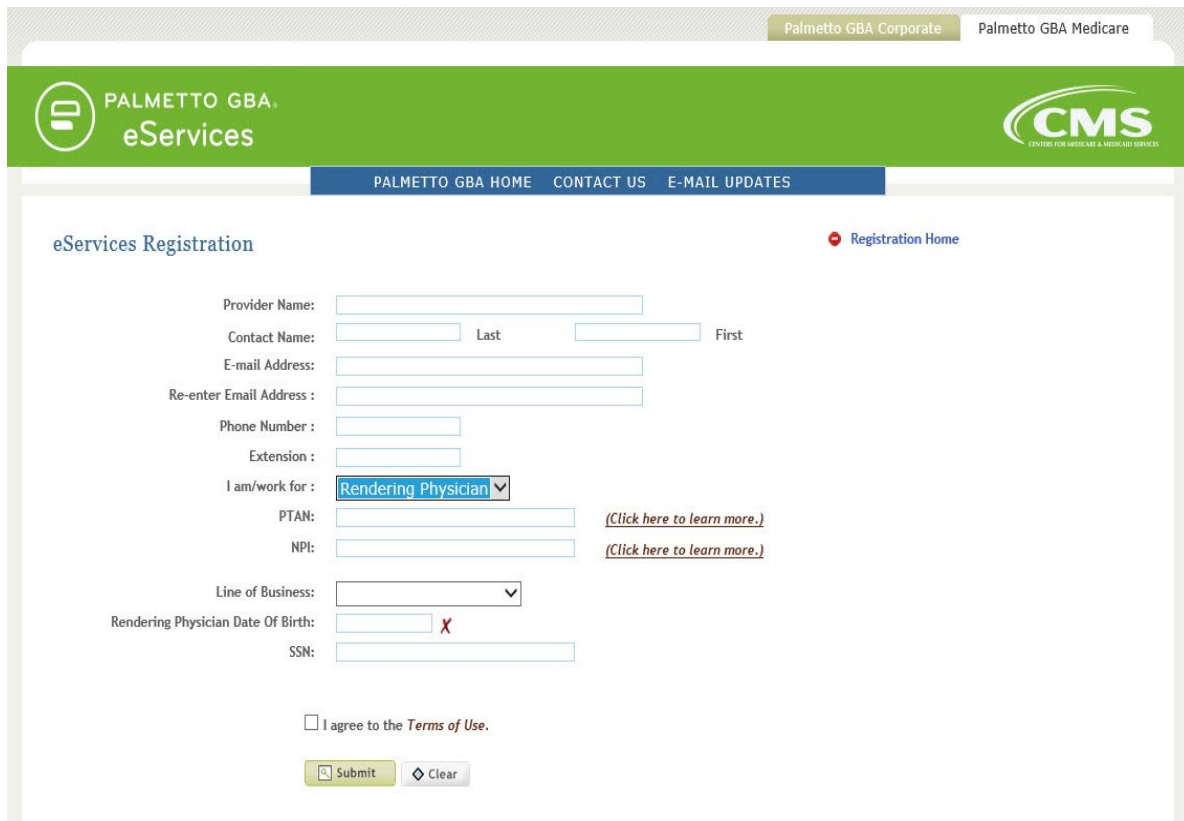
17.0 Rendering Physician Accounts

17.1 Registration

JM Part B rendering physicians who are currently listed in PECOS may register for a rendering physician account in eServices. You must enter the information listed below to register:

- Provider name
- Contact name (The person assigned to this user ID)
- Email address
- Phone number
- Extension
- Rendering physician indicator (After selecting this option from the drop-down list, the registration screen will update to show the remaining required fields for rendering physicians)
- PTAN
- NPI
- Line of business: choose from drop-down selections
- Rendering physician date of birth
- SSN

Figure 123: Rendering Physician Registration



The screenshot shows the 'eServices Registration' page for a 'Rendering Physician'. The page header includes 'PALMETTO GBA eServices' and 'CMS CENTER FOR MEDICARE & MEDICAID SERVICES'. Navigation links for 'PALMETTO GBA HOME', 'CONTACT US', and 'E-MAIL UPDATES' are visible. The registration form contains the following fields and elements:

- Provider Name: [Text Input]
- Contact Name: [Text Input] Last [Text Input] First
- E-mail Address: [Text Input]
- Re-enter Email Address: [Text Input]
- Phone Number: [Text Input]
- Extension: [Text Input]
- I am/work for: [Dropdown Menu] (Selected: Rendering Physician)
- PTAN: [Text Input] ([Click here to learn more.](#))
- NPI: [Text Input] ([Click here to learn more.](#))
- Line of Business: [Dropdown Menu]
- Rendering Physician Date Of Birth: [Text Input] (Error: X)
- SSN: [Text Input]
- I agree to the [Terms of Use](#).
- [Submit] [Clear]

You must also agree to the Terms of Use to register. If you have entered registration information in an incorrect format, the eServices application will display an error message in red at the top of the screen. Carefully read that error message and enter the information again. If the information you enter matches the information on file with PECOS, you will be able to choose a password and security questions and answers.

Once this is completed, you will receive an email at the email address you registered. You must access the email and click on the validation link. If you do not click on the validation link and you try to log in, you will see the profile screen where you can update or correct your email address and submit. If your email address is correct, you may click on the link to request a new email. Please make sure your email address is correct on your profile before calling Palmetto GBA for assistance.

Generic user names are **not** permitted. Each user of eServices must have a unique user ID and password. This means that we expect each user to have a legitimate first and last name. Generic first and last names are not permitted. Examples of generic user names are: Front Desk, Account Coordinator, Billing Department, User A, or the name of your provider office. No sharing of user IDs and passwords is permitted. Palmetto GBA will delete, without notice, any user names we find that are generic.

17.1.1 Minimum System Requirements

To optimize usability of eServices, we recommend that users verify their system adheres to the requirements outlined in [section 1.11](#).

17.1.2 Password Requirements

You will automatically be assigned a user ID in a format defined by CMS. You will be allowed to choose your own password. Your password is case sensitive and must meet the requirements outlined in [section 2.2](#).



17.1.3 Choosing Security Questions

You will be prompted to select security questions and input your answers as part of the registration process. These questions will be used in the event that you forget your password. Please refer to [section 2.3](#) for additional information regarding security questions and their requirements.

17.1.4 Validating Your Registration

After successfully entering your registration information, you will be redirected to the eServices login page and prompted to verify your profile. An email will be sent to the email address provided during registration and will contain a verification link. You will need to click the link or copy and paste it into your browser's address bar to verify your email address and complete the registration process. The link will direct you to the eServices login page. A message will display on the page advising you that your account has been successfully verified and you may now log in.

If you are sure your email address is correct, but you do not receive your email, your company's email security settings may need to be updated to allow incoming emails from Palmetto GBA. The email address you will be receiving the validation email from is ops.no.reply@palmettogba.com.

17.1.5 Registration Troubleshooting

In the event that your registration attempt is unsuccessful, an error message will display advising you of the issue. Correct your entries as needed and try again. Failure to successfully register eight times in a row will result in being locked out of the registration process for one hour. Once the registration lockout period has expired, you may try to register again. Continued failed registration attempts will result in a full registration lockout and an error message advising you to verify your identity. Please contact your Medicare Contractor for assistance.

17.2 Login

Once you have successfully registered for your eServices rendering physician account and verified your profile, you will be able to log into eServices with the user ID assigned to you during your registration. Access our eServices introduction screen and enter your user ID and password. You will then be directed to the multifactor authentication (MFA) screen to request an MFA verification code and complete the login process.

NOTE

A log out link is located in the upper right of each screen, once you have logged in. You must log out to end your session. If you do not log out, your user ID will be locked for one hour.

17.2.1 Multi-factor Authentication (MFA)

To enhance the security of Medicare data, CMS requires the use of multi-factor authentication (MFA) in eServices. After successfully entering your user name and password, you will be

directed to the MFA verification screen where you will need to enter an MFA verification code to complete the login process. Please review [section 3.12](#) for additional information on MFA.

17.2.2 Access Expiration

Palmetto GBA and CMS are dedicated to keeping your information safe. Palmetto GBA will disable any user that has not logged in for the past 30 days or clicked the link in the prevent account suspension email per CMS security requirements. It is recommended that all users log into their account at least once every 30 days or click the link in the prevent account suspension email to keep their access current.

17.2.3 Session Timeouts

To be in compliance with CMS security requirements, your eServices session will timeout after 30 minutes of inactivity. A notification box will display when you are approaching your inactivity limit.

17.2.4 Login Troubleshooting

You must enter your password exactly as it was entered when you chose it. If you do not remember your password, you can click on the 'Forgot or Change Your Password?' link from the returning user box of the eServices introduction screen. You will be presented with two security questions to answer. You must answer both security questions correctly to reset your password. Please refer to [section 3.5](#) for additional information on using the forgot your password tool.

If you attempt to log in incorrectly three times in a 120 minute period, you will be locked out of eServices. To unlock your account, you must contact your Medicare Contractor to verify your identity and regain access.

You can verify or change your security questions and answers through your My Account tab once you are logged in.

NOTE

You cannot change your password more than one time for every 24-hour period. Keep in mind that if you are logged into eServices and you want to exit, click on the log out link in the upper right of every page. If you do not do this, you will be locked out for one hour. We do not unlock accounts that are in the one hour lockout period.

If you cannot find your user ID, please contact your Medicare Contractor for assistance.

Rendering physician accounts only have access to the eReview functions in eServices. If you need access to additional features in eServices i.e., eligibility lookup, form submission, electronic remittances, etc., you will need access to an eServices account associated with the PTAN/NPI combination that matches your billing provider's EDI enrollment agreement with Palmetto GBA.



17.3 eReview

Palmetto GBA gives rendering physicians access to eReview functions to review and analyze their Medicare billing activity.

The electronic Comparative Billing Reports (eCBRs) are an educational tool for providers to use in order to provide insight into your billing patterns and utilization of services in comparison to your peers. Providers can use this information to conduct a self-audit to ensure they are in compliance with the Medicare regulations and prevent improper claims submission in order to avoid possible pre or post-pay medical review. Please see [section 11.1](#) for additional information on eCBR.

Electronic Utilization (eUtilization) reports offer rendering providers access to their personal data. This data can be reviewed to ensure you are aware of when and by whom your NPI is being used for billing Medicare services and when you are notated on a Medicare claim as the ordering referring physician. This will provide you with the ability to identify possible misuse of your NPI. Please refer to [section 11.2](#) for more information on the eUtilization reports.

Electronic Audit (eAudit) reports offer a dashboard of audit results for claims which have been sampled by review contractors for Complex Medical Review. eAudit gives providers the opportunity to see what claims may be pending a complex medical review currently and the results of any recent medical review activities. This information can be used for self-assessment of provider performance on Medicare audits utilizing the dashboard containing common denial reasons. Please reference [section 11.3](#) for further information on eAudit reports.

17.3.1 eReview Troubleshooting

Rendering physicians may not have eReview data available for the reports, topics, and/or timeframes available in eServices. In these instances an error message will display advising you no data is available. If you receive an error message advising that the system eServices access for eReview information is not available, please try your request again later. If you continue to receive the error, please contact your Medicare Contractor.

17.4 Profile Verification

Palmetto GBA and CMS are dedicated to ensuring that access to Medicare data is secure. To do this, CMS requires that all users regularly verify and/or update the information on their eServices profile. This includes validating the user's email address listed on their profile. This must occur for Palmetto GBA to continue to offer eServices. We appreciate your effort to help us keep Medicare data secure.

If you have not completed profile verification for your user ID within the last 240 days, your ID will move into the profile verification period. You will be prompted to complete the profile verification process when you log into eServices. If your profile has not been verified and/or updated within 10 days of entering the profile verification period, your access will be restricted to your My Account tab until this process is completed. If your profile has still not been verified within 250 days of your last profile verification, your user ID will become permanently deactivated and you must re-register.

17.4.1 Profile Verification Troubleshooting

Once you register or update your profile, you will receive an email with a link to validate your access. Make sure that you are logged out of your account before clicking on the link in your email. Once this is completed, you will be able to log in to eServices. If you do not click on the validation link and you try to log in, you will see your profile screen where you can update or correct your email address and submit.

If your email address is correct but you did not receive the email, you may use the request new email button to have another email sent. The process of receiving the email may take a while and is based on your email client configuration and the security configuration of your network. You may have to refresh your inbox to make sure all emails have been received.

If you are sure your email address is correct, but you do not receive your email, your company's email security settings may need to be updated to allow incoming emails from Palmetto GBA. The email address you will be receiving the validation email from is ops.no.reply@palmettogba.com.

If you still do not receive your validation email, please contact your Medicare Contractor for further assistance. Please make sure your email address is correct on your profile before calling Palmetto GBA for assistance.

18.0 Review Choice Demonstration (RCD) Inpatient Rehabilitation Facility (IRF)

The Review Choice Demonstration – Inpatient Rehabilitation Facility program initiated by CMS to review claims/services for inpatient rehab services. The demonstration will help ensure that payments for inpatient rehab services are appropriate through either pre-claim, prepayment or post payment review.

Multiple sub-tabs will display under the RCD tab depending on the provider's review choice selection and the user's permissions.

Figure 124: Review Choice Selection Page (IRF)

Inpatient Rehab Facility Review Choice Selection

Contract/Region 10111/Part A Alabama	Provider Name _____	Provider Number (PTAN) _____	National Provider Identifier (NPI) _____
---	------------------------	---------------------------------	---

Status

Current Choice Selection:	None
Choice Selection Period Status:	Open
Choice Selection Period End Date:	06/28/2023

Review Choice as of

Please select from one of the review choice options for medical review of your inpatient rehabilitation facility claims. Be sure to read each option thoroughly prior to making a selection. Once this period ends you will be unable to change your review choice until the next selection period or cycle period.

For more information about this topic, please see the Review Choice category at www.PalmettoGBA.com

Post-Payment Review Post Payment Review - 100% of claims are reviewed after final claim submission. If this option is selected, you will participate in the option until the next selection period.

Pre-Claim Review (PCR) Pre-Claim Review (PCR) - 100% of claims are reviewed prior to final claim submission. If this option is selected, you will participate in the option until the next selection period.



18.1 RCD Choice Selection Sub-tab

The RCD Choice Selection sub-tab is where IRF providers will make their review choice selection. AT the beginning of the demonstration, providers will have two review choices, Pre-Claim Review and Post Payment.

Important information about RCD selection:

- Providers should read each option thoroughly prior to making a selection as some review choice selections require the provider to remain in that choice for the duration of the demonstration.
- Only eServices provider administrators are able to make the review choice selection.
- The selection period will last for multiple weeks and the page will inform providers when the selection period ends. Providers can change their selection as often as they wish during the selection period.
- Multiple selections can be made in one day. Only the last one of the day will be processed.
- The page will indicate the selection is In Processing until the selection updates overnight.
- Under History, the last five selections can be viewed.
- Once the selection period ends, providers will not be able to change the review choice selection until the next selection period begins. The page will display the start of the next selection period.
- If no selection choice is made before the selection period ends, the default choice will be the provider's selection.

18.2 Pre-Claim Review (PCR) Submission Sub-tab

Inpatient Rehabilitation Facilities that have chosen Pre-Claim Review Selection Choice Demo will have the ability to send PCR requests in eServices. The Pre-Claim Review Submission sub-tab is located under the RCD tab at the top of the page. To access the form, you will need the Pre-Claim Review permission. Provider administrators will have this permission by default and can grant this permission to other users.

- You have the option to save, submit, or clear the form. In order to save, the user must have completed through the Beneficiary Information section.
- You may submit PDF attachments up to 40 megabytes (MB) each to a form. While there is no limit to the number of files that can be attached to this form, the combined size of all attachments cannot exceed 150 MB.
- The questions in the second portion of the form must be answered as Yes or No. Within the questions you will be asked to upload attachments as tasks. You must upload at least one document. You can reference documents previously uploaded in other tasks. A list of all attachments will be displayed in the Attached Files section at the bottom of the page.

Figure 125: Pre-Claim Review Form



- Immediately upon submission of the form, you will receive a message that the form was received.

18.3 Tracking the status of a Pre-Claim Review (PCR) Submission

Within 24 hours, Monday through Friday, you will receive official acknowledgement of receipt when a Document Control Number (DCN) is assigned for tracking.

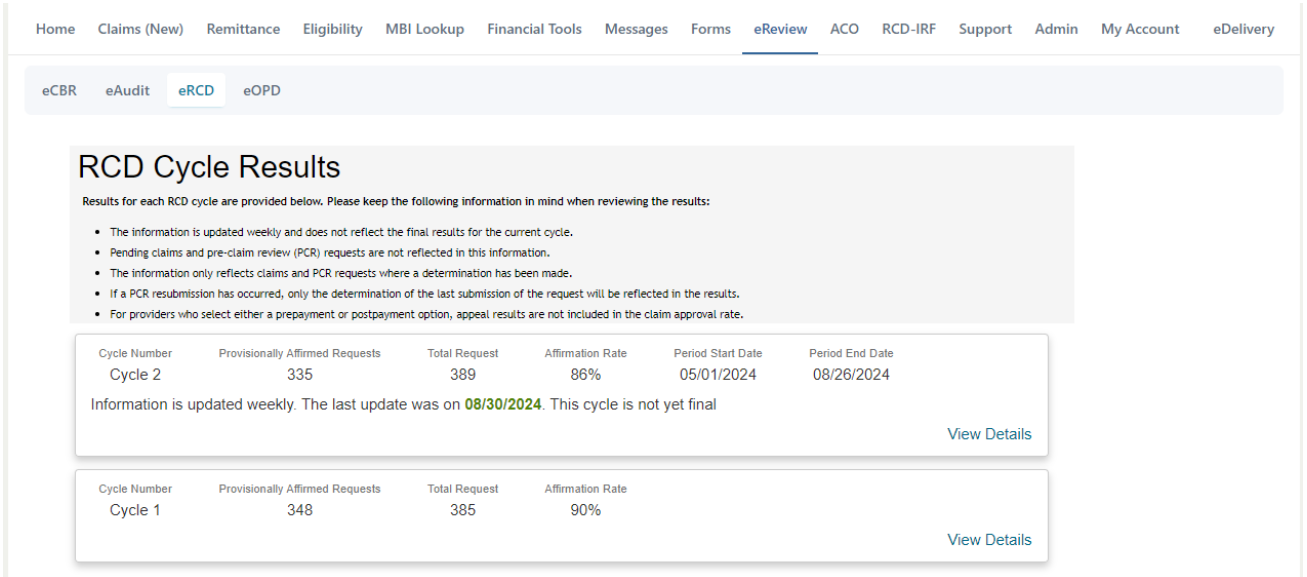
The Messages Function allows you to track the progress/status of your PCR submission. Besides displaying the DCN, it will be updated with the UTN and Decision. See Section 15 of the User Guide for more information on the Messages Inbox Function.

If you receive a decision of non-affirmed, you may submit a resubmission. On the PCR form click the radio button “Yes”, that the request is a resubmission. You will be prompted to enter the UTN. Once you enter the UTN, click the Get Previous Submission button to retrieve all of the information you entered on the initial form submission. For a resubmission, information must be changed and/or additional documentation must be uploaded to the initial submission.

18.4 RCD Cycle Results

The RCD Cycle Results eRCD sub-tab is located under the eReview tab at the top of the page. You can view your results during the current cycle and also see your results for prior cycles.

Figure 126: RCD Cycle Results



Home Claims (New) Remittance Eligibility MBI Lookup Financial Tools Messages Forms **eReview** ACO RCD-IRF Support Admin My Account eDelivery

eCBR eAudit **eRCD** eOPD

RCD Cycle Results

Results for each RCD cycle are provided below. Please keep the following information in mind when reviewing the results:

- The information is updated weekly and does not reflect the final results for the current cycle.
- Pending claims and pre-claim review (PCR) requests are not reflected in this information.
- The information only reflects claims and PCR requests where a determination has been made.
- If a PCR resubmission has occurred, only the determination of the last submission of the request will be reflected in the results.
- For providers who select either a prepayment or postpayment option, appeal results are not included in the claim approval rate.

Cycle Number	Provisionally Affirmed Requests	Total Request	Affirmation Rate	Period Start Date	Period End Date
Cycle 2	335	389	86%	05/01/2024	08/26/2024

Information is updated weekly. The last update was on **08/30/2024**. This cycle is not yet final

[View Details](#)

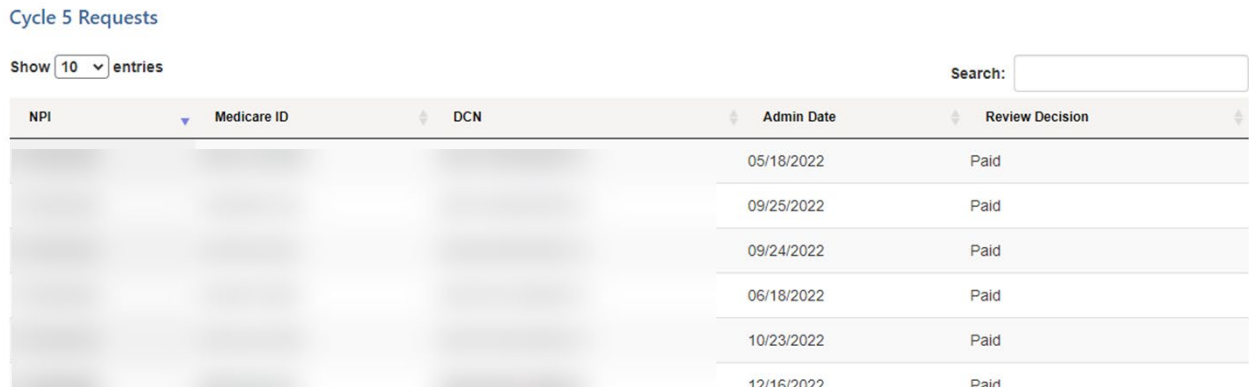
Cycle Number	Provisionally Affirmed Requests	Total Request	Affirmation Rate
Cycle 1	348	385	90%

[View Details](#)

- Note: Pending claims and PCRs without determinations are not included.

If you click on the View Details link, you can see the specific claims that contributed to the results.

Figure 127: RCD Cycle Results Details



Cycle 5 Requests

Show **10** entries Search:

NPI	Medicare ID	DCN	Admin Date	Review Decision
			05/18/2022	Paid
			09/25/2022	Paid
			09/24/2022	Paid
			06/18/2022	Paid
			10/23/2022	Paid
			12/16/2022	Paid

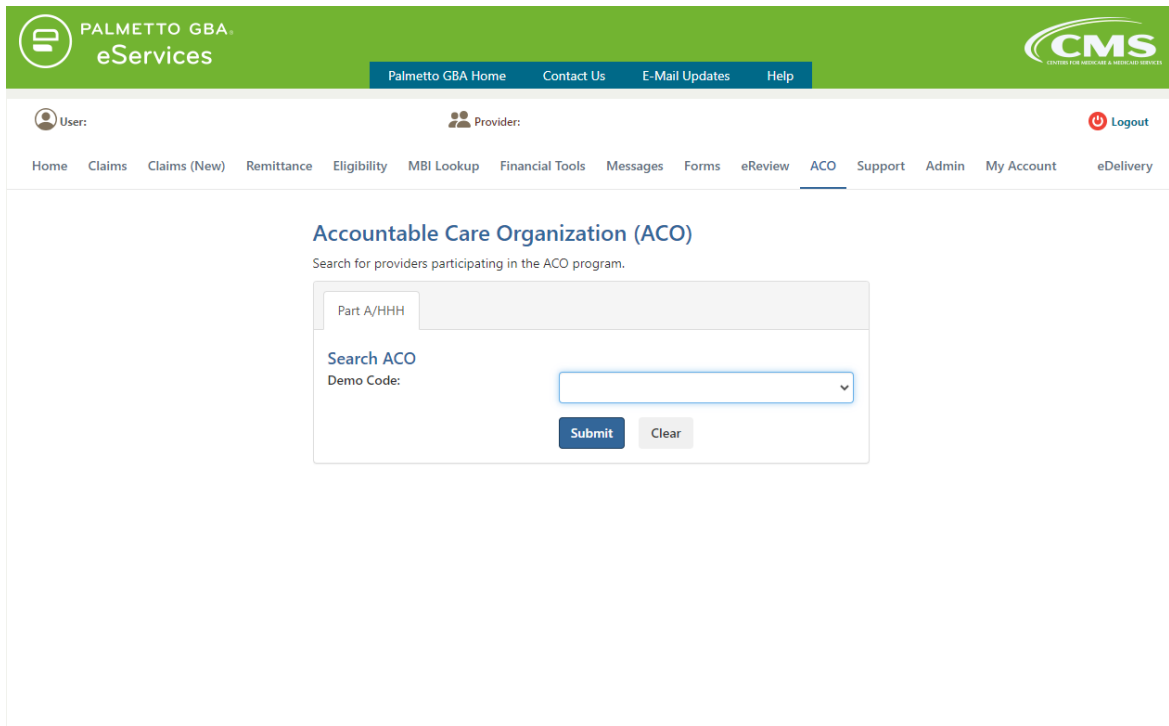
19.0 Accountable Care Organization

Accountable Care Organizations (ACO) are assembled from various providers and hospitals to ensure high quality care to Medicare beneficiaries. The providers voluntarily come together to give coordinated high quality care to their patients.

Information related to the models (ACO types) can be found on the ACO menu tab. The ACO menu tab is available to provider account administrators who then can grant permission to other account users to see this information.

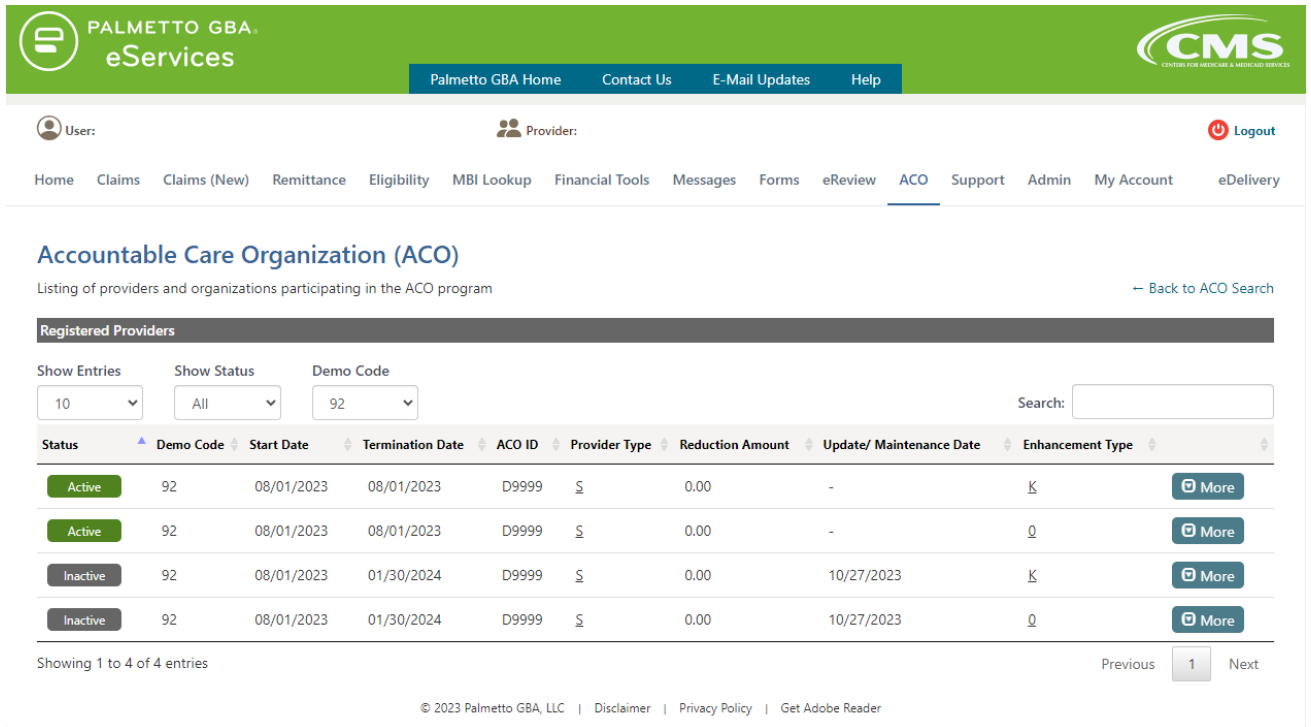
Part A providers will need to select a specific model or demo code to see their provider's results. Part B providers will not need to select a model.

Figure 128: Part A Search Screen



The screenshot shows the Palmetto GBA eServices interface. At the top, there is a green header with the Palmetto GBA logo and 'eServices' text on the left, and the CMS logo on the right. Below the header is a navigation bar with links: Palmetto GBA Home, Contact Us, E-Mail Updates, and Help. A secondary navigation bar contains 'User:', 'Provider:', and 'Logout'. A main navigation menu includes: Home, Claims, Claims (New), Remittance, Eligibility, MBI Lookup, Financial Tools, Messages, Forms, eReview, ACO (highlighted), Support, Admin, My Account, and eDelivery. The main content area is titled 'Accountable Care Organization (ACO)' and includes the instruction 'Search for providers participating in the ACO program.' Below this is a search form with a dropdown menu set to 'Part A/HHH', a 'Search ACO Demo Code:' label, a text input field, and 'Submit' and 'Clear' buttons.

Figure 129: Part A Results Screen



Accountable Care Organization (ACO)
Listing of providers and organizations participating in the ACO program [← Back to ACO Search](#)

Registered Providers

Show Entries: 10 | Show Status: All | Demo Code: 92 | Search:

Status	Demo Code	Start Date	Termination Date	ACO ID	Provider Type	Reduction Amount	Update/ Maintenance Date	Enhancement Type	
Active	92	08/01/2023	08/01/2023	D9999	<u>5</u>	0.00	-	<u>K</u>	More
Active	92	08/01/2023	08/01/2023	D9999	<u>5</u>	0.00	-	<u>Q</u>	More
Inactive	92	08/01/2023	01/30/2024	D9999	<u>5</u>	0.00	10/27/2023	<u>K</u>	More
Inactive	92	08/01/2023	01/30/2024	D9999	<u>5</u>	0.00	10/27/2023	<u>Q</u>	More

Showing 1 to 4 of 4 entries | Previous **1** Next

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The results can be sorted and filtered. Click the More button to get additional details about the model. The values that are underlined can be clicked to view additional information.

If your provider is not participating in an ACO, the page will display a message, similar to, “No data found”.