TRUECARE™ | Partner with Purpose

USER GUIDE FOR TRUECARE PROVIDER PORTAL

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I - Claims

Submit Claims Online

It is easy to submit your claims online through the Provider Portal. Follow these simple steps:

1. From the "Claims" menu, click "Online Claim Submission."
   NOTE: The dashboard for online claims submission opens in a separate browser window.

2. Click "New Claim." If needed, select the appropriate provider from the "Providers" list. Based upon the type of claim you want to submit, select the appropriate option from the "DocType" list.
   - HCFA – used for claim submission for physicians and suppliers.
   - UB – institutional providers.
3. Complete the necessary fields for each part of form and click Submit.
   NOTES:
   - Please refer to your Provider Manual for submitting other claim types.
   - You must complete all required fields before submitting your claim.
   - You can complete Coordination of Benefit (COB) information and submit it with your claim.
   - You can add attachments as necessary to your claim up to 100 MB.

Submit a Corrected Claim

Use the "Claims" > "Online Claim Submission" to enter the corrected claim. Enter the original claim number in the "Document Control" field and enter "7" in "Box 22" to indicate it is a replacement to a previously submitted claim.

View Claim Status

After you have submitted a claim, you can check the status of any claim you have submitted in the last 24 months. We update our claim statuses daily. If there were issues receiving your claim for processing, you can also check the "Rejected Claims" page for additional information. If you locate your claim on the "Rejected Claims" page, you must make any corrections needed and resubmit it in order for it to be processed.

1. From the "Claims" menu, click "Claim Information and Attachments."
2. Enter your search criteria to locate the claim using any of the available options, and then click "Search." The search results and member information display at the bottom of the page. You can enter multiple claim numbers, if needed, when searching by claim number.
3. When the claim appears in the "Claim Summary" section of the page, do one of the following to view more details:
   - Click "View Details" to view additional information, such as the process reason, adjustment reason and remittance reason. While viewing the claim details, you can view the information in the "List View" or the "Table View" to review details for each line of your claim.
   - Click the Explanation of Payment (EOP) link to view what is available for the claim.

Submit Medical Records for Denied Claims

A "Document Upload" tab is available on the "Claims Detail" view when a claim is denied due to missing medical records. Use this option to upload documentation instead of submitting an appeal or corrected claim.

To upload documentation for a denied claim, do the following:

1. From the left-hand "Claims" menu, click "Claim Information and Attachments". You can locate the claim in question by using one of the search criteria available on the page.
2. Click the "View Detail" link for the denied claim.
3. On the "Document Upload" tab, review the reason the claim was denied and then upload the appropriate documentation. The file size is limited to 100 MB.
4. Complete the required fields (marked with a red asterisk).
5. Add notes, if needed.
6. Click "Submit Documents."

NOTES:

- Please submit records that directly correspond to and support the billed services that were denied. Submitting an entire medical record versus documents related to a specific stay/visit could delay the processing turnaround time.
- The documents that are uploaded will be available on the "Attached Documents" tab approximately 30 minutes after they are uploaded.

Submit a Claims Recovery Request

Do the following to submit a Claim Recovery Request.

1. From the left-hand navigation menu, select "Claims" > "Recovery Request."
2. Complete the required contact and claim information.
3. Select the appropriate "Reason for Adjustment." If you select "Overpayment/Other," enter an explanation for your request.
4. Select a "Takeback Type." If you select "Partial Claim Takeback," enter the partial dollar amount you are requesting.
5. Enter the required "Primary Insurance Name" and "Subscriber's Policy Number" (and list the member ID).
6. Click "Add Claim" to add the entered claim information to your request.
7. Add the appropriate attachment and click "Submit Request."

Submit Medical Records Proactively for Claims

If you need to submit documentation for proper processing of your claim, you can upload it on the "Claim Information and Attachments" page.

1. From the left-hand navigation menu, select "Claims" > "Claim Information and Attachments."
2. Do one of the following to upload documentation:
    - If you have the claim number, search for the claim. After locating the claim, click "View Detail," and then upload the documentation using the "Document Upload" tab.
    - If you do not have the claim number, search for the member record. After searching for the member, enter the correct date of service for the claim you have submitted. Select the appropriate reason for submitting documentation, and then upload your attachments.
3. Enter your contact information before submitting your attachments.

NOTES:

- Attachment size is limited to 100 MB.
- If you are submitting documentation for a claim and do not indicate the specific claim number for which the documentation applies, the documentation will apply only to claims received after the receipt date of the consent form or hospital medical records. For example, documents uploaded on August 1, 2025, will systematically apply to claims received by TrueCare on or after August 1,

2025. It will not apply to claims received prior to August 1, 2025. To upload documents applicable to a previously submitted claim, you must enter the corresponding claim number when submitting the attachment to ensure systematic alignment.

II - Eligibility & Coverage

Check Eligibility and View Member Information

To check a member's eligibility for a specific date of service, do the following:

1. From the "Member Search" menu, click "Member Eligibility."
2. Click a tab to enter search information.
    a. TrueCare ID - Search defaults to TrueCare subscriber, unless you specifically include the suffix associated with the recipient of the service. Every member is their own subscriber; the suffix will be "00" for every member.
    b. Medicaid ID
    c. Member Info (name and date of birth)
    d. Case Number
    e. Multiple TrueCare IDs
    f. Multiple Medicaid IDs

    NOTE: If you are using a search option that allows multiple member IDs at once, you can either separate the multiple IDs with commas or utilize the Excel template to upload a spreadsheet of member IDs.

3. Enter the date of service. The date of service cannot be greater than the current date but can be up to 24 months in the past.

4. Click "Search" to display the search results.

    NOTES:
    - If a list of members displays, click the "View Details" link to view information for a specific member.
    - Eligibility for the member for the date of service you specified displays at the top of the screen. If a member is ineligible for service on the specified date, that message will appear in red.

5. The search results for a member displays in multiple sections.
    - Member Information displays:
        - Demographic information (e.g., address, ID numbers, phone, date of birth)
        - Program (or Plan) information
        - Link to a "Member Profile Report," if available. The Member Profile contains the following sections:
            - **Member Information.** Demographic information about the member and primary care provider (PCP)

- **Case Management.** Open or re-opened cases, if the member is in case management (case number, disease type, acuity and ACG stratification)
- **Admissions.** Up to five of the most recent hospital admissions (service date range, CPT code and description, and location name)
- **Emergency Room Visits.** Up to 15 of the most recent visits to an emergency room during the last six months (service date range, CPT code and description, and location name)
- **Pharmacy.** Up to 10 rows of three-month prescription summary by clinical category (clinical category, number of prescriptions filled in the category, narcotic flag)
- **Specialty.** Up to five rows of summary claims by provider specialty
- **Expanded Diagnosis Clusters (EDCs).** Up to 10 rows of medical claims summaries, using ACG-derived mapping for ICD codes to clinically relevant categories
- **Prescriptions by Clinical Category.** Unlimited number of rows provide details of the information in "Pharmacy" section grouped by clinical category (drug name, whether a brand or generic, date filled, prescribing provider, number of days' supply will last, quantity dispensed)

  - Primary Care Provider information.
  - Case Manager information, if applicable.

- Additional member information is available in the panels listed below the "Member Information". See the descriptions of each panel below.
  - **Subscriber Information.** Displays the subscriber's information, which may be different from the member's.
  - **Member Covered Benefits Summary.** Displays benefits available for the member as well as benefits that have been used, showing remaining benefits for the calendar year.
  - **Member Dental & Vision Services History.** Displays the dental and vision services used by the member.
  - **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Alerts.** Displays EPSDT alerts that are applicable to the member.
  - **Upload Consent Form.** Use to upload a member consent form for abortion, hysterectomy or sterilization claims.
  - **Clinical Alerts.** Displays information about the member's status for necessary visits and screenings, and whether any items are urgent.
  - **Assessments Taken.** Provides access to member assessments if the member is receiving care management.
  - **Care Treatment Plan.** For high-risk case management, disease management provides up-to-date patient medical info including health needs, psychosocial needs, socioeconomic needs, interventions, information related to progress toward meeting these needs.
  - **Triage Summaries.** Provides access to the member's triage summaries, if applicable, from recent hospital visits.

- **Admissions & Discharges.** Displays up to five of the most recent hospital admissions.
- **COB Information.** Displays primary insurance information for the member. To add or update COB information for the member, please refer to the following section.
- **Eligibility Spans.** Displays all effective and termination dates for a member.

View, Add or Update a Member's Coordination of Benefit (COB) Information

You can view a member's COB information (primary insurance) while viewing the "Member Information" panel. If you need to add or update COB for the member, do the following:

1. Search for the member using on the "Member Search" > "Member Eligibility" page.
2. After locating the member record, click the COB Information panel to review the applicable COB for the member. The following COB Information displays:
   - Carrier name
   - Policy and group numbers
   - Policy holder and member's relationship to the policy holder
   - Effective and term dates
   - Type of insurance

   NOTE: If a member has multiple pages of COB information, the most recent primary insurance information displays first.
3. To add COB information for the member, do the following:
   a. Click "Add COB Information."
   b. Fill out the applicable information.
   c. Click the check box if there are claims that must be adjusted due to this update.
   d. Click "Submit Request."
4. To edit COB information for the member, do the following:
   a. Click "Edit COB Information."
   b. Edit out the applicable information.
   c. Click the check box if there are claims that must be adjusted due to this update.
   d. Click "Submit Request."

NOTE: TrueCare will automatically adjust the claims that originally denied for COB when the claim meets the following criteria:

- Primary insurance has been updated retroactively to show coverage terminated AND
- If a claim denies for termed COB coverage from another payer, providers should submit updated COB information to TrueCare via the Provider Portal or along with a corrected claim submission. If the claim has denied after submitting new COB information to TrueCare through the Provider Portal, disputes can be submitted to TrueCare within 90 calendar days of the denial.

III - Prior Authorization

Submit Prior Authorization Requests

1. Click "Prior Authorization"
2. Click a tab:
   a. Medical (Inpatient & Outpatient)
      NOTE: Visit the "Prior Authorization" page for "Inpatient" and "Outpatient Elective" tip sheets.
   b. Status

Submit an inpatient or outpatient prior authorization:

1. Choose the "Medical (Inpatient & Outpatient)" tab (default).
2. Click the appropriate tab to enter the member's TrueCare ID, Medicaid ID, or name and date of birth (Member Info).
3. Click the "Search" button to display member information and the types of inpatient and outpatient authorizations.
4. Click the type of request.
   a. Does the member have other insurance?
      i. If "Yes," contact TrueCare Utilization Management at **1-833-230-2174**.
      ii. If "No," the rest of the form displays.

      NOTE: If this is for a retro authorization request, please follow the Submit a Retro Authorization process (immediately below). The Provider Portal may block retro authorizations from being submitted if the COB was not active on the date of service (DOS) but is now active.
5. Complete the "Member Information," "Provider Information" (servicing and ordering providers) and "Contact Information."
6. Click the "Submit Request" button.

Submit a Retro Authorization Request

1. From the "Providers" menu, select "Prior Authorization and Notifications."
2. Click the "Medical (Inpatient & Outpatient)" tab.
3. Click the appropriate tab to enter the member's TrueCare ID, Medicaid ID or name and date of birth (Member Info).
4. Enter the "Start Date of Service" and click "Search."
5. Click the COB Information tab and verify if the member has other insurance.
   NOTES:
   - The Provider Portal may block retro authorizations from being submitted if the COB was not active on the DOS but is now active.
   - If the member has other insurance (another authorization on file), contact the TrueCare Utilization Management team.
6. If neither of the two scenarios above apply, click "Verified" to continue the retro authorization.
7. Select the "Inpatient" or "Outpatient" authorization type.
8. Complete the "Member Information," "Provider Information" (servicing and ordering providers) and "Contact Information," then click "Continue."
9. If clinical documentation is needed, upload the appropriate information, then submit the authorization.

View Prior Authorization Status

1. Click the "Status" tab.
2. Click the appropriate tab to type the member's TrueCare Member ID, Medicaid ID, or

name and date of birth (Member Info).

3. Click the "Search" button to display member information and a list of authorizations, if any.
4. Click the "View Details" link for the status of the authorization you want to view.
   Note: If an authorization has multiple lines, click the link at the bottom of the page to view different lines.
5. Click the "X" in the upper right corner to close the status box and return to the Provider Portal.

IV – Disputes and Appeals

Submit a Dispute

File a claim payment dispute for a claim underpayment, a partially or fully denied claim (please see below for a few exceptions) or for an adverse claim payment decision.

A claim number is required to submit your claim dispute through the Provider Portal. Any supporting documentation should also be attached.

If the dispute is for an overpayment, please submit a Claim Recovery Request. If you do not agree with a claim recovery TrueCare has initiated, please use the dispute process.

NOTE: TrueCare is currently unable to receive dental appeals or disputes through the Provider Portal. If you need to submit an appeal or dispute involving a dental claim, please mail your submission to:

TrueCare
Attn: Grievance and Appeals
P.O. Box 1947
Dayton, OH 45401-1947

You can also fax your submission to **937-531-2398**.

The following should not be submitted as a dispute:

- If you are responding to a denied authorization that required medical necessity review, please submit an appeal.
- If you are submitting a request due to overpayment, please submit a Claim Recovery Request. However, only use this request if TrueCare overpaid a claim. If you do not agree with a claim recovery TrueCare has initiated with you, you should still follow the dispute process.
- If your claim was denied due to missing medical records, please upload the medical records.

To submit a dispute, do the following:

1. From the "Claims" menu, click "Claim Disputes."
2. Locate the claim for which you want to submit a dispute.
3. Complete the appropriate information and upload an attachment (up to 100 MB) if needed. At a minimum, the dispute must include:
   - Sufficient information to identify the claims in dispute.
   - A statement of why you believe a claim adjustment is needed.
   - Pertinent documentation to support the adjustment.
4. Click "Submit."

NOTE: You can return to the "Claim Disputes" page to check status of your dispute using the Claim ID or Dispute ID that was generated when you submitted the dispute.

Submit an Appeal

A post-service claim appeal can be submitted through the Provider Portal for any post-service claim issue that you do not agree with. To submit your claim appeal through the Provider Portal, you will need a valid claim number. For specific information regarding timely filing of appeals, please refer to your provider manual.

NOTE: Please do not submit the following items as appeals:

- Retroactive authorization requests
- Coordination of benefits updates
- New claims
- Corrected claims
- Claims that have denied due to missing documentation. See the "Submit Medical Records for Denied Claims" section.

To submit an appeal, do the following:

1. From the "Claims" menu, click "Appeals."
2. Locate the claim for which you want to submit an appeal.
3. Select the appropriate "Appeal Type" from the drop-down list.
4. Complete the remaining required information (marked with a red asterisk).
5. Enter the reason for the appeal and any other applicable information in the Notes box.
6. You can upload an attachment, up to 100 MB, that is necessary for your appeal.
7. Click "Submit Appeal."

NOTES:

You can return to the "Claim Appeals" page to check status of your appeal using the Claim ID or Appeal ID that was generated when you submitted the appeal.

Appeal acknowledgement and decision letters, when available, can be located on the "Provider Documents" page.

V – Provider Documents

The "Provider Documents" page provides visibility to many of the documents that are mailed to providers, such as:

- Appeal acknowledgement and decision letters
- Claim recovery notification letters
- Dispute decision letters
- Controlled substance scorecards
- Welcome letters
- Abortion, hysterectomy or sterilization consent forms that have been uploaded on the Provider Portal

To access the "Provider Documents" page, click the link above, or select "Provider Documents" from the "Providers" drop-down on the left-hand menu.