

Engolve Vision. Web Adjudication Denial Detection (WADD).

Use the website as normal and fill in the form to submit the claim. There is no new process necessary to enable this feature.

Unsubmitted Claim i
?

| | | |
|--|---|---|
| 2. Patient's Name WHEELER, CAROL A (submitting) | 3. Patient's BirthDate 11/15/1961 | 4. Insured's Name WHEELER, CAROL A (submitting) |
| 5. Patient's Address Merrill 5500 CENTER RD | 7. Insured's Address Merrill 5500 CENTER RD | |
| City BIRNAMWOOD | State WI | City BIRNAMWOOD |
| Zip 54414 | Phone 764-8887 | State WI |
| Physician's Name: DR.KILDARE, JAMES | | 11. Insureds Policy Group Or Feca #: W100000000 |
| | | a. Insured's Dob: |
| | | c. Insurance Plan / Program Name: MHS/NHP WI - Standard Plan |
| 19. Reserved For Local Use | | |
| 21. Diagnosis or Nature Of Illness Or Injury (RELATE items below to 24E By LINE) | | ODSP:ODCYL-ODAX: |
| 1367.0 2. 3. 4. 5. 6. | | OSSP: OSCYL- OSAX: |
| 7. 8. 9. 10. 11. 12. | | 23. Prior Auth# |
| | | 24. E |
| Date(s) Of Service | | |
| From | To | Pos |
| Tos | Cpt | Mod |
| Diag | Charges | Days Or Units |
| 1. 8/1/2015 | 8/1/2015 | 11 |
| | | 1 |
| | | 66984 |
| | | 1 |
| | | \$1.00 |
| | | 1 |
| Referring Provider: | | Ordering Provider: |
| Acct# | Total Charge | Paid |
| | \$1.00 | \$0.00 |
| | | \$1.00 |
| 32. Facility Address 112 PERFECT PARKWAY112 STANFORD IL 111122 | | 33. Billing Address 112 ZEBULON CT ROCKY MOUNT NC 27804 |

Submit
Print

Confirm the claim details and then click on "Submit" button to see any notifications that could possibly deny this claim.

Processing your request, please wait...
⌄
Submit
Print

Example of a possible Adjudication and Denial Notification(s) shown next to each service line affected.

| | | | | | | | | | | |
|---|--------------|--------|---------------------|-------|--------------------------------------|--------------------|---------|---|---|-------------|
| 19. Reserved For Local Use | | | | | | | | | | |
| 21. Diagnosis or Nature Of Illness Or Injury (RELATE items below to 24E By LINE) | | | | | ODSP:ODCYL:ODAX: OSSP:OSCYL:OSAX: | | | | | |
| 1.367.1 2. 3. 4. 5. 6. | | | | | | | | | | |
| 7. 8. 9. 10. 11. 12. | | | | | 23. Prior Auth# | | | | | |
| 24. E | | | | | | | | | | |
| Date(s) Of Service | | | | | | | | | | |
| From | To | Pos | Tos | Cpt | Mod | Diag | | | | |
| 1. 8/1/2015 | 8/1/2015 | 11 | 1 | 66984 | | 1 | \$55.00 | 1 |  | |
| Referring Provider: | | | | | Ordering Provider: | | | | | |
|  It's <i>possible</i> that the payment for this service will be denied and/or reduced. Rollover the image for details. | | | | | | | | | | |
| Acct# | Total Charge | Paid | Balance Due | | | | | | | |
| | \$55.00 | \$0.00 | \$55.00 | | | | | | | |
| 32. Facility Address | | | | | 33. Billing Address | | | | | |
| 112 PERFECT PARKWAY112 STANFORD IL 111122 | | | | | 112 ZEBULON CT ROCKY MOUNT NC 27804 | | | | | |
|  Continue | | | Continue w/ Comment | | | Retract This Claim | | | Print | Attachments |

Denied: Claim was not received within the timely filing or re-filing period. Refer to Plan Specifics for timely filing period guidelines.

This service was not submitted within the contract filing period. Please refer to Section C 11.2.1 of your contractual agreement.

Available Action(s)

1. Continue and send this claim as is. (Existing action)
 - a. Click on the "Continue" button.
2. Continue and Send claim with a message. (New Action)
 - a. Compose a response and Press the "Send Message" button.
3. Do not send this claim - Retract. (New Action)
 - a. Click on the "Retract This Claim" button.

Action 2

| | | | | | | | | | | |
|---|----------|-----|---------------------|-------|-------------------------------------|--------------------|---------|---------------|---|-------------|
| Date(s) Of Service | | | | | | | | | | |
| From | To | Pos | Tos | Cpt | Mod | Diag | Charges | Days Or Units | | |
| 1. 8/1/2015 | 8/1/2015 | 11 | 1 | 66984 | | 1 | \$55.00 | 1 |  | |
| Referring Provider: | | | | | Ordering Provider: | | | | | |
|  It's <i>possible</i> that the payment for this service will be denied and/or reduced. Rollover the image for details. | | | | | | | | | | |
|  Click Here to send us a message. Please provide any information the will help us approve any denied or pending services associated with this claim. | | | | | | | | | | |
| 32. Facility Address | | | | | 33. Billing Address | | | | | |
| 112 PERFECT PARKWAY112 STANFORD IL 111122 | | | | | 112 ZEBULON CT ROCKY MOUNT NC 27804 | | | | | |
|  Continue | | | Continue w/ Comment | | | Retract This Claim | | | Print | Attachments |

 **Click Here to send us a message.**
Please provide any information the will help us approve any denied or pending services associated with this claim.

You will **Not be able to **Retract** this claim once the message has been received.*

Physician's Name: DR. ZILDARE, JAMES Insured's Policy Group Or Feca #: WI190349SABS

19. Reserved For

21. Diagnosis or (RELATE items)

1 3 6 7 1 2 3 4 5 6

7 8 9 10 11 12

Date(s) Of Service

| From | To | Pos | Tos | Cpt | Mod | Diag | Charges | Days Or Units |
|------------|----|-----|-----|-----|-----|------|---------|---------------|
| 1 8/1/2015 | | | | | | | \$55.00 | 1 |

Referring Provider:

Ordering Provider:

It's *possible* that the payment for this service will be denied and/or reduced. Rollover the image for details.

SEND A MESSAGE

This is a Corrected Claim

Cancel
Send

After typing in your message, click on the "Send" button to submit this claim with comments.

Message received. Print Attachments

Action 3

| Date(s) Of Service | | | | | | | | | |
|--------------------|----------|-----|-----|-------|-----|------|---------|---------------|---|
| From | To | Pos | Tos | Cpt | Mod | Diag | Charges | Days Or Units | |
| 1 8/1/2015 | 8/1/2015 | 11 | 1 | 66984 | | 1 | \$55.00 | 1 | ⚠ |

Referring Provider: Ordering Provider:

⚠ It's *possible* that the payment for this service will be denied and/or reduced. Rollover the image for details.

| Acct# | Total Charge | Paid | Balance Due |
|-------|--------------|--------|-------------|
| | \$55.00 | \$0.00 | \$55.00 |

32. Facility Address 33. Billing Address

112 PERFECT PARKWAY112 STANFORD 112 PERFECT PARKWAY112 STANFORD CT ROCKY MOUNT NC 27804

⚠ Click Here to retract this claim.

Continue
Continue w/ Comment
Retract This Claim
Print
Attachments

"Confirm"

Continue
Continue w/ Comment
Confirm
CancelDelete
Print
Attachments

The Claim will be discarded from our database.

The submitter is then returned to the services entry screen.